



**Northern Lakes  
Community Mental  
Health Authority**

**Board of Directors Packet**

**April 16, 2026**



The Northern Lakes Community Mental Health Authority Board will meet on April 16, 2026, at 105 Hall St. Traverse City, MI 49684 & Virtually at: <https://www.northernlakescmh.org/about-us/board-of-directors/> or via phone: [+1 810-258-9588](tel:+18102589588), 877 408 48#

#### AGENDA - April 16<sup>th</sup>, 2026

- | <b>Time</b> | <b>Item #</b> |   |
|-------------|---------------|---|
| 1:00 p.m.   | 1             | Opening: <ul style="list-style-type: none"><li>• Confirm Quorum and Pledge of Allegiance</li><li>• Approval of Agenda</li><li>• Conflict of Interest</li><li>• Consent Agenda (Minutes)*</li><li>• Appointment of Timekeeper</li></ul>  |
| 1:05 p.m.   | 2             | Public Comment  |
| 1:10 p.m.   | 3             | Celebrate Northern Lakes – CHAT Team, Jeremiah Williams   |
| 1:15 p.m.   | 4             | Report of Officers: <ul style="list-style-type: none"><li>• Recipient Rights Director Report<ul style="list-style-type: none"><li>○ Lisa Jones, Interim Director of the Office of Recipient Rights</li></ul></li><li>• Chief Executive Officer Report<ul style="list-style-type: none"><li>○ Lynda Zeller, Chief Executive Officer</li></ul></li><li>• Chief Financial Officer Report<ul style="list-style-type: none"><li>○ Melissa Bentgen, Chief Financial Officer</li></ul></li></ul>   |
|             | 5             | Service Area Presentation: Behavioral Health and Justice  |
| 2:00 p.m.   | 6             | Committee Reports: <ul style="list-style-type: none"><li>• NMRE Update<ul style="list-style-type: none"><li>○ Ruth Pilon</li></ul></li><li>• Executive<ul style="list-style-type: none"><li>○ Greg McMorrow</li></ul></li><li>• Finance<ul style="list-style-type: none"><li>○ Al Cambridge</li></ul></li><li>• Policy<ul style="list-style-type: none"><li>○ Dave Freedman</li></ul></li><li>• Personnel<ul style="list-style-type: none"><li>○ Ruth Pilon</li></ul></li><li>• Community Engagement<ul style="list-style-type: none"><li>○ Christal Frost Anderson</li></ul></li><li>• Nominating Committee<ul style="list-style-type: none"><li>○ Al Cambridge, Mary Marois, Dean Smallegan</li></ul></li></ul> |
| 2:45 p.m.   | 7             | Unfinished Business <ul style="list-style-type: none"><li>- Board Retreat</li><li>- Policy - Administrative Federal Grants</li></ul>  |
| 2:50 p.m.   | 8             | Public Comment  |
| 2:55 p.m.   | 9             | Announcements/Board Comments/Presentations <ul style="list-style-type: none"><li>- Congratulations to Mark Crane on Retiring.</li></ul>   |
| 3:00 p.m.   | 10            | Adjourn   |

Next Meeting: May 21, 2026 – Houghton Lake

NOTICE: If any person with a disability needs accommodation, please call 231-933-4936 three days prior to the posted meeting date.



Administrative Office, 105 Hall Street, Suite A, Traverse City, MI 49684

## Board of Directors Meeting Minutes

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March 19<sup>th</sup>, 2026

NLCMHA Traverse City Office

1:00 p.m.

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**Board Members Present:** Christal Frost Anderson, Kim Morely, Ruth Pilon, Mark Nyman, Dean Smallegan, Ben Townsend, Penny Morris, Shawn Kraycs, Ty Wessell, Dave Freedman, Tony Lentych, Mary Marois, Al Cambridge, Greg McMorrow.

Quorum was confirmed.

**Others Present:** Hilary Rappuhn, Alexandra Coon, Kim Silbor, Jeremiah Williams, Lisa Jones, Lori Stendel, Mark Crane, Melissa Bentgen, Lynda Zeller, Neil Rojas, Becky Brown, Caleb Gomez, Dr. Cummins, Bobbi Hudson, Cindy Peterson, Dawn Galbraith-Kantz, Hannah Driver, Amanda Ritchie, Stephanie Mackin

**Virtual Attendees:** Aimee Horton Johnson, Alexandra Coon, Angie Schroeder, Ann Ketchum, April Weinrick, Candace Kauska-Dietrich, Cindy Evans, Daniel Mauk, Deb Freed, Elizabeth Totten Erica Longstreet, Erica Smith, Erin Brotherton, Joseph Barkman, Kaitlin Merritt, Kaitlyn Reinink, Kari Barker, Kayla Sklener, Kellee Hoag, Kirstie Maier, Lisa Woodcox, Lynn Pope, Mats Andtbacka, Melissa Trout, Michael Corby, Rob Palmer, Somer Quinlan, Teri Dougherty, Terri Henderson, Tiffany Fewins, Victoria McDonald, Vince Cornellier.

**Call to Order:** 1:00 p.m. by Board President, Greg McMorrow

**Conflict of Interest:** None

**Timekeeper:** Ruth Pilon

**Approval of Agenda:** Yes, no changes requested.

**MOTION: Approval of Agenda**

**RESULT: ADOPTED [UNANIMOUS]**

**MOVER: T. Lentych**

**SECONDER: D. Smallegan**

**MOTION: Approval of Agenda (Minutes)**

**RESULT: ADOPTED [UNANIMOUS]**

**MOVER: M. Marois**

**SECONDER: D. Freedman**

**Public Comment:** None.

**Celebrate Northern Lakes:** The Board of Directors and the Leadership Team recognized Facilities Supervisor, Doug Nielsen, for his excellent work across 17 facilities within 6 counties.

**Report of Officers:**

**Recipient Rights Report:** Lisa Lashley, Interim Director of the Office of Recipient Rights, presented her report to the Board. The report can be found in the Board packet along with the Annual Report. Compliance remains at 100%.

**Chief Executive Officer's Report:**

Lynda Zeller, Chief Executive Officer of Northern Lakes, presented highlights from her report to the Board. The full report can be found in the Board packet. The final draft of the Annual Report will be presented for board action today. Distribution will be primarily electronic to minimize cost of printing, however if hard copies are desired please contact the CEOs office and we can provide them.

Lynda provided highlights from the demographic and cost reports and the efficiencies reports. Most cost and demographic count reports are trending similarly to prior months. The charts suggest low efficiency remains a concern in several areas: ACT, Crisis Services, and I/DD Adult. Board members suggested Lynda reach out to other CMHs and NMRE to compare the methods of efficiency tracking used by others.

Lynda distributed letters of gratitude from the Board sent to Chip Johnston, CEO and Donna Nieman, CFO of Centra Wellness; as well as Megan Rooney, CEO of Northcare Network PIHP. Both have been providing countless hours of support to leadership and staff. The support has been invaluable in strengthening fiscal and operational systems at NLCMHA.

**Chief Financial Officer's Report:** Melissa Bentgen, Chief Financial Officer, provided financial reports for the month of January. These are the same abbreviated reports as have been presented the past several months, and will continue until we have accounts reconciled and ability to run a Trial Balance. The work continues to reconcile accounts with the volunteer support of Donna Nieman at Centra Wellness and from TBD solutions by contract. At the next board meeting Melissa will provide a report on Year To Date expenses on contracts against budget.

The State and NMRE have extended the deadline for our FSR and EQI reports till May 1. Melissa provides weekly updates on progress toward meeting that goal. NMRE continues to provide us with

early capitation payment around the third week of every month, however the amount we are short each month has been slowly but steadily improving.

### **Committee Reports:**

#### **NMRE:**

Ms. Pilon shared NMRE and Region 1 are still working closely with information showing that MDHHS still would like to have only 3 Regions instead of 10. Mr. Freedman shared that Ms. Zeller gave a report on our expenditures and it was well received by the other Mental Health Centers.

#### **Executive:**

Greg McMorrow, Chair of the Board provided the Executive Committee report. Topics from the Executive Committee meeting included the review of the Annual Report and the Bylaws draft in anticipation of approval at this meeting. The committee also discussed the need for new member orientation soon. It was noted that other board members are willing to help with this orientation if desired.

**Finance:** Mr. Cambridge shared that the April finance committee meeting will be on a different day than the April Board meeting due to the recipient rights training for Board members happening on April 9 (board meeting day). Mr. Cambridge presented the "Administration of Federal Awards" policy for board for board review and approval decision next month. Mr. Cambridge shared there were new SRS contracts added but contracts staff reported to the committee that we are still with-in budget.

**Policy:** Mr. Freedman Shared that they have not met. They stand ready to meet once the overall structure of new policy system is ready for review.

**Personnel:** Ms. Pilon shared that the turnover rate is higher at 31% which came right after the layoffs. Applauding staff for still filling out a survey so we can see the progress we are making. The Climate survey spoke volumes to the integrity of the organization as the survey reflected that staff really enjoy working at NLCMHA. The Average headcount of employees is 314. The new Contract with Paychex saved us \$25,000.00/ year for the next 3 years.

**Community Engagement:** Ms. Frost Anderson shared Club Cadillac and Traverse House hold impressive amounts of community engagement. The Clubs complete a strategic planning on how to involve the community more within their programs.

**Nominations Process:** The following Board members will make up the committee: Mr. Cambridge, Ms. Marois, Mr. Smallegan. The unanimous decision of: Greg as Chair, Penny as Secretary, Lynn as Treasury.

### **Unfinished Business:**

- **New Member Orientation:** None.
- **Annual Report Approval :**

**MOTION: Formalize the Annual Report by a Board Vote.**

**RESULT: Motion Carries**

**MOVER: Kim Morley**

**SECONDER: Christal Frost Anderson**

- **Bylaws Approval:** Annual review of the Bylaws and Lynda had recommendations and took it to leadership and Heider for review of the changes. The updates can be reviewed on Page 6.

**MOTION: Approve the updated Bylaws that include legal review**

**RESULT: Roll Call- Motion Carries**

**MOVER: Kim Morley**

**SECONDER: Tony Lentych**

**Public Comment:** None.

**Announcements/ Board Member Reports/ Board Association:** Ms. Frost Anderson is offering a reentry simulation of someone going from prison to community through Networks Northwest. Get in touch with her if you are interested in checking it out April 15<sup>th</sup> 10:00 AM.

**Next Meeting:** April 16th, 2026 – Traverse City

**Adjournment:** 3:00 p.m.

Respectfully submitted,

Hilary Rappuhn, Executive Administrator

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Greg McMorrow, Board Chairperson

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Lynn Pope, Secretary

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### **Unfinished Business:**

- **New Member Orientation:** None.
- **Annual Report Approval :**

## Office of Recipient Rights Director's Report April 2026

Dates represented	10/01/23-04/07/24	10/1/24-04/07/25	10/1/25-04/07/26	Board Operated Homes
Complaints	292	253	170	25
OJ, No Right Inv.	52	49	29	1
Interventions	23	27	21	5
Investigations	218	177	121	19
Investigations Comp	218	177	75	12
Investigations open	0	0	46	7
Inv > 90 days	1	0	1	0
Inv < 90 days	217/218 (99.5%)	177/177(100%)	74/75 (98.7%)	12/12 (100%)
Summary Report Avg	221/221 (100%)	178/178(100%)	65/67 (97%)	10/11 (90.9%)
NLCMHA staff alleg.	80	73	20	13
NLCMHA Staff W/I 1 yr	9	13	4	3

### Complaint Source

Complaint Source	Count
Anonymous	6
Community/General Public	4
Guardian/Family	9
ORR	45
Recipient	32
Staff	74
<b>Total</b>	<b>170</b>

### 5 Year Trends

	Abuse I & II	Abuse III	Neglect I & II	Neglect III	Services Suited to Condition	Total
FY2022	44	46	25	152	151	418
FY2023	39	17	21	144	126	347
FY2024	29	26	4	98	169	326
FY2025	33	12	11	93	146	295
FY2026	11	7	5	15	27	65

### Complaints Per Provider: October 1, 2025- April 7, 2026

Program	Substantiated	Pending	Not Substantiated	NA
Assertive Community Treatment	1	0	0	0
Beacon Home at Trolley Center	2	0	0	0
Beacon Home at Woodland	1	5	4	0
Beacon Mission Point	4	2	1	0
Beacon Silverview	3	2	0	0
Danes AFC	1	0	0	0
Elmwood AFC	11	4	2	0
Evergreen Home	0	2	0	0
Fort Road Residence, LLC	0	3	0	0
Frances Specialized Residential	0	1	0	0
Friendship Family Home	2	0	2	0
Grand Traverse Industries, Inc.	3	0	0	0
Grand Traverse Mental Health Crisis and Access	1	1	3	0
Great lakes Center for Autism	2	0	0	0

Heart and Soul Living LLC	3	3	0	0
Hickory Hill AFC LLC	0	0	3	0
Hillcrest AFC	0	1	0	0
HL Office/Roscommon County	0	0	1	0
Hope Network Neo Birdsong	1	0	0	0
Hope Network Neo Breton	0	0	1	0
Hope Network Neo Bristol	6	0	0	0
Hope Network Neo Grandville	1	0	0	0
Hope Network Rivervalley 1	1	0	0	0
Hope Network West Michigan - Cadillac Center	1	0	0	0
IDD Adult Case Management	1	2	2	0
IDD Children's Case Management	0	0	1	0
Jones Lake AFC Home	1	0	1	0
Kennedy House West, LLC	1	0	0	0
Mama T's AFC	0	0	2	0
MI Independent Living, LLC	1	5	2	0
MIA Case Management	0	1	0	0
North Arrow ABA - Cadillac	0	1	0	0
North Arrow ABA - Grayling	1	1	1	0
North Arrow ABA - Traverse City	1	0	0	0
Northern Lakes CMH Authority	1	5	9	0
Ohana AFC	1	0	0	0
Outpatient Services	1	1	0	0
Packard Specialized Residential	0	0	1	0
Pearl Street Home	5	1	0	0
Psychiatric Services	1	3	1	0
Real Life Living Services	1	0	0	0
Seneca Place Home	5	3	2	0
Serenity AFC	0	1	2	0
Spectrum Community Services	1	0	0	0
Spectrum Community Services SIP - Bremmer	1	0	0	0
Spectrum Community Services SIP - Kentucky	2	1	0	0
Summerfield AFC	1	1	0	0
Sunrise AFC Home LLC	1	0	1	0
TC Office/Grand Traverse County	2	0	2	0
TLK AFC Home, Inc.	0	1	0	0
Westwood Specialized Residential	0	1	0	0
Wright Street AFC Home	2	4	0	0

Respectfully Submitted by,

*Lisa Kay Lashley*

Interim Director of Recipient Rights  
 Lisa Kay Lashley  
 4/7/2026

## Chief Executive Officer's

### Report to the Board

April 8, 2026

#### GOVERNANCE AND ACCOUNTABILITY:

##### NLCMHA Board:

- **Public Comment Follow up:**

- Last month public comment was received from Cindy Evans of Grand Traverse Industries (GTI), raising awareness of the challenge of meeting the minimum wage requirement without receiving additional state funding. I had a follow up discussion with Cindy. She provided helpful perspective and information, though there has not been financial relief provided from the State.
- Hannah Driver (Traverse House) also provided comment highlighted upcoming events at the Clubhouse including 30<sup>th</sup> Anniversary celebration May 28. Other than "saving the date" for board members and leadership, no other follow up is required.

- **CMHAM Rural Workgroup-Resolution Draft for Consideration:** The CMHs in northern lower Michigan and the Upper Peninsula have been working together to raise awareness of rural issues and promote system improvements. Included in your packet is a letter addressed to the board explaining the work of the Rural Caucus and requesting consideration of formal support of the work of this caucus. I will further explain at the board meeting.

##### County:

- **Communication with Counties:** As required in Section XVI of the Enabling Agreement, several documents were provided to County Administrators this past month. All have been reviewed in prior board meetings: FY 2025 Annual Report, Quarterly Key Performance Indicator Reports through January, MDHHS Performance Indicator report.
- **Upcoming County Commission Meetings:** I am tentatively on agendas to provide NLCMHA updates at the Commission meetings noted below. The only remaining Commission that I have not presented to is Roscommon (those meetings are 2<sup>nd</sup> and 4<sup>th</sup> Wednesday at 9 am):
  - Wednesday April 15, 4:00 PM, Wexford
  - Tuesday April 21, 6:30 PM, Leelanau
  - Thursday April 23, 10 AM, Crawford
  - Wednesday May 13, 9:00 AM, Grand Traverse

##### STATE:

- **Weekly Reporting-Updates on FSR and EQI:** The CFO and CEO continue to provide weekly updates to MDHHS and NMRE on our account clean-up activities, working toward clean Financial Status Report (FSR) and Encounter Quality Data Initiative (EQI) submissions for FY 2025. This continues to be a huge lift for our CFO, supported by Donna Nieman of Centra Wellness and Megan Rooney of Northcare PIHP. The original due date was February 28 for

these reports, but MDHHS with the support of NMRE extended this to May 1<sup>st</sup>. All areas are completed except areas related to self-insurance and lease liabilities, so we are optimistic we will meet this deadline.

- **State Budget and CMH Association:** I included a very helpful summary of the Executive (Governor) Proposed State Budget prepared by the CMH Association of Michigan (Alan Bolter). It highlights areas of importance to CMHs statewide. Also included is a second document that summarizes key issues for FY 2027 in the appropriations process as it moves forward toward a final budget. The budget and appropriations process were one of several important topics discussed at a recent CMH Directors Forum in Lansing which I attended. I will also be attending a strategic planning discussion with all other CMH directors in May.

#### NMRE:

- **“Look Back 2020, 2021, 2022”.** Once the FSR and EQI are run and reported to NMRE and the State (target date May 1), we can also then run the same reports for the “look back” years. These new reports for those years will inform further discussions with NMRE toward final resolution. We are on target to meet the extended deadline of May 1, 2026, for the FSR and EQI, and will proceed promptly with any remaining analysis needed to complete look back (internally and by auditors).
- **Compliance Areas of Concentration:** Our quality and compliance areas conduct regular chart reviews to monitor quality and compliance with Medicaid and other regulations. Some systemic issues have been identified with untimely authorizations, challenges with sufficient documentation for out of catchment placements in particular and other compliance issues. We alerted NMRE to some of the issues as required. This is a high priority as any encounters that are retracted from Medicaid reimbursement will be expensed to our limited general fund.

#### SERVICES AND WORKFORCE:

- **Loan Repayment MDHHS:** One program that helps attract and retain clinical staff is a loan repayment program. Since October, we have had twenty-six individuals apply for the federal Public Service Loan Forgiveness, processed through the State (MDHHS). The seven newest applicants (since January) include two Child and Family Homebased Therapists; Four additional Clinical Therapists; and one Crisis/Access Specialist. Everyone accepted into the program can receive up to \$60k over the next 2 years. In addition to applicants noted above, we currently have four already approved and in the loan repayment process: an Outpatient Therapist; Clinical Supervisor; Jail Diversion Therapist; and Crisis/Access FAST Therapist.
- **Network Management Changes:** Mark Crane (Provider Network and Facilities) has announced his retirement effective April 30. We congratulate him on his retirement and wish him well. We are receiving valuable support from Chip Johnston and Chris VanWagoner of NMRE in this area already, as significant processes evaluations and improvements have already been initiated. Both have graciously agreed to continue to support our system improvement efforts during the time this critical position is vacant.
- **Accommodation Barriers:** As I mentioned at last board meeting, we have internal processes to encourage reporting of Accommodation Barriers. These are defined as: challenges or obstacles the agency faces when trying to provide support for consumers, employees, or board members

with disabilities or special needs. There is a slide deck in the packet with further information about the areas where barriers may exist, and about which we encourage regular reporting so we can work to remove or mitigate barriers.

#### COMMUNITY AND PARTNERSHIPS:

- **Recovery Celebration-Manton-Barn Hall: October 14** from 10-2 NLCMH is having a recovery celebration. About 80-100 staff and consumers typically attend. The staff organizing the event would be honored to have a board member attend and provide remarks such as words of encouragement and/or personal experiences with the power of recovery. Please let me know if you are interested and willing to provide remarks (at approximately 10:15 to 10:30).
- **Grand Traverse-Justice Facility Advisory Council (JFAC):** I have attended two sessions of the JFAC. This is one of several groups providing feedback and information for Grand Traverse County Commissioners and Sheriff as they consider the design of a new justice facility (inclusive of the jail, law enforcement and more). Dr. Curt Cummins and Christal Frost Anderson are also members of the JFAC. There is a strong focus on health, behavioral health, and justice/reentry programs in the discussions thus far.

#### STEWARDSHIP AND FINANCES:

- **Financial Reports:** Once we have reliable FSR and EQIs run we will be able to return to a much richer set of documents for Finance Committee and board reporting. Given the extended deadline for FSR and EQI is May 1<sup>st</sup>, the new fuller packet of Financials should be available at the May board meeting.
- **Community Placement/ SRS:** We are over budget in our community placements (residential including SRS homes). Without aggressive action we would be \$2 million overspent by the end of this fiscal year. This is particularly problematic as we used actual spending in FY 2025 as our baseline for FY 2026 budget. Recently, we met with a provider with proven expertise in developing creative, successful supported independent placements. We are going to be piloting the same staffing and payment model used today by Centra Wellness to bring three people closer to home using this new model. This model has shown significant positive impact clinically while reducing costs for other CMHs, and we will expand this effort if successful.
- **General Fund (GF):** We are digging more deeply into details about the services that are expensed to general fund (\$2.9 million). We must ensure sufficient funds for the full year to provide Crisis and Inpatient to everyone without insurance, after which we serve based on need (as identified in statute) and only as resources allow. We have not been able to serve uninsured people on our waiting list for several months due to limited GF. Our reimbursement, clinical and IT teams are building new tools to use in reviewing the uses of GF for services other than crisis and inpatient. This is a very important area of focus as it is GF that needs to be used for services such as prevention, jail diversion and other services that cannot be covered by Medicaid and are of high priority for county commissioners and community leaders.

Respectfully submitted, Lynda Zeller, CEO



## Rural and Frontier Caucus

*A Caucus of the Community Mental Health Association of Michigan*

3/27/2026

Northern Lakes CMH Board of Directors,

The attached FY27 budget boilerplate proposal from the Rural and Frontier Caucus of the Community Mental Health Association of Michigan is presented for your review.

This proposal centers on a straightforward objective: ensuring that rural communities are treated consistently, thoughtfully, and proactively in state policy decisions that affect access to behavioral health services. Currently, varying definitions of “rural” across MDHHS programs create instability for providers and counties. These inconsistencies can impact funding eligibility, disrupt service planning, and ultimately affect access to care. In addition, rural stakeholders are often engaged late in the policymaking process, limiting the ability to address practical challenges before implementation.

**The proposed boilerplate** addresses these issues in three ways. **It establishes a single, consistent definition of rural, partially rural, and frontier areas** across all department programs. It reinforces the **need to account for the realities of rural service delivery**, including workforce shortages and geographic barriers. It also **creates a formal Rural Consultation Caucus** to ensure rural perspectives are incorporated before major policy decisions are finalized.

The Rural Caucus is actively engaging regional healthcare leaders across rural Michigan, alongside Boards such as this one, to build broad support for this initiative. With that collective backing, the intent is to present a unified voice to the Michigan Legislature that compels action and advances inclusion of this language in the FY27 state budget.

Approval from this and other Boards signals alignment with this coordinated effort and positions this organization as part of a broader coalition advocating for fair, consistent, and effective rural health policy.

Respectfully,

### Rural and Frontier Caucus

Alan Bolter, CMHA  
Bryan Krogman, CMH of Central MI  
Brian Babbitt, North Country CMH  
Carol Mills, Newaygo CMH  
Chip Johnston, Centra Wellness  
Courtney Grant, Hiawatha Behavioral Health  
Eric Kurtz, Northern Michigan Regional Entity  
Lynda Zeller, Northern Lakes CMH

Mandy Padget, Northpointe Behavioral Health  
Matt Maskart, Pathways CMH  
Megan Rooney, NorthCare Network  
Mike Bach, Copper Country CMH  
Nena Sork, Northeast Michigan CMH  
Tess Greenough, Gogebic CMH  
Trish Otremba, Wellvance  
Wilbert Morris, Sanilac CMH

## **Protecting Rural Access to Behavioral Health Services Proposed FY27 Budget Boilerplate**

The Rural and Frontier Caucus of the Community Mental Health Association of Michigan (CMHA) is proposing the attached boilerplate language for the FY27 budget. This proposal ensures that rural communities are defined consistently across all programs administered and/or funded (either directly or via a pass through/fiduciary arrangement) by the Michigan Department of Health and Human Services (MDHHS), recognizes the unique challenges faced by frontier areas, and establishes a structured process for rural consultation on policies that affect access to care.

### **The Challenge:**

- Rural communities are often defined inconsistently, which can affect eligibility for funding, grants, and program participation.
- Rural communities are often consulted late or not at all, limiting opportunities to address unintended impacts on rural service delivery.
- Rural and frontier communities face structural barriers such as workforce shortages, long travel distances, and limited provider networks that must be recognized in program design.

### **What the Proposed Boilerplate Language Does:**

#### **1. Protect Access to Behavioral Health Services in Rural and Frontier Communities**

- Rural and frontier counties face persistent barriers to behavioral health access, including limited workforce availability, long travel distances, and transportation challenges.
- CMHSPs and other rural providers must organize services around these realities. When definitions of “rural” change across programs, it disrupts planning and can affect access to funding and program eligibility.
- Stable policy definitions and predictable program rules are necessary to support workforce recruitment, service placement, and transportation solutions.

#### **2. Establish a Clear and Consistent Definition of Rural**

- MDHHS programs currently rely on multiple and sometimes conflicting definitions of “rural,” creating uncertainty for counties and providers trying to plan services and access funding opportunities.
- The proposed boilerplate establishes a single statewide framework for defining rural, partially rural, and frontier areas, based on the U.S. Department of Agriculture’s Frontier and Remote Area (FAR) methodology.
- A consistent definition promotes fairness, transparency, and predictable policy implementation across department programs

#### **3. Ensure Rural Communities Have a Voice in State Policy Decisions**

- State policy changes related to Medicaid, behavioral health delivery, and program funding can have unintended consequences for rural communities.
- The proposed language establishes a Rural Consultation Caucus to ensure that rural counties, providers, and residents have a formal opportunity to provide input before major policy decisions are finalized.
- Early consultation improves policy outcomes and helps the department identify rural implementation challenges before policies are adopted.

### **Why It Matters:**

Consistent definitions and meaningful consultation help ensure that rural communities are treated fairly across state programs and that policies affecting access to care reflect the realities of rural service delivery.

## Proposed FY 2027 MDHHS Budget Boilerplate

### Standard Definition of Rural

Sec. XXXX. To assist in providing policy-relevant information about conditions in sparsely-settled, remote areas of the Michigan, the following has been established to use a single definition of rural, partial rural, and frontier that is applied consistently across all department programs for the purposes of administering and implementing department programs, services, grants, and policies.

- (1)** For purposes of this section, the department's standard definition of rural and frontier shall be based upon the U.S. Department of Agriculture's Economic Research Service Frontier and Remote Area Codes.
- (2)** The department may designate counties as rural, partially rural, or frontier counties for purposes of program eligibility, service delivery, funding flexibility, or policy implementation based on the following criteria in (3), (4), or (5).
- (3)** The department shall designate counties that meet the criteria described in this section as rural counties for department programming purposes if the county meets one or more of the following criteria:
  - (a)** Frontier and Remote Area (FAR) Level One - consist of rural areas up to 50,000 people that are 60 minutes or more driving time from an urban area of 50,000 or more people.
  - (b)** Frontier and Remote Area (FAR) Level Two - consist of rural areas up to 25,000 people that are 45 minutes or more driving time from an urban area of 25,000-49,999 people and 60 minutes or more from an urban area of 50,000 or more people.
- (4)** The department may designate counties as partially rural if those counties include census tracts meeting the following criteria:
  - (a)** Census tracts located within metropolitan counties that are designated with Rural-Urban Commuting Area (RUCA) codes 4 through 10.
  - (b)** Census tracts located within metropolitan counties that are at least 400 square miles in area, have a population density of 35 or fewer persons per square mile, and are designated with RUCA codes 2 or 3.
  - (c)** Census tracts located within metropolitan counties that are designated as Rural-Rural Strong (RRS) level 5, have RUCA codes 2 or 3, and are at least 20 square miles in area.
- (5)** The department shall designate counties that meet the criteria described in this section as frontier counties for department programming purposes if the county meets one or more of the following criteria:
  - (a)** Frontier and Remote Area (FAR) Level Three - consist of rural areas and urban areas up to 10,000 people that are: 30 minutes or more from an urban area of 10,000-24,999; 45 minutes or more from an urban area of 25,000-49,999 people; and 60 minutes or more from an urban area of 50,000 or more people.
  - (b)** Frontier and Remote Area (FAR) Level Four - consist of rural areas that are: 15 minutes or more from an urban area of 2,500-9,999 people; 30 minutes or more from an urban area of 10,000-24,999 people; 45 minutes or more from an urban area of 25,000-49,999 people; and 60 minutes or more from an urban area of 50,000 or more people.
- (6)** The department shall apply the standard definition established under this section consistently across department programs to the extent practicable, except where a different definition of rural is required by federal law or regulation.

**(7)** To ensure meaningful and ongoing consultation with rural communities regarding Medicaid and other department programs, the department shall establish a Rural Consultation Caucus.

**(8)** The Rural Consultation Caucus shall include:

- (a)** One representative appointed by each county designated as rural.
- (b)** A proportional number of representatives from partially rural and frontier counties.
- (c)** Representatives of rural health providers, rural community mental health authorities, and other rural-serving organizations identified by the department.
- (d)** Up to four at-large members representing rural consumers, families, or caregivers.
- (e)** Legislators representing rural districts may participate in an advisory capacity.

**(9)** The department shall engage in consultation with the Rural Consultation Caucus before proposing, adopting, amending, or implementing any policy, state plan amendment, waiver, operational change, funding methodology, or administrative action that has a substantial effect on rural access, service availability, financing, or delivery.

**(10)** Consultation under this section shall include:

- (a)** Written notice of the proposed action provided at least 60 days before finalizing or submitting the proposal, including a summary of the proposed action and its expected impact on rural communities.
- (b)** A minimum of one scheduled consultation meeting, virtual or in person, at which department officials with decision-making authority are present.
- (c)** Opportunities for written and verbal comment from caucus members.
- (d)** A written departmental response summarizing rural input and explaining how such input was incorporated or the reasons for declining specific recommendations.

**(11)** When federal requirements or urgent circumstances do not permit a 60-day notice period, the department may initiate an expedited consultation process, with consultation occurring within 21 days of notice.

**(12)** The department shall maintain written records of all consultation activities conducted under this section, including notices, meeting summaries, written comments, and the department's responses.

**(13)** The department shall report to the senate and house appropriations subcommittees on health and human services no later than March 1, 2027, on the implementation of the standard rural definition, including a list of counties designated as rural, partially rural, or frontier.



## FY27 Executive Budget Proposal

### Specific Mental Health/Substance Abuse Services Line items

	<u>FY'25 (Final)</u>	<u>FY'26 (Final)</u>	<u>FY'27 (Exec Rec)</u>
-CMH Non-Medicaid services	\$125,578,200	\$125,578,200	\$125,578,200
-Medicaid Mental Health Services	\$3,387,066,600	\$3,188,847,900	\$3,667,513,800
-Medicaid Substance Abuse services	\$95,650,100	\$96,323,300	\$84,902,600
-State disability assistance program	\$2,018,800	\$2,018,800	\$2,018,800
-Community substance abuse (Prevention, education, and treatment programs)	\$79,626,200	\$79,207,900	\$79,221,100
-Health Homes Program	\$53,418,500	\$50,239,800	\$50,239,800
-Autism services	\$329,620,000	\$467,644,200	\$560,716,600
-Healthy MI Plan (Behavioral health)	\$527,784,600	\$438,267,500	\$525,256,200
-CCBHC	\$525,913,900	\$916,062,700	\$916,062,700
-Total Local Dollars	\$10,190,500	\$9,943,600	\$9,943,600

### Other Highlights of the FY27 Executive Budget:

#### H.R. 1 Implementation

The Executive Budget includes funding to implement the requirements of H.R. 1. Signed on July 4, 2025, H.R. 1 introduces new eligibility requirements for recipients of Medicaid and the Supplemental Nutrition Assistance Program (SNAP). It also requires additional efforts by state agencies that administer those programs to achieve compliance. Accordingly, the Executive Budget provides new funding to increase capacity within local offices, bolster community engagement and outreach efforts, and enhance information technology capabilities. The intent of these efforts is to (1) help Michigan residents who are eligible to receive public assistance demonstrate compliance and maintain enrollment, and (2) enforce new eligibility requirements.

Proposed investments include:

- \$97 million (\$154.6 million general fund) to DHHS for H.R. 1 Implementation:
  - \$94.3 million (general fund), offset with a like reduction in federal revenue (net zero total) for SNAP administrative costs due to the state's required cost share increasing from 50% to 75% beginning in fiscal year 2027.
  - \$80.3 million for additional full-time employees (\$54.2 million general fund) to meet workload increases resulting from new requirements within H.R. 1. This investment includes an additional 589.0 FTEs for assistance payment workers, Office of Inspector General agents, departmental analysts, supervisors, and administrative assistants.
  - \$16.7 million to expand beneficiary support (\$6.1 million general fund) by increasing access to beneficiary help-line services and providing educational support on H.R. 1 changes. This includes a \$5 million federal grant from the Centers for Medicare and Medicaid Services (CMS), included in the FY26 supplemental proposal, to support costs related to Medicaid community engagement requirements.

### **Behavioral Health Facility and Capacity Expansions**

The Executive Budget prioritizes needed investments in Michigan's behavioral health system. These investments include supplemental funding for the transition of staff, supplies, and materials to the Southeast Michigan State Psychiatric Hospital (SMSPH), a new facility that is currently under construction and expected to open in October 2026. The Executive Budget includes the following behavioral health facility and capacity expansion investments:

- \$7.9 million in supplemental funding and 53.8 FTEs to transfer staff and materials (general fund) from Walter Reuther Hospital to SMSPH. This will allow newly hired staff to shadow and receive necessary training from experienced caregivers transitioning from established facilities to the new hospital.
- \$72.2 million and 323.0 FTEs to begin operating SMSPH (\$65.8 million general fund), bringing 264 new beds online and increasing total statewide capacity by 54 beds (32 adult beds and 22 pediatric beds). This investment includes operational support and hiring staff to provide services at the facility.
- A net zero transfer of \$99.4 million and 584.2 FTEs (\$71 million general fund) from Walter Reuther to the SMSPH. This will transfer the entire Walter Reuther appropriation to SMSPH, as Walter Reuther will be closed following the scheduled opening of the new facility in October 2026.
- \$7.2 million (general fund) to support the following one-time investments: • \$6 million for upgrades to the psychiatric hospitals' electronic medical and business records system to better manage patient data, ensure appropriate billing, and increase effective use of medication dispensing systems.
- \$1.2 million to purchase personal protection devices (PPDs) at Caro Regional Mental Health Center, Center for Forensic Psychiatry, and Kalamazoo Psychiatric Hospital (PPDs have already been purchased for SMSPH). PPDs are wearable, digital panic devices used to reduce violence in health care workplace settings and are expected to significantly increase staff and patient safety across the state hospital system.

- \$8.3 million in federal authorization for new psychiatric residential treatment facilities in Grand Rapids, Lansing, and Livonia that together are expected to bring 50 new transitional beds online. Psychiatric residential treatment facilities (PRTFs) provide short-term, intense, and focused mental health treatment to promote successful integration into the community. PRTFs function as a step-up from the community and as a step-down from state inpatient treatment.

Collectively, these investments intend to expand capacity, address aging infrastructure, and strengthen the state's ability to deliver timely, clinically appropriate care.

### **Health Care Workforce**

The Executive Budget pursues multiple strategies to strengthen Michigan's health care workforce by addressing shortages and enhancing capacity. Direct care worker supports and minimum wage increases seek to improve recruitment and retention efforts by increasing compensation and benefits for frontline caregivers.

- \$258.4 million to support 2025 and 2026 direct care worker minimum wage increases (\$87.3 million general fund), which preserves \$3.40 per hour in increased wages received by workers over the past two years. Currently, federal American Rescue Plan (ARP) funds that expire at the end of FY26 support these increases. This investment backfills the lost ARP funds with general fund to continue drawing down federal Medicaid match dollars.
- \$69.5 million to support the 2027 direct care worker minimum wage increase of \$1.27 per hour (\$23.5 million general fund).
- \$24 million to provide sick leave for direct care workers consistent with Public Acts 338 and 369 of 2018 (\$8.1 million general fund). Nearly all employers, such as those employing members of the direct care workforce, are required to provide paid sick leave to eligible employees. This investment transitions the cost to general fund and Medicaid matching dollars, as time-limited ARP funds currently support this requirement.
- \$10 million one-time investment to improve staffing levels in nursing homes (Civil Monetary Penalties). This aims to address chronic workforce shortages that impact the quality of care for residents in long-term care facilities. A recent CMS campaign increased the scope of eligible staffing projects that can be funded with Civil Monetary Penalties.

### **Medicaid Sustainability**

The Executive Budget recognizes the need to bend the curve in Medicaid cost growth, while ensuring access to the necessary and quality care that one in four Michiganders depend on. As health care costs continue to increase at rates exceeding overall inflation, access to affordable care remains a growing concern for families across the nation. Mirroring national trends, Michigan Medicaid has seen significant cost growth in recent years, and it is more important than ever that the state strategically change the trajectory of health care expenditures, pursue new approaches and utilize existing tools to ensure the viability of its Medicaid program for years to come.

Michigan has incorporated a variety of strategies to curb Medicaid cost growth, while ensuring access to necessary and quality care, such as:

- Establishing provider partnerships whereby health care entities such as hospitals, health plans, skilled nursing facilities, and ambulance service providers pay into assessment programs to generate non-federal revenue.
- Implementation of policies, procedures, and technology solutions to increase program efficiencies.

The Governor's budget seeks to use the following funding streams and strategies to support the Michigan Medicaid program in the coming years:

- Tobacco Tax: forecast to generate \$232 million in FY27.
- Vape Tax: forecast to generate \$95 million in FY27 to be used for cancer prevention, smoking prevention, children's coordinated health care, and for the Medicaid Benefits Trust Fund.
- New internet tax rate on largest casinos: forecast to generate \$135.5 million in new tax revenue in FY27, with the majority going directly to the Medicaid Benefits Trust Fund.
- Per-Wager Sports Betting Tax: forecast to generate \$38.8 million for the Medicaid Benefits Trust Fund in FY27.
- Elimination of Free Play Deduction: eliminating this deduction is forecast to generate \$21.1 million for the Medicaid Benefits Trust Fund in FY27.
- Digital Advertising: the tax is forecast to generate \$282 million in FY27.

**\$150 million in efficiency savings identified in collaboration with stakeholders to address costs, accountability and resource effectiveness while maintaining sustainability of services.**

**Behavioral Health Boilerplate Changes from FY 26 → FY 27**

**NEW: Sec. 8-902.** From the funds appropriated in part 1, the department shall make a final authorization to a CMHSP or PIHP upon execution of a contract containing an approved plan and budget. Contracts are not valid unless total obligations do not exceed appropriated amounts. The department must immediately report to standard report recipients when entering into or amending a contract that affects a rate or expenditure.

**EDITED: Sec. 8-917.** From the funds appropriated in part 1 for opioid response activities, \$55,000,000.00 from the Michigan opioid healing and recovery fund must be allocated according to a detailed framework specifying funding amounts for primary prevention, harm reduction (including naloxone distribution), substance use disorder treatment, recovery supports, oversight, data, and Tribal community investments.

**REMOVED: Sec. 8-918.** Quarterly reporting requirement on funding paid to PIHPs for the Medicaid managed mental health care program, including per capita rates, eligibility groups, and year-to-date expenditures.

**REMOVED: Sec. 8-922.** \$600,000.00 allocation to a specified nonprofit to administer and update the protected health information consent tool, including related trainings and integration with systems such as CareConnect360.

**REMOVED: Sec. 8-926.** \$1,000,000.00 allocation for a specialized substance use disorder detoxification project administered by a 9-1-1 service district in conjunction with a substance use and case management provider, including outcome reporting requirements.

**REMOVED: Sec. 8-928.** Requirement that each PIHP provide local funds as part of the Medicaid state match to increase capitation rates, along with lapse reporting requirements.

**REMOVED: Sec. 8-965.** Requirement that the bundled rate H0020 for methadone administration and services be maintained at not less than \$19.00.

**REMOVED: Sec. 8-1002.** Prohibition on using appropriated funds to expand the certified community behavioral health clinic (CCBHC) demonstration.

**EDITED: Sec. 8-1006.** From the funds appropriated in part 1 for certified community behavioral health clinics, the department shall submit the CCBHC cost efficiency evaluation to the standard report recipients not later than 7 business days after receipt of the final information required from the relevant contractors (clarifying language updated).

**NEW: Sec. 8-1011.** From the funds appropriated in part 1 for behavioral health community supports and services, \$400,000.00 shall be allocated to a qualified Yemeni nonprofit organization meeting specified establishment date, tax-exempt status, and population-based geographic criteria.

**EDITED: Sec. 8-1014.** Multicultural health services grants section expanded to:

- Require compliance with performance-related metrics for contractors receiving over \$1,000,000.00 in state grant funding.
- Require funds to be used only for proven or established programs.
- Require an annual report detailing services, client populations, wraparound services, and expenditures, to be submitted to standard report recipients by February 1.

**REMOVED: Sec. 8-1015.** Requirement to provide federal mental health block grant funds, to the extent possible, to local public entities and one statewide private entity providing community-based mental health services.

**NEW: Sec. 8-1034.** PIHPs must quarterly verify reimbursement compliance with required rates, providing actual claims and utilization data. The department must audit the data, may seek CMS approval to exclude noncompliant PIHPs from performance incentives, and must notify standard report recipients of noncompliance. Oversight explicitly includes state psychiatric hospitals and forensic mental health facilities.

**EDITED: Sec. 8-1055.** State hospital closure and consolidation safeguards retained; language updated for clarity and consistent references to hospitals, centers, and facilities without substantive policy changes.

**EDITED: Sec. 8-1056.** Clarifies that patient reimbursement revenue collection authority applies to state hospitals and centers.

**EDITED: Sec. 8-1059.** State-operated hospital performance metrics updated with technical clarifications, including broader references to "court" and consistent inclusion of hospitals and centers in admission, discharge, and waitlist metrics.

**EDITED: Sec. 8-1060.** Workforce reporting requirements maintained with updated references to state psychiatric hospitals and centers.

**REMOVED: Sec. 8-1061. Semiannual construction status reporting for the new state psychiatric hospital and required transition plan for the Walter P. Reuther Psychiatric Hospital.**



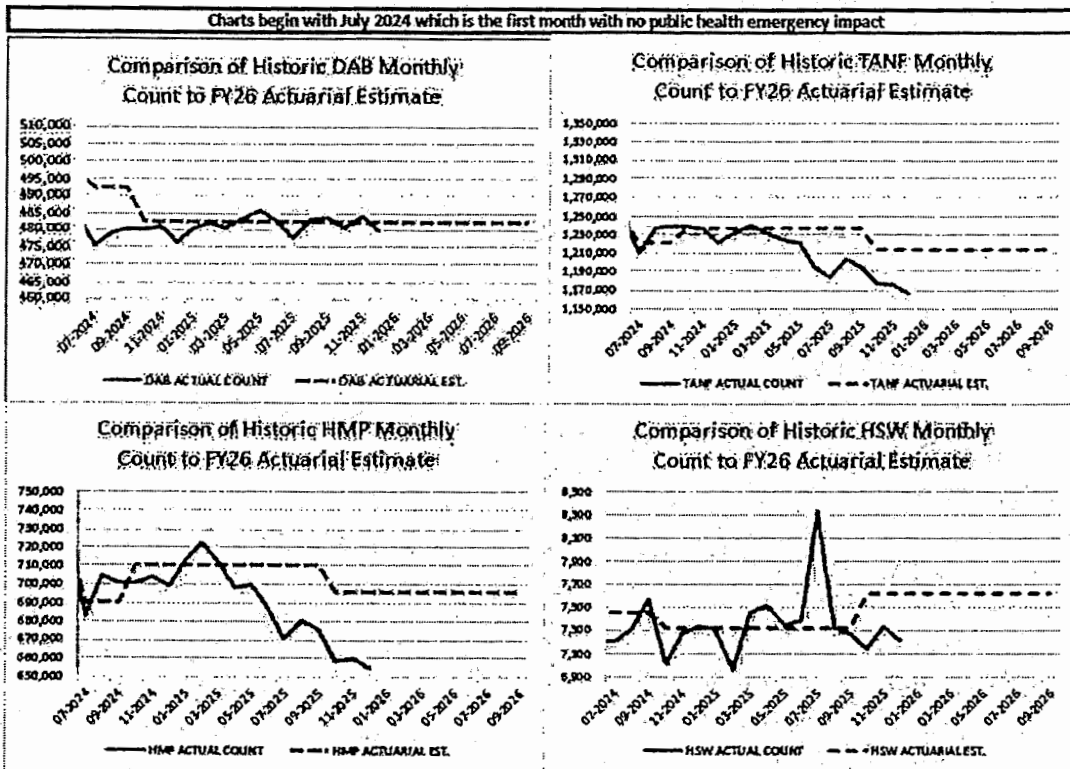
## CMHA FY27 Appropriations Key Issues

### FY26 MEDICAID RATES MUST BE ADJUSTED

- **CMHA members face over a \$100 million Medicaid shortfall for FY26 due to a drop in Medicaid enrollment.** Rate adjustments from MDHHS throughout FY25 and FY26 were not able to keep up with the dramatic drop in Medicaid enrollment.
  - **HOW OUR MEMBERS GET PAID:** Our members receive a payment for every person enrolled in Medicaid regardless if we see them or not. The more people the more payments (and the smaller the payment would be), but as people starting losing their coverage during redeterminations our members lost those payments, when that occurs the payments we receive must grow in order for the system to have adequate funding to provide the services and supports required. In FY25 and again in FY26 those payments did not grow fast enough which is causing a Medicaid shortfall.
  - **NO NEW MONEY IS NEEDED FOR A FY26 rate adjustment – if revenue projections remain there will be over \$250 million leftover in the Mental Health Medicaid line items.**
    - If Medicaid rates are not adjusted in a timely manner, declining enrollment will continue to widen the funding gap. The longer MDHHS waits to respond, the more severe the financial impact becomes.

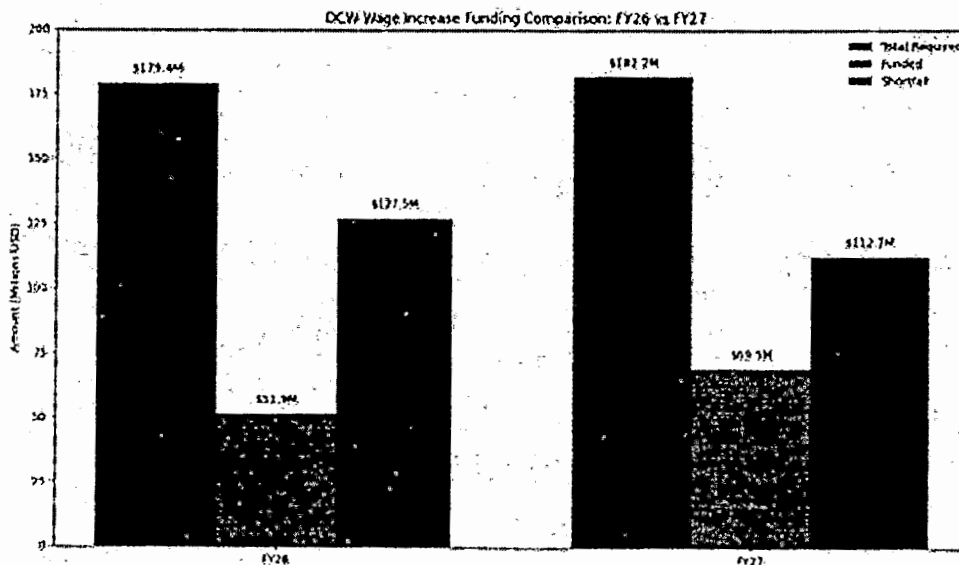
Area of Capitation Funding Projection	FY25 Full Year	FY26 Initial	Difference	% Difference
DAB Funding per Certification Documents + FY25 Adjustments:	\$ 2,502,500,000	\$ 2,436,200,000	\$ (66,300,000)	-2.6%
TANF Funding per Certification Documents + FY25 Adjustments:	\$ 662,600,000	\$ 600,200,000	\$ (62,400,000)	-9.4%
HMP Funding per Certification Documents + FY25 Adjustments	\$ 484,600,000	\$ 440,000,000	\$ (44,600,000)	-9.2%
HSW, CWP, & SED funding per Certification Documents + FY25 Adjustments:	\$ 709,800,000	\$ 774,600,000	\$ 64,800,000	9.1%
<b>Capitation funding totals per Certification Documents + FY25 Adjustments:</b>	<b>\$ 4,359,500,000</b>	<b>\$ 4,251,000,000</b>	<b>\$ (108,500,000)</b>	<b>-2.5%</b>

- FY26 Medicaid Enrollment declines below those projected by Milliman



**INADEQUATE FUNDING OF DCW WAGE REQUIREMENTS ARE CREATING STRUCTURAL DEFICITS**

- MDHHS has provided the PIHP system with only 29% (\$51.9 million) of the necessary funding to support the FY26 DCW costs to cover the required \$17.13/hour wage (\$13.73 minimum wage as of 01/01/26 + \$3.40 DCW pass through) - \$179.4 million is needed to meet requirement.



- FY27 Executive Budget recommendation continues to underfund DCW costs for the minimum wage increase that will occur January 1, 2027 - \$69.5 million is ONLY 38% if the necessary funding, \$182.2 million is needed to meet requirement.
  - **HOW THE MATH WORKS:** The legislative appropriation for a \$0.20 per hour DCW wage increase for behavioral health and aging services combined was \$28.7 million in FY25. The amount therefore required to cover a wage increase of \$1.25 for FY26 would be \$179.4M. The amount required to cover the wage increase of \$1.27 in 2027 would be \$182.2M
- FY27 Executive Budget recommends \$258.4 million to support 2025 and 2026 direct care worker minimum wage increases (\$87.3 million general fund), which preserves \$3.40 per hour in increased wages received by workers over the past two years.
  - \$476 million is needed to fully fund the \$3.40/per hour DCW wage passthrough

**SUPPORT REVENUE INCREASES TO MAINTAIN MEDICAID FUNDING LEVELS**

- Support the FY27 executive budget recommendations to increase revenue to ensure the Medicaid program is fully funded and supported.

**CONTINUED PHASE OUT OF LOCAL MATCH DRAW DOWN – SECTION 928**

- FY27 budget to include \$5 million GF/GP to offset local/county resources for Medicaid match purposes and continue the 5-year phase out of the use of local/county dollars for Medicaid match purposes.
- Include the following language (from FY23 budget):
  - (3) It is the intent of the legislature that the amount of local funds used in subsection (1) be phased out and offset with state general fund/general purpose revenue in equal amounts over a 5-year period.

**CMHA OPPOSES ANY NEW LEGISLATIVE MANDATED RATE INCREASE FOR A SPECIFIC SERVICE THAT INTERFERES WITH PIHPS AND CMHSPS REQUIREMENT TO ESTABLISH FAIR MARKET RATES**

- Recently, the legislature has increased rates for ABA autism services and methadone reimbursements. CMHA supports adjusting rates and increasing funding levels overall, which then give our members maximum flexibility on how best to use those funds within their communities and allows them to negotiate fair markets rates with their providers.

## **REDUCE ADMINISTRATIVE BURDENS**

- Require MDHHS to comply with section 994 from the FY26 budget
  - **Sec. 994. National Accreditation Review Criteria for Behavioral Health Services – NEW** House requires DHHS to seek, if necessary, a federal waiver to allow a CMHSP, PIHP, or subcontracting provider agency that is reviewed and accredited by a national accrediting entity for behavioral health care services to be in compliance with state program review and audit requirements; requires a report that lists each CMHSP, PIHP, and subcontracting provider agency that is considered in compliance with state requirements; requires DHHS to continue to comply with state and federal law not initiate an action by negatively impacts beneficiary safety; defines "national accrediting entity."
- **Section 994 will reduce the number of non-value added audits and reports**
  - Tremendous amount of duplication and redundancy in state program/financial reviews and audits. There should be oversight of the system, but we want to eliminate the duplication and non-value added requirements.
  - Ohio and Illinois both have deemed status Illinois found there was 40% redundancy between state requirements and national accreditation requirements
    - CMHA members (PIHPs/CMHs/Providers) spend thousands of staff hours and resources complying with state reviews that do not provide value, are not used in a substantive manner or are duplicative.

## **BOILERPLATE SUGGESTIONS**

### **PROHIBIT MDHHS FOR SPENDING ADDITIONAL DOLLARS ON PIHP RFP PROCESS**

Include language in a FY26 supplemental budget and FY27 budget that blocks any further action of MDHHS regarding this RFP process:

Sec. \_\_\_\_ The department shall not issue, implement, or otherwise proceed with any request for proposals, rebid, or procurement process related to the delivery, financing, or administration of public behavioral health or mental health services, nor expend state or federal funds for such purposes, unless the request for proposals fully complies with the Michigan Mental Health Code and the statutory framework governing Michigan's public behavioral health system, has received approval through enactment of legislation or approval by the legislature as provided in law, and the department has returned to the legislature for approval of a plan for implementation prior to taking any further action.

- Bridge Magazine published an article that highlighted that **MDHHS paid consultants \$2.9M for failed mental health redesign** Request for Proposals (RFP) – the RFP that was

found to violate state law. This amount did NOT include all of the legal fees incurred by the state through the Attorney General's office.

**STRIKE CCBHC LANGUAGE PROHIBITING EXPANSION – REPLACE WITH CONTUNUED FUNDING**

Strike section 1002 in FY27 Exec Rec Budget – The funds appropriated in part 1 must not be used by the department to expand the certified community behavioral health clinic demonstration.

Replace with the following language: Sec. 1002. From the funds appropriated in part 1 for the certified community behavioral health clinic demonstration, the department shall maintain the number of certified community behavioral health clinics as of September 30 of the previous fiscal year. After October 1 of the current fiscal year, the department may expand the number of certified community behavioral health clinics in PIHP regions 1 and 2 if funding is available, the prospective site meets applicable certification criteria, and the department and the participating site determine that participation is mutually beneficial.

- **CCBHC Expands access through a “no wrong door” approach**, ensuring children and adults can receive mental health, substance use, and physical health services regardless of insurance, ability to pay, location, or level of need.
- **CCBHC strengthens the public behavioral health system** by expanding the provider network and responding to local community needs (law enforcement, schools, crisis systems), integrating mental health, substance use, and physical health care in one plan of service, establishing national expectations for evidence-based care, and ensuring federal funding and accountability through state and federal quality outcome reporting.

**PROHIBIT MDHHS FOR MOVING FORWARD WITH MENTAL HEALTH FRAMEWORK**

(1) From the funds appropriated in this part, the department shall not expend state general fund/general purpose revenue, federal funds, or any other funds to develop, implement, administer, or advance the proposal commonly referred to as the “Mental Health Framework” or any similar policy initiative that alters the current responsibilities for behavioral health services between prepaid inpatient health plans, community mental health services programs, or Medicaid health plans.

(2) The department shall not take administrative, contractual, regulatory, or policy actions to transfer, delegate, or otherwise modify responsibility for psychiatric inpatient admissions or behavioral health service management in a manner inconsistent with the responsibilities established under the Michigan Mental Health Code, 1974 PA 258, MCL 330.1001 to 330.2106.

(3) The department shall not implement policies that shift management of psychiatric inpatient benefits or related behavioral health services to Medicaid health plans unless specifically authorized by a subsequent act of the legislature.

(4) The department shall maintain the current structure of responsibility for behavioral health services unless otherwise directed by law.

## **CREATE STANDARD DEFINITION OF RURAL**

Develop boilerplate: To assist in providing policy-relevant information about conditions in sparsely-settled, remote areas of the Michigan, the following has been established to use a single definition of rural, partial rural, and frontier that is applied consistently across all department programs for the purposes of administering and implementing department programs, services, grants, and policies.

- A standardized definition ensures fairness, transparency, and predictable policy implementation for counties, CMHSPs, providers, and beneficiaries.
- Rural communities face unique workforce shortages, transportation barriers, and service gaps.
- Program rules that change rural definitions can undermine planning and service delivery for CMHSPs and PIHPs serving rural populations.
- The department should not apply different definitions of rural depending on the program, funding source, or policy objective.
  - MDHHS should be prohibited from narrowly defining rural for regulatory requirements (such as CFAP compliance) while expanding the definition for grant or demonstration programs (such as RHTP).

TOPIC	TIME ON AGENDA	BOARD MTG	FREQUENCY	MONTH	RESPONSIBLE PARTY
Review and Approval of Board By-Laws	10 MIN	X	Annual	January	Board Chair, CEO
Needs Assessment	15 MIN	X	Annual	January	CEO
Financial, Single and Compliance Audit Initiated	30 MIN	X	Annual	January	CFO
FY 2025 Northern Lakes CMHA Quality Assurance and Improvement, Regulatory Compliance, and Customer Services Report Attachment 3, Enabling Agreement (KPI)	10 MIN	X	Quarterly	January	CEO
Human Resources: Annual report to Personnel Committee	10 MIN		Annual	February	CHRO
2025 Annual Report	30 MIN	X	Annual	February	CEO
Annual Recipient Rights Report to the Board	20 MIN	X	Annual	February	Recipient Rights Director
Annual Report to the Board from prior FY as submitted to MDHHS					
CEO Evaluation Distribute	5 MIN	X	Annual	February	Board Chair
CEO Evaluation	30 MIN		Annual	April	Board Chair
Introducing Slate of Officers' Candidates	10 MIN	X	Annual	April	Board Chair
Service Area Presentation: Behavioral Health and Justice: Jail Services, Assisted Outpatient Treatment (AOT)	10 MIN	X	Annual	April	CEO, CCO

<b>TOPIC</b>	<b>TIME ON AGENDA</b>	<b>BOARD MTG</b>	<b>FREQUENCY</b>	<b>MONTH</b>	<b>REPSIBLE PARTY</b>
Recipient Rights Training for the Board Members	3-hour time block		Annual	April	Recipient Rights Director
FY 2025 Northern Lakes CMHA Quality Assurance and Improvement, Regulatory Compliance, and Customer Services Report Attachment 3, Enabling Agreement (KPI)	10 MIN	X	Quarterly	April	CEO, COO
Conflict of Interest Disclosure Statement	5 Min	X	Annual	May	Board Chair
Code of Conduct Declaration	5 MIN		Annual	May	Board Chair All Board Members
Election of Officers	10 MIN	X	Annual	May	Board Chair
CEO Compensation	10 MIN	X	Annual	May	Board Chair
<u>Service Area Presentation:</u> Services for Persons with Mental Illness (MI/SMI): ACT, Outpatient, Crisis	10 MIN	X	Annual	May	CEO, COO
Strategic Plan Review and Update	10 MIN	X	Annual	May	CEO, Board Chair
<u>Service Area Presentation:</u> Services for People with Intellectual/Developmental Disability	10 MIN	X	Annual	June	CEO, COO
Recipient Rights Semi-Annual Report to the Board	10 MIN	X	Semi Annual	June	Recipient Rights Director
First 6 months of 2026 Financial, Single and Compliance Audit Discussion	30 MIN	X	Annual	June	CFO

TOPIC	TIME ON AGENDA	BOARD MTG	FREQUENCY	MONTH	RESPONSIBLE PARTY
FY 2026 Budget Amendment, Initial FY 2027 Budget and 2026 Capitalization Plan	20 MIN	X	Annual	July	CFO, Finance Chair
Board Member Per Diem & Cost of Governance	10 MIN		Annual	July	CEO, Board Chair, Finance Chair, CFO
FY 2025 Northern Lakes CMHA Quality Assurance and Improvement, Regulatory Compliance, and Customer Services Report Attachment 3, Enabling Agreement (KPI)	10 MIN	X	Quarterly	July	CEO
<u>Service Area Presentations:</u> Recovery and Prevention	10 MIN	X	Annual	August	CEO, COO
Compliance, Quality and Customer Services: Annual Report and Board Training	20 MIN	X	Annual	August	CEO, COO
Public Hearing	90 min – 2 Hours		Annual	September 10 <sup>th</sup>	CEO
<u>Service Area Presentations:</u> Services for Children with Serious Emotional Disturbance (SED)	10 MIN	X	Annual	September	CEO
Information, Technology and Security: Annual Report	10 MIN	X	Annual	October	CEO, CIO
FY 2025 Northern Lakes CMHA Quality Assurance and Improvement, Regulatory Compliance, and Customer Services Report Attachment 3, Enabling Agreement (KPI)	10 MIN	X	Quarterly	October	CEO

TOPIC	TIME ON AGENDA	BOARD MTG	FREQUENCY	MONTH	RESPONSIBLE PARTY
Annual Planning Calendar for 2027 Calendar Year	10 MIN	X	Annual	November	CEO, Board Chair
Board Meeting Schedule for 2027 Calendar Year	10 MIN	X	Annual	November	Board Chair
Board Member Terms for 2027	5 MIN	X	Annual	November	Board Chair
<b>Each meeting will also include:</b> Report of Officers <ul style="list-style-type: none"> <li>• ORR Director</li> <li>• CEO Report</li> </ul> CFO Report	45 Min	X	Monthly	Every Month	Recipient Rights Director, CEO, CFO
Committee Reports (from the committee Chairs): <ul style="list-style-type: none"> <li>• NMRE Update</li> <li>• RRAC Update after meeting</li> <li>• Executive</li> <li>• Finance</li> <li>• Policy</li> <li>• Community Engagement and Services</li> <li>• Personnel</li> </ul>	45 min	X	Monthly	Every Month	Committee Chairs
Dashboard Report <ul style="list-style-type: none"> <li>• Persons served, cost, efficiencies</li> </ul>	10 MIN	X	Monthly	Every Month	CEO

<b>TOPIC</b>	<b>TIME ON AGENDA</b>	<b>BOARD MTG</b>	<b>FREQUENCY</b>	<b>MONTH</b>	<b>RESPONSIBLE PARTY</b>
Celebrate Northern Lakes	10 Min	X	Monthly	Every Month	Board Chair, CEO
Celebrate Community	10 minutes	X	Monthly	Every Month (or at lesser frequency as determined by Community Engagement Committee and Executive Committee)	Community Engagement Chair, Board Chair

**Attachment III - Submitted April 2026 (encompassing Oct/Nov/Dec 2025)**

**Northern Lakes CMH Authority Key Performance Indicators  
(to be reported to the NLCMHA Member Counties Quarterly)**

**NLCMHA Mission:** To improve the overall health, wellness, and quality of life of the individuals, families, and communities that we serve.

**❖ Strategic Objectives**

Objective	Strategic Objective
1	Transform the NLCMHA’s behavioral health services into a nationally recognized, results-based model of care by promoting a common vision, accountable collective action, transparency, and innovative programs.
2	Ensure individuals served at NLCMHA receive quality services to meet their unique needs.
3	Ensure individuals and families receive quality services to meet their unique needs, resulting in access to the right services, at the right time, in the right amount.
4	Build and support a community that promotes recovery and resilience to help individuals and families thrive.
5	Promote behavioral health wellness through prevention and early intervention services and supports.
6	Strengthen community partnerships to better integrate and coordinate services towards a sustained shared vision of excellence
7	Create and maintain a highly efficient, transparent, and responsive organization.

**❖ Key Performance Indicators**

Measure	FY25 Q4	Target	FY26 Q1
<b>Ensure individuals served at NLCMHA receive quality services to meet their unique needs. (5 Measures)</b>			
Percent of consumers at NLCMHA readmitted to psychiatric inpatient services within 90 days	23%	<20%	20%
Percent of consumers who were diverted from psychiatric inpatient admission	46%	>30%	51%
Number of substantiated Recipient Rights’ Complaints.	37	<5	42
Number of Upheld Appeals	9	<5	7
Number of Upheld Grievances	6	<5	6
<b>Ensure individuals and families receive quality services to meet their unique needs, resulting in access to the right services, at the right time, in the right amount. (6 Measures)</b>			
Percent of adults newly enrolled in Mental Health services who had their first clinical service within 14 days of enrollment	71%	>80%	69%

Percent of children newly enrolled in Mental Health services who had their first clinical service within 14 days of enrollment	63%	>80%	59%
Percent of adults newly enrolled in Substance Abuse services who had their first clinical service within 14 days of enrollment	N/A	>80%	N/A
Percent of adults newly enrolled in developmental disability services who had their first clinical service within 14 days of enrollment	92%	>80%	40%
Percent of children newly enrolled in developmental disability services who had their first clinical service within 14 days of enrollment	71%	>80%	75%
Percent of Substance Use Disorder (SUD) clients successfully discharged who re-entered services within 90 days	N/A	<25%	N/A
<b>Build and support a community that promotes recovery and resilience to help individuals and families thrive. (2 Measures)</b>			
Number of certified peers employed during the quarter	10	>8	10
Percent of consumers surveyed in the Behavioral Health Satisfaction Survey who were satisfied with the person-centered planning process (This is done annually).	100%	>85%	100%
<b>Strengthen community partnerships to better integrate and coordinate services towards a sustained shared vision of excellence (1 Measure)</b>			
Percent of consumers who were discharged from a psychiatric hospital and had a follow-up service within 30 days	98%	>90%	90%

## Workload Measures

Measure	FY25 Q4	Target	FY26 Q1
<b>Peer Specialists and Recovery Coaches (2 Measures)</b>			
Number of <u>new</u> Certified Peer Specialists to include those in specialty tracks of family and youth	0	>2	0
Number of people trained in Recovery Coaching	1	>5	1
<b>Communication (2 Measures)</b>			
Number of public outreach events per quarter	13	>3	13
Number of hits to the NLCMHA website	49,000	>100	
<b>Outreach Services (1 Measure)</b>			
Number of interventions from Crisis Response Team	4	>24	12
<b>Operational/Legal Matters (2 Measures)</b>			
Staff turnover per quarter	16%	<10%	5%
Claims filed with Michigan Municipal Risk Management Authority	1	<3	2

FY2025-26 Service Information For Grand Traverse County (Code Rate Increase in July)														
Area of Service	December	January	February	March	April	May	June	July	August	September	October	November	December	January
Additional Supports (Homebased, Respite, Residential, Clubhouse and Nursing)	\$ 126,785.58	\$ 177,081.10	\$ 147,689.74	\$ 173,738.79	\$ 181,862.82	\$ 177,136.48	\$ 177,594.55	\$ 216,750.07	\$ 200,635.95	\$ 186,350.89	\$ 178,284.14	\$ 162,246.91	\$ 160,577.79	\$ 135,469.44
Autism Services	\$ 147,770.67	\$ 176,268.96	\$ 136,598.30	\$ 159,651.04	\$ 171,791.76	\$ 156,045.92	\$ 136,468.59	\$ 159,465.35	\$ 125,735.44	\$ 118,267.85	\$ 134,866.94	\$ 114,380.28	\$ 115,394.45	\$ 120,364.86
Case Management, ACT and Treatment Planning	\$ 185,160.99	\$ 245,460.81	\$ 231,700.72	\$ 244,653.27	\$ 274,550.16	\$ 262,931.78	\$ 253,698.00	\$ 376,252.02	\$ 329,497.70	\$ 344,518.26	\$ 326,306.38	\$ 261,843.77	\$ 251,175.29	\$ 268,128.76
Community Living Supports	\$ 1,294,191.10	\$ 1,389,204.91	\$ 1,231,167.88	\$ 1,443,864.21	\$ 1,383,753.24	\$ 1,407,510.64	\$ 1,424,617.70	\$ 1,544,727.65	\$ 1,573,568.45	\$ 1,518,767.81	\$ 1,528,863.44	\$ 1,429,395.62	\$ 1,516,592.57	\$ 1,527,895.25
Crisis Services, Assessments and Testing Evaluation and Management Physician Level	\$ 98,925.90	\$ 147,945.26	\$ 116,378.24	\$ 139,544.38	\$ 145,407.60	\$ 133,419.96	\$ 125,548.83	\$ 270,512.15	\$ 290,430.71	\$ 295,795.13	\$ 247,984.64	\$ 258,341.21	\$ 248,789.01	\$ 263,724.39
Psychiatric Inpatient	\$ 86,819.15	\$ 103,471.05	\$ 97,989.60	\$ 98,212.30	\$ 108,139.89	\$ 101,973.36	\$ 102,791.39	\$ 111,330.42	\$ 95,528.57	\$ 105,432.89	\$ 134,427.63	\$ 95,644.08	\$ 104,526.67	\$ 106,268.56
Psychiatric Inpatient	\$ 149,221.39	\$ 255,878.70	\$ 196,960.59	\$ 199,966.39	\$ 249,802.10	\$ 208,626.58	\$ 311,454.68	\$ 186,660.79	\$ 325,130.63	\$ 217,753.67	\$ 394,961.83	\$ 323,743.69	\$ 135,395.85	\$ 174,037.53
Psychotherapy and Outpatient Services Vocational & Skills Building, Family and Health Services	\$ 107,930.28	\$ 141,587.14	\$ 137,597.40	\$ 145,770.38	\$ 142,824.10	\$ 139,516.97	\$ 139,392.39	\$ 419,746.33	\$ 378,225.10	\$ 391,817.06	\$ 501,395.84	\$ 367,191.19	\$ 335,646.64	\$ 370,817.43
Other	\$ 50,039.84	\$ 69,722.09	\$ 62,145.45	\$ 62,337.76	\$ 61,805.93	\$ 65,776.45	\$ 66,087.42	\$ 70,301.82	\$ 54,964.54	\$ 54,583.20	\$ 63,346.79	\$ 51,530.61	\$ 49,554.48	\$ 53,603.94
Total	\$ 8,669.05	\$ 9,058.44	\$ 10,290.00	\$ 9,059.76	\$ 15,047.40	\$ 12,614.06	\$ 12,047.49	\$ 13,682.34	\$ 10,790.30	\$ 10,983.28	\$ 8,097.30	\$ 5,359.83	\$ 6,013.98	\$ 7,300.80
Total	\$ 2,255,513.95	\$ 2,715,678.46	\$ 2,368,517.92	\$ 2,676,798.28	\$ 2,734,985.00	\$ 2,665,552.20	\$ 2,749,701.04	\$ 3,369,428.94	\$ 3,384,507.39	\$ 3,244,270.04	\$ 3,518,534.93	\$ 3,069,677.19	\$ 2,923,666.73	\$ 3,027,610.96
Number of Registered People Receiving Services	900	1,002	962	993	1,029	1,032	1,033	1,056	1,034	1,043	1,029	985	989	977
Average Cost per Registered Person Served	\$ 2,506.13	\$ 2,710.26	\$ 2,462.08	\$ 2,695.67	\$ 2,657.91	\$ 2,582.90	\$ 2,661.86	\$ 3,190.75	\$ 3,273.22	\$ 3,110.52	\$ 3,419.37	\$ 3,116.42	\$ 2,956.18	\$ 3,098.89
Service Transactions Provided	100,059	110,942	98,795	110,558	105,956	106,123	105,811	112,692	108,072	102,321	107,198	90,738	93,775	91,561
Average Cost per Transaction	\$ 23	\$ 24	\$ 24	\$ 24	\$ 26	\$ 25	\$ 26	\$ 30	\$ 31	\$ 32	\$ 33	\$ 34	\$ 31	\$ 33
Count of Adult IDD	261	278	268	274	283	283	281	278	274	272	269	266	262	266
Count of Child IDD	64	63	73	73	70	81	81	72	79	75	75	72	75	76
Count of Adult SMI	477	545	505	532	546	536	548	588	559	574	553	522	523	516
Count of Child SED	98	116	116	114	130	132	123	118	122	122	132	125	129	119
Total	900	1,002	962	993	1,029	1,032	1,033	1,056	1,034	1,043	1,029	985	989	977
IDD Adult Cost	\$ 1,130,089.00	\$ 1,247,780.39	\$ 1,098,995.75	\$ 1,270,108.54	\$ 1,216,163.83	\$ 1,248,704.14	\$ 1,276,832.58	\$ 1,451,973.84	\$ 1,478,956.02	\$ 1,413,908.22	\$ 1,468,703.44	\$ 1,338,945.46	\$ 1,368,472.45	\$ 1,390,101.31
IDD Child Cost	\$ 237,981.82	\$ 269,449.84	\$ 233,087.91	\$ 268,308.04	\$ 283,484.99	\$ 277,586.11	\$ 254,877.25	\$ 297,337.54	\$ 263,033.11	\$ 253,185.67	\$ 304,466.42	\$ 238,965.09	\$ 240,255.42	\$ 231,974.28
Adult SMI Cost	\$ 749,726.02	\$ 1,018,856.83	\$ 885,593.07	\$ 980,362.59	\$ 1,033,664.37	\$ 955,234.87	\$ 1,030,654.90	\$ 1,382,183.76	\$ 1,432,424.08	\$ 1,329,098.96	\$ 1,433,232.02	\$ 1,276,707.30	\$ 1,131,834.28	\$ 1,219,355.07
Child SED Cost	\$ 137,717.11	\$ 179,591.40	\$ 150,841.19	\$ 158,019.11	\$ 201,671.81	\$ 184,027.08	\$ 187,336.31	\$ 237,933.80	\$ 210,094.18	\$ 248,077.19	\$ 312,133.05	\$ 215,059.34	\$ 183,104.58	\$ 186,180.30
Total	\$ 2,255,513.95	\$ 2,715,678.46	\$ 2,368,517.92	\$ 2,676,798.28	\$ 2,734,985.00	\$ 2,665,552.20	\$ 2,749,701.04	\$ 3,369,428.94	\$ 3,384,507.39	\$ 3,244,270.04	\$ 3,518,534.93	\$ 3,069,677.19	\$ 2,923,666.73	\$ 3,027,610.96
Adult IDD Cost per consumer	\$ 4,329.84	\$ 4,488.42	\$ 4,100.73	\$ 4,635.43	\$ 4,297.40	\$ 4,412.38	\$ 4,543.89	\$ 5,222.93	\$ 5,397.65	\$ 5,198.19	\$ 5,459.86	\$ 5,033.63	\$ 5,223.18	\$ 5,225.94
Child IDD Cost per consumer	\$ 3,718.47	\$ 4,276.98	\$ 3,192.99	\$ 3,675.45	\$ 4,049.79	\$ 3,426.99	\$ 3,146.63	\$ 4,129.69	\$ 3,329.53	\$ 3,375.81	\$ 4,059.55	\$ 3,318.96	\$ 3,203.41	\$ 3,052.29
Adult SMI Cost per consumer	\$ 1,571.75	\$ 1,869.46	\$ 1,753.65	\$ 1,842.79	\$ 1,893.16	\$ 1,782.15	\$ 1,880.76	\$ 2,350.65	\$ 2,562.48	\$ 2,315.50	\$ 2,591.74	\$ 2,445.80	\$ 2,164.12	\$ 2,363.09
Child SED Cost per consumer	\$ 1,405.28	\$ 1,548.20	\$ 1,300.36	\$ 1,386.13	\$ 1,551.32	\$ 1,394.14	\$ 1,523.06	\$ 2,016.39	\$ 1,722.08	\$ 2,033.42	\$ 2,364.64	\$ 1,720.47	\$ 1,419.42	\$ 1,564.54
Total	\$ 2,506.13	\$ 2,710.26	\$ 2,462.08	\$ 2,695.67	\$ 2,657.91	\$ 2,582.90	\$ 2,661.86	\$ 3,190.75	\$ 3,273.22	\$ 3,110.52	\$ 3,419.37	\$ 3,116.42	\$ 2,956.18	\$ 3,098.89

FY 2025-26 Monthly Service Information for Crawford County (Code Rate Increase in July)														
Area of Service	December	January	February	March	April	May	June	July	August	September	October	November	December	January
Additional Supports (Homebased, Respite, Residential, Clubhouse and Nursing	\$ 22,476.40	\$ 27,812.05	\$ 22,631.85	\$ 29,706.13	\$ 38,540.06	\$ 34,495.29	\$ 36,825.47	\$ 32,672.42	\$ 32,069.61	\$ 31,974.25	\$ 35,309.39	\$ 45,553.34	\$ 40,977.40	\$ 38,336.90
Autism Services	\$ 25,683.47	\$ 24,501.77	\$ 23,010.98	\$ 22,365.20	\$ 18,789.53	\$ 22,589.52	\$ 31,709.31	\$ 32,717.49	\$ 32,626.68	\$ 38,488.53	\$ 49,231.79	\$ 41,711.69	\$ 49,149.97	\$ 53,253.82
Case Management, ACT and Treatment Planning	\$ 36,930.14	\$ 49,588.52	\$ 37,787.76	\$ 51,818.93	\$ 48,725.63	\$ 53,970.75	\$ 48,496.89	\$ 82,890.23	\$ 64,357.31	\$ 82,073.47	\$ 81,013.78	\$ 76,060.28	\$ 83,980.59	\$ 85,529.34
Community Living Supports	\$ 337,538.57	\$ 368,818.78	\$ 348,682.87	\$ 371,896.84	\$ 347,576.59	\$ 363,828.86	\$ 385,163.52	\$ 403,890.40	\$ 409,582.27	\$ 404,295.46	\$ 418,989.27	\$ 393,063.94	\$ 357,157.54	\$ 346,574.78
Crisis Services, Assessments and Testing	\$ 14,790.00	\$ 20,016.20	\$ 11,570.00	\$ 23,479.00	\$ 17,271.00	\$ 16,813.26	\$ 12,991.00	\$ 14,995.42	\$ 32,917.80	\$ 25,110.63	\$ 21,809.82	\$ 23,831.07	\$ 27,399.76	\$ 28,973.87
Evaluation and Management	\$ 19,997.36	\$ 23,814.39	\$ 23,696.47	\$ 24,647.61	\$ 23,031.94	\$ 29,199.89	\$ 22,858.46	\$ 23,961.25	\$ 29,048.23	\$ 30,283.86	\$ 32,053.78	\$ 24,768.07	\$ 30,076.95	\$ 18,550.71
Physician Level	\$ 70,589.82	\$ 65,509.37	\$ 10,989.11	\$ 36,020.66	\$ 45,094.47	\$ 10,119.58	\$ -	\$ -	\$ 46,768.07	\$ 46,921.31	\$ 47,481.00	\$ -	\$ 48,327.10	\$ 58,635.25
Psychotherapy and Outpatient Services	\$ 14,905.36	\$ 22,065.54	\$ 21,946.72	\$ 19,428.00	\$ 25,769.74	\$ 24,150.26	\$ 21,149.38	\$ 37,229.06	\$ 22,808.28	\$ 24,506.74	\$ 56,080.58	\$ 52,831.18	\$ 62,429.98	\$ 57,725.10
Vocational & Skills Building, Family and Health	\$ 1,972.52	\$ 4,221.29	\$ 3,657.02	\$ 2,813.52	\$ 3,175.25	\$ 2,969.09	\$ 3,134.31	\$ 1,771.81	\$ 1,131.92	\$ 3,824.77	\$ 5,035.01	\$ 3,416.32	\$ 2,295.02	\$ 3,070.21
Other	\$ 936.00	\$ 624.00	\$ 936.00	\$ 1,404.00	\$ 2,184.00	\$ 2,964.00	\$ 2,028.00	\$ 3,075.48	\$ 2,477.47	\$ 341.72	\$ 683.44	\$ 341.72	\$ 341.72	\$ 341.72
Total	\$ 545,819.64	\$ 606,971.91	\$ 504,908.78	\$ 583,579.89	\$ 570,158.21	\$ 561,100.50	\$ 564,356.34	\$ 633,203.56	\$ 673,787.64	\$ 687,820.74	\$ 747,687.86	\$ 661,577.61	\$ 702,136.03	\$ 690,991.70
Number of Registered People Receiving Services	178	183	178	192	196	196	177	182	190	186	191	189	198	188
Average Cost per Registered Person Served	\$ 3,066.40	\$ 3,316.79	\$ 2,836.57	\$ 3,039.48	\$ 2,908.97	\$ 2,862.76	\$ 3,188.45	\$ 3,479.14	\$ 3,546.25	\$ 3,697.96	\$ 3,914.60	\$ 3,500.41	\$ 3,546.14	\$ 3,675.49
Service Transactions Provided	23,657	26,229	22,947	25,173	24,362	25,771	25,141	26,791	27,400	29,600	32,004	26,162	15,273	13,728
Average Cost per Transaction	\$ 23	\$ 23	\$ 22	\$ 23	\$ 23	\$ 22	\$ 22	\$ 24	\$ 25	\$ 23	\$ 23	\$ 25	\$ 46	\$ 50
Count of Adult IDD	42	41	40	39	38	39	38	36	39	37	38	38	37	37
Count of Child IDD	10	11	12	11	16	9	9	12	15	10	13	14	15	17
Count of Adult SMI	102	107	99	115	113	120	103	108	107	105	109	101	111	105
Count of Child SED	24	24	27	27	29	28	27	26	29	34	31	36	35	29
Total	178	183	178	192	196	196	177	182	190	186	191	189	198	188
IDD Adult Cost	\$ 256,121.10	\$ 279,945.85	\$ 260,749.39	\$ 268,822.36	\$ 255,580.46	\$ 268,125.88	\$ 258,145.20	\$ 262,247.55	\$ 279,762.98	\$ 277,143.46	\$ 296,044.90	\$ 265,617.00	\$ 214,292.04	\$ 214,351.57
IDD Child Cost	\$ 63,791.69	\$ 70,269.21	\$ 62,269.04	\$ 62,921.90	\$ 62,682.83	\$ 63,765.48	\$ 70,271.65	\$ 78,797.24	\$ 86,888.08	\$ 78,715.16	\$ 92,521.05	\$ 96,728.16	\$ 127,464.02	\$ 149,444.58
Adult SMI Cost	\$ 194,471.85	\$ 224,122.85	\$ 156,409.35	\$ 217,048.63	\$ 213,953.92	\$ 190,746.14	\$ 197,268.49	\$ 251,906.52	\$ 274,408.56	\$ 274,767.69	\$ 309,355.73	\$ 241,323.59	\$ 279,223.03	\$ 267,091.00
Child SED Cost	\$ 31,435.00	\$ 32,634.00	\$ 25,481.00	\$ 34,787.00	\$ 37,941.00	\$ 38,463.00	\$ 38,671.00	\$ 40,252.25	\$ 32,728.02	\$ 57,194.43	\$ 49,766.18	\$ 57,908.86	\$ 81,156.94	\$ 60,104.55
Total	\$ 545,819.64	\$ 606,971.91	\$ 504,908.78	\$ 583,579.89	\$ 570,158.21	\$ 561,100.50	\$ 564,356.34	\$ 633,203.56	\$ 673,787.64	\$ 687,820.74	\$ 747,687.86	\$ 661,577.61	\$ 702,136.03	\$ 690,991.70
Adult IDD Cost per consumer	\$ 6,098.12	\$ 6,827.95	\$ 6,518.73	\$ 6,892.88	\$ 6,725.80	\$ 6,875.02	\$ 6,793.29	\$ 7,284.65	\$ 7,173.41	\$ 7,490.36	\$ 7,790.66	\$ 6,989.92	\$ 5,791.68	\$ 5,793.29
Child IDD Cost per consumer	\$ 6,379.17	\$ 6,388.11	\$ 5,189.09	\$ 5,720.17	\$ 3,917.68	\$ 7,085.05	\$ 7,807.96	\$ 6,566.44	\$ 5,792.54	\$ 7,871.52	\$ 7,117.00	\$ 6,909.15	\$ 8,497.60	\$ 8,790.86
Adult SMI Cost per consumer	\$ 1,906.59	\$ 2,094.61	\$ 1,579.89	\$ 1,887.38	\$ 1,893.40	\$ 1,589.55	\$ 1,915.23	\$ 2,332.47	\$ 2,564.57	\$ 2,616.84	\$ 2,838.13	\$ 2,389.34	\$ 2,515.52	\$ 2,543.72
Child SED Cost per consumer	\$ 1,309.79	\$ 1,359.75	\$ 943.74	\$ 1,288.41	\$ 1,308.31	\$ 1,373.68	\$ 1,432.26	\$ 1,548.16	\$ 1,128.55	\$ 1,682.19	\$ 1,605.36	\$ 1,608.58	\$ 2,318.77	\$ 2,072.57
Total	\$ 3,066.40	\$ 3,316.79	\$ 2,836.57	\$ 3,039.48	\$ 2,908.97	\$ 2,862.76	\$ 3,188.45	\$ 3,479.14	\$ 3,546.25	\$ 3,697.96	\$ 3,914.60	\$ 3,500.41	\$ 3,546.14	\$ 3,675.49

FY2025-26 Service Information For Lclanau County (Code Rate Increase in July)														
Area of Service	December	January	February	March	April	May	June	July	August	September	October	November	December	January
Additional Supports (Homebased, Respite, Residential, Clubhouse and Nursing	\$ 11,046.73	\$ 18,001.76	\$ 16,987.41	\$ 20,175.20	\$ 22,586.82	\$ 16,791.13	\$ 17,833.58	\$ 16,860.43	\$ 19,526.78	\$ 19,708.18	\$ 17,408.05	\$ 15,164.17	\$ 11,545.29	\$ 14,251.37
Autism Services	\$ 5,959.00	\$ 8,554.75	\$ 9,542.50	\$ 11,539.79	\$ 11,346.00	\$ 12,270.00	\$ 12,541.75	\$ 10,417.83	\$ 11,376.52	\$ 4,094.75	\$ 3,536.52	\$ 1,888.68	\$ 3,040.75	\$ 2,457.75
Case Management, ACT and Treatment Planning	\$ 18,732.00	\$ 17,367.68	\$ 18,915.95	\$ 19,465.47	\$ 21,277.29	\$ 17,536.22	\$ 13,926.29	\$ 28,619.07	\$ 20,851.17	\$ 24,365.35	\$ 26,830.86	\$ 26,061.30	\$ 17,683.04	\$ 25,235.44
Community Living Supports	\$ 158,902.24	\$ 169,351.80	\$ 147,824.12	\$ 170,850.34	\$ 157,247.67	\$ 166,165.43	\$ 154,113.50	\$ 172,963.93	\$ 174,097.57	\$ 168,504.87	\$ 183,401.06	\$ 162,978.64	\$ 161,054.98	\$ 169,724.86
Crisis Services, Assessments and Testing	\$ 5,373.00	\$ 4,163.00	\$ 6,796.00	\$ 7,101.00	\$ 13,102.00	\$ 12,107.00	\$ 6,619.00	\$ 9,975.56	\$ 11,091.27	\$ 9,412.05	\$ 15,987.50	\$ 9,744.15	\$ 13,052.38	\$ 7,792.20
Evaluation and Management Physician Level	\$ 5,922.14	\$ 6,871.14	\$ 7,691.52	\$ 6,993.34	\$ 10,908.31	\$ 8,690.91	\$ 5,441.79	\$ 8,869.98	\$ 10,423.80	\$ 7,612.49	\$ 5,826.08	\$ 11,360.33	\$ 6,797.58	\$ 6,638.76
Psychiatric Inpatient	\$ 14,110.32	\$ 11,519.66	\$ 20,903.28	\$ -	\$ 5,152.58	\$ 23,749.46	\$ 24,693.06	\$ 12,410.58	\$ 25,349.00	\$ 9,750.84	\$ 23,870.00	\$ 6,683.70	\$ -	\$ 6,408.00
Psychotherapy and Outpatient Services	\$ 9,301.18	\$ 10,099.18	\$ 9,606.28	\$ 8,070.56	\$ 12,865.23	\$ 9,766.38	\$ 17,775.39	\$ 38,004.86	\$ 27,084.03	\$ 21,937.78	\$ 26,984.48	\$ 7,719.26	\$ 15,592.95	\$ 18,552.84
Vocational & Skills Building, Family and Health Services	\$ 4,915.89	\$ 9,023.47	\$ 8,364.57	\$ 7,984.43	\$ 7,151.92	\$ 8,843.68	\$ 8,013.49	\$ 7,878.60	\$ 6,144.28	\$ 5,759.04	\$ 6,807.15	\$ 5,856.57	\$ 3,884.66	\$ 3,425.81
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 512.58	\$ 512.58	\$ 512.58	\$ 512.58	\$ -	\$ 512.58
Total	\$ 234,262.50	\$ 254,952.44	\$ 246,631.63	\$ 252,180.13	\$ 261,637.82	\$ 275,920.21	\$ 260,957.85	\$ 306,000.84	\$ 306,457.00	\$ 271,657.93	\$ 311,164.28	\$ 247,969.38	\$ 232,651.63	\$ 254,999.61
Number of Registered People Receiving Services	93	88	91	94	98	95	82	99	91	92	81	93	84	84
Average Cost per Registered Person Served	\$ 2,518.95	\$ 2,897.19	\$ 2,710.24	\$ 2,682.77	\$ 2,669.77	\$ 2,904.42	\$ 3,182.41	\$ 3,090.92	\$ 3,367.66	\$ 2,952.80	\$ 3,841.53	\$ 2,666.34	\$ 2,769.66	\$ 3,035.71
Service Transactions Provided	10,449	12,112	11,542	12,518	12,312	11,625	11,780	11,982	11,964	10,685	12,001	9,804	9,760	9,646
Average Cost per Transaction	\$ 22	\$ 21	\$ 21	\$ 20	\$ 21	\$ 24	\$ 22	\$ 26	\$ 26	\$ 25	\$ 26	\$ 25	\$ 24	\$ 26
Count of Adult IDD	37	38	37	39	40	40	40	39	35	36	38	38	39	40
Count of Child IDD	4	4	4	5	4	3	4	5	3	3	3	4	3	3
Count of Adult SMI	42	37	41	41	45	41	30	43	43	45	32	37	33	33
Count of Child SED	10	9	9	9	9	11	8	12	10	8	8	14	9	8
Total	93	88	91	94	98	95	82	99	91	92	81	93	84	84
IDD Adult Cost	\$ 167,462.58	\$ 182,693.91	\$ 163,462.65	\$ 187,418.07	\$ 175,822.97	\$ 185,233.01	\$ 171,868.46	\$ 190,330.72	\$ 195,214.00	\$ 183,603.55	\$ 210,785.31	\$ 183,843.58	\$ 178,984.27	\$ 188,445.75
IDD Child Cost	\$ 7,363.00	\$ 9,989.56	\$ 11,646.50	\$ 15,500.79	\$ 15,098.00	\$ 13,996.60	\$ 13,247.75	\$ 13,914.87	\$ 13,132.36	\$ 6,554.43	\$ 8,041.82	\$ 5,786.54	\$ 5,013.24	\$ 4,596.56
Adult SMI Cost	\$ 49,150.74	\$ 38,863.89	\$ 58,963.48	\$ 37,068.27	\$ 55,035.85	\$ 53,548.20	\$ 66,196.96	\$ 82,383.06	\$ 84,998.72	\$ 67,355.48	\$ 77,800.28	\$ 38,096.25	\$ 38,649.72	\$ 54,465.65
Child SED Cost	\$ 10,286.18	\$ 23,405.08	\$ 12,559.00	\$ 12,193.00	\$ 15,681.00	\$ 23,143.00	\$ 9,644.68	\$ 19,372.19	\$ 13,111.92	\$ 14,144.47	\$ 14,536.87	\$ 20,243.01	\$ 10,004.40	\$ 7,491.65
Total	\$ 234,262.50	\$ 254,952.44	\$ 246,631.63	\$ 252,180.13	\$ 261,637.82	\$ 275,920.21	\$ 260,957.85	\$ 306,000.84	\$ 306,457.00	\$ 271,657.93	\$ 311,164.28	\$ 247,969.38	\$ 232,651.63	\$ 254,999.61
Adult IDD Cost per consumer	\$ 4,526.02	\$ 4,807.73	\$ 4,417.91	\$ 4,805.59	\$ 4,395.57	\$ 4,630.83	\$ 4,296.71	\$ 4,880.27	\$ 5,577.54	\$ 5,100.10	\$ 5,546.98	\$ 4,837.99	\$ 4,589.34	\$ 4,711.14
Child IDD Cost per consumer	\$ 1,840.75	\$ 2,497.39	\$ 2,911.63	\$ 3,100.16	\$ 3,774.50	\$ 4,665.33	\$ 3,311.94	\$ 2,782.97	\$ 4,377.45	\$ 2,184.81	\$ 2,680.61	\$ 1,446.64	\$ 1,671.08	\$ 1,532.19
Adult SMI Cost per consumer	\$ 1,170.26	\$ 1,050.38	\$ 1,438.13	\$ 904.10	\$ 1,223.02	\$ 1,306.05	\$ 2,206.57	\$ 1,915.89	\$ 1,976.71	\$ 1,496.79	\$ 2,431.26	\$ 1,029.63	\$ 1,171.20	\$ 1,650.47
Child SED Cost per consumer	\$ 1,028.62	\$ 2,600.56	\$ 1,395.44	\$ 1,354.78	\$ 1,742.33	\$ 2,103.91	\$ 1,205.59	\$ 1,614.35	\$ 1,311.19	\$ 1,768.06	\$ 1,817.11	\$ 1,445.93	\$ 1,111.60	\$ 936.46
Total	\$ 2,518.95	\$ 2,897.19	\$ 2,710.24	\$ 2,682.77	\$ 2,669.77	\$ 2,904.42	\$ 3,182.41	\$ 3,090.92	\$ 3,367.66	\$ 2,952.80	\$ 3,841.53	\$ 2,666.34	\$ 2,769.66	\$ 2,297.29

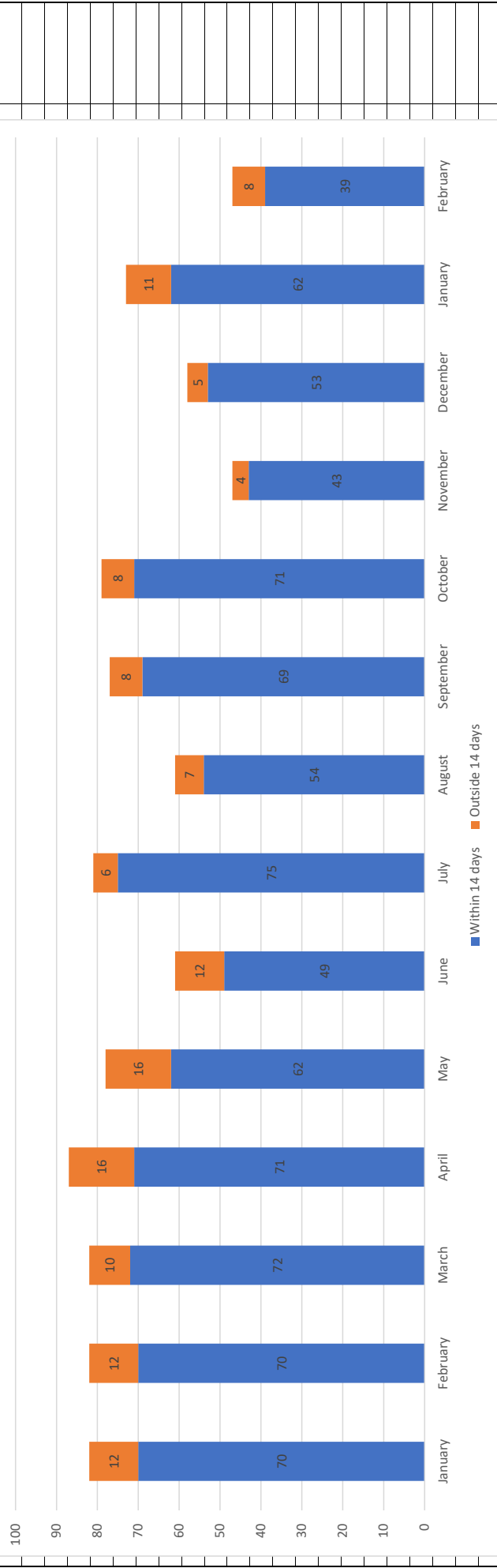
FY 2025-26 Service Information For Missaukee County (Code Rate Increase in July)														
Area of Service	FY 2025-26 Service Information For Missaukee County (Code Rate Increase in July)													
	December	January	February	March	April	May	June	July	August	September	October	November	December	January
Additional Supports (Homebased, Respite, Residential, Clubhouse and Nursing)	\$ 18,217.61	\$ 26,085.43	\$ 20,931.92	\$ 29,330.26	\$ 31,041.85	\$ 28,561.86	\$ 29,668.21	\$ 26,355.37	\$ 21,097.16	\$ 21,243.15	\$ 19,380.91	\$ 17,522.83	\$ 22,501.76	\$ 15,822.83
Autism Services	\$ 11,111.75	\$ 22,011.50	\$ 22,744.01	\$ 25,534.96	\$ 21,866.49	\$ 26,064.85	\$ 24,741.25	\$ 25,715.83	\$ 23,286.75	\$ 17,008.50	\$ 19,894.05	\$ 17,018.99	\$ 18,138.74	\$ 21,537.21
Case Management, ACT and Treatment Planning	\$ 21,207.03	\$ 22,186.02	\$ 22,587.14	\$ 26,554.30	\$ 28,351.06	\$ 35,378.38	\$ 37,522.93	\$ 56,257.10	\$ 46,928.24	\$ 45,675.92	\$ 72,280.32	\$ 44,164.30	\$ 41,893.33	\$ 43,765.62
Community Living Supports	\$ 409,528.67	\$ 419,866.47	\$ 379,893.96	\$ 413,987.92	\$ 398,937.56	\$ 406,726.17	\$ 401,249.01	\$ 424,520.29	\$ 431,670.70	\$ 396,357.68	\$ 397,575.98	\$ 334,627.10	\$ 364,290.86	\$ 360,894.78
Crisis Services, Assessments and Testing	\$ 14,725.20	\$ 3,775.00	\$ 11,591.75	\$ 11,324.00	\$ 17,768.48	\$ 9,162.00	\$ 9,611.00	\$ 19,568.88	\$ 15,520.82	\$ 17,139.05	\$ 20,802.21	\$ 10,197.17	\$ 11,550.24	\$ 14,175.75
Evaluation and Management Physician Level	\$ 12,509.81	\$ 13,759.94	\$ 15,394.15	\$ 15,214.85	\$ 15,121.82	\$ 16,726.84	\$ 15,889.81	\$ 17,964.87	\$ 15,461.21	\$ 16,240.56	\$ 21,370.56	\$ 16,513.67	\$ 11,767.68	\$ 13,133.59
Psychiatric Inpatient	\$ 23,110.32	\$ 13,745.35	\$ -	\$ 43,163.77	\$ 144,062.39	\$ 8,883.00	\$ 24,773.20	\$ 51,991.44	\$ 34,796.38	\$ -	\$ 17,613.20	\$ 34,375.75	\$ 69,384.21	\$ -
Psychotherapy and Outpatient Services	\$ 10,984.28	\$ 16,721.21	\$ 12,109.38	\$ 14,106.00	\$ 15,770.12	\$ 29,036.83	\$ 22,426.12	\$ 43,867.66	\$ 40,103.32	\$ 36,586.82	\$ 56,939.42	\$ 29,043.96	\$ 37,176.66	\$ 45,405.54
Vocational & Skills Building, Family and Health Services	\$ 13,025.94	\$ 17,938.48	\$ 14,058.04	\$ 14,698.25	\$ 11,347.05	\$ 10,083.63	\$ 13,224.57	\$ 11,955.49	\$ 8,782.23	\$ 10,717.40	\$ 10,497.58	\$ 10,582.45	\$ 9,081.15	\$ 13,580.97
Other	\$ 1,950.00	\$ 2,853.11	\$ 1,985.64	\$ 825.11	\$ 2,229.11	\$ 2,003.14	\$ 4,008.88	\$ 1,560.51	\$ 1,508.53	\$ 2,029.78	\$ 1,822.24	\$ 626.22	\$ 113.64	\$ 1,403.16
Total	\$ 536,370.61	\$ 558,942.51	\$ 501,295.99	\$ 594,739.42	\$ 686,495.93	\$ 572,626.70	\$ 583,114.98	\$ 679,757.44	\$ 639,155.34	\$ 562,998.86	\$ 638,176.47	\$ 514,672.44	\$ 585,898.27	\$ 529,719.45
Number of Registered People Receiving Services	125	116	127	134	132	138	132	139	134	135	148	131	127	124
Average Cost per Registered Person Served	\$ 4,290.96	\$ 4,818.47	\$ 3,947.21	\$ 4,438.35	\$ 5,200.73	\$ 4,149.47	\$ 4,417.54	\$ 4,890.34	\$ 4,769.82	\$ 4,170.36	\$ 4,312.00	\$ 3,928.80	\$ 4,613.37	\$ 4,271.93
Service Transactions Provided	24,026	25,961	23,991	28,082	20,880	20,524	18,031	17,663	16,816	16,175	17,165	14,278	14,619	14,754
Average Cost per Transaction	\$ 22	\$ 22	\$ 21	\$ 21	\$ 33	\$ 28	\$ 32	\$ 38	\$ 38	\$ 35	\$ 37	\$ 36	\$ 40	\$ 36
Count of Adult IDD	43	43	45	46	44	44	43	43	43	43	44	42	42	41
Count of Child IDD	10	10	10	9	11	14	9	8	8	8	10	9	9	8
Count of Adult SMI	60	47	54	60	53	55	54	64	59	57	64	56	53	49
Count of Child SED	12	16	18	19	24	25	26	24	24	27	30	24	23	26
Total	125	116	127	134	132	138	132	139	134	135	148	131	127	124
IDD Adult Cost	\$ 368,587.39	\$ 379,324.87	\$ 344,310.42	\$ 384,882.38	\$ 372,920.09	\$ 375,271.13	\$ 387,043.66	\$ 399,626.99	\$ 385,407.77	\$ 386,534.37	\$ 412,726.58	\$ 338,791.42	\$ 362,914.87	\$ 374,708.06
IDD Child Cost	\$ 18,977.49	\$ 29,375.50	\$ 28,678.58	\$ 32,768.16	\$ 62,507.67	\$ 35,173.34	\$ 32,204.21	\$ 34,685.59	\$ 32,373.10	\$ 21,871.35	\$ 31,974.21	\$ 24,700.67	\$ 29,804.41	\$ 28,557.48
Adult SMI Cost	\$ 135,386.73	\$ 128,903.14	\$ 105,259.99	\$ 147,751.63	\$ 198,101.42	\$ 125,136.23	\$ 129,232.11	\$ 205,136.19	\$ 169,892.63	\$ 111,818.40	\$ 121,146.76	\$ 110,655.63	\$ 148,631.22	\$ 90,091.36
Child SED Cost	\$ 13,419.00	\$ 21,339.00	\$ 23,047.00	\$ 29,337.25	\$ 52,966.75	\$ 37,046.00	\$ 34,635.00	\$ 40,308.67	\$ 51,481.84	\$ 42,774.74	\$ 72,328.92	\$ 40,524.72	\$ 44,547.77	\$ 36,362.55
Total	\$ 536,370.61	\$ 558,942.51	\$ 501,295.99	\$ 594,739.42	\$ 686,495.93	\$ 572,626.70	\$ 583,114.98	\$ 679,757.44	\$ 639,155.34	\$ 562,998.86	\$ 638,176.47	\$ 514,672.44	\$ 585,898.27	\$ 529,719.45
Adult IDD Cost per consumer	\$ 8,571.80	\$ 8,821.51	\$ 7,651.34	\$ 8,367.01	\$ 8,475.46	\$ 8,528.89	\$ 9,001.02	\$ 9,293.65	\$ 8,962.97	\$ 8,989.17	\$ 9,380.15	\$ 8,066.46	\$ 8,640.83	\$ 9,139.22
Child IDD Cost per consumer	\$ 1,897.75	\$ 2,937.55	\$ 2,867.86	\$ 3,640.91	\$ 5,682.52	\$ 2,512.38	\$ 3,578.25	\$ 4,335.70	\$ 4,046.64	\$ 2,733.92	\$ 3,197.42	\$ 2,744.52	\$ 3,311.60	\$ 3,569.69
Adult SMI Cost per consumer	\$ 2,256.45	\$ 2,742.62	\$ 1,949.26	\$ 2,462.53	\$ 3,737.76	\$ 2,275.20	\$ 2,393.19	\$ 3,205.25	\$ 2,879.54	\$ 1,961.73	\$ 1,892.92	\$ 1,975.99	\$ 2,804.36	\$ 1,838.60
Child SED Cost per consumer	\$ 1,118.25	\$ 1,333.69	\$ 1,280.39	\$ 1,544.07	\$ 2,206.95	\$ 1,481.84	\$ 1,332.12	\$ 1,679.53	\$ 2,145.08	\$ 1,584.25	\$ 2,410.96	\$ 1,688.53	\$ 1,936.86	\$ 1,398.56
Total	\$ 4,290.96	\$ 4,818.47	\$ 3,947.21	\$ 4,438.35	\$ 5,200.73	\$ 4,149.47	\$ 4,417.54	\$ 4,890.34	\$ 4,769.82	\$ 4,170.36	\$ 4,312.00	\$ 3,928.80	\$ 4,613.37	\$ 4,271.93

FY2025-26 Service Information for Roscommon County (Code Rate Increase in July)														
Area of Service	December	January	February	March	April	May	June	July	August	September	October	November	December	January
Additional Supports (Homebased, Respite, Residential, Clubhouse and Nursing	\$ 42,613.50	\$ 56,659.37	\$ 28,657.81	\$ 44,518.45	\$ 43,223.74	\$ 44,602.38	\$ 40,698.72	\$ 48,280.04	\$ 39,152.35	\$ 42,768.49	\$ 46,961.47	\$ 41,565.10	\$ 40,832.05	\$ 30,009.13
Autism Services	\$ 23,061.13	\$ 25,491.84	\$ 29,722.65	\$ 35,190.67	\$ 35,670.82	\$ 33,342.10	\$ 35,943.20	\$ 46,559.96	\$ 48,767.66	\$ 53,966.29	\$ 55,368.02	\$ 41,088.49	\$ 42,872.51	\$ 52,766.81
Case Management, ACT and Treatment Planning	\$ 61,279.39	\$ 72,861.52	\$ 74,586.56	\$ 81,599.40	\$ 94,376.59	\$ 96,356.34	\$ 75,427.40	\$ 136,872.13	\$ 123,444.42	\$ 123,459.51	\$ 133,867.02	\$ 105,429.32	\$ 107,008.82	\$ 106,083.23
Community Living Supports	\$ 459,977.64	\$ 499,852.74	\$ 492,121.09	\$ 527,188.56	\$ 533,095.49	\$ 544,635.31	\$ 523,969.67	\$ 559,863.33	\$ 530,889.61	\$ 539,154.04	\$ 567,039.48	\$ 508,564.19	\$ 493,149.26	\$ 519,818.14
Crisis Services, Assessments and Testing	\$ 18,375.00	\$ 10,422.00	\$ 13,968.00	\$ 19,756.00	\$ 21,743.00	\$ 23,284.88	\$ 14,083.88	\$ 15,721.72	\$ 21,228.74	\$ 34,226.45	\$ 32,760.48	\$ 18,940.56	\$ 21,799.99	\$ 16,796.38
Evaluation and Management	\$ 33,695.83	\$ 43,166.32	\$ 39,987.99	\$ 36,325.39	\$ 38,422.54	\$ 37,955.34	\$ 34,229.26	\$ 41,983.53	\$ 42,653.83	\$ 37,213.60	\$ 39,653.72	\$ 36,106.78	\$ 27,924.41	\$ 36,870.27
Physician Level	\$ 39,337.28	\$ 89,034.43	\$ 50,135.14	\$ 32,466.02	\$ 12,797.79	\$ 58,830.58	\$ 33,818.21	\$ 82,488.67	\$ 8,021.00	\$ 49,620.88	\$ 93,966.73	\$ 33,794.17	\$ 63,756.36	\$ 32,596.01
Psychiatric Inpatient	\$ 51,423.72	\$ 66,627.40	\$ 66,158.08	\$ 56,801.30	\$ 55,347.14	\$ 69,298.49	\$ 55,631.74	\$ 98,355.00	\$ 97,790.02	\$ 90,769.84	\$ 112,883.24	\$ 102,341.54	\$ 93,278.12	\$ 105,739.00
Psychotherapy and Outpatient Services	\$ 7,278.28	\$ 12,130.10	\$ 10,863.10	\$ 7,546.30	\$ 12,096.05	\$ 12,400.88	\$ 11,543.51	\$ 11,463.40	\$ 10,031.60	\$ 14,914.82	\$ 16,236.75	\$ 10,553.68	\$ 8,203.42	\$ 9,493.26
Vocational & Skills Building, Family and Health Services	\$ 1,146.99	\$ 3,496.68	\$ 2,123.72	\$ 1,872.00	\$ 2,555.60	\$ 3,043.67	\$ 3,144.44	\$ 2,506.51	\$ 551.07	\$ 1,467.65	\$ 1,041.17	\$ 372.66	\$ 612.33	\$ 691.72
Other	\$ 738,188.76	\$ 879,742.40	\$ 808,324.14	\$ 843,264.09	\$ 849,328.76	\$ 923,749.97	\$ 828,490.03	\$ 1,044,094.29	\$ 922,530.30	\$ 987,561.57	\$ 1,098,841.08	\$ 898,756.49	\$ 899,437.27	\$ 910,863.95
Total	\$ 3,470,033.58	\$ 3,919,629.95	\$ 3,647,833.31	\$ 3,822,848.89	\$ 3,989,947.78	\$ 4,199,988.17	\$ 3,871,605.59	\$ 4,301,888.12	\$ 4,045,529.61	\$ 4,418,821.76	\$ 4,738,292.02	\$ 4,281,192.94	\$ 4,185,546.63	\$ 4,249,133.38
Number of Registered People Receiving Services	304	303	296	296	293	307	303	296	303	291	292	288	283	281
Average Cost per Registered Person Served	\$ 2,428.25	\$ 2,903.44	\$ 2,730.82	\$ 2,848.87	\$ 2,898.73	\$ 3,008.96	\$ 2,734.29	\$ 3,527.35	\$ 3,044.65	\$ 3,393.68	\$ 3,763.15	\$ 3,120.68	\$ 3,178.22	\$ 3,241.51
Service Transactions Provided	21,226	25,681	25,335	27,475	26,409	26,013	25,346	25,822	26,481	28,699	31,814	26,715	22,566	20,992
Average Cost per Transaction	\$ 35	\$ 34	\$ 32	\$ 31	\$ 32	\$ 36	\$ 33	\$ 40	\$ 35	\$ 34	\$ 35	\$ 34	\$ 40	\$ 43
Count of Adult IDD	67	61	62	61	63	62	65	64	63	65	67	68	71	68
Count of Child IDD	19	17	21	20	18	22	19	20	22	25	29	26	28	25
Count of Adult SMI	175	170	166	166	161	169	164	169	171	147	147	147	138	148
Count of Child SED	43	55	47	49	51	54	55	43	47	54	49	47	46	40
Total	304	303	296	296	293	307	303	296	303	291	292	288	283	281
IDD Adult Cost	\$ 347,003.58	\$ 391,962.95	\$ 364,783.31	\$ 382,284.89	\$ 398,947.78	\$ 419,988.17	\$ 387,160.59	\$ 430,188.12	\$ 404,529.61	\$ 441,821.76	\$ 473,829.02	\$ 428,192.94	\$ 418,546.63	\$ 424,913.38
IDD Child Cost	\$ 39,560.97	\$ 45,617.46	\$ 49,278.41	\$ 58,021.23	\$ 56,839.67	\$ 69,082.51	\$ 56,184.77	\$ 83,655.87	\$ 83,592.03	\$ 104,128.48	\$ 99,653.73	\$ 90,127.42	\$ 79,160.23	\$ 89,777.75
Adult SMI Cost	\$ 302,561.51	\$ 374,424.98	\$ 335,001.71	\$ 327,517.47	\$ 313,916.06	\$ 365,220.71	\$ 320,423.31	\$ 448,883.55	\$ 356,724.58	\$ 344,400.39	\$ 407,001.43	\$ 305,840.51	\$ 335,704.29	\$ 332,827.87
Child SED Cost	\$ 49,062.70	\$ 67,737.01	\$ 59,260.71	\$ 75,440.50	\$ 79,625.25	\$ 69,458.58	\$ 64,839.81	\$ 81,366.75	\$ 77,684.08	\$ 97,210.94	\$ 118,356.90	\$ 74,595.62	\$ 66,026.12	\$ 63,344.95
Total	\$ 738,188.76	\$ 879,742.40	\$ 808,324.14	\$ 843,264.09	\$ 849,328.76	\$ 923,749.97	\$ 828,608.48	\$ 1,044,094.29	\$ 922,530.30	\$ 987,561.57	\$ 1,098,841.08	\$ 898,756.49	\$ 899,437.27	\$ 910,863.95
Adult IDD Cost per consumer	\$ 5,179.16	\$ 6,425.62	\$ 5,883.60	\$ 6,266.97	\$ 6,332.50	\$ 6,774.00	\$ 5,956.32	\$ 6,721.69	\$ 6,421.10	\$ 6,797.26	\$ 7,072.07	\$ 6,296.96	\$ 5,895.02	\$ 6,248.73
Child IDD Cost per consumer	\$ 2,082.16	\$ 2,683.38	\$ 2,346.59	\$ 2,901.06	\$ 3,157.76	\$ 3,140.11	\$ 2,957.09	\$ 4,182.79	\$ 3,799.64	\$ 4,165.14	\$ 3,436.34	\$ 3,466.44	\$ 2,827.15	\$ 3,591.11
Adult SMI Cost per consumer	\$ 1,728.92	\$ 2,202.50	\$ 2,018.08	\$ 1,973.00	\$ 1,949.79	\$ 2,161.07	\$ 1,953.80	\$ 2,656.12	\$ 2,086.11	\$ 2,342.86	\$ 2,768.72	\$ 2,080.55	\$ 2,432.64	\$ 2,248.84
Child SED Cost per consumer	\$ 1,140.99	\$ 1,231.58	\$ 1,260.87	\$ 1,539.60	\$ 1,561.28	\$ 1,286.27	\$ 1,178.91	\$ 1,892.25	\$ 1,652.85	\$ 1,800.20	\$ 2,415.45	\$ 1,587.14	\$ 1,435.35	\$ 1,583.62
Total	\$ 2,428.25	\$ 2,903.44	\$ 2,730.82	\$ 2,848.87	\$ 2,898.73	\$ 3,008.96	\$ 2,734.68	\$ 3,527.35	\$ 3,044.65	\$ 3,393.68	\$ 3,763.15	\$ 3,120.68	\$ 3,178.22	\$ 3,241.51

FY 2025-26 Service Information for Wexford County (Code Rate Increase in July)														
Area of Service	December	January	February	March	April	May	June	July	August	September	October	November	December	January
Additional Supports (Homebased, Respite, Residential, Clubhouse and Nursing)	\$ 97,535.82	\$ 110,287.02	\$ 106,253.66	\$ 131,627.67	\$ 134,984.94	\$ 134,112.09	\$ 140,142.35	\$ 171,910.58	\$ 156,501.68	\$ 154,884.46	\$ 167,097.93	\$ 148,519.99	\$ 132,901.59	\$ 123,642.65
Autism Services	\$ 68,649.85	\$ 83,183.29	\$ 73,293.01	\$ 89,412.00	\$ 98,699.52	\$ 99,324.30	\$ 89,322.81	\$ 98,489.79	\$ 94,713.08	\$ 93,753.25	\$ 102,815.39	\$ 80,344.89	\$ 83,562.20	\$ 90,513.93
Case Management, ACT and Treatment Planning	\$ 103,027.21	\$ 123,732.91	\$ 115,475.56	\$ 123,359.26	\$ 138,858.32	\$ 144,552.49	\$ 126,536.84	\$ 213,262.94	\$ 195,401.81	\$ 197,057.35	\$ 220,520.58	\$ 157,865.13	\$ 175,723.68	\$ 185,444.37
Community Living Supports	\$ 810,395.28	\$ 800,342.19	\$ 769,514.50	\$ 860,782.11	\$ 852,618.03	\$ 861,246.97	\$ 844,151.30	\$ 893,534.38	\$ 880,216.84	\$ 878,097.74	\$ 876,984.56	\$ 835,529.11	\$ 878,037.69	\$ 864,812.15
Crisis Services, Assessments and Testing	\$ 36,281.00	\$ 43,621.42	\$ 42,460.12	\$ 46,751.32	\$ 38,429.00	\$ 42,246.00	\$ 45,833.98	\$ 68,285.97	\$ 62,883.19	\$ 71,770.87	\$ 92,638.12	\$ 77,231.19	\$ 69,333.14	\$ 71,516.86
Evaluation and Management Physician Level	\$ 52,446.95	\$ 64,307.44	\$ 67,339.02	\$ 67,598.41	\$ 80,216.89	\$ 60,132.11	\$ 56,866.82	\$ 71,810.37	\$ 57,669.98	\$ 71,331.45	\$ 76,037.08	\$ 59,407.43	\$ 62,023.69	\$ 57,713.67
Psychiatric Inpatient	\$ 98,915.52	\$ 121,542.41	\$ 66,757.46	\$ 86,123.01	\$ 164,984.04	\$ 66,015.01	\$ 116,269.73	\$ 74,751.65	\$ 125,712.74	\$ 84,535.35	\$ 131,898.73	\$ 180,034.20	\$ 50,876.56	\$ 30,818.00
Psychotherapy and Outpatient Services	\$ 61,867.06	\$ 104,318.10	\$ 112,300.88	\$ 96,756.45	\$ 130,211.56	\$ 117,464.21	\$ 120,197.17	\$ 235,791.77	\$ 194,925.40	\$ 213,443.50	\$ 224,208.98	\$ 162,147.36	\$ 162,529.28	\$ 176,432.78
Vocational & Skills Building, Family and Health Services	\$ 48,048.71	\$ 65,355.67	\$ 61,541.46	\$ 53,193.68	\$ 53,347.43	\$ 50,252.93	\$ 53,081.95	\$ 53,639.67	\$ 46,105.40	\$ 54,496.10	\$ 57,083.36	\$ 46,599.52	\$ 42,946.43	\$ 51,147.21
Other	\$ 6,156.61	\$ 7,609.29	\$ 7,419.89	\$ 7,073.27	\$ 10,254.06	\$ 8,958.00	\$ 9,594.22	\$ 7,510.99	\$ 9,517.86	\$ 8,438.27	\$ 8,507.62	\$ 6,091.34	\$ 7,501.70	\$ 8,616.20
Total	\$ 1,383,324.01	\$ 1,524,299.74	\$ 1,422,355.56	\$ 1,562,677.18	\$ 1,702,803.79	\$ 1,584,304.11	\$ 1,602,017.17	\$ 1,888,988.11	\$ 1,823,647.98	\$ 1,827,808.34	\$ 1,957,692.35	\$ 1,753,770.16	\$ 1,665,435.96	\$ 1,660,657.82
Number of Registered People Receiving Services	498	539	528	541	583	557	546	549	522	536	562	528	517	510
Average Cost per Registered Person Served	\$ 2,777.76	\$ 2,828.01	\$ 2,693.86	\$ 2,888.50	\$ 2,920.76	\$ 2,844.35	\$ 2,934.10	\$ 3,440.78	\$ 3,493.58	\$ 3,410.09	\$ 3,483.44	\$ 3,321.53	\$ 3,221.35	\$ 3,256.19
Service Transactions Provided	50,730	56,167	53,986	61,232	58,637	57,998	58,317	61,014	58,084	58,683	60,448	50,501	52,719	51,829
Average Cost per Transaction	\$ 27	\$ 27	\$ 26	\$ 26	\$ 29	\$ 27	\$ 27	\$ 31	\$ 31	\$ 31	\$ 32	\$ 35	\$ 32	\$ 32
Count of Adult IDD	122	126	121	128	132	124	124	127	124	125	125	126	124	123
Count of Child IDD	52	54	52	55	57	59	61	54	64	56	62	61	58	57
Count of Adult SMI	238	264	260	259	277	262	258	273	232	246	253	242	234	234
Count of Child SED	86	95	95	99	117	112	103	95	102	109	122	99	101	96
Total	498	539	528	541	583	557	546	549	522	536	562	528	517	510
IDD Adult Cost	\$ 738,286.68	\$ 755,105.79	\$ 720,797.26	\$ 769,927.14	\$ 753,700.70	\$ 744,837.33	\$ 742,491.94	\$ 805,641.55	\$ 790,334.40	\$ 797,954.09	\$ 822,907.33	\$ 760,729.49	\$ 785,120.58	\$ 791,482.18
IDD Child Cost	\$ 107,979.79	\$ 126,301.58	\$ 114,392.26	\$ 132,677.15	\$ 142,686.70	\$ 154,664.72	\$ 146,861.65	\$ 172,088.27	\$ 169,959.27	\$ 163,508.36	\$ 172,211.43	\$ 138,080.49	\$ 143,750.15	\$ 157,252.84
Adult SMI Cost	\$ 472,768.56	\$ 499,293.30	\$ 483,375.54	\$ 523,028.70	\$ 620,265.45	\$ 561,199.90	\$ 588,555.96	\$ 736,890.65	\$ 691,092.24	\$ 646,191.47	\$ 706,233.02	\$ 667,059.36	\$ 578,516.95	\$ 538,216.61
Child SED Cost	\$ 64,288.98	\$ 143,599.07	\$ 103,790.50	\$ 137,044.19	\$ 186,150.94	\$ 123,602.16	\$ 124,107.62	\$ 174,367.64	\$ 172,262.07	\$ 220,154.42	\$ 256,340.57	\$ 187,900.82	\$ 158,048.28	\$ 173,706.19
Total	\$ 1,383,324.01	\$ 1,524,299.74	\$ 1,422,355.56	\$ 1,562,677.18	\$ 1,702,803.79	\$ 1,584,304.11	\$ 1,602,017.17	\$ 1,888,988.11	\$ 1,823,647.98	\$ 1,827,808.34	\$ 1,957,692.35	\$ 1,753,770.16	\$ 1,665,435.96	\$ 1,660,657.82
Adult IDD Cost per consumer	\$ 6,051.53	\$ 5,992.90	\$ 5,957.00	\$ 6,015.06	\$ 5,709.85	\$ 6,006.75	\$ 5,987.84	\$ 6,343.63	\$ 6,373.66	\$ 6,383.63	\$ 6,583.26	\$ 6,037.54	\$ 6,331.62	\$ 6,434.81
Child IDD Cost per consumer	\$ 2,076.53	\$ 2,338.92	\$ 2,199.85	\$ 2,412.31	\$ 2,503.28	\$ 2,621.44	\$ 2,407.57	\$ 3,186.82	\$ 2,655.61	\$ 2,919.79	\$ 2,777.60	\$ 2,263.61	\$ 2,478.45	\$ 2,758.82
Adult SMI Cost per consumer	\$ 1,986.42	\$ 1,891.26	\$ 1,859.14	\$ 2,019.42	\$ 2,239.23	\$ 2,141.98	\$ 2,281.22	\$ 2,699.23	\$ 2,978.85	\$ 2,626.79	\$ 2,791.43	\$ 2,756.44	\$ 2,472.29	\$ 2,300.07
Child SED Cost per consumer	\$ 747.55	\$ 1,511.57	\$ 1,092.53	\$ 1,384.28	\$ 1,591.03	\$ 1,103.59	\$ 1,204.93	\$ 1,895.45	\$ 1,688.84	\$ 2,019.77	\$ 2,101.15	\$ 1,897.99	\$ 1,564.83	\$ 1,809.44
Total	\$ 2,777.76	\$ 2,828.01	\$ 2,693.86	\$ 2,888.50	\$ 2,920.76	\$ 2,844.35	\$ 2,934.10	\$ 3,440.78	\$ 3,493.58	\$ 3,410.09	\$ 3,483.44	\$ 3,321.53	\$ 3,221.35	\$ 3,256.19

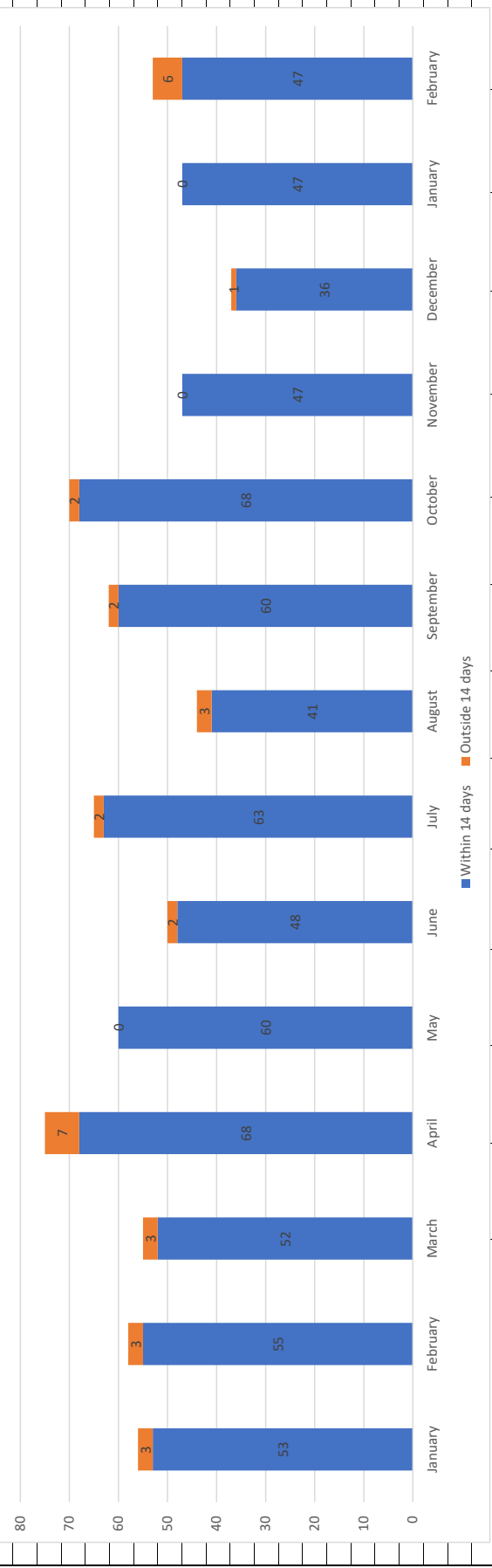
FY2025-26 Monthly Access Timeliness, Request to Assessment														
	January	February	March	April	May	June	July	August	September	October	November	December	January	February
Within 14 days	70	70	72	71	62	49	75	54	69	71	43	53	62	39
Outside 14 days	12	12	10	16	16	12	6	7	8	8	4	5	11	8
Consumer Cancelled/Reschedule	10	9	10	10	11	6	11	10	4	13	7	8	11	12
Consumer Requested outside 14	0	1	9	9	4	5	3	4	3	1	2	5	5	11
Consumer No Showed	23	18	28	18	22	21	17	17	26	28	18	16	26	20
Other (denial, no follow up)	15	13	12	23	17	11	9	9	13	6	6	15	15	16

FY25-26 Access Timeliness, Request to Assessment



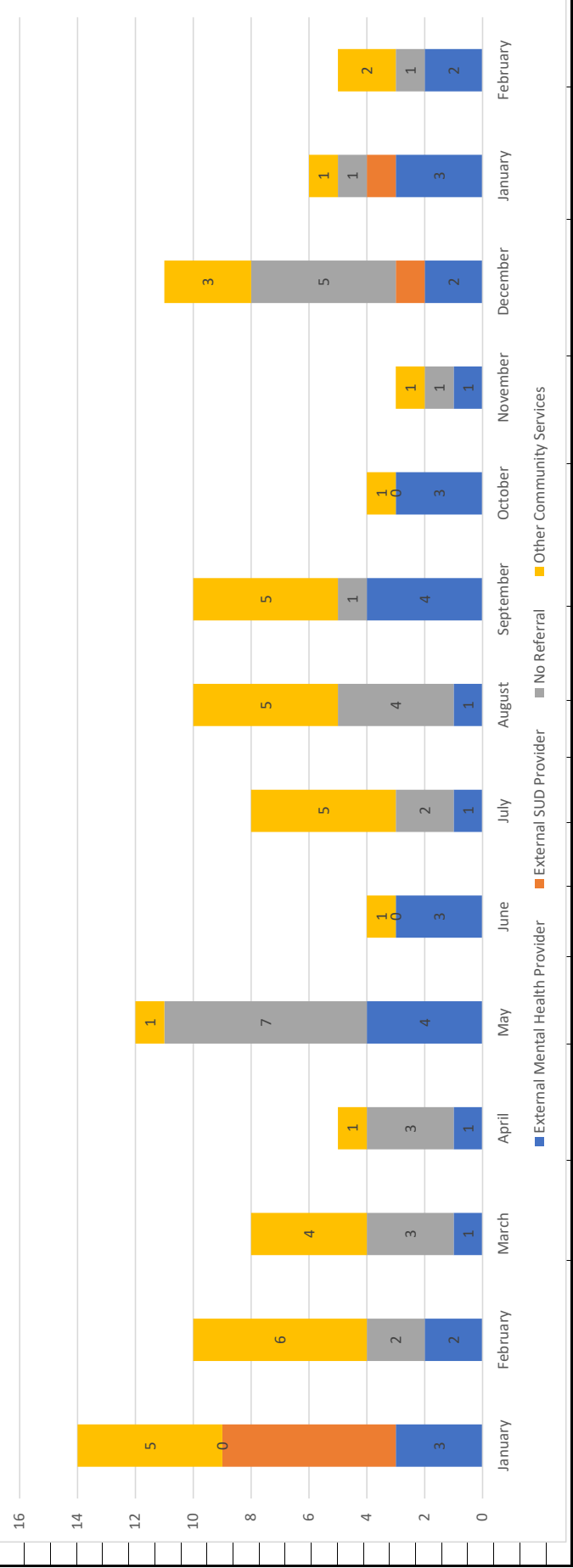
FY2025-26 Monthly Access Timeliness, Assessment to Service														
	January	February	March	April	May	June	July	August	September	October	November	December	January	February
Within 14 days	53	55	52	68	60	48	63	41	60	68	47	36	47	47
Outside 14 days	3	3	3	7	0	2	2	3	2	2	0	1	0	6
Consumer Cancelled/Reschedule	6	1	4	9	2	2	3	2	3	6	3	3	3	2
Consumer Requested outside 14	1	6	4	10	8	13	5	1	3	5	6	6	2	4
Consumer No Showed	11	16	11	11	9	13	10	10	11	9	11	11	10	8
Consumer Chose to Not Pursue S	2	1	0	1	2	3	4	1	1	1	1	0	2	1
Other (denial, no follow up)	0	6	17	10	12	7	3	5	9	6	4	8	5	5
Monthly % seen in 14 Days	94.6%	94.8%	94.5%	90.7%	100.0%	96.0%	96.9%	93.2%	96.8%	97.1%	100.0%	97.3%	100.0%	

FY25-26 Access Timeliness, Assessment to Service

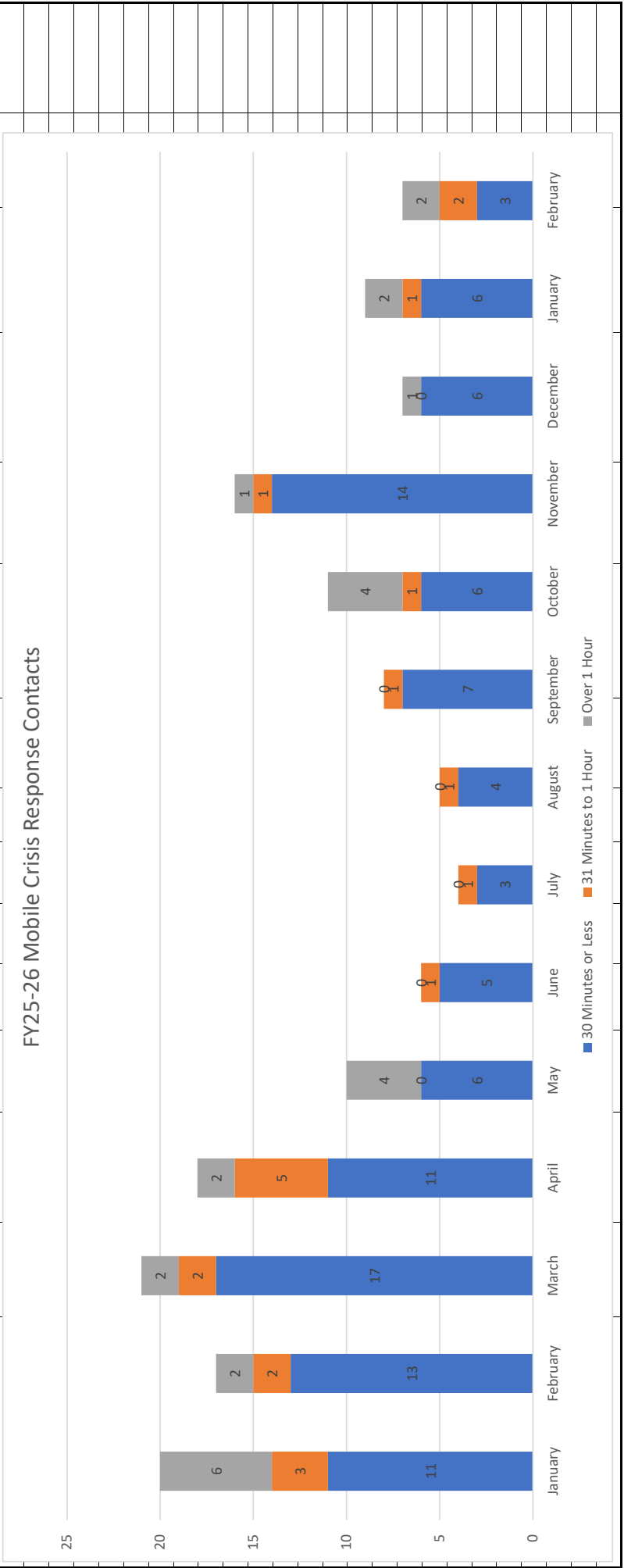


FY2025-26 Referrals for Denied Initial Clinical Assessments														
	January	February	March	April	May	June	July	August	September	October	November	December	January	February
External Mental Health Provi	3	2	1	1	4	3	1	1	4	3	1	2	3	2
External SUD Provider	6	0	0	0	0	0	0	0	0	0	0	1	1	0
No Referral	0	2	3	3	7	0	2	4	1	0	1	5	1	1
Other Community Services	5	6	4	1	1	1	5	5	5	1	1	3	1	2

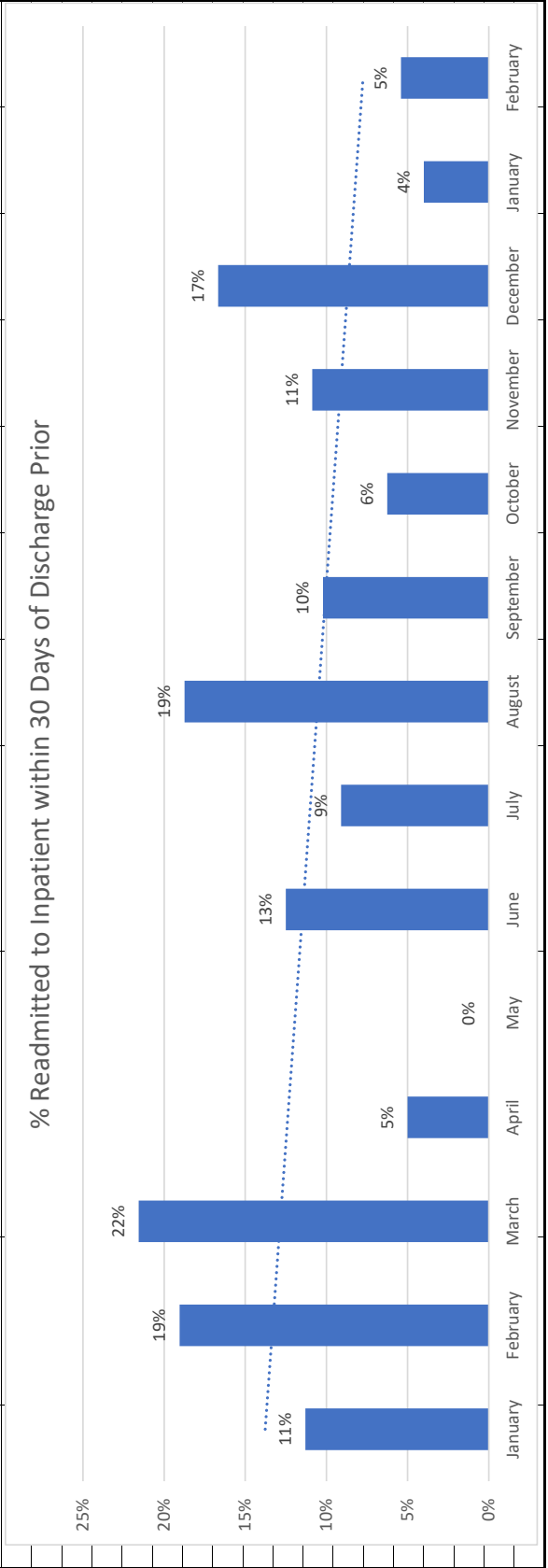
FY25-26 Referrals from Initial Assessment Denial



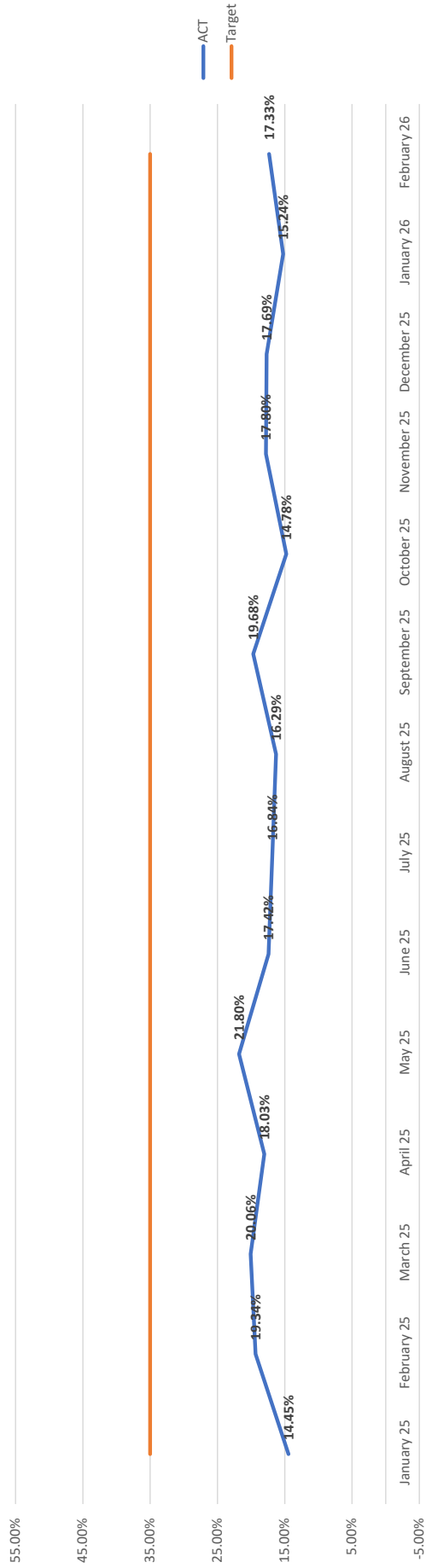
FY2025-26 Mobile Crisis Response Times, Monthly														
	January	February	March	April	May	June	July	August	September	October	November	December	January	February
<b>30 Minutes or Less</b>	11	13	17	11	6	5	3	4	7	6	14	6	6	3
<b>31 Minutes to 1 Hour</b>	3	2	2	5	0	1	1	1	1	1	1	0	1	2
<b>Over 1 Hour</b>	6	2	2	2	4	0	0	0	0	4	1	1	2	2



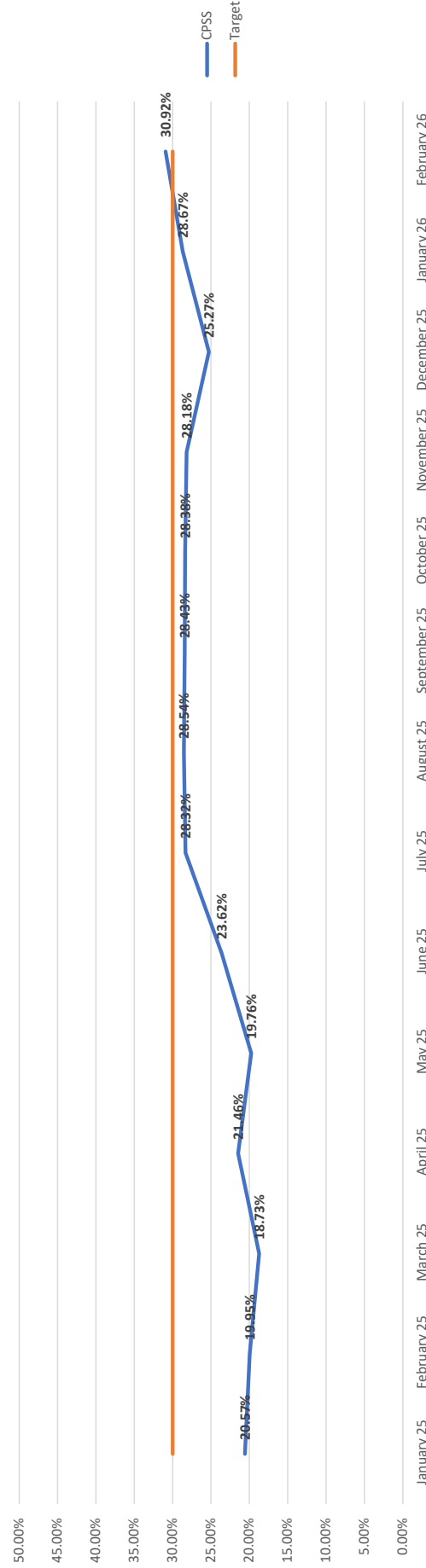
FY2025-26 Inpatient Readmission Rate			
	Admissions	Readmits in 30 Days	% Readmitted
January	62	7	11%
February	42	8	19%
March	51	11	22%
April	60	3	5%
May	44	0	0%
June	48	6	13%
July	44	4	9%
August	48	9	19%
September	49	5	10%
October	48	3	6%
November	46	5	11%
December	30	5	17%
January	50	2	4%
February	37	2	5%
<b>TOTAL</b>			<b>11%</b>



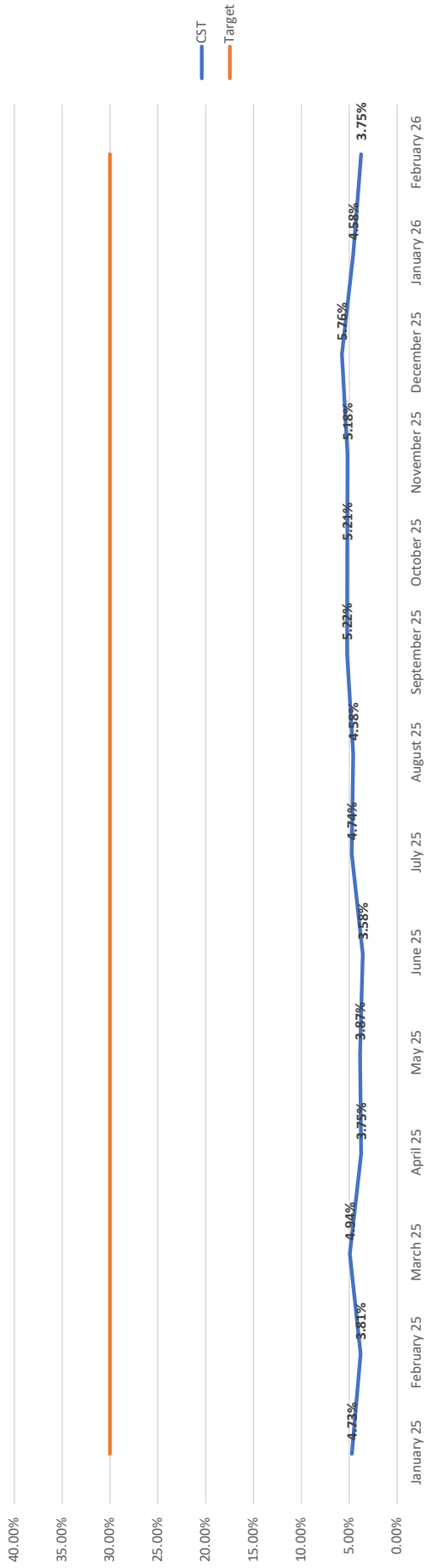
### Assertive Community Treatment Staff Efficiency, 13 Month Trending



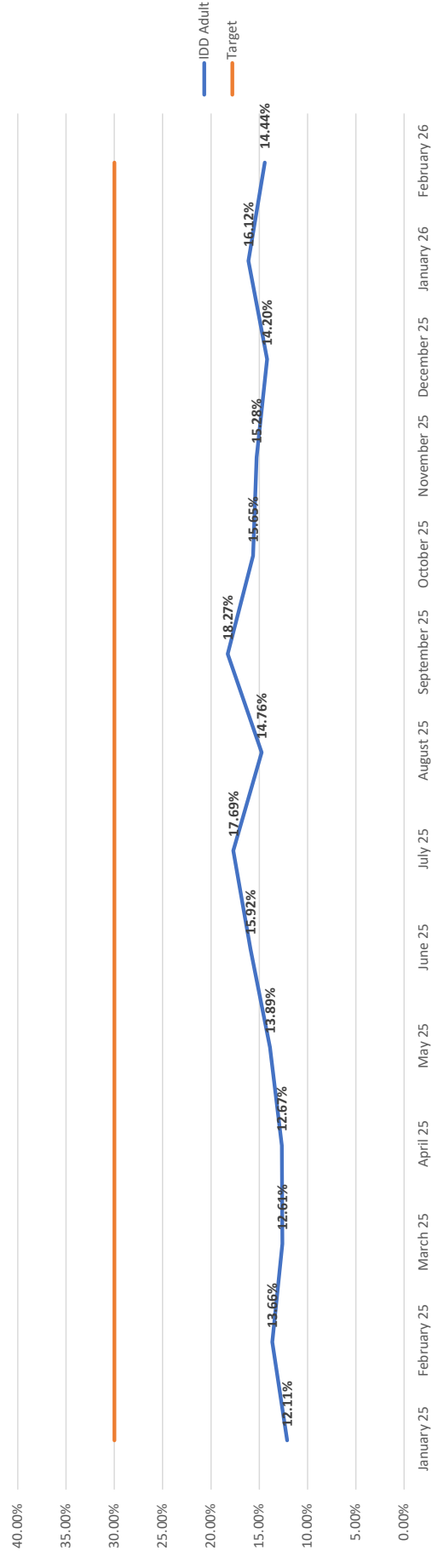
### CPSS Staff Efficiency, 13 Month Trending



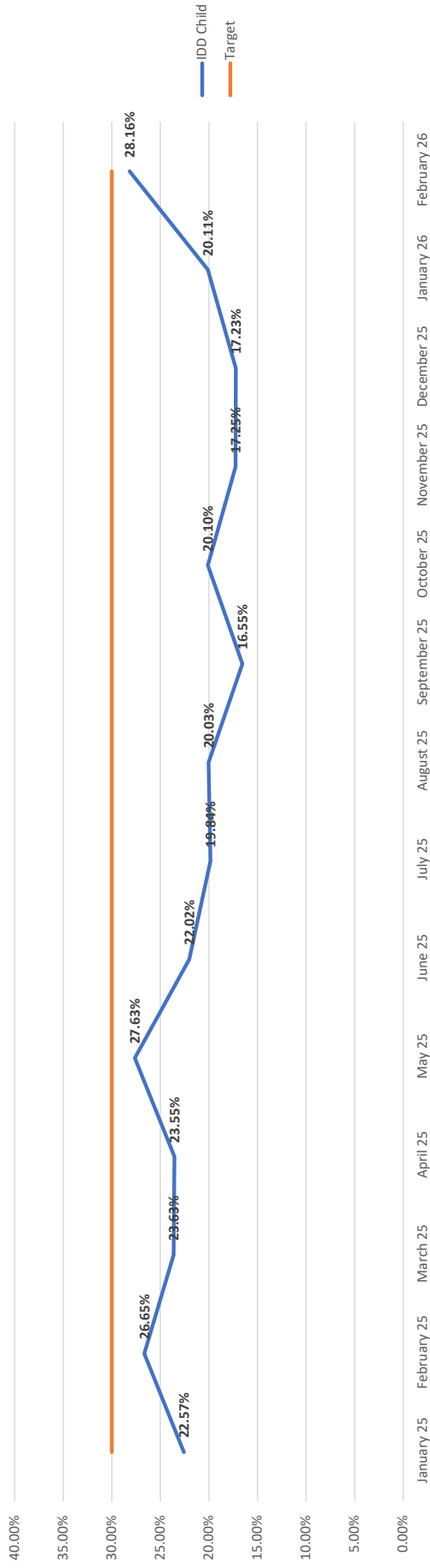
Crisis Services Staff Efficiency, 13 Month Trending



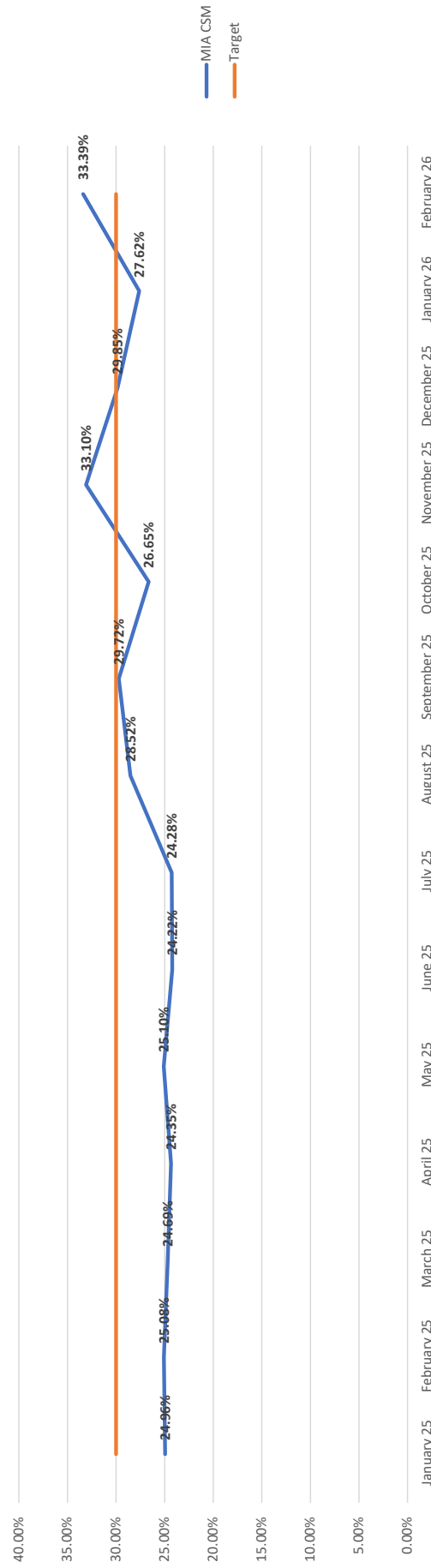
IDD Adult Services Staff Efficiency, 13 Month Trending



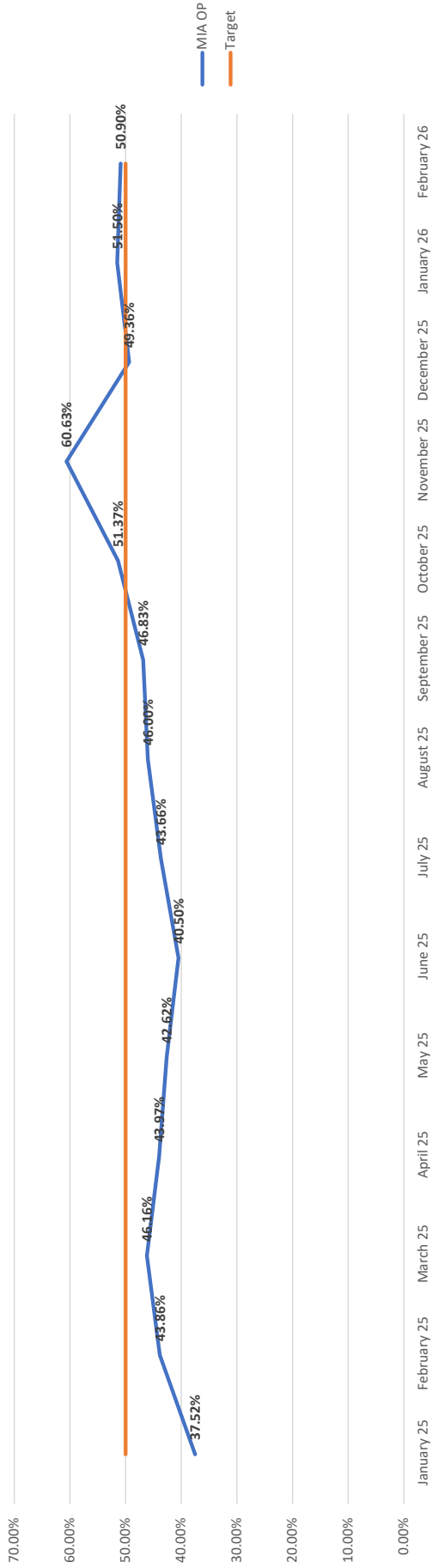
IDD Children Services Staff Efficiency, 13 Month Trending



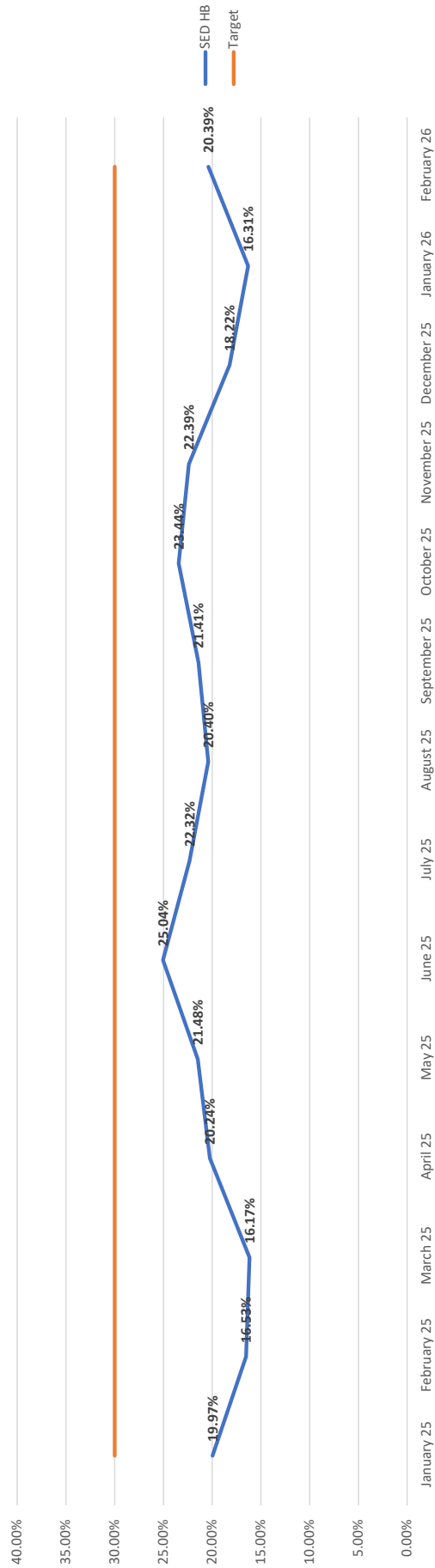
MIA CSM Services Staff Efficiency, 13 Month Trending



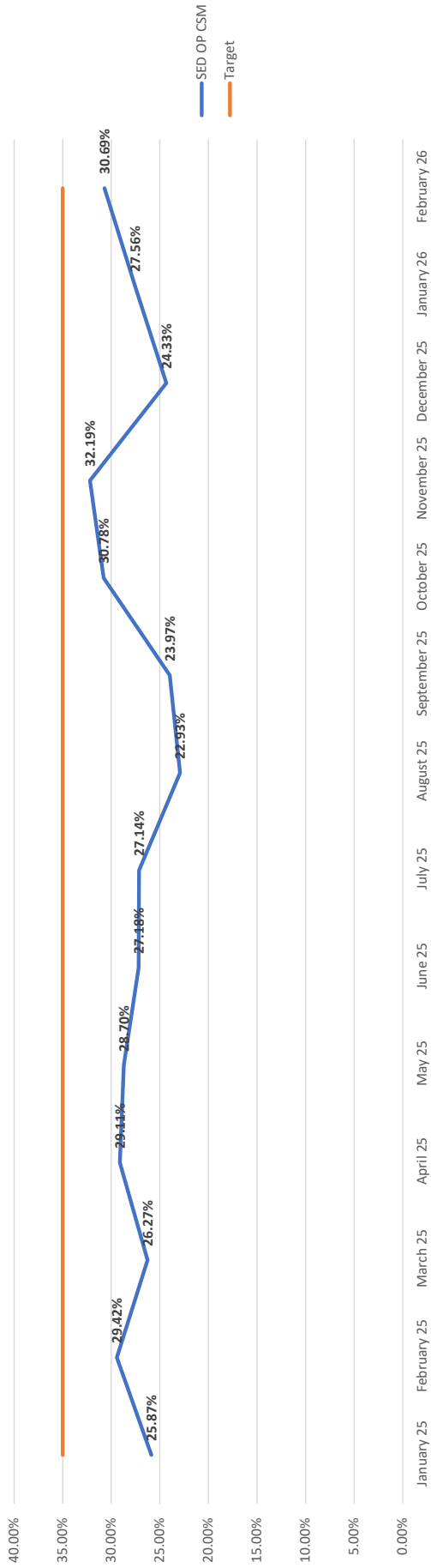
MIA OP Services Staff Efficiency, 13 Month Trending



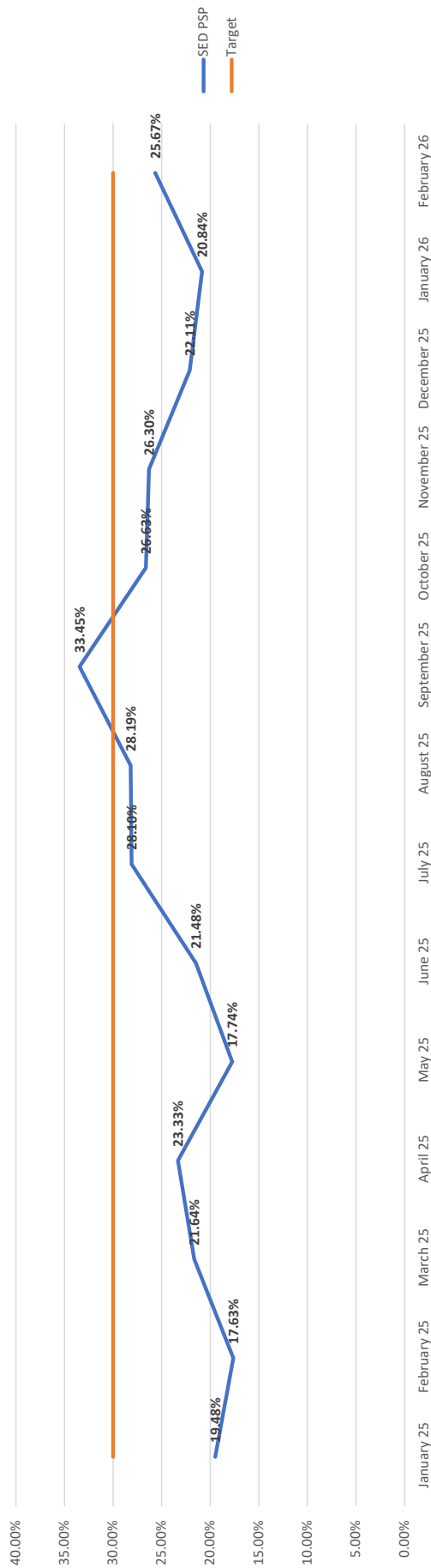
SED Home Based Services Staff Efficiency, 13 Month Trending



SED OP and CSM Services Staff Efficiency, 13 Month Trending



SED PSP Services Staff Efficiency, 13 Month Trending



# Accommodation Barriers

Tiffany Fewins, Customer Service Specialist/ Grievance and Appeals Coordinator  
Phone: 800-337-8598, Email: [tiffany.fewins@nlcmh.org](mailto:tiffany.fewins@nlcmh.org)

# What Are Accommodation Barriers?

Accommodation barriers refer to challenges or obstacles that our agency face when trying to provide equal access to service and support our consumers, employees or board members with disabilities or special needs.

# Types of Accommodation Barriers

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## Architecture:

- Physical obstacles - Making it difficult or impossible for individuals to access or navigate spaces.
- High counter tops, making it difficult for wheelchairs or those of shorter stature.
- Inadequate signage - Poorly placed or unclear signage.
- Lack of Accessible Restrooms - Restrooms that are not designed for accessibility.
- Uneven or Obstructed Walkways – Sidewalks or pathways with uneven surfaces, potholes or obstacles.
- Inadequate parking

## Attitude:

- Not understanding the needs of individuals who may need special services.

## Communication:

- Lack of sign language interpreters, braille material, or captioning services.

# Types of Accommodation Barriers

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## Employment:

- Limited job opportunities and/ or lack of support for job retention.

## Environment:

- High levels of noise, stress or overcrowding in the facility can negatively impact consumers or employees.

## Financial:

- Lack of government funding, grants, donation, sliding scale fees or providing or assisting with financial assistance programs. It could also mean simplifying our agencies billing system.

## Technology:

- Agency website, digital communication tools, electronic forms, online scheduling systems or virtual meetings that may not accommodate people with visual, auditory or cognitive disabilities.

## Transportation:

- Lack of accessible transportation options, high transportation costs, infrequent or unreliable transportation and geographical barriers.

# What Happens Next... Continue to Identify Barriers!

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Consumer Reported  
Accommodation Barriers



Employee Reported  
Accommodation Barriers



Board Member Reported  
Accommodation Barriers



# Leadership Team

## Drill Observation Form

**Location:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Actual Event?**    **Yes**    **No**

**Type of Drill:**

<b>Fire</b>	<b>Violent Person</b>	<b>Utility Failure</b>
<b>Bomb Threat</b>	<b>Natural Disaster</b>	<b>Medical Emergency</b>

**Conducted By:** \_\_\_\_\_

**Scenario:** \_\_\_\_\_

**Start Time:** \_\_\_\_\_ **End Time:** \_\_\_\_\_

<b>During the Drill</b>			
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<b>Communication</b>			
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Y	N	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was simple language used to make emergency announcements (i.e. Lockdown, Evacuation, Shelter-in-Place, Bomb Threat.)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was an emergency code used (i.e. Code Red, "Mr. Greene is in the bldg", etc.)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were cell phones and walkie-talkies and other electronic devices used?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was the fire alarm system activated?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there an "All Clear" procedure to terminate the action?

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>General Procedures - Evacuation</b>			
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Y	N	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were building occupants evacuated to designated safety locations?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were office floors swept by designated staff?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did all building occupants evacuate? (i.e. office staff, clinical staff, consumers, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was the building evacuated within the designated time frame?

**Number of people in building:** \_\_\_\_\_ **Were all accounted for?** \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Lessons Learned

*\*Additional Items to Assess: Was there any new or interesting use of technology? How were doors locked if there were no keys or locks in doors? Were there any exemplary practices?*

## Drill Observation Form

Date:

Drill Conducted:

Conducted By:

Scenario:

Start Time:

End Time:

### During The Drill

Y N N/A

#### Communication

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was simple language used to make emergency announcements (i.e. Lockdown, Evacuation, Shelter-in-Place, Bomb Threat.)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was an emergency code used (i.e. Code Red, "Mr. Greene is in the bldg", etc.)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were cell phones and walkie-talkies and other electronic devices used?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was the fire alarm system activated?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there an "All Clear" procedure to terminate the action?

Comments:

Y N N/A

#### General Procedures – Evacuation

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were building occupants evacuated to designated safety locations?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were office floors swept by designated staff?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did all building occupants evacuate? (i.e. office staff, clinical staff, consumers, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was the building evacuated within the designated time frame?
			Number of people in building: _____ Were all accounted for? YES <input type="checkbox"/> NO <input type="checkbox"/>

Comments:

#### Lessons Learned

Comments: **\*Additional Items to Assess: Was there any new or interesting use of technology? How were doors locked if there were no keys or locks in doors? Were there any exemplary practices?**

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## 5-star Google Reviews

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I can actually absolutely say that I have had a very outstanding experience with the Dr. I can assure you that the Dr I have and the Therapist that I had brought me out of a dark space. I was 22 years old. I'm 47 now. I will assure you that they give it 110% there all. I think the negative reviews will be with someone that doesn't put their time in. Appointments and putting that first everything falls into place. It takes time. It's not an overnight process. Hang in there and I know you will have a better outcome.

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This one is for Cadillac!

I have had 110% experience. You have to put your time in. Going to all Dr. appointments and counseling services. It's not a one appointment deal. It takes months. The Dr that I have is a diamond in a rock . I got very fortunate to have a very disciplined Dr. The counselor I had was absolutely amazing. You may get a Dr that doesn't get you. Call and ask to try a different doctor and or Therapist. You have to put your time in as well. I can tell you that when I was almost 22 years old. That I was lucky to see a head Dr and it was the right fit. You know what it was a very hard time in my life why can't I be like most of the world? That Dr gave me a light at the end of a tunnel. In the early 2000s it was so ridiculous hard to have help with mental health. I will and never take it for granted. Don't take it lightly if you get a chance at help.

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# 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.*