

BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY POLICIES AND PROCEDURES MANUAL

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|---|------------------------------------|------------------------|--|
| Chapter: 9 | Information Management | | |
| Section: 5 | Technology SafeGuards | | |
| Topic: 11 | Use of AI and Generative AI | | |
| Page: 1 of 2 | Supersedes Date: Pol: Proc: | Approval Date: Pol: | <hr style="border: none; border-top: 1px solid black;"/> <i>Board Chairperson Signature</i> <hr style="border: none; border-top: 1px solid black;"/> <i>Chief Executive Officer Signature</i> |
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DO NOT WRITE IN SHADED AREA ABOVE

Policy

Bay-Arenac Behavioral Health Authority (BABHA) recognizes that Artificial Intelligence (AI) tools hold great potential to enhance access, efficiency, and quality of behavioral health care. At the same time, AI raises serious ethical, legal, clinical, and privacy risks - especially when used in vulnerable populations. This policy establishes guiding principles and requirements to ensure that AI is used in ways that respect clients' rights, protect privacy and safety, maintain professional accountability, and ensure clinical appropriateness. Additionally, it is the policy of BABHA to have processes in place for directing and safeguarding the creation, use, movement, reuse, storage, data backup, and/or disposal of data created with the assistance of artificial intelligence (AI), generative AI, or generative AI technology. ****This policy outlines how artificial intelligence (AI) tools may be used within BABHA. It applies to all employees, contractors, and third-party vendors who use AI tools in the course of their work with or for the company/agency. The goal is to support responsible, secure, and ethical use of AI while minimizing risks.**

Purpose

To ensure the safe, ethical, equitable, and legally compliant use of Artificial Intelligence (AI) tools and systems in providing mental health services, support, and administration, in order to protect clients, staff, data, and community trust.

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:

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| SUBMISSION FORM | | | | |
|---------------------|---|-----------------------------|---|--|
| AUTHOR/ REVIEWER | APPROVING BODY/ COMMITTEE/ SUPERVISOR | APPROVAL/ REVIEW DATE | ACTION (Deletion, New, No Changes, Replacement or Revision) | REASON FOR ACTION If replacement, list policy to be replaced |
| M. Prusi | C. Pinter | | New | New policy that addresses the use of AI and Generative AI |
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**TO: BABHA Emergency and Access Services Department
BABHA Direct Operated Providers,
BABHA Contract Providers,
BABHA Customer Services Department**

FROM: BABHA General Fund Work Group

MEMO DATE: April 7, 2026

PLAN EFFECTIVE DATE: June 1, 2026

RE: FY26 priority admission criteria and waitlist criteria for general fund support services

This guidance is specific to the reimplementation of a specialty mental health services BABHA General Fund (GF) plan for FY26 that outlines the priority population to obtain GF supported services. This guidance supersedes all prior BABHA GF plans (2010, 2014, 2016).

Consumers who meet criteria for specialty mental health services, but who do not meet the GF referral criteria, will be placed on a GF waitlist, which will be maintained by the BABHA Emergency Services Department. Provisional diagnosis not identified in this document will require consultation with the EAS supervisor and/or program manager to obtain permission to place on the waitlist.

Individuals being discharged from hospital admission shall be approved for a GF Initial Assessment referral with a BABHA Assessment Specialist. If the initial assessment supports medical necessity for specialty mental health services, a referral may be made through the contracted provider network. Any exceptions for internal referral must be approved by the department program manager and the department director.

All referrals for an Initial Assessment should be made to a BABHA Assessment Specialist. If the initial assessment supports medical necessity of specialty mental health services, all admissions of eligible consumers for GF supported services must be made through the contracted provider network. Any request for BABHA direct provided services is considered an “exception” and must be approved by the department program manager and the department director.

Current GF Cases (prior to new GF Plan): GF cases open to services prior to the date of the FY26 GF plan shall remain open to services. During their next PCP/IPOS cycle, the IPOS will transition to the FY26 GF plan with the 6-month authorization. For individuals who do not meet the BABHA GF eligibility criteria, yet the individual is not appropriate for community-based support and services, the primary caseholder should submit a GF Request in Phoenix.

Minimum Eligibility Criteria for GF services include all eligibility criteria for specialty mental health services plus the BABHA GF admission criteria for general fund supported services.

Referral for Initial Assessment – Individuals who meet the minimum eligibility criteria during the EAS Access Screening will be referred to a BABHA Assessment Specialist for the intake and comprehensive assessment to determine medical necessity and eligibility for specialty mental health GF services.

Waitlist for Referral Assessment – As a result of the EAS Access Screening process, individuals who meet criteria for specialty mental health services, but who do not meet the minimum eligibility criteria for specialty mental health GF services will be placed on a GF Waitlist, which will be maintained by the BABHA Emergency Services Department.

Service Provision: GF services referrals are for those individuals who need a **minimum** of Targeted Case Management services. The CSM will address additional program/service referrals, such as psychiatric services or therapy, in the Individual Plan of Service (IPOS).

MI Adult: All admissions to GF supported specialty mental health services of eligible adult consumers experiencing a mental illness must be made to the contractual BABHA provider network. Any referrals for BABHA direct provided services must be approved by the BABHA department manager and director.

Children SED/IDD: All requests for services that meet general screening eligibility for specialty mental health supports and services should be referred to the Children’s program Assessment Specialist for the initial assessment. The Initial Assessment will determine if the individual is eligible for specialty services via a waiver program. All admissions of eligible children/youth for general fund supported services require the approval of the BABHA department manager and director.

IDD Adult: All requests for services that meet general screening eligibility should be referred to the BABHA Adult IDD program for the initial assessment . The Initial Assessment will determine if the individual is eligible for specialty services via a waiver program. All admissions to general fund supported specialty mental health services of eligible adults experiencing an intellectual and/or developmental disability require approval of the BABHA department manager and director.

Medicaid Application Requirement: Individuals admitted to GF supported services are expected to apply for Medicaid benefits within 45 days of the referral for treatment. It is an expectation that service providers will assist the individual with the Medicaid application process as needed. A copy of the Medicaid/Healthy Michigan eligibility shall be obtained by the service provider and placed in the consumer’s chart.

Spend-down: The GF Admission Criteria **is not in effect** for Medicaid Spend down consumer. However, a GF Request may be needed for services not covered by Medicaid. The BABHA GF Workgroup continues to work out details for cost containment strategies specific to the Medicaid Spend down population.

Authorization Duration: Authorizations will be for a duration of 6 months. It is anticipated that the individual may qualify for Medicaid or Healthy MI benefits during that timeframe.

If after 6 months the individual has not obtained alternate benefits, and the individual continues to meet criteria for specialty mental health services **AND** the BABHA GF criteria, the primary case holder should complete the Periodic Review **AND** a “GF Request” in Phoenix for an additional 6-month authorization.

If during the treatment episode the individual’s symptoms and impairments have stabilized (for at least 4-6 weeks) and they no longer meet BABHA GF criteria, the individual should be referred to community resources (i.e., Helen M. Nickless Free Clinic).

BABHA General Fund (GF) Benefit Authorization Plan FY26

| Service Authorization Grid Post Initial Assessment and PCP | GF Plan FY26 6-month auth Max | Requires Special Approval | Notes |
|--|---------------------------------|-------------------------------|--|
| Assessment | 1 | No | Required annually |
| Person Center Planning | 1 | No | Required annually |
| PCP Monitoring | 1 | No | Periodic review |
| Case Management – Contract provider | 24 | No | New referral meeting GF criteria for CSM services. All referrals, including inpatient discharge with LOCUS of 20 . 24 units = average of 1 hour per month |
| Case Management – BABHA Direct | 24 | Yes | High intensity case: New referrals post impatience on court order with LOCUS over 20 . 24 units = average of 1 hour per month. Additional units may be requested via the GF Request form. |
| Psychiatric Evaluation | 1 | IPOS authorization | Not needed if previous psychiatric evaluation was completed within the past 3 years. |
| Medication Reviews | 5 | IPOS authorization | Additional units may be requested as an “Over the Threshold” (additional clinical justification required for approval) |
| Medication Injection Administration | Based on frequency of injection | IPOS authorization | Some injectable meds are 2x per month, some 1x per month. Those with a higher frequency will require a GF Exceptions request. |
| OPT- Group Therapy | 12 | IPOS Referral | A typical group is 1x per week for 9-12 weeks. 1 additional group therapy round may be requested and approved at 12 sessions. Additional groups beyond the first 2 require a GF Request. |
| OPT- Individual Therapy | 0 | Referral from Group Therapist | GF Request may be submitted by the Group Therapist to refer to <u>individual</u> OPT services. |

| Bay-Arenac Behavioral Health Authority SERVICE APPLICANT ADMISSION CRITERIA FOR GENERAL FUND SUPPORTED SERVICES (By Diagnosis Code) | | | CRITERIA FOR ADMISSION | | WAITING LIST CRITERIA | |
|---|---|-------------------------------------|-------------------------------|--------------|------------------------------|--------------|
| <small>NOTE: Diagnosis is one eligibility criterion; diagnosis alone does not determine eligibility for general fund supported Specialty behavioral health services. NOTE: Individuals being discharged from a hospital admission will automatically be approved for GF services for at least the first 6-month treatment episode.</small> | | | | | | |
| ICD-10 Codes | Diagnostic Category | GENERAL FUND – SUPPORTED | LOCUS RANGE | DANGER SCORE | LOCUS RANGE | DANGER SCORE |
| | | YES | BOTH CRITERIA MUST BE MET | | BOTH CRITERIA MUST BE MET | |
| F20.1 | Schizophrenia, Disorganized Type | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F20.2 | Schizophrenia, Catatonic Type | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F20.2 | Schizophrenia, Paranoid Type | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F20.5 | Schizophrenia, Residual Type | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F20.3 | Schizophrenia, Undifferentiated Type | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F25.0 | Schizoaffective disorder; Bipolar Type | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F25.1 | Schizoaffective disorder; Depressive type | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F28 | Other specified schizophrenia spectrum and other psychotic disorder | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F29 | Unspecified schizophrenia spectrum and other psychotic disorder | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F30.13 | Manic episode, severe, without psychotic symptoms | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F30.2 | Manic episode, severe with psychotic symptoms | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F31.0 | Bipolar I disorder, Current or most recent episode hypomanic | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F31.10 | Bipolar disorder, current episode manic without psychotic features, unspecified | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F31.13 | Bipolar I disorder, Current or most recent episode manic; Severe | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F31.2 | Bipolar I disorder, Current or most recent episode manic; With psychotic features | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F31.4 | Bipolar I disorder, Current or most recent episode depressed; Severe | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F31.5 | Bipolar I disorder, Current or most recent episode depressed; With psychotic features | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |
| F31.63 | Bipolar I dis, most rec epis mixed, severe wo/psyc | <input checked="" type="checkbox"/> | >=20 | >=4 | 17-22 | <=3 |

Bay-Arenac Behavioral Health Authority
SERVICE APPLICANT ADMISSION CRITERIA FOR GENERAL FUND SUPPORTED SERVICES
(By Diagnosis Code)

NOTE: Diagnosis is one eligibility criterion; diagnosis alone does not determine eligibility for general fund supported Specialty behavioral health services.
NOTE: Individuals being discharged from a hospital admission will automatically be approved for GF services for at least the first 6-month treatment episode.

| | | | CRITERIA FOR ADMISSION | | WAITING LIST CRITERIA | |
|--------------|---|--------------------------|---------------------------|--------------|---------------------------|--------------|
| | | | LOCUS RANGE | DANGER SCORE | LOCUS RANGE | DANGER SCORE |
| ICD-10 Codes | Diagnostic Category | GENERAL FUND – SUPPORTED | BOTH CRITERIA MUST BE MET | | BOTH CRITERIA MUST BE MET | |
| | | YES | | | | |
| F31.64 | Bipolar I dis, most rec epis mixed, severe w/psych | ☑ | >=20 | >=4 | 17-22 | <=3 |
| F31.81 | Bipolar II disorder (DSM-5) | ☑ | >=20 | >=4 | 17-22 | <=3 |
| F32.2 | Major depressive disorder, Single episode; Severe | ☑ | >=20 | >=4 | 17-22 | <=3 |
| F32.3 | Major Depressive Disorder, Single Episode, Severe With Psychotic Features | ☑ | >=20 | >=4 | 17-22 | <=3 |
| F33.2 | Major depressive disorder, Recurrent episode; Severe | ☑ | >=20 | >=4 | 17-22 | <=3 |
| F33.3 | Major depressive disorder, Recurrent episode; With psychotic features | ☑ | >=20 | >=4 | 17-22 | <=3 |
| F22 | Delusional Disorder | ☑ | 23+ | >=4 | 17-22 | <=3 |
| F40.00 | Agoraphobia | ☑ | 23+ | >=4 | 17-22 | <=3 |
| F40.01 | Agoraphobia with panic disorder | ☑ | 23+ | >=4 | 17-22 | <=3 |
| F41.0 | Panic Disorder | ☑ | 23+ | >=4 | 19-22+ | >=3 |
| F42.2 | Obsessive-Compulsive Disorder | ☑ | 23+ | >=4 | 19-22+ | >=3 |
| F43.10 | Posttraumatic Stress Disorder | ☑ | >=20 | >=4 | 17-22 | <=3 |
| F44.81 | Dissociative identity disorder | ☑ | >=20 | >=4 | 17-22 | <=3 |
| F44.9 | Unspecified dissociative disorder | ☑ | 23+ | >=4 | 19-22 | <=3 |
| F45.2 | Body Dysmorphic Disorder | ☑ | 23+ | >=4 | 17-22 | <=3 |
| F50.00 | Anorexia Nervosa | ☑ | 23+ | >=4 | 17-22 | <=3 |
| F50.20 | Bulimia Nervosa | ☑ | 23+ | >=4 | 17-22 | <=3 |
| F60.2 | Antisocial personality disorder | ☑ | 23+ | >=4 | 19-22+ | >=3 |
| F60.3 | Borderline Personality Disorder | ☑ | >=20 | >=4 | 17-22 | <=3 |
| F63.9 | Impulse disorder, unspecified | ☑ | 23+ | >=4 | 19-22+ | >=3 |

| Bay-Arenac Behavioral Health Authority SERVICE APPLICANT ADMISSION CRITERIA FOR GENERAL FUND SUPPORTED SERVICES (By Diagnosis Code) | | | CRITERIA FOR ADMISSION | | WAITING LIST CRITERIA | |
|---|---|-------------------------------------|--|--------------|------------------------------|--------------|
| <small>NOTE: Diagnosis is one eligibility criterion; diagnosis alone does not determine eligibility for general fund supported Specialty behavioral health services. NOTE: Individuals being discharged from a hospital admission will automatically be approved for GF services for at least the first 6-month treatment episode.</small> | | | | | | |
| ICD-10 Codes | Diagnostic Category | GENERAL FUND – SUPPORTED | LOCUS RANGE | DANGER SCORE | LOCUS RANGE | DANGER SCORE |
| | | YES | BOTH CRITERIA MUST BE MET | | BOTH CRITERIA MUST BE MET | |
| F70 | Intellectual disability (intellectual developmental disorder); Mild | <input checked="" type="checkbox"/> | Refer to Assessment Specialist for eligibility determination | | | |
| F71 | Intellectual disability (intellectual developmental disorder); Moderate | <input checked="" type="checkbox"/> | Refer to Assessment Specialist for eligibility determination | | | |
| F72 | Intellectual disability (intellectual developmental disorder); Severe | <input checked="" type="checkbox"/> | Refer to Assessment Specialist for eligibility determination | | | |
| F73 | Intellectual disability (intellectual developmental disorder); Profound | <input checked="" type="checkbox"/> | Refer to Assessment Specialist for eligibility determination | | | |
| F79 | Unspecified intellectual disability (intellectual developmental disorder) | <input checked="" type="checkbox"/> | Refer to Assessment Specialist for eligibility determination | | | |
| F84.8 | Other pervasive developmental disorders | <input checked="" type="checkbox"/> | Refer to Assessment Specialist for eligibility determination | | | |
| F84.9 | Pervasive developmental disorder, unspecified | <input checked="" type="checkbox"/> | Refer to Assessment Specialist for eligibility determination | | | |
| F88 | Other specified neurodevelopmental disorder | <input checked="" type="checkbox"/> | Refer to Assessment Specialist for eligibility determination | | | |

Bolter: MDHHS mental health plan adds bureaucracy, not care

Alan Bolter

Updated March 31, 2026, 9:26 p.m. ET

When your car is working, you don't generally take it to your mechanic and demand they replace the engine, or the transmission.

Yet Michigan's Department of Health and Human Services (MDHHS) is proposing to do just that by pushing to enact new unnecessary layers of bureaucracy for many Michigan mental health patients.

Unfortunately, this is now the second instance of the MDHHS advancing a costly proposal without regard for true need, financial cost or human impact. Just last year, we fought a legal battle against the MDHHS proposal to bid out the management of the state's public mental health system. Rather than simplifying the system, the deeply flawed and legally dubious proposal added complexity and failed to address real concerns raised by Michiganians.

The MDHHS spent more than \$3 million aggressively pursuing that process, only to pull it from consideration after a judge ruled it unlawful.

Now, the MDHHS continues to pursue a similarly ill-informed idea known as the "Mental Health Framework." As designed, this effort will likely introduce additional layers of bureaucracy and new hurdles for individuals seeking mental health services.

The agency is proposing to pass individuals with mild to moderate mental health needs off to private health insurance companies. This is a dangerous departure from the current structure that allows local

specialized Community Mental Health (CMH) agencies to provide expert support.



By definition, the framework’s focus on individuals with “mild to moderate” mental health conditions raise additional questions about the types of services being discussed. Services such as psychiatric inpatient care, crisis residential treatment, or intensive targeted case management are designed for individuals experiencing severe symptoms or acute crises.

It is difficult to understand how these services would suddenly appropriately apply to individuals whose needs are categorized as mild or moderate. This change would create confusion and blur important distinctions in levels of care. Public policy should reinforce clear clinical pathways, ensuring that the most intensive services remain focused on individuals with the most serious needs. This proposal does the opposite

The proposal also introduces new assessments, administrative processes and shifting lines of responsibility between CMH agencies and private Medicaid health plans. For someone already struggling to navigate the mental health system, additional steps can easily become barriers to care rather than improvements.

Hospitals and providers across the state have already warned that the framework's training, billing and operational requirements could slow access to treatment. The impact would be a new strain on an already overextended behavioral health workforce.

Importantly, the framework also appears to disrupt a system that already has clearly defined responsibilities under Michigan law. The Michigan Mental Health Code outlines that CMH agencies are responsible for coordinating services, including psychiatric inpatient admissions. The proposal to shift management of certain psychiatric inpatient benefits for individuals with mild to moderate conditions to private Medicaid health plans could break the supportive relationship that currently exists between hospitals, community providers and CMH agencies.

Today, when someone is admitted for psychiatric care, the public mental health system works to coordinate discharge planning and connect that person to housing, medication management and ongoing treatment in the community. Sound clinical decisions about psychiatric hospitalization depend on a working knowledge of available community-based alternatives, and Michigan's CMH system is the only entity that currently has both the responsibility and the infrastructure to manage that coordination effectively.

Equally troubling is the lack of clarity around why this sweeping change is being proposed in the first place. There has been no clear explanation as to how the MDHHS framework proposal will improve care. Period.

Care providers, CMH agencies, hospitals and advocacy organizations have all raised concerns noting this proposal appears to address a relatively small number of disputes. In an attempt to reduce a few small issues between health plans, the MDHHS's answer is to impose a large administrative burden on the entire mental health system — truly a “solution” in search of a problem.

From our vantage point, we see both opportunities and risks for change in the mental health space. We are open to sharing our perspective to help make the process more seamless for patients and practitioners, whose experience remains central to our work. At the same time, any proposed changes must prioritize affordability and ensure that resources are directed as much as possible toward direct services. We should move away from administrative changes that add cost without meaningfully improving patient experience or outcomes.

We are urging the MDHHS to forgo yet another pointless proposal and join with us in looking for collaborative opportunities to drive meaningful change for Michigan residents.

Alan Bolter is CEO of the Community Mental Health Association of Michigan.