BAY ARENAC BEHAVIORAL HEALTH

BOARD OF DIRECTORS
REGULAR MEETING

Thursday, January 15, 2026 at 5:00 pm
Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

AGENDA

Page

1. CALL TO ORDER & ROLL CALL

2. PUBLIC INPUT (3 Minute Maximum Per Person)

3. COMMUNICATIONS

4 — 3.1 Community Mental Health Association of Michigan (CMHA) New CEO Announcement – *See page 4*

5-6 — 3.2 Governor's order to lower flags in honor of former State Senator Joel Gougeon – *See pages 5-6*

4. REGULAR BOARD MEETING, 12/18/2025 – Distributed
   4.1 Motion on minutes as distributed

5. RECIPIENT RIGHTS (RR) ADVISORY & APPEALS COMMITTEE, 01/05/2026 – Distributed – McFarland, Ch/ Mrozinski, V Ch
   There were no motions forwarded to the full Board
   5.1 Motion on minutes as distributed

6. FINANCE COMMITTEE, 01/07/2026 – In packet – Banaszak, Ch/ Mrozinski, V Ch

7-8 — 6.1 Motion to accept investment earnings balances for period ending December 31, 2025 – *See pages 7-8*

3, 9 — 6.2 Res# 2601001 Approve the Finance January 2026 contract list with item 4 removed – *See page 3 resolution sheet & page 9*

3 — 6.3 Res# 2601002: Approve the amendment to the employment contract with Ashley Badour – *See page 3 resolution sheet*

3, 10-14 — 6.4 Res# 2601003: Approve the Madison Building expansion project feasibility study by TSSF Architects, Inc. for an amount not to exceed $9,995 – *See page 3 resolution sheet & pages 10-14*

15-17 — 6.5 Motion on minutes as revised – *See pages 15-17*

7. PROGRAM COMMITTEE, 01/08/2026 – Distributed – Girard, Ch/ Schumacher, V Ch

3 — 7.1 Res# 2601004: Approve the requests for clinical privileges for Usha Movva, MD – *See page 3 resolution sheet*

3, 18-19 — 7.2 Res# 2601005: Approve the policy, Videoconferencing, recording, transcribing, and use of Artificial Intelligence (AI), 09-05-10, to begin 30-day review – *See page 3 resolution sheet & pages 18-19*

3, 20 — 7.3 Res# 2601006: Approve the policy, Home and Community Based Rules, 04-05-08, to end 30-day review – *See page 3 resolution sheet & page 20*

7.4 Motion on minutes as distributed

BAY ARENAC BEHAVIORAL HEALTH

BOARD OF DIRECTORS
REGULAR MEETING

Thursday, January 15, 2026 at 5:00 pm
Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

AGENDA

Page

8. AUDIT COMMITTEE, 01/12/2026 – In packet – McFarland, Ch/ Banaszak, V Ch

3, 21-28 8.1 Res# 2601007: Accept financial statements as revised – S*ee page 3 resolution sheet & pages 21-28*

3, 29-32 8.2 Res# 2601008: Accept electronic fund transfers – *See page 3 resolution sheet & pages 29-32*

3, 33 8.3 Res# 2601009: Approve disbursement & health care claims payments – *See page 3 resolution sheet & page 33*

34-36 8.4 Motion on minutes as presented – *See pages 34-36*

9. REPORT FROM ADMINISTRATION
   9.1 Federal & State Health Policy Update

37-55 9.2 MidState Health Network Court of Claims Lawsuit – *See pages 37-55*

10. UNFINISHED BUSINESS
    10.1 None

11. NEW BUSINESS
    11.1 BABHA 2026 Strategic Plan & Executive Summary

56-59 Consideration of a motion to approve the 2026 Strategic Plan – *See pages 56-59 & plan attached to back of packet*

    11.2 Holiday Schedule

BABHA Offices will be closed on Monday, January 19, 2026 for Martin Luther King, Jr. Day and Monday, February 16, 2026 for President's Day.

    11.3 Community Mental Health Association (CMHA) 2026 Winter Conference

60-62 The CMHA Winter Conference is scheduled for Tuesday and Wednesday, February 3 and 4, 2026 at the Radisson Plaza Hotel in Kalamazoo, Michigan – *See pages 60-62*

    11.4 February Audit Committee Meeting

63 The regular scheduled February 16, 2026 Audit Committee meeting has been canceled due to a conflict with President's Day – *See page 63*

12. ADJOURNMENT

BAY ARENAC
BEHAVIORAL HEALTH

BOARD OF DIRECTORS
REGULAR MEETING

Thursday, January 15, 2026 at 5:00 pm
Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

RESOLUTIONS

Finance Committee, January 7, 2026

Res# 2601001: Resolved by Bay Arenac Behavioral Health Authority to approve the Finance January 2026 contract list with item 4 removed.

Res# 2601002: Resolved by Bay Arenac Behavioral Health Authority to approve the amendment to the employment contract with Nurse Practitioner Ashley Badour with terms expiring December 16, 2027.

Res# 2601003: Resolved by Bay Arenac Behavioral Health Authority to approve the Madison Building expansion project feasibility study by TSSF Architects, Inc. for an amount not to exceed $9,995.

Program Committee, January 8, 2026

Res# 2601004: Resolved by Bay Arenac Behavioral Health Authority to approve the requests for clinical privileges for Usha Movva, MD, for a three-year renewal term expiring January 30, 2029.

Res# 2601005: Resolved by Bay Arenac Behavioral Health Authority to approve the policy, Videoconferencing, recording, transcribing, and use of Artificial Intelligence (AI), 09-05-10, to begin 30-day review.

Res# 2601006: Resolved by Bay Arenac Behavioral Health Authority to approve the policy, Home and Community Based Rules, 04-05-08, to end 30-day review.

Audit Committee, January 12, 2026

Res# 2601007: Resolved by Bay Arenac Behavioral Health Authority to approve the Financial Statements for period ending December 31, 2025 as revised.

Res# 2601008: Resolved by Bay Arenac Behavioral Health Authority to approve the electronic fund transfer (EFTs) for period ending December 31, 2025.

Res# 2601009: Resolved by Bay Arenac Behavioral Health Authority to approve the disbursements and health care payments from December 13, 2025 through January 9, 2026.

FOR IMMEDIATE RELEASE

COMMUNITY MENTAL HEALTH ASSOCIATION ANNOUNCES NEW CHIEF EXECUTIVE OFFICER

LANSING, MICH. — November 3, 2025 — The Community Mental Health Association of Michigan (CMHA) Board of Directors today announced the appointment of Alan Bolter as the organization's incoming Chief Executive Officer, effective November 1, 2025. Bolter will succeed Robert Sheehan, who has successfully led CMHA for the past decade. Sheehan will continue serving as CEO through October 31, 2026, to ensure a seamless transition in leadership.

"We feel fortunate to have selected Alan as the next CEO of CMHA, given his caliber and proven track record," said Craig Reiter, President of the CMHA Board of Directors. "Alan has spent the last 25 years dedicated to public policy and governmental affairs—14 of those years advocating on behalf of CMHA. We are confident he will continue to strengthen our mission of informing, educating, and advocating for mental health across Michigan."

A distinguished and highly respected lobbyist, Bolter joined the Community Mental Health Association of Michigan in 2009 and has since been recognized multiple times among Michigan's most effective association lobbyists by the MIRS/EPIC-MRA Michigan Insider's Survey in 2019, 2021, 2023, and again in 2025. His work has been instrumental in advancing the expansion of CCBHC sites statewide, securing increased wages for direct care workers, and championing key state appropriations that have expanded access to essential behavioral health services throughout Michigan.

Prior to joining CMHA, Bolter spent 12 years in Michigan state government, including roles in the Lieutenant Governor's office and as Chief of Staff in both chambers of the Legislature.

"Stepping into this new role is a tremendous honor," said Alan Bolter. "I deeply believe in the mission of the Community Mental Health Association and feel privileged to work alongside so many dedicated professionals who share our commitment to ensuring consistent, reliable, and affordable healthcare for all Michiganders."

The Community Mental Health Association of Michigan (CMHA) is a trade association representing Michigan's public mental health system, which delivers mental health, substance use disorder, and developmental disability services in every community across the state.

# # #

Sara McRae

Subject: FW: RELEASE: Gov. Whitmer Lowers Flags to Honor Former State Senator Joel Gougeon

From: Michigan Executive Office of the Governor <mieog@govsubscriptions.michigan.gov>
Sent: Monday, January 12, 2026 9:36 AM
To: Sara McRae <smcrae@babha.org>
Subject: RELEASE: Gov. Whitmer Lowers Flags to Honor Former State Senator Joel Gougeon

FOR IMMEDIATE RELEASE
January 12, 2026
Contact: press@michigan.gov

Gov. Whitmer Lowers Flags to Honor Former State Senator Joel Gougeon

LANSING, Mich. – Governor Gretchen Whitmer has ordered U.S. and Michigan flags within the State Capitol Complex to be lowered to half-staff on Tuesday, January 13, 2026, to honor and remember former state Senator Joel Gougeon.

"Senator Gougeon was a dedicated public servant who served his community admirably in the U.S. Air Force and the state Senate," said **Governor Whitmer**. "My thoughts are with his family, friends, and all those who worked with and served alongside him."

Former state Senator Joel Gougeon graduated from T.L. Handy High School and then earned a degree in mechanical engineering from General Motors Institute. After graduating, Gougeon served in the United States Air Force as an F-4 Phantom pilot. When he returned home, he founded Gougeon Brothers, Inc. with his brothers, Meade and Jan.

Gougeon served in the Michigan State Senate from 1993-2002 and also served on the Bay County Commissioners from 1984-1990. During his time in the Senate, he helped rewrite the Mental Health Code to reduce stigma and expand support for mental health research. After retiring from the Senate, Gougeon founded his own consulting company and continued to participate in community service.

The State of Michigan recognizes the duty, honor, and service of former state Senator Joel Gougeon by lowering flags to half-staff within the State Capitol Complex. To lower flags to half-staff, flags should be hoisted first to the peak for an instant and then lowered to the half-staff position. The process is reversed before the flag is lowered for the day.

Flags should be returned to full staff on Wednesday, January 14, 2026.

###

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

Balance Dec 1, 2025	8,923,110.31
Balance Dec 31, 2025	7,262,174.98
Average Daily Balance	6,912,190.74
Estimated Actual/Accrued Interest Dec 2025	17,255.38
Effective Rate of Interest Earning Dec 2025	3.00%
Estimated Actual/Accrued Interest Fiscal Year to Date	45,800.55
Effective Rate of Interest Earning Fiscal Year to Date	3.20%

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

Cash Available - Operating Fund

	Rate	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Beg. Balance Operating Funds - Cash, Cash equivalents, Investments		7,785,099	5,777,598	5,192,261	4,585,448	7,971,323	6,179,005	4,597,768	6,261,517	6,775,688	5,966,633	5,274,202	8,431,919
Cash in		11,895,758	12,023,619	12,246,135	20,379,721	12,205,772	12,225,824	20,990,024	16,234,403	12,208,234	13,636,279	21,097,480	13,203,400
Cash out		(13,903,259)	(12,608,956)	(12,852,949)	(16,993,846)	(13,998,090)	(13,807,060)	(19,326,275)	(15,720,233)	(13,017,289)	(14,328,710)	(17,939,763)	(14,858,965)
Ending Balance Operating Fund		5,777,598	5,192,261	4,585,448	7,971,323	6,179,005	4,597,768	6,261,517	6,775,688	5,966,633	5,274,202	8,431,919	6,776,354
Investments													
Money Markets		5,777,598	5,192,261	4,585,448	7,971,323	6,179,005	4,597,768	6,261,517	6,775,688	5,966,633	5,274,202	8,431,919	6,776,354
90.00													
180.00													
180.00													
270.00													
270.00													
Total Operating Cash, Cash equivalents, Invested		5,777,598	5,192,261	4,585,448	7,971,323	6,179,005	4,597,768	6,261,517	6,775,688	5,966,633	5,274,202	8,431,919	6,776,354
Average Rate of Return General Funds		3.50%	3.48%	3.45%	3.43%	3.42%	3.40%	3.37%	3.36%	3.34%	3.06%	2.94%	2.81%
		3.30%	3.38%	3.30%	3.32%	3.32%		3.26%	3.13%	3.28%	3.06%	2.81%	2.56%
average		6,868,080	6,532,916	6,208,338	6,460,193	6,425,045	6,222,014	6,225,964	6,275,939	6,295,231	5,274,202	6,853,061	6,827,492

Cash Available - Other Restricted Funds

	Rate	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Beg. Balance-Other Restricted Funds - Cash, Cash equivalents, Investments		466,575	468,220	469,711	471,366	472,974	474,641	476,260	477,939	479,623	481,232	482,860	484,348
Cash in		1,645	1,491	1,656	1,608	1,667	1,619	1,679	1,684	1,608	1,628	1,488	1,473
Cash out													
Ending Balance Other Restricted Funds		468,220	469,711	471,366	472,974	474,641	476,260	477,939	479,623	481,232	482,860	484,348	485,821
Investments													
Money Market		468,220	469,711	471,366	472,974	474,641	476,620	477,939	479,623	481,232	482,860	484,348	485,821
91.00	0.70%												
91.00	1.10%												
91.00	1.15%												
91.00	1.35%												
90.00	1.70%												
91.00	2.05%												
90.00	2.15%	-	-	-	-	-	-	-	-	-	-	-	-
365.00	80.00%												
Total Other Restricted Funds		468,220	469,711	471,366	472,974	474,641	476,620	477,939	479,623	481,232	482,860	484,348	485,821
Average Rate of Return Other Restricted Funds		4.84%	4.84%	4.84%	4.84%	4.84%	4.75%	4.68%	4.63%	4.58%	4.11%	4.11%	3.93%
		4.84%	4.84%	4.84%	4.84%	4.84%	4.02%	4.02%	4.15%	4.00%	4.11%	4.11%	3.58%
average		465,725	466,523	467,330	468,136	468,942	469,762	470,615	471,434	472,251	482,860	483,604	484,343
Total - Bal excludes payroll related cash accounts		6,245,818	5,661,972	5,056,814	8,444,297	6,653,646	5,074,388	6,739,456	7,255,311	6,447,865	5,757,062	8,916,267	7,262,175
Total Average Rate of Return		3.58%	3.52%	3.51%	3.49%	3.49%	3.47%	3.44%	3.38%	3.39%	3.55%	3.33%	3.20%

Bay-Arenac Behavioral Health
Finance Council Board Meeting
Summary of Proposed Contracts
January 7, 2026
REVISED

			Old Rate	New Rate	Term	Out Clause?	Performance Issues? (Y/N) Risk Assessment Rating (Poor/Fair/Good/Excellent)
SECTION I. SERVICES PROVIDED BY OUTSIDE AGENCIES							
Clinical Services							
1	S	**Superior Care of Michigan LLC (Battle Creek, MI)** Residential Services for one BABHA individual	$276.60/day	Same	1/25/26 - 1/24/27	Y	N
2	M	**Westwood Specialized Residential LLC (Flint, MI)** Residential Services for one BABHA individual. 1:1 staffing increased to up to 24 hrs/day	$749.76/day plus $25.50/hr for 1:1 staffing	Same	12/22/25 - 9/30/26	Y	N
Admin/Other Services							
3	N	**Jennifer Harrison** Pain & Ethics Training - one day virtual training	$0	$1,800 for one full day of trng or $200/hr for presentation time	4/17/2026	Y	N
SECTION II. SERVICES PROVIDED BY THE BOARD (REVENUE CONTRACTS)							
SECTION III. STATE OF MICHIGAN GRANT CONTRACTS							
SECTION IV. MISC PURCHASES REQUIRING BOARD APPROVAL							
~~4~~	~~R~~	~~**MMRMA**~~ ~~Excess crime coverage - annual premium renewal~~	~~$9,714~~	~~$11,375~~	~~1/19/26 - 1/19/27~~	~~N/A~~	~~N/A~~
5	S	**The Doctors Company** Professional liability insurance, Dr. Roderick Smith	$4,322	$4,322	2/1/26 - 2/1/27	N/A	N/A
6	T	**Telnet** Termination of the agreement due to disconnect of service(s)	Varies; Approx. $1,500/month	$0	Terminated eff. 12/31/25	N/A	N/A

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

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

Footnotes:

A PROPOSAL/AGREEMENT FOR THE PROVISION OF SPECIFIED PROFESSIONAL SERVICES

CLIENT: **Eric Strode**
Facilities Manager
Bay-Arenac Behavioral Health
(O) 989-895-2302
(M) 989-225-4907

DATE: January 5, 2026

TSSF PROJECT NO. 26_02

PROJECT:

BRIEF DESCRIPTION OF PROJECT:
Potential Building Study to the Madison Building and Parking- Single Story Structure

Part A – Services

Bay Arenac Behavioral Health – Building Addition to the Madison Building

Part A services shall include the development of preliminary design materials to support evaluation of a potential building project. These services include:

- Preliminary design studies, including sketches and conceptual floor plans for agency review and 2-D Exterior Elevations.
- A conceptual site plan illustrating parking configuration and overall building layout
- A conceptual opinion of probable construction cost based on the preliminary design
- Meetings with Bay Arenac Behavioral Health agency representatives and other key stakeholders involved in project decision-making
- Upon completion of Part A services and receipt of authorization from the Owner, TSSF Architects shall proceed with Part B services to further advance the project.

These services are intended to support early feasibility, planning, and internal review prior to advancing into subsequent design phases.

Next Phase – Part B Proposal (not included in this agreement)

- At the conclusion of the Part A Service Agreement, **TSSF** will provide a Part B Proposal for Architectural and Engineering Services to execute the approved plan.
- Part B Services will include Architectural, Mechanical, Electrical, Structural, and Civil disciplines as the basic scope.
- Additional services may be required upon request, such as Furniture, Food Service, Technology, and Environmental.

SCHEDULE: At direction of the owner

PROFESSIONAL FEE:
Lump Sum Amount……**$9,995.00**

(The lump sum fee, as stated, will be billed on a monthly basis in accordance with work progress. Payment is due within thirty (30) days of the invoice date.)

SPECIAL CONDITIONS: The following services are available for additional fee if requested/required:

We can also provide additional services, including Structural, Environmental, Civil, Mechanical, and Electrical Engineering if necessary.

The attached Terms and Conditions are a part of this Agreement (two pages).

Offered By:

(Signature) Craig J. Schneider

President
(Title)

January 5, 2026
(Date Offered)

For: **TSSF Architects, Inc.**

Accepted By:
Note: Proposed fee remains valid when accepted within 30 days of date offered.

(Signature)

(Title)

(Date Accepted)

For:
(Company)

TERMS AND CONDITIONS

TSSF Architects, Inc. (TSSF) shall perform the services outlined in this agreement for the stated fee arrangement.

Access to Site
Unless otherwise stated, TSSF shall have access to the site for activities necessary for the performance of the services. TSSF will take precautions to minimize damage due to these activities,but has not included in the fee the cost of restoration of any resulting damage.

Fee
The total fee shall be a lump sum, unless indicated otherwise, and is valid for 30 days from date of Agreement. Where the fee arrangement is to be on an hourly basis or additional services are required, the rates shall be those that prevail at the time services are tendered. (Fee and rate schedule are as attached.) Rates and multiples for services as set forth in this agreement shall be adjusted in accordance with the Architect's normal salary review procedures.

Billings/Payments
Invoices for services will be submitted on a monthly basis and shall be payable within 30 days of invoice date. Invoice shall be considered PAST DUE if not paid within 30 days after the invoice date at which time TSSF may, without waiving any claim or right against the Client, and without liability whatsoever to the Client, terminate the performance of the service. A monthly service charge of 1.5% of the unpaid balance may be added to PAST DUE accounts. In the event any portion or all of an account remains unpaid 90 days after billing, the Client shall pay cost of collection, including reasonable attorney's fees. (Retainers shall be credited on the final invoice.)

Insurance
TSSF shall during the course of this project maintain (1) statutory workmen's compensation insurance coverage, (2) comprehensive general liability insurance coverage and automobile liability insurance coverage and (3) professional liability insurance.

Indemnification
The Client shall, to the fullest extent permitted by law, indemnify and hold harmless TSSF, its officers, directors, employees, agents and sub-consultants from and against all damage, liability or cost, including reasonable attorneys' fees and defense costs arising out of or in any way connected with this project or the performance of services by any of the parties above named under this Agreement, excepting only those damages, liabilities or costs attributable to the sole negligence or willful misconduct of TSSF.

Dispute Resolution
In an effort to resolve any conflicts that arise during the design or construction of the project or following the completion of the project, the Client and TSSF agree that all disputes between them arising out of or relating to this Agreement shall be submitted to non-binding mediation unless the parties mutually agree otherwise. The Client and TSSF further agree to include a similar mediation provision in all agreements with independent contractors and consultants retained for the project, thereby providing for mediation as the primary method for dispute resolution between the parties to those agreements.

Standard of Care
TSSF shall endeavor to perform its Professional Services with the standard of care, skill and diligence normally provided by a competent professional in the performance of such services.

Risk Allocation
In recognition of the relative risks, rewards and benefits of the project to both the Client and TSSF, the risks have been allocated such that the Client agrees that, to the fullest extent permitted by law, TSSF's total liability to the Client for any and all injuries, claims, losses, expenses, damages, or claim expenses arising out of this agreement from any cause or causes, shall not exceed $500,000 or remaining insurance coverage available at the time of settlement or judgment, whichever is less. Such causes include, but are not limited to TSSF's negligence, errors, omissions, strict liability, breach of contract or breach of warranty.

Termination of Services
This agreement may be terminated upon seven days written notice by either the Client or TSSF should the other party fail to perform its obligations hereunder. In the event of termination, the Client shall pay TSSF for all services rendered to the date of termination, including all reimbursable expenses, and reimbursable termination expenses.

Assigns and Subcontractors
Neither Client nor TSSF shall assign, sublet or transfer any rights or interest in the Agreement without written consent of the other. TSSF may employ independent consultants, associates, and subcontractors to assist in the performance of these services as deemed appropriate by TSSF.

Changes
The Client may direct TSSF to make changes, including additions or deletions to the Services originally described herein. TSSF shall promptly notify Client in writing if such changes, additions, or deletions affect the time for performance of TSSF's services. An additional 8% to 10% A/E fee on Change Orders will be applied.

Ownership of Documents
The Client acknowledges that all reports, plans, specifications, field data, field notes, laboratory test data, calculations, estimates and other similar documents produced by TSSF and their consultants are instruments of professional service, not products. (The distinction is that the TSSF Design team provides services and does not sell plans or drawings) Ownership of all documents produced by TSSF shall remain the property of TSSF. The Client recognizes that documents produced by the TSSF Design team shall not be subject to re-use by the Client on any project other than what they were intended.

Alteration and Reuse of CAD Information
Client may be provided with copies of the work performed by TSSF in either electronic form or hard copy, (such as Record Drawings, As-Built Drawings, etc.) provided such service is specifically included under the terms of this agreement. Since computer aided design/drafting (CAD) information stored in electronic form can be modified by other parties, intentionally or otherwise, without notice or indication of said modifications, all electronic copies will be provided in PDF format only. Copies shall be used for information by Client for the specific purpose for which TSSF was engaged. Said material shall not be used by Client, or transferred to any other party, for use in other projects, additions to the current project, or any other purpose for which the material was not originally intended, without TSSF's express written permission. Any unauthorized modification or reuse of the materials shall be at Client's risk, and Client, therefore, agrees to defend, indemnify, and hold harmless, TSSF from all claims, injuries, damages, losses, and expenses, including attorney's fees arising out of the unauthorized modification of these materials.

Confidentiality
TSSF agrees to keep confidential and not to disclose to any person or entity, other than TSSF employees, sub-consultants, or general contractor and subcontractors, if appropriate, any data and information not previously known to and generated by TSSF or furnished to TSSF and marked CONFIDENTIAL by the Client. These provisions shall not apply to information in whatever form that comes into the public domain, nor shall it restrict TSSF from giving notices required by law or complying with an order to provide information or data when such order is issued by a court, administrative agency, or other authority with proper jurisdiction, or if it is reasonably necessary for TSSF to defend itself from any suit or claim.

Administration of the Contract
TSSF Architects will not have control over or charge of and will not be responsible for construction means, methods, techniques, sequences or procedures, or for safety precautions and programs in connection with the Work; will not be responsible for the Contractor's failure to carry out the Work in accordance with the Contract Documents; and will not have control over or charge of and will not be responsible for acts or omissions of the Contractor, Subcontractors, or their agents or employees, or of any other person performing portions of the Work.

Applicable Laws
Unless other specified, this Agreement shall be governed by laws of the State of Michigan.

TSSF Architects, Inc.
PROFESSIONAL SERVICES

Compensation/Reimbursable Expenses Rate Schedule
Effective January 1 thru December 31, 2026

Services Compensation
Where our compensation for services is based on hourly billing rates, time expended on behalf of the client/owner will be charged at the following rates:

CLASSIFICATION	HOURLY RATE
Project Architect/Principal	151.00/hr
Sr. Project Manager	142.00/hr
Project Manager	124.00/hr
Senior CAD Technician/Designer	119.00/hr
Interior Design Specialist	98.00/hr
Administrative Assistant	96.00/hr
CAD Technician/Designer	93.00/hr
Word Processor/Clerical	83.00/hr

Overtime authorized in advance by the client/owner will be charged at a rate equal to 1.5 times the above listed standard rate.

The above rates include overhead, profit and costs incidental to the performance of services.

Reimbursable expenses:
Expenses incurred on behalf of the client/owner and not normally included as part of our Basic Services compensation package will be charged at our cost plus 10% for administration. Such expenses include, but are not limited to, the following:

- Printing/reproduction, mailing/delivery costs for multiple sets of drawings, specifications and addenda for bidding and construction purposes
- Same printing etc., as above for other special purposes
- Travel lodging, meals, etc. for overnight duration
- Fees charged by Regulatory Agencies (Michigan DLEG, Bureau of Construction Codes, Bureau of Fire Services, Department of Community Health, Local Building and Zoning Officials, etc.)
- Costs of perspective renderings and models

Consultants:
When consultants are utilized to perform services for which the basis of our compensation is hourly billing rates, such services will be billed at our cost +12%, unless hourly unit rates have previously been established.

MINUTES

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
FINANCE COMMITTEE MEETING

Wednesday, January 7, 2026 at 5:00 pm

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

Committee Members:	Present	Excused	Absent		Present	Excused	Absent
Tim Banaszak, Ch	X			Pam Schumacher	X		
Sally Mrozinski, V Ch	X			Christopher Girard, Ex Off	X		
Richard Byrne	X			Pat McFarland, Ex Off	X		
Jerome Crete		X		Robert Pawlak, Ex Off	X		
Kathy Niemiec	X						

Others Present: Paul Niemiec
BABH: Marci Rozek, Chris Pinter, and Sara McRae

Legend: M-Motion; S-Support; MA-Motion Adopted; AB-Abstained

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call	Committee Chair, T. Banaszak, called the meeting to order at 5:00 pm.	On motion of C. Girard and support by K. Niemiec, J. Crete was excused. The motion was adopted unanimously.
2.	Public Input (Maximum of 3 Minutes)	There were not any members of the public present that wished to address the Committee.	
3.	Unfinished Business 3.1) Bay City Chamber of Commerce Accident Fund	3.1) M. Rozek reported the maximum insurance limits disqualify BABHA from receiving insurance through the Bay City Chamber of Commerce.	3.1) No action was necessary
4.	New Business 4.1) Investment Earnings Reports for Period Ending December 31, 2025	4.1) M. Rozek reviewed the reports noting the interest rate.	4.1) On motion by C. Girard and support by R. Byrne, the investment earnings reports for the period ending December 31, 2025 were referred to the full Board for information. The motion was adopted unanimously.
	4.2) Finance January 2026 Contract List	4.2) M. Rozek reviewed the contract list noting the significant increase for the crime coverage insurance rider. C. Pinter reported the coverage is for $4 million in protection from staff theft or fraud. After discussions, the Committee concurred to not approve this agreement until leadership receives more information regarding the increase.	4.2) On motion by C. Girard and support by P. Schumacher, the Finance January 2026 contract list with item 4 removed was referred to the full Board for approval. The motion was adopted unanimously.

	4.3) Proposed Amendment to Nurse Practitioner Contract	4.3) M. Rozek reported the Medicare telehealth flexibilities are effective until January 31, 2026. M. Rozek noted the proposed amendment is to provide more services onsite versus remotely beginning February 1, if the telehealth flexibilities expire.	4.3) On motion by P. Schumacher and support by C. Girard, the amendment to the employment contract with Nurse Practitioner Ashley Badour with terms expiring December 16, 2027 was referred to the full Board for approval. The motion was adopted unanimously.
	4.4) Sweep Account Interest Income	4.4) M. Rozek reviewed the interest earned on accounts payable for calendar year 2025 noting since the transition to the sweep account, interest income earned has increased $1,000 per month.	4.4) No action was necessary
	4.5) Minimum Wage Effective 01/01/2026	4.5) C. Pinter reported the State Supreme Court determined the new minimum wage effective January 1, 2026, and in future years, resulting from legislation over the ballot initiative from 2017. C. Pinter also reported the legislature passed three mandated direct care wage increases during COVID. According to the Michigan Department of Health and Human Services (MDHHS) actuaries, the mandated direct care wage increases totaling $3.40 must be paid in addition to minimum wage. BABHA leadership does not understand why this directive to pay direct care staff in this manner can come from MDHHS and not the legislature. Paying the direct care wage increases in addition to minimum wage requirements could have a significant impact on the provider network. There were discussions related to the directive coming from MDHHS and not the legislature, Midstate Health Network (MSHN) is projecting a budget surplus this year, information collected from the provider network so far shows all providers will be impacted, and the impacts of wage compression.	4.5) No action was necessary
	4.6) Feasibility Study for Madison Building Expansion	4.6) M. Rozek reported TSSF Architects, Inc. previously renovated the Madison building and reviewed the quote provided along with the total project cost for the feasibility study. The cost falls under the threshold that would require BABHA to obtain additional quotes. There were general discussions regarding the previous floor plans reviewed by the Committee which were developed by staff.	4.6) On motion by S. Mrozinski and support by C. Girard, the Madison Building expansion project feasibility study by TSSF Architects, Inc. for an amount not to exceed $9,995 was referred to the full Board for approval. The motion was adopted.

	4.7) Strategic Plan Initiatives & Dashboard Reports	4.7) M. Rozek reviewed the dashboard reports relating to the Committee's functions.	4.7) No action was necessary
5.	Adjournment	On motion by S. Mrozinski and support by C. Girard, the meeting adjourned at 5:24 pm. The motion passed unanimously.	

_____
Tim Banaszak, Committee Chair

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 9	**Information Management**		
Section: 5	**Technology Safeguards**		
Topic: 10	**Videoconferencing, recording, transcribing, and use of AI**		
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: 1/7/2026. 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 have processes in place for safeguarding the creation, use, movement, reuse, storage, data backup, or disposal of recordings and/or transcriptions of recordings of videoconferencing meetings with or without the assistance of artificial intelligence (AI), generative AI, or generative AI technology.

Purpose

This policy and procedure is established to ensure that all use of software applications ~~,~~or artificial intelligence, that stores or processes or has the potential to store or process confidential information~~,~~ or protected health information (PHI), ~~are~~ is governed by media controls that safeguard such information from unauthorized use and/or disclosure. In addition, this policy also provides additional protections for the privacy of BABHA's employees using videoconferencing. The directives provided herein contemplate the privacy and security issues that arise during videoconferencing and recording and/or transcription of remote live meetings.

Education Applies to:

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
☐ Other:

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 9	**Information Management**		
Section: 5	**Technology Safeguards**		
Topic: 10	**Videoconferencing, recording, transcribing, and use of AI**		
Page: 2 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: 1/7/2026. For controlled copy, view Agency Manuals - Medworxx on the BABHA Intranet site.			

DO NOT WRITE IN SHADED AREA ABOVE

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. Prusi	Corporate Compliance	09/10/2025	New	New policy that addresses the use of recording/transcribing/AI in videoconferencing.

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 04	**Care and Treatment Services**		
Section: 05	**Person Centered Planning**		
Topic: 08	**Home and Community Based Services (HCBS) Compliance**		
Page: 1 of 1	**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: 12/2/2025. 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 ensure compliance with Home and Community Based Services (HCBS) Program Rule federal and state regulations.

Purpose:

BABHA will ensure that internal services and contractual providers of HCBS, including residential and nonresidential home and community-based services are compliant with Federal HCBS Final Rule and Person Centered Planning.

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
☐ 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**
K. Amon	SLT	9/23/25	New	To comply with HCBS Final Rule.

Bay-Arenac Behavioral Health
Financial Statements
For Period Ending 12/31/2025

Certified for Accuracy

Accounting Manager

Chief Financial Officer

Bay-Arenac Behavioral Health Statement of Net Assets

Bay-Arenac Behavioral Health Consolidated Income Statement:

By Month to Date

By Year to Date

Bay-Arenac Behavioral Health Reconciliation of Fund Balance:

Bay-Arenac Behavioral Health Reconciliation of Unreserved Fund Balance:

Bay-Arenac Behavioral Health Fund Balance Summary:

Bay-Arenac Behavioral Health Cash Flow Statement

Bay-Arenac Behavioral Health Projected Cash Flows

PAGE REPLACED

Bay Arenac Behavioral Health
Statement of Net Assets

		Column Identifiers A	Column Identifiers B	Column Identifiers C	
1	**ASSETS**		**Dec 31, 2025**	**Sept 30, 2025**	
2	**Current Assets**				
3	Cash and cash equivalents		$6,254,218.32	$4,975,087.02	
4	Consumer and insurance receivables		193,453.53	272,154.89	
5	Due from other governmental units		5,408,323.21	6,315,079.67	
6	Contract and other receivables		202,749.19	204,140.19	
7	Interest receivable		0.00	0.00	
8	Prepaid items		706,377.84	765,972.93	
9	**Total Current Assets**		**12,765,122.09**	**12,532,434.70**	(3+4+5+6+7+8)
10	**Noncurrent Assets**				
11	**Cash and cash Equivalents - restricted**				
12	Restricted for compensated absences		1,539,184.26	1,534,594.77	
13	Restricted temporarily - other		84,686.70	96,790.49	
14	**Cash and Cash Equivalents - restricted**		**1,623,870.96**	**1,631,385.26**	(12+13)
15	**Capital Assets**				
16	Capital assets - land		424,500.00	424,500.00	
17	Capital assets - depreciable, net		6,246,469.19	6,176,859.27	
18	Capital assets - construction in progress		-	-	
19	GASB 87 Right to Use Bldg		2,272,819.47	2,272,819.47	
20	GASB 87 Accum Depr, Lease Amortization		(613,824.99)	(613,824.99)	
21	Accumulated depreciation		(4,100,470.07)	(4,067,067.78)	
22	**Capital Asset, net**		**4,229,493.60**	**4,193,285.97**	(16+17+18+19+20+21)
23	**Total Noncurrent Assets**		**5,853,364.56**	**5,824,671.23**	(14+22)
24	**TOTAL ASSETS**		**18,618,486.65**	**18,357,105.93**	(9+23)
25	**LIABILITIES**				
26	**Current Liabilities**				
27	Accounts payable		617.46	0.00	
28	Accrued wages and payroll related liabilities		784,731.97	330,132.06	
29	Other accrued liabilities		3,856,907.25	4,448,612.56	
30	Due to other governmental units		191,453.11	218,086.00	
31	Deferred Revenue		3,798.13	3,948.13	
32	Current portion of long term debt		17,280.78	16,738.31	
33	Other current liabilities		-	-	
34	**Total Current Liabilities**		**4,854,788.70**	**5,017,517.06**	(27+28+29+30+31+32+33)
35	**Noncurrent Liabilities**				
36	Long term debt, net of current portion		208,551.37	213,396.67	
37	GASB 87 Noncurrent Lease Liability		1,502,277.10	1,502,277.10	
38	Compensated absences		1,865,974.06	1,336,800.52	
39	**Total Noncurrent Liabilities**		**3,576,802.53**	**3,052,474.29**	(36+37+38)
40	**TOTAL LIABILITIES**		**8,431,591.23**	**8,069,991.35**	(34+39)
41	**NET ASSETS**				
42	**Fund Balance**				
43	Restricted for capital purposes		3,966,653.00	3,966,653.00	
44	Unrestricted fund balance - PBIP		3,258,465.99	3,258,465.99	
45	Unrestricted fund balance		2,961,776.43	3,061,995.59	
46	**Total Net Assets**		**$10,186,895.42**	**$10,287,114.58**	(43+44+45) and (24-40)

Bay Arenac Behavioral Health
Statement of Net Assets - Revised

	Column Identifiers	A	B	C	
1	**ASSETS**		**Dec 31, 2025**	**Sept 30, 2025**	
2	**Current Assets**				
3	Cash and cash equivalents		$6,254,218.32	$4,975,087.02	
4	Consumer and insurance receivables		193,453.53	272,154.89	
5	Due from other governmental units		4,601,066.85	6,315,079.67	
6	Contract and other receivables		202,749.19	204,140.19	
7	Interest receivable		0.00	0.00	
8	Prepaid items		706,377.84	765,972.93	
9	**Total Current Assets**		**11,957,865.73**	**12,532,434.70**	(3+4+5+6+7+8)
10	**Noncurrent Assets**				
11	**Cash and cash Equivalents - restricted**				
12	Restricted for compensated absences		1,539,184.26	1,534,594.77	
13	Restricted temporarily - other		84,686.70	96,790.49	
14	**Cash and Cash Equivalents - restricted**		**1,623,870.96**	**1,631,385.26**	(12+13)
15	**Capital Assets**				
16	Capital assets - land		424,500.00	424,500.00	
17	Capital assets - depreciable, net		6,246,469.19	6,176,859.27	
18	Capital assets - construction in progress		-	-	
19	GASB 87 Right to Use Bldg		2,272,819.47	2,272,819.47	
20	GASB 87 Accum Depr, Lease Amortization		(613,824.99)	(613,824.99)	
21	Accumulated depreciation		(4,100,470.07)	(4,067,067.78)	
22	**Capital Asset, net**		**4,229,493.60**	**4,193,285.97**	(16+17+18+19+20+21)
23	**Total Noncurrent Assets**		**5,853,364.56**	**5,824,671.23**	(14+22)
24	**TOTAL ASSETS**		**17,811,230.29**	**18,357,105.93**	(9+23)
25	**LIABILITIES**				
26	**Current Liabilities**				
27	Accounts payable		617.46	0.00	
28	Accrued wages and payroll related liabilities		784,731.97	330,132.06	
29	Other accrued liabilities		3,856,907.25	4,448,612.56	
30	Due to other governmental units		191,453.11	218,086.00	
31	Deferred Revenue		3,798.13	3,948.13	
32	Current portion of long term debt		17,280.78	16,738.31	
33	Other current liabilities		-	-	
34	**Total Current Liabilities**		**4,854,788.70**	**5,017,517.06**	(27+28+29+30+31+32+33)
35	**Noncurrent Liabilities**				
36	Long term debt, net of current portion		208,551.37	213,396.67	
37	GASB 87 Noncurrent Lease Liability		1,502,277.10	1,502,277.10	
38	Compensated absences		1,058,717.70	1,336,800.52	
39	**Total Noncurrent Liabilities**		**2,769,546.17**	**3,052,474.29**	(36+37+38)
40	**TOTAL LIABILITIES**		**7,624,334.87**	**8,069,991.35**	(34+39)
41	**NET ASSETS**				
42	**Fund Balance**				
43	Restricted for capital purposes		3,966,653.00	3,966,653.00	
44	Unrestricted fund balance - PBIP		3,258,465.99	3,258,465.99	
45	Unrestricted fund balance		2,961,776.43	3,061,995.59	
46	**Total Net Assets**		**$10,186,895.42**	**$10,287,114.58**	(43+44+45) and (24-40)

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

	A	B	C	D	E (C-D)	F (C / D)	G	
		Column Identifiers						
		December Actual	2026 YTD Actual	2026 YTD Budget	Variance	% to Budget	2026 Monthly Budget	
	Income Statement							
1	**REVENUE**							
2	**Risk Contract Revenue**							
3	Medicaid Specialty Supports & Services	5,449,335.21	13,903,642.69	14,369,904.00	(466,261.31)	97%	4,789,968.00	
4	Medicaid Autism	1,150,330.82	3,658,123.44	2,901,722.25	756,401.19	126%	967,240.75	
5	State Gent Fund Priority Population	135,505.00	406,514.00	406,513.50	0.50	100%	135,504.50	
6	GF Shared Savings Lapse	0.00	0.00	0.00	0.00	0%	0.00	
7	**Total Risk Contract Revenue**	**6,735,171.03**	**17,968,280.13**	**17,678,139.75**	**290,140.38**	**102%**	**5,892,713.25**	(3+4+5+6)
8	**Program Service Revenue**							
9	Medicaid, CWP FFS	0.00	0.00	0.00	0.00	0%	0.00	
10	Other Fee For Service	37,767.59	98,561.34	97,533.50	1,027.84	101%	32,511.17	
11	**Total Program Service Revenue**	**37,767.59**	**98,561.34**	**97,533.50**	**1,027.84**	**101%**	**32,511.17**	(9+10)
12	**Other Revenue**							
13	Grants and Earned Contracts	126,880.84	415,135.61	459,245.00	(44,109.39)	90%	153,081.67	
14	SSI Reimbursements, 1st/3rd Party	5,402.50	16,207.50	18,456.00	(2,248.50)	88%	6,152.00	
15	County Appropriation	65,587.83	196,763.49	196,763.62	(0.13)	100%	65,587.87	
16	Interest Income - Working Capital	17,255.38	45,800.55	65,949.25	(20,148.70)	69%	21,983.08	
17	Other Local Income	820.04	4,129.55	112,504.00	(108,374.45)	4%	37,501.33	
18	**Total Other Revenue**	**215,946.59**	**678,036.70**	**852,917.87**	**(174,881.17)**	**79%**	**284,305.96**	(13+14+15+16+17)
19	**TOTAL REVENUE**	**6,988,885.21**	**18,744,878.17**	**18,628,591.12**	**116,287.05**	**101%**	**6,209,530.37**	(7+11+18)
20	**EXPENSE**							
21	**SUPPORTS & SERVICES**							
22	**Provider Claims**							
23	State Facility - Local portion	6,393.19	30,928.00	38,631.00	7,703.00	80%	12,877.00	
24	Community Hospital	619,800.46	1,680,126.66	1,916,333.00	236,206.34	88%	638,777.67	
25	Residential Services	1,580,666.73	4,178,215.49	3,681,022.25	(497,193.24)	114%	1,227,007.42	
26	Community Supports	2,825,793.41	7,169,397.36	6,790,186.00	(379,211.36)	106%	2,263,395.33	
27	**Total Provider Claims**	**5,032,653.79**	**13,058,667.51**	**12,426,172.25**	**(632,495.26)**	**105%**	**4,142,057.42**	(23+24+25+26)
28	**Operating Expenses**							
29	Salaries	1,241,480.96	3,556,523.21	3,704,454.00	147,930.79	96%	1,234,818.00	
30	Fringe Benefits	431,467.86	1,197,323.21	1,217,731.25	20,408.04	98%	405,910.42	
31	Consumer Related	4,273.30	13,214.55	6,188.00	(7,026.55)	214%	2,062.67	
32	Program Operations	143,532.16	438,141.99	413,588.36	(24,553.63)	106%	137,862.79	
33	Facility Cost	43,800.47	128,860.41	129,965.50	1,105.09	99%	43,321.83	
34	Purchased Services	2,021.94	2,807.69	5,594.50	2,786.81	50%	1,864.83	
35	Other Operating Expense	137,675.77	360,922.40	463,106.26	102,183.86	78%	154,368.75	
36	Local Funds Contribution	17,905.00	53,718.00	53,716.75	(1.25)	100%	17,905.58	
37	Interest Expense	593.87	1,793.05	1,922.50	129.45	93%	640.83	
38	Depreciation	12,017.33	33,125.31	40,081.00	6,955.69	83%	13,360.33	
39	**Total Operating Expenses**	**2,034,769.66**	**5,786,429.82**	**6,036,348.12**	**249,918.30**	**96%**	**2,012,116.04**	(29+30+31+32+33+34+35+36+37+38)
40	**TOTAL EXPENSES**	**7,067,423.45**	**18,845,097.33**	**18,462,520.37**	**(382,576.96)**	**102%**	**6,154,173.46**	(27+39)
41	**NET SURPLUS/(DEFICIT)**	**(78,538.24)**	**(100,219.16)**	**166,070.75**	**(266,289.91)**	**-60%**	**55,356.92**	(19-40)

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

BASED ON PEPM FUNDING:
44 Net Medicaid (shortage): ($2,152,280)
45 Medicaid (shortage): ($175,613)
46 Healthy Michigan (shortage): ($595,837)
47 Autism (shortage): ($1,380,830)

BASED ON APPROVED BUDGET:
48 Net Medicaid shortage: ($137,935)
49 Medicaid (surplus): $454,209
50 Healthy Michigan (surplus): $59,340
51 Autism (shortage): ($651,484)
52

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

	TOTALS
Fund Balance 09/30/2025	10,287,114.58
Net (loss)/income December 2025	(100,219.16)
Net Increase/(Decrease) Funds Restricted for Capital Purposes	-
Calculated Fund Balance 12/31/2025	10,186,895.42
Statement of Net Assets Fund Balance 12/31/2025	10,186,895.42
Difference	-

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

	TOTALS
Unrestricted Fund Balance 9/30/2025	6,320,461.58
Net (loss)/income December 2025	(100,219.16)
Increase/Decrease in net assets	-
Calculated Unrestricted Fund Balance 12/31/2025	6,220,242.42
Statement of Net Assets Unrestricted Fund Balance 12/31/2025	6,220,242.42
Difference	-

Bay-Arenac Behavioral Health
Fund Balance Summary

	Sept. 30, 2025 Unrestricted Fund Balance	Dec 31, 2025 Permanently Restricted	Dec 31, 2025 Temporarily Restricted	Dec 31, 2025 Unrestricted/ Reserved	Dec 31, 2025 Total Fund Balance
Unrestricted	3,061,996	-	-	2,961,776	2,961,776
Capital Purposes	844,325	-	-	844,325	844,325
Invested in Capital Assets	3,122,328	-	-	3,122,328	3,122,328
Performance Incentive Pool	3,258,466	-	-	3,258,466	3,258,466
Balances	10,287,115	-	-	10,186,895	10,186,895

BAY-ARENAC BEHAVIORAL HEALTH
Cash Flow

	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26	Oct 26	Nov 26	Dec 26
Estimated Funds:												
Beginning Inv. Balance	-	-	-	-	-	-	-	-	-	-	-	-
Investment	-	-	-	-	-	-	-	-	-	-	-	-
Additions/(Subtractions)	-	-	-	-	-	-	-	-	-	-	-	-
Month End Inv. Balance	-	-	-	-	-	-	-	-	-	-	-	-
Beginning Cash Balance	6,776,977	5,117,644	5,097,925	4,373,064	3,532,061	2,237,342	1,512,481	3,671,478	2,376,760	1,651,899	3,810,896	2,554,891
Total Medicaid	5,140,260	5,140,260	5,140,260	5,140,260	5,140,260	5,140,260	5,140,260	5,140,260	5,140,260	5,140,260	5,140,260	5,140,260
Total General Fund	135,504	135,506	135,505	135,504	135,506	135,505	135,504	135,505	135,505	135,504	135,505	135,505
Estimated Misc. Receipts	89,759	89,759	205,900	89,759	89,759	205,900	89,759	89,759	205,900	89,759	128,473	63,950
Client Receipts	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000	55,000
Interest	14,499	14,499	14,499	14,499	14,499	14,499	14,499	14,499	14,499	14,499	14,499	14,499
Total Estimated Cash	**12,211,999**	**10,552,666**	**10,649,088**	**9,808,085**	**8,967,083**	**7,788,505**	**6,947,502**	**9,106,501**	**7,927,923**	**7,086,920**	**9,284,632**	**7,964,104**
Total Estimated Available Funds	**12,211,999**	**10,552,666**	**10,649,088**	**9,808,085**	**8,967,083**	**7,788,505**	**6,947,502**	**9,106,501**	**7,927,923**	**7,086,920**	**9,284,632**	**7,964,104**
Estimated Expenditures:												
1st Payroll	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000
Special Pay												
ETO Buyouts												
2nd Payroll	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000	550,000
Board Per Diem	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343	3,343
3rd Payroll	550,000											
1st Friday Claims	767,381	767,381	767,381	767,381	767,381	767,381	767,381	767,381	767,381	767,381	767,381	767,381
Mortgage Pmt	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032	2,032
2nd Friday Claims	1,382,266	1,382,266	1,382,266	1,382,266	1,382,266	1,382,266	1,382,266	1,382,266	1,382,266	1,382,266	1,382,266	1,382,266
Board Week Bay Batch	892,320	1,023,989	1,023,989	1,023,989	1,023,989	1,023,989	1,023,989	1,023,989	1,023,989	1,023,989	1,023,989	1,023,989
Board Week Claims	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000	975,000
Credit Card	-	-	-	-	-	-	-	-	-	-	-	-
4th Friday Claims	1,022,013	1,022,013	1,022,013	1,022,013	1,022,013	1,022,013	1,022,013	1,022,013	1,022,013	1,022,013	1,022,013	1,022,013
5th Friday Claims	400,000				400,000			400,000			400,000	
Local FFP payment to MSHN		53,717			53,717			53,717			53,717	
Transfer to State of MI												
Transfer from/(to) Reserve Account												
Settlement with MSHN												
Funds from MSHN		(875,000)					(3,000,000)			(3,000,000)		
Transfer to (from) HRA												
Transfer to (from) Investment												
Transfer to (from) Capital Acct	-	-	-	-	-	-	-	-	-	-	-	-
Total Estimated Expenditures	**7,094,355**	**5,454,741**	**6,276,024**	**6,276,024**	**6,729,741**	**6,276,024**	**3,276,024**	**6,729,741**	**6,276,024**	**3,276,024**	**6,729,741**	**6,276,024**
Estimated Month End Cash Balance	**5,117,644**	**5,097,925**	**4,373,064**	**3,532,061**	**2,237,342**	**1,512,481**	**3,671,478**	**2,376,760**	**1,651,899**	**3,810,896**	**2,554,891**	**1,688,080**

Bay-Arenac Behavioral Health

Cash Flow Forecasting
For the Month of January

		Bank Balance	Investment Balance
Estimated Cash Balance January 1, 2026		**6,776,977**	-
Investment Purchased/Interest		-	
Investments coming due during month		-	-
Estimated Cash Balance January 31, 2026		**6,776,977**	-
Estimated Cash Inflow:			
Medicaid Funds:		5,140,260	
General Fund Dollars:		135,504	
Board Receipts:		89,759	
Client Receipts:		55,000	
Funds from Investment:		-	
Interest:		14,499	
Total Estimated Cash Inflow:		**5,435,021**	
Estimated Cash Outflow:			
Payroll Dated:	**01/02/26**	(550,000)	
Payroll Dated:	**01/16/26**	(550,000)	
Board Per Diem Payroll:	**01/16/26**	(3,343)	
Payroll Dated:	**01/30/26**	(550,000)	
Claims Disbursements:	**01/02/26**	(767,381)	
Claims Disbursements:	**01/09/26**	(1,382,266)	
Claims Disbursements:	**01/16/26**	(975,000)	
A/P Disbursements:	**01/16/26**	(892,320)	
Mortgage Payment:	**01/22/26**	(2,032)	
Claims Disbursements:	**01/23/26**	(1,022,013)	
Claims Disbursements:	**01/30/26**	(400,000)	
Local FFP Payment:		-	
Transfer to Reserve Acct:		-	
HRA transfer:		-	
Transfer to(from) MSHN:		-	
Transfer to State of MI		-	
Purchased Investment		-	
Total Estimated Cash Outflow:		**(7,094,355)**	
Estimated Cash Balance on January 31, 2026		5,117,644	-
		-	-

Bay Arenac Behavioral Health
201 Mulholland, Bay City, MI 48708
Electronic Funds Transfers including Cash Transfers/Wires/ACHs
December 2026

Funds Paid from/ Transferred from:	Funds Paid to/ Transferred to:	Amount	Date of Payment	Description	Authorized By
Flagstar Bank	Flagstar Bank	560,000.00	12/3/2025	Transfer from MMKT Account to General Account	Marci Rozek
Flagstar Bank	Flagstar Bank	145,000.00	12/4/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	560,000.00	12/4/2025	Transfer from General Account to Payroll Account	Marci Rozek
Flagstar Bank	Flagstar Bank	824,674.32	12/4/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	490,000.00	12/5/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	17,801.35	12/8/2025	Credit Card Payment	Marci Rozek
Flagstar Bank	Flagstar Bank	15,000.00	12/8/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	10,000.00	12/11/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	1,928,962.27	12/11/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	880,000.00	12/12/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	170,000.00	12/15/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	25,000.00	12/16/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	765,000.00	12/17/2025	Transfer from MMKT Account to General Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	770,000.00	12/18/2025	Transfer from General Account to Payroll Account	Marci Rozek
Flagstar Bank	Flagstar Bank	1,935,445.23	12/18/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	280,000.00	12/19/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	2,031.96	12/22/2025	Transfer from General Acct for Mortgage payment	Marci Rozek
Flagstar Bank	Huntington Nat'l Bank	3,953.34	12/23/2025	Transfer from General Account to Flex Spending Account	Marci Rozek
Flagstar Bank	Flagstar Bank	870,558.11	12/23/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek
Flagstar Bank	Flagstar Bank	3,610,000.00	12/26/2025	Transfer from General Account to MMKT Account	Marci Rozek
Flagstar Bank	Flagstar Bank	560,000.00	12/30/2025	Transfer from MMKT Account to General Account	Marci Rozek
Flagstar Bank	Flagstar Bank	435,213.09	12/30/2025	Transfer Gross Amt of Accts Payable to Payable Acct	Marci Rozek

Total Transfers: **14,858,639.67**

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

Bay Arenac Behavioral Health
201 Mulholland, Bay City, MI 48708
Electronic Funds Transfers for Vendor ACH Payments
December 2026

Funds Paid from:	EFT #	Funds Paid to:	Amount	Date of Pmt	Authorized By
Flagstar Bank	E9232	Bay Human Services, Inc.	711.08	12/5/2025	Marci Rozek
Flagstar Bank	E9233	MICHIGAN COMMUNITY SERVICES IN	67,107.69	12/5/2025	Marci Rozek
Flagstar Bank	E9234	CENTRAL STATE COMM. SERVICES	66.66	12/5/2025	Marci Rozek
Flagstar Bank	E9235	LIBERTY LIVING, INC.	33,027.04	12/5/2025	Marci Rozek
Flagstar Bank	E9236	HEALTHSOURCE	28,870.00	12/5/2025	Marci Rozek
Flagstar Bank	E9237	PHC OF MICHIGAN - HARBOR OAKS	9,680.00	12/5/2025	Marci Rozek
Flagstar Bank	E9238	MPA GROUP NFP, Ltd.	23,161.92	12/5/2025	Marci Rozek
Flagstar Bank	E9239	LIST PSYCHOLOGICAL SERVICES	2,201.01	12/5/2025	Marci Rozek
Flagstar Bank	E9240	SAGINAW PSYCHOLOGICAL SERVICES	13,487.91	12/5/2025	Marci Rozek
Flagstar Bank	E9241	PARAMOUNT REHABILITATION	6,129.76	12/5/2025	Marci Rozek
Flagstar Bank	E9242	ARENAC OPPORTUNITIES, INC	7,075.50	12/5/2025	Marci Rozek
Flagstar Bank	E9243	DO-ALL, INC.	5,913.57	12/5/2025	Marci Rozek
Flagstar Bank	E9244	TOUCHSTONE SERVICES, INC	8,849.25	12/5/2025	Marci Rozek
Flagstar Bank	E9245	Winningham, Linda Jo	2,218.00	12/5/2025	Marci Rozek
Flagstar Bank	E9246	Nutrition for Wellness	873.60	12/5/2025	Marci Rozek
Flagstar Bank	E9247	WILSON, STUART T. CPA, P.C.	91,542.16	12/5/2025	Marci Rozek
Flagstar Bank	E9248	CAREBUILDERS AT HOME, LLC	14,124.69	12/5/2025	Marci Rozek
Flagstar Bank	E9249	CENTRIA HEALTHCARE LLC	157,268.59	12/5/2025	Marci Rozek
Flagstar Bank	E9250	Flourish Services, LLL	36,194.66	12/5/2025	Marci Rozek
Flagstar Bank	E9251	GAME CHANGER PEDIATRIC THERAPY	45,454.70	12/5/2025	Marci Rozek
Flagstar Bank	E9252	Spectrum Autism Center	26,766.00	12/5/2025	Marci Rozek
Flagstar Bank	E9253	ENCOMPASS THERAPY CENTER LLC	24,946.20	12/5/2025	Marci Rozek
Flagstar Bank	E9254	HEALING WITH HEART	200.00	12/5/2025	Marci Rozek
Flagstar Bank	E9255	APS EMPLOYMENT SERVICES, INC	4,235.94	12/5/2025	Marci Rozek
Flagstar Bank	E9256	NETSOURCE ONE, INC.	1,434.94	12/5/2025	Marci Rozek
Flagstar Bank	E9257	RINGCENTRAL INC	20,680.00	12/5/2025	Marci Rozek
Flagstar Bank	E9258	Yeo & Yeo Technology	162.00	12/5/2025	Marci Rozek
Flagstar Bank	E9259	ZOOM VIDEO COMMUNICATIONS INC	1,149.55	12/5/2025	Marci Rozek
Flagstar Bank	E9260	AUGRES CARE CENTER, INC	3,718.20	12/12/2025	Marci Rozek
Flagstar Bank	E9261	HOPE NETWORK BEHAVIORAL HEALTH	38,849.00	12/12/2025	Marci Rozek
Flagstar Bank	E9262	Hope Network Southeast	128,208.02	12/12/2025	Marci Rozek
Flagstar Bank	E9263	BEACON SPECIALIZED LIVING SVS	9,300.00	12/12/2025	Marci Rozek
Flagstar Bank	E9264	Fitzhugh House, LLC	11,594.70	12/12/2025	Marci Rozek
Flagstar Bank	E9265	Bay Human Services, Inc.	277,649.30	12/12/2025	Marci Rozek
Flagstar Bank	E9266	MICHIGAN COMMUNITY SERVICES IN	218,914.65	12/12/2025	Marci Rozek
Flagstar Bank	E9267	CENTRAL STATE COMM. SERVICES	27,547.65	12/12/2025	Marci Rozek
Flagstar Bank	E9268	VALLEY RESIDENTIAL SERVICES	111,043.82	12/12/2025	Marci Rozek
Flagstar Bank	E9269	LIBERTY LIVING, INC.	32,173.16	12/12/2025	Marci Rozek
Flagstar Bank	E9270	Closer to Home, LLC	18,692.70	12/12/2025	Marci Rozek
Flagstar Bank	E9271	HEALTHSOURCE	44,217.20	12/12/2025	Marci Rozek
Flagstar Bank	E9272	MPA GROUP NFP, Ltd.	36,767.82	12/12/2025	Marci Rozek
Flagstar Bank	E9273	LIST PSYCHOLOGICAL SERVICES	1,520.89	12/12/2025	Marci Rozek
Flagstar Bank	E9274	SAGINAW PSYCHOLOGICAL SERVICES	29,739.10	12/12/2025	Marci Rozek
Flagstar Bank	E9275	PARAMOUNT REHABILITATION	6,895.64	12/12/2025	Marci Rozek
Flagstar Bank	E9276	ARENAC OPPORTUNITIES, INC	5,430.00	12/12/2025	Marci Rozek
Flagstar Bank	E9277	DO-ALL, INC.	3,937.81	12/12/2025	Marci Rozek
Flagstar Bank	E9278	New Dimensions	1,504.30	12/12/2025	Marci Rozek
Flagstar Bank	E9279	TOUCHSTONE SERVICES, INC	21,363.75	12/12/2025	Marci Rozek
Flagstar Bank	E9280	Winningham, Linda Jo	176.00	12/12/2025	Marci Rozek
Flagstar Bank	E9281	Nutrition for Wellness	411.90	12/12/2025	Marci Rozek
Flagstar Bank	E9282	WILSON, STUART T. CPA, P.C.	85,164.64	12/12/2025	Marci Rozek
Flagstar Bank	E9283	CAREBUILDERS AT HOME, LLC	30,141.12	12/12/2025	Marci Rozek
Flagstar Bank	E9284	AUTISM SYSTEMS LLC	9,802.50	12/12/2025	Marci Rozek
Flagstar Bank	E9285	CENTRIA HEALTHCARE LLC	54,736.50	12/12/2025	Marci Rozek
Flagstar Bank	E9286	PERSONAL ASSISTANCE OPTIONS INC	14,234.40	12/12/2025	Marci Rozek
Flagstar Bank	E9287	Flourish Services, LLL	35,777.16	12/12/2025	Marci Rozek
Flagstar Bank	E9288	GAME CHANGER PEDIATRIC THERAPY	37,618.28	12/12/2025	Marci Rozek
Flagstar Bank	E9289	Spectrum Autism Center	12,433.50	12/12/2025	Marci Rozek
Flagstar Bank	E9290	ENCOMPASS THERAPY CENTER LLC	97,422.76	12/12/2025	Marci Rozek
Flagstar Bank	E9291	MERCY PLUS HEALTHCARE SERVICES LLC	55,288.63	12/12/2025	Marci Rozek
Flagstar Bank	E9292	NOBLE PATHWAY PEDIATRIC THERAPY	9,027.00	12/12/2025	Marci Rozek
Flagstar Bank	E9293	AUTISM AND NEURODIVERSITY SERVICES LLC	640.00	12/12/2025	Marci Rozek
Flagstar Bank	E9294	WESTWOOD SPECIALIZED RESIDENTIAL	34,732.80	12/12/2025	Marci Rozek
Flagstar Bank	E9295	APS EMPLOYMENT SERVICES, INC	4,473.18	12/12/2025	Marci Rozek
Flagstar Bank	E9296	MONTCLAIR SPECIALIZED RESIDENTIAL LLC	34,732.80	12/12/2025	Marci Rozek
Flagstar Bank	E9297	PARAMOUNT CHILDRENS THERAPY CENTER IN	36,232.50	12/12/2025	Marci Rozek

Flagstar Bank	E9298	KEITH SPECIALIZED RESIDENTIAL SERVICES LL	133,509.06	12/12/2025	Marci Rozek
Flagstar Bank	E9299	Clean Team, Inc.	216.00	12/12/2025	Marci Rozek
Flagstar Bank	E9300	ADLER, THERESA	100.80	12/19/2025	Marci Rozek
Flagstar Bank	E9301	Aho, Ashley	236.74	12/19/2025	Marci Rozek
Flagstar Bank	E9302	BICKEL, MEREDITH	36.40	12/19/2025	Marci Rozek
Flagstar Bank	E9303	Brothers-Estrada, Abbie	49.00	12/19/2025	Marci Rozek
Flagstar Bank	E9304	BYRNE, RICHARD	192.50	12/19/2025	Marci Rozek
Flagstar Bank	E9305	Deshano, Jennifer	201.60	12/19/2025	Marci Rozek
Flagstar Bank	E9306	Dunnem, Emily	372.54	12/19/2025	Marci Rozek
Flagstar Bank	E9307	FRIEBE, HEATHER	73.50	12/19/2025	Marci Rozek
Flagstar Bank	E9308	GRUSNICK, ASHLEE	154.00	12/19/2025	Marci Rozek
Flagstar Bank	E9309	Gunsell, Stephanie	206.20	12/19/2025	Marci Rozek
Flagstar Bank	E9310	HEWTTY, MARIA	192.64	12/19/2025	Marci Rozek
Flagstar Bank	E9311	HEWTTY, EDDIE	47.04	12/19/2025	Marci Rozek
Flagstar Bank	E9312	JINKS, KIM	120.12	12/19/2025	Marci Rozek
Flagstar Bank	E9313	Kish, Jackie	366.80	12/19/2025	Marci Rozek
Flagstar Bank	E9314	Lagalo, Lori	268.59	12/19/2025	Marci Rozek
Flagstar Bank	E9315	BEYER, NICOLE	569.45	12/19/2025	Marci Rozek
Flagstar Bank	E9316	McClure, Laurel	341.04	12/19/2025	Marci Rozek
Flagstar Bank	E9317	Niemiec, Kathleen	94.50	12/19/2025	Marci Rozek
Flagstar Bank	E9318	NIX, HEATHER	29.40	12/19/2025	Marci Rozek
Flagstar Bank	E9319	Nixon, Heidi	411.11	12/19/2025	Marci Rozek
Flagstar Bank	E9320	O'BRIEN, CAROLE	88.20	12/19/2025	Marci Rozek
Flagstar Bank	E9321	Roznowski, Donna	142.38	12/19/2025	Marci Rozek
Flagstar Bank	E9322	Schneider, Maryssa	223.65	12/19/2025	Marci Rozek
Flagstar Bank	E9323	Schumacher, Pamela	51.92	12/19/2025	Marci Rozek
Flagstar Bank	E9324	STONE, JENNIFER	147.00	12/19/2025	Marci Rozek
Flagstar Bank	E9325	Tenney, Ben	110.55	12/19/2025	Marci Rozek
Flagstar Bank	E9326	WATSON, MELODY	303.10	12/19/2025	Marci Rozek
Flagstar Bank	E9327	WELLS, JEFF	243.03	12/19/2025	Marci Rozek
Flagstar Bank	E9328	Bay Human Services, Inc.	4,501.61	12/19/2025	Marci Rozek
Flagstar Bank	E9329	SAGINAW PSYCHOLOGICAL SERVICES	330.00	12/19/2025	Marci Rozek
Flagstar Bank	E9330	New Dimensions	101,144.08	12/19/2025	Marci Rozek
Flagstar Bank	E9331	TOUCHSTONE SERVICES, INC	90,285.00	12/19/2025	Marci Rozek
Flagstar Bank	E9332	BAY CITY CRU	98,458.00	12/19/2025	Marci Rozek
Flagstar Bank	E9333	APS EMPLOYMENT SERVICES, INC	250.42	12/19/2025	Marci Rozek
Flagstar Bank	E9334	A2Z CLEANING & RESTORATION INC.	3,092.00	12/19/2025	Marci Rozek
Flagstar Bank	E9335	Applied Innovation	99.34	12/19/2025	Marci Rozek
Flagstar Bank	E9336	Bromberg & Associates, LLC	50.00	12/19/2025	Marci Rozek
Flagstar Bank	E9337	Clean Team, Inc.	1,950.00	12/19/2025	Marci Rozek
Flagstar Bank	E9338	ENTERPRISE FM TRUST	7,312.76	12/19/2025	Marci Rozek
Flagstar Bank	E9339	FLEX ADMINISTRATORS INC	921.30	12/19/2025	Marci Rozek
Flagstar Bank	E9340	Griffin Transit	16.00	12/19/2025	Marci Rozek
Flagstar Bank	E9341	HAMPTON AUTO REPAIR	1,221.55	12/19/2025	Marci Rozek
Flagstar Bank	E9342	HOSPITAL PSYCHIATRY PLLC	42,000.00	12/19/2025	Marci Rozek
Flagstar Bank	E9343	Iris Telehealth Medical Group, PA	59,153.00	12/19/2025	Marci Rozek
Flagstar Bank	E9344	KING COMMUNICATIONS	222.95	12/19/2025	Marci Rozek
Flagstar Bank	E9345	McCoy Heating and Cooling	135.00	12/19/2025	Marci Rozek
Flagstar Bank	E9346	MICHIGAN MEDICAL AND REHABILITATION SUPI	230.00	12/19/2025	Marci Rozek
Flagstar Bank	E9347	MILLARS APPLIANCE	100.00	12/19/2025	Marci Rozek
Flagstar Bank	E9348	MOVVA, USHA	9,700.00	12/19/2025	Marci Rozek
Flagstar Bank	E9349	NETSOURCE ONE, INC.	24,754.11	12/19/2025	Marci Rozek
Flagstar Bank	E9350	PRO-SCAPE, INC.	509.60	12/19/2025	Marci Rozek
Flagstar Bank	E9351	RICHARDSON	800.00	12/19/2025	Marci Rozek
Flagstar Bank	E9352	RINGCENTRAL INC	1,062.71	12/19/2025	Marci Rozek
Flagstar Bank	E9353	STATE OF MICHIGAN DEPT OF COMM HEALTH A	3,415.30	12/19/2025	Marci Rozek
Flagstar Bank	E9354	TELNET WORLDWIDE, INC.	1,253.70	12/19/2025	Marci Rozek
Flagstar Bank	E9355	VASCONCELOS, FLAVIA	276.03	12/19/2025	Marci Rozek
Flagstar Bank	E9356	V.O.I.C.E., INC.	1,012.00	12/19/2025	Marci Rozek
Flagstar Bank	E9357	Walgreen Co	2,903.29	12/19/2025	Marci Rozek
Flagstar Bank	E9358	Waystar Health - ZirMed, Inc.	274.13	12/19/2025	Marci Rozek
Flagstar Bank	E9359	Yeo & Yeo Technology	198.00	12/19/2025	Marci Rozek
Flagstar Bank	E9360	HOPE NETWORK BEHAVIORAL HEALTH	87.10	12/19/2025	Marci Rozek
Flagstar Bank	E9361	Bay Human Services, Inc.	192,769.04	12/19/2025	Marci Rozek
Flagstar Bank	E9362	MICHIGAN COMMUNITY SERVICES IN	68,472.97	12/19/2025	Marci Rozek
Flagstar Bank	E9363	VALLEY RESIDENTIAL SERVICES	993.13	12/19/2025	Marci Rozek
Flagstar Bank	E9364	LIBERTY LIVING, INC.	32,976.53	12/19/2025	Marci Rozek
Flagstar Bank	E9365	SUPERIOR CARE OF MICHIGAN LLC	8,298.00	12/19/2025	Marci Rozek
Flagstar Bank	E9366	HEALTHSOURCE	51,017.67	12/19/2025	Marci Rozek
Flagstar Bank	E9367	Memorial HealthCare	3,690.00	12/19/2025	Marci Rozek
Flagstar Bank	E9368	PHC OF MICHIGAN - HARBOR OAKS	6,695.38	12/19/2025	Marci Rozek
Flagstar Bank	E9369	MPA GROUP NFP, Ltd.	23,196.09	12/19/2025	Marci Rozek
Flagstar Bank	E9370	LIST PSYCHOLOGICAL SERVICES	2,954.66	12/19/2025	Marci Rozek
Flagstar Bank	E9371	SAGINAW PSYCHOLOGICAL SERVICES	22,309.93	12/19/2025	Marci Rozek
Flagstar Bank	E9372	PARAMOUNT REHABILITATION	10,874.68	12/19/2025	Marci Rozek
Flagstar Bank	E9373	ARENAC OPPORTUNITIES, INC	6,992.96	12/19/2025	Marci Rozek

Flagstar Bank	E9374	DO-ALL, INC.	6,455.99	12/19/2025	Marci Rozek
Flagstar Bank	E9375	New Dimensions	8,647.92	12/19/2025	Marci Rozek
Flagstar Bank	E9376	TOUCHSTONE SERVICES, INC	9,571.20	12/19/2025	Marci Rozek
Flagstar Bank	E9377	Winningham, Linda Jo	802.00	12/19/2025	Marci Rozek
Flagstar Bank	E9378	Nutrition for Wellness	1,332.00	12/19/2025	Marci Rozek
Flagstar Bank	E9379	WILSON, STUART T. CPA, P.C.	77,453.64	12/19/2025	Marci Rozek
Flagstar Bank	E9380	CAREBUILDERS AT HOME, LLC	16,600.88	12/19/2025	Marci Rozek
Flagstar Bank	E9381	CENTRIA HEALTHCARE LLC	43,995.00	12/19/2025	Marci Rozek
Flagstar Bank	E9382	PERSONAL ASSISTANCE OPTIONS INC	19,723.87	12/19/2025	Marci Rozek
Flagstar Bank	E9383	Flourish Services, LLL	29,044.38	12/19/2025	Marci Rozek
Flagstar Bank	E9384	GAME CHANGER PEDIATRIC THERAPY	51,814.44	12/19/2025	Marci Rozek
Flagstar Bank	E9385	Spectrum Autism Center	24,982.50	12/19/2025	Marci Rozek
Flagstar Bank	E9386	ENCOMPASS THERAPY CENTER LLC	75,911.86	12/19/2025	Marci Rozek
Flagstar Bank	E9387	AUTISM AND NEURODIVERSITY SERVICES LLC	640.00	12/19/2025	Marci Rozek
Flagstar Bank	E9388	HEALING WITH HEART	200.00	12/19/2025	Marci Rozek
Flagstar Bank	E9389	MAXIM HEALTHCARE SEVICES, INC.	1,351.68	12/19/2025	Marci Rozek
Flagstar Bank	E9390	APS EMPLOYMENT SERVICES, INC	3,856.64	12/19/2025	Marci Rozek
Flagstar Bank	E9391	PARAMOUNT CHILDRENS THERAPY CENTER IN	18,378.00	12/19/2025	Marci Rozek
Flagstar Bank	E9392	Insight	20,909.04	12/19/2025	Marci Rozek
Flagstar Bank	E9393	Staples	5,241.47	12/19/2025	Marci Rozek
Flagstar Bank	E9394	CMH FOR CENTRAL MICHIGAN	944.86	12/26/2025	Marci Rozek
Flagstar Bank	E9395	Fitzhugh House, LLC	11,122.05	12/26/2025	Marci Rozek
Flagstar Bank	E9396	MICHIGAN COMMUNITY SERVICES IN	1,251.85	12/26/2025	Marci Rozek
Flagstar Bank	E9397	LIBERTY LIVING, INC.	33,468.19	12/26/2025	Marci Rozek
Flagstar Bank	E9398	HEALTHSOURCE	18,543.60	12/26/2025	Marci Rozek
Flagstar Bank	E9399	CEDAR CREEK HOSPITAL	31,612.00	12/26/2025	Marci Rozek
Flagstar Bank	E9400	PHC OF MICHIGAN - HARBOR OAKS	42,400.00	12/26/2025	Marci Rozek
Flagstar Bank	E9401	MPA GROUP NFP, Ltd.	40,993.92	12/26/2025	Marci Rozek
Flagstar Bank	E9402	LIST PSYCHOLOGICAL SERVICES	2,003.18	12/26/2025	Marci Rozek
Flagstar Bank	E9403	SAGINAW PSYCHOLOGICAL SERVICES	33,462.70	12/26/2025	Marci Rozek
Flagstar Bank	E9404	DO-ALL, INC.	4,551.60	12/26/2025	Marci Rozek
Flagstar Bank	E9405	New Dimensions	9,166.00	12/26/2025	Marci Rozek
Flagstar Bank	E9406	TOUCHSTONE SERVICES, INC	7,546.50	12/26/2025	Marci Rozek
Flagstar Bank	E9407	Winningham, Linda Jo	1,481.00	12/26/2025	Marci Rozek
Flagstar Bank	E9408	WILSON, STUART T. CPA, P.C.	98,740.33	12/26/2025	Marci Rozek
Flagstar Bank	E9409	CAREBUILDERS AT HOME, LLC	16,100.59	12/26/2025	Marci Rozek
Flagstar Bank	E9410	CENTRIA HEALTHCARE LLC	92,443.50	12/26/2025	Marci Rozek
Flagstar Bank	E9411	PERSONAL ASSISTANCE OPTIONS INC	579.92	12/26/2025	Marci Rozek
Flagstar Bank	E9412	Flourish Services, LLL	35,711.32	12/26/2025	Marci Rozek
Flagstar Bank	E9413	GAME CHANGER PEDIATRIC THERAPY	52,680.20	12/26/2025	Marci Rozek
Flagstar Bank	E9414	Spectrum Autism Center	42,474.00	12/26/2025	Marci Rozek
Flagstar Bank	E9415	ENCOMPASS THERAPY CENTER LLC	77,169.30	12/26/2025	Marci Rozek
Flagstar Bank	E9416	MERCY PLUS HEALTHCARE SERVICES LLC	24,493.22	12/26/2025	Marci Rozek
Flagstar Bank	E9417	HEALING WITH HEART	100.00	12/26/2025	Marci Rozek
Flagstar Bank	E9418	APS EMPLOYMENT SERVICES, INC	4,343.35	12/26/2025	Marci Rozek
Flagstar Bank	E9419	Applied Innovation	105.71	12/26/2025	Marci Rozek
Flagstar Bank	E9420	GoTo Technologies USA, Inc.	48.00	12/26/2025	Marci Rozek
Flagstar Bank	E9421	Schumacher, Pamela	207.20	12/26/2025	Marci Rozek
Flagstar Bank	E9422	ZOOM VIDEO COMMUNICATIONS INC	529.20	12/26/2025	Marci Rozek

Total Withdrawals: **4,344,890.48**

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

BAY ARENAC BEHAVIORAL HEALTH

INTEROFFICE CORRESPONDENCE

January 12, 2026

To: Sara McRae, Executive Assistant to the CEO

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

Re: Disbursement Audit Information for Audit Committee

The following is a summary of disbursements as presented

Administration and Services for Behavioral Health

12/19/25 Checks Sequence: #102177-102287, ACH E9300-E9359

Employee travel, conference	$	7,795.59
Purchase Order Invoices	$	28,775.51
Invoices for Routine Maintence, purchase requisitions, & recurring	$	847,937.20
SUBTOTAL - Monthly Batch	**$**	**884,508.30**

ITEMS FOR REVIEW:

EFT transfer - Credit Card 1/06/2026	**$**	**7,210.56**

Weekly Special Checks:

12/26/2025 Checks 102265-102276, E9419-E9422	$	144,430.60
01/02/2026 Checks 102279-102281, E9436-E9439	$	55,593.33
01/09/2026 Checks 102284-102287, E9467-E9470	$	9,399.43
SUBTOTAL - Special Checks	**$**	**209,423.36**

Health Care payments

12/19/25 Checks 102250-102258, ACH Pmts E9360-E9391	$	1,051,928.59
12/26/25 Checks 102260-102264, ACH Pmts E9394-E9418	$	726,127.51
01/02/26 Checks 102277-102278, ACH Pmts E9423-E9435	$	286,177.37
01/09/26 Checks 102282-102283, ACH Pmts E9440-E9466	$	639,731.85
SUBTOTAL - Health Care Payments	**$**	**2,703,965.32**
TOTAL DISBURSEMENTS	**$**	**3,805,107.54**

Prepared by: Karl White

Reviewed by: Michele Perry

MINUTES

BAY ARENAC BEHAVIORAL HEALTH
BOARD OF DIRECTORS
AUDIT COMMITTEE MEETING

Monday, January 12, 2026 at 5:00 pm

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

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

	Agenda Item	Discussion	Motion/Action
1.	Call To Order & Roll Call	Committee Chair, P. McFarland, called the meeting to order at 5:00 pm.	On motion of T. Banaszak and support by P. Conley, J. Crete was excused. The motion passed unanimously.
2.	Public Input (Maximum of 3 Minutes)	There were not any members of the public present.	
3.	Unfinished Business	There was not any unfinished business.	
4.	New Business 4.1) Selection of Disbursements & Health Care Claims from Summary Report 4.2) Financial Statements for Period Ending December 31, 2025	4.1) Administration found the source information for the claims selected for review. 4.2) M. Rozek reported the figures for current assets due from other governmental units and noncurrent liabilities compensated absences require correction by the same amount, which does not affect fund balance. A revised report with the correct figures will be presented to the full Board for consideration. M. Rozek reviewed the reports noting residential and community supports are trending over budget. It is anticipated these expenses will be reduced as the fiscal year continues due to the cost containment strategies leadership has been implementing.	4.1) No action was necessary 4.2) On motion of C. Girard and support by T. Banaszak, the Financial Statements for the period ending December 31, 2025 as amended were referred to the full Board for approval. The motion was adopted unanimously.

	4.3) Electronic Fund Transfers (EFTs) for Period Ending December 31, 2025	4.3) M. Rozek reviewed the EFTs.	4.3) On motion of T. Banaszak and support by C. Girard, the EFTs for the period ending December 31, 2025 were referred to the full Board for approval. The motion was adopted unanimously.
	4.4) Review of Selected Disbursements & Health Care Claims Chosen from Summary Report by CFO	4.4) Administration reviewed the disbursements and health care claim invoices selected for further review. These included 102188 for employee travel reimbursement; E9323 Pam Schumacher for board member travel reimbursement; 102210 Cohl, Stoker, and Toskey, P.C. for legal services; 102194 AT&T for fiber circuits; E9325 for employee travel reimbursement; 102196 Batteries Plus Bulbs for battery replacements at Mulholland and North Bay; 102231 New Image Lawn Care for snow removal and salting services at Horizon Home; E9931 Touchstone Services, Inc. for fiscal year 2025 cost settlement; E9332 Bay City Crisis Residential Unit for crisis residential services in November; E9330 New Dimensions for fiscal year 2025 cost settlement and supported employment services in November; 102238 Protec Collision, Inc. for repairs and maintenance to North Bay vehicles; 102246 Valley Carpet for consumer floor replacement at Liberty Living; E9349 NetSource One for monthly services minus the credit for the ASE circuits; E9341 Hampton Auto Repair miscellaneous vehicle repairs and maintenance; and E9351 Richardson for new tires for an Arenac Center vehicle. There were general discussions regarding charges assigned to the various departments; the charges to Protec Collision are for two different vehicles to each have new brakes; and various acronyms such as for BC CRU, ASE circuits, VDI, and MS Teams.	4.4) No action was necessary
	4.5) Consideration of Approval of Disbursements & Health Care Claims Totals	4.5) The Committee reviewed the disbursement and claim totals. There were general discussions relating to what information is included on this report compared to the EFT report, whether the report is incomplete, the typical	4.5) On motion of C. Girard and support by P. Conley, the disbursements and health care payments from December 13, 2025 through January 9, 2026 were referred to the full Board for approval. The motion was adopted unanimously.

		monthly disbursement and claim payment amounts, and that a Public Act requires the EFTs are reported monthly.	
5.	Adjournment	On motion of C. Girard and support by P. Conley, the meeting adjourned at 5:28 pm. The motion passed unanimously.	

_____
Pat McFarland, Committee Chair

STATE OF MICHIGAN

COURT OF CLAIMS

REGION 10 PIHP, SOUTHWEST MICHIGAN BEHAVIORAL HEALTH, MID-STATE HEALTH NETWORK, ST. CLAIR COUNTY CMHA, INTEGRATED SERVICES OF KALAMAZOO AND SAGINAW COUNTY CMHA,

Plaintiffs,

v

STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, and STATE OF MICHIGAN DEPARTMENT OF TECHNOLOGY, MANAGEMENT, AND BUDGET,

Defendants.
_____/

Consolidated Case Nos. 25-000143-MB and 25-000162-MB

Hon. Christopher P. Yates

CENTRA WELLNESS NETWORK, NORTHEAST MICHIGAN COMMUNITY MENTAL HEALTH AUTHORITY, WELLVANCE, GOGEBIC COMMUNITY MENTAL HEALTH AUTHORITY, NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY, and MANISTEE COUNTY,

Plaintiffs,

v

STATE OF MICHIGAN, STATE OF MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, and STATE OF MICHIGAN DEPARTMENT OF TECHNOLOGY, MANAGEMENT, AND BUDGET,

Defendants.
_____/

OPINION AND ORDER DENYING DEFENDANTS' MOTION FOR SUMMARY DISPOSITION UNDER MCR 2.116(C)(10) AND GRANTING, IN PART, PLAINTIFFS' REQUEST FOR SUMMARY DISPOSITION PURSUANT TO MCR 2.116(I)(2)

On October 14, 2025, this Court issued an opinion and order granting, in part, defendants' summary disposition motion, ruling that Michigan law allows defendant, the Michigan Department of Health and Human Services (MDHHS), to transition from a single-source procurement system to a competitive procurement system. The Court further determined that the MDHHS may reduce the number of prepaid inpatient health plan (PIHP) regions from ten to three. But the Court denied defendants summary disposition on the question of the legality of the terms in the 2025 request for proposal (RFP) that the Michigan Department of Technology, Management, and Budget (DTMB) issued on behalf of the MDHHS to effectuate that transition because the record was insufficient to decide whether the RFP conflicts with Michigan law and impairs the ability of community mental health service programs (CMHSPs) to carry out their statutorily-mandated duties. To address that question, the parties conducted discovery on an expedited basis, and they were joined by additional plaintiff-CMHSPs, which sued the same defendants in a separate complaint filed in case number 25-000162-MB.[1] The parties presented arguments and evidence at a three-day hearing that began on December 8, 2025.[2]

---

[1] The plaintiffs in case number 25-000162-MB include Manistee County and numerous CMHSPs, including: Manistee-Benzie Community Mental Health d/b/a Centra-Wellness Network; AuSable Valley Community Mental Health Authority d/b/a Wellvance; Gogebic Community Mental Health Authority; Northeast Michigan Community Mental Health Authority; North Country Community Mental Health Authority. They filed their lawsuit against the State of Michigan, the MDHHS and the DTMB. The two cases were consolidated through a stipulated order of consolidation entered on November 26, 2025.

[2] The Court permitted the parties to present testimony as well as other evidence and oral argument because plaintiffs had requested a preliminary injunction in addition to declaratory relief regarding the actions of the MDHHS.

Based on the record developed by the parties, the Court shall deny summary disposition to defendants and grant plaintiffs partial summary disposition coupled with a declaration that the RFP violates Michigan law by inhibiting the CMHSPs from fulfilling numerous statutory mandates set forth in the Michigan Mental Health Code, MCL 330.1011 *et seq*. But the Court shall decline, at this time, to issue an injunction barring the MDHHS and the DTMB from selecting PIHPs through a competitive-bidding process or requiring specific action with respect to the 2025 RFP. The RFP must be brought into compliance with Michigan law, which requires, at a minimum, that sufficient Medicaid funds must be allocated to CMHSPs to allow them to perform their statutorily-mandated obligations through financial contracts with other providers. Whether compliance with Michigan law should be achieved through a notice of deficiency, an amended RFP, or a pull-back of the RFP is a matter that the Court must leave to defendants.

I. FACTUAL BACKGROUND

The underlying facts are set forth in the October 14, 2025 opinion and order.[3] The primary issue requiring further consideration is the relationship among the MDHHS, the CMHSPs, and the PIHPs in the provision of mental-health services to Medicaid and non-Medicaid beneficiaries.

[3] After the Court issued its October 14, 2025 opinion and order, the parties submitted briefing prior to the hearing on December 8, 2025. Defendants cited the doctrines of ripeness and standing as defenses to plaintiffs' claims. Those defenses challenge the justiciability of plaintiffs' claims, but both lack merit. Specifically, ripeness attacks justiciability based on timing because "[a] claim is not ripe if it rests upon contingent future events that may not occur as anticipated, or may not occur at all." *Citizens Protecting Mich's Constitution v Secretary of State*, 280 Mich App 273, 282; 761 NW2d 210 (2008), aff'd in part, appeal denied in part, 482 Mich 960 (2008). In contrast, "the standing inquiry focuses on whether a litigant is a proper party to request adjudication of a particular issue[.]" *Lansing Sch Ed Ass'n v Lansing Bd of Ed*, 487 Mich 349, 355; 792 NW2d 686 (2010) (quotation marks and citations omitted). Plaintiffs were under contract with either a PIHP or the MDHHS to offer services that are the subject of the 2025 RFP, and their claims are based on an actual or alleged inability to continue doing so under the 2025 RFP. The instant case is not

Both the MDHHS and the CMHSPs play leading roles in providing mental health services in Michigan. As explained in the opinion and order, the MDHHS is responsible for "support[ing] the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries" that "shall be managed and delivered by specialty prepaid health plans chosen by [the MDHHS]." MCL 400.109f. The MDHHS must "continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state." MCL 330.1116(1). To this end, the MDHHS "shall" "[d]irect services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance," prioritizing those who have the "most severe forms of mental illness, serious emotional disturbance, or developmental disability" and who "are in urgent or emergency situations." MCL 330.1116(2)(a). The MDHHS must carry out that duty by including promotion and maintenance of "an adequate and appropriate system of [CMHSPs] throughout the state." MCL 330.1116(2)(b). "[I]t shall be the objective of the [MDHHS] to shift primary responsibility for the direct delivery of public mental health services from the state to a [CMHSP] whenever the [CMHSP] has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for . . . that service area." MCL 330.1116(2)(b).

CMHSPs play a crucial role not only as a direct provider of mental health services, but also in management or coordination of such care. Created pursuant to the Mental Health Code, MCL

---

like *UAW v Central Mich Univ*, 295 Mich App 486; 815 NW2d 132 (2012), in which the plaintiff was found to lack standing to challenge procedures that existed solely in draft form. The 2025 RFP at issue in this case is final, bids were submitted months ago, and the results of the 2025 RFP will be contracts that significantly alter funding and services that the plaintiffs are authorized to provide to Medicaid beneficiaries in their geographic regions. Thus, plaintiffs' claims are ripe for review, and the CMHSPs have a sufficient interest in their claims to provide standing.

330.1204, CMHSPs are governmental entities, formed by one or more counties, with policies and procedures set by the CMHSP's board or the board of commissioners in the CMHSP's counties. MCL 330.1204(1), (2); MCL 330.1204a; MCL 330.1205. Each CMHSP receives an annual, direct appropriation through a general fund contract with the MDHHS, which each CMHSP can use for services for Medicaid or non-Medicaid beneficiaries. General fund allocations account for only a small portion of the budget through which CMHSPs provide services in their geographic regions, which include both Medicaid and non-Medicaid-eligible consumers.

A CMHSP is required by Michigan law "to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay." MCL 330.1206(1). Such services "shall include, at a minimum, all of the following":

> (a) Crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service that is prepared to respond to a person experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment.
>
> (b) Identification, assessment, and diagnosis to determine the specific needs of the recipient and to develop an individual plan of services.
>
> (c) Planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services.
>
> (d) Specialized mental health recipient training, treatment, and support, including therapeutic clinical interactions, socialization and adaptive skill and coping skill training, health and rehabilitative services, and pre-vocational and vocational services.
>
> (e) Recipient rights services.
>
> (f) Mental health advocacy.
>
> (g) Prevention activities that serve to inform and educate with the intent of reducing the risk of severe recipient dysfunction.
>
> (h) Any other service approved by the [MDHHS]. [MCL 330.1206(1).]

CMHSPs must fulfill that obligation for both Medicaid and non-Medicaid recipients. In fact, CMHSPs are prohibited from denying services because a person is financially unable to pay. MCL 330.1208(4). And CMHSPs are statutorily authorized to bill Medicaid or other appropriate payers for the services. MCL 330.1202(2). Indeed, CMHSPs do not often know whether a person in need of services is covered by any third-party payor, including Medicaid.

The Mental Health Code recognizes that CMHSPs may contract with service providers for the services described above. This is evident in Section 206a, which requires that recipients must be afforded an opportunity to request mediation "to resolve a dispute between the recipient . . . and the [CMHSP] or *other service provider under contract with the* [*CMHSP*] related to planning and providing services or supports to the recipient." MCL 330.1206a(1) (emphasis added). There is good reason to believe that that applies to Medicaid recipients because that same section provides that the right to mediation does not preclude a recipient from pursuing other forms of alternative resolution, including "the state Medicaid fair hearing[.]" See MCL 330.1206a(6).

Further support for the right of CMHSPs to contract with service providers can be gleaned from the CMHSPs' duty to furnish at least a plan for services to individuals prior to their release to an appropriate community placement. Section 209a of the Mental Health Code makes clear that that CMHSPs, "with the assistance of the state facility or licensed hospital under contract with" a CMHSP, "shall develop an individualized prerelease plan for appropriate community placement and a prerelease plan for aftercare services appropriate for each resident" unless a state facility fulfills that duty. MCL 330.1209a(1). CMHSPs may contract with a service provider to carry out that duty, including a "licensed hospital under contract with a [CMHSP] or state facility," and the CMHSP must offer prerelease planning services and "develop a release plan in cooperation with

the individual unless the individual refuses this option." MCL 330.1209a(2), (3). The plan has to be prepared "within 10 days after release." MCL 330.1209a(4). The directors of CMHSPs find it impractical, if not impossible, to fulfill that duty without the ability to negotiate a financial contract with other providers that applies to services afforded to Medicaid recipients. Payment of funds is the consideration promised in exchange for ensuring each provider's cooperation with CMHSPs.

The Mental Health Code also requires CMHSPs to have "a written interagency agreement in place for a collaborative program to provide mental health treatment and assistance" to "persons with serious mental illness" who are involved in the criminal justice system. MCL 330.1207a(1). A CMHSP, rather than the MDHHS or a PIHP, is a required party to each interagency agreement, and the mandatory components of an interagency agreement include "(a) Guidelines for program eligibility, . . . (c) Day-to-day program administration, . . . (g) Resource sharing between the parties to the interagency agreement, (h) Screening and assessment procedures, (i) Guidelines for case management, . . . [and] (m) Procedures for first response to potential cases, including response to crises." MCL 330.1207a(3). Counties are not required to provide funds for the program except to the extent appropriated annually by the Legislature. MCL 330.1207a(7). The statute provides no release of this obligation for people within the CMHSP's duties who are recipients of Medicaid.

A similar situation exists with respect to the CMHSPs' duties for preadmission screening. The Mental Health Code permits CMHSPs to enter into contracts with hospitals and other agencies qualified to serve those needing urgent and emergent care. It also requires CMHSPs to coordinate with providers both before and after the provision of services. CMHSPs must "establish 1 or more preadmission screening units with 24-hour availability to provide assessment and screening for individuals being considered for admission into hospitals, assisted outpatient treatment programs,

or crisis services on a voluntary basis." MCL 330.1409(1). CMHSPs may satisfy that requirement by employing mental health service professionals or contracting with another agency with similar qualifications. MCL 330.1409(1). The duties extend beyond screening to mandate coordination with the various entities involved in the person's care. To address the needs of the individual being screened, the CMHSP "shall assess an individual being considered for admission into a hospital operated by [the MDHHS] or under contract with" the CMHSP. And if the individual is clinically suitable for hospitalization, the "preadmission screening unit shall authorize voluntary admission to the hospital." MCL 330.1409(3). A hospital that receives a person taken into protective custody who has been referred by a CMHSP's preadmission screening unit "shall notify the unit of the results of an examination of that individual conducted by the hospital." MCL 330.1427(3).

When an individual does not meet the requirements for hospitalization, the "preadmission screening unit shall ensure provisions of follow-up counseling and diagnostic and referral services if needed." MCL 330.1427(1). The preadmission screening unit is also responsible for providing "information regarding alternative services and the availability of those services" and "making appropriate referrals" to individuals who are found not clinically suitable for hospitalization. MCL 330.1409(5). A CMHSP's preadmission screening unit may also operate a crisis stabilization unit pursuant to MCL 330.1971 *et seq.*, followed by the "clinically appropriate level of care" including referrals to outpatient services, a partial hospitalization program, a residential treatment center, an inpatient bed, or an order for involuntary treatment. MCL 330.1409(7).

Even in the case of voluntary admissions, the CMHSP's preadmission screening unit must authorize admission to a hospital or an outpatient treatment program. Specifically, MCL 330.1410 states that "an individual who requests, applies for, or assents to either informal or formal voluntary

admission to a hospital or outpatient treatment program operated by [MDHHS] or a hospital or outpatient treatment program under contract with a [CMHSP] may be considered for admission by the hospital or outpatient treatment program only after authorization by a [CMHSP] preadmission screening unit." MCL 330.1410.

Ensuring that people receive the benefit of the recipient rights legislation is also within the purview of the CMHSPs. Chapter 7 of the Mental Health Code, MCL 330.1700 *et seq.*, identifies numerous rights that must be afforded to the recipients of mental health services. A CMHSP must "establish an office of recipient rights," MCL 330.1755, which shall have "unimpeded access" to programs and services offered by the CMHSP or licensed hospitals, staff employed under contract with the entities, and evidence needed to "conduct a thorough investigation or fulfill its monitoring function." MCL 330.1755(2)(a), (d)(*i*)-(*iii*). In addition, "[e]ach contract between the [CMHSP] or licensed hospital and a provider" must ensure each provider and its employees receive recipient rights training and that recipients are "protected from rights violations while they are receiving services under the contract." MCL 330.1755(2)(f). The office of recipient rights must "[p]rovide or coordinate the protection of recipient rights for all directly operated or contracted services" and ensure that recipients have access to summaries of such rights and that records are maintained of "reports of apparent or suspected violations of rights within the [CMHSP] system or the licensed hospital system." MCL 330.1755(5). CMHSPs are responsible for site visits and ensuring that people within the CMHSP, "contract agency, or licensed hospital" are trained on recipient rights protection. MCL 330.1755(5)(f). The board of the CMHSP is responsible for reviewing an annual report on the status of recipient rights within its community. MCL 330.1755(6).

CMHSPs are obligated to furnish all recipients with a "choice of physician or other mental health professional" in accordance with the policies of the CMHSP, licensed hospital, or "service provider under contract with the [CMHSP]." MCL 330.1713. Also, CMHSPs must "ensure that appropriate disciplinary action is taken against" entities or individuals who "have engaged in abuse or neglect" of recipients of mental health services. MCL 330.1722. Under that statute, CMHSPs are regarded as akin to the MDHHS, licensed hospitals, and service providers under contract with the MDHHS or the CMHSP. MCL 330.1722(2).

Defendants issued the challenged RFP on August 4, 2025, proposals had to be submitted by October 6, 2025, and contracted services are scheduled to begin on October 1, 2026. During the hearing, MDHHS representatives testified that the operational aspects of the RFP have not yet been worked out. By its terms, the RFP requires that bidders must be either a nonprofit, a public body or governmental entity, or a public university, and its proposal must provide services to one of three regions of the state, "not by individual counties." According to the RFP, "[b]idders must demonstrate the ability to be fully operational across the entire geographic area of the region for which they are submitting a proposal. Bidders that cannot provide services throughout the entire region will not be considered." Further, defendants have the right to discontinue the RFP process "at any time for any or no reason," or to "[a]ward multiple, optional-use contracts, or award by Contract Activity." The RFP affects between $5 and $6 billion in state-administered funding.

The successful bidder for each of the three regions is to serve as the PIHP with the sole and nondelegable right to provide managed care functions to Medicaid beneficiaries, except CMHSPs may authorize inpatient admissions through preadmission screenings. As Section 1.1 of the RFP explains:

> Contractors are expected to provide managed care functions to beneficiaries. Those functions cannot be delegated to contracted network providers with the exception of Preadmission screening for emergency intervention services per Mental Health Code MCL 330.1409 which shall be performed by the CMHSP with Contractor authorization of inpatient admissions as indicated by the preadmission screening unit. Managed care functions include, but are not limited to, eligibility and coverage verification, utilization management, network development, contracted network provider training, claims processing, activities to improve health care quality, and fraud prevention activities. . . . Contractor may not directly provide or deliver health care services beyond these managed care functions.

The contractor is responsible for managing the Specialty Behavior Health Services population in one of three regions and serving beneficiaries eligible for Medicaid Specialty Behavioral Services in the service area identified in the contract. The contractor must ensure that "the residential (adult foster care, specialized residential, providers owned/controlled) and non-residential services (skills building, community living supports, and out of home non-vocational)" furnished to individuals supported by several federal and state programs "maintain a home and community character setting as required by federal regulation and outlined in the HCBS Section of the Medicaid Provider Manual."

The RFP places responsibility on each contractor to pay service providers and to establish, maintain, and evaluate an effective provider network. But the "Contractor remains the accountable party for the Medicaid beneficiaries in its service area." According to the RFP, the contractor is "responsible for development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this Contract." When subcontractors are employed to do the work, the contractor must adhere to applicable provisions of the federal procurement requirements.

The contractor is responsible for "medically necessary community-based SUD treatment services for individuals under the supervision of the [Michigan Department of Corrections]" who

are "typically under parole or probation orders." Those "referred by court and services through local community corrections (PA 511) systems must not be excluded from these Medicaid/Healthy Michigan program funded medically necessary community-based behavioral health and SUD treatment services." With respect to those services, the contractor is "solely responsible for the composition, compensation, and performance of its contracted provider network." The contractor is also required to "develop and implement a transition of care policy," as well as the provision of "certain enhanced community support services for those beneficiaries in the service area who are enrolled in one of three Michigan's 1915(c) HCBS Waivers."

The RFP also requires the contractor to provide substance abuse home health services and behavioral health services that consist of "comprehensive care management and coordination" to Medicaid beneficiaries with serious mental illness or substance use disorders. The substance use and behavioral health services are the "central point of contact for directing patient-centered care across the broader health care systems." Additionally, the RFP requires the contractor to "restrict the entity (CMHSP or contracted provider) that develops the person-centered service plan from providing services without the direct approval of the state."

The Court heard testimony during the hearing from executive directors of CMHSPs, who stated that up to 95% of the CMHSPs' budgets were paid through Medicaid's capitated payment system, and performing the duties assigned to CMHSPs under the Mental Health Code necessarily required CHMSPs to perform some of the functions designated as "managed care functions" in the RFP. CMHSPs serve as more than just providers. Rather, they coordinate with a local provider network through contracts with the providers that involve not only payment, but also an agreement that the provider will allow an investigation into noncompliance that includes, without limitation,

the failure to provide beneficiaries with the rights required as recipient rights under Chapter 7 of the Mental Health Code, MCL 330.1700 *et seq.* Additional contract functions mandate the right to mediation, person-centered planning, pre-release plans, and the CMHSP's right to ensure that disciplinary action is taken against those who violate beneficiaries' rights under MCL 330.1722(1).

Providers entering into these contracts include more than just hospitals, but may include providers of rehabilitation services, members of law enforcement, and other individuals or entities that interact with those who face mental health crises in the CMHSP's geographic area. Provider contracts accounted for approximately $9 million of the $21 million budget for Centra Wellness Network, a CMHSP serving Manistee and Benzie counties. Those funds are essential for meeting the CMHSP's statutory duties, especially in situations requiring crisis intervention. The CMHSP directors testified that the contracts were necessary for them to perform the functions mandated by Michigan law. This is especially significant in the context of the CMHSP's responsibility under MCL 330.1438 to those who present with an emergency. Multiple contracts are necessary because recipients must be given a choice of physician or mental health professional "in accordance with the policies of the [CMHSPs]." MCL 330.1713.

Medicaid funds are necessary to enable CMHSPs to furnish the administrative, assessment, and service-identification functions mandated by MCL 330.1226(1)(a). Some of those costs are required by statute. For example, CMHSPs must "select a physician, a registered nurse with a specialty certification issued under [MCL 333.17210], or a licensed psychologist to advise the [CMHSP] on treatment issues." MCL 330.1226(1)(m). With respect to the spreading of this cost, Michigan law permits CMHSPs to "[s]hare the costs or risks, or both, of managing and providing publicly funded mental health services with other [CMHSPs] through participation in risk pooling

arrangements, reinsurance agreements, and other joint or cooperative arrangements as permitted by law." MCL 330.1226(2)(e). In addition, the Mental Health Code allows CMHSPs to "[e]nter into agreements with other providers or managers of health care or rehabilitative services to foster interagency communication, cooperation, coordination, and consultation." MCL 330.1226(2)(f).

This prominently plays out in the situation when a person presents at a community mental health facility with the need for inpatient psychiatric treatment. Preadmission screening remains a responsibility of the CMHSPs even under the RFP, but CMHSPs cannot carry out that function unless they are allowed to provide the managed care functions designated exclusively to the PIHPs in the RFP. Without the ability to enter into contracts incentivized through payments to hospitals and other providers of services to people who present for involuntary or voluntary admission, the CMHSP cannot adequately serve those people. In emergent situations, neither the CMHSP nor the provider knows whether the individual is covered by Medicaid at the time of the screening, so the ability of the CMHSP to guarantee payment at the time of admission is crucial. Moreover, if the individual is a child, the CMHSP must undertake a search for the child's parent or guardian prior to admission, and the source of funding is unclear in that situation.

Wrap-around services are another area that CMHSP directors described as a crucial part of their work in serving their communities, and something that requires them to serve in a managed-care capacity, rather than as a provider. To be sure, CMHSPs have sources of funding other than Medicaid, such as commercial insurance, Medicare, general funds, or various grants. But CMHSP directors explained that they do not always know whether a person who presents for care qualifies for funding from any of those sources.

Marissa Grove, who serves as a solicitation manager at DTMB, explained the process for issuing an RFP. She explained that DTMB has three options for revising an issued RFP. It can issue a notice of deficiency, it can issue an amendment to the RFP, or it can pull back the RFP if major problems exist. Here, five amendments have already been made to the RFP. The RFP sets the terms of the contract, and both the contract terms and the RFP are subject to change after the bid is accepted, even if there is a change that cancels the RFP.

Raymie Postema, the MDHHS Director of the State Office of Recipient Rights, testified that she had concerns about the RFP and its potential negative impact on the protection of recipient rights throughout the state. CMHSPs are statutorily required to train and enforce recipient rights, so transferring that responsibility to the successful bidders for PIHP roles impedes that process.

Aneza Smith-Butterwick, the MDHHS's subject-matter expert for substance use disorder (SUD) in the context of the RFP, explained that SUD services are governed by the Mental Health Code, and they must be provided by a CMHSP or a regional entity. The RFP allows for more than one entity in a single geographic region if the entities bid together, but a public university cannot receive block-grant funds for SUD services.

Kristen Morningstar, the MDHHS Bureau Administrator, who served as program manager for procurement at the MDHHS, stated that managed-care functions are a core feature of the RFP, and those functions cannot be delegated, so CMHSPs cannot contract with a provider for managed-care services. Morningstar was unsure how CMHSPs could fulfill their statutory duties under MCL 330.1309 and MCL 330.1422. Several others with authority at the MDHHS, including Postema, raised concerns about the RFP and compliance with Michigan law. Postema commented that SUD services cannot be managed under the RFP if a PIHP is not a regional entity or a CMHSP.

Leslie Asman from the Bureau of Legal Affairs offered reasons for the RFP. Specifically, she mentioned introducing competitive procurement, the possibility of the federal government not renewing a waiver for the Medicaid program, and concerns about administrative duplication. At present, seven of the ten existing PIHPs delegate functions to CMHSPs. Asman testified that the RFP resolves conflicts of interest because it places the payor role solely in the hands of the PIHPs, not the CMHSPs, which act as providers of some services. She also described the operation of the PIHPs and the system established by the RFP. How this will take place in terms of operations has yet to be determined, but because the MDHHS has experience in carrying out operations without details set in advance, Asman had no concerns about that matter. Therefore, defendants asked the Court to place its imprimatur on the existing RFP by awarding them summary disposition.

II. LEGAL ANALYSIS

Defendants sought summary disposition under MCR 2.116(C)(8) and (10), and plaintiffs responded by asking for similar relief under MCR 2.116(I)(2). What remains unresolved after the Court's October 14, 2025 opinion and order is a single issue under MCR 2.116(C)(10) and MCR 2.116(I)(2). A motion requesting summary disposition under MCR 2.116(C)(10) "tests the *factual sufficiency* of a claim." *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159-160; 934 NW2d 665 (2019). Summary disposition under MCR 2.116(C)(10) may be awarded only if "there is no genuine issue of material fact." *Id.* Such a genuine issue of material fact exists "when the record leaves open an issue upon which reasonable minds might differ." *Id.* The remaining issue here is whether the RFP conflicts with the Mental Health Code, and particularly MCL 330.1206(1), which assigns certain functions to CMHSPs, rather than PIHPs. Several significant conflicts exist.

The RFP does not obligate the PIHPs selected through the bidding process to give priority to CMHSPs for the "comprehensive array of mental health services appropriate to conditions of

individuals who are located within its geographic service area," except pre-admission screening for inpatient hospital services, which the CMHSPs are statutorily mandated to provide "regardless of an individual's ability to pay." MCL 330.1206(1). More importantly, the RFP bars successful bidders for PIHP roles from paying CMHSPs for services provided through contracts with service providers. This conflicts with numerous provisions of the Mental Health Code, which recognizes that CMHSPs must provide certain services and ensure recipients of those services receive various rights either directly from the CMHSPs or through contracts with other service providers.

Indeed, each of the mental health services that CMHSPs are required, "at a minimum," to provide pursuant to MCL 330.1206 requires CMHSPs to develop a network of providers (through contractual relationships) to furnish services to Medicaid beneficiaries, to carry out eligibility and coverage verification for Medicaid beneficiaries, and to engage in activities to improve health care quality. Crisis stabilization and response, for example, requires CMHSPs to maintain a network of providers to react with flexibility and in a short timeframe. See MCL 330.1206(1)(a). Recipient rights services are incentivized through financial contracts that give CMHSPs authority to conduct the necessary investigations into beneficiaries' complaints. See MCL 330.1206(e). And mental-health advocacy and prevention activities that inform and educate with the "intent of reducing the risk of severe recipient dysfunction" are closely related, if not identical, to activities that improve health-care quality. See MCL 330.1206(g). Those duties are imposed on the CMHSPs regardless of whether or not the recipients are Medicaid beneficiaries and, in fact, directors of the CMHSPs commented that they often do not know whether those seeking services are eligible for Medicaid. Medicaid funding is such a significant portion of the budgets of CMHSPs that it is impractical, if not impossible, for CMHSPs to differentiate Medicaid beneficiaries from others to whom they are statutorily obligated to provide mental-health services. CMHSPs must provide services regardless

of an individual's ability to pay, MCL 330.1208(4), and CMHSPs are statutorily authorized to bill Medicaid or other appropriate payers for the services. MCL 330.1202(2).

That obligation extends far beyond the duties identified in MCL 330.1206. The CMHSPs' statutory duty to provide preadmission screening requires the CMHSPs to have flexibility to enter into financial contracts with service providers above and beyond inpatient hospital admissions to address the complex needs of individuals to whom they provide services. Their contracts must be negotiated in advance because preadmission screening must be available seven days a week, 24 hours a day. MCL 330.1409(1). Moreover, the duties following the screening require coordination with other entities involved in each person's care. MCL 330.1409(5), (7). Services following pre-admission screening may include hospitalization, or if the person does not meet the requirements for hospitalization, the CMHSP instead must "ensure the provisions of follow-up counseling and diagnostic and referral services if needed." MCL 330.1427. Individuals determined not clinically appropriate for inpatient placement must be directed to clinically appropriate levels of care that may include outpatient services or a residential treatment center. MCL 330.1409(7). Medicaid funding is crucial to the CMHSPs' ability to carry out those statutory mandates because it depends on the maintenance of a provider network.

Numerous provisions of the Mental Health Code require CMHSPs to contract with service providers. Those provisions include recipients' rights to request mediation and receive individual prerelease plans for appropriate community placement as well as plans for aftercare services. MCL 330.1206a; MCL 330.1209a(1), (2), (3). Also, CMHSPs must enter into interagency agreements for a collaborative program to provide mental-health treatment and assistance to qualifying people involved in the criminal justice system. MCL 330.1207a(3).

Finally, CMHSPs' contracts with providers ordinarily include a provision authorizing the CMHSPs to carry out investigations and take disciplinary actions to ensure that the recipient rights provisions in Chapter 7 of the Mental Health Code are carried out. The RFP's prohibition of PIHPs delegating that function to CMHSPs through financial contracts conflicts with Michigan law.

III. CONCLUSION

For the reasons explained above, defendants' motion for summary disposition beyond the award in the Court's October 14, 2025 opinion and order is denied, and the Court hereby issues a declaratory pronouncement that the RFP, as drafted, impermissibly conflicts with Michigan law in numerous respects, especially insofar as the RFP restricts CMHSPs from entering into financial contracts for the purpose of funding CMHSPs' managed-care functions. However, the Court will not yet issue injunctive relief that directs defendants to amend or pull back the RFP.[4] Defendants must decide, in the first instance, how to address the conflicts between Michigan law and the RFP that the Court has identified.

IT IS SO ORDERED.

This is not a final order. It does not resolve the last pending claim or close the case.

Date: January 8, 2026

Hon. Christopher P. Yates (P41017)
Judge, Michigan Court of Claims

[4] Michigan law disfavors injunctive relief against state agencies and officials except in cases where declaratory relief has failed. See *Davis v Detroit Fin Review Team*, 296 Mich App 568, 614; 821 NW2d 896 (2012). Consequently, the Court will stay its hand unless and until defendants prove unable or unwilling to fulfill their obligations under this Court's declaratory pronouncement.

2026 Environmental Scan and Breakthrough Initiatives

Finance Committee

1. Management of Internal Operations and Provider Network within BABHA Annual Budget and Available Revenue
   - Monitor Long Term (3-5 year) Financial Plan based on revenue trends
   - Monitor Medicaid, Healthy Michigan, ABA and General Fund expenses in every programmatic, personnel and financial consideration; continually monitor fiscal year revenue projections
   - Investigate options to revise eligibility/authorization criteria for inpatient care, outpatient services and autism services to reduce the increasing expense curve in 2026
   - Evaluate the financial impact of MDHHS ABA reimbursement rates against the actual cost of related services
   - Identify other options to reduce autism, Healthy Mi and General Fund expenses consistent with contract requirements including formal procurement and discount pricing arrangements
   - Partner with CMHAM, MSHN and county officials to advocate with State for sustainable public mental health funding levels

Program Committee

2. Cost Containment Strategies and Availability of Community Living Support Services (CLS) for Adults & Children
   - Review current CLS approval process and make necessary changes to implement a more comprehensive and consistent CLS Assessment and Committee approval process:
     - Review the existing CLS Committee structure and consider revisions that will enhance consistency with approvals.
     - Provide training on the Assessment Tool to all internal and external Case Management providers.
     - Assure that CLS is the last resort for consumers and that all other avenues have been pursued prior to approval of CLS.
   - Implement Procurement Strategy for highest cost community living supports (CLS) and North Bbay arrangements and transition to new providers.
     - Identify/solicit network of available CLS providers to transition approximately 50% of the existing NB consumers over time.
     - Identify CLS arrangements that may need a transition period utilizing North Bay CLS filling the gap between referrals to a provider and/or in times of crisis.
     - Identify internal BABHA options to utilize North Bay staff to provide limited CLS and explore other services that the North Bay staff might be able to provide (i.e. Supports Coordinator Assistants, limited CLS for barrier free access, individuals with high behavioral needs).
     - Continue to expand the CLS provider network, including for children.
     - Transition vocational providers on a cost settlement contract back to a fee for service contract with CLS rates being more in line with other CLS providers.
   - Identify and transition any duplicative CLS arrangements.
     - End CLS social/recreational services at vocational programs for consumers who already receive CLS services in AFC settings.
     - Establish consistent and stricter, time limited parameters for CLS social recreation services for consumers living in non-licensed settings.
     - Review and assure that Self Determination arrangements are covering all CLS services and not getting CLS services outside of the Self Determination arrangement.
   - Explore additional areas for cost containment:
     - Continuously review all HMP consumers to determine if eligible for Medicaid.
     - Implement discharge proceedings for enrollees that lose Medicaid/fail to meet spend down requirements in CLS arrangements.
     - Establish more robust UM parameters for medical necessity for CLS in vocational services.
     - Explore consolidation of vocational services to two primary vendors

- Implement quality review process to ensure EVV compliance standards are met.
    - Identify key members to participate in this review process
    - Continue to review EVV bulletins for updates and train CLS providers and staff on correct us of EVV.

3. Stabilization and Cost Containment Strategies for Residential System
    - Continue to advocate, prioritize and support efforts to stabilize the residential services and advocate at all levels for improving the Direct Care workforce.
        - Explore development of more direct and provider operated living arrangements that are capable of providing adequate services for individuals with higher behavioral needs.
        - Explore more individualized and potentially unlicensed arrangements to be able to meet the needs of individuals with higher behavioral needs in more appropriate settings.
        - Continue to collaborate with the Crisis Residential home to provide services to individuals with higher behavioral needs in crisis.
    - Support staff's ability to perform effectively and to ensure residents' needs are met.
        - Increase the residential provider network's ability to handle workforce challenges, crises, and people with challenging behaviors, etc. by providing additional supports such as psychological services, Quality of Life Mentor services, debrief resources and other necessary support services.
    - Address high cost out of county placements and vacancies in the Specialized Residential provider network.
        - Eliminate payments for vacant bed days to encourage providers to increase current occupancy rates.
        - Explore consolidation of vacant specialized residential beds to either direct operate or contract out to a provider who will provide services to higher need individuals.
        - Explore the possibility of adding another crisis residential home
        - Transition North Bay CLS staff to residential technicians if assume another direct operated home.
        - If vacancies can't be filled in the existing provider network, consider closing a current residential facility.
4. Applied Behavior Analysis (ABA) Services Stabilization and Cost Containment Strategies
    - Develop a value-based care model for services.
        - BABHA will work with a consultant to develop this significant shift from the traditional model.
        - Form a time limited work group to develop key standards.
        - Incorporate the use of data analytics to support an outcomes-based approach to ABA treatment.
    - Improve operational efficiencies within the ABA provider network.
        - Develop a procurement process/ Request for Proposal (RFP).
        - Educate current provider network on new model and expectations.
        - Increase ABA provider meetings to twice per year to help improve communication and education of expectations.
5. Evidence-Based and Best Practices in Clinical Service Delivery
    - Trauma Informed Services:
        - Continuation of the three-year organizational Assessment for Trauma and develop the Improvement Plan based on the results of the Assessment.
        - Incorporate recommendations from the Wellness/Compassion Satisfaction Initiative (CSI) team to reduce vicarious trauma/secondary traumatic stress. - continue
        - Evaluate capacity and need for EBP to treat trauma in all populations. - continue
        - Identify and Implement Trauma Treatment Groups (Seeking Safety, TREM, Helping Women Recover, etc.)
    - Clinical Effectiveness and Expanding Evidenced Based Practices
        - Monitor LOCUS training plan that includes ongoing activities to strengthen model fidelity throughout the provider network serving adults with a Serious Mental illness (SMI). Evaluate implementation and capacity of existing Evidence Based Practices. Evaluate existing system structures to determine if the agency has created a system that supports ongoing successful implementation of existing EBP
        - Focus on co-occurring SED/IDD training for the Children's Department.
        - Develop outcomes monitoring processes to assure and measure fidelity to EBPs, including participating in the MiFAST reviews for existing EBPs; completing the MiFAST for the LOCUS. MiFAST for LOCUS will be conducted in FY24.
        - Monitor activity for the Infant and Early Childhood Mental Health Consultation grant.

- Monitor activities for the Alternative Outpatient Treatment (AOT) grant program. Determine program sustainability post grant. Apply for new grant opportunities for additional grant funding as they arise.
- Expand IPS services and improve fidelity amongst current providers. Increase referrals and expand on education around the impact of IPS services.
- Improve education on Benefits to Work coaching and dispelling myths associated with working while receiving benefits.

6. Community and Employee Engagement
   - Continue to work with Community partners (law enforcement, courts, MDHHS, schools, medical facilities, etc.) to increase understanding, reduce stigma and promote trauma informed communities.
   - Re-instate a process for keeping behavioral health literature in community partner lobbies and available to the public. (Possibility to have secretaries be responsible for distribution and two way communication for community events.)
   - Maintain efforts to actively include service providers in prompt communication and opportunities for collaboration
   - Implement Staff recognition process for milestone years of service developed by Wellness Committee
   - Add a Critical Incident Response Team to expand BABHA capacity to respond to disaster behavioral health and other community emergencies

Personnel and Compensation Committee

7. Recruitment and Retention
   - Strategies to attract and retain qualified LBSW and MSW candidates.
   - Explore the option to consider Case Management Assistant positions.
   - Strategy to attract and retain qualified and invested direct care staff – maintain continuous posting practices-post positions as needed.
   - Financial impact of additional potential compensation adjustments (salary and/or benefits) for the organization – consider adding compensation review on an annual basis to the Board By-Laws.
8. Development of Workforce
   - Increase cross-departmental understanding through increased exposure during orientation/training, all-staff events, etc., including job shadowing and document – continue to utilize alternate methods to present training; look at use of alternative training programs for direct care post pandemic
   - Staff development will explore ways to improve the new employee orientation process to include increased awareness of BABH locations
   - Increase consistency in the application of standards by supervisory staff
   - Continue to increase SUD competency of BABHA clinical programs through training and expanding the number of certified/licensed staff; modify job descriptions as warranted
   - Develop/promote staff training on common MH diagnosis in order to increase staff competency in providing education to persons served. Suggestions from the Employee Survey regarding specific training topics will be forwarded to Staff Development for consideration
   - Formally outline the role for case management in an integrated healthcare environment and educate staff
   - Continue to support residential staffing for BABHA's direct operated home and apartment settings through training and redeployment during the pandemic and beyond
   - Continue initiatives that support agency efforts relative to recovery-based care, trauma informed services, co-occurring services and fostering a culture of gentleness
   - Increase communication with staff by making Agency Leadership Meeting minutes available on the intranet
   - Provide leadership training related to employment practices at monthly all-leadership meetings. Provide leadership and/or management training to Agency management staff
   - Continue to fully develop succession planning, health care competencies, and supervisory competencies into the performance management process

Facility Committee

9. Review of Remote Work and Physical Plant needs CLS is less available than is needed and therefore the demand for services across multiple clinical populations and service settings is not being met.

- Implement Leadership Dashboard and other reports to allow Supervisors and Managers for real time monitoring and evaluate staff's activity.
- Evaluate long term staff equipment and space needs post remote work implementation.
- Maintain an inventory of equipment for deployment; hold on 20265 Replacement schedule
- Prepare long term physical plant recommendations related to Bay County locations for Board consideration

CMHA

Community Mental Health Association of Michigan

Annual Winter Conference

IGNITE Action!

February 2, 2026 • Pre-Conference

February 3-4, 2026 • Main Conference

Radisson Plaza Hotel
Kalamazoo, Michigan

CMHA's New Registration & Training Platform

We are excited to share that CMHA will be launching a new registration and training platform, along with a refreshed CMHA website in December. As part of this upgrade, you will soon have access to a member portal, where you can register for trainings and access your CE certificates and training history all in one place—a major enhancement to your learning experience.

Beginning **January 1, 2026**, CMHA will also require **payment at the time of registration** for all trainings, conferences, events, and recipient rights book orders. This change will streamline processing, reduce delays, and allow for more timely refunds.

Please note that this improvement may result in a slight delay in some registration openings as we finalize the new system. We appreciate your patience during this transition and encourage you to visit CMHAM.org for updates. Thank you for your understanding and support. More details will be shared in the coming weeks. Stay tuned!

REGISTRATION FEES (per person)

The Main Conference registration fee provides you with a program packet, admission to all keynote sessions, all workshops, 2 breakfasts, 2 lunches, and all breaks.

	Member Early Bird	Member After 1/16/26	Non-Member Early Bird	Non-Member After 1/16/26
Full Conference	**$445**	**$485**	**$530**	**$575**
One Day Tuesday	**$350**	**$390**	**$415**	**$460**
One Day Wednesday	**$305**	**$345**	**$365**	**$410**

SCHOLARSHIPS AVAILABLE

A limited number of scholarships are available to individuals who receive services and their families.
Conference scholarships will cover conference registration fees only.
Consumers who serve as CMH board members are not eligible.
Deadline to request scholarship: Friday, January 16, 2026.
To request a scholarship form, contact Sarah Botruff at sbotruff@cmham.org or 517-237-3143

EARLY BIRD DEADLINE: FRIDAY, JANUARY 16, 2026

CONFERENCE REGISTRATION DEADLINE: 5:00PM ON TUESDAY, JANUARY 27, 2026

PAYMENT AND CANCELLATION INFORMATION

- Payment MUST be received at the time of registration.
- No checks or ACH will be accepted.
- No exceptions to this policy.
- No shows will not receive a refund.

Cancellation Policy: If you do not cancel and do not attend, you will not receive a refund. Substitutions are permitted based on availability. Cancellations must be received in writing at least 14 days prior to the training for a full refund less the cancellation fee.

- Main Conference or One Day Conference: $50 cancellation fee
- Pre-Conference Institute: $10 cancellation fee

To cancel or request a substitution, please notify sbotruff@cmham.org.

Radisson Plaza Hotel & Suites, 100 W. Michigan Ave., Kalamazoo, MI 49007

2026 Room Rates: **Standard Room: $179 plus taxes (Single/Double)**
Suites: $219 (Single/Double)

Parking: Discounted rate for self-parking: $12 per night/car for all attendees.

Hotel Check In: 4 p.m. **Hotel Check Out:** Noon

To Make Your Reservations at the Radisson Plaza Hotel:

Phone Reservations: (269) 343-3333
- Reservations team is available M-F 8 a.m. - 5 p.m. EST.
- For discounted rates, guests need to mention "CMHA Winter Conference."

Book Your Hotel Reservation Online

Deadline for Reduced Rate:

Booking online: Deadline of 11:59 p.m. EST the day BEFORE 1/9/26 or until the room block fills.

Phone reservations: Deadline of 5:00 p.m. EST on the day OF 1/9/26 or until the room block fills.

Cancellation Policies:

- If you find it necessary to cancel or change plans, please inform the hotel 24 hours prior to check-in time to avoid one night's room and tax charged to your credit card. If the reservation was booked as an advance purchase, non-cancel, or non-refundable, then full penalty applies.
- Reservations can be modified or canceled by calling in-house reservations team at (269) 343-3333.
- If a reservation is canceled after this time, it will be subject to a late-cancellation fee (one night's guestroom rate + taxes). If there is a credit card on file, this fee will be routed to the credit card.
- If a guest does not arrive for their reservation, it will be subject to a no-show fee (one night's guestroom rate + taxes). If there is a credit card on file, this fee will be routed to the credit card.
- If a guest does not arrive for their reservation and check-in for the first night, their reservation will be CANCELED. The hotel can reinstate the reservation as able and requested (based on hotel availability).

Conference Details and Registration Coming Soon!

February 2026

BABHA Board of Directors

February 2026

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

March 2026

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Feb 1	2	3	4	5 5:00pm Corporate Compliance Committee	6	7
8	9 5:00pm Recipient Rights Advisory & Appeals Committee	10	11 5:00pm Finance Committee	12 5:00pm Program Committee	13	14
15	16 President's Day/BABH Offices Closed	17	18	19 5:00pm REGULAR BOARD MEETING (Arenac Center, 1000 W. Cedar St., Standish, MI 48658)	20	21
22	23	24	25	26	27	28

2026~~5~~ Strategic Plan

Agency Leadership Team Approval Date: ~~1/7/25~~ 01/06/2026
Strategic Leadership Team Approval Date: ~~1/14/25~~
Full Board Approval Date: ~~1/16/25~~

2026~~5~~ Strategic Plan

Table of Contents

PURPOSE **3**
SUBSIDIARY OPERATIONAL PLANS 3
SCOPE AND METHODOLOGY **3**
STRATEGIC PLANNING METHODOLOGY 3
EDUCATION 4
MONITORING AND REPORTING 5
Target Dates 5
Reporting 5
Leadership Dashboard Indicators 5
ORGANIZATIONAL DESCRIPTION **6**
HISTORY 6
STATISTICS ..... 13~~13~~12
STRATEGIC AND OPERATIONAL RELATIONSHIPS ..... 19~~19~~16
ORGANIZATIONAL CONCEPT STATEMENT ..... 20~~20~~17
MISSION STATEMENT ..... 20~~20~~17
VALUES/GUIDING PHILOSOPHIES ..... 20~~20~~17
CORE STRATEGIES ..... 20~~20~~17
ENVIRONMENTAL SCAN AND BREAKTHROUGH INITIATIVES ..... **21~~21~~18**
ENVIRONMENTAL SCANS, SWOT AND BREAKTHROUGH INITIATIVES FOR 20~~2~~6~~4~~ ..... 22~~22~~19
~~*Health Care Improvement and Compliance Committee* ..... *22~~22~~19~~
~~Integrated Health and Coordination of Care (Mental Health, Physical Health and Substance Use Disorders) ..... 22~~22~~19~~
Finance Committee ..... *24~~24~~21*
Management of Internal Operations and Provider Network within BABHA Annual Budget and Available Revenue 24~~24~~21
Program Committee ..... *26~~26~~23*
Availability of Community Living Support Services (CLS) for Adults & Children ..... 26~~26~~23
Stabilization and Long-Term Viability of Residential System ..... 29~~29~~25
Integration with Substance Use Disorder Treatment and Prevention ..... 32~~32~~26
Evidence-Based and Best Practices in Clinical Service Delivery ..... 33~~34~~27
Community and Employee Engagement ..... 35~~36~~29
Personnel and Compensation Committee ..... *37~~38~~31*
Recruitment and Retention ..... 37~~38~~31
Development of Workforce ..... 38~~38~~32
Review of Remote Work and Physical Plant needs ..... 40~~40~~33
ATTACHMENTS ..... **41~~41~~35**
Attachment One: Organizational Chart ..... *42~~42~~36*
Attachment Two: Organizational Relationships ..... *45~~45~~37*
Attachment Three: Leadership Dashboard Indicators by Committee of the Board of Directors ..... *48~~48~~40*

Purpose

The purpose of this document is to fulfill Bay-Arenac Behavioral Health Authority's (BABHA's) need for an organizational plan, which describes the history of the organization and depicts its operational structure and community relationships, as well as a strategic document outlining the mission, vision, values and core strategies of the organization, and current strategic initiatives. The BABHA Strategic Plan describes the purpose and goals of the organization, as well as strategies to ensure the organization can continue accomplishing its mission. It documents Leadership's current assessment of any forces in the environment with the potential to impact the organization and defines strategies for responding.

The BABHA Strategic Plan is the master plan for the organization. The BABHA Strategic Plan is focused on functions which impact all areas of the organization, such as its legal structure, personnel management, financial management, quality management, recipient rights, information technologies, corporate compliance and so on. It outlines strategic initiatives for the operation of the provider network of BABHA, which delivers behavioral health services in Bay and Arenac counties. It also addresses BABHA's delegated responsibilities for behavioral health managed care functions for specialty mental health and substance use disorder services for Arenac and Bay Counties.

Subsidiary Operational Plans

BABHA generates a number of operational plans which are companions to this document, in that they address sub-elements of the organization's overall mission and functions (see graphic below). In addition, BABHA develops annual revenue and expense budgets which are approved by the Board of

Directors and compiled based upon financial planning activities with organizational departments and their leadership. A mid-year amendment is completed to adjust this financial plan to accommodate intra- and inter-organizational revenue and expense fluctuations throughout the year.

Scope and Methodology

Strategic Planning Methodology

Strategic planning for the organization is performed by the BABHA Chief Executive Officer (CEO), members of the BABHA Strategic Leadership Team (SLT), and the entirety of agency Leadership, to foster leadership skill development among future senior managers of the organization. Agency Leadership encompasses leadership positions in the organization including Directors, Managers, Supervisors and Team Leaders. Once a first draft is prepared, additional stakeholder input is obtained, from the Board of Directors, Medical Staff and Consumer Councils.

The components of the planning process include establishing the organizational concept statement, the mission statement, the vision statement, organizational values and core strategies which will guide the

organization to achieving the mission while staying true to its stated values.

An environmental scan is performed to identify threats and opportunities in the environment in which BABHA operates. From the most important of these scans, strengths and weaknesses of the organization relative to pursuing opportunities and blocking threats are identified, and strategic or breakthrough initiatives established for the year.

Findings and recommendations from BABHA planning and evaluative processes which are systemic and strategic in nature are considered by agency Leadership as warranted in the development of the strategic plan, including[1]:

- BABHA Quality Assessment and Performance Improvement Plan and associated performance reports, which encompass organizational performance data and adverse/sentinel events
- Corporate Compliance Plan and associated reports
- Emergency Preparedness Plan
- Risk and Accessibility Plans
- Information Management Plan
- BABHA Annual (Community) Needs Assessment Summary and Attachments, and the BABHA Annual Submission
- Recommendations from Consumer Advisory Councils
- Results of surveys of provider networks, employees and consumers
- Suggestion Box submissions
- Employee Exit Interview findings
- Employee Survey findings
- Provider site review findings
- Financial Audits and reports
- Findings of external audits and reviews, such as Michigan Department of Health and Human Services (MDHHS) and Mid-State Health Network (MSHN) site reviews, finance compliance audits and CARF accreditation reviews

Education

The BABHA Board of Directors reviews and approves the BABHA Strategic Plan each year.

BABHA staff are educated on the BABHA Strategic Plan via the BABHA electronic staff education system, Relias, and/or during CEO All Staff Meeting(s), including review of the plan and the status of strategic initiatives.[2]

The BABHA Strategic Plan is shared with persons served[3] for feedback through review on an annual basis with the BABHA consumer population councils. The BABHA Strategic Plan is shared with other stakeholders[4] via the BABHA website and strategic initiatives are reviewed with key contracted clinical service provider groups via network meetings as appropriate.

[1] CARF Standard: Section I Aspire to Excellence: C Strategic Planning: Standards 1and 2
[2] CARF Standard: Section I Aspire to Excellence: C Strategic Planning: Standard 3b
[3] CARF Standard: Section I Aspire to Excellence: C Strategic Planning: Standard 3a
[4] CARF Standard: Section I Aspire to Excellence: C Strategic Planning: Standard 3c

Monitoring and Reporting

Target Dates

The timeframe for completion of strategic initiatives is assumed to be one year, unless otherwise specified in this plan. Strategic changes are worked on throughout the year and the order in which the initiatives are listed suggests necessary contingencies or sequencing.

Reporting

Members of agency Leadership report as needed on progress in accomplishing breakthrough initiatives during monthly agency Leadership Meetings. Initiatives are deleted, revised, or added mid-year as needed based upon shifts in the environment, changes in the needs or capacities of the organization, or as new information is gathered about optimal strategies.

The CEO and other members of agency Leadership engage in ongoing monitoring of the environment for opportunities and threats and report such information to other stakeholders and the Board of Directors as warranted.

Staff provide input to leadership decision making, including strategic planning, through an ongoing suggestion program, program/team level staff meetings and a periodic employee survey process.

In addition to agency Leadership reporting on strategic initiatives, significant reporting occurs through BABHA's internal staff teams and committees/ councils. Charters for the various committees are included in BABHA operational plans.

Leadership Dashboard Indicators

Key indicators are identified by the organization as a means of monitoring variables that may impact the organization's ability to continue to fulfill its purpose, operate within its value system, and accomplish its core strategies. The indicators are used by the Board of Directors, CEO and agency Leadership to adjust priorities, make strategic decisions and identify areas of emerging risk for the organization. Key indicator data is presented in a Leadership Dashboard Report and through Power Business Intelligence reports. The monitoring of key indicators is a companion process to the environmental scan, strengths, weaknesses, opportunities, and threats (SWOT) analysis and breakthrough initiatives.

Indicators are chosen based upon the organization's mission, purpose, values, core strategies and results of the environmental scan. Depending on the nature of the indicator, source data is generated by subject matter experts within BABHA and analyzed by either a member of agency Leadership or BABHA staff committees, councils, or teams. The resulting information then flows up to Leadership, for review at Strategic Leadership Team meetings with the CEO.

Reporting to leadership and the Committees of the Board of Directors occurs on a monthly, quarterly, semi-annual, or annual basis, depending upon the indicator. Board Committees receive and file the reports. The CEO or designee presents the reports and participates in discussion at the discretion of the Committee Chair.

The data for each indicator is presented in a graph. If performance targets, benchmarks or control limits have been established, they are included. Data trend-lines are shown where value-added for purposes of analysis and action planning. The current list of indicators is included as an Attachment to this Plan.

Organizational Description

History

On October 31, 1963, Congress passed, and President John F. Kennedy signed into law, the Community Mental Health (CMH) Centers Act. This legislation recognized society's growing awareness that people with mental illness are constitutionally entitled to receive voluntary treatment in the least restrictive environment. It authorized federal grants for construction of public, nonprofit, CMH centers and ended the prolonged institutional confinement of thousands of citizens with mental illnesses, making it possible for them to receive community-based care and allowing them to remain a part of their homes and communities.

In February 1963, the Michigan Senate and House of Representatives had introduced identical bills that were later signed into law by then Governor George W. Romney as Act 54 of the Public Acts of 1963. This legislation was Michigan's own CMH Center Act and gave counties the option to create a CMH program if they so desired. Counties could develop a local CMH program through the appointment of a 12- member board, who would select a chief executive officer and other professional staff while contributing 25% of local funds to the overall budget. The State would fund the remaining 75%.

On September 10, 1963, the Bay County Board of Supervisors adopted Act 54 and authorized the Chair to appoint a CMH Board. The Bay County Community Mental Health Board (BCCMHB) was formed under Public Act 54 as a single county board and the first BACMHB board members were appointed on September 23, 1963. State recognition of the local CMH program was ensured once the local county Board of Commissioners passed a resolution establishing the Board as a CMH.

Effective July 23, 1965, the Department of Public Health was created under Section 16.503 of Act 380 of the Public Acts of 1965. This legislation reorganized Michigan governmental departments.

In 1967, the Michigan Association of Community Mental Health Boards (MACMHB) was organized in response to the growing number of counties in the state creating CMH programs under Act 54.

During the mid-1960s, BCCMHB recruited a psychiatrist as its director. The original outpatient clinic was located at Mercy Hospital in 1964. It included an adult clinic for psychiatric and outpatient services for persons recently discharged from state facilities. It also received referrals from Mercy Hospital. There were no separate administrative offices for the board since it was a function of county government. Concurrently, BCCMHB contracted with the Bay Area Child Guidance Center to provide children's services.

Paul Dingman, a clinical psychologist, was hired as the BCCMHB Executive Director and the board expanded to include Arenac County in 1968. An outpatient clinic was opened on the grounds of Standish Community Hospital to serve the residents of Arenac County.

Some of the clinical operations were moved to 1600 Center Avenue in 1970. This is the building currently occupied by the CPA firm of Weinlander- Fitzhugh. A separate Board Administrative office was also located in this site to manage the increasing number of services offered to the community. This site was eventually converted entirely to clinical operations and the Board administrative offices were moved to Garfield Avenue

In 1971, Arenac County joined with Bay County to form the Bay-Arenac Community Mental Health Board (BACMHB). BACMHB approved the Arenac County By-Laws on August 9, 1974 and the Arenac County Board of Commissioners approved the BACMHB By-Laws on September 24, 1974.

Throughout the years, measures had been taken by the State of Michigan to address the changing needs of those affected by mental illness, among them is the enactment of the Michigan Mental Health Code (MMHC) in 1974 as Public Act (P.A.) 258 and expansion of services, including treatment for children and those who suffered from drug and/or alcohol addiction. With the Arenac County partnership, BACMHB aggressively began to develop services for persons with substance use disorders and for persons with developmental disabilities.

William B. Cammin, Clinical Psychologist, was promoted to Executive Director in 1972 upon Mr. Dingman's departure. On August 8, 1975, Bay County elected to come under P.A. 258 of 1974. The required rules for complying with the MMHC were approved by Bay County on July 15, 1975, and by Arenac County on August 4, 1975.

In the mid-1970s, BACMHB applied for a federal CMH center construction grant. The Mental Health Center federal grant was approved on May 24, 1976, enabling construction of a comprehensive CMH center. A lease between BACMHB and the Bay Medical Center was signed January 17, 1977, after which BACMHB leased the Mental Health Center building located at 201 Mulholland. In accordance with the requirements associated with the construction grant, BACMHB followed federal guidelines for providing the minimal five essential services: inpatient, outpatient, children's services, adult services, and consultation and education.

Most administrative and clinical operations were ultimately consolidated at Bay Medical Center upon completion of the Behavioral Health Center in 1978. This has remained the central location of most operations and the ~~location of the~~ Board Office for more than 43 years.

On July 1, 1987, the Bay Area Guidance Center employees transferred to BACMHB, as children's services were now being delivered in-house rather than through contract as was previously done.

With the arrival of the 1980s, Michigan recognized the need for public mental health services in local communities. At that time, a significant amount of responsibility and resources went into the state psychiatric hospital system and local CMH boards had few resources to provide a complete range of services, particularly for people with serious and long-term impairments. By the mid-1980s, CMH boards were given the opportunity to assume primary responsibility for all public mental health services in their respective counties. Over the course of the next decade, the state hospital system shrank dramatically and individuals with mental illness and developmental disabilities were returned to their counties of residence to receive services.

In the mid-1980s, BACMHB applied to the Michigan Department of Community Health (MDCH) (formerly known as the Michigan Department of Mental Health) to be recognized and sanctioned as a Full Management Board. This permitted the Board to move forward with the development of a full array of community-based services and pursue moving area residents from state hospital care to community care. During this period, the Board developed a significant network of residential homes for individuals with mental illness and developmental disabilities, along with appropriate specialty support services and a case management component to ensure the appropriate coordination and monitoring of community-based services.

Throughout the later 1980's and into the first half of the 1990's, BACMHB grew its service array and participated in several statewide funding and community-inclusive service delivery initiatives which focused on the provision of ever more intensive treatment in non-clinic settings. This included the

establishment of Medicaid Habilitation and Support Waiver funding for services to persons with developmental disabilities and the adoption of specialized models such as; supported employment, Assertive Community Treatment (ACT) for adults experiencing mental illness, and Home Based care for children and families. An additional focus during this time was the formation of collaborative community efforts. BACMHB took the lead in applying to MDCH for funds to support personnel, including administrative support for a coordinator to staff a multi-purpose collaborative body. The Board, to this day, continues to support this position and provides leadership in promoting this effort which brings together a variety of human service agencies in a common effort to maximize collaboration, reduce duplication, and evaluate community needs for financial and other support.

The MMHC was revised and enacted into P. A. 290, effective March 27, 1996. This resulted in a massive reorganization of health-related functions at the state level. One of the significant provisions of this Act was the requirement to recruit and include people receiving services to serve on the Board of Directors for CMH Centers.

In 1995-1996, MDCH announced its intention to seek a Health Care Financing Authority (HCFA) waiver to implement a public mental health managed care program. In 1995, BACMHB, along with nine other CMHs, discussed potential collaboration for purposes of efficiency and managed care service delivery, forming the Mid-Michigan Community Mental Health Partnership (MMCMHP). The partnership included CMH Boards from Central Michigan, Gratiot, Midland-Gladwin, Montcalm, Newaygo, Saginaw, and Western Michigan.

In 1997, MDCH went further and stated its goal of contracting with fewer entities to manage specialty services. The potential for a competitive bid process for the selection of providers of public mental health services increased and provoked far reaching debate locally and statewide. MDCH issued a Request for Information (RFI) to the CMH system to trigger shifts in CMH operational strategies toward managed care and market driven principles. At this time, the MMCMHP engaged a consulting firm to develop a plan and possible structure to meet managed care guidelines and prepare for a possible competitive bid process. Concurrently, Western Michigan CMH decided to join a region on a west side of the state.

The new direction entered by MDCH included a focus on quality and customer service. This required CMH boards to follow the principles of Person-Centered Planning and Self-Determination, both of which are designed to give an individual greater control of the service delivery process. A shift toward “consumerism” encompassed ideas of choice of provider and the opportunity to appeal service delivery decisions. The term “mental health” transitioned to the more widely used term in health care systems, “behavioral health”, and “clients” became “consumers” of services.

This was accompanied by the development of continuous quality improvement (CQI) programs and performance improvement initiatives, both within BACMHB and the State. Accreditation of CMH centers became part of the dialogue as a means of assuring standards of quality, and in 1998, BACMHB received its first accreditation from the Joint Commission on Accreditation of Healthcare Organizations.

In June of 1998, MDCH obtained HCFA approval of a managed specialty care waiver. In October of 1998, MDCH implemented the specialty care waiver as a carve-out of the Medicaid Health Plan for physical health care services and began to fund the bulk of the service delivery system using a capitated payment model.

BACMHB continued to prepare for operation in a competitive managed care world. In conjunction with its regional collaborators, BACMHB developed a managed care division to provide access, authorization, and claims management, called the Access Alliance of Michigan (AAM). Midland-Gladwin CMH decided

to leave the regional partnership, so AAM was designed and implemented with the participating CMHs of Bay-Arenac, Gratiot, Montcalm, and Saginaw Counties. An Information Systems Alliance (ISA) was also developed now, aimed at providing state-of-the-art and leading-edge information systems capacity.

In September of 1999, MDCH issued a concept paper "Competition for Management of Publicly Funded Specialty Services" which identified an optimal size of 20,000 covered Medicaid lives.

In addition, HCFA mandated a shift from sole source to competitive procurement for public behavioral health care in Michigan. Through extensive negotiations with MACMHB and HCFA, the MDCH maintained the carve out but incorporated into the system a selection process that would foster competitive procurement in the provider network and provide incentives for single mental health boards to merge or affiliate to enhance efficiencies, reduce duplication, etc.

On June 12, 2001, the Arenac County Board of Commissioners adopted a resolution creating a Community Mental Health Authority. On June 19, 2001, the Bay County Board of Commissioners followed suit and adopted a resolution creating the Bay-Arenac Community Mental Health Authority. Shortly thereafter, on July 19, 2001, BACMHB approved changing the name of the organization to Bay-Arenac Behavioral Health Authority (BABHA), subject to adoption by the Bay and Arenac County Boards of Commissioners as an amendment to the original resolution.

From 1998 to 2002, AAM functioned as an administrative service organization for the affiliated CMH centers. Further shifts in the AAM membership occurred as Community Mental Health Services Programs (CMHSPs) throughout the state responded to MDCH's call for at least 20,000 covered lives for each entity hoping to secure contracts to provide public behavioral health services. Changes were driven by regional affiliation models, capitation rates, and operating philosophies. The AAM was joined by Tuscola County in the summer of 1999. During 2000-2001, Huron and Shiawassee Counties joined while Gratiot and Saginaw ~~-~~departed, and the AAM eventually formed its own region.

By May of 2000, the Michigan legislature had issued a plan for Medicaid and indigent specialty services. In August of 2000, MDCH issued a revised plan to HCFA. The MDCH now required local CMH boards to submit an Application for Participation (AFP). The purpose of the AFP was to determine whether the CMH program met the state requirements for selection as a pre-paid health plan.

BABHA, along with its affiliate boards, Tuscola Behavioral Health Systems (TBHS), Huron Behavioral Health (HBH), Shiawassee County Community Mental Health (SCCMH), and Montcalm Center for Behavioral Health (MCBH), was successful in being awarded a contract in 2002 to be the Pre-Paid Inpatient Health Plan (PIHP) for Specialty Behavioral Health Services for Medicaid recipients in Arenac, Bay, Huron, Montcalm, Shiawassee, and Tuscola counties.

Another very significant development in 2002 was the formation of a regional substance abuse coordinating agency. The State's reorganization of substance abuse services was initiated to complement the pre-paid health plan specialty services and to include the treatment and prevention of substance use disorders in the affiliate counties.

Among the five (5) AAM partners there were also five (5) regional Substance Abuse Coordinating Agencies through which to coordinate services. Following a detailed analysis, BABHA and its affiliation partners developed a plan to realign CMH and Substance Abuse Coordinating Agency responsibilities. In 2001, BABHA began working closely with MDCH to become designated as a Coordinating Agency. In August of 2002, MDCH designated BABHA as the single Coordinating Agency for the six (6) county region and on October 1, 2002, BABHA Coordinating Agency operations became fully operational.

While BABHA organized and administered the AAM, the affiliated CMHSPs assisted through functional and contractual arrangements with a network of specialty supports and administrative planning. From 2002 through 2006, the AAM and its affiliate CMHSPs worked on developing uniform, and where possible, integrated operational systems to facilitate performance of managed care functions but also to achieve the desired efficiencies wherever possible. In addition, BABHA further evolved mechanisms to address its responsibilities as a health plan for specialty mental health, developmental disability, and substance use disorder services.

Robert Blackford, previously the AAM Director, was promoted to Chief Executive Officer in 2007 upon Dr. Cammin's retirement. In April of 2008, BABHA purchased a residential home and its adjacent lot to operate an Intensive Residential Services Program. This was initiated by the need to provide a safe home for persons who were receiving services from BABHA after MDCH's decision to close the Mt. Pleasant Center. Named the "Horizon Home", it officially opened in September of that same year with two people moving in for an ultimate census of six people.

In the fall of 2009, BABHA leadership decided to actively pursue changing its accrediting body from the Joint Commission (JCAHO) to the Commission on Accreditation and Rehabilitation Facilities, otherwise known as CARF. This decision was made primarily because CARF's standards specifically targeted BABHA's needs as a community mental health organization and supported the Agency's ongoing commitment to offer programs and services focused on the needs of individuals served and based on the highest standards of quality and accountability. Subsequently in January of 2010, BABHA was awarded a three year accreditation by CARF for the following programs: Assertive Community Treatment: Mental Health - Adults; Case Management/Services Coordination: Developmental Disability (DD)/Mental Health - Adults; Case Management/Services Coordination; Integrated DD/Mental Health - Children and Adolescents; Community Integration: Psychosocial Rehabilitation - Adults; Crisis Intervention: Mental Health - Adults; Crisis Intervention: Integrated DD/Mental Health - Children and Adolescents; Intensive Family-Based Services: Family Services - Children and Adolescents; Outpatient Treatment: Mental Health - Adults; and Outpatient Treatment: Integrated DD/Mental Health - Children and Adolescents

In February of 2010, plans were put in place for all clinical staff currently residing on the third floor of Mulholland (except for Emergency Services staff) to move to the Davidson Building in downtown Bay City. It was also decided that the AAM would close their Saginaw location and move their staff into the offices vacated by the clinical staff. These moves were accomplished by mid-June, 2010.

Due to deep general fund cuts by the State in fiscal years 2010 and 2011, all operations were reviewed for efficiency and quality, which led to the exploration of alternative sources of revenue. BABH joined with other CMHSP's in the AAM affiliation forming an association which would organize two different service organizations and a charitable entity to assist with generating funding for critically needed services for indigent populations; one of the service organizations, Crossroads was developed but ultimately closed in 2014. Tele-psychiatry services were added as a component of existing treatment programs after other means of providing timely and cost-efficient psychiatric services were explored. The Riverhaven Coordinating Agency (RCA) and the AAM aligned and integrated their managed care functions for increased efficiency including access, prevention, utilization and quality management, and contract management.

As the second decade of the new century began, a national and statewide focus on integration of physical and behavioral health emerged, in addition to emphasis on recovery and wellness. Of interest were individuals with chronic health conditions who also experience serious mental illness(es), as studies identified such populations were dying decades earlier than those without such co-morbid

health conditions. BABHA instituted the Health Integration Project at the Arenac Center site in Arenac County. Numerous wellness and health education classes were offered to consumers such as smoking cessation, nutrition, exercise classes, computer training to access health information, etc. In addition, wellness goal setting and support at Person Centered Planning meetings and home and telephone support from a Peer Support Specialist were also available through the Project.

Mr. Blackford departed BABHA in 2012 and was replaced by Christopher Pinter, Clinical Social Worker, who was promoted from the AAM Director role. BABHA remained a Community Mental Health Services Program and a Substance Abuse Coordinating Agency (d.b.a., Riverhaven Coordinating Agency) employing over 250 personnel. BABHA's designation as a Pre-Paid Inpatient Health Plan (d.b.a., Access Alliance of Michigan) ended December 31, 2013.~~12/31/13.~~ In 2014, BABHA became a CMHSP operating under a collaborative agreement within the Mid-State Health Network (MSHN), a 21-county region designated by the Michigan Department of Community Health as one of ten Pre-Paid Inpatient Health Plans for Medicaid specialty behavioral health services. Since that time BABHA has continued to perform numerous managed care functions on behalf of MSHN on a contractual basis, based upon its previous experience operating as the AAM.

In 2014 further transitions occurred in the region, as effective October 1, 2014 the Coordinating Agency network in Michigan was folded into the PIHP system by the MDCH. Thus, MSHN assumed responsibility for substance use disorder prevention and treatment services for all its 21 counties. To facilitate a seamless and expedited transition, MSHN issued a request for proposals to the CMHSP's in the region for selection of sub-regional entities to manage these services and BABHA was awarded a contract for 12 of the 21 counties, specifically Arenac, Bay, Clare, Gladwin, Huron, Isabella, Mecosta, Midland, Montcalm, Osceola, Shiawassee and Tuscola.

This sub-regional arrangement for substance use disorder services lasted for approximately one year until all related administrative functions were consolidated at the MSHN central office in Lansing on October 1, 2015. BABHA retained some local prevention responsibilities for Arenac and Bay Counties and provided similar administrative supports to Huron and Tuscola CMHSPs via contract arrangement.

The Michigan Department of Human Services merged with MDCH into a consolidated structure in February 2015 to create the Michigan Department of Health and Human Services ("MDHHS"). In addition, the new MDHHS continued to initiate affirmative efforts to reduce historical funding inequality for mental health and substance use services, restored some CMHSP general funds and encouraged further integration of care between regional PIHPs and the Medicaid Health Plans. These actions served to strengthen the ability of BABHA to continue to effectively serve the most vulnerable persons in the community for the foreseeable future.

MDHHS presented final proposals for physical and behavioral health integration for Specialty Mental Health Services and Supports in 2017 based on extensive public stakeholder feedback. These recommendations and other legislative priorities have led to continued dialogue regarding the future roles of private Medicaid health plans and public CMHSPs in the management and delivery of public mental health services.

BABHA ended the last of its administrative service agreements with MSHN to provide selected PIHP managed care functions as of December 31, 2017, BABHA now performs only those managed care functions which are delegated to all CMHSP's in the region.

In 2020, BABHA faced significant challenges to service delivery when the COVID-19 virus spread throughout the world, infecting millions. Michigan was particularly hard hit, including Bay County. BABHA worked closely with local public health officials and by the end of March 2020 had transitioned

all but direct support staff and selected psychiatric clinic staff to virtual offices. On-site services at BABHA locations were reduced to only those services that could not be performed remotely. Audio and video telehealth options were expanded markedly by Medicaid and Medicare. Obtaining and rationing needed personal protective equipment (PPE) became critical to BABHA's ability to continue to operate. Staffing capacity de-stabilized as the virus spread through congregate settings such as specialized residential homes. BABHA sought and obtained a grant to establish an emergency shelter at its North Bay location should a congregate setting no longer have the ability to operate or a isolative non-inpatient care space be needed. ~~As of the end of 2020, BABHA remained in a state of partial shutdown.~~

The BABHA Board authorized Strategic Leadership to initiate several actions between 2021 and 2023 to respond to the pandemic and protect the safety of our communities. These actions included extensive COVID screening and monitoring at service locations, enhanced infection control and PPE requirements, installation of improved air filtration mechanisms, establishment of emergency shelter protocols, use of remote/virtual technology for public meetings, financial stabilization payments and revised contract amendments to support vulnerable network providers, and enhanced compensation/retention payments to direct care staff. In addition, BABHA in partnership with Bay County Public Health was designated as a COVID-19 vaccination clinic by MDHHS and began providing the Moderna initial and booster vaccines to Bay and Arenac County residents in January 2021. BABHA prioritized persons in residential and individual housing arrangements that might be more vulnerable to community spread and/or have less access to primary care and included mobile clinics throughout both Bay and Arenac Counties. BABHA continued offering vaccination services to all consumers, employees, retirees, board members and members of the public through the end of the public health emergency in May 2023.

The pandemic created an environment that forced BABH to consider more remote work opportunities for certain services and departments. Not only to provide greater access to individuals served but to recruit and retain employees. Throughout 2024, BABH has continued to update policies, procedures and practices to address the move towards a more remote workforce and provision of services via telehealth. The decreased need for office space and the expanded equipment needs due to the remote work environment continues to be evaluated and addressed.

On August 4, 2025, MDHHS released a Request for Proposals (RFP) for replacing the 10 CMHSP Regional PI~~P~~HPs. The RFP as originally released permitted the new PIHP contractor to be a private nonprofit organization and mandated that it operate as a "payor-only" entity and forbade the delegation of core managed care functions such as utilization management, network development, and claims processing to its contracted network providers such as CMHSPs. The RFP dictated a specific, private-style corporate governance structure for the PIHP contractor and mandated a board of no more than 15 members that must be entirely separate from any provider entity. In addition, the RFP contractually required the contractor to establish and manage its own internal grievance and appeals process for beneficiaries which may interfere with the Michigan Mental Health Code Chapter 7 (MCL 330.1700) which establishes a comprehensive and independent Recipient Rights system. The existing CMHSP and MDHHS systems have statutory power to investigate and remedy rights violations separate from the entities making payment decisions. As a result of the RFP, PIHP and CMHSPs throughout the state have engaged in legal objections based on the potential violations imbedded in the RFP requirements. On October 9, 2025, the Court of Claims held an evidentiary hearing regarding the MSHN lawsuit against MDHHS's PIHP Procurement Process and on October 14, 2025, the Court of Claims issued its initial determinations. The Court determined that (1) MDHHS has the unilateral authority to shift to a competitive procurement model for Medicaid behavioral health services; and (2) MDHHS can reduce the number of regions.

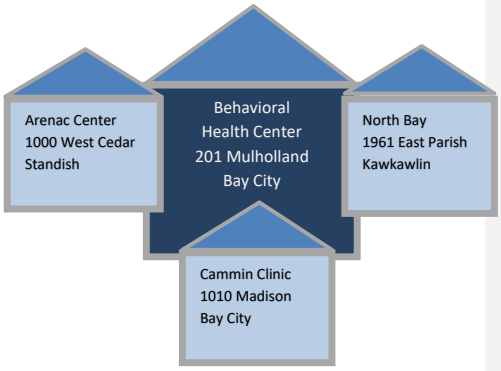
The Court also said that it could not issue a final decision in the case because the PIHP procurement as written may violate Michigan law in assigning functions to the new PIHPs that belong to county CMHSPs ~~Community Mental Health Services Programs~~ by statute. BABHA will continue to respond to future actions of MDHHS and/or the Court's decisions.

As a result of the federal government shutdown in 2025, the Supplemental Nutrition Assistance Program (SNAP) was also paused which caused the loss of food assistance for a vast majority of individuals served through BABHA. SLT members met to discuss planning for assisting individuals supported by BABHA and its contracted provider network in finding resources to assist those individuals. Thankfully the federal shutdown ended in November permitting S~~A~~NAP and Medicaid benefits to continue to be available to eligible parties. As BABHA enters 2026, we are preparing for further legal and legislative actions to protect the public mental health system under the RFP and respond to significant federal changes in Medicaid expected in 2027.~~However, despite the federal shutdown, Michigan's budget including MDHHS's budget was passed in October 2025. This resulted~~ .

Statistics

BABHA operates out of ~~five~~ four office locations (see Figure 1: BABHA Office Locations~~Figure 1: BABHA Office Locations~~~~Figure 1: BABHA Office Locations~~), with its main offices located in the Behavioral Health Center at 201 Mulholland in Bay City and additional administrative offices housed at the Wirt (United Way) building.

Figure 1: BABHA Office Locations



Clinics are operated at the Arenac Center in Standish and at the Madison and Mulholland locations. Community Living services are provided out of the North Bay location, as well as additional clinical services, such as case management and support coordination services. BABHA directly operates a licensed adult foster care home, which is certified as a specialized residential setting, and some related supported independent living arrangements.

BABHA employs psychiatrists, nurses/practitioners, licensed social workers, professional counselors, psychologists, and other licensed professionals, as well as certified direct care staff, administrative support staff, human resource professionals, accountants, and other administrative professionals (See Figure 2: # of Employees~~Figure 2: # of Employees~~Figure 2: # of Employees).
BABH has had an increase in the number of employees in 2024. New positions have been added to cover the outpatient service gaps, the expanding children's service needs and the development of the Mobile Response Team. The Horizon Home staffing increased to adequately address the ongoing crises occurring in the Specialized Residential system.

Figure 2: # of Employees

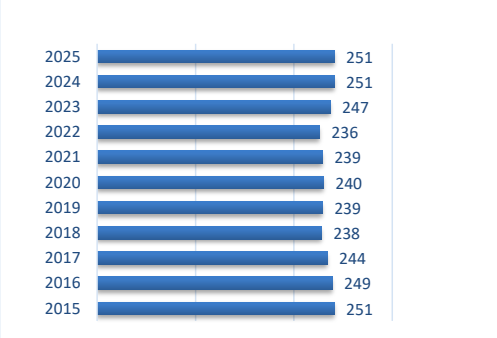
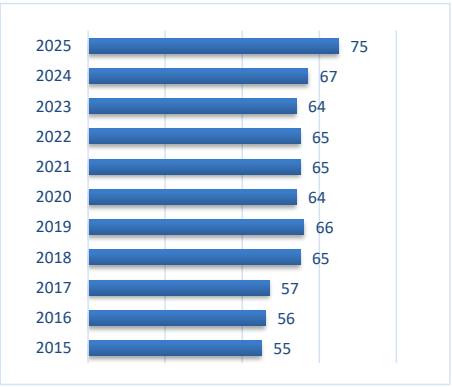


Figure 3: # of Contracted Clinical Service Providers

BABHA contracts with several licensed independent practitioners, organizational service providers, Applied Behavioral Analysis providers, adult foster care homes and psychiatric inpatient hospitals (See Figure 3: # of Contracted Clinical Service Providers~~Figure 3: # of Contracted Clinical Service Providers~~Figure 3: # of Contracted Clinical ~~Service Providers~~). The number of providers increased around 2018 due to expansion of demand for Autism related services.



Clinical service populations include:

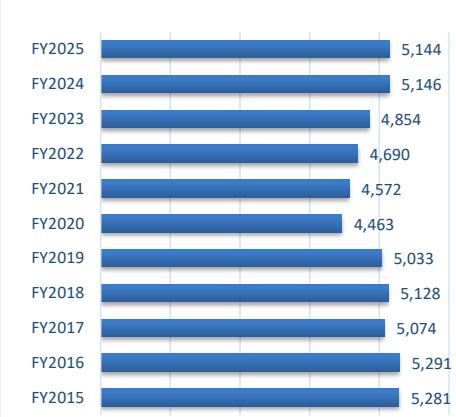
- Adults with mental illness
- Children with serious emotional disturbance
- Adults and children with intellectual and developmental disabilities.
- Individuals with co-occurring substance use disorders

BABHA expanded our provider network in FY24 due to an ongoing need for ABA services and due to factors resulting in out-of-county residential placements.

Figure 4: Total # of Individuals Served

Typically, over 5,000 residents of Arenac and Bay Counties are served each fiscal year (FY) by BABHA direct operated programs and contracted service providers (See Figure 4: Total # of Individuals Served~~Figure 4: Total # of Individuals Served~~Figure 4: Total # of Individuals Served~~Figure 4: Total # of Individuals Served~~).

The number of people served was significantly impacted by the international pandemic which began in the Spring of 2020 and continued through the Fall of 2021. Emergency public health related orders, the inability to deliver some types of services via tele-health, the illness of people served and/or BABHA personnel and contracted service providers, among other challenges reduced the number of people able to access services. Every year since the pandemic, the numbers of individuals served has steadily increased.

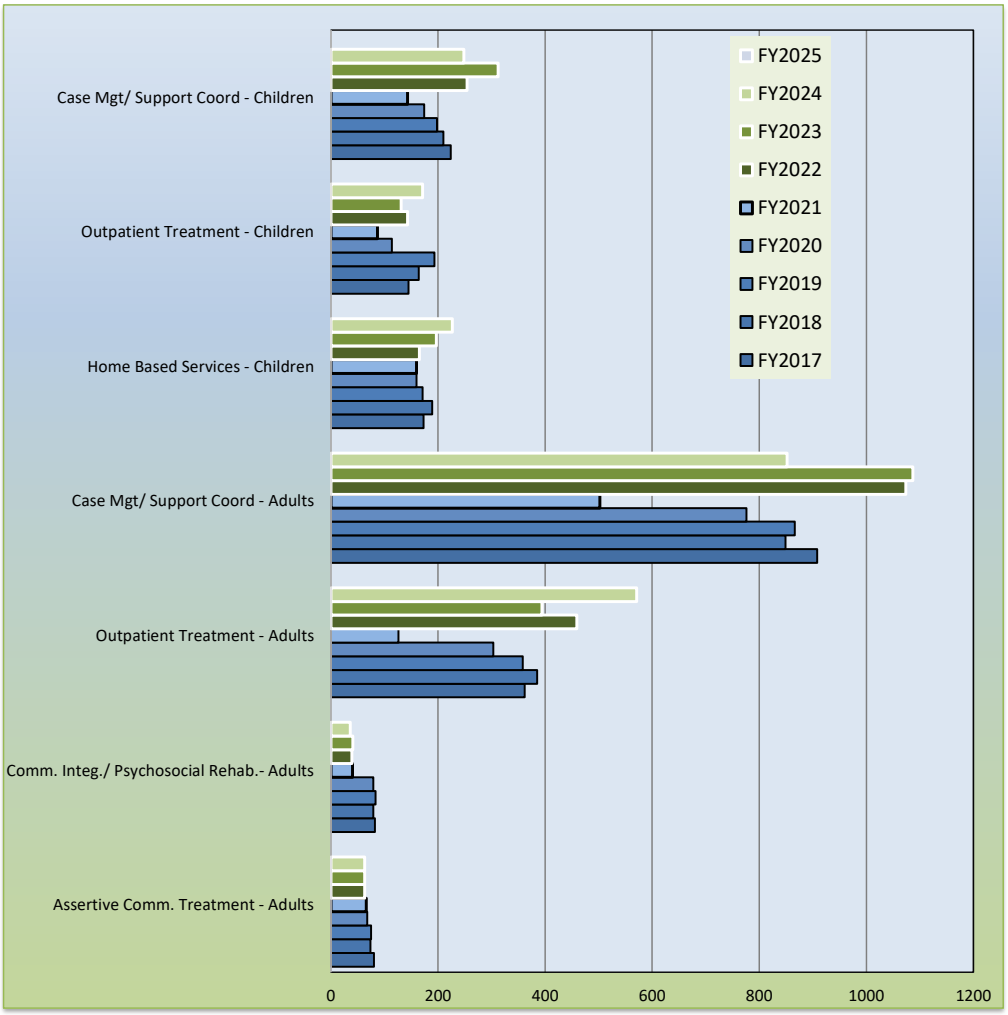


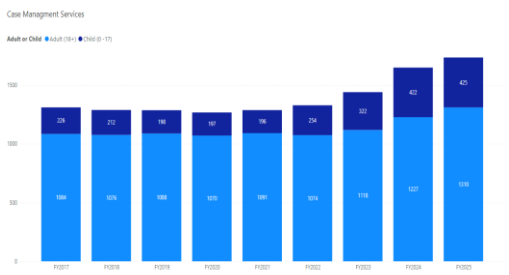
The numbers of individuals served in ~~2024~~ FY24 and FY25 ~~have exceeded~~continue to exceed the numbers of people served pre-pandemic years~~.~~

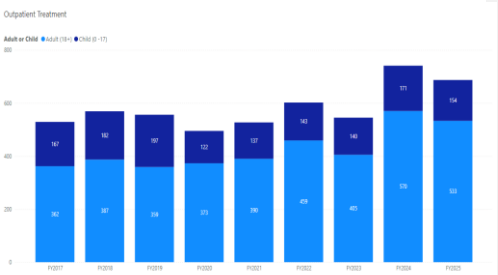
Services provided through the BABHA service provider network include clinical assessment, psychological testing, psychiatric evaluation, medication management, outpatient therapy, behavioral treatment, case management, support coordination, nursing, occupational therapy, speech/ language therapy, independent living support, residential living, vocational services, skill building services and psychiatric inpatient care, among others.

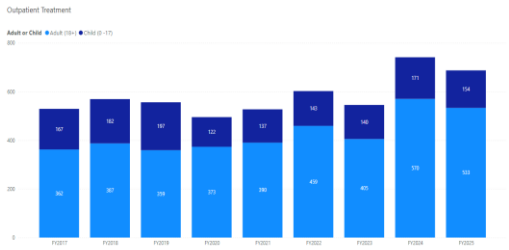
BABHA is CARF accredited for specific clinical programs, as shown in Figure 5: Unduplicated Consumers Served per Accredited Program~~Figure 5: Unduplicated Consumers Served per Accredited Program~~~~Figure 5: Unduplicated Consumers Served per Accredited Program~~. The number of people needing outpatient therapy continues to increase at the same time there is a shortage of qualified clinicians to support the need. BABH has increased internal capacity to help address the gap in services. BABH hired one full time therapist and one telehealth therapist and provided group therapy to address the increased need for outpatient therapy. Emergency Services/Access Services have added Intake workers to quickly get people into services to reduce the dropout rate and gap of time between contact and actual service provision.

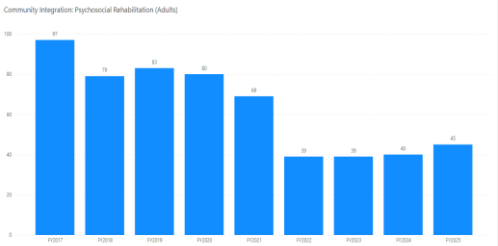
Figure 5: Unduplicated Consumers Served per Accredited Program FY17 to FY25

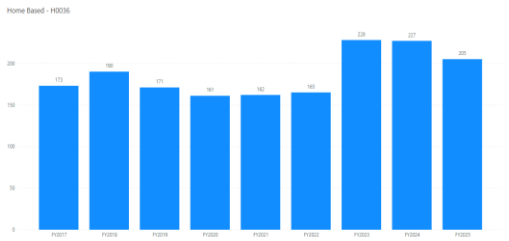


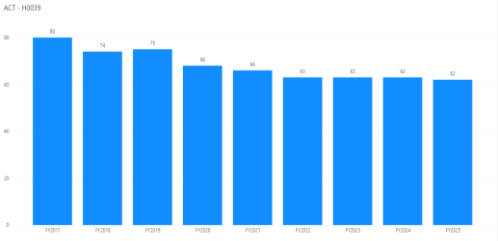


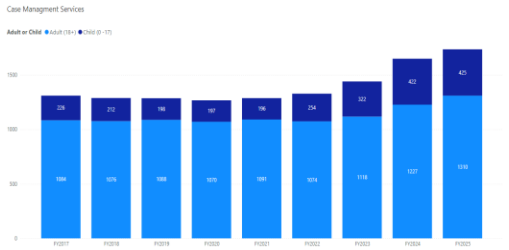


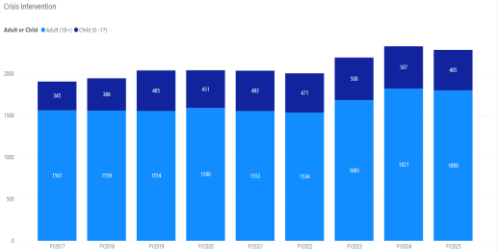












Please note: there were several changes to the formula for identifying "sent" encounters between 2021 and 2022 in order to more accurately account for many service locations that had been excluded prior to COVID-19. The changes were designed to reflect the significant increase in telehealth services during public health emergencies and primarily impacted outpatient and case management services. In addition, BABHA migrated information from previous sources to PowerBI as a means to compile data for the dashboard reports noted in the Strategic Plan to ensure accuracy moving forward.

One area BABH is addressing is the increasing use of Applied Behavioral Analysis (ABA), which has increased from 100 consumers served in FY2017 to 368 consumers served in 2025 as noted in Figure 6.

Figure 6: Unduplicated Consumers Served in ABA FY17 to FY25

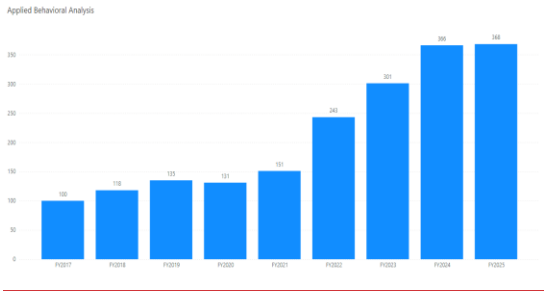
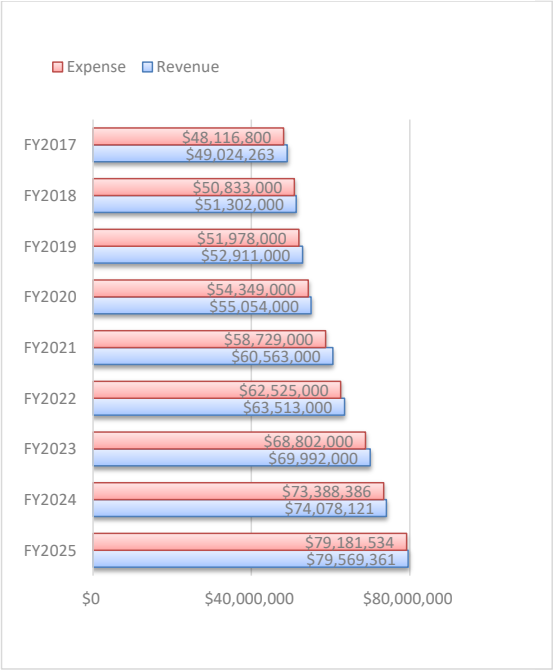


Figure 7: Revenue and Expenses

BABHA revenue and expense for community mental health services are shown in Figure 7~~6~~. Expenses are closely managed to remain within regional Medicaid revenue levels for BABHA to operate within the resources provided by local counties and regional and state payers.



~~**Figure 6: Revenue and Expenses**~~

During the pandemic years 2020 & 2021 when service utilization declined due to restrictions on face-to face services, BABH implemented strategies with Network Providers to ensure their longevity and financial viability. BABH Per Member Per Month Funding (PMPM) during these years permitted the agency to stabilize Providers. Beginning in 2022 as restrictions were lifted in regards to face-to-face services, BABH experienced an increase in service utilization. This coupled with the MDHHS rate setting process and BABH's higher penetration rate as compared to the MSHN region CMHSPs, BABH service expenditures exceeded revenue by approximately 15%. Due to the financial stability of the MSHN Region, BABH PMPM Medicaid Funds were supplemented by MSHN over the last 4 four years in following amounts:

- FY 2022 $3.2M
- FY 2023 $8.4M
- FY 2024 $10.1M
- FY 2025 $10.9M

An Organizational Chart is included as Attachment One, which depicts the functions of BABHA at a summative level.

Strategic and Operational Relationships[5]

Bay-Arenac Behavioral Health operates within the context of its role as a component of the federally mandated and state certified public safety net and government funded health care delivery systems, as well a regional participant and collaborator, a county authority with a Board of Directors appointed by Arenac and Bay Counties, and a community partner for local human service agencies and health care providers. Functioning effectively in this rich mixture of often competing expectations necessitates close attention to communication and collaboration.

As a result, BABHA personnel are seated on ~~a~~numerous external groups, including work groups, councils and committees of the Michigan Department of Health and Human Services, Michigan Community Mental Health Association, Mid-State Health Network and regional and community collaboratives.

In addition, BABHA's internal operations require frequent gatherings of staff, contracted service providers and other stakeholders directly related to BABHA daily activities to transmit information, manage networks, improve operations and coordinate workflows.

Attachment Two of this document is a list of such Organizational Relationships for BABHA.

[5] CARF Standard Section I: Aspire to Excellence; C Strategic Planning; Standard 1i: Strategic planning considers the organizations relationships with external stakeholders

Organizational Concept Statement

Bay-Arenac Behavioral Health is in existence to ensure the delivery of a comprehensive array of health-related supports and services for people with developmental disabilities, mental illness, and/or substance use disorders that are inherently accountable to the persons and families in our community.

Mission Statement

It is the mission of Bay-Arenac Behavioral Health to improve health outcomes, to enhance quality of life and strengthen the community safety net for citizens of Arenac and Bay counties.

Values/Guiding Philosophies

All who are associated with carrying out the mission of Bay-Arenac Behavioral Health are governed by the highest ethical standards and the following values…

- Each person is unique and will be treated with **dignity** and will be respected regardless of ethnicity, religious preference, age, race, sex, sexual preference, gender identity and respected for their lived experience.
- We are committed to delivering services in a manner that is **responsive to urgent, emergent, and long term community** needs of our stakeholders.
- We seek to provide a **recovery**-focused and **trauma**-informed system of care.
- We believe that individual and community wellness is enhanced by the delivery of **integrated healthcare** services that are directed by and responsive to the person served.
- We are committed to promoting **independence, choice, control** and meaningful engagement with peers, family, friends, and community.
- We are committed to collaborating with our community partners to encourage **wellness**, to promote **prevention**, and to increase health literacy.

Core Strategies

1. Effectively manage behavioral health care services for persons with developmental disabilities, mental illness, severe emotional disturbance, and substance use disorders.
2. Delivery of integrated behavioral health care through a coordinated network of services.
3. Coordinate service delivery and collaborate in decision making with stakeholders to maximize responsiveness to community needs.
4. Operate in compliance with local, state and federal regulatory and/or contractual requirements.
5. Maximize administrative and clinical efficiency, including coordination of benefits, to minimize the cost of service and optimize revenues.
6. Ensure individual safety, service quality, and management accountability through use of evidence-based practices, measurement of outcomes and effective use of information.
7. Seek to maintain an organizational environment that promotes excellence and workforce competence and utilizes recruitment and retention strategies to remain competitive in the behavioral healthcare marketplace**.**
8. Apply principles of good customer service to all clinical, business and service relationships.

Environmental Scan and Breakthrough Initiatives

BABHA reviews what is occurring in the environment external to the organization and engages in an analysis and action planning process to ensure the organization continues to remain viable to achieve its mission. An ENVIRONMENTAL SCAN identifies OPPORTUNITIES AND THREATS in the environment that may impact the organization's ability to achieve its core strategies in the present or near future (1-2 years). The organization defines opportunities and threats as follows:

Opportunities: Conditions external to the organization that the organization may want to take advantage of to facilitate achievement of core objectives

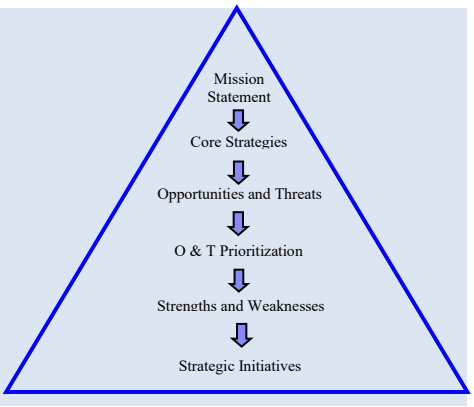
Threats: Conditions external to the organization that may hinder achievement of core objectives if not decreased or eliminated

Organizational STRENGTHS AND WEAKNESSES are then assessed for the highest priority opportunities and threats. The organization defines these terms as follows:

Strengths: Attributes of the organization that are expected to be helpful to the organization in taking advantage of an opportunity or fending off a threat

Weaknesses: Attributes of the organization that may hinder the organization's ability to take advantage of an opportunity or fend off a threat

BREAKTHROUGH INITIATIVES, present short-term strategies (12-24 months) to address the highest priority environmental opportunities and threats, taking into consideration the organization's strengths and weaknesses. The strategies are specific with responsible parties, sub-tasks and due dates defined.



STRATEGIC INITIATIVES by their nature do not include operational activities and are transformative in nature. The focus is on opportunities and threats with the potential to impact achievement of core strategies. Top priority is given to mission critical strategic opportunities and threats, with secondary priority given to systems transformation. Not every opportunity or threat warrants action.

Most of the organization's activity will be operational, so it is important when reviewing this plan to not consider the resulting breakthrough initiatives as representative of the organization's total outputs. The following graphic illustrates this point.

Highest Priority	Mission Critical
⇩	Systems Transformation
Lowest Priority	Operational

A STRATEGIC INITIATIVE TIMELINE is defined to portray when the strategic initiatives will be targeted for completion and to represent potential sequential relationships or contingencies between initiatives. The timeline may also be used by the CEO to hold lead team members accountable for strategic action.

Environmental Scans, SWOT and Breakthrough Initiatives for 20264

Program Committee

Environmental Scan:	**Integrated Health and Coordination of Care (Mental Health, Physical Health and Substance Use Disorders)**		
Lead Team Member(s):	Karen Amon, Joelin Hahn, Heather Friebe, Amy Folsom, Sarah Van Paris, Jesse Bellinger	**Status:**	Revised for 2025

Impact on Ability to Accomplish Mission:

- Must be able to evolve with changing health care industry or may lose opportunity to continue mission
- Improved health status of consumers and reduced co-morbidities through stronger coordination with community partners and reverse integrated practice models
- Improved Health Status of consumers and effective management of co-morbidities through expansion of Advanced Health Serviced Nursing.

Opportunities/Threats:

Threats

- Accountable care initiatives based upon health performance indicators
  - PIHP Medicaid contract to include performance incentives
- PIHP/CMHSP and Health Plan contract requirements
  - Coordination of Care with primary care physician
  - Coordination of care with SUD providers
  - Incorporating results into the Individual Plan of Service
  - Basic health screening including vitals and blood glucose levels if not seen by primary care physician for more than 12 mos.
  - Basic annual health screening including percentage of members 18-64yo w/schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.
  - MDHHS likely to add requiring sending of ACRS (i.e., consumer identifying information) files to Michigan

Strength/Weaknesses:

Strengths

- Implemented the MDHHS Universal Consent Form 2023.
- Current access to nursing and psychiatrist support:
  - Psychiatric clinic – Outpatient services
  - Residential services include access to nursing as medically necessary)
  - ACT model includes access to nursing and psychiatry
  - Advanced Health Nursing Services
  - Triage by Medical Assistants (Madison Clinic and Arenac Center)
- Availability to BABHA of Medicaid claims data for non-behavioral health services, including the Mi Gateway access for medical staff and other selected staff MDHHS Care Connect 360 and Zenith Integrated Care Delivery Platform (ICDP) provided by MSHN, including Key Performance Indicators
- Consumer health literacy materials developed by BABHA
- EHR that supports integrated health care:
  - DIRECT messaging (secure communication between healthcare provider EHR's)
  - Inbound and outbound Admission-Discharge-Transfer records (ADT's)
  - E-consent module compliant with MDHHS standardized behavioral health consent
  - Patient portal for document sharing and e-signature capabilities implemented 2023Lab ordering and interfaced test results (BABHA is active with Quest Labs, McLaren and Ascension Standish labs)
- Psychiatric Clinic – currently fully staffed and meeting demand of referrals and follow-ups. Wait times are less of a problem
- Automated patient appointment reminder system largely functional. Updated 2023 to rolling reminders and improved language to clarify destination site of virtual appointments
- Federal and state information resources to support integrated health care initiatives

Commented [MP1]: Consider putting on hold/remove?

Health Information Network Services (MiHIN)

- Poly-pharmacology – to include individuals who get psychotropic medication from external prescribers and CMH network prescribers and/or individuals on multiple medications and their needs cannot be met in community care once stabilized
- On going epidemic of opiate and other addictions in the community
- CMHSP's still lack billing codes to support integrated health care, such as consultation codes
- Difficulty in maintaining fully staffed nursing services
- Community prescriber staffing shortages in the physical health care environment

Opportunities

- Behavioral Health Home Models emerging in Michigan
- Preventative or early intervention with youth before health conditions become chronic – including but not limited to obesity
- Community health care potential partners
  - Bay County Public Health - possible co-located health and wellness facility
  - Great Lakes Bay Health Centers (FQHC)Sterling Area Health Center
  - Recovery Pathways
  - Echo Project
- Potential to become a learning center for student nurses, nurse practitioners and physicians through partnership with local university medical schools as well as local high school co-op placements
- Educate medical staff to the introduction of nursing case management role(s)
- Availability of the option to utilize certified peer specialists to support integrated health efforts
- State health care initiatives
  - Beh. Health Home initiative
  - Certified Community Behavioral Health Clinics
- Improved coordination of care letter now electronic in 2023 allows BABH to receive more information from PHCP and other medical providers
- Using certified electronic health record with capability to transmit continuity of care documents, receive admission/ discharge/ transfer documents and direct message
- Already entered into an agreement with a health information exchange (GLHC, now part of MiHIN) for lab results interface
- BABH Clinic Staff routine use of MiGateway with MiHIN for ADTs in addition to VIPR. Being used by nursing staff at all states of treatment.
- Helen Nickless Free Medical Clinic relationship – Helen Nickless staff provide screening for mental health symptoms/distress, Great Lakes Bay Health Center provides a psychiatric provider and mental health professional (therapist) from BABHA who then assesses for CMH level of care and referral if eligible. Helen Nickless staff assist individuals in applying for Medicaid.
- Emergency and Access Services Department has hired two Intake Assessment Specialists. However, they are often at capacity and do not have room for Same Day Intake. Another EAS Intake Assessment Specialist would need to be hired to enable same day intake.

Weaknesses

- Inpatient and outpatient demand post-COVID exceeds current provider capacities.
- BABHA performance on MMBPIS access indicators has declined
- Loss of staff competencies in motivational interviewing (including assessing stage of change), mindfulness and recovery- oriented systems of care; nurses not yet at desired level of competence
- Discomfort among some non-medical staff in addressing whole health issues
- Consumers not currently utilizing BABHA nursing and psychiatric support services, including some:
  - Children and families experiencing developmental disabilities or serious emotional disturbances (SED)
  - Consumers with MI and DD case management not living in residential settings nor receiving psychiatric services
  - Consumers using contracted primary service providers who do not have nursing staff
- Integrated health related competencies of staff are variable
- Integrated health not adequately addressed or implemented with internal staff or with contracted service provider contracts and scope of work
- Lack of understanding among community primary healthcare providers regarding behavioral health, including hospital emergency room staff
- Openness to collaboration often limited to primary healthcare providers on Medicaid Health Plan provider network panels
- Management of chronic health conditions is difficult, especially for people not in recovery or with unstable housing
- Multi-generational families with poor health management skills
- Lack of certified peer specialists
- Lack of transportation for healthcare
- Existing Coordination of Care system with general practitioners is not as effective as it could be but improvement has been made with clinic only letter and electronic coordination of care document for primary case holders
- Coordination of care with SUD providers is lacking
- Recent federal regulatory changes did not lessen the burden of protecting substance abuse treatment information

(CCBHCs) Duals Projects (MI-Health Link)
- Bay City Crisis Residential Unit has opened in Bay City for Bay and Arenac County individuals.

- Lack of awareness/understanding/use among other health care providers for DIRECT messaging, Admission-Discharge-Transfer records (ADT's), Continuity of Care Document (CCD's), etc.

Breakthrough Initiatives:	Resources:
1. Investigate CCBHC option for implementation in Bay and Arenac Counties a. Review CCBHC experience and financial results with existing CMHSPs for Ionia, Washtenaw, Sanilac and Clinton-Eaton-Ingham counties b. Discuss strengths and weaknesses of CCBHC model with SLT and Agency Leadership c. Present final recommendation to BABHA board for consideration	Extended SLT, Agency Leadership, Health Care Integration Steering Committee (HCISC)
2. Implement CCBHC or alternative reverse integration model at BABHA a. Baseline evaluation of readiness against selected integration standards b. Explore federal and state grant opportunities for related infrastructure c. Identify necessary improvements in BABHA operations to comply with related standards d. Create a work plan that incorporates every department so that health integration becomes a natural part of clinical flow.	Extended SLT, Agency Leadership, Health Care Integration Steering Committee (HCISC)
3. Implementation of health literacy training guidelines for staff and individuals served	Sarah VanParis, Jennifer Lasceski

Finance Committee

Environmental Scan: **Management of Internal Operations and Provider Network within BABHA Annual Budget and Available Revenue**

Lead Team Member: ~~Marci Rozek; Christopher Pinter~~CFO, CEO

Status: Revision for 202~~6~~5

Impact on Ability to Accomplish Mission:

- It is important to make strategic decisions while maintaining competitive business operations and a strong Provider Network in a manner that is consistent with organizational values
- As resources are impacted, service arrays, provider networks, staffing, and supporting infrastructure are also changed
- Shared risk nature of contract financing requires similar commitment from MDHHS, MSHN and BABHA to meet population service needs

Opportunities/Threats:

- Annual Performance Improvement Bonus Incentive Payment
- An increasing fund balance
- State and federal grant opportunities for integration ~~and staff retention~~
- Funding of mandated direct care wage increase through capitated rates
- Michigan's earned sick time act and minimum wage~~s~~ changes will affect Provider Network

Strengths/Weaknesses:

- Board aware of budget status and supportive of investments in provider systems
- Zero-based budgeting not performed periodically

- Threat to public services posed by financial integration strategies
- Inpatient utilization/expense has increased 40% in two years
- Autism funding not sufficient to meet volume of services provided
- Demand for autism services greater than internal and external capacity
- MDHHS mandate to pay a minimum hourly rate for behavioral tech services
- Waskul Settlement creating wage disparities for CLS workers
- Community Living Support expenses have increased 16% in last two years
- Medicaid expansion has outpaced available mental health providers for all service populations
- Maintaining a stable Provider Network crucial. Staff recruitment and retention still a concern even after the pandemic.
- Long term financial viability of residential contracts
- ~~Evaluation/monitoring of outcomes based vocational contracts~~
- ~~Expansion of Mobile Response Team to second shift with financial assistance from grant funds and MSHN~~
- Pervasiveness of need in some areas, such as SUD services in Arenac County
- MDHHS Home and Community Based Services changes and potential Waskul settlement will dramatically increase CMHSP costs without offsetting revenue enhancements
- Post COVID labor market increasing all provider expenses.
- Lower cost crisis residential unit to divert higher cost inpatient hospitalizations
- Expansion of CCBHC site in the MSHN region consuming excess Medicaid funding/savings
- MDHHS procurement of the PIHPs jeopardizes financial viability of CMHSPs
- Scale of MSHN region allows opportunity to fund additional budget requests annually when MSHN's Medicaid savings and ISF allows
- Use of non-representational service utilization trends affects the MDHHS rate setting process
- ~~MSHN supportive of Provider Stabilization efforts within each CMHSP budget~~
- Efficient use of EHR.
- Regional capitation basis not reflective of the specific needs of individual geographic areas, particularly with autism and healthy MI
- MDHHS actuarial rate calculations have negatively impacted funding the behavioral health and SUD system.
- BABH PMPM funding has not kept up with service utilization/expenditure trends
- Medicaid redeterminations are affecting benefits and as a result funding the system
- Lack of consistent information to community – i.e., services available before a crisis arises
- High turn-over rate and over-time costs with Network Providers of direct care services
- MDHHS eligibility specialist and staff critical to monitoring Medicaid benefits
- MDHHS phasing out CMHSP local match drawdown commitments

Breakthrough Initiatives:	**Resources:**
1. Monitor Long Term (3-5 year) Financial Plan based on revenue trends	Extended SLT; Finance Department; IT Department
2. Monitor Medicaid, Healthy Michigan, ABA and General Fund expenses in every programmatic, personnel and financial consideration; continually monitor fiscal year revenue projections	"
3. ~~Monitor financial stability of Network Providers; Monitor staff retention and impact of recent CLS and provider rate adjustments related to the DCW mandate~~	"
4. ~~Monitor financial impact of Individual Placement and Support (IPS) Evidence Based Model, related vocational service, Outcome Based Contracts and community living support services in response to home and community based waiver.~~	"

5.	~~Implement local crisis residential facility and pursue expansion of inpatient psychiatric beds in Bay and/or Saginaw counties as alternative service options~~	"
6.	~~Expand use of telehealth and mobile technology to increase productivity and compliance at individual service and staff level~~	"
7.	Investigate options to revise eligibility/authorization criteria for inpatient care, outpatient services and autism services to reduce the increasing expense curve in 202~~5..~~	"
8.	Evaluate the financial impact of MDHHS ABA reimbursement rates against the actual cost of related services	
9.	Identify other options to reduce autism, Healthy Mi and General Fund expenses consistent with contract requirements including formal procurement and discount pricing arrangements	
10.	Partner with CMHAM, MSHN and county officials to advocate with State for sustainable public mental health funding levels ~~.~~	

Program Committee

Environmental Scan: ~~Availability of~~Cost Containment Strategies and Availability~~for~~ of Community Living Support Services (CLS) for Adults & Children

Lead Team Member: ~~Director of Integrated Services, Melanie Corrion~~Karen ~~Amon,, Nicole Sweet, Emily Gerhardt~~ Director of Integrated Services-Long Term.

Status: Revised~~Revised~~ for 202~~5~~6

Impact on Ability to Accomplish Mission:
Community Living Service staffing is less available than is needed and therefore the demand for services across multiple clinical populations and service settings is not being met. The significant increase in the costs of CLS services has negatively impacted our budget and cost containment strategies must be implemented to assure that BABHA will be able to continue to provide adequate services to those in most need.

Opportunities/Threats:

Opportunities:
- Partnering with MALA and other Advocacy organizations to advocate for increase in wages for CLS positions.
- Possibility to look at existing and new provider network/programs to fulfill this gap in services.
- North Bay has moved to community based services.
- HCBS rules may require more community-based service provision increasing the need for more CLS;
- North Bay CLS services have been able to assist in supporting other CLS arrangements.
- Potential to increase Self Directed Arrangements utilizing Peer Support Brokers
- MDHHS requirement and implementation of Electronic Visit Verification systems for Personal Care and CLS

Threats:
- Lack of ~~Negative impact on~~ availability of staff, ~~during and after pandemic ;~~ ~~i~~increased staffing crisis in CLS including specialized residential settings
- Wages are a barrier to hiring and retaining qualified staff.

Strengths/Weaknesses:

Strengths:
- Currently have multiple providers who provide CLS services. Have added three new CLS providers over the last two years.
- Provider system is in place with potential individuals who can provide CLS services.
- Direct Care Workers have received permanent post COVID and minimum wage rate increases.
- Implementation of Self-Directed services for people with SPMI.
- Have been able to pay a differential rate for Arenac County CLS.
- Have included the CLS Leadership Providers at Residential Meetings with BABHA staff.
- North Bay is providing CLS services and has successfully met HCBS rule requirements
- North Bay and Horizon Home staff have successfully supported a variety of emergent situations and has stabilized those situations. Transitions to new providers have been smooth as a result of the Crisis Team interventions.
- Have expanded CLS Services with the Vocational providers to include new consumers.
- BABHA has vehicles for each of the internal programs and Client Services Specialist assist with transportation when possible.

- Needed hours of services are generally less than a typical 8-hour shift and reduces the likelihood of being able to hire and retain staff.
- ABA Technicians, Assisted Living Workers, and other similar workers etc. currently make more than the CLS workers.
- Other entry level jobs generally pay more than CLS positions~~.; heightened awareness during pandemic of vulnerability and wage disparities~~.
- As Self Determined arrangements increase, the demand increases for CLS staffing and there is a potential that services will not meet the needs of individuals as identified in their Individual Plan of Service.
- Individuals with high support needs have waited for services which contributes to increased family stress and increased risk of crises.
- HCBS rule implementation may create a situation that will require more use of CLS and there is already a wait list for these services.
- Changes that add administrative burdens to implement the 1915(i) process.
- Conflict Free Access and Planning Work at MDHHS is a threat and could affect our Horizon Home, Northbay CLS and Case Management services.
- EVV implementation has placed administrative burdens on current CLS providers. New compliance standards for EVV may threaten funding for CLS services.
- Lost of two~~one of our~~ CLS providers.
- Providers reluctant to provide both adult home help and CLS as wages are less for adult home help.
- Implementation of ESTA~~Paid medical leave act will~~ forces providers to provide paid time off
- Increase in minimum wage happening 2/1/25 (increased cost to BABHA)
- CLS services are difficult to monitor regarding compliance to standards and there has been an increase in substantiated fraud as well as non-compliant documentation.
- BABHA doesn't have the financial revenue to support continued practices and increases in CLS services similar to the increases from 2024 to 2025 ($3.3 million).
- Waskul Settlement raising wages for only a select group of CLS providers, may cause losses of workers who do not fall under that provider category.
- Hired a Peer Support Broker and expanding the self-directed services for individuals with SPMI
- Development of the CLS Assessment tool and implementation of the CLS Approval Committee to achieve more consistency in the approval of CLS services.
- Have added a new CLS provider in Arenac County for children
- Have added a new CLS provider for Bay County and the provider serves children
- Existing providers accepted additional referrals.
- AOI accepted more children in Arenac County.

Weaknesses:

- The individualized nature of CLS services creates a situation that makes it difficult to hire adequate staffing, i.e. small numbers of hours needed per person per day.
- Uncertainty of the financial environment. CLS services have increased from 2024 to 2025 by $1.7 million and an increase of $1.6 million CLS-Autism.
- Lack of resources in Arenac County for CLS staffing.
- There continues to be a lack of available CLS workers in Arenac County despite providers efforts to provide this service.
- ~~22~~Vocational CLS providers not doing in home CLS due to EVV implementation process and extra administrative burden this creates.
- Vocational providers have been on a cost settlement contract and this has inflated the CLS rates. Conversion back to a Fee for Services has resulted in a reduction in the rates for those providers for CLS services.
- Self Determination and provision of self-directed services are inherently higher risk for abuse and fraud.
- Reimbursement rate doesn't cover provider transportation costs to send a staff from Bay County to Arenac. Clarification on rate differential for Arenac.
- Long wait lists due to providers not having staff to do the work.
- DNMM has ended their Independent Facilitation and now the only provider in Bay and Arenac County is the Arc of Bay County.
- The CLS Assessment Tool is not always completed consistently, and the Committee isn't as cohesive in determining approvals as it should be.
- CSM's need more training on the Assessment Tool and Managers and Supervisors need to be more diligent on reviewing and signing before they are submitted to the Committee.
- Duplicate CLS providers to the same consumer has significantly increased the costs of CLS services.
- Northbay CLS has periods of time when the staff are not providing CLS Services.
- Northbay CLS is only available during regular business day hours, not on weekends nor holidays.

Breakthrough Initiatives: **Resources:**

1. Review current CLS approval process and make necessary changes to implement a more comprehensive and consistent CLS Assessment and Committee approval process: ~~Expand options for CLS services.~~ a. Review the existing CLS Committee structure and consider revisions that will enhance consistency with approvals. b. Provide training on the Assessment Tool to all internal and external Case Management providers. c. Assure that CLS is the last resort for consumers and that all other avenues have been pursued prior to approval of CLS. ~~a. Continue to expand Northbay/Horizon Home CLS services to take on new referrals that contracted providers are not able to provide the services due to capacity issues, crisis situations, and to help provide immediate CLS supports until providers can secure staffing.~~ ~~b. Continue to explore options to expand hiring for individuals in Self Determined arrangements.~~ ~~c. Explore options to increase existing and new providers of children's and adult CLS services.~~ ~~d. Encourage external providers to participate in Advocacy efforts to explore options to address staffing crisis and maintain accountability to meet service needs and contractual requirements~~	CLS Program Manager, All Director's of Integrated Services, CLS Committee members. All Program Managers. Financial Department. ~~Self Determination Coordinator, Certified Peer Supports Broker, MI Adult Team, IDD Adult team, CLS Program Manager, Financial Department, Northbay Leadership, Children's Leadership~~
2. Implement Procurement Strategy for highest cost community living supports (CLS) and Northbay arrangements and transition to new providers. ~~Assist providers and families with maintaining CLS staffing.~~ a. Identify/solicit network of available CLS providers to transition approximately 50% of the existing NB consumers over time. b. Identify CLS arrangements that may need a transition period utilizing Northbay CLS filling the gap between referrals to a provider and/or in times of crisis. c. Identify internal BABHA options to utilize Northbay staff to provide limited CLS and explore other services that the Northbay staff might be able to provide (i.e. Supports Coordinator Assistants, limited CLS for barrier free access, individuals with high behavioral needs). d. Continue to expand the CLS provider network, including for children. e. Transition vocational providers on a cost settlement contract back to a fee for service contract with CLS rates being more in line with other CLS providers. ~~a. Increase the network's ability to handle workforce challenges, crises, and people with challenging behaviors, etc. by providing additional supports such as psychological services, Quality of Life Mentor services, Mobile Crisis Response Team, and other necessary support services.~~ ~~b. Continue to ensure that all CLS staff are trained in the Individual Plan of Service initially and ongoing.~~ ~~c. Advocate for Statewide efforts for Direct Care Worker wage increases and professional certification.~~ ~~d.~~f. ~~Develop and implement additional training for individuals in Self Determination arrangements including topics of Fraud/Waste and Abuse, the EVV system, and other training to assist them in the role of employer.~~	Director of Integrated Services-Long term, CLS Program Manager, IDD Program Manager, Northbay Supervisor, Children's Program Manager, Contracts Manager, Finance Department CLS Committee members. ~~Self Determination Coordinator, Certified Peer Supports Broker, MI Adult Team, IDD Adult team, CLS Program Manager, Financial Department, Northbay Leadership, Horizon Home Leadership, Emergency Services, MI Adult Case Management Leadership Team, IDD Leadership Team, Fiscal Intermediaries, Corporate Compliance Officer~~
3. Identify and transition any duplicative CLS arrangements. a. End CLS social/recreational services at vocational programs for consumers who already receive CLS services in AFC settings. b. Establish consistent and stricter, time limited parameters for CLS social recreation services for consumers living in non-licensed settings.	Clinical Program Managers, Directors of Integrated Services, Self Determination Coordinator, Finance and Contracts Managers, CLS Committee members.

c. Review and assure that Self Determination arrangements are covering all CLS services and not getting CLS services outside of the Self Determination arrangement.	
4. Explore additional areas for cost containment: a. Continuously review all HMP consumers to determine if eligible for Medicaid. b. Implement discharge proceedings for enrollees that lose Medicaid/fail to meet spend down requirements in CLS arrangements. c. Establish more robust UM parameters for medical necessity for CLS in vocational services. d. Explore consolidation of vocational services to two primary vendors.	Clinical Program Managers, Directors of Integrated Services, Finance Department. Clinical Program Manager
5. Implement quality review process to ensure EVV compliance standards are met. a. Identify key members to participate in this review process b. Continue to review EVV bulletins for updates and train CLS providers and staff on correct us of EVV.	CLS, Horizon Home Supervisors, Directors of Integrated Care, Finance Department, Quality ~~Improvement~~Manager

Commented [NS2]: Not sure the official title of Sarah Holsingers team

Environmental Scan: ~~**Stabilization and Long-Term Viability of**~~**Stabilization and Cost Containment Strategies for Residential System**

Lead Team Member: ~~Director of Integrated Services-Long Term, Melanie Corrion, Sarah Van Paris~~Karen Amon Director of Integrated Services-Long Term

Status: Revise for 202~~5~~

Impact on Ability to Accomplish Mission:

- Services with long "episodes of care" are highly sensitive to changes in the economy, and there is a tendency for staff turnover warranting close monitoring to ensure continuing effectiveness

Opportunities/Threats:

Opportunities

- Home and Community Based Services (HCBS) revised rules may promote the development of more individualized and integrated living situations
- MDHHS has maintained increases that have helped retain staff. There are several advocacy groups working to increase the wages of DCW and competencies of that workforce.
- Higher wages may increase quality
-
- More individuals living arrangements may be developed
- Addition of crisis residential home

Threats

- Licensing consultants – not on same page, suggesting guardianship, recommending provider gives emergency notice for behavioral challenges
- BABHA financial picture less stable than in previous years
- Population aging so seeing increase in dementia/Alzheimer's
- Paid medical leave act will force providers to provide paid time off

Strengths/Weaknesses:

Strengths

- Multiple providers. Numerous homes in both counties which gives us options
- Longevity of providers both with BABHA and experience overall
- Provider commitment/buy in for Gentle Teaching
- Provider have made progress with the Quality of Life Initiative
- BABHA Group Home Training. Web based training has been positive for some. COVID has forced us to look at accepting alternative and other CMHSP trainings for the direct care workers. Alternative training platforms available for direct care workers.
- Several Specialized Residential providers have begun using an electronic Medication Administration Record with built in safeguards and time saving features.
- Providers open to other financial arrangements
- Most providers haven't refused to provide service – always willing to help even with financial concerns
- ~~Many truly care about the people we support~~
- Several successful crisis interventions utilizing a Crisis Team to assist in transitions.
- Ancillary care providers such as Occupational Therapy, Dietician, and Nursing are providing care

- Increase in minimum wage ~~happening 2/1/25~~ (increased cost to BABHA)
- HCBS revised rules and identification of 'Heightened Scrutiny' status for some providers.
- Providers may not be able to meet HCBS rules or may choose not to meet HCBS rules and opt out of providing services for people with Medicaid.
- ABA Benefit expansion – brings increased financial costs and wages are higher than Residential DCW's causing a problem with retention of Staff
- Competition for low wage jobs
- Losing long term direct care staff with experience and passion
- Seeing people w/higher support needs (autism, aggression, personal care)
- Affordable Care Act requirements – effecting some providers
- Providers saying they cannot meet needs with current reimbursement
- Providers having difficulty w/challenging behaviors
- High staff turnover rate in homes (direct care workers and managers) and difficulty recruiting
- Home staff have multiple personal/social issues (low income, single parents…)
- Lack transition options
- Increase in out of county placements due to lack of local providers willing/able to provide higher level of care.
-
- Ongoing Collaboration related to working through the HCBS rules and implementation, developing Plans of Correction and to address Heightened Scrutiny status.
- Pass through on DCW wage increase to providers and increase in the minimum wage
- Quality of Life Mentor is providing services in the Specialized Residential Homes and other CLS arrangements
- North Bay has moved ~~to community~~to community based CLS services.
- Increase the development of individual crisis plans to direct residential staff on appropriate responses to crisis situations.

Weaknesses

- Not enough supported independent living options
- Center for Positive Living Supports no longer does mobile crisis team.
- Funds for Self Determination limited
- Low direct care wages – state assistance level wages – many on Medicaid/Healthy Michigan Plan (HMP)
- Closed three specialized residential homes for a total of 19 beds. One provider ended a contract for another specialized residential home. Providers are struggling and making decisions to close homes.
- Home managers not getting support they need from their corporations
- Vacant bed expenses
- Overtime/long hours. Large number are working multiple jobs.
- Providers look to us for the answers in a crisis – have limited solutions of their own (some providers better than others)
- Lease rates of some facilities may be above market
- Need more barrier free homes
- Pressure and cost related to constant training
- Support for high need people (behavioral challenges, dementia)
- Gentle Teaching training is stand-alone – costs providers so they don't send staff
- Other counties direct staff wages are higher – they have provided increases, bonuses, annual percentage increases to contracts
- Lack of safe, affordable housing in Arenac County.
- Increase of vacant beds for long periods of time.

Breakthrough Initiatives:	**Resources:**
1. Continue to advocate, prioritize and support efforts ~~appropriate financial adjustments~~ to stabilize the residential services and advocate at all levels for improving the Direct Care workforce. a. Explore development of more direct and provider operated living arrangements that are capable of providing adequate services for individuals with higher behavioral needs. b. Explore more individualized and potentially unlicensed arrangements to be able to meet the needs of individuals with higher behavioral needs in more appropriate settings. c. Continue to collaborate with the Crisis Residential home to provide services to individuals with higher behavioral needs in crisis.	SLT, Financial Department, Board of Directors, ~~,~~ Horizon Home Leadership, North Bay Leadership, IDD Team Leadership, Residential Liaison

2. Support staff's ability to perform effectively and to ensure residents' needs are met. a. Increase the residential provider network's ability to handle workforce challenges, crises, and people with challenging behaviors, , etc. by providing additional supports such as psychological services, Quality of Life Mentor services, debrief resources~~counseling~~ and other necessary support services.	Staff Development, Quality of Life Mentor, Specialized Residential and CLS Providers, Clinical Leadership, IDD Team/MI Adult Team, Horizon Home Leadership, North Bay Leadership, Behavior Treatment Committee, Residential Nursing Staff, BI Department and Quality Assurance Team
3. Address high cost out of county placements and vacancies in the Specialized Residential provider network. a. Eliminate payments for vacant bed days to encourage providers to increase current occupancy rates. b. Explore consolidation of vacant specialized residential beds to either direct operate or contract out to a provider who will provide services to higher need individuals. c. Explore the possibility of adding another crisis residential home d. Transition Northbay CLS staff to residential technicians if assume another direct operated home. e. If vacancies can't be filled in the existing provider network, consider closing a current residential facility.	Directors of Integrated Services, Program Managers, Residential Liaison, Residential Referral Committee, Specialized Residential providers, Finance Department.

Environmental Scan: **Applied Behavior Analysis (ABA) Services Stabilization and Cost Containment Strategies**

Lead Team Member: Directors of Integrated Care – Children **Status:** New for 2026

Impact on Ability to Accomplish Mission:

Applied Behavior Analysis (ABA) Service referrals have consistently expanded each year since the implementation of the program in FY16. The volume of referrals continues to exceed both the available program capacity and the program budget. The significant increase in referrals for ABA services has had a negative impact on our budget and cost containment strategies must be implemented to assure that BABHA will be able to continue to provide adequate services to those in most need.

Opportunities/Threats:

Opportunities:

- Utilization of effective ABA services will improve language and communication, social skills, daily living and adaptive skills, and a reduction in challenging behaviors for children.
- Outcomes Monitoring: Internal quality oversight equivalent to oversight of contracted provider network and measurement of clinical outcomes/ evidence-based practices
- Development of outcome measures will assist in thoughtful implementation of cost containment strategies.

Strengths/Weaknesses:

Strengths:

- BABH staff knowledge and expertise related to ABA service regulations.
- Longevity of BABH ABA services program. ABA services were implemented in FY16.
- Expertise of the current BABH ABA provider network.
- Agency commitment to providing quality services.
- Early and consistent ABA intervention has been linked to better educational outcomes and greater social integration later in life.

Threats:

- BABHA does not have the financial revenue to support the volume of referrals for ABA services.
- State mandated rates for ABA services provided by Behavioral Technician. The State has not increased the budget to adequately fund the mandated rates.

Weaknesses:

- Inadequate State funding for the volume of children in Bay and Arenac Counties who have been diagnosed with Autism Spectrum Disorder (ASD) and who meet medical necessity criteria for ABA services.
- Low direct care wages – state assistance level wages

Breakthrough Initiatives:	**Resources:**
1. Develop a value-based care model for services. a. BABH will work with a consultant to develop this significant shift from the traditional model. b. Form a time limited work group to develop key standards. c. Incorporate the use of data analytics to support an outcomes-based approach to ABA treatment.	Director Integrated Care – Children, Financial Department, Children's Leadership team, BI
2. Improve operational efficiencies within the ABA provider network. a. Develop a procurement process/ Request for Proposal (RFP). b. Educate current provider network on new model and expectations. c. Increase ABA provider meetings to twice per year to help improve communication and education of expectations. ~~Selection of ABA providers~~	

~~**Breakthrough Initiatives:Environmental Scan:**~~

~~**Resources:Integration with Substance Use Disorder Treatment and Prevention**~~

~~Increase treatment and/or referral activities, including consultation with BABH Addictionologist, for adolescents and adults identified with co-occurring SUD conditions.~~

~~Joelin Hahn, Heather Friebe, Stacy Krasinski, Emergency & Access Services (EAS), Child/Family programs, Dr. Morrone .Joelin Hahn, Heather Friebe~~

~~**Status:**~~ ~~Revise for 2025~~

~~**Lead Team Member:**~~

~~Support Arenac County efforts related to Recoverythe Recovery court and continued expansion of SUD service in the area.~~ ~~**Impact on Ability to Accomplish Mission:**~~

~~Joelin Hahn, , Heather Friebe, Arenac County Commission, Chief Judge, Sheriff, Prosecutor , Recovery Pathways, , Arenac County Prevention Coalition (ACPC)), The Well Outreach, Sterling Area FQHC and MSHN.~~

- ~~Increase coordination of care and increase the ability to navigate smoothly between mental health and substance use disorder treatment providers. BABHA must be responsive to changes in the prevalence of health conditions in the environment in which it operates~~
- ~~BABHA must address necessary shifts in resources and respond in a timely manner in response to shifting community needs.~~

~~Joelin Hahn, PNOQMC, BCPN, ACPC, local MSHN SUD~~ provider network.

~~Increase co-occurring capability within provider network.~~

~~Joelin Hahn, Heather Friebe, PNOQMC, Staff Development Department.~~ ~~**Strengths/Weaknesses:**~~

Commented [MP3]: Move to training initiatives

Opportunities/Threats:

- Minimal availability of SUD providers in Arenac Co.
- Increased Substance Use during the COVID-19 pandemic
- Availability of Opioid Settlement funds.
- Working with medical community
- Increasing training and collaboration with community partners
- Limited financial resources for substance use disorders
- More dangerous substances in communities
- Increased access to drugs
- Expansion of Medicaid/SUD Behavioral Health benefit
- Increase in availability of potential grant funding
- Continuation of problems with underage alcohol use
- BABHA Access and ES staff continue to provide SUD screening, referring and coordination to Arenac, Bay, Huron and Tuscola Counties
- Standish The Well Outreach, Recovery Pathways, Ten16, and Peer 360 interested in collaboration to develop SUD continuum in Arenac County
- Collaboration and partnership with court system and law enforcement in Bay County.
- Participation in Project ECHO, Bay County Prevention Network (BCPN), Arenac County Prevention Coalition (ACPC), and the Heroin Task Force
- Participation with Great Lakes Bay Families Against Narcotics (FAN).
- Expanded community education and distribution of Narcan kits
- Obtaining Narcan and harm reduction vending machines in both Arenac and Bay Counties.
- Program/Provider development to increase co-occurring enhanced services.
- Bay and Arenac Counties both have local coalitions to address SUD public health issues
- Lack of access to detox and residential services in Bay and Arenac Counties
- Limited available programs/services in Arenac County to meet needs of expanded benefit packages
- Limited transportation to out-county SUD facilities
- Lack of recovery housing in Arenac and Bay Counties
- BABHA's Bay Consumer Advisory Council is supportive
- Breadth of staff competencies in SUD treatment and prevention is improving, but is not as broad as needed
- MCBAP requiring supervisors to have specific supervision credential which takes two years
- MSHN system and funding design continues to encourage segregated mental health and SUD service systems

Breakthrough Initiatives:	**Resources:**
1. Increase treatment and/or referral activities, including consultation with BABH Addictionologist, for adolescents and adults identified with co-occurring SUD conditions. 1.	Joelin Hahn, Heather Friebe, Stacy Krasinski, Emergency & Access Services (EAS), Child/Family programs, Dr. Morrone .
2. Support Arenac County efforts related to Recoverythe Recovery court and continued expansion of SUD service in the area.	Joelin Hahn, , Heather Friebe, Arenac County Commission, Chief Judge, Sheriff, Prosecutor , Recovery Pathways, , Arenac County Prevention Coalition (ACPC)), The Well Outreach, Sterling Area FQHC and MSHN.
3. Increase coordination of care and increase the ability to navigate smoothly between mental health and substance use disorder treatment providers.	Joelin Hahn, PNOQMC, BCPN, ACPC, local MSHN SUD provider network.
4. Increase co-occurring capability within provider network.	Joelin Hahn, Heather Friebe, PNOQMC, Staff Development Department.

Commented [MP4]: Move to training initiatives

Environmental Scan: Evidence-Based and Best Practices in Clinical Service Delivery

Lead Team Member: Joelin Hahn, Heather Friebe, , Nicole SweetDirectors of Integrated Care

Status: Revise for 20265

Impact on Ability to Accomplish Mission:

- Use of validated practices supports achievement of clinical outcomes and therefore the organizational mission

Opportunities/Threats:

Opportunities:
- Continued operationalization of culture of gentleness (Region 5-AFP 2013, 5.1.7)
- Internal quality oversight equivalent to oversight of contracted provider network and measurement of clinical outcomes/ evidence-based practices
- Continued operationalization of recovery oriented and trauma informed system(s) of care – with a link to integration of care efforts and including attention to co-occurring capacity within the organization in light of recent personnel changes (Region 5-AFP 2013, 5.5 Recovery), see MH Commission Wellness Plan - #5 societal impact, data/outcome, anti-stigma
- Utilization of effective services will improve the lives of consumers and reduce costs.
- Development of outcome measures will assist in thoughtful implementation of clinical practices.
- Partnering with local colleges who educate criminal justice students

Threats:
- Limited finances can prohibit some of the more expensive EBP's.
- Focus on more pressing threats, including COVID-19, has created less attention on implementing EBP.
- With the focus on efficiency and with staff adding on more individuals to their caseloads, it leaves less time to focus on the more time consuming EBP.
- With a greater focus on reduction in revenue, focus on EBP's may become less in the forefront.

Strengths/Weaknesses:

Strengths:
- Already have multiple Best Practices and EBP's implemented.
- Agency commitment to providing quality services.
- Agency has already developed and implemented pilot projects that have increased the quality of life and reduced costs of services.
- Systems are in place to support ongoing implementation of these practices.
- Successful Mi-FAST (fidelity) Reviews have been conducted and improvement continues in the existing EBP's.
- BABHA's Bay Consumer Advisory Council is supportive
- BABHA financial status has stabilized and it's likely that more resources may be able to be invested in EBP's.
- Arenac Center therapists have been trained in SUD and Trauma Group Curriculum and began to implement groups prior to the pandemic.
- Currently have Individual Placement Supports and Outcome Based Supported Employment models for vocational services.

Weaknesses:
- Lack of Peer and Parent Support options in both counties
- Loss of champions for these practices and reduction in trained staff/loss of workforce.
- Multiple directions and many changes for the agency.
- Lack of specific Trauma Treatment methods for adults.
- Lack of knowledge between ABA providers and the Specialized Residential staff on the different philosophies and methods of treatment.
- Turnover of staff
- Reduction of the EBP's that have been utilized in the past
- Lack of knowledge on benefit counseling and employment services
- Current IPS referrals are low given the number of individuals served by BABH.
- Lack of IPS referrals in Arenac County

Breakthrough Initiatives:

Trauma Informed Services:
1. Continuation of the three-year organizational Assessment for Trauma and develop the Improvement Plan based on the results of the Assessment.
2. Incorporate recommendations from the Wellness/Compassion Satisfaction Initiative (CSI) team to reduce vicarious trauma/secondary traumatic stress. - continue
3. Evaluate capacity and need for EBP to treat trauma in all populations. - continue
4. Identify and Implement Trauma Treatment Groups (Seeking Safety, TREM, Helping Women Recover, etc.)

Resources:

~~J. Hahn~~Directors Integrated Care, Clinical Leadership, Staff Development, PNOQMC, Contract Provider Agencies; Wellness/Compassion Satisfaction Initiative (CSI) Committee~~,~~ ~~TF-CBT Initiative/ Emily Gerhardt, MDHHS Trauma Initiative to address Secondary Traumatic Stress, Quality Assurance/Sarah Holsinger, Arenac Center Outpatient Therapists/Pam VanWormer~~

Clinical Effectiveness and Expanding Evidenced Based Practices	
1. Monitor LOCUS training plan that includes ongoing activities to strengthen model fidelity throughout the provider network serving adults with a Serious Mental illness (SMI). Evaluate implementation and capacity of existing Evidence Based Practices. Evaluate existing system structures to determine if the agency has created a system that supports ongoing successful implementation of existing EBP	Director Integrated Care- Acute Care/Arenac, ~~J. Hahn~~, ~~Kaytie Brooks~~, Staff Development, BABA internal LOCUS trainers.
2. Focus on co-occurring SED/IDD training for the Children's Department.	~~Emily Gerhardt, Kelli Wilkinson, Kaytie Brooks, Joelin Hahn~~Director Integrated Care-Children, Children's Leadership, Staff Development.
3. ~~Develop and implement Peer Support Services programs to include Peer Support Specialist, Parent Support Partners, and Youth Peer Support.~~	~~J. Hahn, Clinical Leadership, SLT~~
4. ~~Assess and increase staff competence in the following areas: Motivational Interviewing, Transtheoretical Model (Stages of Change), Dialectical behavior therapy (DBT) basic skills, Co-occurring BH/SUD treatment, Child Parent Interaction, Fetal Alcohol Syndrome Disorder (FASD), Child Parent Psychotherapy (CPP), and Integrated Care competencies.~~	~~SLT, Clinical Leadership, Staff Development, Health Care Practices Committee, Provider Network Operations Quality Improvement Committee, MDHHS resources such as www.improvingMIpractices website and MiFAST teams.~~
5. Develop outcomes monitoring processes to assure and measure fidelity to EBP', including participating in the MiFAST reviews for existing EBP's; completing the MiFAST for the LOCUS. MiFAST for LOCUS will be conducted in FY24.	~~MDHHS Practice Improvement Committee, MDHHS MiFAST Review Teams, SLT~~Directors of Integrated Care, Clinical Leadership, ~~Population Committees~~, Provider Network Operations Quality Improvement Committee, Vocational Providers
6. Monitor activity for the Infant and Early Childhood Mental Health Consultation grant.	~~Pam VanWormer, Kelli Maciag~~Children Clinical Supervisor – Arenac and Bay
7. Monitor activities for the Alternative Outpatient Treatment (AOT) ~~and the Mobile Response Team (MRT)~~ grant program~~s~~. Determine program sustainability post grant. Apply for new grant opportunities for additional grant funding as they arise.	EAS Clinical Program Manager, ~~Stacy Krasinski~~, ~~James Spegel~~, Finance Department, ~~Joelin Hahn~~Director of Integrated Care
8. Expand IPS services and improve fidelity amongst current providers. Increase referrals and expand on education around the impact of IPS services. 9. Improve education on Benefits to Work coaching and dispelling myths associated with working while receiving benefits.	~~Nicole Sweet~~, Clinical Program Manager, MDHHS and MIFAST Team, Clinical leadership, Vocational Providers ~~Nicole Sweet~~, Clinical Program Manager, MDHHS and MIFAST Team, Clinical Leadership, Vocational Providers.

Environmental Scan: **Community and Employee Engagement**

Lead Team Members: ~~Chris Pinter, Amy Folsom, Melissa Prusi, Stacy Krasinski, Jennifer Lasceski~~CEO, Strategic Leadership Team, Agency Leadership, Wellness Committee

Status: Revise for 2026~~5~~

Impact on Ability to Accomplish Mission:

- A lack of awareness of BABH mission and services and how the public may access them
- Lack of understanding of CMHSP disaster behavioral health responsibilities and obligations to ~~conditions and the impact on special populations in~~ the larger community ~~is negatively impacting access to care and coordination of services~~
- Lack of understanding for employees concerning strategic and resource decisions and detrimental effects on morale

Opportunities/Threats:

Opportunities:

- Information is welcomed when it is made available.
- Availability of several media outlets to get information out (Facebook, agency website, paper educational materials, social media venues, program to program sharing of information, Linked In, X).
- Community Events (Saginaw Spirit has MH night, Bay County Prevention Network, Great Start Collaborative-Winter Family Fun Fest, A Night Out, Yellow Ribbon events, Recovery Community events).
- People we serve have support systems with resources
- NPR Delta College advertising or Behavioral Health awareness
- Local library systems offer community education series keeping BABH leaflets there or provide education to their staff
- Area Colleges & Social work department organizations (speaking engagements)
- Local association or Groups in our community including PFLAG, Great Lakes Bay Mental Health Consortium
- Improve relationships with local colleges and area high schools for recruiting and training for real-world experiences. Offer and advertise BABH as a learning-based site for social work, nursing, medical assistants, physicians, and high school students who are interested in this field.
- ~~BABH has a dedicated school liaison to two schools~~
- BABH to be a presence at area job fairs for recruitment as well as exposure to services.
- ~~Improved communication with employees~~
- Community engagement with youth services.
- MRT is available Monday through Friday daytime and some evening hours.
- Participate in the Bay City Housing (Homeless) Task Force Coalition.
- ~~Establish collaboration with new community partners.~~
- Leadership meeting synopsis disseminated to agency staff via internet and leadership to review at staff meetings.
- Collaboration with Good Samaritan Rescue Mission with the opening of their new Overnight Drop In Center.
- Collaboration with United Way and their Connect Up program to improve access to community resources.

Threats:

- Lack of understanding and stigma fosters failure to access needed care, potentially leading to avoidable negative clinical outcomes

Strengths/Weaknesses:

Strengths:

- ~~Establishment of dedicated school liaison position~~
- Mental Health First Aid Training program
- Motivational Interviewing Training program
- QPR Question Persuade Refer Suicide Prevention Training Program
- Two CIT Crisis Intervention Team trainers on staff
- BHEP Behavioral Health Emergency Partnership trainings partnership with law enforcement.
- BABH Staff who participate in community meetings/events
- ~~Established relationships exist~~
- BABH Staff are willing to participate at community events even on weekends when supported by agency.
- Expanding use of intranet and social medial platforms for community engagement~~BABH does have an existing FB page and website~~.
- BABH has a large, contracted provider network that is and can be used to disseminate information.
- Establishment of mobile response team with Bay Couty First responders.
- Improved relationship with the police, jail, Bay and Arenac County court systems.
- Network providers report improved timeliness and input/collaboration of BABH decision-making processes
- Established agency leadership processes
- Comprehensive employee survey process

Weaknesses:

- Schools do not fully understand BABH services
- General community lacks understanding of mental illness, substance use disorders and developmental challenges
- Community Partners do not understand mild to moderate vs SMI.
- Employees of BABH are not fully aware of what others are doing or involved in.
- Lack of public relations staff to oversee efforts or create sustainability.
- ~~Many BABH staff participate in community meetings but BABH does not track who participates or where resources are shared. Consider Sharepoint site to log all community events/opportunities.~~
- ~~Lack of community support to our partners with their initiatives. Consider piggybacking community events with community partners.~~
- Inconsistent Team Meeting agendas or communication requirements
- ~~Little to no social media presence. Staff are not aware of our Facebook. [Each department responsible for posting once a month? Employee spotlight? Postings must be~~

• Community Partners practice in their own vacuum; not realizing the resources available to people who meet criteria for CMH level of care • Lack of knowledge about what kinds of information community partners need—what is helpful and what is not • Missed opportunities to impact those who need services • Failure to engage employees in crucial agency decisions	~~related to BABHA/Mission/Values/Services. Must have approval by SLT? May benefit employee recruitment.]~~

Breakthrough Initiatives:	**Resources:**
1. Continue to work with Community partners (law enforcement, courts, MDHHS, schools, medical facilities, etc.) to increase understanding, reduce stigma and promote trauma informed communities	Extended SLT, Agency Leadership, Bay County Prevention Network, Arenac Drug and Alcohol Containment task Force, Arenac and Bay County Sheriffs, McLaren MHU and Emergency Department, MyMichigan Standish Hospital, MyMichigan Bay City ED, Recovery Pathways, Sacred Heart, Great Lakes Bay Southside and Westside FQHC, Sterling Area Health Center, Bay County Public Health Department
2. Re-instate a process for keeping behavioral health literature in community partner lobbies and available to the public. (Possibility to have secretaries be responsible for distribution and two way communication for community events.)	Extended SLT, Agency Leadership. Helen Nickless Free Medical Clinic, Good Samaritan Rescue Mission, Opportunity Center, Arenac Community Center, Bay Area Women's Center, Bay Arenac ISD, CAN Council, MI Works in Standish and Bay City, Great Lakes Bay, McLaren, Recovery Pathways, Sacred Heart, DOT Caring Center, 1016 House, Catholic Family Services, MyMichigan Standish, MyMichigan Bay City ED
3. Maintain efforts to actively include service providers in prompt communication and opportunities for collaboration	Extended SLT, Agency Leadership, Provider Network Operations and Quality Committee
4. Implement Staff recognition process for milestone years of service developed by Wellness ~~Create~~Committee ~~a shared site for informative educational series to share on social media. (Sharepoint, Facts for Families, Phoenix library for meds and diagnoses)~~	Agency Leadership, Human Resources Department ~~Staff Development, Information Technology and Help Desk~~
~~5.~~ Add a Critical Incident Response Team ~~SCHISM~~ team to expand BABHA capacity to respond to disaster behavioral health and other community emergencies ~~Expand Stepping Up Initiative to address safety net and treatment issues for youth and juveniles into Arenac County.~~ 5.	Strategic Leadership Team, Human Resources Director, Director of Integrated Services-Acute Care ~~J. Hahn, H. Friebe, P. Van Wormer, Arenac County Probate Judge, Arenac County Prosecutor's Office, Arenac County DHHS, Arenac County Sheriff, Arenac County ISD, Arenac County Commission~~
~~6.~~	

Personnel and Compensation Committee

Environmental Scan: **Recruitment and Retention**

Lead Team Member: ~~Jennifer Laseceski~~HR Director **Status:** Continue for 202~~6~~5

Impact on Ability to Accomplish Mission:

- Inability to recruit qualified staff – Masters and bachelors level clinician shortage across the state; shortage of direct care staff across the state
- Staff dissatisfaction with compensation
- Staff turnover negatively impacts service delivery
- Scheduled increases in minimum wage
- Uncertain state/federal funding to sustain increases
- Shortage of qualified candidates in this geographic area and statewide impacts efforts to fill long term vacancies

Opportunities/Threats:

- Increased staff morale
- Improved competitive edge in recruitment
- Improve quality of job applicants
- Positive effect on employee retention
- Financial impact may affect sustainability
- Perceived inequality of implementation (not all positions may be positively impacted)
- Use of non-traditional incentives (signing and referral bonuses)

Strengths/Weaknesses:

- Market-based compensation structure in place
- Total compensation ~~i~~was competitive for a number of positions as adjusted in 2018, 2020, 2021, 2022 and 2024, however a lack of wage adjustment in 2025 has put BABH behind area competitors
- Agency training opportunities exceed many area employers
- Agency continues to be guarded due to the uncertainty of adequate funding
- Ability to maintain competitive compensation levels and benefits is impacted by current economic environment
- Competing priorities for limited budget
- Competing industries offering -higher pay and bonuses with reduced risk and responsibility

Breakthrough Initiatives:	**Resources:**
1. Strategies to attract and retain qualified LBSW and MSW candidates. 2. Explore the option to consider ~~other qualified candidates that meet QIDP and QMHP criteria for~~ Case Management Assistant positions.	~~Joelin Hahn,~~ Director of Integrated Care
3. Strategy to attract and retain qualified and invested direct care staff – ~~maintain continuous posting practices~~post positions as needed	~~Justeen Blair,~~Residential Supervisor - Horizon Director of Integrated Care
4. Financial impact of additional potential compensation adjustments (salary and/or benefits) for the organization – consider adding compensation review on an annual basis to the Board By-Laws	~~M. Rozek~~CFO; SLT

Environmental Scan: **Development of Workforce**

Lead Team Member: Director of Human Resources ~~I~~ **Status:** Continue for 2026~~5~~

Impact on Ability to Accomplish Mission:

- Time involved in replacing key staff
- Loss of institutional knowledge, history & experience
- Continued need for ongoing leadership training & documented succession plans
- Advance staff skills to ensure continuing organizational viability
- Increase internal educational opportunities to reduce budget impact
- Improve competencies and health literacy of BABH staff
- Continue to reduce stigma

Opportunities/Threats:

- Lack of provisions for back-up/coverage (i.e., cross-training)
- Need department buy-in and commitment to succession planning process
- Planned departures provide lead time to groom successors
- Need to expand staff training on SUD, recovery, trauma and cultural competence

Strengths/Weaknesses:

- Training capacity is stretched, if unexpected absence we lack back-up
- Increased communication (SLT): All staff meetings; all-Leadership meetings; regular SLT updates on intranet site
- More robust succession planning policy and procedure implemented
- Continue to identify potential internal talent
- Staff development plan (w/in annual performance evaluations) to identify leadership potential & development activities
- Encourage team building and other employee engagement activities
- Increased demands on staff

- Continued training support for non-clinical staff related to mental health conditions, customer service, CPI, etc.
- Need for leadership orientation and continued learning
- Increased turnover may lead to gaps in service
- Increase opportunities to engage stakeholders and relay organizational messaging
- Competing training opportunities
- Limited financial resources

- Knowledgeable staff as subject matter experts
- Dedicated training facilities
- Many training opportunities made available via Zoom and other technology
- Short notice of training affects ability of Staff Development Center to obtain CEUs
- Breadth of staff competencies in SUD treatment and prevention is not as broad as needed
- Staff turnover has decreased since 2018, however ~~and~~ a ~~more~~lack of consistent wage increases has affected a competitive wage structure.

Breakthrough Initiatives:	**Resources:**
1. Increase cross-departmental understanding through increased exposure during orientation/training, all-staff events, etc., including job shadowing and document – continue to utilize alternate methods to present training; look at use of alternative training programs for direct care post pandemic	Agency Leadership
2. Staff development will explore ways to improve the new employee orientation process to include increased awareness of BABH locations	Staff Development
3. Increase consistency in the application of standards by supervisory staff	Agency Leadership
4. Continue to increase SUD competency of BABHA clinical programs through training and expanding the number of certified/licensed staff; modify job descriptions as warranted	Clinical Directors; Agency Leadership
5. Develop/promote staff training on common MH diagnosis in order to increase staff competency in providing education to persons served. Suggestions from the Employee Survey regarding specific training topics will be forwarded to Staff Development for consideration.	Agency Leadership
6. Formally outline the role for case management in an integrated healthcare environment and educate staff	~~Sara VanParis;~~Nursing Manager
7. Continue to support residential staffing for BABHA's direct operated home and apartment settings through training and redeployment during the pandemic and beyond	~~Justeen Blair~~Residential Supervisor - Horizon; ~~Nicole Sweet~~ Clinical Team Leader; ~~Melissa Spellerberg~~Human Resources Generalist
8. Continue initiatives that support agency efforts relative to recovery-based care, trauma informed services, co-occurring services and fostering a culture of gentleness.	Directors of Integrated Care; ~~Nicole Sweet~~Clinical Team Leader
9. Increase communication with staff by making Agency Leadership Meeting minutes available on the intranet.~~Investigate CEU process for other disciplines such as nurses, psychologists, etc.~~	SLT~~Kaytie Brooks~~
10. Provide leadership training related to employment practices at monthly all-leadership meetings. Provide leadership and/or management training to Agency management staff.	HR Director
11. Continue to fully develop succession planning, health care competencies, and supervisory competencies into the performance management process	Agency Leadership

Facilities

Environmental Scan: **Review of Remote Work and Physical Plant needs**

Lead Team Members: CFO, CEO ~~Karen, Marci and Jennifer~~ **Status:** Continue 2026~~5~~

Impact on Ability to Accomplish Mission:

The remote work environment has a direct affect on the need for office space, equipment needs and accommodation at work sites for those staff working remotely when they need work space in office.

Opportunities/Threats:

Opportunities:

- Flexibility in staffing schedules to recruit more employees.
- Reduce costs for buildings and work spaces.
- Advance the use of technology to be more efficient.
- Lease~~s~~ renewal options for ~~the Wirt Building and the~~ Mulholland office space extends through February 2033.~~are soon going to be expired~~.
- Option to expand the Madison Building to accommodate other departments

Threats:

- Perceived lack of supervision for remote staff.
- Potential distancing and lack of cohesiveness among teams and within the Organization
- Potential reduction in effective communication between staff and within departments.
- Legacy costs associated with older North Bay property
- Lack of equity value in 201 Mulhoalland location

Strengths/Weaknesses:

Strengths:

- Have had three years during the Pandemic to work through remote work issues.
- Prior to the Pandemic, had a successful virtual office arrangement in place for several years.
- IS staff are very familiar with technology that is needed for more remote work.
- BABHA owns Arenac Center, North ~~b~~Bay and the Madison Clinic.
- BABHA has been able to adapt well during the Pandemic.
- There are many reports that have been developed to be able to monitor quality, effectiveness and efficiency of staff and services.
- Remote work experience has modeled opportunities for further consolidation of physical space including vacating the United Way building in 2025.

Weaknesses:

- Past satisfaction surveys have identified a lack of communication from BABHA, which could worsen if remote work lessens responsiveness.
- Costs for equipment may increase if there are additional needs to accommodate remote work.
- Mulholland and North Bay locations are aging, i.e. 50 and 70 years respectively, and may not be conducive to significant renovation or remodeling.
- Constant changes in McLaren Bay Region leadership renders long term lease arrangements difficult to predict

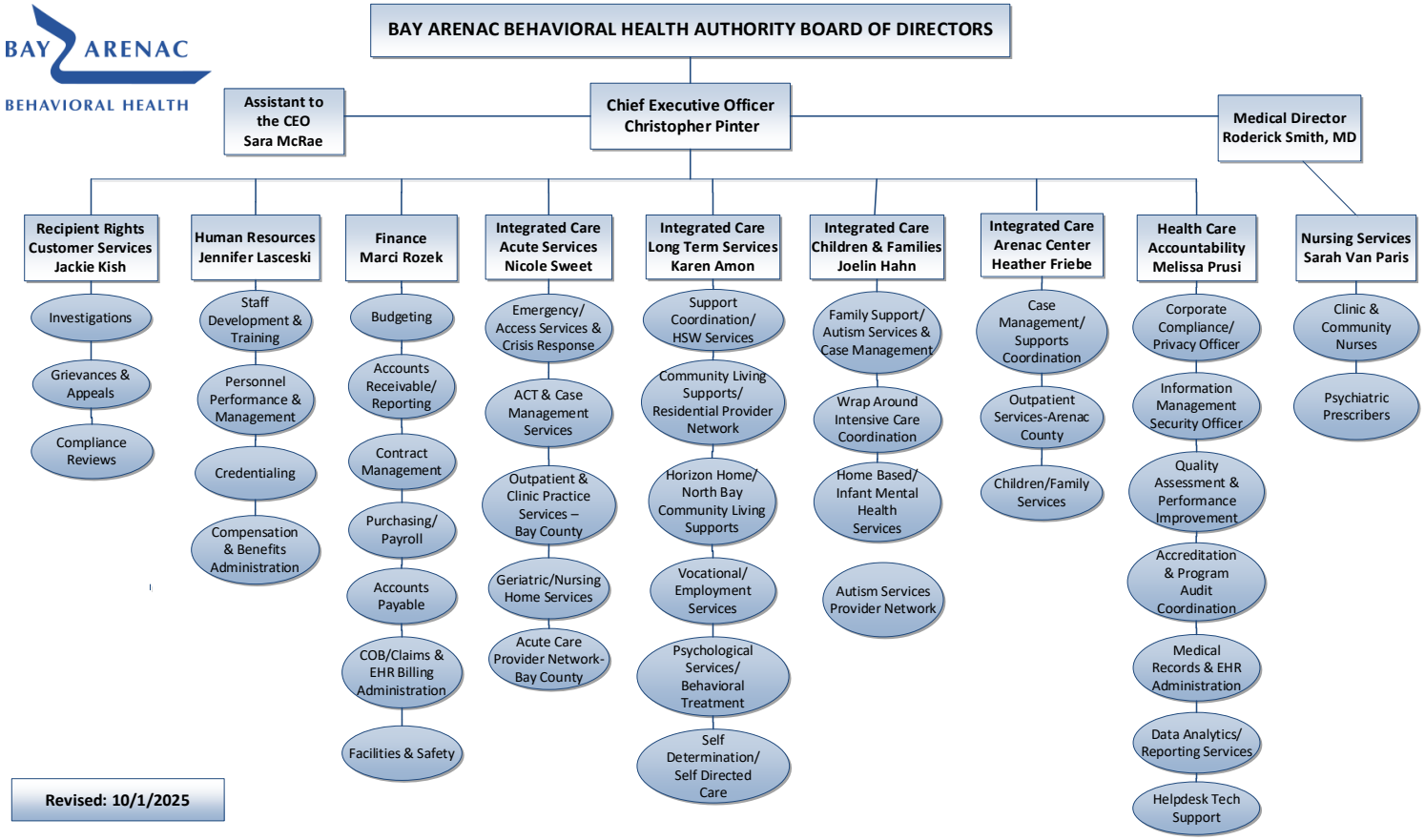
Breakthrough Initiatives:	**Resources:**
1. Implement Leadership Dashboard and other reports to allow Supervisors and Managers for real time monitoring and evaluate staff's activity.	BI Department, Leadership
2. Evaluate long term staff equipment and space needs post remote work implementation.	IS Department, Facility Manager, Leadership
3. ~~Prepare/Revise~~ Maintain an inventory of equipment for deployment; hold on 2026~~5~~ Replacement schedule ~~for Board consideration~~.	IS Manager, CFO~~Finance Manager~~
4. Prepare long term physical plant recommendations related to Bay County locations for Board consideration.	Leadership, CFO,~~Finance Manager,~~ Facilities Manager

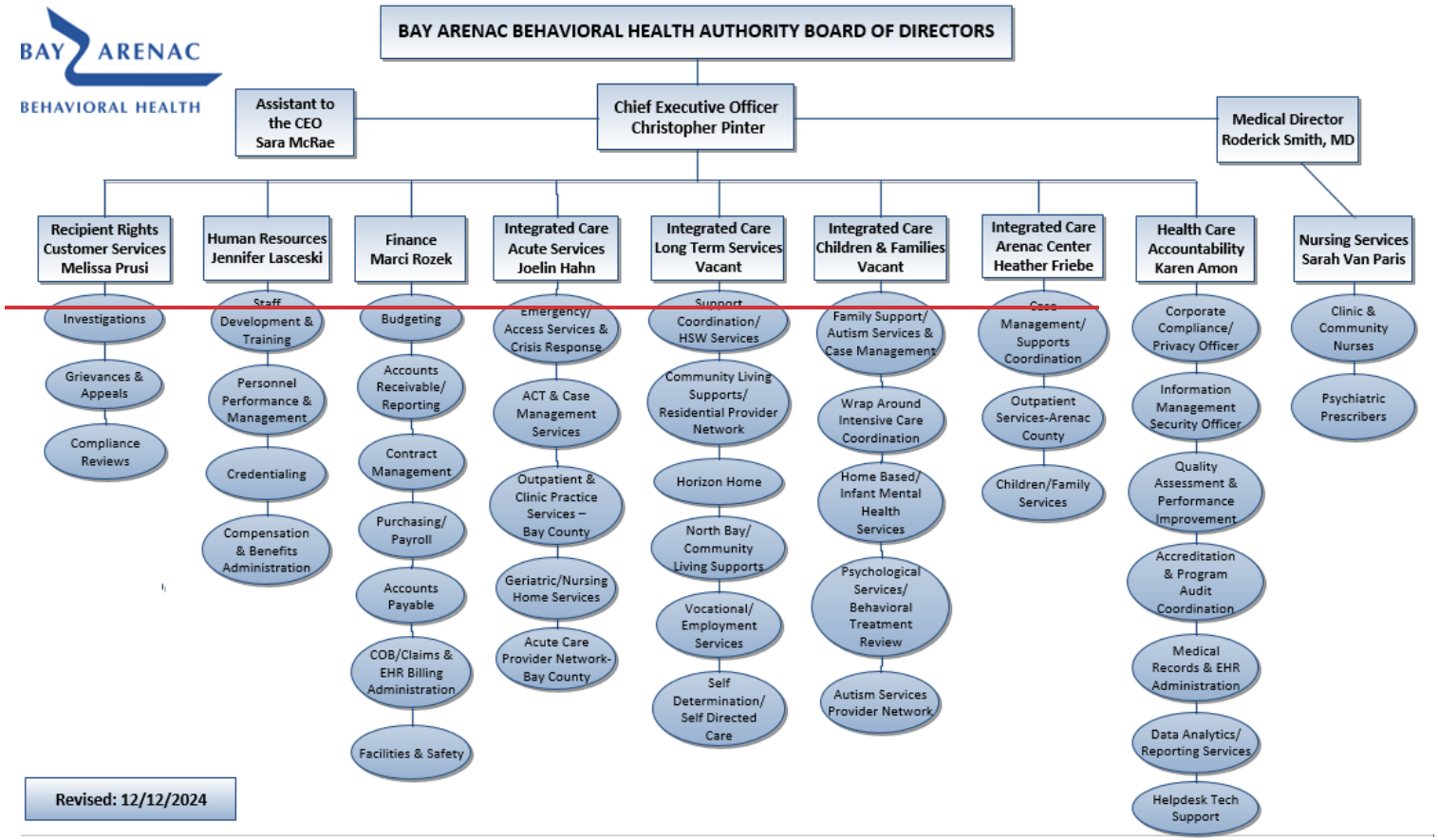
Bay-Arenac Behavioral Health

20265 Strategic Plan

Attachments

Attachment One: Organizational Chart


BAY ARENAC BEHAVIORAL HEALTH AUTHORITY BOARD OF DIRECTORS
Assistant to the CEO Sara McRae
Chief Executive Officer Christopher Pinter
Medical Director Roderick Smith, MD
Recipient Rights Customer Services Jackie Kish
Investigations
Grievances & Appeals
Compliance Reviews
Human Resources Jennifer Lasceski
Staff Development & Training
Personnel Performance & Management
Credentialing
Compensation & Benefits Administration
Finance Marci Rozek
Budgeting
Accounts Receivable/ Reporting
Contract Management
Purchasing/ Payroll
Accounts Payable
COB/Claims & EHR Billing Administration
Facilities & Safety
Integrated Care Acute Services Nicole Sweet
Emergency/ Access Services & Crisis Response
ACT & Case Management Services
Outpatient & Clinic Practice Services – Bay County
Geriatric/Nursing Home Services
Acute Care Provider Network-Bay County
Integrated Care Long Term Services Karen Amon
Support Coordination/ HSW Services
Community Living Supports/ Residential Provider Network
Horizon Home/ North Bay Community Living Supports
Vocational/ Employment Services
Psychological Services/ Behavioral Treatment
Self Determination/ Self Directed Care
Integrated Care Children & Families Joelin Hahn
Family Support/ Autism Services & Case Management
Wrap Around Intensive Care Coordination
Home Based/ Infant Mental Health Services
Autism Services Provider Network
Integrated Care Arenac Center Heather Friebe
Case Management/ Supports Coordination
Outpatient Services-Arenac County
Children/Family Services
Health Care Accountability Melissa Prusi
Corporate Compliance/ Privacy Officer
Information Management Security Officer
Quality Assessment & Performance Improvement
Accreditation & Program Audit Coordination
Medical Records & EHR Administration
Data Analytics/ Reporting Services
Helpdesk Tech Support
Nursing Services Sarah Van Paris
Clinic & Community Nurses
Psychiatric Prescribers
Revised: 10/1/2025


BAY ARENAC BEHAVIORAL HEALTH
BAY ARENAC BEHAVIORAL HEALTH AUTHORITY BOARD OF DIRECTORS
Assistant to the CEO Sara McRae
Chief Executive Officer Christopher Pinter
Medical Director Roderick Smith, MD
Recipient Rights Customer Services Melissa Prusi
Investigations
Grievances & Appeals
Compliance Reviews
Human Resources Jennifer Lasceski
Staff Development & Training
Personnel Performance & Management
Credentialing
Compensation & Benefits Administration
Finance Marci Rozek
Budgeting
Accounts Receivable/ Reporting
Contract Management
Purchasing/ Payroll
Accounts Payable
COB/Claims & EHR Billing Administration
Facilities & Safety
Integrated Care Acute Services Joelin Hahn
Emergency/ Access Services & Crisis Response
ACT & Case Management Services
Outpatient & Clinic Practice Services – Bay County
Geriatric/Nursing Home Services
Acute Care Provider Network- Bay County
Integrated Care Long Term Services Vacant
Support Coordination/ HSW Services
Community Living Supports/ Residential Provider Network
Horizon Home
North Bay/ Community Living Supports
Vocational/ Employment Services
Self Determination/ Self Directed Care
Integrated Care Children & Families Vacant
Family Support/ Autism Services & Case Management
Wrap Around Intensive Care Coordination
Home Based/ Infant Mental Health Services
Psychological Services/ Behavioral Treatment Review
Autism Services Provider Network
Integrated Care Arenac Center Heather Friebe
Case Management/ Supports Coordination
Outpatient Services-Arenac County
Children/Family Services
Health Care Accountability Karen Amon
Corporate Compliance/ Privacy Officer
Information Management Security Officer
Quality Assessment & Performance Improvement
Accreditation & Program Audit Coordination
Medical Records & EHR Administration
Data Analytics/ Reporting Services
Helpdesk Tech Support
Nursing Services Sarah Van Paris
Clinic & Community Nurses
Psychiatric Prescribers
Revised: 12/12/2024

Organizational Relationships

External

MDHHS

- MDHHS National Core Indicators Work Group – Sarah Holsinger
- Parent Management Training Oregon Model MDHHS Steering Committee – Andrea Rayl
- MDHHS Children's Administration Meeting – , ~~,~~ Kelli ~~Maciag~~Wilkinson
- Michigan Motivational Interviewing Team – Karen Amon
- MDHHS Peer Liaison Meeting – ?
- MDHHS Recharging Supported Employment – ~~Nicole Sweet~~Stephani Rooker
- MDHHS Medical Clearance Work Group – Stacy Krasinski
- Fair Hearings Officers – ~~Kim Cereske~~ Kim Cereske, NEED BACK UP
- MDHHS ORR Directors Quarterly Group – ~~Melissa Prusi~~Jackie Kish
- Practice Improvement Steering Committee – ~~J. Hahn~~Karen Amon
- MDHHS Transition to Community – Melanie Corrion
- MDHHS Medical Directors Advisory Committee – Dr. Smith
- MDHHS Public Relations Committee – Lynn Blohm
- MDHHS Contract and Finance Issue Committee – Marci Rozek

State Association

- MDHHS/CMHA Capitation/Cost Allocation Work Group – Chris Pinter
- CMHA Legislative and Policy Committee-Chris Pinter, ~~Karen Amon~~Melissa Prusi
- Chief Information Officer (CIO) Forum – Jesse Bellinger, Greg Lietzow
- CMHA Customer Services Work Group – Jackie Kish ~~Melissa Prusi~~; Kim Cereske
- Walk-A-Mile Planning Committee – Lynn Blohm

Regional (Mid-State Health Network – MSHN)

- Councils/ Committees
  - MSHN Operations Council – Chris Pinter
  - MSHN Finance Council – Marci Rozek
  - MSHN Quality Improvement Council – ~~-~~Sarah Holsinger; ~~Karen Amon~~Melissa Prusi
  - MSHN Corporate Compliance – ~~Karen Amon;~~ Melissa Prusi
  - MSHN IT Council – Jesse Bellinger
  - MSHN Customer Service Committee – Jackie Kish, Kim Cereske
  - MSHN Utilization Management Committee – Joelin Hahn, Heather Friebe, Nicole Sweet, Karen Amon
  - MSHN Provider Network Committee – Marci Rozek, Stephanie Gunsell
  - MSHN Clinical Leadership – Joelin Hahn; ~~-~~Karen Amon, Heather Friebe, Nicole Sweet
  - MSHN Medical Directors – Dr. Smith
- Work Groups/Teams
  - MSHN Regional Autism Monitoring – Sarah Holsinger, Melissa Deuel
  - MSHN HSW Coordinators-Melanie Corrion; ~~Jackie Kish~~Craig Kanicki/Brad Parker
  - MSHN HCBS Coordinators –Melanie Corrion; ~~Jackie Kish~~Craig Kanicki/Brad Parker

- MSHN 1915(i) Lead Staff- Melanie Corrion; ~~Jackie Kish~~Craig Kanicki/Brad Parker
- MSHN Autism Work Group – Amanda Johnson; ~~-~~Emily ~~Young~~Gerhardt
- MSHN Data Analytics –Lisa Nagel; Sarah Holsinger
- MSHN Care Management Ad Hoc Committee – Amy Folsom
- MSHN Inpatient Reciprocity ~~– Melissa Prusi;~~ Sarah Holsinger
- MSHN Behavioral Treatment (data) Review Committee – Karen Amon ~~(temporarily),~~ Flavia Vasconcelos, Casey Binkley
- MSHN Recipient Rights – ~~Melissa Prusi~~Jackie Kish
- MSHN Training Coordinators Work Group – Jennifer Lasceski; Kayt~~i~~ee Brooks
- ~~MSHN East Recovery Oriented System of Care (ROSC) – Joelin Hahn~~

Regional/State CMHSP Professionals:

- Occupational Therapy Area Quarterly Group Meeting - Meredith Bickel
- Statewide Contract Network – Stephani Rooker.
- Michigan Nursing Forum Meetings – ~~,~~ Sara Van Paris, Amy Folsom, Nicole Konwinski

Community/County

General

- ~~Bay County Services Partners for Homelessness~~Mid-Michigan Local Planning Body – ~~Allison Gruehn~~Taylor Keyes
- Bay Human Services Collaborative Council - Joelin Hahn
- Arenac Multi-Purpose Collaborative Body – Heather Friebe
- ~~Human Trafficking Multi-Disciplinary Team (Arenac County) – Heather Friebe~~
- Vulnerable Adult Committee (Arenac) – Monica Baniel
- ~~Project Echo – No one assigned~~
- Enhanced Mental Health Provider Access = Jackie Kish~~:~~
- Great Lakes Bay – lookup – Jackie Kish

Child and Family

- Bay-Arenac Great Start Collaborative – Amanda Johnson (when resumes)Bay Community Collaborative Service Partners –Sue ~~Guertin~~Vian
- Arenac County Child Protection Council – Pam VanWormer, Kaitlyn Kokaly
- Preschool Partnership Advisory Council – Kelli Maciag
- Child Death Review Team (Bay County) – Kelli Maciag
- Child Death Review Team (Arenac County) – Heather Friebe
- ACE's & Trauma Informed Care Committee – Emily ~~Young~~Gerhardt, Brad Parker
- Youth and Family Connect (Systems of Care for Children) - ~~Stacy Krasinski,~~ Amanda Johnson, Ashley Aho~~, Shannon Leyton~~
- DHHS Partnership (Bay) ~~–~~ ~~Noreen Kulhanek;~~ Emily Gerhardt; Stacy Krasinski
- DHHS Trauma –Pam VanWormer
- ISD Mental Health Meeting – Pam VanWormer; Emily Gerhardt and Brad Parker.
- Great Lakes Bay PFLAG- Jill~~.~~ Schultz
-

Crisis Response and Prevention

- Bay Arenac Suicide Prevention Coalition – Stacy Krasinski, Jill Schultz, Heather Friebe
- Regional Suicide Prevention Coalition (Bay, Saginaw, Midland) – Stacy Krasinski

Educational/Vocational

- Seamless Transitions Committee (w ISD)~~–;~~ Melanie Corrion
- Bay Arenac ISD Youth and Vocational Committee: Nicole Sweet, Melanie Corrion

Law Enforcement and the Courts

- Community Corrections Board (511 Board- Bay County) – Joelin Hahn
- Stepping Up (Bay County) – Joelin Hahn; Stacy Krasinski; Amy Folsom
- Bay County Adult SUD Treatment Court – vacant
- Adolescent Treatment Court – Jane Bollinger; Kelli Maciag
- Family Treatment Court – Jill Schultz

Service to Senior Adults

- Adult Services Collaborative – Melanie Corrion; ~~Melissa Prusi~~Jackie Kish; Stacy Krasinski

Substance Use Disorders/Co-Occurring Disorders

- Arenac County Prevention Coalition (ACPC)) – Heather Friebe
- Bay County Prevention Network – Joelin Hahn
- Families Against Narcotics – Joelin Hahn
- Northern Michigan Opioid Response Consortium– Heather Friebe

Internal

Councils/Committees (and facilitator/chair)

- SLT and All Leadership – Chris Pinter; Rotation Schedule
- Arenac Consumer Council – Kim Cereske
- Bay Consumer Council – Kim Cereske
- Medical Staff Meeting – Dr. Roderick Smith; Sara Van Paris; Amy Folsom
- Healthcare Practices Committee – Dr. Roderick Smith; Sarah Van Paris; Amy Folsom
- Health Care Integration Steering Committee – Amy Folsom; Joelin Hahn ?
- Behavior Treatment Plan Review Committee –Karen Amon~~(temporarily)~~
- Safety Committee – Eric Strode
- Corporate Compliance Committee – ~~Karen Amon~~Melissa Prusi
- Ethics Committee – ~~Melissa Prusi~~Jackie Kish
- Autism Provider Meeting – Amanda Johnson
- Residential/CLS Provider Meeting – Melanie Corrion
- Vocational Provider Meeting – ~~Nicole Sweet~~Stephani Rooker
- Primary Network Operations and Quality Management Committee (PNOQMC) – Joelin Hahn; Sarah Holsinger
- Residential/CLS Crisis Response Team (Ad Hoc) –~~;~~ ~~Nicole Sweet~~Stephani Rooker; Melanie Corrion
- CLS Committee- ~~Nicole Sweet~~Karen Amon; Stephani Rooker
- Residential Referral Committee- Rachel Lemiesz; Melanie Corrion
- EHR Management Team – ~~Karen Amon~~Melissa Prusi
- ~~Data Governance Committee – Jesse Bellinger~~
- Internal Provider Management - Melissa Prusi

Attachment Three: Leadership Dashboard and Power BI Report Indicators by Committee of the Board of Directors

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
Corporate Compliance Committee	Status and Nature of Fraud and Abuse Investigations by Quarter – Direct Operated Programs	# of investigations: not-substantiated; substantiated regarding documentation issues, credentialing issues or potential fraud/abuse; or in-process (for direct operated programs)	Open and closed fraud/abuse investigations as of the last date of the quarter
Corporate Compliance Committee	Status & Nature of Fraud/Abuse Investigations by Quarter - Contracted Service Providers	# of investigations: not-substantiated; substantiated regarding documentation issues, credentialing issues or potential fraud/abuse; or in-process (for contracted service providers)	Open and closed fraud/abuse investigations as of the last date of the quarter
Corporate Compliance Committee	Status & Nature of Privacy/Security Investigations by Quarter - Direct Operated Programs	# of investigations: not-substantiated; substantiated with and without breach notice required; or in process (for direct operated programs)	Open and closed privacy/security investigations as of the last date of the quarter
Corporate Compliance Committee	Status & Nature of Privacy/Security Investigations by Quarter - Contracted Service Providers	# of investigations: not-substantiated; substantiated with and without breach notice required; or in process (for contracted service providers)	Open and closed privacy/security investigations as of the last date of the quarter
Corporate Compliance Committee	% Audited Services w/ Proper Doc for Encounters Billed (BABHA Direct, Contracted Secondary & Tertiary) Per Quarter	Total billable encounters without appropriate documentation	Total billable encounters
Corporate Compliance Committee	% Audited Services w/ Proper Doc for Encounters Billed (BABHA Direct) Per Quarter	Direct # of services billed without appropriate documentation	BABHA Direct # of encounters billed that were reviewed
Corporate Compliance Committee	% Audited Services w/ Proper Doc for Encounters Billed (Secondary - MPA, LPS, SPS) Per Quarter	Secondary (MPA, LPS, SPS) # of services billed without appropriate documentation	Secondary (MPA, LPS, SPS) # of encounters billed that were reviewed
Corporate Compliance Committee	% Audited Services w/ Proper Doc for Encounters Billed (Tertiary - Specialized Residential, Vocational, etc.) Per Quarter	Tertiary (Specialized Residential, Vocational) # of services billed without appropriate documentation	Tertiary (Specialized Residential, Vocational) #of encounters billed that were reviewed
Program Committee	% Of Consumers Diagnosed w/ Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Are Screened for Diabetes	# Of those that have had a diabetes screening (glucose or A1c(HbA1c)) in the measurement period	# Of Adult (18-64) Medicaid consumers with a diagnosis of Schizophrenia or Bipolar actively receiving services who are prescribed at least one atypical antipsychotic medication.
Program Committee	% Of Consumers Diagnosed w/ Schizophrenia and Diabetes Who Received Lab Work to Monitor Diabetes	# Of those that have had an HbA1c and LDL-C test in the measurement period	# Of Adult (18-64) Medicaid consumers with a diagnosis of Schizophrenia who have been diagnosed with diabetes
Program Committee	% of Consumers Diagnosed w/ Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Received a Cardiovascular Screening~~% of Consumers Diagnosed w/~~	# of those that have had one or more LDL-C screenings performed during the measurement year	# of Adults (25-64) consumers with a diagnosis of Schizophrenia or Bipolar Disorder who were prescribed an antipsychotic medication

Board Committee	Indicator (including unit of measure)	Numerator	Denominator
	~~Schizophrenia or Bipolar Disorder Taking an Antipsychotic Who Received a Cardiovascular Screening~~		
Program Committee	Count of Reportable and Non-Reportable Adverse Events Per Quarter.	# of sentinel events (as defined by CARF/MDHHS); # of critical events (injuries-harm to self or others, med errors, suicide, non-suicide death, arrests)	
Program Committee	Count of Reportable Risk Behavior Treatment Events Per Quarter	# of 911 Calls made by staff; # of Emergency Physical Interventions	
Program Committee	% Adults w/MI Served by BABHA Indicating "General Satisfaction" w/Services on Survey	# of MI Adults CSM/ACT/OPT whose average response was less than or equal to 2.5 for domain	# of MI Adults CSM/ACT/OPT who had valid responses to this domain
Program Committee	% Children w/ SED Served by BABHA Indicating "Appropriate/Quality" Services, i.e., General Satisfaction on Survey	# of MI Children CSM/HBS/OPT whose average response was greater than or equal to 3.5 the for domain. Excludes contract providers	# of MI Children CSM/HBS/OPT who had valid responses to this domain. Excludes contract providers
Corporate Compliance Committee	% of user phishing preparedness compared to industry standard	Number of users who report simulated phishing emails and number of users who click on simulated phishing emails compared to industry standard.	
Corporate Compliance Committee	# of security incidents per month	Number of security findings, false positives, and resolved issues	
Corporate Compliance Committee	Critical system outages per month	Number and duration of outages including network, communications, and critical software	
Program Committee	Penetration Rate for Medicaid, Healthy Michigan		
Program Committee	Service Penetration Rate Proxy Measures	Frequency count of persons served (i.e., unduplicated # of people with sent encounters) per month	MSHN Eligibles Paid file (includes Total of DAB, HMP and TANF for Arenac and Bay Counties)
Program Committee	State Facility Days Per Month	Frequency Count	
Program Committee	Community Inpatient Days Per Fund Source (Power BI Report)	# of community inpatient days per month for adults per fund source: General Fund; Medicaid State Plan; Healthy Michigan Plan; # of community inpatient days per month for children per fund source: General Fund; Medicaid State Plan; Healthy Michigan Plan	
Program Committee	People Served, By Population and Age (Power BI Report)	Frequency count per disability designation per quarter: # of Adults w SMI; # of Children w SED; # Adults w IDD/SMI; # of Children w IDD/SMI; # of Adults w IDD; # of Children w IDD; # Not Evaluated/Reported; # w SUD Diagnosis	

Board Committee	**Indicator (including unit of measure)**	**Numerator**	**Denominator**
Program Committee	% of Pre-Admission Screening Dispositions By Type for Adults/Children (Power BI report)	# of mental health diversions, substance use diversions, partial hospitalizations, intensive crisis stabilization service referrals, inpatient admissions, crisis residential placements, withdrew/declined to finish, and other	Total pre-admission screenings completed
Program Committee	Adults/Children Who Received Emergency Services (Power BI report)	# of adults and children who received a crisis intervention that was billable (i.e., 'sent'), per quarter; # of adults and children who received a crisis intervention that was non-billable (i.e., not 'sent'), per quarter; # of adults who received partial hospitalizations, in total and per provider, per quarter; # of adults and children who received crisis residential stays, in total and per provider, per quarter; # of children who received crisis stabilization/mobile crisis response services, in total and per provider, per quarter; # of adults and children who received psychotherapy for crisis, in total and per provider, per quarter	
Program Committee	Adults Who Received Core Services (Power BI Report)	# of Adults who received ACT per quarter # of Adults who received CSM/SC, in total and per provider, per quarter # of Adults who received Outpatient Therapy, in total and per provider, per quarter	
Program Committee	Adults Who Received CLS Day Activity Services (Power BI Report)	Total # of Adults who received CLS services through North Bay, per quarter	
Program Committee	Adults Attending Clubhouse (Power BI Report)	Total # of Adults who received Psychosocial Rehabilitation Services through Touchstone Services, per quarter	
Program Committee	Adults Who Received Services in Vocational Settings (Power BI Report)	# of Adults who received CLS 15 Minute (H2015; place of service code 99) through a vocational provider, in total and per provider, per quarter; # of Adults who received Skill Building services, in total and per provider, per qtr; # of Adults who received Supported Employment services, in total and per provider, per quarter # of Adults who received IPS (Individual Placement Services), in total and per provider, per quarter	
Program Committee	Adults and Children Who Received Community Living Supports (Power BI Report)	# of Adults who received CLS Per Diems (H2016) in a specialized residential setting, in total and per provider, per quarter; # of Adults who received CLS Per Diems (H0043; place of service code 12) in unlicensed independent living or their own home, in total and per provider, per qtr; # of Adults who received CLS 15 Minute (H2015; place of service code 12) in-home supports, in total and per provider, per quarter; # of Children who received CLS Per Diems (H2016) in a foster care home or a CCI, in total and per provider, per quarter; # of Children who received CLS Per Diems (H0043; place of service code 12) in their own home, per quarter; # of Children who received CLS 15 Minute (H2015; place of service code 12) in-home supports, per quarter	

Board Committee	**Indicator (including unit of measure)**	**Numerator**	**Denominator**
Program Committee	Children Who Received Core Services (Power BI Report)	# of Children who received Homebased services, per quarter; # of Children who received CSM/SC, in total and per provider, per quarter; # of Children who received Outpatient Therapy, in total and per provider, per qtr; # of Children who received Autism Services, in total and per provider, per quarter	
Recipient Rights Advisory Committee	Substantiated BABH Abuse & Neglect Complaints Per Quarter	# of Substantiated Complaints	# of complaints
Recipient Rights Advisory Committee	Recipient Rights Appeals	# of Investigations upheld	# of Appeals (those that meet the criteria to be appealed)
Recipient Rights Advisory Committee	Medicaid Grievance Decisions in Favor of CMHSP vs. Beneficiary Per Quarter	# of Decisions if Favor of CMHSP # of Decisions in Favor the Beneficiary	# of Medicaid Grievances filed
Recipient Rights Advisory Committee	Medicaid/GF Appeal Decisions in Favor of CMHSP vs Beneficiary Per Quarter	# of Decisions in Favor of CMHSP # of Decisions in Favor of Beneficiary # Resolved, not wholly in favor of Beneficiary or CMHSP	# Medicaid/GF Appeals
Recipient Rights Advisory Committee	Medicaid Fair Hearing Decisions in Favor of CMHSP vs Beneficiary Per Quarter	# of Decisions if Favor of CMHSP # of Decisions in Favor the Beneficiary	# of Medicaid Hearing Decisions
Personnel & Compensation Committee	New Positions Added Per Quarter		
Personnel & Compensation Committee	New Hires Per Quarter		
Personnel & Compensation Committee	Voluntary Terminations Per Quarter		
Personnel & Compensation Committee	Percent of employees attending training sessions on site (at SDC outside of NEO, RR Fair and Fall/Spring on-line training cycles)	# of employees who have attended trainings on site that are not part of the mandatory identified training for employees	# of employees employed on the last day of the reporting period
Personnel & Compensation Committee	Non BABHA Staff attending BABHA sponsored trainings	Non BABHA Staff attending BABHA sponsored trainings	
Facilities & Safety Committee	Employee Accidents/ Illnesses/Injuries Per 100 Employees; By Reporting Status; Per Quarter	# of reportable incidents (employee accidents/ employee; illness/ employee injuries) per MIOSHA standards; # of non-reportable incidents (employee accidents/ employee illness/employee injuries) that are not reportable to MIOSHA; # of employees at the end of the reporting period	
Facilities & Safety Committee	Facility Site Review Compliance	# of Sites Compliant (that do not need corrective action)	# of Sites Reviewed

Board Committee	**Indicator (including unit of measure)**	**Numerator**	**Denominator**
Finance	Revenue Versus Funds Expended by Fund Source Per Quarter in Thousands (fund sources include GF, Medicaid, Healthy MI, and MI Child, Children's Waiver) Reported for each quarter formulas must calculate accumulative	GF Revenue Medicaid Revenue Healthy Michigan Revenue	GF Expense Medicaid Expense Healthy Michigan Expense
Finance	Number of days of operations ratio (unrestricted fund balance/total daily expenditures) (Determine target days/threshold)	Unrestricted fund balance	Total daily expenditures