Mission: To promote hope, recovery, resilience, quality of life and wellness in Washtenaw County by providing high quality, integrated services to eligible individuals.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) BOARD MEETING AGENDA

**** In person at 4135 Washtenaw Ave, Ann Arbor**

OR

Virtually at https://zoom.us/j/98457698351

August 25, 2023

9:30 – 11:30AM

I. Roll Call (5 minutes)

II. Audience Participation (see guidelines below) (5 minutes)

III. Board Response to Audience Participation (5 minutes)

IV. Consent Agenda (Attachment #1) (5 minutes) **ACTION**

A. WCCMH Millage Advisory Committee Meeting Minutes and Actions 6/12/23 (Attachment #1A)
B. WCCMH Quality-Finance Committee Meeting Minutes and Actions from 6/12/23 (Attachment #1B)
C. WCCMH Board Meeting Minutes and Actions-6/23/23 (Attachment #1C)
D. WCCMH Consumer Advisory Council Meeting Minutes and Actions-5/10/23 (Attachment #1D)
E. Executive Director Authorizations (recommended approval by Quality-Finance Committee on 8/14/23 (Attachment #1E)
F. Program Dashboard FY23, Quarter 2 2023 (Attachment #1F)
G. Program Committee Annual Year End Performance Improvement Report (Attachment #1G)
H. Semi-Annual Recipient Rights Report (Attachment #1H)
I. FY22 Compliance Examination (Attachment #1I)
J. Millage Advisory Committee Funding Requests totaling $330,000.00 (recommended approval by Millage Advisory Committee on 8/14/2023) (Attachment #1J)
    1. Washtenaw Health Project Presentation and Funding Proposal (Attachments #1J1 & #1J2)
K. CMHPSM Policy – Reviewed and Recommended for Approval by Regional Operations Committee
    1. Credentialing for Licensed Independent Providers (Attachment #1K)
    2. Consumer Appeals Policy (Attachment #1L)
    3. Customer Services Policy (Attachment #1M)
    4. Notice of Privacy Practices and Consumer Complaints for Protected Health Information (Attachment #1N)
    5. Organizational Credentialing/Recredentialing and Monitoring (Attachment #1O)
    6. Employee Competency and Credentialing Policy 2023 (Attachment #1P)
    7. Training Policy (Attachment #1Q)
    8. Abuse and Neglect (Attachment #1R)
    9. Communication by Mail Telephone and Visits (Attachment #1S)
    10. Consent to Treatment and Services (Attachment #1T)
    11. Dignity and Respect (Attachment #1U)
    12. Family Planning (Attachment #1V)
    13. Fingerprints, Photographs, Recordings, or Use of 1-Way Glass (Attachment #1W)
    14. Freedom of Movement (Attachment #1X)
    15. Limitation of Rights (Attachment #1Y)
    16. Non-Discrimination if Provision of Service (Attachment #1Z)
    17. Office of recipient Rights (Attachment #1AA)
    18. Personal Property and Funds (Attachment #1BB)

Audience Participation Guidelines:

- Three (3) minutes are allowed per speaker
- Speakers are asked to bring a copy of their concerns/comments in writing
- Resolutions on issues will be brought to the appropriate committee as necessary

Mission: To promote hope, recovery, resilience, quality of life and wellness in Washtenaw County by providing high quality, integrated services to eligible individuals.

19. Physical Management and Restraint (Attachment #1CC)
20. Recipient Payment for Damage to Property (Attachment # 1DD)
21. Religious Freedom and Treatment by Spiritual Means (Attachment #1EE)
22. Report and Review of Recipient Death (Attachment #1FF)
23. Right to Entertain Materials, Information and News (Attachment #1GG)
24. Services Suited to Condition (Attachment #1HH)
25. Work Performed by Recipients (Attachment #1II)

V. Treasurer's Report **ACTION** (15 minutes)
- Financial Status Report (Attachment #2) - **N. Phelps ACTION**
- WCCMH Millage and CCBHC Financial Status Report (Attachment #3) **N. Phelps ACTION**

VI. Executive Director Report - **T. Cortes** (10 minutes)

VII. CMHPSM Regional Update (5 minutes)

VIII. New Business (65 minutes)
- Consumer Advisory Council – **M. Hershberger/B. Higman**
- WCCMH FY2024 Annual Operating Budget (Attachment #4) **N. Phelps ACTION**
- WCCMH FY2024 Annual Budget Book (Attachment #5) **N. Phelps**
- WCCMH FY2024 Master Contract List (Attachment #6) **M. Taylor ACTION**

IX. Old Business (5 minutes)
- June 23, 2023, Closed Session Minutes (Distributed at the Meeting) ACTION

X. Items for Future Discussions (5 minutes)
- Development of Reserve Capital
- Employee Engagement Survey
- Single Point of Access
- Youth Assessment Center

XI. Adjournment of Public Meeting (Next WCCMH Board Meeting: October 27, 2023)

****Board members are required to participate in person to count towards a quorum**

VIRTUAL MEETING LINK IS:

Join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. https://zoom.us/j/98457698351

Or One tap mobile:
+13126266799, 98457698351# US (Chicago)
+16465189805, 98457698351# US (New York)

Or join by phone:
Dial (for higher quality, dial a number based on your current location):
US: +1 312 626 6799 or +1 646 518 9805 or
+1 929 205 6099 or +1 267 8310333

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Mission: To promote hope, recovery, resilience, quality of life and wellness in Washtenaw County by providing high quality, integrated services to eligible individuals.

Webinar ID: 984 5769 8351

International numbers available: https://zoom.us/u/agGg9RYut

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WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) BOARD

AUGUST 25, 2023

CONSENT AGENDA

A. WCCMH Millage Advisory Committee Meeting Minutes and Actions 6/12/23 (Attachment #1A)
B. WCCMH Quality-Finance Committee Meeting Minutes and Actions from 6/12/23 (Attachment #1B)
C. WCCMH Board Meeting Minutes and Actions-6/23/23 (Attachment #1C)
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G. Program Committee Annual Year End Performance Improvement Report (Attachment #1G)
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    2. Consumer Appeals Policy (Attachment #1L)
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    4. Notice of Privacy Practices and Consumer Complaints for Protected Health Information (Attachment #1N)
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    12. Family Planning (Attachment #1V)
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24. Services Suited to Condition (Attachment #1HH)
25. Work Performed by Recipients (Attachment #1II)

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH MILLAGE ADVISORY COMMITTEE MEETING MINUTES *DRAFT*
June 12, 2023
Learning Resource Center-Michigan Room (in person)
https://zoom.us/j/99559977315 (virtual)
3:30–5:00 pm

N. Graebner-Sundling called the meeting to order at 3:32 pm.

ROLL CALL:
A. Carlisle attending in person
N. Graebner-Sundling attending in person
H. Heaviland attending
B. Higman attending in person
D. Jackson attending in person (non-voting)
M. Radzik attending virtually
R. Rion attending in person
A. Rooks attending in person
M. Udow-Phillips attending in person
G. Waddles Jr attending in person
K. Walker attending in person

MEMBERS ABSENT: A. Sommerville

STAFF PRESENT: R. Avedisian, T. Cortes, N. Phelps, M. Harding, L. Gentz, M. Taylor, S. Ray, B. Hagaman

OTHERS PRESENT: M. Creekmore, M. Cook, T. Gavalier, K. Snodgrass, L. Lutomski, T. Moss, E. Spanier

I. Introductions
- M. Cook (NAC), K, Snodgrass (CHRT), E. Spanier (CHRT)

II. Audience Participation
- NONE

III. Committee Response to Audience Participation
- NONE

IV. Millage Advisory Committee Minutes and Actions from 4/10/23 (Attachment #1)
- Millage Advisory Committee Minutes and Actions of 4/10/23 were reviewed

MOTION BY A. CARLISLE, SUPPORTED BY R. RION TO RECOMMEND APPROVAL OF THE MINUTES AND ACTIONS FROM THE APRIL 10, 2023, MILLAGE ADVISORY COMMITTEE MEETING AS PRESENTED.

ROLL CALL VOTE:

CARLISLE	**Y**	**GRAEBNER-SUNDLING**	**Y**
HEAVILAND	**Y**	**HIGMAN**	**Y**
RADZIK	**N/A (virtual)**	**SOMERVILLE**	**N/A**
RION	**Y**	**ROOKS**	**Y**
UDOW-PHILLIPS	**Y**	**WADDLES, JR.**	**Y**
WALKER	**Y**		

MOTION CARRIED

V. Discussion Items

- Millage Process, Investments and Progress Update (Attachment #2)
  - L. Gentz presented the Millage Process, Investment and Progress Update to the Committee.

VI. Financial Budget Update (Attachment #4)

- N. Phelps presented the Financial Budget update ending April 30, 2023, to the Committee.

VII. Old Business

- Washtenaw County Sheriff's Office (WCSO) Millage and Financial Status Update
  - D. Jackson provided an update and highlights from the Spring Summit.

VIII. New Business –

- Youth Assessment Center Presentation
  - L. Gentz/M. Cook presented on the Youth Assessment Center to the Committee.
- Millage Annual Impact Report
  - K. Snodgrass/E. Spanier provided updates on the Millage Annual Impact Report.
- Youth Millage Investment Visual
  - L. Gentz presented the Youth Millage Investment Visual to the Committee.
  - M. Udow-Phillips requested visual enhancement with showing collaboration of providers involved.

IX. Items for Future Discussions

- Millage Investment Plan
- Washtenaw Coordinated Funding Partnership Update
- CHRT gaps analysis
- Youth Millage Investment Visual
- Committee asked for another presentation for the Youth Assessment Center

MOTION BY A. ROOKS, SUPPORTED BY A. CARLISLE TO ADJOURN THE WCCMH MILLAGE ADVISORY COMMITTEE MEETING.

Meeting adjourned at 4:54 pm.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)

WCCMH QUALITY-FINANCE COMMITTEE MEETING MINUTES

DRAFT

June 12, 2023

Learning Resource Center-Michigan Room (in person)

https://zoom.us/j/98809260474 (virtual)

2:00-3:30 pm

ROLL CALL: S. Antonow attending virtually
A. Dusbiber attending virtually
B. Higman attending in person
N. Graebner-Sundling attending in person
M. Udow-Phillips attending in person

MEMBERS ABSENT: H. Heaviland

STAFF PRESENT: R. Avedisian, M. Harding, T. Cortes, L. Gentz, N. Phelps; S. Ray, Sally Amos O'Neal, M. Taylor, L. Higle, H. Linky, S. Lossing, B. Hagaman, M. Tasker, K. Hoener, E. Montgomery

OTHERS PRESENT: Kari Walker; K. Homan; T. Gavalier, L. Lutomski

N. Graebner-Sundling called the meeting to order at 2:01 pm.

:

I. Introductions
- None

II. Audience Participation
- None

III. Committee Response to Audience Participation
- None

IV. Quality-Finance Committee Meeting Minutes and Actions from 4/10/23 (Attachment #1)
- Quality-Finance Committee Meeting Minutes and Actions of 4/10/23 were reviewed

MOTION BY M. UDOW-PHILLIPS SUPPORTED BY A. DUSBIBER TO RECOMMEND APPROVAL OF THE MINUTES AND ACTIONS FROM APRIL 10, 2023, QUALITY-FINANCE COMMITTEE MEETING AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**Y**	**HIGMAN**	**Y**
HEAVILAND	**N/A**	**UDOW-PHILLIPS**	**Y**

MOTION CARRIED

V. Financial Status Report
- N. Phelps presented the Financial Status Report for the period ending April 30, 2023 (Attachment #2)

MOTION BY M. UDOW-PHILLIPS SUPPORTED BY B. HIGMAN TO RECOMMEND APPROVAL OF THE FINANCIAL STATUS REPORT ENDING APRIL 30, 2023, AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y (virtual)**	**DUSBIBER**	**Y (virtual)**
GRAEBNER-SUNDLING	**Y**	**HIGMAN**	**Y**
HEAVILAND	**N/A**	**UDOW-PHILLIPS**	**Y**

MOTION CARRIED

VI. Contracts and Leases
- None

VII. Executive Director Authorizations
- None

VIII. Regional Finance Update
- N. Phelps provided an update to the committee

IX. Old Business
- CCBHC I/DD Data Overview
  - M. Harding presented the Cares and CCBHC Data Overview.
  - Condensed CARES audit/site visit went well.
- Board Education: OBRA
  - S. Lossing provided OBRA education to the Committee.

X. New Business
- Hospital Rate Increase
  - T. Cortes discussed the hospital rate increases with the Committee.
  - Michigan Medicine's contractual psychiatric hospitalization rates are increasing substantially.
  - M. Harding reviewed inpatient adult/children's rates for hospitalization costs for CMH clients.
  - The number of cases has increased in addition to rate increases driving costs upwards.
- Program Committee Dashboard - FY23 Quarter 1 (Attachment #3)
  - L. Higle presented the Program Dashboard FY23 Quarter 1 for the Committee.

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY B. HIGMAN TO RECOMMEND APPROVAL OF PROGRAM DASHBOARD FY23 QUARTER 1 AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**Y**	**HIGMAN**	**Y**

HEAVILAND	**N/A**	**UDOW-PHILLIPS**	**Y**

MOTION CARRIED

XI. Items for Future Discussions
- Accounts Receivable
- Cost Per Case Comparisons
- Hospital Rate Increases

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY B. HIGMAN, TO ADJOURN THE WCCMH QUALITY-FINANCE COMMITTEE MEETING.

XII. Meeting adjourned at 3:22 pm.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH BOARD MEETING MINUTES *DRAFT*

In Person: Learning Resource Center-Michigan Room
4135 Washtenaw Ave, Ann Arbor, MI
Virtually: https://zoom.us/j/92898908270
June 23, 2023
9:30am

K. Walker called the meeting to order at 9:35.

ROLL CALL: S. Antonow attending virtually
A. Dusbiber attending virtually
H. Heaviland attending in person
B. Higman attending in person
B. King attending in person
A. LaBarre attending in person
A. Rooks attending in person
A. Somerville attending in person
M. Udow-Phillips attending in person
K. Walker attending in person

MEMBERS ABSENT: N. Graebner-Sundling, K. Scott

STAFF PRESENT: T. Cortes, M. Harding, N. Phelps, S. Ray, H. Linky, S. Amos O'Neal, R. Dornbos, L. Gentz, K. Snay, K. DeWeese, M. Taylor, S, Hungerford, T. Florence

OTHERS PRESENT: G. Dill, J. Hodge, M. Billard, B. Byers, K. Homan, T. Gavalier

K. Walker requested the WCCMH Board move into closed session for the purpose of discussing the pending litigation.

I. Introductions
- T. Cortes introduced N. Marchand who will be providing an update on the pending litigation to the WCCMH Board during closed session.

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. ROOKS TO MOVE THE WCCMH BOARD INTO CLOSED SESSION FOR THE PURPOSE OF DISCUSSING THE PENDING LITIGATION.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**NA**	**HEAVILAND**	**Y**
HIGMAN	**Y**	**KING**	**Y**
LABARRE	**NOT PRESENT AT TIME OF VOTE**	**ROOKS**	**Y**
SCOTT	**NA**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**Y**

MOTION CARRIED

The WCCMH Board moved to closed session at 9:36 am to discuss pending litigation.

WCCMH Board resumed the public meeting at 10:23am

II. Audience Participation

- B. Byers, a member from the audience attending virtually, requested that her name be included on the list of attendees on the WCCMH Board Meeting Minutes dated 4/28/23.

III. Board response to audience participation
- K. Walker noted that their attendance will be noted in the 4/28/23 WCCMH Board Minutes as requested.

IV. Consent Agenda Actions (Attachment #1)
- WCCMH Millage Advisory Committee Meeting Minutes and Actions 4/10/23 (Attachment #1A)
- WCCMH Quality-Finance Committee Meeting Minutes and Actions 4/10/23 (Attachment #1B)
- WCCMH Board Meeting Minutes and Actions-4/28/23 (Attachment #1C)
- WCCMH Consumer Advisory Council Meeting Minutes and Actions-4/12/23 (Attachment #1D)
- WCCMH Consumer Advisory Council Meeting Minutes and Actions-3/8/23 (Attachment #1F)
- Program Dashboard FY23 Quarter 1 2023 (Attachment #1E)

MOTION BY M. UDOW-PHILLIPS SUPPORTED BY B. KING TO ADD B. BYERS TO THE WCCMH BOARD MINUTES FROM 4/28/23 AS AN ATTENDEE.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**NA**	**HEAVILAND**	**Y**
HIGMAN	**Y**	**KING**	**Y**
LABARRE	**Y**	**ROOKS**	**Y**
SCOTT	**NA**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**Y**

MOTION CARRIED

MOTION BY B. KING, SUPPORTED BY A. LABARRE TO APPROVE CONSENT AGENDA WITH THE REQUESTED EDIT TO THE APRIL 28, 2023, WCCMH BOARD MINUTES.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**NA**	**HEAVILAND**	**Y**
HIGMAN	**Y**	**KING**	**Y**
LABARRE	**Y**	**ROOKS**	**Y**
SCOTT	**NA**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**Y**

MOTION CARRIED

V. Treasurer's Report
- WCCMH Financial Status Report
  - N. Phelps presented the Financial Status Report to the Board for the period ending April 30, 2023. (Attachment #2).

MOTION BY A. LABARRE, SUPPORTED BY A. SOMMERVILLE TO ACCEPT AND APPROVE THE WCCMH FINANCIAL STATUS REPORT ENDING APRIL 30, 2023, AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**

GRAEBNER-SUNDLING	**NA**	**HEAVILAND**	**Y**
HIGMAN	**Y**	**KING**	**Y**
LABARRE	**Y**	**ROOKS**	**Y**
SCOTT	**NA**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**Y**

MOTION CARRIED

- WCCMH Millage Financial Status Report
  - N. Phelps presented the Millage financial status reports ending April 30, 2023 (Attachment #3).

MOTION BY M. UDOW-PHILLIPS, SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE WCCMH MILLAGE AND CCBHC FINANCIAL STATUS REPORT ENDING APRIL 30, 2023, AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**NA**	**HEAVILAND**	**Y**
HIGMAN	**Y**	**KING**	**Y**
LABARRE	**Y**	**ROOKS**	**Y**
SCOTT	**NA**	**SOMMERVILLE**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**Y**

MOTION CARRIED

VI. Executive Director report
- T. Cortes presented the Executive Director report to the WCCMH Board
  - The Annual Report for the Millage should be distributed by the end of this month.
  - CCBHC site review and the audit went very well.

  WCCMH received approval from MDHHS to use State General Funds to support workforce retention and recruitment efforts for FY 2023.

VII. CMHPSM Regional Update
- B. King presented the regional update.
- Bob King distributed the PIHP Preliminary Statement of Revenues and Expenses Notes for the period ending April 31, 2023, to the board. This will be sent electronically to the WCCMH Board.

VIII. New Business
- WCCMH FY2022 Financial Audit
  - D. Merritt from Rehmann presented the WCCMH Fiscal Year 2022 Financial Audit to the WCCMH Board.

MOTION BY H. HEAVILAND SUPPORTED BY A. LABARRE TO ACCEPT THE WCCMH FY2022 FINANCIAL AUDIT AS PRESENTED

ROLL CALL VOTE:

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER-SUNDLING	**NA**	**HIGMAN**	**Y**
KING	**Y**	**LABARRE**	**Y**
ROOKS	**Y**	**SCOTT**	**NA**
SOMERVILLE	**Y**	**HEAVILAND**	**Y**
UDOW-PHILLIPS	**Y**	**WALKER**	**Y**

MOTION CARRIED

- Millage Presentation
    - L. Gentz provided the Millage 2022 Impact Preview to the WCCMH Board.
    - B. King requested a copy of the NAMI booklet to be distributed to the board.
    - A. LaBarre requested a detailed graphic with WCCMH to explain the vitality of the program to present to the commissioners.
    - M. Udow-Phillips suggested to shorten this presentation with an executive summary andsend to the State and other external stakeholders.

IX. Old Business
- None

X. Items for future discussion
- Development of Reserve Capital
- Employee Engagement Survey
- Single Point of Access
- Youth Assessment Center
- Chelsea Inpatient Hospitalization Closing Update

MOTION BY A. LABARRE SUPPORTED BY M. UDOW-PHILLIPS TO ADJOURN THE WCCMH BOARD MEETING.

Meeting adjourned at 11:33am.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY
WC-CMH ADVISORY COUNCIL MEETING – MINUTES

May 10, 2023

Members Present on the Call: Lisa Porzondek (Chair), Anton Clark, Melissa Concannon (Assistant Secretary), Leo Hanifin, Barb Higman, Halo May, Pam Rathbun (co-chair).
Staff: Mert Hershberger (Staff Liaison)
Absent: Jason Zurawski (secretary), Alayna Manzanares.

Meeting called to order at: _12:32 _ pm_.
MOTION BY _ Melissa_ - SUPPORTED BY _Leo _: APPROVE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) ADVISORY COUNCIL (AC) CONSENT AGENDA. MOTION CARRIED

I. **Elected Officials:** Felicia Brabec moved her meeting to 11am, so nobody was present. She would like folks to go to her meeting. Visit her Facebook Page for coffee hour visits. Visiting officials during their coffee hours may be best.

II. **Speaker's Bureau Training**: August if there are interested Trainees. Halo was trained and shared her story of hope & recovery. She also plans to share her story with the WC-CMH-Board on June 23.

III. **Council Leadership:** Melissa Concannon took on the responsibilities of Assistant Secretary. We also need additional members. Mert will reach out to the PA and supervisors at Youth & Family to see if additional members may be found among the parents of clients or the adult graduates of the program.

IV. **CMH Peer Groups Feedback:** We discussed the starting of an art group at the Annex and the possibilities of having a collaborative in helping plan a structure for certain peer groups at the Annex, Ellsworth, and Towner sites: especially art, writing, & wellness groups. Most present seemed okay if these groups were peer-led and guided by some curriculum planning related to topics/themes/projects.
Part-Time Peers: it was suggested that it would be good to have more part-time peer positions for those who are not yet ready to work full-time, but who want to give back in some way. After cutbacks, it may be time to bring back part-time staff.

V. **Regional Picnic** – August 2 @Maas Shelter @GallupPark, Ann Arbor. @11am-2pm.
Enter & edit what you will be bringing, check out the map:
https://docs.google.com/document/d/1KpG8bfzSYxs2SjAEofVRXT_h-7TxRXF4nuphhceLKXM/edit?usp=sharing
Mert will type up text directions coming from various directions to the park shelter and put those on the Google Document.

VI. **Walk-A-Mile** – Wednesday, September 13, 2023. Cars are starting to be reserved. The CPSS-Liaison was appointed to start organizing this event which will happen in Lansing from 10:30-2:30PM. Meet at Ellsworth around 8:30-9am. Motto: "Believe in Me" was the agreed upon motto. Leo will start working on a T-Shirt Design with that on the back and with the WC-CMH logo and the Walk-A-Mile logo on the front. We will appoint flag holders & a reader later. Per Sally, Leo plans to have the design done & ready to order T-Shirts by early August so Sally can order white shirts with black designs. We will try to tie-dye 1 week before (Wednesday,

September 6, 2023) at Ellsworth in the grass on some tables. Anton, Melissa, and Lisa are all needing rides. We need to secure the food for the day a little earlier.

VII. **Celebration of Success** – Mid to late-October. The consensus was to have a Monthly nomination from each CMH service team for a consumer of the month and a monthly nomination from each CMH site for a staff of the month. All monthly nominees from throughout the year will be automatically entered into the Annual Celebration of Success. Nominees could have their name shared, if they are willing. After some discussion of the pros & cons, the Advisory Council came to a consensus that if CMH leadership was willing to release staff to go to a daytime recognition (perhaps late afternoon, towards the end of the workday) & celebration of success in Late October in order to encourage staff & consumer participation, we would support such a decision to facilitate more ample involvement and to allow transport of clientele being recognized.

VIII. **Regional Training** – Topics you would like to learn about this fall (November 8, 2023)? There will be a short subcommittee meeting on the regional picnic & training on the 2nd Wednesday of each month at 10-10:30am.

IX. **Newsletter: Fall 2023** Newsletter – Be thinking about the next edition in early August. Possible topics? … Celebration of success, Speaker's Bureau Training (Mert), Advisory Council invite, Walk a Mile (1 short paragraph on each). Anton offered to write a piece on "Get-Up" about getting up from falls and fails and rising to the occasion to face the adversities of life. Melissa will work on something as well.

X. **988:** NPR did a piece on the roll-out of 988 which can be found: https://www.michiganradio.org/show/stateside/2023-05-09/stateside-tuesday-may-9-2023
You can find the report on 988 and response starting at the 31 minute mark.
Halo reported that times that she and her friend used the number in Wayne County recently, they had a very positive experience. She also reminded us that this could be called or texted to get a response. – The city of Ann Arbor continues to consider an Unarmed Response Team for certain situations, different from CMH LEADD team.

XI. **NAMI:** - Next online Peer-To-Peer class on Tuesdays, May 9th 6-8pm for 8 weeks. Halo reported that of 14 who signed up, 10 showed up, and only two didn't give a reason for not showing up. Anton reiterated that he would like to be notified of when there is a face-to-face peer group again. He had missed the previous notification due to illness.
Story Jam Process for Garrett's Space: There was a unanimous vote to recommend the adjustment of the Zoning to allow for the establishment of Garrett's Place. Many people showed up to speak up on behalf of the new refuge. It got out past 11pm. The final vote for the Zoning allowance will be May 15. Anton and Melissa would be interested in joining the NAMI group with Pat Doyle that reaches out to do hospital presentations & visits. Mert will send a copy of CMH group lists to NAMI-Washtenaw via Barb.

XII. **New Business**:
Anton emphasized that Case Managers need to let clients know what programs are available.

Pam motioned to adjourn the meeting at _ 1:58 pm_, Supported by _Melissa _.

The next meeting will be June 14, 2023 at 12:30pm – Mert will be present at 2140 East Ellsworth with Pam and any other people who choose to attend in person. Please arrive a few minutes early (12:20) if possible, or join a few minutes early via Zoom to help us set up and iron-out any technical details.

Executive Director Contract Authorizations
August 2023 Quality-Finance Committee Meeting

REQUEST: Recommend acceptance of the Executive Director's signature on contracts with a value of less that $25,000

Contractor	Amount	Term	Purpose	Approval Date
Lakeway Consulting	$1,500	January 1, 2023-September 30, 2023	Workplace Violence Prevention Trainings	2/24/2023
CPDA Initiatives	$10,000	February 1, 2023-September 30, 2023	Will provide Medication Administration Trainings	2/24/2023
Irvin Daphnis	$275	February 16, 2023	Black Lives Matter Chat and Chew Speaker	2/24/2023
LaShawn Gary	$250	February 26, 2023	Performer at a Black Lives Matter Event	2/24/2023
Ryheem Johnson	$1,590	February 19, 2023	Performer at a Black Lives Matter Event	2/24/2023
Washtenaw Community College	$815	February 8, 2023 & February 26, 2023	Facility reservations for "Sounds of Blackness" and "Emancipation".	2/24/2023
Shannell Farris	$500	February 19, 2023	Performer at a Black Lives Matter Event	2/24/2023
Mike Chase	$250	February 19, 2023	Performer at a Black Lives Matter Event	2/24/2023
DP Interactive LLC	$200	February 6, 2023	Will provide media graphic video for Black Lives Matter Task Force	2/24/2023

Richard Parris	$200	February 26, 2023	Performer and Paneled Speaker for Black Lives Matter Event	2/24/2023
Staffy Blakely	$175	February 26, 2023	Performer, Moderator, and Mistress of Ceremony for a Black Lives Matter Event	2/24/2023
Marvin Miller	$250	February 26, 2023	Performer and Panelist at a Black Lives Matter Event	2/24/2023
Lonnie Chapman	$375	February 1, 2023-February 28, 2023	Will provide Black Lives Matter Task Force Event Flyers	2/24/2023
Jamall Bufford	$450	February 19, 2023-February 26, 2023	Performer, Panelist, and DJ at two Black Lives Matter Events	2/24/2023
Athena Johnson	$250	February 26, 2023	Performer and Panelist at a Black Lives Matter Event	2/24/2023
Deborah Kennard	$3,150	April 1, 2023-September 30, 2023	Eye Movement Desensitization and Reprocessing Therapy (EMDR) training	4/28/2023
Ryan Lindsay	$1,800	June 1, 2023-August 31, 2023	Motivational Interviewing & Communication Styles Training	4/28/2023

Mission Hills Consulting LLC	$1,500	January 1, 2023-October 31, 2023	Workplace Violence Prevention Trainings & Consultation Services	4/28/2023
Qualigence International	Up to $10,000	April 1, 2023-September 30, 2023	Recruitment Services	4/28/2023
Esteemed Provision LLC	$575	April 5, 2023	Human Trafficking Training	4/28/2023
Ann Arbor Center for Independent Living DBA Disability Network Washtenaw Monroe Livingston	$9,000	August 1, 2023 – September 30, 2024	Youth Transition Community Supports	

Program and Quality Board Committee
Dashboard Data FY 2023 2nd Qtr (Jan - Mar 2023)

2nd quarter Human Resources Turnover Rate:

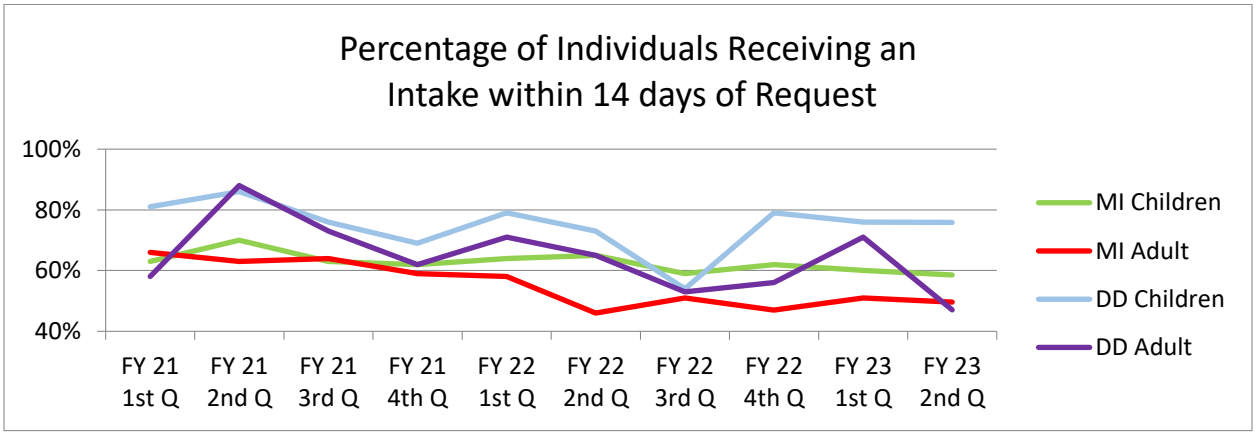
2nd Qtr– 2.4% 9 terminations (both involuntary and voluntary) divided by average number of active positions during the quarter (362).

(1st Qtr was 4.1%)

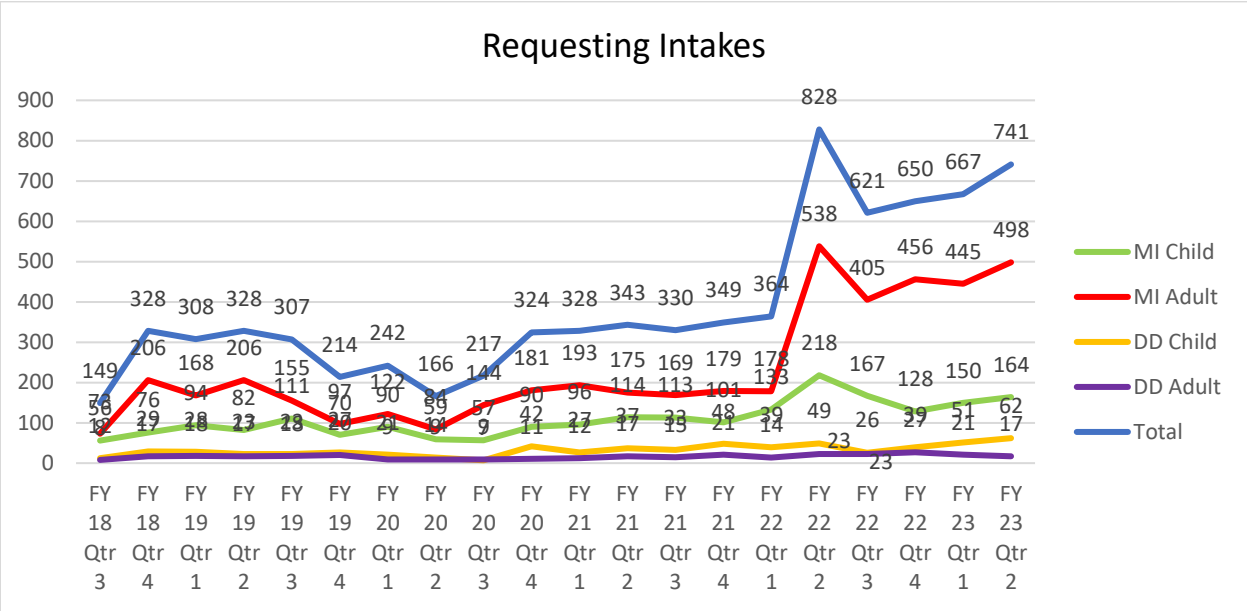
Michigan Department of Health and Human Services (MDHHS) Performance Indicators:

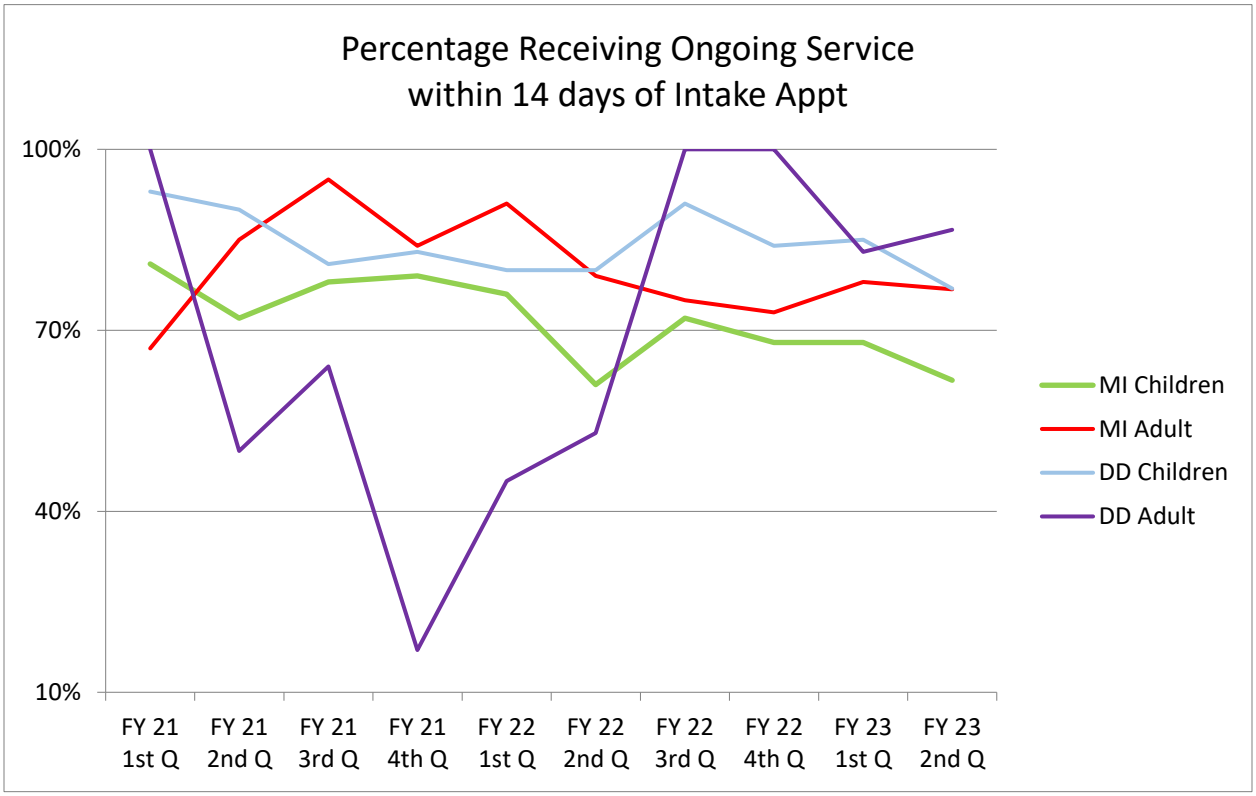
As of April 1 2020, MDHHS changed the operational definitions for calculating Indicators #2 (14 days to Intake) and #3 (14 days to Ongoing Service) and removed the 95% historical expected goal.

The major change in the operational definition does not allow accounting for consumer choice and for counting every request of service. Consumer choice is indicated by requesting an appointment outside of the 14 day window, rescheduling, canceling or not attending an appointment. If an individual requests a service, is found eligible but declines our services or even passes away, this is still considered "out of compliance".

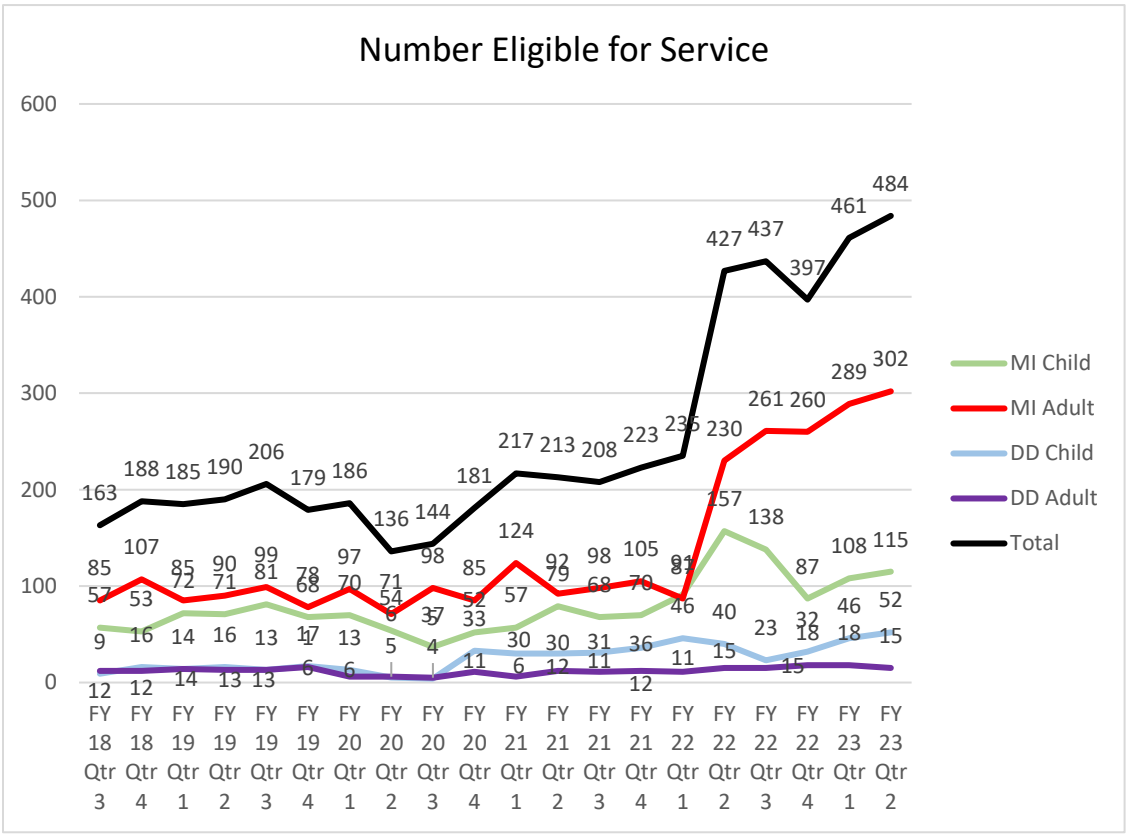


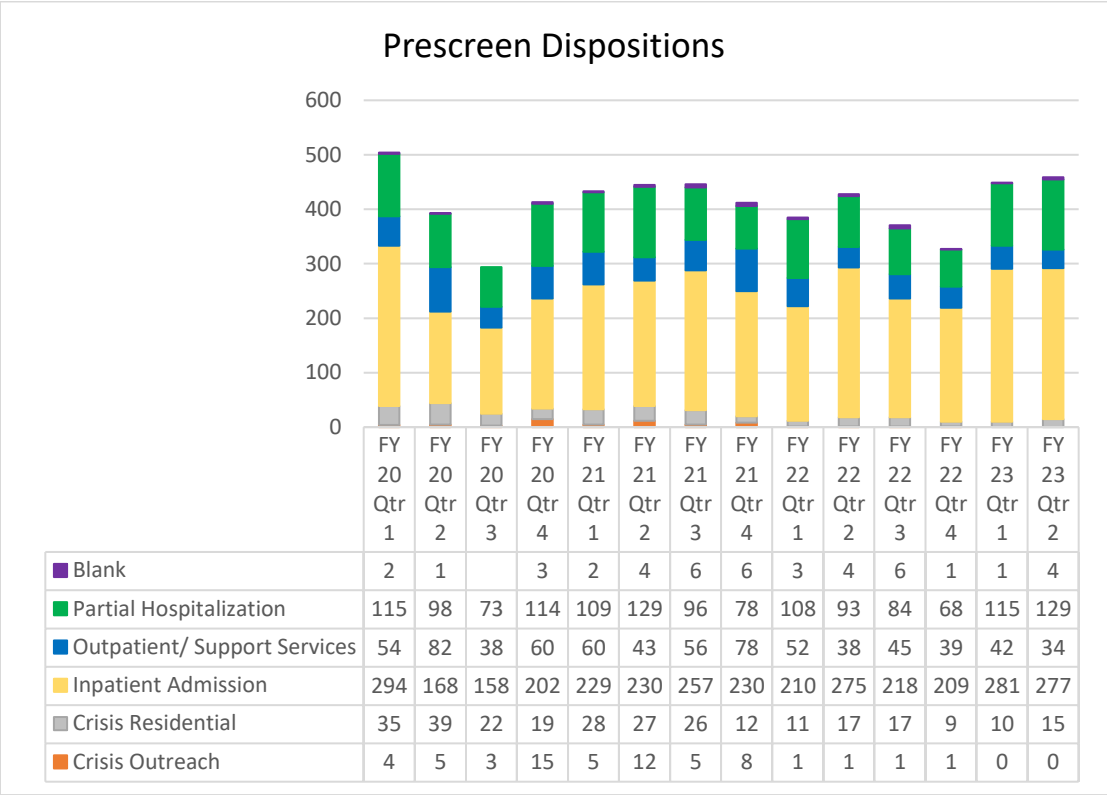
FY 23 2nd Qtr Intake Appt within 14 days Detail						
Population	Total # of new persons requesting service	Number receiving appt. within 14 days of request	State defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- was formerly removed from the denominator	Percent Compliant by new State definition	Percent Compliant in previous definition
MI Child	164	96	68	64	56%	96%
MI Adult	498	247	251	247	50%	98%
DD Child	62	47	15	13	76%	96%
DD Adult	17	8	9	8	47%	89%


Requesting Intakes
900
800
700
600
500
400
300
200
100
0
FY 18 Qtr 3
FY 18 Qtr 4
FY 19 Qtr 1
FY 19 Qtr 2
FY 19 Qtr 3
FY 19 Qtr 4
FY 20 Qtr 1
FY 20 Qtr 2
FY 20 Qtr 3
FY 20 Qtr 4
FY 21 Qtr 1
FY 21 Qtr 2
FY 21 Qtr 3
FY 21 Qtr 4
FY 22 Qtr 1
FY 22 Qtr 2
FY 22 Qtr 3
FY 22 Qtr 4
FY 23 Qtr 1
FY 23 Qtr 2
MI Child
MI Adult
DD Child
DD Adult
Total

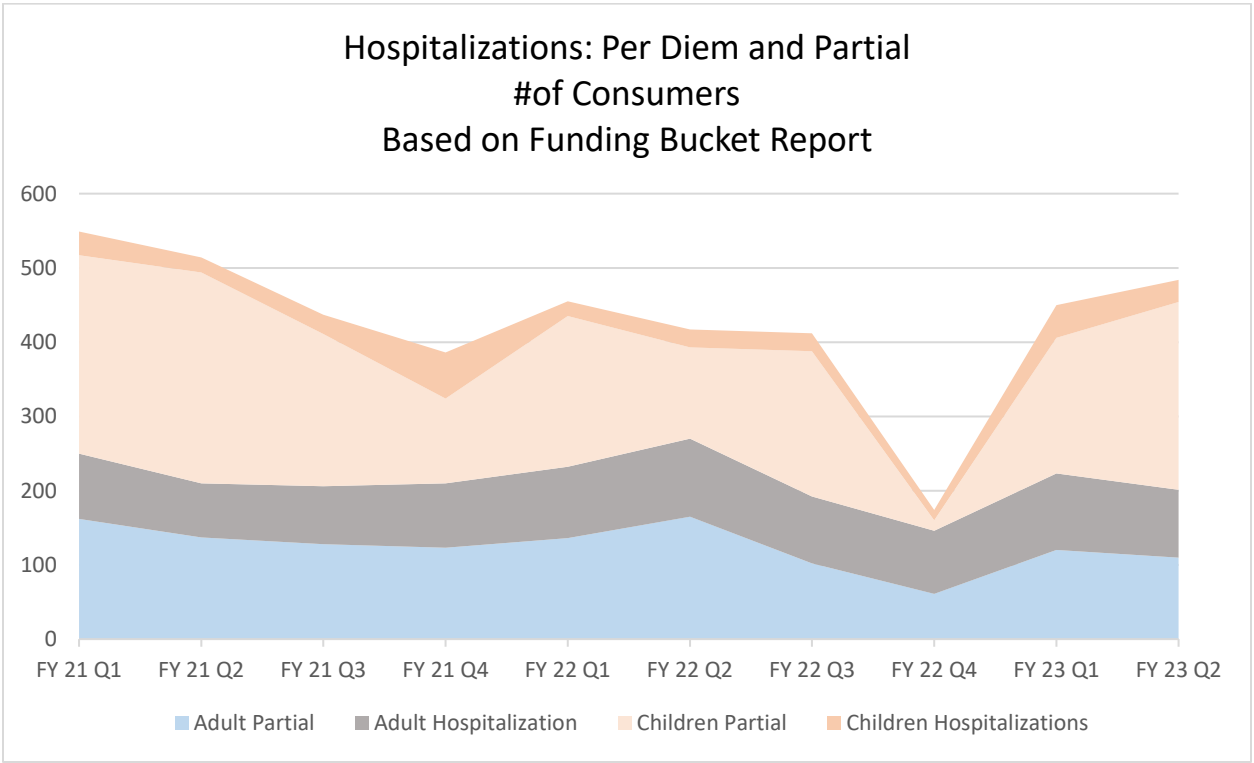

Percentage Receiving Ongoing Service within 14 days of Intake Appt
100%
70%
40%
10%
FY 21 1st Q
FY 21 2nd Q
FY 21 3rd Q
FY 21 4th Q
FY 22 1st Q
FY 22 2nd Q
FY 22 3rd Q
FY 22 4th Q
FY 23 1st Q
FY 23 2nd Q
MI Children
MI Adult
DD Children
DD Adult

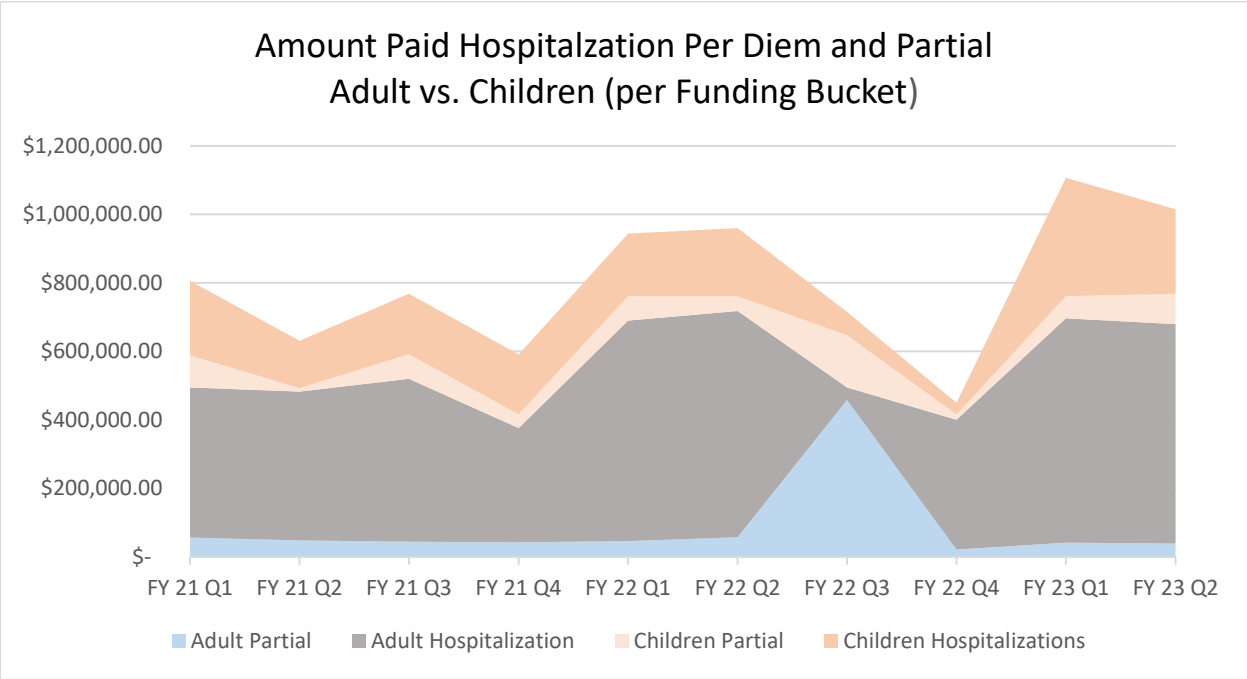
FY 23 2nd Qtr Detail Ongoing Service						
Population	# of New Persons Eligible for Service	# of New Persons who started a new service within 14 days of eligibility	State Defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- used to be removed from the denominator	Percent Compliant under new definition	Percent Compliant under previous definition
MI Child	115	71	44	40	62%	95%
MI Adult	302	232	70	67	77%	99%
DD Child	52	40	12	11	77%	97%
DD Adult	15	13	2	0	87%	87%

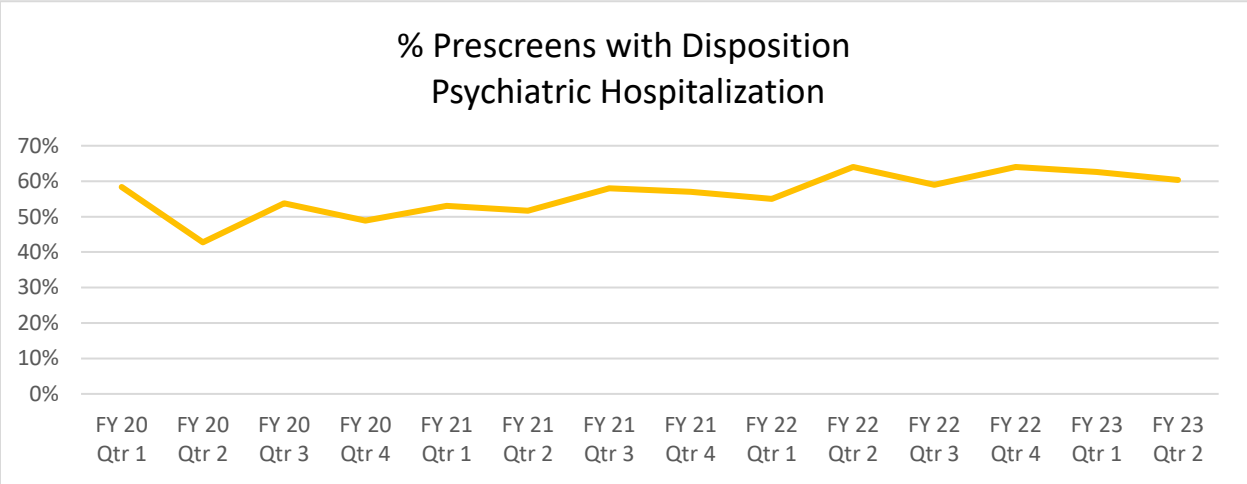


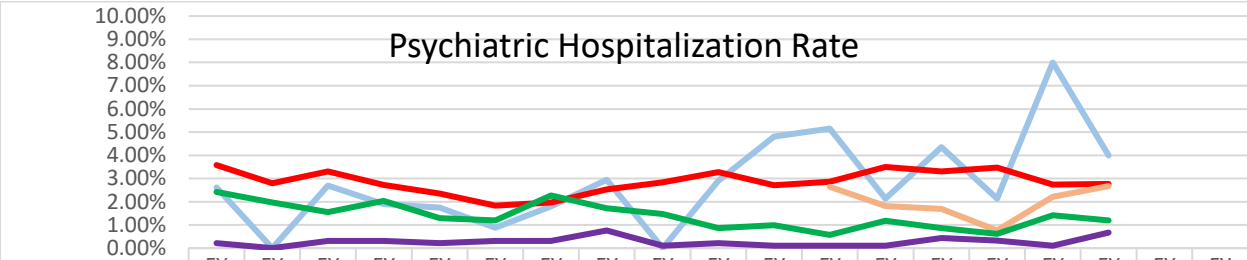


	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4	FY 21 Qtr 1	FY 21 Qtr 2	FY 21 Qtr 3	FY 21 Qtr 4	FY 22 Qtr 1	FY 22 Qtr 2	FY 22 Qtr 3	FY 22 Qtr 4	FY 23 Qtr 1	FY 23 Qtr 2
Blank	2	1		3	2	4	6	6	3	4	6	1	1	4
Partial Hospitalization	115	98	73	114	109	129	96	78	108	93	84	68	115	129
Outpatient/ Support Services	54	82	38	60	60	43	56	78	52	38	45	39	42	34
Inpatient Admission	294	168	158	202	229	230	257	230	210	275	218	209	281	277
Crisis Residential	35	39	22	19	28	27	26	12	11	17	17	9	10	15
Crisis Outreach	4	5	3	15	5	12	5	8	1	1	1	1	0	0



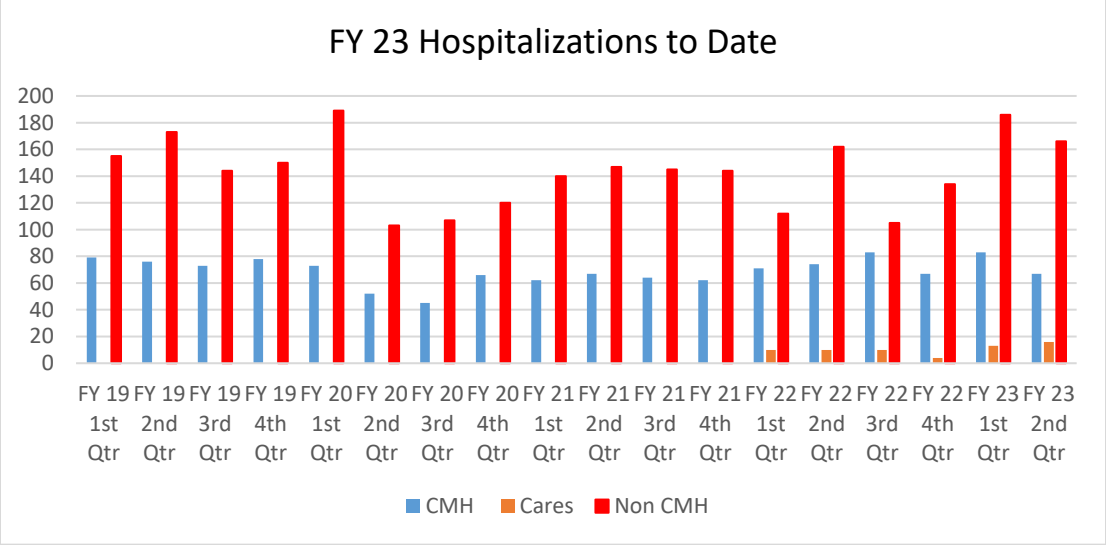

Amount Paid Hospitalzation Per Diem and Partial
Adult vs. Children (per Funding Bucket)
$1,200,000.00
$1,000,000.00
$800,000.00
$600,000.00
$400,000.00
$200,000.00
$-
FY 21 Q1
FY 21 Q2
FY 21 Q3
FY 21 Q4
FY 22 Q1
FY 22 Q2
FY 22 Q3
FY 22 Q4
FY 23 Q1
FY 23 Q2
Adult Partial
Adult Hospitalization
Children Partial
Children Hospitalizations

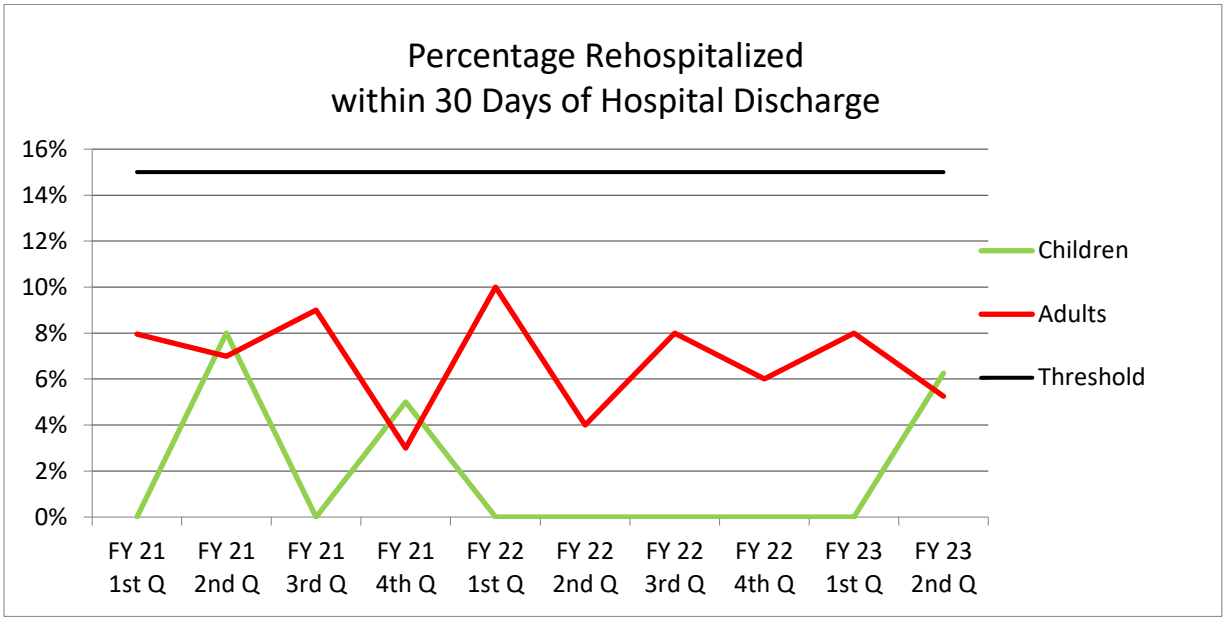

% Prescreens with Disposition
Psychiatric Hospitalization
70%
60%
50%
40%
30%
20%
10%
0%
FY 20 Qtr 1
FY 20 Qtr 2
FY 20 Qtr 3
FY 20 Qtr 4
FY 21 Qtr 1
FY 21 Qtr 2
FY 21 Qtr 3
FY 21 Qtr 4
FY 22 Qtr 1
FY 22 Qtr 2
FY 22 Qtr 3
FY 22 Qtr 4
FY 23 Qtr 1
FY 23 Qtr 2



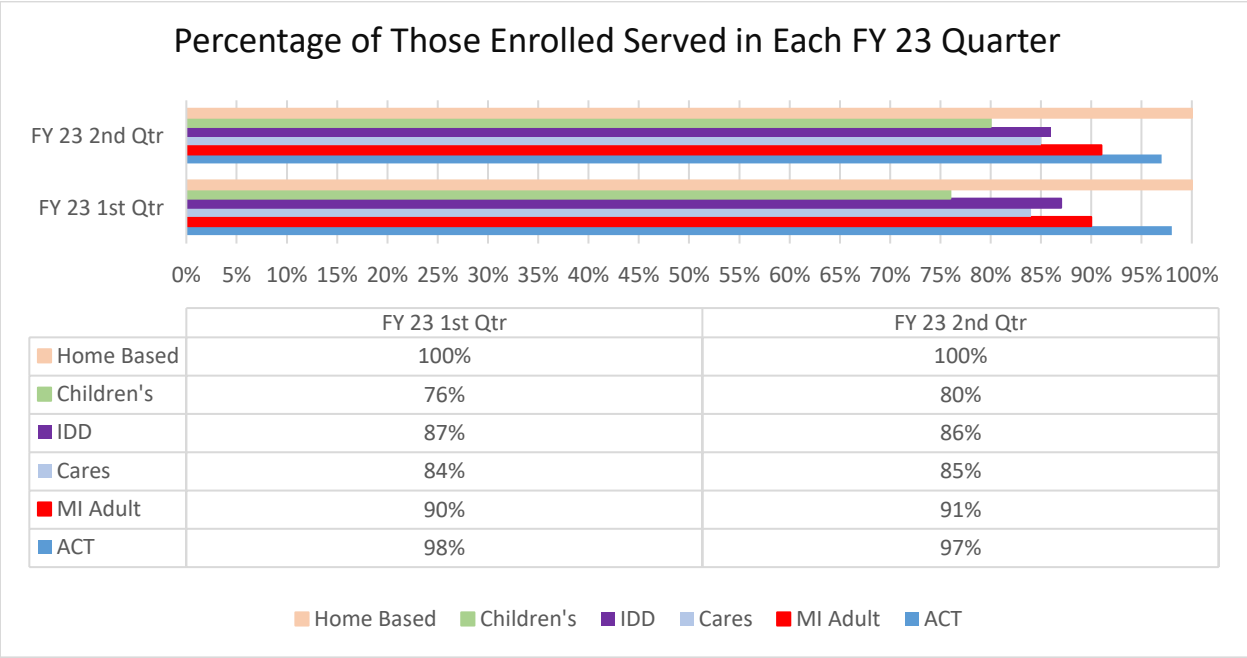
	FY 19 2nd Qtr	FY 19 3rd Qtr	FY 19 4th Qtr	FY 20 1st Qtr	FY 20 2nd Qtr	FY 20 3rd Qtr	FY 20 4th Qtr	FY 21 1st Qtr	FY 21 2nd Qtr	FY 21 3rd Qtr	FY 21 4th Qtr	FY 22 1st Qtr	FY 22 2nd Qtr	FY 22 3rd Qtr	FY 22 4th Qtr	FY 23 1st Qtr	FY 23 2nd Qtr	FY 23 3rd Qtr	FY 23 4th Qtr
ACT	2.61	0.00	2.70	1.90	1.75	0.88	1.80	2.94	0.00	2.91	4.81	5.15	2.13	4.35	2.13	8%	4%		
MI Adult	3.58	2.79	3.30	2.73	2.35	1.83	1.97	2.53	2.83	3.28	2.71	2.86	3.50	3.30	3.47	2.74	2.77		
Cares												2.64	1.82	1.69	0.76	2.21	2.67		
IDD	0.21	0.00	0.31	0.31	0.21	0.31	0.31	0.76	0.10	0.21	0.11	0.11	0.11	0.43	0.32	0.11	0.67		
Y & F	2.42	1.96	1.55	2.04	1.29	1.19	2.27	1.72	1.47	0.86	0.99	0.57	1.18	0.86	0.61	1.42	1.20		

FY 23 2nd Qtr Detail Hospitalizations			
Program	Number Served	Number Hospitalized (Multiple Admits)	% Consumers Hospitalized
ACT	100	4 (1)	4%
MI Adult	1622	45 (3)	2.77%
Cares	600	16 (1)	2.67%
IDD	895	6 (0)	0.67%
Y & F	915	11 (1)	1.20%
Y & F Home Based	19	1 (0)	5.26%





FY 23 2nd Qtr Detail Readmit within 30 days of Discharge			
Population	# Discharged and Core Team Assignment	# Readmitted within 30 days of Discharge	% Readmit
Child	16	1	6.25%
Adult	114	6	5.26%



	FY 23 1st Qtr	FY 23 2nd Qtr
Home Based	100%	100%
Children's	76%	80%
IDD	87%	86%
Cares	84%	85%
MI Adult	90%	91%
ACT	98%	97%

Critical Event Data Reported Thru Qtr 2 FY 2023

Critical Events are population and category driven with definitions mandated by MDHHS. Besides reporting deaths, events are typically reflective of ER treatment or hospital admissions due to injury or medication error and involve Waiver or Residential clients. Arrests are only reported when the individual is either a recipient of a Waiver or is in a Specialized AFC setting.

Time period	Team at Event	Type	Total
Qtr 1	ACT	Hospitalization	1
	Cares	Non Suicide Death	1
	Children's Services	Non Suicide Death	1
	IDD	Arrest	1
		Non Suicide Death	8
	MI Adult	Non Suicide Death	7
		Suicide	1
Qtr 1 Total			20
Qtr 2	ACT	Non Suicide Death	1
	IDD	Suicide	1
		Non Suicide Death	8
	MI Adult	Arrest	1
		Suicide	1
		Non Suicide Death	4
		Hospitalization due to Injury	1
Qtr 2 Total			17

Mortality Data Thru Qtr 2 FY 2023

Cause of Death	Number of Deaths FY 18	Number of Deaths FY 19	Number of Deaths FY 20	Number of Deaths FY 21	Number of Deaths FY 22	Number of Deaths FY 23
Aspiration Pneumonia				2	3	1
Cancer	8	9	7	10	3	3
Cardiovascular	13	14	14	6	12	5
Dehydration	1					
Diabetes				1		
Drug Abuse	12	6	8	2	6	4
Endocrine System (Diabetes)						
Environmental Hypothermia		1				
Fluid Electrolyte Disturbance						1
Gastrointestinal			3	1		2
Hip Fracture Complications	1					
Homicide	3					1
Hyponatremia					2	
Inanition			2			
Infection	3	1	4 (2 - COVID 19)	5 (4 - COVID 19)	4 (3 - COVID 19)	
Kidney Disease	1		1			1
Liver Disease	2		2	3	1	1
Metabolic		1				
Natural/Other	1					
Neurological	2	1	3	7	3	2
Respiratory	5	10	10	4	5	3
Suicide	2	2	6	2	2	3
Trauma	1	2		2	3	
Unknown	10	10	8	15	10	6
Grand Total (Previous years may not include detail of all causes of deaths but Grand Total is accurate.)	**65**	**55**	**68**	**57**	**54**	**33**

Sentinel Events: There was one sentinel event in the second quarter.

Washtenaw County Community Mental Health (WCCMH)
Annual Year End Performance Improvement Report
Fiscal Year 22 (October 1, 2021 – September 30, 2022)

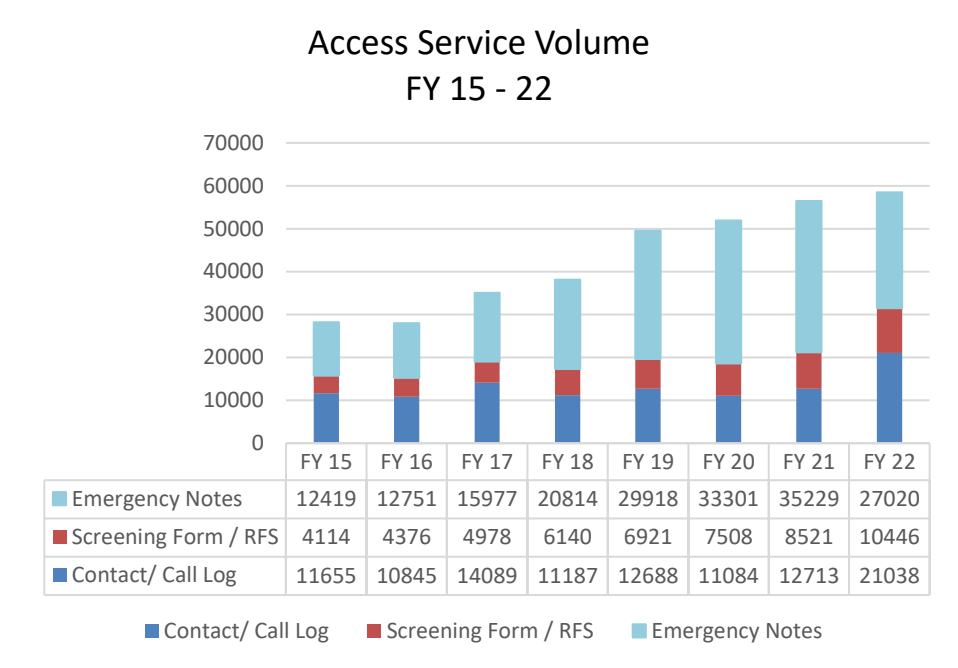
FY 22 Organizational Foci

- WCCMH implemented and actively participated in the Certified Community Behavioral Health Clinic (CCBHC) programming as part of the Michigan demonstration.
- WCCMH, working with Community Partners, implemented and provided ongoing communication of millage initiatives, results and outcomes.
- Reviewed and updated the WCCMH Strategic Plan to include integration of millage, CCBHC and the Community Mental Health Partnership of Southeast Michigan (CMHPSM) funding streams.
- Integrated significant Equity focus within all Strategic Plan goals.
- WCCMH Administration worked to increase funding levels by leading advocacy efforts at local and state levels for a diverse portfolio of funding opportunities, including, but not limited to: Medicaid, CCBHC, Managed Care, and grants.
- WCCMH pursued Medicaid Reimbursement for prior period cost settlement from the State of Michigan to reimburse Washtenaw County for coverage of Medicaid cost overruns.
- WCCMH worked with recruiting companies and advertising agencies to help identify and attract applicants.
- WCCMH advocated for and succeeded in delivering retention bonuses to employees.
- Network Management continued to support, recognize and fund our network provider management system via advocacy and a Caring Hearts Capable Hands recruitment/retention campaign, which includes advertising, a website/QR code, car magnets, and swag items.
- Worked with the Washtenaw Diversion Council to develop recommendations for implementation to impact greater diversion efforts of youth and adults from both the Juvenile and Adult Justice System and into appropriate mental health and substance use disorder alternatives.
- The organization continued to focus on responding to risks presented by the ongoing public health emergency due to the pandemic. Continual changes in mandates, developing hybrid staff schedules and engaging with consumers regarding COVID vaccine acceptance and personal safety during the pandemic were all responded to. This focus included COVID vaccine clinics administered by WCCMH and in conjunction with Public Health and Genoa Pharmacy.
- The Delonis Shelter experienced a significant COVID outbreak between Thanksgiving and the New Year. WCCMH advocated for and worked with the County Administration to develop and staff a temporary housing location (at the Washtenaw County Learning Resource Center) for 65 homeless individuals.
- Continued implementation of the Black Lives Matter (BLM) Task Force with nine events implemented during FY 22 (including Facebook events, "Chat and Chews", and Community events.
- Assessing Suicide Risk - The organization finalized a multi-year focus on using a standardized tool (Columbia Suicide Severity Rating Scale) to assess suicide risk. This focus occurred throughout the region and included upgrading the electronic health record, using the tool, identifying the level of risk, implementing training for all staff and monitoring the use of the C-SSSR.
- Joint Commission Reaccreditation occurred in the summer of 2022 with minimal findings.
- 2022 was the fourth year that the Public Safety and Mental Health Preservation Millage provided funding to expand access to mental health and substance use services across Washtenaw County. These dollars were used to support Washtenaw County youth, to get homeless people into stable housing, to provide services to people who would not otherwise qualify for them, and to divert low-level, low-risk offenders away from the criminal justice system and into much-needed mental health and substance use treatment. The Annual Report provides additional information: https://wccmh-millage-impact-repo-2ead25c4e9faa.webflow.io/

This concludes a narrative overview of various activities conducted during FY 22. Additional information follows which includes WCCMH's performance in some areas of efficiency and effectiveness as indicated by presenting various indicators monitored throughout the year. These indicators may reveal trends and patterns which assist our future foci. This is a summary review of our status in FY 22. Please note, this year we have integrated the CARES datasets into this report.

Access, Triage and Crises

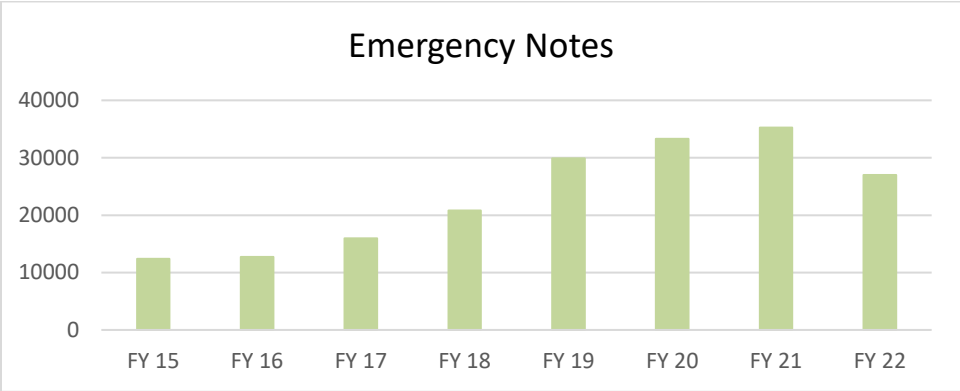
Our indicator monitoring begins with a focus on access to our services. Typically, the process starts with a phone call. The phone call may result in a Call Log or Request for Services (RFS). If the phone call is considered urgent, the call will be routed to the Crisis Team which results in an Emergency Note. Below is a graph of Access Services from FY 15 – FY 22.



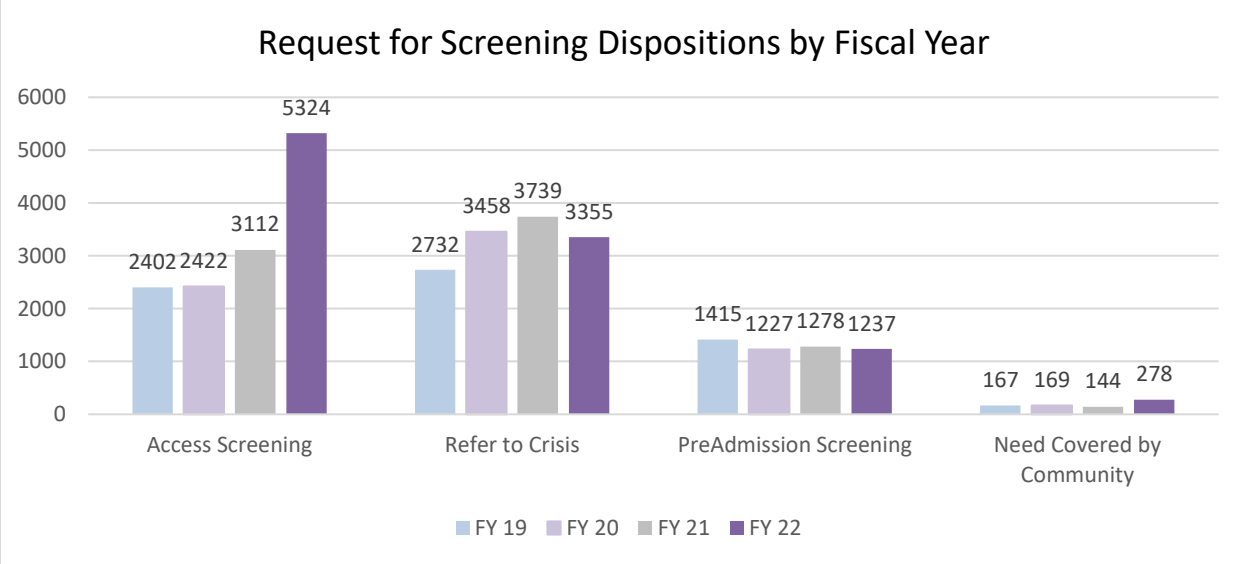
	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22
Emergency Notes	12419	12751	15977	20814	29918	33301	35229	27020
Screening Form / RFS	4114	4376	4978	6140	6921	7508	8521	10446
Contact/ Call Log	11655	10845	14089	11187	12688	11084	12713	21038

Monitoring the total number of services over eight fiscal years continues to reveal a steady increase in services. This past year there were almost twice as many Call Logs as last year. The overall increase is most likely a result of millage funded expansions of services, increased collaborations with various law enforcement departments, marketing, and the development and implementation of our Certified Community Behavioral Health Clinics (CCBHC). It is clear we have increased our ability to identify and respond to the needs in the community.

Continuing to monitor the flow of a request for service, individuals who contact us for services and present with an urgent situation are referred to the Crisis Team which then results in an emergency note. The emergency note will also occur when a Prescreen is needed. Monitoring the volume of emergency notes by fiscal year reveals a significant increasing trend through FY 21 with FY 22 showing a decrease:



The RFS document produces dispositions that can help understand the type of requests that are being fielded. When an individual requests a service, the caller can be routed to an Access Screen, referred to the crisis team if there is an urgent issue, routed for a preadmission screening if there is an emergent situation or given information of options in the community. The graph below includes FY 19 – FY 22 RFS disposition data that pertain to a service request.



A summary of the data is as follows:

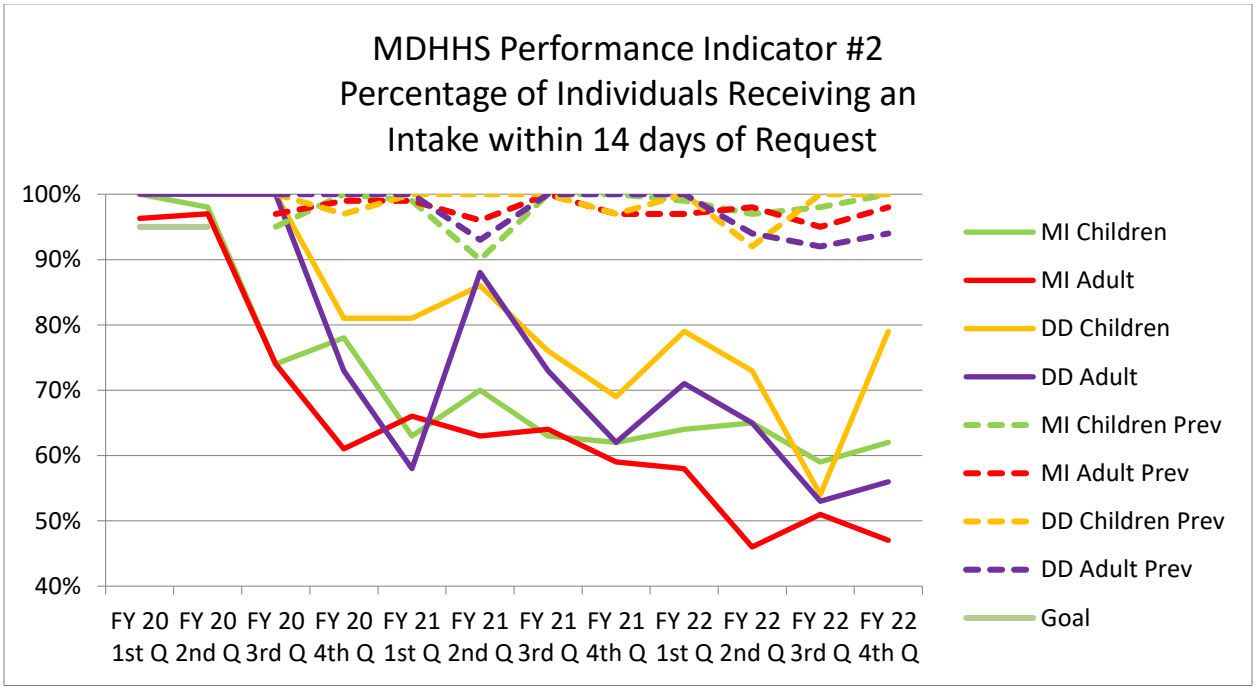
- Over the past four years, there is an overall increase in request for service calls resulting in a disposition of Access Screenings with the past year showing a significant increase. This is most likely a product of both integrating the Cares dataset and implementing the CCBHC.
- For the first three years we saw an overall increase in referrals to our Crisis Team but then a decrease in referrals in the past year.
- Conversely, we see a minimal decrease in the number of calls that resulted in a preadmission screening though in the past three years this is somewhat stable.
- In the past year we saw a strong increase in requests where the need was covered by the community.

These data points suggest the Millage funded services (CARES) and CCBHC may be resulting in:

- More individuals are aware of our services, call us for assistance with their urgent situation, and more individuals are engaged with the Crisis Team.
- More individuals are proceeding to the intake process.
- A decrease in the number of emergent situations possibly because WCCMH and/or the community may have more options to respond to situations when they are urgent.
- WCCMH is providing services for more consumers (CARES and CCBHC services).

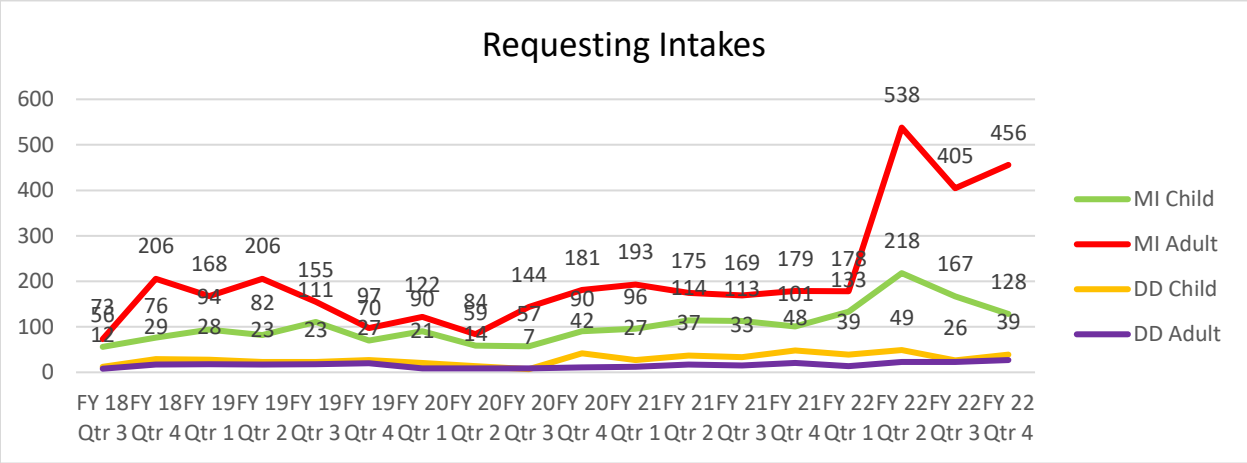
RFS dispositions, resulting in "Access Screening" leads to the Access department determining if the individual would benefit from an eligibility assessment which results in the scheduling of a Biopsychosocial (BPS) appointment. (Please note, callers seeking substance use services may be routed elsewhere.) The individual receiving their BPS/intake appointment within fourteen days of the request is one of the Michigan Department of Health and Human Services (MDHHS) performance indicators (specifically indicator #2). As of April 1, 2020, the MDHHS changed the operational definitions for calculating Indicators #2 (14 days to Intake) and #3 (14 days to ongoing service) and removed the historical goal of 95% compliance. The major change in the operational definition does not allow accounting for individual choice of when they want their appointment or choosing to not attend the appointment. The new definition identifies a case as noncompliant if the BPS does not occur within 14 days regardless of the consumer's preference. Because of the changes in the definition, the number of out of compliance cases has increased statewide.

The graph below shows our historical compliance rate for Indicator #2 (14 days to intake) under the previous definition and the new definition starting third quarter FY 20 (April 1, 2020). The "dashed lines" indicate where our compliance would have been under previous definitions. (Please note, for State Performance Indicators, all population naming follows the MDHHS population naming convention. MDHHS continues to identify adults who experience a developmental disability as "DD Adult" while our internal programming describes these individuals as experiencing an Intellectual and/or Developmental Disability (IDD)).



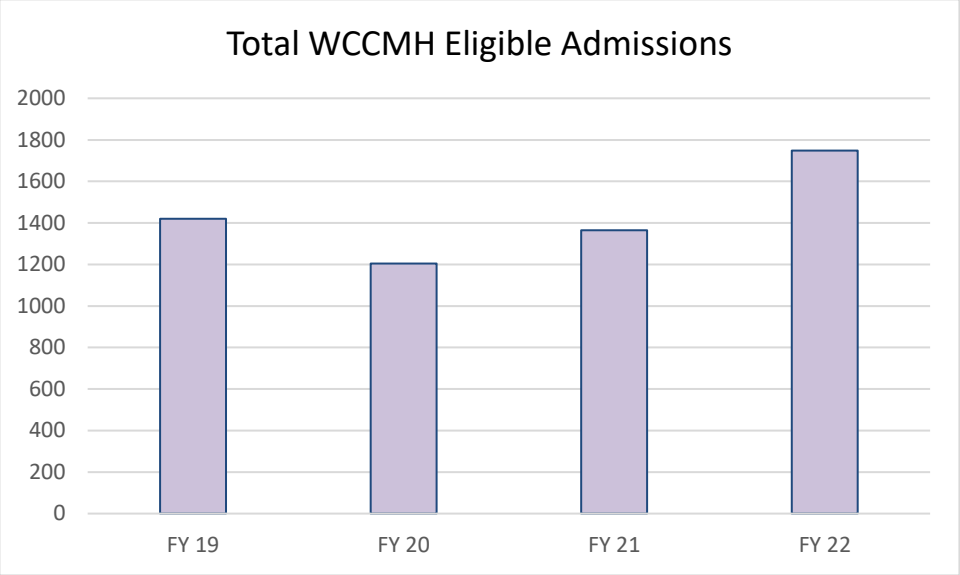
The Performance Improvement Department and Program Administrators evaluate each case out of compliance to identify trends and / or patterns and identify possible systemic improvements. This arduous focus continually identifies the individual's preference has a significant impact on the intake occurring within 14 days. This preference is indicated by the consumer scheduling the appointment outside of 14 days, rescheduling the appointment, or not showing up for the appointment. Our Access Department offers appointments as close to the request as possible hoping this will help the consumer keep the appointment as a priority. However, consumers seeking services often have competing priorities or other variables that prohibit them from attending appointments within 14 days.

With the implementation of CCBHC and the integration of CARES datasets, we saw a significant increase of requests for intakes as indicated below:

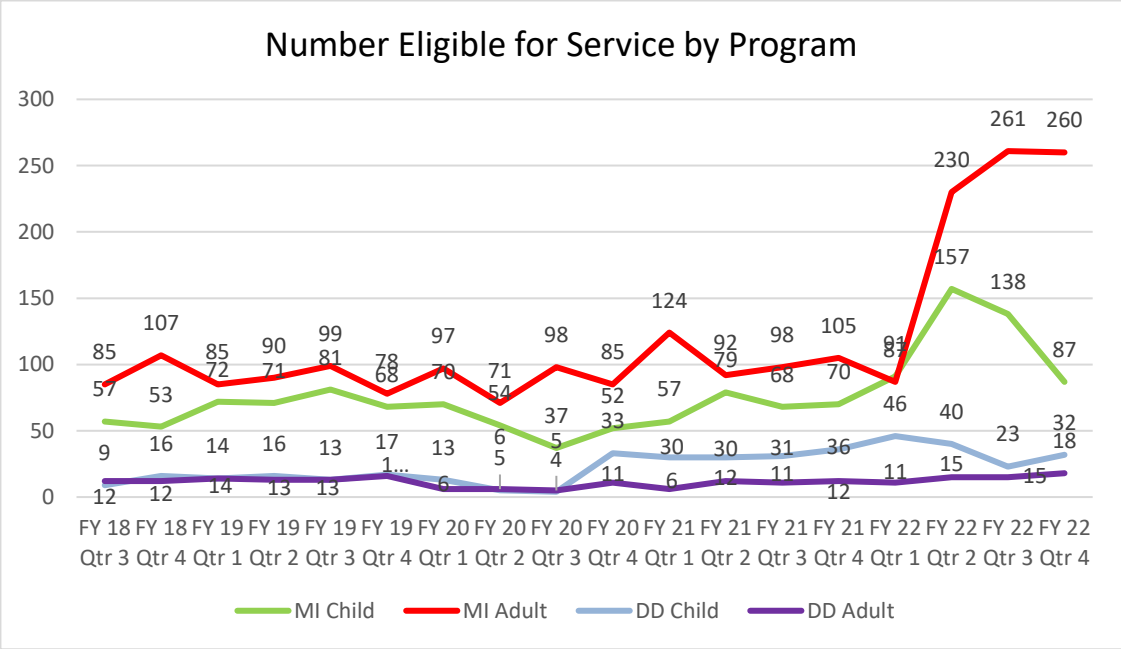


The increase in requests for Adults who experience mental health complications is remarkable. Children with mental health complications is also increasing. These increases reflect CCBHC's ability to service the mild to moderate symptoms which allows WCCMH to be able to identify and serve more individuals with mental health complications. This is great for the community and the increase in volume is challenging given the number of vacancies and the difficulty attracting applicants.

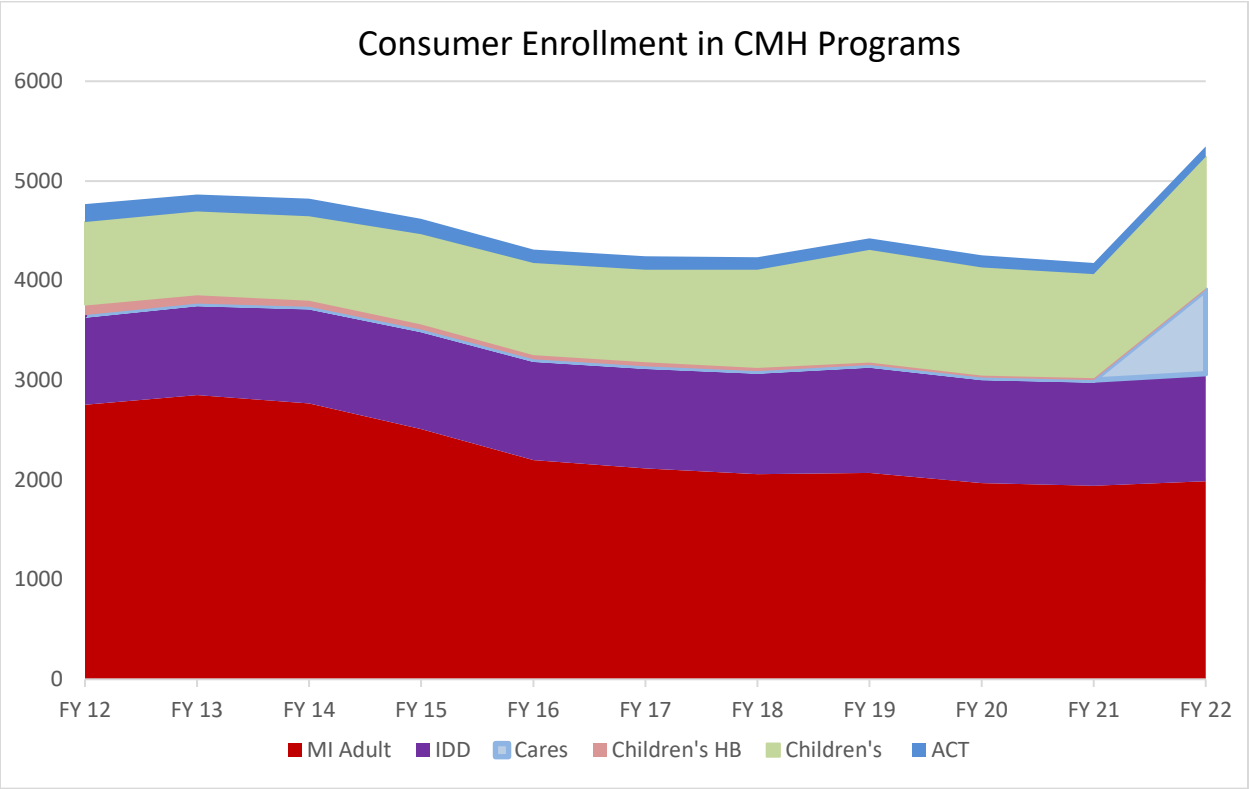
The BPS (intake) results in identifying eligibility. With the increase in BPSes it is not surprising the number of individuals identified as eligible has increased a great deal as well.



The FY 22 admissioms are significantly higher than in years past. Those eligible for services are then admitted into one of our programs. Tracking these admissions into WCCMH reveals the following graph:



Not surprisingly, with intakes increasing for adults and children who experience mental health symptoms, the number of consumers eligible for program is increasing as well. The following graph identifies the cumulative enrollment in each of the WCCMH core programs by fiscal year.

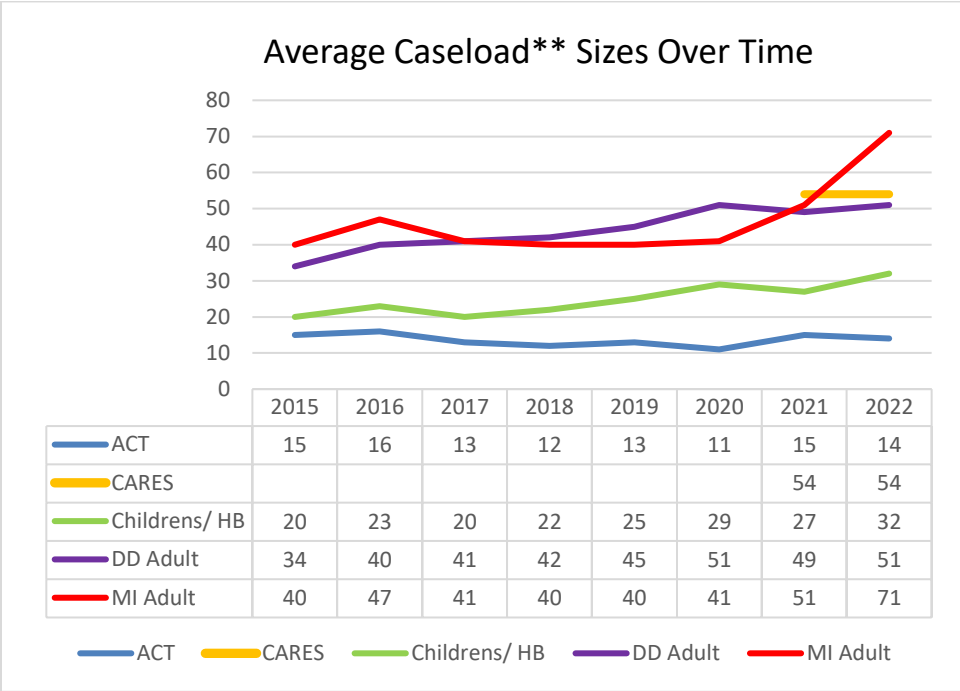


Cumulative enrollment shows overall increase in admission to WCCMH services which is impacted by the implementation of CCBHC and integration of the CARES dataset.

While experiencing higher enrollment, we also juggled higher vacancy rates. In the second quarter of FY 22, we began monitoring our turnover rate defined as the the number of terminations (voluntary and involuntary) divided by the average number of active positions during the quarter. This rate for each quarter was:

Quarter	Average Number of Active Positions	Number of Terminations	Turnover Rate
2nd	372	14	3.8%
3rd	362	20	5.5%
4th	364	16	4.3%

Higher enrollment amidst ongoing turnover impacted caseload sizes. As individuals are found eligible for service, their case is opened, assigned to a program and then assigned to a caseload. The graphic below displays the average caseloads. The trending increase of caseload sizes began in FY 19 (due to a hiring freeze). In the past two years there has also been a higher number of vacancies due to very few applicants for open positions (note- this phenomena is not limited to Washtenaw County and continues to impact all Community Mental Health centers throughout the state).

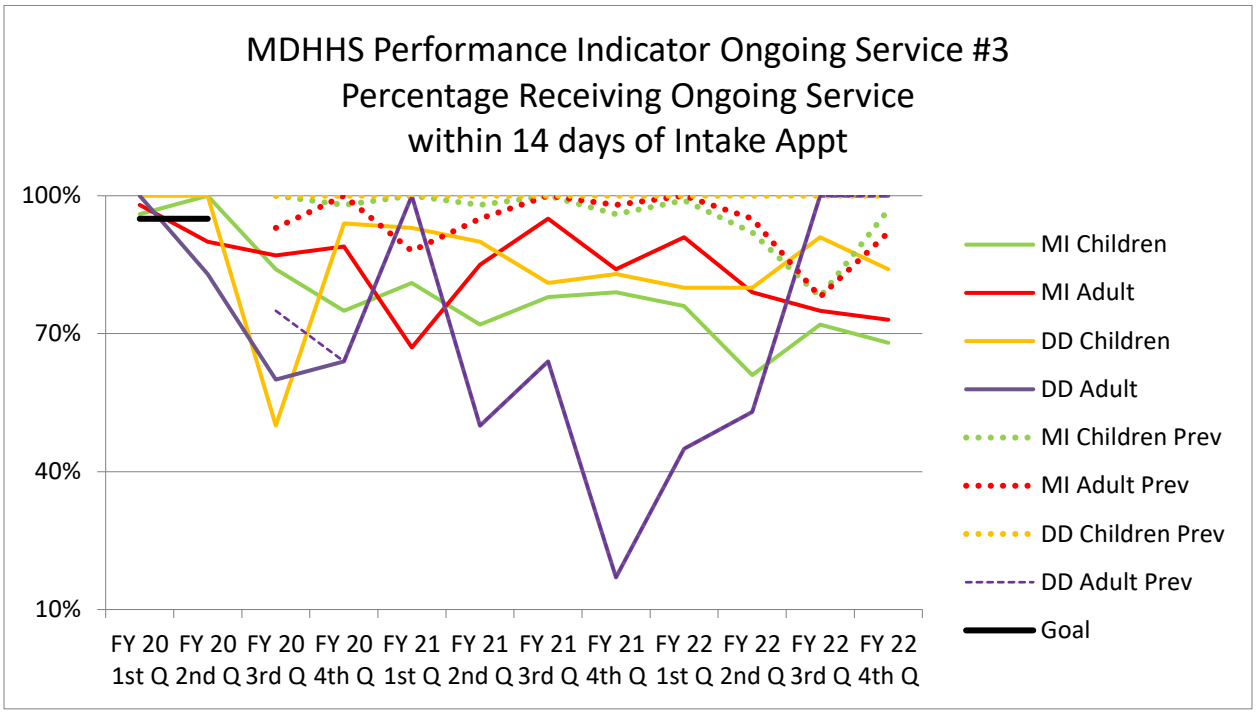


	2015	2016	2017	2018	2019	2020	2021	2022
ACT	15	16	13	12	13	11	15	14
CARES							54	54
Childrens/ HB	20	23	20	22	25	29	27	32
DD Adult	34	40	41	42	45	51	49	51
MI Adult	40	47	41	40	40	41	51	71

*Children's/ Home Based and Assertive Community Treatment (ACT) have much lower caseload sizes due to MDHHS and/or Medicaid mandates.
**Average caseload does not reflect the full variance a program can experience over the course of a year

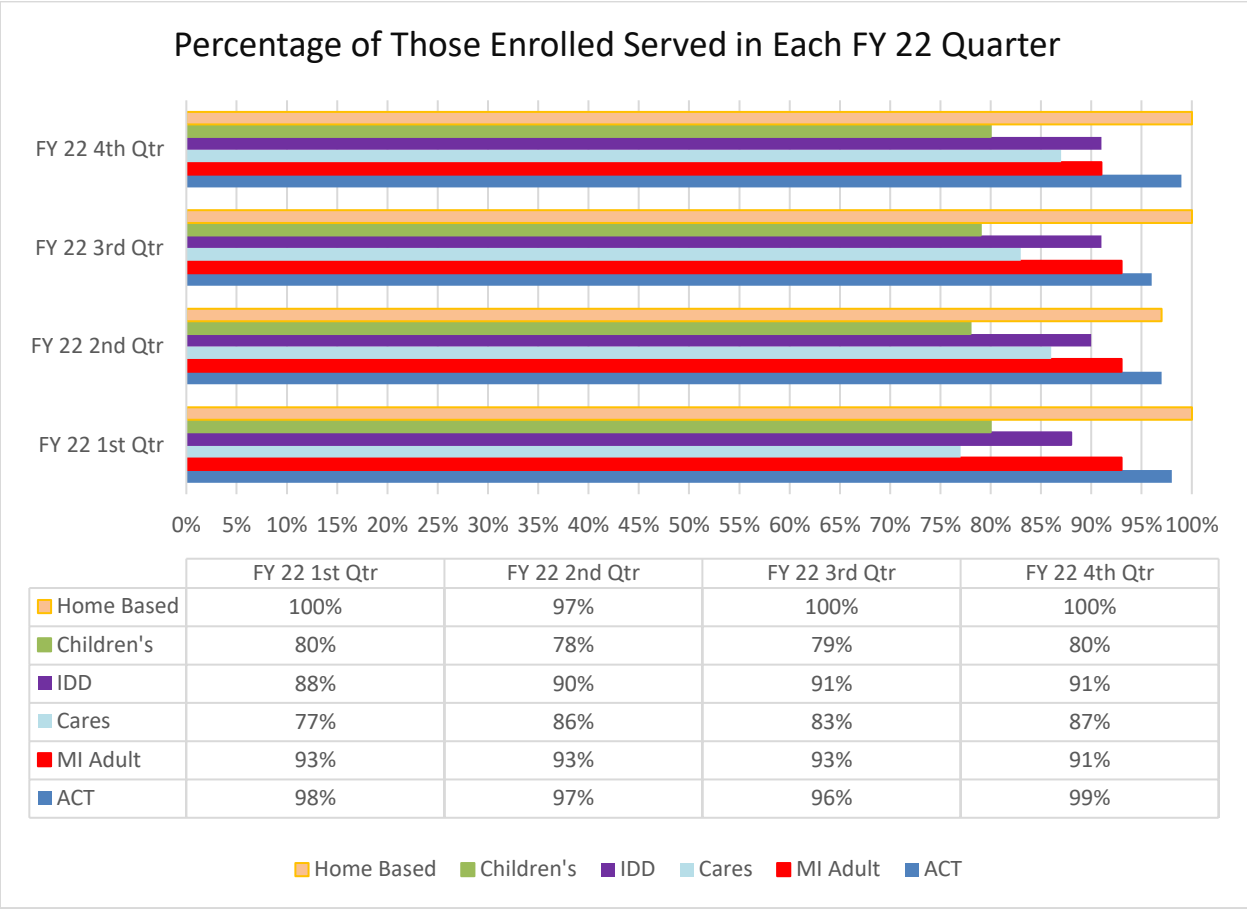
MI Adult continues to experience an increase in the average caseload with FY 22 being 28% higher than FY 21 and 42% higher than FY 19 & 20. Children's programs have also experienced increased caseload sizes which hit their highest marks in FY 22 and are 30% higher than before the hiring freeze. IDD also experienced an overall increase in caseload sizes and are about 20% higher than before the hiring freeze. ACT caseload sizes experienced variance. CARES baseline appears to be 54.

Once a case is assigned to a primary staff, ongoing services are initiated. Below is a graph showing the percentages of consumers who received their first ongoing appointment within 14 days which is the MDHHS Performance Indicator #3. As in indicator #2, the definition of compliance changed for indicator #3 in 2020 and the new definition does not take into account the consumer's preference (e.g. scheduled outside of 14 days, rescheduled by consumer or no show). The new compliance rate is much lower than prior to the definition change.



The DD Adult dashed line merges with the solid line of actual compliance indicating the individual's preference is not impacting on overall compliance. There has been an increase in DD Adult meeting with the consumer for the ongoing service within 14 days due to strong and effective programmatic changes.

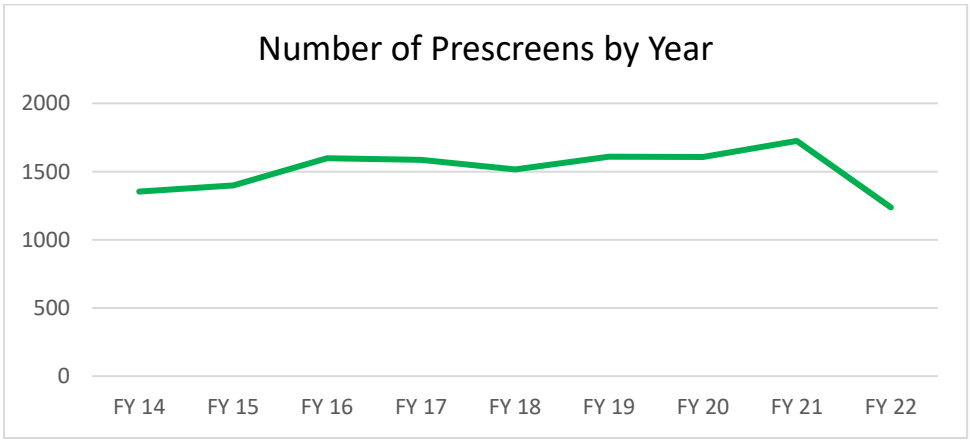
The organization's priority has been to ensure the individual is receiving their services and that we remain in contact with them. Of those enrolled, it is helpful to monitor the percentage receiving a service in the designated time period as indicated below:



	FY 22 1st Qtr	FY 22 2nd Qtr	FY 22 3rd Qtr	FY 22 4th Qtr
Home Based	100%	97%	100%	100%
Children's	80%	78%	79%	80%
IDD	88%	90%	91%	91%
Cares	77%	86%	83%	87%
MI Adult	93%	93%	93%	91%
ACT	98%	97%	96%	99%

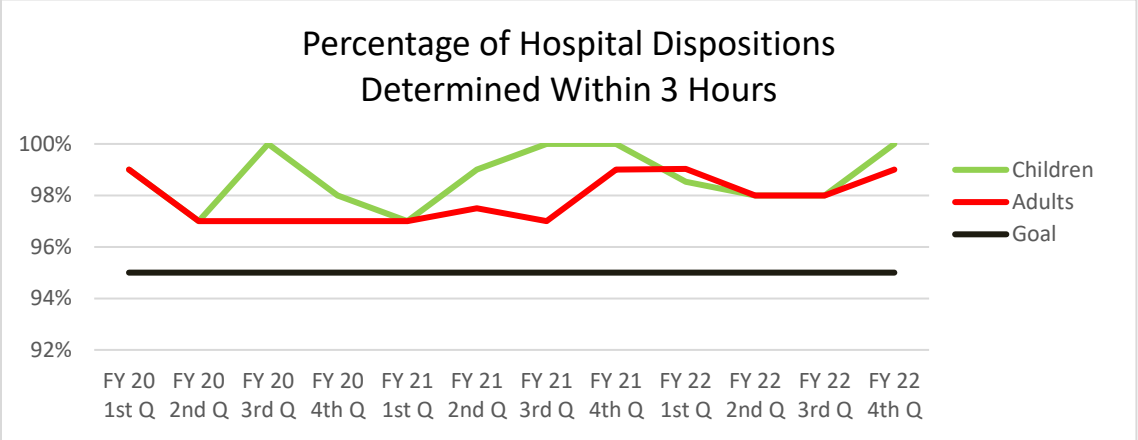
This graph displays the percentage of individuals receiving at least one service in the corresponding time period. It should be noted, engaging those enrolled in the Children's program can be quite challenging due to the complexity and competing priorities in the family's life.

Whether or not a consumer is open to our organization, they may experience a psychiatric crisis. The consumer is evaluated for the appropriate level of care during a Preadmission Screening. Below are the total number of Crisis Hospital Prescreens over a nine-year period:



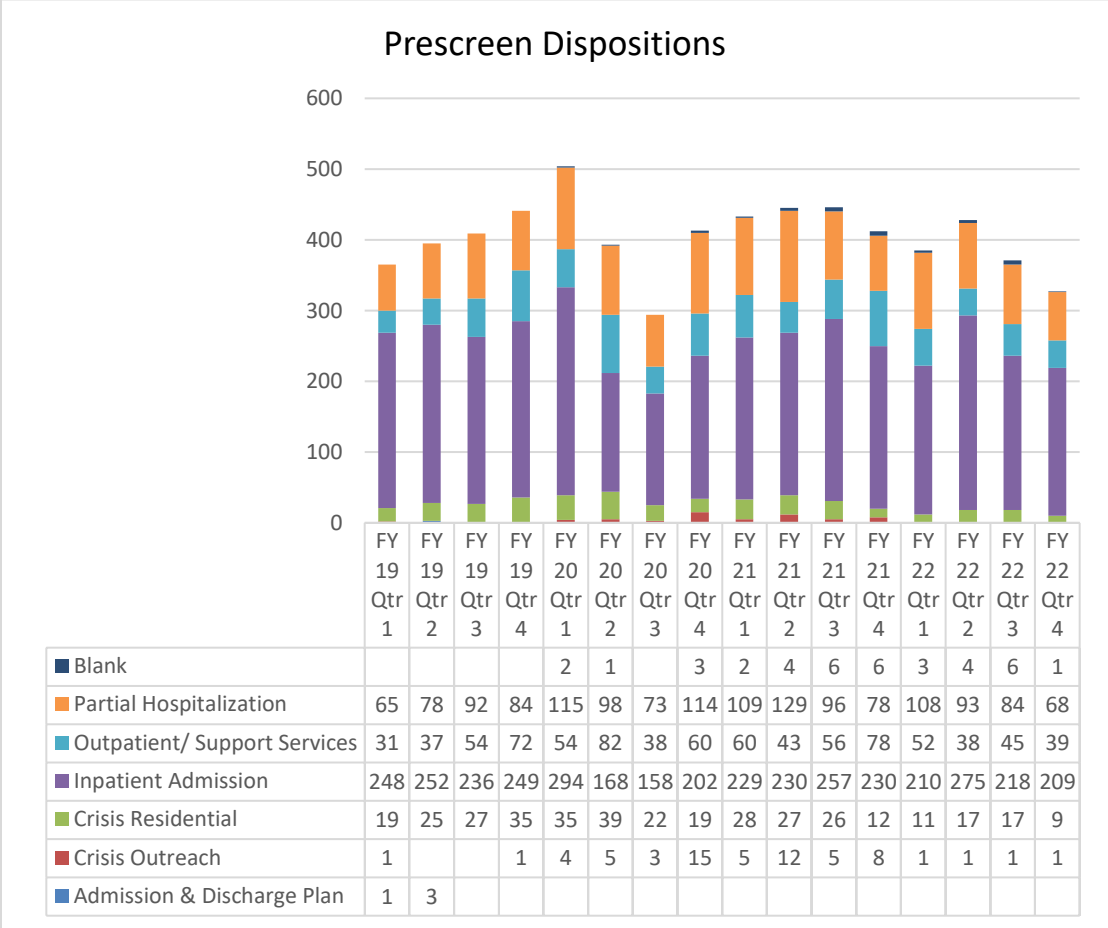
Overall, the number of Crisis prescreens increased through FY 21 and decreased to its lowest number in nine years in FY 22.

During the hospital prescreen, the organization has three hours from the moment the individual is medically cleared to complete the disposition which includes identifying the level of service needed to address the emergent issue. This is another performance indicator monitored by MDHHS (Indicator #1). Our ability to achieve higher than the expected 95% compliance is depicted below:



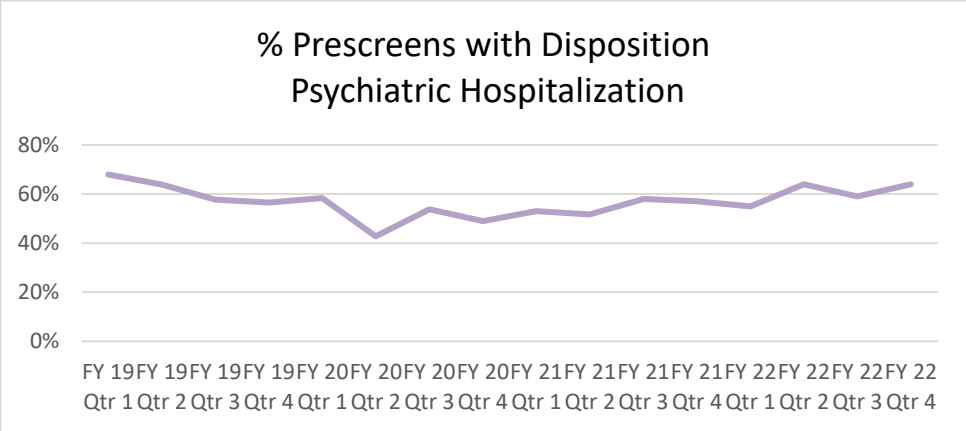
We continue to excel beyond expectations.

Of the Crisis Prescreens, it is useful to look at all disposition categories that resulted from the screening. The following graph helps to pictorially represent these dispositions.



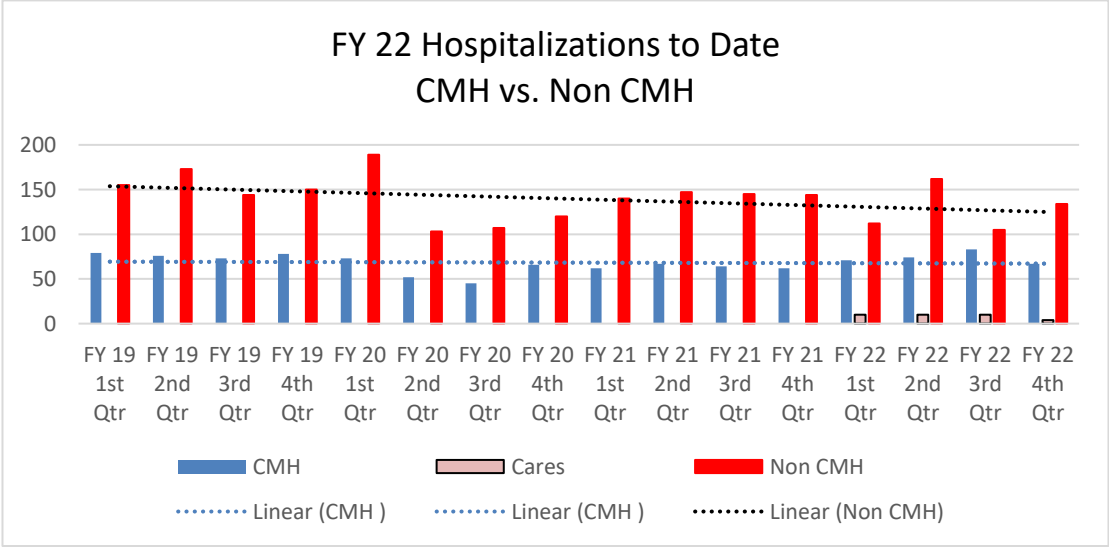
	FY 19 Qtr 1	FY 19 Qtr 2	FY 19 Qtr 3	FY 19 Qtr 4	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4	FY 21 Qtr 1	FY 21 Qtr 2	FY 21 Qtr 3	FY 21 Qtr 4	FY 22 Qtr 1	FY 22 Qtr 2	FY 22 Qtr 3	FY 22 Qtr 4
Blank					2	1		3	2	4	6	6	3	4	6	1
Partial Hospitalization	65	78	92	84	115	98	73	114	109	129	96	78	108	93	84	68
Outpatient/ Support Services	31	37	54	72	54	82	38	60	60	43	56	78	52	38	45	39
Inpatient Admission	248	252	236	249	294	168	158	202	229	230	257	230	210	275	218	209
Crisis Residential	19	25	27	35	35	39	22	19	28	27	26	12	11	17	17	9
Crisis Outreach	1			1	4	5	3	15	5	12	5	8	1	1	1	1
Admission & Discharge Plan	1	3														

Overall, the need for inpatient admissions remained somewhat consistent while the use of outpatient support services had a high in first quarter and then decreased. There was also a trending decrease in the use of partial hospitalization. Monitoring the percentage of prescreens that result in dispositions of psychiatric hospitalizations reveals the following:



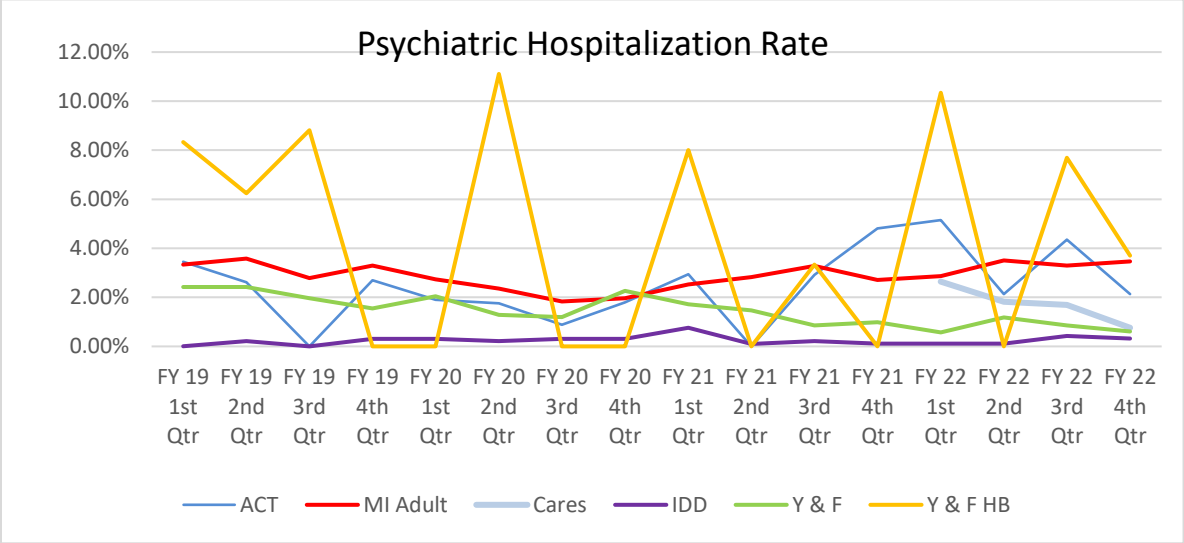
This overall increase in percentages suggests a high clinical acuity.

Many of our prescreens occur for individuals who are not open to our services but are in the community, do not have insurance or are underinsured and may require inpatient psychiatric hospitalization. These medically necessary situations are funded by WCCMH. Below are hospitalization data points differentiating those in the community and not open to us (NON CMH), those open to our CMH services (CMH) and Consumers assigned to the CARES program. Monitoring a trend of how many individuals experiencing a psychiatric crisis resulting in an inpatient hospitalization assists us in understanding community need. Data regarding the hospitalization trends over four fiscal years between these two categories is depicted below and also includes the CARES data in FY 22:



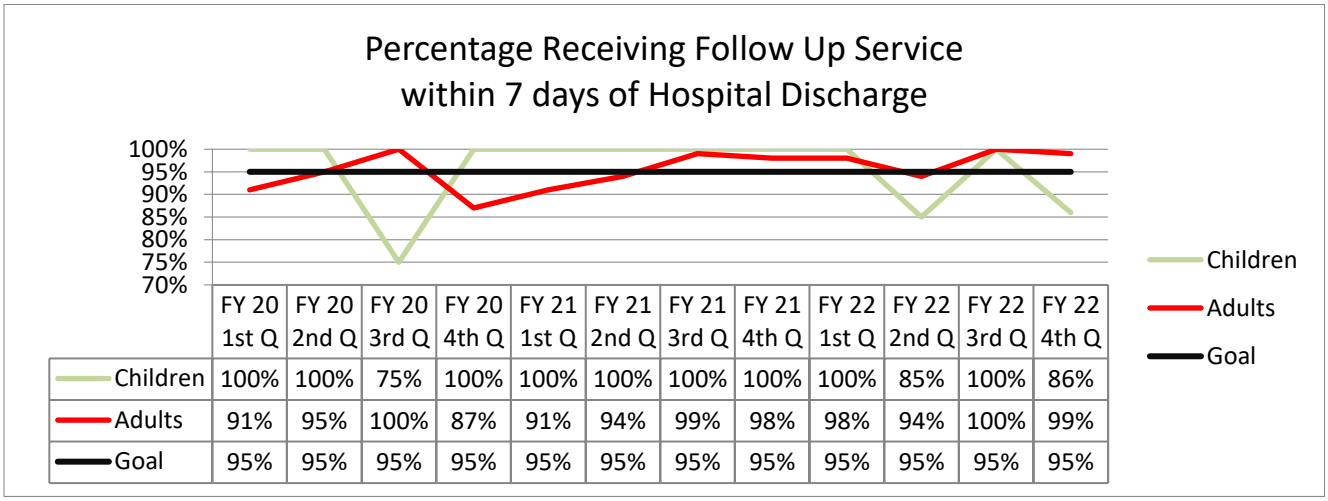
Psychiatric hospitalizations of CMH-served individuals (open CMH cases) overall seems to have a somewhat stable pattern though is influenced from low data points in the pandemic time period. Non-CMH individuals show a decrease in hospitalizations. Hospitalization data for the CARES program is now included in this graph though the baseline is still being understood.

Considering a psychiatric hospitalization rate (number of individuals hospitalized compared to number of individuals served as an open case) can be a very useful measure to monitor as it helps identify the percentage of admissions per those served. The following graph helps depict these rates and possible trends:



The Youth and Family Home Based program experiences significant variance due to their low numbers in the program (i.e., if one or two people are hospitalized, their percentage rate is high due to a low denominator). ACT continues to experience a higher hospitalization rate than in the past which is also consistent with the overall increased acuity that programs have been identifying. The MI Adult Team experiences a higher rate as well.

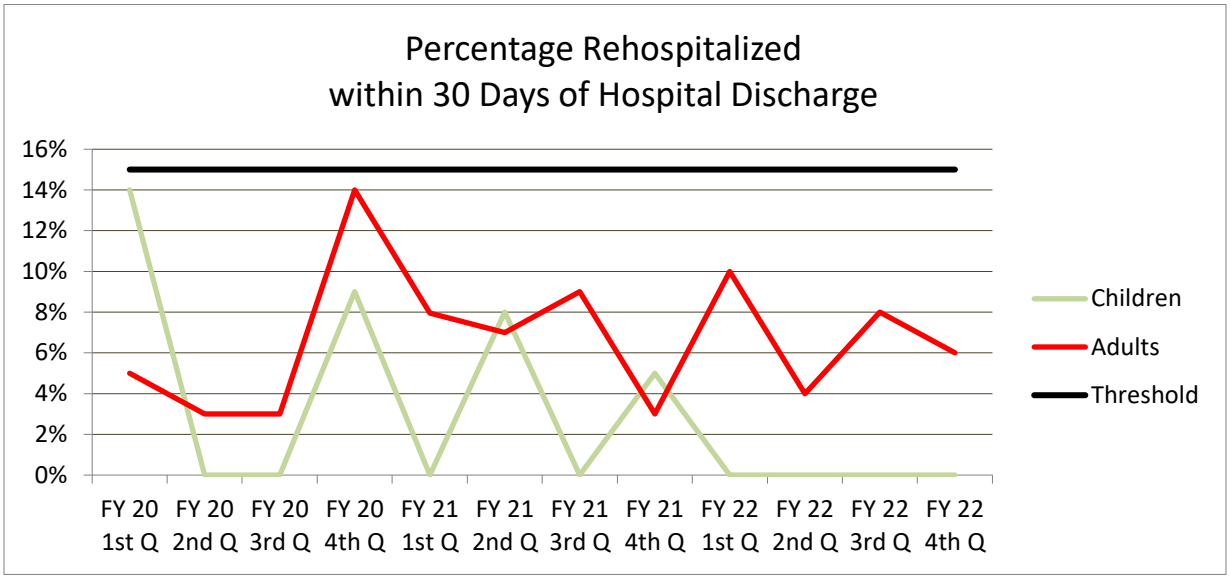
When an individual is discharged from a psychiatric hospitalization, we schedule a service within 7 days of their discharge. Below are graphs of the MDHHS Performance Indicator monitoring open WCCMH cases of children and adults who were psychiatrically hospitalized and received a face-to-face service within 7 days of their discharge.



	FY 20 1st Q	FY 20 2nd Q	FY 20 3rd Q	FY 20 4th Q	FY 21 1st Q	FY 21 2nd Q	FY 21 3rd Q	FY 21 4th Q	FY 22 1st Q	FY 22 2nd Q	FY 22 3rd Q	FY 22 4th Q
Children	100%	100%	75%	100%	100%	100%	100%	100%	100%	85%	100%	86%
Adults	91%	95%	100%	87%	91%	94%	99%	98%	98%	94%	100%	99%
Goal	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

The percentage rates for Children's services were below the goal for the second and fourth quarters due to their denominator being very low so if one case is out of compliance, this can result in not meeting the goal. Adult programs dipped a bit below the goal for the second quarter. Children's and Adult services did very well otherwise.

The following MDHHS Performance Indicator helps to monitor our effectiveness of avoiding repeat hospitalization within 30 days of discharge from the hospital. This graph is comprised of adults and children who are enrolled in and receive services from WCCMH, were hospitalized and then re-hospitalized within 30 days of discharge.



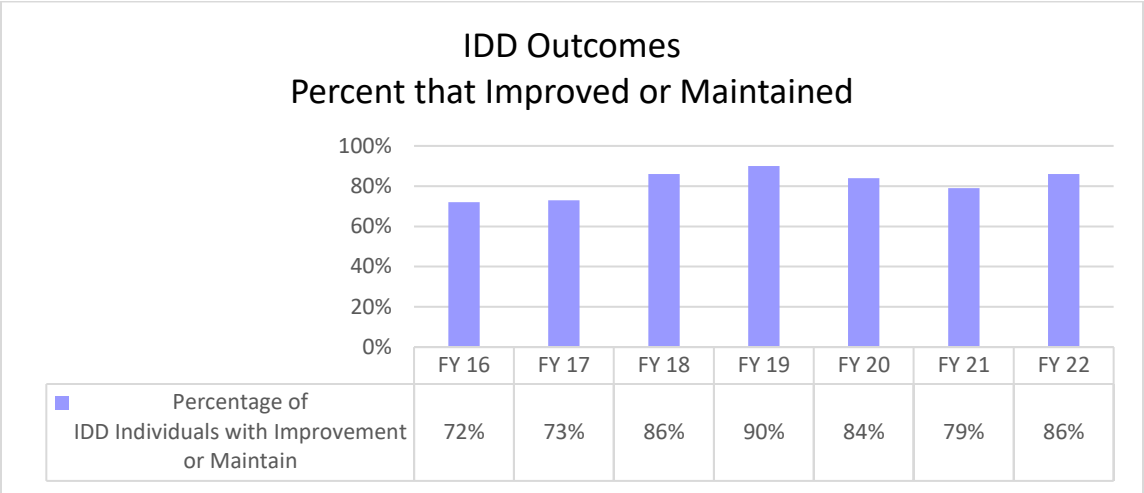
The organization continues to remain below the MDHHS threshold of 15%. Children's services did not have a repeat hospitalization within 30 days of discharge for the entire year.

Program Outcomes

IDD Program Outcomes

Adults with an Intellectual/Developmental Disability are continually assessed with the standardized "DD Outcome" tool. The tool was developed in 2007 to quantify the status of an individual's life domains and needs. The tool was then implemented to achieve a standardized manner of collecting outcome data. The tool focuses on the individual's status and/or level of independence in factors of Self Determination (Work, Community Living, Choice & Decision Making, Relationships, Housing) and Health and Welfare (Safety, Safety Education, Health Access, and Wellness). Their status in each of these items is assigned a quantitative designation. The range of assigned number is from 1 – 5. "1" reflects extreme need while "5" reflects that specific area is addressed and in place. Based on the sum of completed items, an average for all items is determined. This tool continues to be used in a standardized manner by WCCMH.

Identifying aggregated results of maintaining status or improving are developed based on calculating differences between the average scores of the most recent assessment and the initial assessment.



IDD shows an increase in the percentage of individuals who improved or maintained their outcome values and is on par with FY 20.

Youth and Family Program Outcomes

The Youth and Family program uses the Child, Adolescent Functional Assessment System (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) as valid and reliable outcome measures for children who experience a serious emotional disorder. The CAFAS is used for children who are in school and are between 7 and 18 years old. The PECFAS is used for children 3 years old and under 7 years old.

The CAFAS Total Score is the sum of the impairment ratings for the 8 subscales for the youth. For each subscale, the rater selects the item(s), which are true for the youth, which in turn, determines the youth's level of impairment for that subscale. There are 4 levels of impairment based on the score (indicated parenthetically): Severe Impairment (30), Moderate (20), Mild (10), and No or Minimal (0) Impairment. Reviewing this outcome for FY 20 indicates the program has made a significant difference in the individuals they serve. For this administrative report, CAFAS Total Scores are aggregated across youths and a comparison is made between the scores for the initial and most recent assessments. A lower score at the most recent assessment indicates a positive change. The difference in scores is also calculated: a positive number indicates improvement in functioning, 0 indicates no change, and a negative number indicates greater functional impairment. The findings are broken down between inactive episodes of care (closed cases) and for both inactive and active episodes of care (closed and open cases).

FY 22 Child and Adolescent Functional Assessment Scale (CAFAS)

Difference Between Average CAFAS Youth Total Score for Initial and Most Recent Assessments (for inactive episodes of care with a sample size of 247): **20**

Average CAFAS Youth Total Score on Initial Assessment: **99**

Average CAFAS Youth Total Score on Most Recent Assessment: **79**

Difference Between Average CAFAS Youth Total Score for Initial and Most Recent Assessments (for both active and inactive episodes of care with a sample size of 601): **19**

Average CAFAS Youth Total Score on Initial Assessment: **97**

Average CAFAS Youth Total Score on Most Recent Assessment: **78**

The finding for inactive cases identifies a significant improvement (a score greater than 20 indicates a statistically significant change) and an impressive difference between initial and most recent assessment. The significant improvement is consistent with previous year's findings though inactive cases showed a higher change in FY 21.

The finding that includes both active and inactive cases indicate a change just below what is considered statistically significant (20) though still reflects positive improvement for the children suggesting the program model is effective. Typically, we do not see a statistically significant change in this category because the active cases are still receiving interventions and may not have experienced a significant change yet. The same change amount was identified in FY 21.

The PECFAS is a "preschool" version of the CAFAS that assesses the child's functioning over relevant life domains and overall improvement. The PECFAS Total Score is based on the same subscales as the CAFAS and also includes information from the Caregiver (Material Needs, Family/Social Support). The four levels of impairment are the same as the CAFAS.

For this administrative report, PECFAS Total Scores are aggregated across youths and a comparison is made between the scores for the initial and most recent assessments. A lower score of the most recent assessment indicates a positive change. The difference score is also calculated: a positive number indicates improvement in functioning, 0 indicates no change, and a negative number indicates greater functional impairment. The findings are broken down between inactive episodes of care (closed cases) and for both inactive and active episodes of care (closed and open cases).

FY 22 Preschool and Early Childhood Functional Assessment Scale (PECFAS)

Difference Between Average PECFAS Youth Total Score for Initial and Most Recent Assessments (for inactive episodes of care with a sample size of 27: **26**

Average PECFAS Youth Total Score on Initial Assessment: **70**

Average PECFAS Youth Total Score on Most Recent Assessment: **44**

Difference Between Average PECFAS Youth Total Score for Initial and Most Recent Assessments (for both active and inactive episodes of care with a sample size of 74): **20**

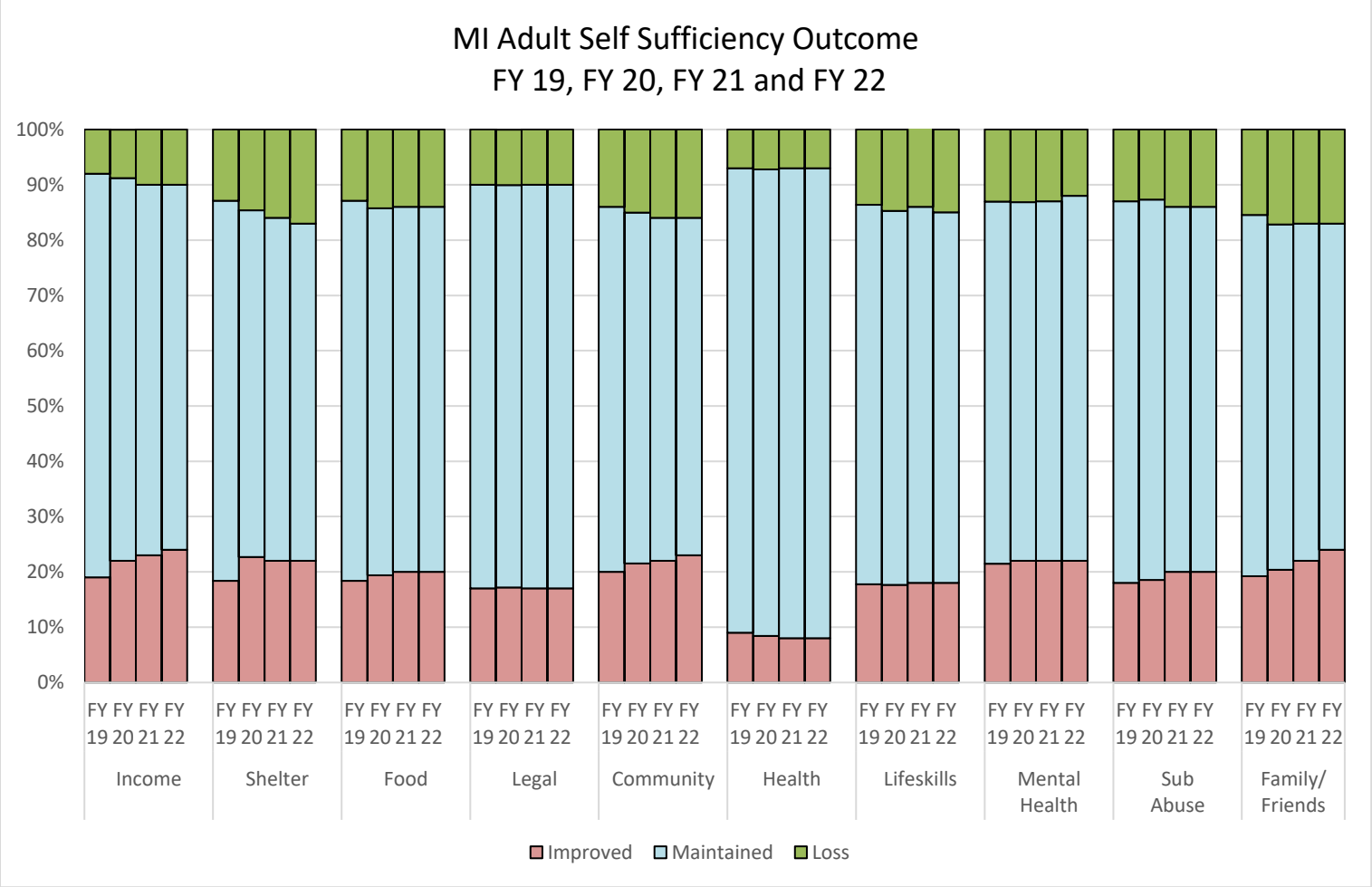
Average PECFAS Youth Total Score on Initial Assessment: **80**

Average PECFAS Youth Total Score on Most Recent Assessment: **60**

PECFAS Outcomes for FY 21 had changes between Intake and final assessment of 13 (sample size 22) and 14 (sample size 56) for inactive episodes of care and both active and inactive respectively. In FY 21, the changes were not significant. However, in FY 22, the changes for both outcomes were significant which shows very good improvement.

MI Adult Program Outcomes

Adults with a Mental Illness are continually assessed with the standardized outcome tool called the Self Sufficiency Matrix. The Self Sufficiency tool reviews an individual's status on 13 indicators (Income, Shelter, Education, Healthcare, Mental Health, Family/ Friends, Community, Employment, Food, Legal, Life Skills, Substance Abuse and Mobility). However, for purposes of efficient display, education, employment, and mobility are not included in the graph. Values can include In Crisis, Vulnerable, Safe, Building Capacity or Empowered. Aggregated results of improving, maintaining or loss of status are developed based on calculating differences between the initial and most recent item score, categorizing for each item and each case if there was an improvement, loss or maintained and then subsequent percentages for the overall program.



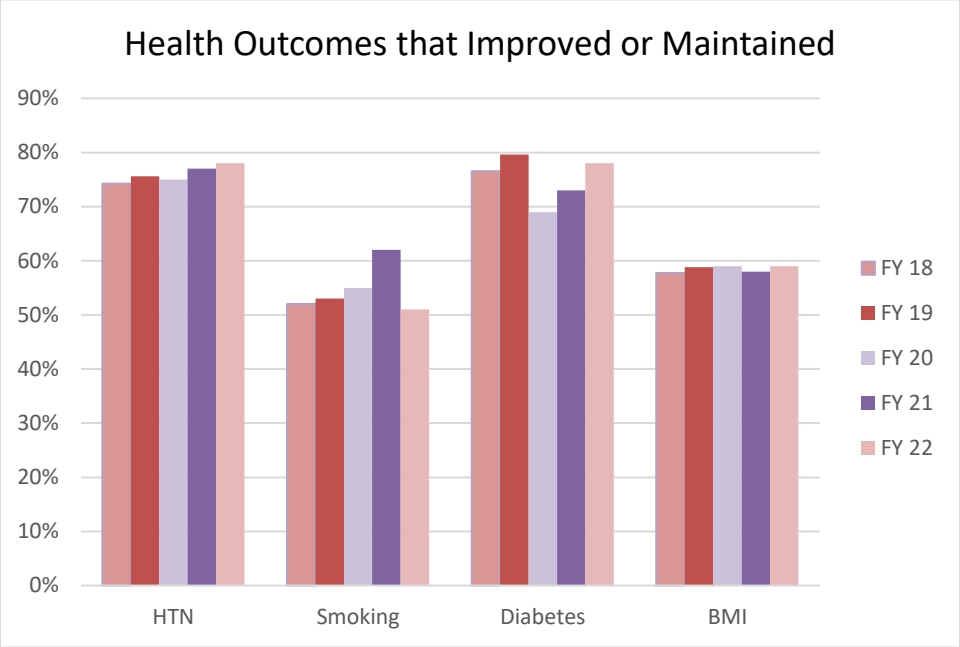
The graphs identify percentages of cases with Improvement, Maintained, and Loss of outcome status over a four-year time period. Sometimes there will be a percentage that Improved and a percentage that experienced Loss, sometimes on the same domain. This can occur because the aggregated data may reflect individuals who moved from "Maintained" and either moved to "Improved" or "Loss." Comparing results to last year, MI Adult services impacted on consumer outcomes by either improving or maintaining in nine of the ten categories (Income, Shelter, Food, Legal, Community, Health, Lifeskills, Substance Abuse and Family/Friends) while a higher percentage show more loss in their outcomes in four categories (Income, Community, and Family/ Friends). Again, the aggregated findings can show a higher improvement and loss in the same category, and which indicate the aggregated percentage of those who maintained as a lower number.

Integrated Care

WCCMH continues to maintain a strong focus of integrated care. We monitor indicators of Hypertension (HTN), Smoking, Diabetes and Body Mass Index (BMI) for improvements. These definitions are:

Hypertension: the percentage of individuals diagnosed with Hypertension who either improved or maintained their health based on their blood pressure.
Smoking: the percentage of individuals who either smoked in the past or currently smoke who either improved or maintained their health based on their smoking status.
Diabetes: the percentage of individuals who have a Diabetes diagnoses and a current laboratory value (within 12 months of the end of the fiscal year) who either improved or maintained their health as indicated by an improvement or maintained level of their A1C.
BMI: the percentage of individuals who either improved or maintained their health by a static or decrease in their BMI.

The graph below depicts the percentage of individuals who either improved or maintained on measures of health:



HTN, Diabetes and BMI improved or maintained from FY 21. The percentage of those improving/ maintaining on their Smoking behavior is lower than FY 21.

Health and Mortality

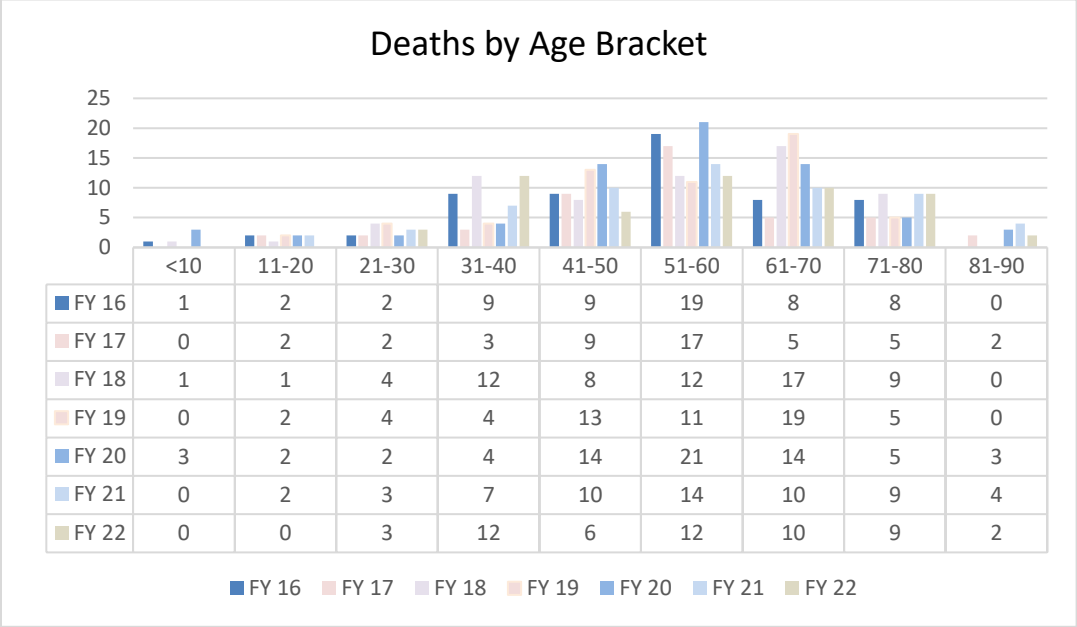
Research and industry trends identify those individuals who experience a severe mental illness tend to die much younger than their counterparts. WCCMH monitors our mortality rate, as well as the average age of the individual at the time of death. The data below are commensurate with research identified trends. For every reported individual death, WCCMH process includes reviewing the chart, obtaining the death certificate (if available) and presenting this information and the death report to the Medical Director. The Medical Director then classifies the cause of death. Below are the aggregated categories of cause of death and the average age at the time of death for each category.

Mortality

Cause of Death	FY 18	*Age FY 18*	FY 19	*Age FY 19*	FY 20	*Age FY 20*	FY 21	*Age FY 21*	FY 22	*Age FY 22*
Aspiration Pneumonia							2	*76*	3	*66*
Cancer	8	*62*	9	*59*	7	*57*	10	*62*	3	*51*
Cardiovascular	13	*58*	14	*61*	14	*61*	6	*69*	12	*64*
Dehydration	1	*75*								
Diabetes							1	*50*		
Drug Abuse	12	*39*	6	*42*	8	*45*	2	*37*	6	*43*
Endocrine System (Diabetes)										
Environmental Hypothermia			1	*51*						
Gastrointestinal					3	*60*	1	*65*		
Hip Fracture Complications	1	*60*								
Homicide	3	*30*								
Hyponatremia									2	*43*
Inanition					2	*61*				
Infection	3	*72*	1	*61*	4 (2 - COVID19)	*53*	5 (4 - COVID 19)	*1*	4 (3 were COVID 19)	*49*
Kidney Disease	1	*61*			1	*81*				
Liver Disease	2	*62*			2	*49*	3	*1*	1	*61*
Metabolic			1	*61*						
Natural/Other	1	*38*								
Neurological	2	*33*	1	*80*	3	*50*	7	*60*	3	*69*
Respiratory	5	*66*	10	*53*	10	*51*	4	*40*	5	*60*
Suicide	2	*44*	2	*22*	6	*45*	2	*23*	2	*36*
Trauma	1	*53*	2	*63*			2	*40*	3	*50*
Unknown	10	*51*	10	*38*	8	*45*	15	*49*	10	*38*
Grand Total	**# of Deaths 65**	***Avg Age 53***	**# of Deaths 55**	***Avg Age 52***	**# of Deaths 68**	***Ave Age 53***	**# of Deaths 57**	***Avg Age 54***	**# of Deaths 54**	***Avg Age 52***

Mortality data is based on death certificates from the Washtenaw County Medical Examiner. If an individual dies out of county, we do not receive that death certificate and it is coded as "unknown". The number of deaths tend to vary as indicated by the five-year dataset.

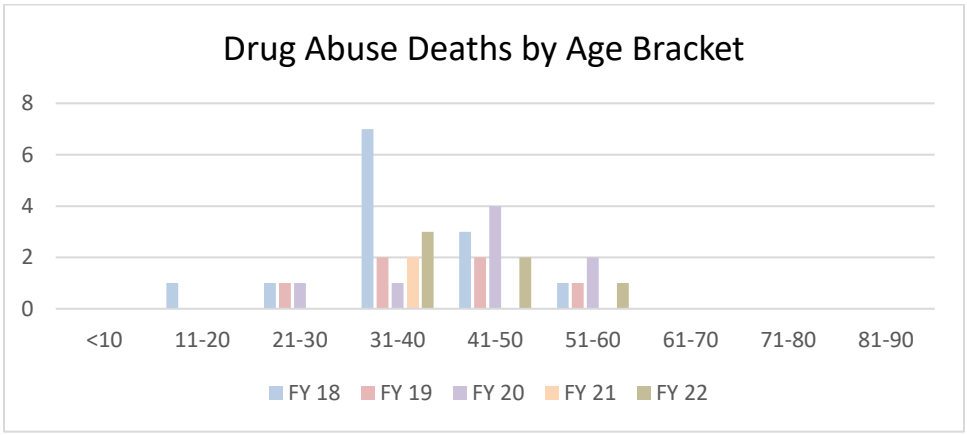
Reviewing the number of individuals who were receiving services and passed away in Fiscal Year 22 between frequency of deaths per bracketed age categories helps monitor and review baseline data and possible trends/ patterns.



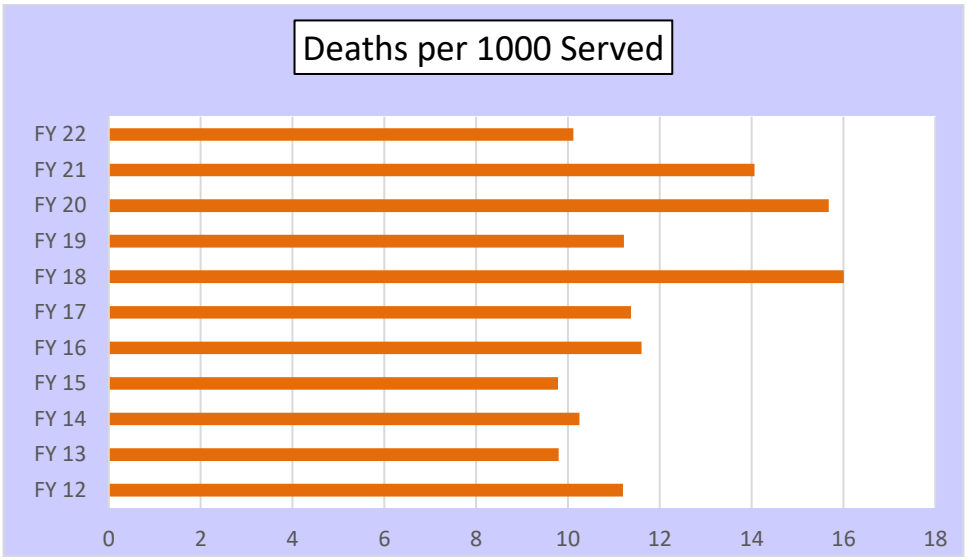
	<10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90
FY 16	1	2	2	9	9	19	8	8	0
FY 17	0	2	2	3	9	17	5	5	2
FY 18	1	1	4	12	8	12	17	9	0
FY 19	0	2	4	4	13	11	19	5	0
FY 20	3	2	2	4	14	21	14	5	3
FY 21	0	2	3	7	10	14	10	9	4
FY 22	0	0	3	12	6	12	10	9	2

Not surprisingly, a higher frequency of deaths occurs in the older decades. We hope that helping individuals with their health needs will result in the frequency of deaths moving to the right on the graph, i.e., occurring in older age. While the number of deaths did increase in the 31-40 age range, the bracketed age groups 41-50, 51-60, and 61-70 are showing fewer deaths over two years in this age group while bracketed age groups 71-80 and 81-90 continue to show an increased number of individuals which may indicate a trend toward living longer.

Deaths that occurred due to accidental overdose (Drug Abuse) are overall lower than in years previous, though there was an increase in the age bracket of 31-40. These deaths from FY 22 and their bracketed age group are depicted below:

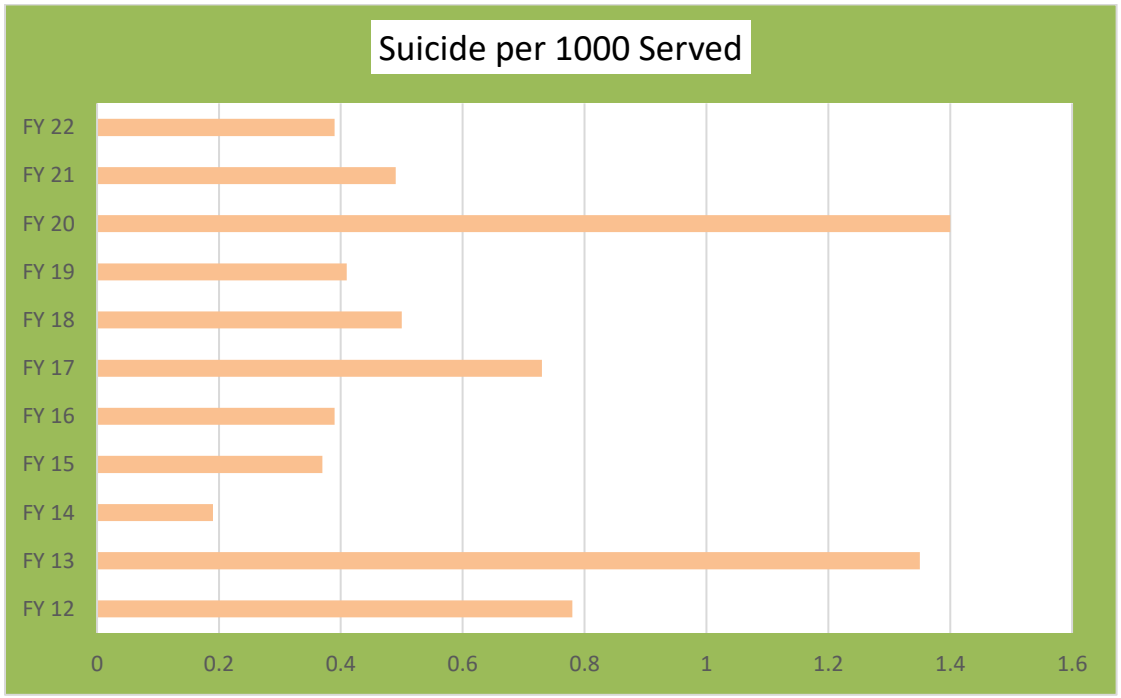


Reviewing deaths over the past eleven years has helped us identify the number of deaths compared to the number of individuals served. There is a great deal of variance with no obvious pattern identified.



The ratio of deaths / individuals served this past year is much lower than last year. This driven by both a lower number of deaths and a higher number of consumers served due to CCBHC increasing our admissions. There are no identified systemic mental health treatment factors contributing to these deaths. To the best of the organization's ability, we know of a total of nine deaths of an individual whose COVID-19 test results was positive since the onset of the pandemic.

Monitoring the ratio of suicides per 1,000 individuals served is also important. This is the data trend over the past eleven fiscal years:



The ratios for FY 22 is tied for the third lowest ratio in the evaluated time period, again this may be impacted by a higher number of consumers served. It should also be noted that all suicides are reviewed with a root cause analysis. This is a very thorough and thoughtful review process beyond the normal death review process. There were no practice-of-care issues in these suicides and no systemic patterns or trends identified.

Satisfaction Survey Results

The Customer Service department, working with the Region, developed a new Satisfaction Survey and implemented it to all populations with results reported accordingly. Scores less than 80% resulted in corrective action plan steps to help improve these areas.

Survey Results from Those Who Receive Services

Question	Yes	No	I don't know
I feel respected when I call or see my CMH staff	95%	3%	2%
My phone calls are returned by the next day	79%	11%	10%
I saw my CMH staff within 15 minutes of my appointment	91%	3%	4%
I decide what is important when working with my CMH staff	91%	2%	7%
I understood what my CMH staff said today	97%	1%	2%
My CMH staff helps to achieve my goals	76%	12%	12%
My CMH Staff follow up about my physical health needs	67%	22%	12%
I feel able to complain or disagree with my CMH staff	87%	10%	3%
I know how to file a complaint	72%	22%	7%
Would you like for Customer Services staff to call you?	2%	77%	20%

Areas for Program to focus on include returning phone calls by the next day, CMH staff assisting consumers to help with their goals, CMH staff following up with a consumer's physical health needs and knowing how to file a complaint.

Summary

The industry of Community Mental Health services is a complex, demanding and high-risk environment seeking to service individuals who experience functional impairment, poverty, disabilities and severe symptoms in a limited resourced environment. Additionally, adding the CCBHC model allows us to also serve those who experience symptoms in the mild to moderate range. We continue to seek out ways to strengthen our organization in a manner that will help to improve the lives of those we are honored to serve.

Report on Compliance

Washtenaw County Community Mental Health

September 30, 2022

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

525 WEST WARWICK DRIVE, SUITE A, ALMA, MICHIGAN 48801

Washtenaw County Community Mental Health
Table of Contents
September 30, 2022

RPC
Roslund Prestage & Company
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT ACCOUNTANT'S REPORT ON COMPLIANCE

To the Members of the Board
Washtenaw County Community Mental Health
Ypsilanti, Michigan

Report On Compliance
We have examined Washtenaw County Community Mental Health's (the CMHSP) compliance with the compliance requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and General Fund (GF) Contract for the year ended September 30, 2022.

Management's Responsibility
Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to the Medicaid Contract and GF Contract.

Independent Accountants' Responsibility
Our responsibility is to express an opinion on the CMHSP's compliance with the Medicaid Contract and GF Contract based on our examination of the compliance requirements referred to above.

Our examination of compliance was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the CMHSP complied, in all material respects, with the compliance requirements referred to above.

An examination involves performing procedures to obtain evidence about the CMHSP's compliance with the specified compliance requirements referred to above. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risk of material noncompliance, whether due to fraud or error. The nature, timing and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the compliance requirements described in the *Compliance Examination Guidelines* issued by the Michigan Department of Health and Human Services.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement.

We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion. However, our examination does not provide a legal determination of the CMHSP's compliance.

Opinion on Each Program
In our opinion, the CMHSP complied, in all material respects, with the specified compliance requirements referred to above that are applicable to the Medicaid Contract and GF Contract for the year ended September 30, 2022.

Other Matters
The results of our examination procedures disclosed instances of noncompliance, which are required to be reported in accordance with Compliance Examination Guidelines, and which are described in the accompanying Schedule of Findings and Comments and Recommendations as items 2022-01 and 2022-02. Our opinion is not modified with respect to these matters.

The CMHSP's responses to the noncompliance findings identified in our examination are described in the accompanying Schedule of Findings and Comments and Recommendations. The CMHSP's responses were not subjected to the examination procedures applied in the examination of compliance and, accordingly, we express no opinion on the responses.

Purpose of this Report
This report is intended solely for the information and use of the board and management of the CMHSP and the Michigan Department of Health and Human Services, and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.

Roslund, Prestage & Company, P.C.
Certified Public Accountants

June 27, 2023

Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract and General Fund Contract:

2022-01 Ability to Pay Forms

Criteria or specific requirements:
The CMHSP is required to determine the responsible party's insurance coverage and ability to pay before, or as soon as practical after, the start of services as required by MCL 330.1817. Also, the CMHSP must annually determine the insurance coverage and ability to pay of individuals who continue to receive services and of any additional responsible party as required by MCL 330.1828.

Condition:
The CMHSP is not in compliance with MCL 330.1817 and MCL 330.1828.

Examination adjustments:
None.

Context and perspective:
The CMHSP has adopted and implemented *ability to pay* policies and procedures as required. However, during our testing of their implementation of these procedures we found 32 out of 40 consumers selected did not have *ability to pay* documentation completed or the consumer had an ability to pay that was not billed.

Effect:
The CMHSP may not be billing and collecting available fees from individuals or third party payers for services provided to them.

Recommendations:
The CMHSP should review its current policies and procedures regarding ability to pay forms and make the necessary changes to ensure that forms are completed, or consumers are billed as required. Also, policies and procedures should require periodic monitoring for compliance and include adequate documentation of such monitoring.

Views of responsible officials:
Management is in agreement with our recommendation.

Planned corrective action:
Management has implemented procedures to improve the gathering of consumer information and processing time for calculating an individual's ability to pay and continues to work towards full compliance of this requirement. Changes in consumer benefit eligibility causes confusion to individuals being served and often this process takes time to troubleshoot and resolve. Staffing challenges both administratively and clinically have resulted in increased challenges to financial determination compliance. Management continues to work towards full compliance of this requirement while ensuring consumer eligibility for entitlements is being processed accurately and timely by the local MDHHS office.

Responsible party:
Nicole Phelps, CFO & Christy Diallo, Management Analyst

Anticipated completion date:
September 30, 2023

Material noncompliance with the provisions of laws, regulations, or contracts related to the Medicaid Contract and General Fund Contract:

None

Known fraud affecting the Medicaid Contract and General Fund Contract:

None

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
FINANCIAL STATUS REPORT - ALL NON MEDICAID

ATTACHMENT #1I
AUGUST 2023

CMHSP:	Washtenaw County Community Mental Health	FISCAL YEAR:	FY 21 / 22		
		SUBMISSION TYPE:	YE Final	YEAR TO DATE REPORTING	**EXAMINATION ADJUSTMENTS**	**EXAMINED TOTALS**
		SUBMISSION DATE:	2/28/2023		
			Column A	**Column B**		
A		**MEDICAID SERVICES - Summary From FSR - Medicaid (incl Direct Care Wage)**				
AC		**CCBHC SERVICES - Summary From FSR - Certified Community Behavioral Health Clinic**				
AE		**OPIOID HEALTH HOME SERVICES - Summary From FSR - Opioid Health Home Services**				
AG		**HEALTH HOME SERVICES - Summary From FSR - Health Home Services**				
AI		**HEALTHY MICHIGAN SERVICES - Summary From FSR - Healthy Michigan (incl Direct Care Wage)**				
AK		**MI HEALTH LINK SERVICES - Summary From FSR - MI Health Link**				
RES		**RESTRICTED FUND BALANCE ACTIVITY**				
B		**GENERAL FUND**				
B	100	**REVENUE**				
B	101	CMH Operations		4,235,050		4,235,050
B	120	**Subtotal - Current Period General Fund Revenue**		4,235,050	-	4,235,050
B	121	1st & 3rd Party Collections (Not in Section 226a Funds) 100% Services		337,557		337,557
B	122	1st & 3rd Party Collections (Not in Section 226a Funds) 90% Services				-
B	123	Prior Year GF Carry Forward		193,622		193,622
B	140	**Subtotal - Other General Fund Revenue**		531,179	-	531,179
B	190	**TOTAL REVENUE**		4,766,229	-	4,766,229
B	200	**EXPENDITURE**				
B	201	100% MDHHS Matchable Services / Costs		972,679		972,679
B	202	100% MDHHS Matchable Services Based on CMHSP Local Match Cap		-	-	-
B	203	90% MDHHS Matchable Services / Costs - REPORTED	2,740,464			
B	204	90% MDHHS Matchable Services / Costs - EXAMINATION ADJUSTMENTS				
B	205	90% MDHHS Matchable Services / Costs - EXAMINED TOTAL	2,740,464	2,466,418	-	2,466,418
B	290	**TOTAL EXPENDITURE**		3,439,097	-	3,439,097
B	295	**NET GENERAL FUND SURPLUS (DEFICIT)**		1,327,132	-	1,327,132
B	300	**Redirected Funds (To) From**				
B	304	(TO) Targeted Case Management - **D301**		-	-	-
B	309	(TO) Allowable GF Cost of Injectable Medications - **G301**		-	-	-
B	310	(TO) PIHP to Affiliate Medicaid Services Contracts - **I304**		-	-	-
B	310.1	(TO) PIHP to Affiliate CCBHC Medicaid Contracts - **IA304**		-	-	-
B	310.2	(TO) PIHP to Affiliate Opioid Health Home Services Contracts - **IB304**		-	-	-
B	310.3	(TO) PIHP to Affiliate Health Home Services Contracts - **IC304**		(5,175)	-	(5,175)
B	310.4	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID304**		-	-	-
B	310.5	(TO) PIHP to Affiliate CCBHC Non-Medicaid Contracts - **L304**		(421,992)	-	(421,992)
B	312	(TO) CMHSP to CMHSP Earned Contracts - **J305** (explain - section Q)		-	-	-
B	313	FROM CMHSP to CMHSP Earned Contracts - **J302**		75,721		75,721
B	314	FROM Non-MDHHS Earned Contracts - **K302**				-
B	330	**Subtotal Redirected Funds rows 301 - 314**		(351,446)	-	(351,446)
B	331	FROM Local Funds - **M302**				-
B	332	FROM Risk Corridor - **N303**				-
B	390	**Total Redirected Funds**		(351,446)	-	(351,446)
B	400	**BALANCE GENERAL FUND (cannot be < 0)**		975,686	-	975,686
OTHER GF CONTRACTUAL OBLIGATIONS						
C		**CCBHC NON-MEDICAID - (PIHP Use Only)**				
FEE FOR SERVICE MEDICAID						
D		**TARGETED CASE MANAGEMENT - (GHS Only)**				
D	190	Revenue				-
D	290	Expenditure				-
D	295	**NET TARGETED CASE MANAGEMENT (cannot be > 0)**		-	-	-
D	300	**Redirected Funds (To) From**				
D	301	FROM General Fund - **B304**				-
D	302	FROM Local Funds - **M304**				-
D	303	(TO) CMHSP to CMHSP Earned Contracts - **J304.4**		-	-	-
D	304	FROM CMHSP to CMHSP Earned Contracts - **J303.4**				-
D	390	**Total Redirected Funds**		-	-	-
D	400	**BALANCE TARGETED CASE MANAGEMENT (GHS Only) (must = 0)**		-	-	-
E		**INTENTIONALLY LEFT BLANK**				
F		**INTENTIONALLY LEFT BLANK**				
G		**INJECTABLE MEDICATIONS**				
G	190	Revenue		190,398		190,398
G	290	Expenditure		190,398		190,398
G	295	**NET INJECTABLE MEDICATIONS (cannot be > 0)**		-	-	-
G	300	**Redirected Funds (To) From**				
G	301	FROM General Fund - **B309**				-
G	302	FROM Local Funds - **M309**				-
G	390	**Total Redirected Funds**		-	-	-
G	400	**BALANCE INJECTABLE MEDICATIONS (must = 0)**		-	-	-
OTHER FUNDING						

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
FINANCIAL STATUS REPORT - ALL NON MEDICAID

ATTACHMENT #1I
AUGUST 2023

CMHSP:	Washtenaw County Community Mental Health	FISCAL YEAR:	FY 21 / 22		
		SUBMISSION TYPE:	YE Final	YEAR TO DATE REPORTING	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
		SUBMISSION DATE:	2/28/2023			
			Column A	Column B		

H		**MDHHS EARNED CONTRACTS**			
H	100	**REVENUE**			
H	101	Comprehensive Services for Behavioral Health	1,206,953		
H	102	Housing and Homeless Services	-		
H	103	Juvenile Justice Programs	-		
H	104	Suicide Lifeline Programs	-		
H	105	Projects for Assistance in Transition from Homelessness	180,367		
H	106	Regional Perinatal Collaborative	-		
H	107	Substance Abuse & Mental Health COVID-19 Grant Program	-		
H	108	Substance Use and Gambling Services	-		
H	150	Other MDHHS Earned Contracts (describe):	-		
H	151	Other MDHHS Earned Contracts (describe):	-		
H	190	**TOTAL REVENUE**	1,387,320		
H	200	**EXPENDITURE**			
H	201	Comprehensive Services for Behavioral Health	1,206,953		
H	202	Housing and Homeless Services	-		
H	203	Juvenile Justice Programs	-		
H	204	Suicide Lifeline Programs	-		
H	205	Projects for Assistance in Transition from Homelessness	180,367		
H	206	Regional Perinatal Collaborative	-		
H	207	Substance Abuse & Mental Health COVID-19 Grant Program	-		
H	208	Substance Use and Gambling Services	-		
H	250	Other MDHHS Earned Contracts (describe):	-		
H	251	Other MDHHS Earned Contracts (describe):	-		
H	290	**TOTAL EXPENDITURE**	1,387,320		
H	400	**BALANCE MDHHS EARNED CONTRACTS (must = 0)**	-		

I		**PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS - CMHSP USE ONLY**			
I	100	**REVENUE**			
I	101	Revenue - from PIHP Medicaid (incl Direct Care Wage)	73,138,544		73,138,544
I	104	Revenue - from PIHP Healthy Michigan Plan (incl Direct Care Wage)	5,214,209		5,214,209
I	122	1st & 3rd Party Collections - Medicare/Medicaid Consumers - Affiliate	44,568		44,568
I	123	1st & 3rd Party Collections - Healthy Michigan Plan Consumers - Affiliate			-
I	190	**TOTAL REVENUE**	78,397,321	-	78,397,321
I	201	Expenditure - Medicaid (incl Direct Care Wage)	73,183,112		
I	202	Expenditure - Healthy Michigan Plan (incl Direct Care Wage)	5,214,209		
I	203	Expenditure - MI Health Link (Medicaid) Services (incl Direct Care Wage)	-		
I	290	**TOTAL EXPENDITURE**	78,397,321		
I	295	**NET PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS SURPLUS (DEFICIT)**	-		
I	300	**Redirected Funds (To) From**			
I	301	(TO) CMHSP to CMHSP Earned Contracts - **J306**	-	-	-
I	302	FROM CMHSP to CMHSP Earned Contracts - **J303**			-
I	303	FROM Non-MDHHS Earned Contracts - **K303**			-
I	304	FROM General Fund - **B310**			-
I	306	FROM Local Funds - **M309.1**			-
I	390	**Total Redirected Funds**	-	-	-
I	400	**BALANCE PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS (must = 0)**	-	-	-

IA		**PIHP to AFFILIATE CCBHC SERVICES CONTRACTS - CMHSP USE ONLY**			
IA	100	**REVENUE**			
IA	101	Revenue - Medicaid Base	13,470,254		13,470,254
IA	102	Revenue - Medicaid Supplemental	2,570,902		2,570,902
IA	103	Revenue - MI Health Link CCBHC Consumers			-
IA	104	1st & 3rd Party Collections - Medicaid			-
IA	121	Revenue - Healthy Michigan Base	2,695,584		2,695,584
IA	122	Revenue - Healthy Michigan Supplemental	844,573		844,573
IA	124	1st & 3rd Party Collections - Healthy Michigan			-
IA	190	**TOTAL REVENUE**	19,581,313	-	19,581,313
IA	200	**EXPENDITURE**			
IA	201	Expenditure - Medicaid (Including MI Health Link)	14,723,998		14,723,998
IA	202	Expenditure - Healthy Michigan	3,208,376		3,208,376
IA	290	**TOTAL EXPENDITURE**	17,932,374	-	17,932,374
IA	295	**NET PIHP to AFFILIATE CONTRACTS SURPLUS (DEFICIT)**	1,648,939	-	1,648,939
IA	300	**Redirected Funds (To) From**			
IA	301	(TO) CMHSP to CMHSP Earned Contracts - **J306.2**	-	-	-
IA	302	FROM CMHSP to CMHSP Earned Contracts - **J303.2**			-
IA	303	FROM Non-MDHHS Earned Contracts - **K303.2**			-
IA	304	FROM General Fund - **B310.1**			-
IA	305	(TO) Local Funds - **M316**	(1,648,939)	-	(1,648,939)
IA	306	FROM Local Funds - **M309.2**			-
IA	390	**Total Redirected Funds**	(1,648,939)	-	(1,648,939)
IA	400	**BALANCE PIHP to AFFILIATE CCBHC SERVICES CONTRACTS (must = 0)**	-	-	-

IB		**PIHP to AFFILIATE OPIOID HEALTH HOME SERVICES CONTRACTS - CMHSP USE ONLY**			
IB	190	Revenue - Medicaid Opioid Health Home Services - from PIHP			-
IB	290	Expenditure - Medicaid Opioid Health Home Services			-
IB	295	**NET PIHP to AFFILIATE OPIOID HEALTH HOME SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
IB	300	**Redirected Funds (To) From**			
IB	304	FROM General Fund - **B310.2**			-
IB	306	FROM Local Funds - **M309.3**			-
IB	390	**Total Redirected Funds**	-	-	-
IB	400	**BALANCE PIHP to AFFILIATE OPIOID HEALTH HOME SERVICES CONTRACTS (cannot be < 0)**	-	-	-

IC		**PIHP to AFFILIATE HEALTH HOME SERVICES CONTRACTS - CMHSP USE ONLY**			
IC	190	Revenue - Medicaid Health Home Services - from PIHP	63,643		63,643
IC	290	Expenditure - Medicaid Health Home Services	68,818		68,818
IC	295	**NET PIHP to AFFILIATE HEALTH HOME SERVICES CONTRACTS SURPLUS (DEFICIT)**	(5,175)	-	(5,175)
IC	300	**Redirected Funds (To) From**			

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
FINANCIAL STATUS REPORT - ALL NON MEDICAID

ATTACHMENT #1I
AUGUST 2023

CMHSP:	Washtenaw County Community Mental Health	FISCAL YEAR:	FY 21 / 22		
		SUBMISSION TYPE:	YE Final	YEAR TO DATE REPORTING	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
		SUBMISSION DATE:	2/28/2023			
				Column A	Column B	
IC	304	FROM General Fund - **B310.3**		5,175		5,175
IC	306	FROM Local Funds - **M309.4**				-
IC	390	**Total Redirected Funds**		5,175	-	5,175
IC	400	**BALANCE PIHP to AFFILIATE HEALTH HOME SERVICES CONTRACTS (cannot be < 0)**		-	-	-

ID		PIHP to AFFILIATE MI HEALTH LINK SERVICES CONTRACTS - CMHSP USE ONLY			
ID	100	**REVENUE**			
ID	101	Revenue - MI Health Link - from PIHP			-
ID	122	1st & 3rd Party Collections - MI Health Link Consumers - Affiliate			-
ID	190	**TOTAL REVENUE**	-	-	-
ID	200	**EXPENDITURE**			
ID	201	Expenditure			-
ID	290	**TOTAL EXPENDITURE**	-	-	-
ID	295	**NET PIHP to AFFILIATE MI HEALTH LINK SERVICES CONTRACTS SURPLUS (DEFICIT)**	-	-	-
ID	300	**Redirected Funds (To) From**			
ID	301	(TO) CMHSP to CMHSP Earned Contracts - **J306.3**	-	-	-
ID	302	FROM CMHSP to CMHSP Earned Contracts - **J303.3**			-
ID	303	FROM Non-MDHHS Earned Contracts - K303.3			-
ID	304	FROM General Fund - **B310.4**			-
ID	306	FROM Local Funds - **M309.5**			-
ID	390	**Total Redirected Funds**	-	-	-
ID	400	**BALANCE PIHP to AFFILIATE MI HEALTH LINK SERVICES CONTRACTS (must = 0)**	-	-	-

J		CMHSP to CMHSP EARNED CONTRACTS			
J	190	Revenue	871,569		871,569
J	290	Expenditure	795,848		795,848
J	295	**NET CMHSP to CMHSP EARNED CONTRACTS SURPLUS (DEFICIT)**	75,721	-	75,721
J	300	**Redirected Funds (To) From**			
J	302	(TO) General Fund - **B313**	(75,721)	-	(75,721)
J	303	(TO) PIHP to Affiliate Medicaid Services Contracts - **I302**	-	-	-
J	303.2	(TO) PIHP to Affiliate CCBHC Medicaid Contracts - **IA302**	-	-	-
J	303.3	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID302**	-	-	-
J	303.4	(TO) Targeted Case Management - **D304**	-	-	-
J	303.5	(TO) PIHP to Affiliate CCBHC Non-Medicaid Contracts - **L302**	-	-	-
J	304.4	FROM Targeted Case Management - **D303**			-
J	305	FROM General Fund - **B312**			-
J	306	FROM PIHP to Affiliate Medicaid Services Contracts - **I301**			-
J	306.2	FROM PIHP to Affiliate CCBHC Medicaid Contracts - **IA301**			-
J	306.3	FROM PIHP to MI Health Link Services Contracts - **ID301**			-
J	306.4	FROM PIHP to Affiliate CCBHC Non-Medicaid Contracts - **L301**			-
J	307	FROM Local Funds - **M310**			-
J	390	**Total Redirected Funds**	(75,721)	-	(75,721)
J	400	**BALANCE CMHSP to CMHSP EARNED CONTRACTS (must = 0)**	-	-	-

K		NON-MDHHS EARNED CONTRACTS			
K	190	Revenue	165,134		165,134
K	290	Expenditure	165,134		165,134
K	295	**NET NON-MDHHS EARNED CONTRACTS SURPLUS (DEFICIT)**	-	-	-
K	300	**Redirected Funds (To) From**			
K	302	(TO) General Fund - **B314**	-	-	-
K	303	(TO) PIHP to Affiliate Medicaid Services Contracts - **I303**	-	-	-
K	303.2	(TO) PIHP to Affiliate CCBHC Medicaid Contracts - **IA303**	-	-	-
K	303.3	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID303**	-	-	-
K	303.4	(TO) PIHP to Affiliate CCBHC Non-Medicaid Contracts - **L303**	-	-	-
K	304	(TO) Local Funds - **M315**	-	-	-
K	305	FROM Local Funds - **M311**			-
K	390	**Total Redirected Funds**	-	-	-
K	400	**BALANCE NON-MDHHS EARNED CONTRACTS (must = 0)**	-	-	-

L		PIHP to Affiliate CCBHC Non-Medicaid Contracts - CMHSP USE ONLY			
L	100	**REVENUE**			
L	101	Revenue	616,064		616,064
L	102	1st & 3rd Party Collections (Not in Section 226a Funds)			-
L	190	**TOTAL REVENUE**	616,064	-	616,064
L	200	**EXPENDITURE**			
L	201	Expenditure	1,038,056		1,038,056
L	290	**TOTAL EXPENDITURE**	1,038,056	-	1,038,056
L	295	**NET SURPLUS (DEFICIT)**	(421,992)	-	(421,992)
L	300	**Redirected Funds (To) From**			
L	301	(TO) CMHSP to CMHSP Earned Contracts - **J306.4**	-	-	-
L	302	FROM CMHSP to CMHSP Earned Contracts - **J303.5**	-		-
L	303	FROM Non-MDHHS Earned Contracts - **K303.4**	-		-
L	304	FROM General Fund - **B310.5**	421,992		421,992
L	305	(TO) Local Funds - **M316.1**	-	-	-
L	306	FROM Local Funds - **M309.6**			-
L	390	**Total Redirected Funds**	421,992	-	421,992
L	400	**BALANCE PIHP to Affiliate CCBHC Non-Medicaid Contracts (must = 0)**	-	-	-

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
FINANCIAL STATUS REPORT - ALL NON MEDICAID

ATTACHMENT #1I
AUGUST 2023

CMHSP:	Washtenaw County Community Mental Health	FISCAL YEAR:	FY 21 / 22		
		SUBMISSION TYPE:	YE Final	YEAR TO DATE REPORTING	EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
		SUBMISSION DATE:	2/28/2023			
			Column A	Column B		
M		**LOCAL FUNDS**				
M	100	**REVENUE**				
M	101	County Appropriation for Mental Health		3,543,654		3,543,654
M	102	County Appropriation for Substance Abuse - Non Public Act 2 Funds				-
M	103	Section 226 (a) Funds		88,765	-	88,765
M	105	Medicaid Fee for Service Adjuster Payments				-
M	106	Local Grants				-
M	107	Interest				-
M	109	SED Partner				-
M	110	All Other Local Funding		44,955		44,955
M	111	Performance Bonus Incentive Pool (PBIP) Restricted Local Funding				-
M	190	**TOTAL REVENUE**		3,677,374	-	3,677,374
M	200	**EXPENDITURE**				
M	201	GF 10% Local Match		274,046	-	274,046
M	202	Local match cap amount				
		Examination Adjustment Local match cap amount				
		Examined Total Local match cap amount	$ -			
M	203	GF Local Match Capped per MHC 330.1308		-	-	-
M	204	Local Cost for State Provided Services		411,272	524,401	935,673
M	205	Local Contribution to State Medicaid Match (CMHSP Contribution Only)		935,673	(524,401)	411,272
M	207	Local Match to Grants and MDHHS Earned Contracts				-
M	209	Local Only Expenditures		21,051		21,051
M	290	**TOTAL EXPENDITURE**		1,642,042	-	1,642,042
M	295	**NET LOCAL FUNDS SURPLUS (DEFICIT)**		2,035,332	-	2,035,332
M	300	**Redirected Funds (To) From**				
M	302	(TO) General Fund - **B331**		-	-	-
M	304	(TO) Targeted Case Management - **D302**		-	-	-
M	309	(TO) Injectable Medications - **G302**		-	-	-
M	309.1	(TO) PIHP to Affiliate Medicaid Services Contracts - **I306**		-	-	-
M	309.2	(TO) PIHP to Affiliate CCBHC Medicaid Service Contracts - **IA306**		-	-	-
M	309.3	(TO) PIHP to Affiliate Opioid Health Home Services Contracts - **IB306**		-	-	-
M	309.4	(TO) PIHP to Affiliate Health Home Services Contracts - **IC306**		-	-	-
M	309.5	(TO) PIHP to Affiliate MI Health Link Services Contracts - **ID306**		-	-	-
M	309.6	(TO) PIHP to Affiliate CCBHC Non-Medicaid Contracts - **L306**		-	-	-
M	310	(TO) CMHSP to CMHSP Earned Contracts - **J307**		-	-	-
M	311	(TO) Non-MDHHS Earned Contracts - **K305**		-	-	-
M	313	(TO) Activity Not Otherwise Reported - **O302**		-	-	-
M	315	FROM Non-MDHHS Earned Contracts - **K304**		-		-
M	316	FROM PIHP to Affiliate CCBHC Medicaid Services Contracts - **IA305**		1,648,939		1,648,939
M	316.1	FROM PIHP to Affiliate CCBHC Non-Medicaid Contracts - **L305**		-		-
M	390	**Total Redirected Funds**		1,648,939	-	1,648,939
M	400	**BALANCE LOCAL FUNDS**		3,684,271	-	3,684,271

N		**RISK CORRIDOR**			
N	100	**REVENUE**			
N	101	Stop/Loss Insurance			-
N	190	**TOTAL REVENUE**	-	-	-
N	300	**Redirected Funds (To) From**			
N	303	(TO) General Fund - **B332**	-	-	-
N	390	**Total Redirected Funds**	-	-	-
N	400	**BALANCE RISK CORRIDOR (must = 0)**	-	-	-

O		**ACTIVITY NOT OTHERWISE REPORTED**			
O	100	**REVENUE**			
O	101	Other Revenue (describe): Yost St. Rent	18,631		18,631
O	102	Other Revenue (describe): Private Grants	163,899		163,899
O	103	Other Revenue (describe):			-
O	190	**TOTAL REVENUE**	182,530	-	182,530
O	200	**EXPENDITURE**			
O	201	Other Expenditure (describe): Private Grants	163,899		163,899
O	202	Other Expenditure (describe):			-
O	203	Other Expenditure (describe):			-
O	290	**TOTAL EXPENDITURE**	163,899	-	163,899
O	295	**NET ACTIVITY NOT OTHERWISE REPORTED SURPLUS (DEFICIT)**	18,631	-	18,631
O	300	**Redirected Funds (To) From**			
O	302	FROM Local Funds - **M313**			-
O	390	**Total Redirected Funds**	-	-	-
O	400	**BALANCE ACTIVITY NOT OTHERWISE REPORTED**	18,631	-	18,631

P		**GRAND TOTALS**			
P	190	**GRAND TOTAL REVENUE**	109,898,895	-	109,898,895
P	290	**GRAND TOTAL EXPENDITURE**	105,220,307	-	105,220,307
P	390	**GRAND TOTAL REDIRECTED FUNDS (must = 0)**	-	-	-
P	400	**NET INCREASE (DECREASE)**	4,678,588	-	4,678,588

Q		**REMARKS**
Q		This section has been provided for the CMHSP to provide narrative descriptions as requested in the FSR instructions or where additional narrative would be meaningful to the CMHSP / MDHHS.
Q		On the FSR that was submitted to MDHHS, Row M204 Local Cost for State Provided Services was transposed with Row 205 Local Contribution to State Medicaid Match. An examination adjustment was made to correct this: - Row M204 was increased from $411,272 to $935,673; a difference of $524,401 - Row M205 was decreased from $935,673 to $411,272; a difference of $(524,401)
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MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF) **ATTACHMENT #1**

FINANCIAL STATUS REPORT - ALL NON MEDICAID - SUPPLEMENTAL

AUGUST 2023

CMHSP:	Washtenaw County Community Mental Health		FISCAL YEAR:	FY 21 / 22		YEAR TO DATE REPORTING	
		SUBMISSION TYPE:	YE Final				
		SUBMISSION DATE:	2/28/2023				
			Column A	**Column B**	**Column C**	**Column D**	

H	Grant Program Code	Grant Program Title	Project Code	Project Title	REVENUE	EXPENDITURES	CCBHC EXPENDITURES	BALANCE	
H	**MDHHS EARNED CONTRACTS**								
H	CBH	Comprehensive Services for Behavioral Health	ABHS	Asian Behavioral Health Services				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BC / BWC	Benefits Coaches / Benefits to Work Coaches				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BCDP	Branch County Diversion Project				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BHC	Behavioral Health Consultant				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BHH	Behavioral Health Home				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BHSNA	Behavioral Health Services for Native Americans				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	BHSVV	Behavioral Health Services for Vietnam Veterans				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CLUB	Clubhouse Engagement				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CRIM	Criminal Justice	134,450	134,450		-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CRMGT	Care Management				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	CSC	Child System of Care				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	DROP**					-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	DROP**					-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	DROP**					-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	FIT	Fit Together				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	HBHS	Hispanic Behavioral Health Services				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	IECMHC	Infant and Early Childhood Mental Health Consultation				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	IHC	Integrated Healthcare				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	**CSSE	Intensive Crisis Stabilization Service(s) Expansion				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	JIHC	Justice Involved Health Coach				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MHAJJ	Mental Health Access and Juvenile Justice Diversion				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MHJJSE	Mental Health and Juvenile Justice Screening Expansion				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MHJJSP	Mental Health Juvenile Justice Screening Project				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MHTC	58th District Mental Health Court Expansion				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	MICHT	Michigan Healthy Transitions				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	NCC	Enhanced Nutrition Care Coordination and Medical Culinary Ed Prgms				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	NTPH	Navigators for Transition from Psychiatric Hospitals				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	OBRA	Pre-Admission Screening Annual Resident Reviews	1,072,503	1,072,503		-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PACC	Promoting Access and Continuity of Care				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PCPCP	Psychiatric Consultation to Primary Care Practices				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PDTOB	Peer Driven Tobacco Cessation				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PHC	Peer(s) as Health Coach(es)				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PIPBHC	Promoting Integration of Primary and Behavioral Health Care				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	PMTO*					-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	RCVC	Recovery Conference				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	RPTS	Regional PMTO Training Support				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	RT	Rural Transportation				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	RTTSE	Infant and Early Childhood Mental Health Consultation.				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	SCCHB	Saginaw Community Care HUB				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	SCLCA	988 Suicide and Crisis Lifeline SAMHSA Cooperative Agreement				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	SFEP	First Episode Psychosis				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	SPTTA	Statewide PMTO Training and TA				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TBRS	Technology-Based Recovery Support				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TCR	Transportation to Crisis Residential				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TCSCCT	Tri-County Strong Crisis Counseling & Training				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TFCCT	Trauma Focused CBT Coordination & Training				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TFCO	Treatment Foster Care Oregon				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TIC / TISC	Trauma Informed Care / System of Care				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	TPC	Tuscola Peer Center				-	Must = 0
H	CBH	Comprehensive Services for Behavioral Health	VET*					-	Must = 0
H	**SUBTOTAL Comprehensive Services for Behavioral Health**				1,206,953	1,206,953	-	-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	CCR	Children's Crisis Residential				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	CMHCSS	Children's Mental Health COVID Supplemental Services				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	EOPSA	Early Onset Psychosis Set-Aside				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	MHCM*	Mental Health COVID Mitigation and Testing				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	MHCSS	Mental Health COVID Supplemental Services				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	NMOS	CCBHC Non-Medicaid Operations Support				-	Must = 0
H	CCBH	COVID-19 Comprehensive Services for Behavioral Health	WFSS	ACT and Dual ACT/IDDT Financial Incentive				-	Must = 0
H	**SUBTOTAL COVID-19 Comprehensive Services for Behavioral Health**				-	-	-	-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	ADM	ARPA Administration				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	PREV	ARPA Prevention				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	PREVII	Prevention II COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	SUDADII	Substance Use Disorder Administration COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	TRMTA	ARPA Treatment and Access				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	TRMTII	Treatment COVID				-	Must = 0
H	CSUGS	COVID-19 Substance Use and Gambling Services	WSSII	Women's Specialty Services COVID				-	Must = 0
H	**SUBTOTAL COVID-19 Substance Use and Gambling Services**				-	-	-	-	Must = 0
H	EBSJJ	Evidence Based Services for Youth in the Juvenile Justice System	EBSJJ	Evidence Based Services for Youth in the Juvenile Justice System				-	Must = 0
H	**SUBTOTAL Evidence Based Services for Youth in the Juvenile Justice System**				-	-	-	-	Must = 0
H	HHS	Housing and Homeless Services	PSH	Permanent Supportive Housing Dedicated Plus				-	Must = 0
H	HHS	Housing and Homeless Services	RRP	Consolidated Rapid Re-Housing				-	Must = 0
H	HHS	Housing and Homeless Services	SH	Permanent Supportive Housing Statewide Leasing				-	Must = 0
H	HHS	Housing and Homeless Services	SPC*	Permanent Supportive Housing				-	Must = 0
H	**SUBTOTAL Housing and Homeless Services**				-	-	-	-	Must = 0
H	JURT	Juvenile Urgent Response Teams	JURT	Juvenile Urgent Response Teams				-	Must = 0
H	**SUBTOTAL Juvenile Urgent Response Teams**				-	-	-	-	Must = 0
H	MCSHR	Midland County Supportive Housing Resource	MCSHR	Midland County Supportive Housing Resource				-	Must = 0
H	**SUBTOTAL Midland County Supportive Housing Resource**				-	-	-	-	Must = 0
H	PATH	Projects for Assistance in Transition from Homelessness	PATH	Projects for Assistance in Transition from Homelessness	180,367	180,367		-	Must = 0
H	**SUBTOTAL Projects for Assistance in Transition from Homelessness**				180,367	180,367	-	-	Must = 0
H	RPC	Regional Perinatal Collaborative	RPC	Regional Perinatal Collaborative				-	Must = 0
H	**SUBTOTAL Regional Perinatal Collaborative**				-	-	-	-	Must = 0
H	SAMHC	Substance Abuse & Mental Health COVID-19 Grant Program	SAMHC	Substance Abuse & Mental Health COVID-19 Grant Program				-	Must = 0
H	**SUBTOTAL Substance Abuse & Mental Health COVID-19 Grant Program**				-	-	-	-	Must = 0
H	SLCBG	Suicide Lifeline Capacity Building Grant	SLCBG	Suicide Lifeline Capacity Building Grant				-	Must = 0
H	**SUBTOTAL Suicide Lifeline Capacity Building Grant**				-	-	-	-	Must = 0

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF) **ATTACHMENT #1**

FINANCIAL STATUS REPORT - ALL NON MEDICAID - SUPPLEMENTAL **AUGUST 2023**

CMHSP:	Washtenaw County Community Mental Health		FISCAL YEAR:	FY 21 / 22		
		SUBMISSION TYPE:	YE Final			YEAR TO DATE REPORTING
		SUBMISSION DATE:	2/28/2023			

H	MDHHS EARNED CONTRACTS				Column A	Column B	Column C	Column D	
H	Grant Program Code	Grant Program Title	Project Code	Project Title	REVENUE	EXPENDITURES	CCBHC EXPENDITURES	BALANCE	
H	SUGS	Substance Use and Gambling Services	GRT	Gambling Residential Treatment				-	Must = 0
H	SUGS	Substance Use and Gambling Services	MGDPP	Michigan Gambling Disorder Prevention Project				-	Must = 0
H	SUGS	Substance Use and Gambling Services	MYTIEP	Michigan Youth Treatment Improvement & Enhancement PIHP				-	Must = 0
H	SUGS	Substance Use and Gambling Services	PPWP	Pregnant and Postpartum Women-Pilot				-	Must = 0
H	SUGS	Substance Use and Gambling Services	PREV	Prevention				-	Must = 0
H	SUGS	Substance Use and Gambling Services	SDA	State Disability Assistance				-	Must = 0
H	SUGS	Substance Use and Gambling Services	SORII	State Opioid Response II				-	Must = 0
H	SUGS	Substance Use and Gambling Services	SUDADM	Substance Use Disorder - Administration (ADM)				-	Must = 0
H	SUGS	Substance Use and Gambling Services	SUDTII	Substance Use Disorder Services - Tobacco II				-	Must = 0
H	SUGS	Substance Use and Gambling Services	TRMT	Treatment and Access Management				-	Must = 0
H	SUGS	Substance Use and Gambling Services	WSS	Substance Use Disorder Services - Womens' Specialty Services				-	Must = 0
H	**SUBTOTAL Substance Use and Gambling Services**				-	-	-	-	Must = 0
H		Other MDHHS Earned Contracts (describe):						-	Must = 0
H		Other MDHHS Earned Contracts (describe):						-	Must = 0
H	**SUBTOTAL Other MDHHS Earned Contracts**				-	-	-	-	Must = 0
H	**BALANCE MDHHS EARNED CONTRACTS (must = 0)**				1,387,320	1,387,320	-	-	Must = 0

Q		REMARKS
Q		This section has been provided for the CMHSP to provide narrative descriptions as requested in the FSR instructions or where additional narrative would be meaningful to the CMHSP / MDHHS.
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ATTACHMENT #1
AUGUST 2023

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
FINANCIAL STATUS REPORT - ALL NON MEDICAID DIRECT CARE WAGE - SUPPLEMENTAL

CMHSP:	Washtenaw County Community Mental Health	FISCAL YEAR:	FY 21 / 22	
	SUBMISSION TYPE:	YE Final		YEAR TO DATE
	SUBMISSION DATE:	2/28/2023		REPORTING
			Column A	**Column B**

			Fiscal period	
I			**10/1/21-9/30/22**	**Total**
I		**PIHP to AFFILIATE MEDICAID SERVICES CONTRACTS - CMHSP USE ONLY**		
I	201	Expenditure - Medicaid	66,132,231	66,132,231
I	201	Expenditure - Medicaid Direct Care Wage	7,050,881	7,050,881
I	201	**SUBTOTAL Medicaid Expenditures (incl Direct Care Wage)**	73,183,112	73,183,112
I	202	Expenditure - Healthy Michigan Plan	5,109,375	5,109,375
I	202	Expenditure - Healthy Michigan Plan Direct Care Wage	104,834	104,834
I	202	**SUBTOTAL Healthy Michigan Plan Expenditures (incl Direct Care Wage)**	5,214,209	5,214,209
I	203	Expenditure - MI Health Link		-
I	203	Expenditure - MI Health Link Direct Care Wage		-
I	203	**SUBTOTAL MI Health Link Expenditures (incl Direct Care Wage)**	-	-
I	290	**TOTAL EXPENDITURE**	78,397,321	78,397,321

		REMARKS	
		Remarks may be added about any entry or activity on the report for which additional information may be useful.	
		Total Medicaid Direct Care Wage (Medicaid DCW - I. 201 + MI Health Link DCW - I. 203)	7,050,881

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
GENERAL FUND CONTRACT RECONCILIATION AND CASH SETTLEMENT

ATTACHMENT #11
AUGUST 2023

CMHSP: Washtenaw County Community Mental Health
FISCAL YEAR: FY 21 / 22
SUBMISSION TYPE: YE Final
SUBMISSION DATE: 2/28/2023

1.	General Fund Services - Available Resources	Funding Resources
a.	CMH Operations (FSR B 101)	4,235,050
b.	Intentionally left blank	
c.	Intentionally left blank	
d.	Sub-Total General Fund Contract Authorization	$ 4,235,050
e.	1st & 3rd Party Collections (FSR B 121 + B 122)	337,557
f.	Prior Year GF Carry-Forward (FSR B 123)	193,622
g.	Intentionally left blank	
h.	Redirected CMHSP to CMHSP Contracts (FSR B 313)	75,721
i.	Redirected Non-MDHHS Earned Contracts (FSR B 314)	-
j.	Sub-Total Other General Fund Resources	$ 606,900
k.	Local 10% Associated to 90/10 Services (FSR M 201)	274,046
l.	Local 10% Match Cap Adjustment (FSR M 203)	-
m.	Sub-Total Local 10% Associated to 90/10 Services	$ 274,046
n.	Total General Fund Services - Resources	$ 5,115,996

3.	Summary of Resources / Expenditures	Amount
a.	Total General Fund Services - Resources	5,115,996
b.	Total General Fund Services - Expenditures	4,140,310
c.	Sub-Total General Fund Services Surplus (Deficit)	$ 975,686
d.	Less: Forced Lapse to MDHHS (GF work sheet 5 d column F)	-
e.	Net General Fund Services Surplus (Deficit)	$ 975,686

4.	Disposition:	Amount
a.	**Surplus**	
b.	Transfer to Fund Balance - GF Carry-Forward Earned	(211,753)
c.	Lapse to MDHHS - Contract Settlement	(763,933)
d.	Total Disposition - Surplus	$ (975,686)
e.	**Deficit**	
f.	Redirected from Local (FSR B 331)	-
g.	Redirected from risk corridor (FSR B 332)	-
h.	Total Disposition - Deficit	$ -

5.	Cash Settlement: (Due MDHHS) / Due CMHSP	Amount
a.	Forced Lapse to MDHHS	-
b.	Lapse to MDHHS - Contract Settlement	(763,933)
c.	Return of Prior Year General Fund Carry-Forward	
d.	Intentionally left blank	
e.	Contract Authorization - Late Amendment	-
f.	Intentionally left blank	
g.	Misc: (please explain)	
h.	Total Cash Settlement: (Due MDHHS) / Due CMHSP	$ (763,933)

2.	General Fund Services - Expenditures	90/10 - Local Cap	Expenditures
a.	100% MDHHS Matchable Services (FSR B 201)		972,679
b.	100% MDHHS Matchable Services - CMHSP Local Match Cap (FSR B 202)		-
c.	90/10% MDHHS Matchable Services (FSR B 203 Column A)	2,740,464	
d.	Local 10% Match Cap Adjustment (FSR M 203)	-	2,740,464
e.	Intentionally left blank		
f.	Intentionally left blank		
g.	Sub-Total General Fund Services - Expenditures		$ 3,713,143
h.	Intentionally left blank		
i.	Intentionally left blank		
j.	Intentionally left blank		
k.	Intentionally left blank		
l.	Intentionally left blank		
m.	Intentionally left blank		
n.	GF Supplement for Unfunded Targeted Case Management (FSR B 304)		-
o.	Intentionally left blank		
p.	Intentionally left blank		
q.	GF Supplement for Injectable Medications (FSR B 309)		-
r.	GF Supplement for PIHP to Affiliate Medicaid Services Contracts (FSR B 310)		-
s.	GF Supplement for PIHP to Affiliate CCBHC Medicaid Contracts (FSR B 310.1)		-
t.	GF Supplement for PIHP to Affiliate Opioid Health Home Services Contracts (FSR B 310.2)		-
u.	GF Supplement for PIHP to Affiliate Health Home Services Contracts (FSR B 310.3)		5,175
v.	GF Supplement for PIHP to Affiliate MI Health Link Services Contracts (FSR B 310.4)		-
w.	GF Supplement for PIHP to Affiliate CCBHC Non-Medicaid Contracts (FSR B 310.5)		421,992
x.	GF Supplement for CMHSP to CMHSP Contracts (FSR B 312)		-
y.	Sub-Total General Fund Services Supplement - Expenditures		$ 427,167
z.	Total General Fund Services - Expenditures		$ 4,140,310

6.	General Fund MDHHS Commitment	
a.	MDHHS / CMHSP Contract Funded Expenditures	3,259,364
b.	Earned General Fund Carry-Forward	211,753
c.	Total MDHHS General Fund Commitment	$ 3,471,117

7. Report Certification

	Cash Settlement	Carry Forward
Examined	$ (763,933)	$ 211,753
Original	-763933	211753
Increase (Decrease)	$ -	$ -

Comments:

MDHHS/CMHSP MANAGED MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT (GF)
GENERAL FUND CONTRACT SETTLEMENT WORKSHEET

ATTACHMENT #1I
AUGUST 2023

CMHSP: Washtenaw County Community Mental Health
FISCAL YEAR: FY 21 / 22
SUBMISSION TYPE: YE Final
SUBMISSION DATE: 2/28/2023

1. General Fund (Formula and Categorical Funding)		Contract Authorization	Cash Received Through 9/30	Cash Received After 9/30 Prior to Settlement	Cash Received Total	Amount Due CMHSP / (MDHHS) Cash Settlement
a.	CMH Operations	4,235,050	4,235,050		4,235,050	-
b.	Intentionally left blank				-	-
c.	Total Current FY GF Authorization / Cash Received / Cash Settlement	$ 4,235,050	$ 4,235,050	$ -	$ 4,235,050	$ -

2. Current Year - General Fund Carry-Forward - Maximum		Contract Authorization	Maximum C/F
a.	CMH Operations	4,235,050	
b.	Total Current Year Maximum Carry-Forward	$ 4,235,050	$ 211,753

3. Prior Year - General Fund Carry-Forward		FY	If balance of Prior Year GF Carry-Forward is not zero, balance must be explained
a.	Prior Year GF Carry-Forward Earned	193,622	
b.	Prior Year GF Carry-Forward (FSR B 123)	193,622	
c.	Balance of Prior Year General Fund Carry-Forward	$ -	

4. Categorical - Categories		Authorization	Expenditures	Lapse	Cost Above Authorizations
a.	Other Funding - Please explain			-	-
b.	Other Funding - Please explain			-	-
c.	Other Funding - Please explain			-	-
d.	Totals	$ -	$ -	$ -	$ -

5. Narrative: Both CRCS and Contract Settlement Worksheet

SPECIAL FUND ACCOUNT
For Recipient Fees and Third-Party Reimbursement
As Added to Mental Health Code per PA 423, 1980

CMHSP: Washtenaw County Community Mental Health
FISCAL YEAR: FY 21 / 22
SUBMISSION TYPE: YE Final
SUBMISSION DATE: 2/28/2023

Part A: Mental Health Code (MHC) 330.1311 - County Funding Level		EXAMINATION ADJUSTMENTS	EXAMINED TOTAL
1. County Funding - 1979/1980	$ 583,301		$ 583,301
2. County Funding - Current Fiscal Year	$ 1,528,080		$ 1,528,080

Part B: Mental Health Code (MHC) 330.1226a - Cash Collections
Year to Date by Service Category and Source

Service Category	(1) Individuals Relatives	(2) Insurers Including Medicare	(3) Medicaid Health Plan Organizations	(4) Total	EXAMINATION ADJUSTMENTS	EXAMINED TOTAL
1. Inpatient Services				$ -		$ -
2. Residential Services				$ -		$ -
3. Community Living Services				$ -		$ -
4. Outpatient Services	$ 5,647	$ 83,118		$ 88,765		$ 88,765
5. Total	$ 5,647	$ 83,118	$ -	$ 88,765	$ -	$ 88,765

Part C: Mental Health Code (MHC) 330.1226a - Cash Collections Quarterly Summary		EXAMINATION ADJUSTMENTS	EXAMINED TOTALS
1. First Quarter	$ 21,422		$ 21,422
2. Second Quarter	$ 17,246		$ 17,246
3. Third Quarter	$ 19,574		$ 19,574
4. Fourth Quarter	$ 30,523		$ 30,523
5. Total	$ 88,765	$ -	$ 88,765

Explanation of Accrual and Examination Adjustments

section 7.2.4 Special Fund Account of the CMHSP contract

Washtenaw County Community Mental Health
Explanation of Examination Adjustments
September 30, 2022

Section M Transposition

On the FSR that was submitted to MDHHS, Row M204 Local Cost for State Provided Services was transposed with Row 205 Local Contribution to State Medicaid Match. An examination adjustment was made to correct this:

- Row M204 was increased from $411,272 to $935,673; a difference of $524,401
- Row M205 was decreased from $935,673 to $411,272; a difference of $(524,401).

During our compliance audit, we may have become aware of matters that are opportunities for strengthening internal controls, improving compliance and increasing operating efficiency. These comments and recommendations are expected to have an impact greater than $25,000, but not individually or cumulatively be material weaknesses in internal control over the Medicaid Contract and General Fund Contract. Furthermore, we consider these matters to be immaterial deficiencies, not findings. The following comments and recommendations are in regard to those matters.

2022-02 FSR Examination Adjustments

Criteria or specific requirements:
The CMHSP shall provide the financial reports to MDHHS as listed in the General Fund Contract. Forms and instructions are posted to the MDHHS website. (Contract Attachment C6.5.1.1)

Condition:
The CMHSP submitted financial reports that were not in compliance with FSR instructions referenced in Attachment C6.5.1.1 to the General Fund Contract.

Examination adjustments:
Examination adjustments were made to sections of the FSR. See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Context and perspective:
Management was aware of the rules regarding reporting of revenues and expenditures on the *Financial Status Report - All Non Medicaid*.

Effect:
See detailed descriptions of these examination adjustments in the Explanation of Examination Adjustments section of this report.

Recommendations:
The CMHSP should review its current policies and procedures regarding the preparation and review of the Financial Status Report to assure that all amounts are reported in compliance with the reporting instructions. Specifically, a review of the final draft should be performed by a knowledgeable person who is independent from the original preparation of the report(s).

Views of responsible officials:
Management is in agreement with our recommendation.

Planned corrective action:
Management will continue to work towards full compliance with this requirement. Management's review of the draft final report does include a two person review. Management will implement the use of a check-list to compare lines used in the previous year to current year to mitigate mistakes.

Responsible party:
Nicole Phelps, CFO & Ronisa Clark, Accounting Manager

Anticipated completion date:
September 30, 2023

Communication with Those Charged with Governance at the Conclusion of the Audit

To the Members of the Board
Washtenaw County Community Mental Health
Ypsilanti, Michigan

We have examined Washtenaw County Community Mental Health's (the CMHSP) compliance with the compliance requirements described in the *Compliance Examination Guidelines* issued by Michigan Department of Health and Human Services that are applicable to the Medicaid Contract and General Fund Contract for the year ended September 30, 2022. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you during planning. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Matters

Qualitative Aspects of Compliance Practices
Management is responsible for the selection and use of appropriate accounting and compliance policies. We noted no compliance matters entered into by the CMHSP during the year for which there is a lack of authoritative guidance or consensus.

Accounting estimates are prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the compliance requirements, particularly those that may have an impact on the Financial Status Report (FSR). The most sensitive estimates relating to the compliance requirements were as follows:

> Management uses estimates when preparing the CMHSP's cost allocation workbook. The cost allocation workbook is used to spread shared costs across the programs and funding sources that benefit from these shared costs. Examples of allocation methodologies used to spread shared costs that use estimates may include full-time equivalent (FTE), square footage of space used, percentage of total salaries and wages, etc. These allocation methodologies should follow the guidance provided by MDHHS and 2 CFR 200 Subpart E.

Difficulties Encountered in Performing the Audit
We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements
Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. If any of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, they would be reported on Schedule of Findings as shown above. If any of the misstatements detected as a result of audit procedures were expected to have an impact greater than $25,000, but were not material, either individually or in the aggregate, they would be reported on Comments and Recommendations as shown above.

Disagreements with Management
For purposes of this letter, a disagreement with management is an accounting, reporting, compliance, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the CMHSP's compliance with the compliance requirements described in the *Compliance Examination Guidelines*. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations
We have requested certain representations from management that are included in the management representation letter.

Management Consultations with Other Independent Accountants
In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves the CMHSP's compliance with the compliance requirements or a determination of the type of auditor's opinion that may be expressed, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues
We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the CMHSP's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters
The CMHSP's responses to the noncompliance findings identified in our examination are described in the accompanying Schedule of Findings and Comments and Recommendations. The CMHSP's responses were not subjected to the examination procedures applied in the examination of compliance and, accordingly, we express no opinion on the responses.

Restriction on Use
This information is intended solely for the information and use of the Board and management of the CMHSP and is not intended to be, and should not be, used by anyone other than these specified parties.

Sincerely,

Roslund, Prestage & Company, P.C.
Certified Public Accountants

Millage Funding Summary August 2023

Washtenaw Health Project:

Goals:

- The provision, coordination, and expansion of mental health services to WHP members and immigrants whose native language is not English, including an evaluation of and expansion of existing provider capacity: $125k
- Outreach, communication, insurance navigation, and connection to services in the Latinx and youth communities: $40k

What:

The provision, coordination, and expansion of mental health services to WHP members and immigrants whose native language is not English. This work would include:

- The ongoing provision, coordination, and expansion of mental health services to WHP members in their native language.
- Expanding our contracting providers to allow members to receive mental health services that are coordinated with their primary care.
- Providing a landscape analysis of mental health services availability in languages other than English. This work builds on WHP's previous Immigrant Mental Health Needs Assessment.
- Create a Spanish-speaking parental support group for parents of youth who need mental health services.

Outreach, communication, insurance navigation, and connection to services in the Latinx and youth communities.

- Assist entire immigrant families with accessing health insurance and other benefits.
- Much of the communication in the Spanish-speaking community happens through informal networks, many of which the WHP is involved in. These include Facebook groups, WhatsApp message chains, and community groups (e.g. Mexiquenses, Buenos Vecinos, Spanish Healthcare Outreach Collaborative, and Washtenaw Interfaith Coalition for Immigrant Rights). The WHP is currently working on establishing a Latinx Health Services Consortium.
- The WHP has an existing connection to public schools through our Child Health Advocate, Kelly Stupple, and our collaboration with Washtenaw County Success by 6 Great Start Collaborative.

Funding Amount: $165,000/ year for 2 years

washtenaw health project
connecting our community to care

Washtenaw Health Project Mental Health and Public Safety Millage Report and Renewal Request

August 14, 2023

washtenaw health project
connecting our community to care

Outline

A. Previous Funding Summary
B. Summary of work these last two years
C. Request for renewed funding for two more years

washtenaw health project
connecting our community to care

The Washtenaw Health Plan is changing its name

Washtenaw Health Plan | Healthcare Advocacy | Community Health Workers | Medicaid & Marketplace Navigation

Previous Funding Summary

The Mental Health and Public Safety Millage provided $165k per year to the Washtenaw Health Project for:

- The provision, coordination, and expansion of mental health services to Washtenaw Health Plan members and immigrants whose native language is not English.

- Outreach, communication, insurance navigation, and connection to services in the Latinx and youth communities.

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connecting our community to care

Summary of work these last two years

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connecting our community to care

Increased mental health provider capacity for Washtenaw Health Plan members, particularly amongst Spanish speakers

Before millage funding:

705 visits

from Oct 2019-June 2021

Wait time as long as **6 months**

After millage funding:

982 visits

from Oct 2021 – June 2023

Wait time is **2 weeks**

We also partnered to help mental health providers apply for grant funding for Spanish-speaking therapists

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Completed a landscape analysis to understand which mental health providers are available in languages other than English

- The landscape includes **10 different providers** offering mental health therapy in **18 languages**, and how to contact them.

- Case managers across the county can now better identify mental health providers for their clients who speak languages other than English.

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connecting our community to care

Outreach and Groups for Teens and Youth

HOW CAN THERAPY HELP ME?

As we recover from the pandemic, we can all use a bit of extra support! Here are just some of the things that a therapist can help you with

- Anxiety and panic
- Behavioral issues
- Confusion
- Family concerns
- Feeling like you've lost control
- Feeling overwhelmed
- Feeling that life has no meaning
- Feeling unsafe
- Grief & loss
- Life transitions
- Relationship issues
- Substance use
- Sleep difficulties
- Trauma

Therapy is available in person, over the phone, or on a computer/tablet. Therapists are available in several languages. If you have insurance or not, please call, and we will help you find options!

Call **(734) 544-3079,** and leave a voicemail. If no one picks up, We will call you back by the next business day.

washtenaw

ON THE GROUND Ypsilanti

Latinx Teen Empowerment Group offers community and mental health support for Ypsi students

SHARE

RYLEE BARNSDALE | WEDNESDAY, JULY 26, 2023

The bilingual group helps immigrant students build lasting relationships, as well as learn skills to navigate anxiety, depression, and other mental health challenges.

Doug Coombe

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connecting our community to care

Helped CMH and other clients with mental health needs maintain insurance

From Oct 2021 - June 2023

140 people connected to mental health services

From Oct 2021 - June 2023

WHP provided health insurance and healthcare navigation assistance to:

2,000 individuals from the Latinx community*

1,708 individuals under 18*

*Numbers not mutually exclusive

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We're requesting that funding is renewed for two more years

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If funding is renewed, these are the next steps:

- Build on infrastructure to expand visits, with the goal of reaching 1500 visits in 2 years for Washtenaw Health Plan members
- Continue Latinx Youth Empowerment Groups, with possibility of expansion to African American teens at Ypsilanti High School
- Partner with The Women's Center of Southeastern Michigan to host a Latinx support group for Spanish-speaking mothers of young children
- Continue Mental Health Outreach in schools
- Maintain the list of therapists who provide therapy in languages other than English
- Continue health insurance support for individuals with need access to mental health services

washtenaw health project
connecting our community to care

Contact us!

Kelly Stupple, MSEd

Program Manager

stupplek@washtenaw.org

734-544-3079

Jeremy Lapedis, DrPH

Executive Director

lapedisj@washtenaw.org

734-714-9929

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6/29/21

Washtenaw Health Plan Mental Health Millage Ask

The following ask was developed as a result of conversations between the Washtenaw Health Plan and Washtenaw County Community Mental Health around mental health access needs in our community.

Key Components of the Ask

A total of $165k per year in ongoing funding for:

- The provision, coordination, and expansion of mental health services to WHP members and immigrants whose native language is not English, including an evaluation of and expansion of existing provider capacity: $125k
- Outreach, communication, insurance navigation, and connection to services in the Latinx and youth communities: $40k

Background

WHP's core services

The Washtenaw Health Plan is a 501(c)3, physically located in the 555 Towner building. The WHP's core services are:

- **Providing a managed care plan** for approximately 2,000 uninsured county residents, many of whom are ineligible for Medicaid due to their immigration status.
- **Health insurance enrollment and access to healthcare and supportive services.** We conduct outreach, enrollment and care management programs targeted to the community's poorest and most isolated populations. This work includes the enrollment of approximately 3,500 people yearly in Medicaid, Medicare, and Marketplace and coordination of care management staff across the county.
- **Being a place of trust and healthcare access expertise** for clients and health safety-net partners. We connect people to resources and are the go-to place for when people can't solve a problem. During the COVID-19 pandemic, the WHP has served as the place for trusted information and resource assistance for the Latinx community.

WHP Existing Mental Health Access and Therapy Services

- Current members of the WHP's managed care plan, about 75% of whom are native-Spanish speakers, can receive service at one of three organizations: Catholic Social Services, Jewish Family Services, and Amplify Colectivo. Services are available in Spanish, Mandarin, French, Italian, and Russian. The ability to provide services in our members' native language is key to successful engagement in therapy. About 2% of our members received services in FY2020. We think that this low percentage represents a lack of service availability, rather than a lack of need. In fact, we know that COVID-19 has increased mental health issues, particularly in Latinx community. We have been actively working to expand the capacity to serve our members over the last year, reducing wait time from 6 months to less than 2 weeks. The average number of monthly sessions in FY2020 was 24. In February and March 2021, we averaged 54 sessions, and we expect this number to keep growing, possibly up to 100 sessions per month. Still, we anticipate running into provider capacity issues without efforts to increase our network.
- WHP ensures that people have healthcare coverage, either through WHP Plan B, Medicaid, or Marketplace insurance, if they are eligible. We work with individuals in their native language to

get them connected to the provider that is most appropriate—this includes managing waitlists for our members and assessing provider fit by evaluating language capacity, provider availability, and individual member preferences.
- When an uninsured individual needs Medicaid to access CMH services, many times WHP will assist those individuals with obtaining Medicaid coverage.

Proposed Scope of Work

We propose work funded by the Public Safety and Mental Health Millage falling into two complementary categories:

The provision, coordination, and expansion of mental health services to WHP members and immigrants whose native language is not English. This work would include:

- The ongoing provision, coordination, and expansion of mental health services to WHP members in their native language. Our goal is to have at least 90 visits per month amongst our members by the end of FY2022.
- Expanding our contracting providers to allow members to receive mental health services that are coordinated with their primary care.
- Providing a landscape analysis of mental health services availability in languages other than English. This work builds on WHP's previous Immigrant Mental Health Needs Assessment.
- We also hope to create a Spanish-speaking parental support group for parents of youth who need mental health services.

We expect that this work will be complementary to the CMH CARES team, as it builds the capacity of mental health services in languages other than English in the community.

Outreach, communication, insurance navigation, and connection to services in the Latinx and youth communities. Once we are sure that we have sufficient capacity to serve these populations, we can begin an effort to promote these services. We expect this work to build on WHP's existing strengths, namely:

- We assist entire immigrant families with accessing health insurance and other benefits. Many of our adult WHP members have children who are eligible for and covered by Medicaid. Through the relationships we develop in this work, we can assess interest in mental health services and promote mental health services.
- Much of the communication in the Spanish-speaking community happens through informal networks, many of which the WHP is involved in. These include Facebook groups, WhatsApp message chains, and community groups (e.g. Mexiquenses, Buenos Vecinos, Spanish Healthcare Outreach Collaborative, and Washtenaw Interfaith Coalition for Immigrant Rights). The WHP is currently working on establishing a Latinx Health Services Consortium.
- The WHP has an existing connection to public schools through our Child Health Advocate, Kelly Stupple, and our collaboration with Washtenaw County Success by 6 Great Start Collaborative.

We anticipate that much of this work would involve targeted outreach through our existing networks to individuals and groups. This would include developing targeted informational flyers in multiple languages about where and how to access mental health services. Over the course of 12 months, we expect our staff to have 400 touchpoints with families facilitating access to health insurance, mental

health services, and other benefits coordination. We would expect to provide mental health information and set up informational meetings as needed with middle and high schools in Ann Arbor and Ypsilanti, as well as with the WHP's existing network of over 30 healthcare providers. In addition to including mental health coordination as a piece of the Latinx Health Services Consortium and promoting these efforts through our existing Latinx communication networks, the WHP will also promote mental health access on Spanish language radio. This work will be coordinated with the Washtenaw Health Department's mental health promotional work, which is a much broader educational campaign, as well as other millage-funded work (such as the WISD initiatives).

Alignment with Millage Priorities and Conclusion

We believe that this work aligns very well with the millage investment priorities, particularly the following:

- Serve all residents, regardless of insurance status.
- Target additional millage resources to serve persons, families, and areas with high levels of disparity and risk including youth; persons with moderate to severe mental health needs and co-occurring illnesses who are uninsured or underinsured; underserved zip codes with high levels of risk or disparity (i.e., 48197, 48198, 48189); and persons with very low economic and/or social resources.
    - Notably, 66% of WHP members live in the zip codes above. WHP serves approximately 2,500 people total each year in these zip codes.
- Build on current demonstrated capacity and expertise in the community, optimizing community partnerships, especially with other sources of funding.

We are asking for ongoing funding for this work. By building these outreach and referral networks, as well as helping people to access insurance, we will expand mental health service capacity and access to quality mental health services in these underserved communities. These efforts will go a long way to preventing and quickly responding to the mental health crises exacerbated by the COVID-19 pandemic.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Credentialing for Licensed Independent Providers***
Department: **Network Management Committee**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	06/14/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To outline the processes and guidelines for the Community Mental Health Partnership of Southeast Michigan (CMHPSM) partners' review of credentials, competence, assessment, and delineation of duties and responsibilities for independent providers who are licensed independent providers (LIP).

II. REVISION HISTORY

DATE	MODIFICATION
3/2007	
10/2009	
8/2013	Revisions to PIHP language and modification to persons affected by this policy. Standards revised to align with current requirements.
10/2014	Updated regional entity language and made some EQR-related corrections.
5/2016	Revision based on updated standards from The Joint Commission.
7/2019	Scheduled Review
2/1/2021	Policy updates to meet EQR requirements and HSAG EQR review
Will be Regional Approval Date	Policy updates to meet EQR requirements and HSAG EQR review

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☐ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☐ SUD Prevention Providers

☒ Other as listed: Licensed Independent Practitioners (LIPs)

A. LIP Professionals Covered by This Policy, and Their Required Licensure/Certification.

This policy applies to the following licensed independent providers providing contracted professional services to the CMHPSM and CMHSPs who are not operating as part of a credentialed organizational provider:

Art Therapist: An individual board certified as an Art Therapist (ATR-BC) by the Art Therapy Credentials Board, Inc.

Audiologist: A licensed individual; has the equivalent educational requirements and work experience necessary for the license; or has completed the academic program and is acquiring supervised work experience to qualify for the license.

Behavior Analyst: An individual certified by the Behavior Analyst Certification Board**. After April 3, 2019, licensed by the State of Michigan as a Behavior Analyst under Act 368 of 1978, Part 182A.**

Clinical Nurse Specialist: An individual licensed as a registered professional nurse who has been granted a specialty certification as a clinical nurse specialist by the Michigan Board of Nursing under section 17210.

Dietitian: An individual who is a Registered Dietitian or an individual who meets the qualification of Registered Dietitian established by the Academy of Nutrition and Dietetics.

Licensed Practical Nurse (LPN): An individual who is licensed by the State of Michigan to practice as a licensed practical nurse under the supervision of a registered nurse, physician, or dentist. LPNs include licensed psychiatric attendant nurses per MCL§ 333.17209.

Massage Therapist: An individual licensed by the State of Michigan to practice as a Massage Therapist under Part 179A of Michigan Public Act 368 of 1978.

Music Therapist: An individual board certified as a Music Therapist (MT-BC) by the Certification Board for Music Therapists, or registered as ACMT, CMT or RMT by the National Music Therapy Registry. For Child Waiver services only MT-BC is accepted.

Nurse Practitioner (NP): An individual licensed to practice as a registered nurse and certified in a nursing specialty by the State of Michigan. under Part 172 of Michigan Public Act 368 of 1978, as amended.

Occupational Therapist (OT): An individual who is licensed by the State of Michigan to practice as an occupational therapist under Part 183 of Michigan Public Act 368 of 1978.

Occupational Therapy Assistant (OTA): An individual who is licensed by the State of Michigan to practice as an occupational therapy assistant and who is supervised by a qualified occupational therapist.

Physical Therapist (PT): An individual licensed by the State of Michigan as a physical therapist Michigan under Part 178 of Michigan Public Act 368 of 1978, as amended.

Physical Therapy Assistant: An individual who is a graduate of a physical therapy assistant associate degree program accredited by an agency recognized by the Commission on the Accreditation in Physical Therapy Education (CAPTE), and who is supervised by the physical therapist licensed by the State of Michigan. The individual must be supervised by the physical therapist licensed by the State of Michigan.

Physician (MD or DO): An individual who possesses a permanent license to practice medicine in the State of Michigan, a Michigan Controlled Substances license, and a Drug Enforcement Administration (DEA) registration.

Physician Assistant: An individual licensed by the State of Michigan as a physician assistant. Practice as a physician assistant means the practice of medicine with a participating physician under a practice agreement Public Act 368 of 1978, as amended.

Professional Counselor: An individual licensed by the state of Michigan to practice as a professional counselor under Part 181, Public Act 368 of 1978, as amended. This includes Rehabilitation Counselors.

Psychiatrist: M.D. or D.O. possessing a permanent license to practice medicine in the State of Michigan, a Michigan Controlled Substances license and a Drug Enforcement Agency registration, who is Board eligible, or Board certified in psychiatry.

Psychologist: An individual who possesses a full license by the State of Michigan to independently practice psychology; or a master's degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a limited-licensed psychologist (LLP); or a master's degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a temporary-limited-licensed psychologist, per Part 182 of Michigan Public Act 368 of 1978, as amended.

Recreation Therapist: An individual certified as a Certified Therapeutic Recreation Specialist (CTRS) by the National Council for Therapeutic Recreation.

Registered Nurse: An individual licensed by the State of Michigan to practice nursing under Part 172 of Michigan Public Act 368 of 1978, as amended.

Social Worker: An individual who possesses Michigan licensure as a master's social worker, or Michigan licensure as a bachelor's social worker, or has a limited license as a bachelor's social worker or master's social worker. Limited licensed social workers must be supervised by a licensed MSW (MCL 333.18501 - 507).

Speech/Language Pathologist: An individual engaged in the practice of Speech-Language Pathology and is licensed by the State of Michigan to provide such services. under Part 176 of Michigan Public Act 368 of 1978, as amended.

In the event that regulations and/or accreditation standards allow for the inclusion of other professionals, these professionals would be credentialed in accordance with this policy.

IV. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Competence**:** The knowledge, skills, ability, and behaviors that a person possesses in order to perform tasks correctly and skillfully.

Credentialing (or credentials review): The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide mental health or substance use disorder services based on established criteria.

The members of the CMHPSM LIP Credentialing Committee will be appointed by the Regional Operations Committee. Members may include representatives from a variety of professional disciplines. Individuals from professional disciplines not represented on the Committee may be asked to participate on a temporary, as-needed basis. Meetings will occur monthly or as needed.

Credentialing Criteria: The minimum qualifications expected for network providers such as: licensure, education, experience, training, current competence, malpractice/liability insurance limitations and claims history, and ability to perform clinical responsibilities.

Cultural Competence: The ability to provide services tailored to the unique needs of a particular population. This can include language competence or knowledge of and sensitivity to specific issues related to cultural or group values and norms.

Licensed Independent Provider (LIP): Any individual permitted by law and the contracting organization to provide care and services without direction or supervision, within the scope of the individual's license.

LIP Credentialing Committee: A group of behavioral healthcare providers and other staff assigned specific responsibilities for the oversight and management of the credentialing and re-credentialing processes. These responsibilities include: the development and review of credentialing criteria; development and review of competency assessment mechanisms; review of Licensed Independent Provider(LIP) applications to verify accuracy; verification of LIP credentials; review and determination of the status of LIPs who have problematic consumer/individual served satisfaction, consumer/individual served complaints/grievances, and/or practice patterns; and development and implementation of an appeal process for adverse credentialing decisions.

National Practitioner Data Bank (NPDB): a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers.

Peer Review: For the purposes of this policy, an assessment of the competence of an individual, performed by another individual of the same professional discipline, typically

completed through reviewing clinical documentation and examples of the individual's work, against existing professional standards.

Primary Source Verification (PSV): The confirmation of specific credentials of a network provider applicant such as licensure, education, experience, training, etc., obtained directly from the original source from or by which the applicant received the credential.

Professional Reference: Professional references are people who can vouch for an LIP applicant's qualifications based on their insight into the practitioner's professional qualities, skills, capabilities, work ethic, skills, strengths, and achievements. References may provide information and correspondence that serves as proof of service of a participant's length of employment, achievements, and qualifications. Typically, a professional reference is a former employer, client, colleague, teacher, supervisor, etc.

Provider Network: The comprehensive list of LIPs who are credentialed as outlined in this policy.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

V. POLICY

The CMHPSM ensures the following:

- The provision of high-quality, cost-effective mental health and substance use disorder services to CMHPSM consumers/individuals served.
- Consumer/individual served access to a timely, geographically convenient, and specialized array of mental health and substance use disorder treatment and support services.
- LIPs meet and/or exceed the accreditation and regulatory standards for practicing and delivering services independently.
- The decision to enter into a contractual relationship with any LIP credentialed by the CMHPSM under this policy is left to each CMHSP based on the needs of their board and community.

VI. STANDARDS

A. Delineation of CMHPSM and CMHSP Responsibilities

1. For all payer-provider relationships, the PIHP retains the right to approve, suspend, or terminate providers from participation in Medicaid funded services including when a provider is selected/contracts/subcontracts with a delegated entity.

2. The CMHPSM will conduct the credentialing process for Licensed Independent Providers. This policy applies to professionals meeting the definitions under section III.A who enter into a contract as an individual, not as an employee of an accredited provider organization.

3. CMHSPs who wish to contract with a LIP will refer those providers to the CMHPSM Network/Operations Manager for credentialing, along with a verified picture identification issued by a state or federal agency (e.g., driver's license or passport).

4. The CMHPSM will collect, verify and evaluate the provider's credentials and communicate its decision as to whether the provider is approved and for which populations to the CMHSP. The CMHSP may then choose to enter into a contractual relationship with the provider if it is the CMHSP's desire to do so. The execution of a service contract is the responsibility of CMHSP. It is at the discretion of each CMHSP whether or not to contract with a LIP recommended by the CMHPSM LIP Credentialing Committee. Each CMHSP will follow its own board approved procedures for offering a contract to a LIP credentialed under this policy. The duties and responsibilities of the LIP provider including the services to be provided must be identified in the contract and must conform to those services allowed under their Michigan licensure and the Medicaid Manual and Medicaid Provider Qualifications published by the State of Michigan. LIP's will be oriented to the organization, relevant policies and procedures, and to their duties and responsibilities regarding consumers/individuals served, prior to delivering services.

5. The LIP credentialing process is implemented by the PIHP as follows:
   a. CMHPSM Chief Executive Officer: Responsible for overall oversight and implementation of credentialing process;
   b. CMHPSM Network Management Committee: Appoint CMHPSM LIP Credentialing Committee chair, provide oversight to CMHPSM LIP Credentialing Committee;
   c. CMHPSM assigned staff: receive and process credentialing requests, conduct and compile credentials verification, present completed credentialing packets to CMHPSM LIP Credentialing Committee for review, communicate results of credentialing review and recommendations to CMHSPs and providers.

B. Initial Credentialing Process

1. Credentialing of all licensed independent providers (LIPs) will require primary source verification to confirm degree awarded, state licensure/ certification/registration, psychiatric residency, board certification, and insurance coverage. Credentialing of all LIPs will also include a criminal background check, and a Child Abuse/Neglect Central Registry Check.

2. Credentialing of all licensed independent providers will include verification that the provider is not excluded from participation in federal health care programs through the Office of Inspector General's exclusions database, per MDHHS contract specifications. It will include queries from the American Medical Association and the National Practitioners Database and other resources for applicable disciplines. Any identified restrictions or sanctions of clinical responsibilities enacted by these, or other behavioral health care organizations will be investigated through the primary source.

3. The CMHPSM shall ensure that the credentialing and re-credentialing processes do not discriminate against any healthcare professional solely on the basis of licensure, registration, or certification; or due to the fact that the individual serves high-risk populations or specializes in the treatment of conditions that require costly treatment.

4. Credentialing of all LIPs will include verification of current competence by obtaining a written attestation by the applicant of their ability to perform the applicable duties and

responsibilities and verified by at least two written peer recommendations from professionals of the same or equivalent discipline.

5. Collection, verification of credentialing information, and the retention of the completed file will be conducted by staff of the CMHPSM. A completed file for each applicant will contain:
   a. The start date (receipt of application) and the end date (when the credentialing/re-credentialing decision is sent to the applicant) is clearly documented.
   b. A standard timeframe of 90 days for which verification or credentialing/re-credentialing requirements is acceptable. If the timeframe is not met, the credentialing/re-credentialing application will need to be declined with clear reasons as to what was not complete in the response to the provider.
   c. The individual or committee reviewing the provider includes reviewers with the same/similar credentials of that provider, especially for files considered adverse, including the names and credentials of the committee members/individuals who completed the review with either manual signatures on the review for or copies of email confirmation with the members credentials saved in the file.
   d. A completed, signed, and dated credentialing application which includes attestation of:
      i. lack of current illegal drug use;
      ii. any history of loss of license and/or felony convictions;
      iii. any history of loss or limitations of privileges or disciplinary action;
      iv. correctness and completeness of the application;
      v. ability to perform duties and responsibilities.

   e. Verification of identity conducted by viewing a valid picture identification issued by a state or federal agency (e.g., driver's license or passport).
   f. Resume/curriculum vitae covering at least the last five years.
   g. Education - verification of highest degree awarded from an accredited school.
   h. Training – verification of residency completion and board certification (physician only).
   i. Licensure – verification of license/certification/registration including any actions against license/certification/registration.
   j. Sanctions/exclusions/restrictions – results of queries of Medicaid/Medicare sanctioned providers list; results of follow up on identified restrictions to clinical responsibilities/privileges; results of follow up on any disciplinary status with a regulatory board or agency; results of NPDB query for applicable disciplines.
   k. Results of criminal background check.
   l. Results of Child Abuse/Neglect Central Registry Check.
   m. Minimum of two written peer recommendations of the same discipline or equivalent.
   n. Professional liability insurance – verification of current & adequate coverage and history of professional liability claims resulting in a judgment or settlement.
   o. Verification of Drug Enforcement Agency registration, and if applicable, controlled substance certificate. (Physicians, Physician Assistants, and Nurse Practitioners only)
   p. Attestation and disclosure questions.
   q. National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following:

i. A minimum five-year history of professional liability claims resulting in a judgment or settlement.
ii. Disciplinary status with regulatory board or agency.
iii. Medicare/Medicaid sanctions.
iv. Approval (or denial) of credentials by the credentialing committee or designee.
v. The initial credentialing and all subsequent recredentialing applications,
vi. Information gained through PSV.
vii. Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and recredentialing standards.
viii. Screen shots of verification sources in each credentialing file

r. The Background Check Resource Guide required verification of a Drug Enforcement Administration (DEA) registration for physicians be updated to ensure a DEA registration is verified for all prescribers including nurse practitioners (NPs) and physician assistances (PAs).

6. The CMHPSM will conduct the credentialing process in a timely manner. Applicants will be notified as soon as possible of missing information that prevents the process from proceeding. Applicant files which remain incomplete after 90 days will be closed with notice sent to the applicant.

7. Completed application files will be presented to the CMHPSM LIP Credentialing Committee for review. The CMHPSM LIP Credentialing Committee will ensure a credentialing decision is made and a decision sent within 90 days from receipt of a completed application.

At the request of the Executive Director of a CMHSP, and due to immediate consumer/individual served need, the above credentialing process described above may be expedited. Under the expedited process, credentialing may be temporarily approved without the Child Abuse/Neglect Central Registry Check, as long as the criminal background check is conducted; and the professional references may be taken verbally instead of in writing. These items shall be obtained and included for a full review by the CMHPSM LIP Credentialing Committee during the month following the expedited process. See the Temporary/Provisional Credentialing of Individual Practitioners section of this policy for additional requirements.

8. In some instances, the CMHPSM may decide to use and not duplicate the credentialing process of an LIP credentialed by a hospital accredited by The Joint Commission. The CMHPSM will notify the hospital of its intention to use the hospital's credentialing decision as a basis for contracting with a LIP credentialed by that hospital.

9. Upon receipt of a completed application file from the CMHPSM, the CMHPSM LIP Credentialing Committee will review the application materials to establish that the applicant's education and training, experience, licensure, competency, and ability to perform duties and responsibilities are appropriate for their professional discipline and for the populations requested. Based on this review, the CMHPSM will communicate the decision that the provider is approved or denied, and for which populations, to the CMHSP Network Managers.

C. Re-Credentialing

1. The credentialing of licensed independent providers in accordance with this policy must be renewed at least every two years. The CMHPSM LIP Credentialing Committee will re-credential providers at the request of the CMHSPs. CMHPSM will not re-credential providers with whom CMHSP intends to contract. At the end of the two-year credentialing period, a LIP who no longer wishes to provide services for the CMHPSM or CMHSPs will not be re-credentialed. The CMHPSM will initiate the re-credentialing process at least 60 days before the expiration of the current credentialing term.

2. During the re-credentialing process, if a LIP is determined by the CMHPSM LIP Credentialing Committee to not meet the necessary standards, a recommendation will be presented by the CMHPSM to the CMHSP to terminate its contract with the LIP. The CMHPSM will provide notification to the LIP in writing of the recommendation and reason for the recommendation along with written notification of the appeal process. The LIP file will contain the appropriate documentation supporting the decision for not re-credentialing the LIP.

3. For a LIP to be re-credentialed, a completed re-credentialing file for each applicant will contain updated information on all of the following:

    a. An update of information obtained during the initial credentialing (see Section B of this policy).
    b. Ongoing monitoring and intervention, if appropriate, of provider sanctions, complaints, and quality issues pertaining to the provider, which includes:
    c. Sanctions/exclusions/restrictions – results of queries of Medicaid/ Medicare sanctioned providers list, results of follow up on identified restrictions to clinical responsibilities, results of NPDB query for applicable disciplines.
    d. Licensure – verification of license/certification/registration including any actions against license/certification/registration.
    e. A review of member grievances and appeal for that provider during 2-year recredentialing cycle, including if there was no activity to review
    f. A review of any Recipient Rights violations for that provider during 2-year recredentialing cycle, including if there was no activity to review

4. Verification of current competence by Peer Review, as defined in section VI above. The LIP and/or contracting CMHSP will identify cases to be reviewed. For a LIP that has not contracted with a CMHSP or in a case where consumer/individual served files are not available to be peer reviewed, two professional references will be obtained from the same or equivalent discipline.

5. Verification of current competence by CMHSP Review, to include confirmation of adherence to organization policies and procedures or contract requirements, verification of meeting training requirements, consumer/individual served feedback or concerns, including any grievances or appeals against the LIP, any relevant performance improvement issues/feedback, and clinical performance that either exceeds or fails to meet acceptable standards, if applicable.

6. Professional liability insurance – verification of current & adequate coverage provided by the insurance carrier.

7. Verification of Drug Enforcement Agency registration and, if applicable, controlled substance certificate.

8. The CMHPSM will conduct the re-credentialing process in a timely manner. Applicants will be notified as soon as possible of missing information which prevents the process from proceeding. Completed application files will be presented to the CMHPSM Credentialing Committee for review.

9. The CMHPSM LIP Credentialing Committee review will occur, and a decision sent to the practitioner within 90 days from the date the applicant's completed recredentialing application, information is verified, and prior to the LIPs credentialing expiration date. Based on this review, the CMHPSM will communicate the decision that the provider is approved or denied, and for which populations, to the CMHSP Network Managers.

10. An applicant brought forward for re-credentialing who does not have all necessary information submitted for the credentialing committee review prior to the credentialing expiration date, shall not deliver services past the expiration date. Upon completion of the application and a favorable credentialing committee recommendation, the applicant shall be allowed to deliver services.

D. Deemed Status

The CMHPSM LIP Credentialing Committee may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where the CMHPSM LIP Committee chooses to accept the credentialing decision of another PIHP, the CMHPSM must maintain copies of the credentialing PIHPs decisions in the individual practitioner's credentialing file.

E. Temporary/Provisional Credentialing of Individual Practitioners

In cases where there is a need to increase the available network of practitioners in underserved areas, the CMHPSM LIP Committee may grant an LIP temporary or provisional credentials when it is in the best interest of consumers/individuals served practitioners be available to provide care prior to formal completion of the entire credentialing process.

Temporary or provisional credentialing must not exceed 150 days.

The CMHPSM has up to 31 days from receipt of a completed application, accompanied by the minimum documents identified below, to render a decision regarding temporary or provisional credentialing:

1. A written application that is completed, signed, and dated by the individual practitioner and attests to the following elements:
   a. Lack of present illegal drug use.
   b. History of loss of license, registration, certification, and/or felony convictions.
   c. Any history of loss or limitation of privileges or disciplinary action.
   d. Attestation by the applicant of the correctness and completeness of the application.

2. An evaluation of the individual practitioner's work history for the prior five years. Gaps in employment of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.
3. Verification from primary sources of:
   a. Licensure or certification and in good standing.
   b. Board Certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training.
   c. Official transcript of graduation from an accredited school and/or LARA license.
   d. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following must be verified:
      i. Minimum five (5) year history of professional liability claims resulting in a judgment or settlement;
      ii. Disciplinary status with regulatory board or agency; and
      iii. Medicare/Medicaid sanctions.
   e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a.), (b.), and (c.) above.

4. The CMHPSM LIP Committee must review the information obtained, determine whether to grant provisional credentials, and ensure the decision is sent to the practitioner by the 31st day from the receipt of a completed application.

5. Following approval of provisional credentials, the process of verification, as outlined in the Initial Credentialing section of this policy, shall be completed.

F. Additional Responsibilities of the CMHPSM LIP Credentialing Committee

In addition to the responsibilities identified in previous sections of this policy, the CMHPSM LIP Credentialing Committee is charged with the following responsibilities:

1. Make recommendations to the CMHPSM Network Management Committee regarding additions, deletions, or changes to the list of professions covered by this policy.
2. Review a LIP's documented performance between credentialing and re-credentialing time periods per the request of the CMHPSM and/or CMHSP. Make recommendations to the CMHSP whether to maintain credentialing status, withdraw, or deny credentialing status. If credentialing status is withdrawn, the CMHSP shall proceed with termination of the contract. The CMHPSM will provide notification to the LIP in writing of the recommendation and reason for the recommendation along with written notification of the appeal process.
3. Ensure members of the CMHPSM LIP Credentialing Committee have representation sufficient to review and make decisions regarding LIP credentialing and re-credentialing applications based on the professional discipline being reviewed.
4. Develop credentialing criteria and update these criteria, as needed. Criteria will be based on The Joint Commission standards, MDHHS, federal or other state

requirements, and other relevant professional standards. CMHPSM & CMHSP approval for these criteria will be obtained as necessary.

5. Assist CMHPSM staff in creating provider applications and other forms or processes to assist in the implementation of this policy.

G. Reporting

The CMHPSM and CMHSPs shall ensure that practitioner misconduct is reported to the appropriate authorities (i.e., MDHHS, the provider's regulatory board or agency, the Attorney General, and/or the Office of the Inspector General, etc.), if such conduct results in the termination or denial of credentialing status. Reporting procedures will be consistent with current federal and state requirements, including those specified in the MDHHS Medicaid Managed Specialty Supports and Services Contract.

The CMHPSM and CMHSPs will ensure MDHHS data reporting requirements for credentialing and recredentialing of LIPs by CMHPSM is completed in compliance with MDHHS-PIHP contractual requirements.

H. Appeal Process for Licensed Independent Providers

1. An individual practitioner that is denied credentialing or recredentialing by the PIHP must be informed of the reasons for the adverse credentialing decision in writing by the PIHP within 30 days of the decision.

2. Licensed independent providers may appeal adverse CMHPSM credentialing decisions. LIPs will be notified in the written decision of their right to appeal adverse decisions, during initial credentialing and re-credentialing processes.

3. Information relevant to a LIP's ability, suitability or appropriateness to fulfill CMHPSM's credentialing requirements will be considered by the CMHPSM Credentialing Committee during the initial credentialing and subsequent re-credentialing processes, and at any other time that such information comes to the attention of CMHPSM. Additional information from the LIP or from other sources, when available, will be included for consideration. Criteria to terminate or deny credentialing may include:
   a. Failure to maintain appropriate insurance as required by contract;
   b. Failure to maintain an active license and failure to inform the CMHPSM of any changes in licensure status, pending investigations relating to licensure or malpractice suits being filed;
   c. Falsifying information on initial or renewal application;
   d. Falsifying any documents submitted with the initial or renewal application;
   e. Failure to abide by the terms of the contract;
   f. Illegal or fraudulent billing practices;
   g. Exclusion from participation in Federal health care programs;
   h. Clinical performance outside acceptable standards.

4. The LIP may request to appeal an adverse decision regarding credentialing by contacting the CMHPSM Chief Executive Officer/designee directly within 10 business days of the date of the written notification. The appeal must be in writing and must specify the nature of the disagreement or the facts in dispute.

5. The CMHPSM Chief Executive Officer/designee will schedule a hearing within 10 business days of the LIP's request for appeal. The CMHPSM Chief Executive Officer/designee will convene an appeal committee which may include: members of the CMHPSM LIP Credentialing Committee; another licensed independent practitioner who has clinical responsibilities in the same discipline as the LIP requesting the hearing, clinical staff, board members, consumers/individuals served, and/or others based on their relevance to the nature of the appeal.

6. The CMHPSM Chief Executive Officer/designee will preside over the hearing. The agenda will include: a restatement of the CMHPSM LIP Credentialing Committee's adverse recommendation; an opportunity for the LIP requesting the appeal to present reasons why the adverse recommendation should be changed and to present any supporting information in oral and/or written form; and an opportunity for the appeal committee members to ask questions.

7. Following the hearing the CMHPSM Chief Executive Officer/designee will consult with the appeal committee members. The CMHPSM Chief Executive Officer/designee will make a final decision about the appeal and notify the LIP in writing. A copy of all appeal documentation will be retained in the licensed independent practitioner's CMHPSM credentialing file.

VI. EXHIBITS

None

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
The Joint Commission: Comprehensive Accreditation Manual for Behavioral Health Care	X	**Human Resources Management Chapter** **Leadership Chapter**
CMHPSM Financial Fraud and Abuse Reporting Policy	X	
MDHHS Michigan Medicaid Provider Manual, Provider Staff Qualifications	X	
MDHHS Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services & HCPCS/CPT Codes	X	
Medicaid and CHIP Managed Care Final Rule, 42 CFR Parts 431, 433, 438, et al.	X	
Michigan Department of Health and Human Services – PIHP Contract, Attachment P 7.1.1, Credentialing Policy	X	

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Consumer Appeals Policy***
Committee/Department: Regional UM Committee	**Local Policy Number (if used)**
Implementation Date	**Regional Approval Date**

Reviewed by:	**Recommendation Date:**
ROC	06/14/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish policy and procedures to receive and resolve appeals regarding the denial, suspension, reduction, or termination of services; the timeliness of service provision; family support subsidy appeals; second opinion requests; local level appeals, and state level appeals.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
06/05/2015	Revised to reflect the External Quality Review recommendations.
02/24/2017	Revised to reflect Section 942 of P A 268 of 2016 Revised Memo 12 15 16
10/01/2017	Revised to reflect the revised Managed Care Rules.
01/28/2019	Revised to reflect corrections from EQR review
12/17/2021	Revised to reflect new ABD language that provides grievance rights only.
06/24/2022	Revised to clarify local appeal roles; add state mediation option, notification requirements for extension of service authorization decisions, clarification of 2nd opinion, SUD provider roles; updated reporting requirements
Will be Regional Approval Date	Revised to reflect the External Quality Review required actions and recommendations.

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

All grievance processes will be initiated at the local Board level and will be handled by the local Customer Services department of each local Board. All policy and procedures for grievance processes can be found in the CMHPSM Customer Services Policy.

All appeal processes will be initiated at the local Board level and will be handled locally. Each CMHSP/ROSC Core Provider/SUD Provider shall have a designee to handle internal/local appeals until:

a. A Medicaid consumer/individual served requests a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR) after receiving notice that an adverse benefit determination (ABD) was upheld by the Local Dispute Resolution Committee (LDRC).
b. A Medicaid consumer/individual served initiates a State Fair Hearing with MOAHR because the PIHP/CMHSP/SUD Provider failed to adhere to the notice and timing requirements. (When this occurs, a consumer/individual served is deemed to have exhausted the internal appeals processes).
c. A Non-Medicaid consumer/individual served completes the local appeal/Local Dispute Resolution Process and requests a Michigan Department of Health and Human Services (MDHHS) Alternative Dispute Resolution Hearing.

Upon the request of a state level hearing/appeal, the designated Fair Hearings Officer will assume responsibility for the process in collaboration with the local Board. This includes working in conjunction with MOAHR on behalf of the local Board, representing the local Board for the State Fair Hearing requests and representing the local Board for MDHHS Alternative Dispute Resolution requests.

All appeal processes will be handled in accordance with the procedures attached to this policy. All appeal processes shall be:

1. Timely
2. Fair to all parties
3. Administratively simple
4. Objective and credible
5. Accessible and understandable to consumers/individuals served and providers
6. Cost and resource efficient
7. Subject to quality improvement review

These processes shall:

i. Not interfere with communication between consumers/individuals served and their service providers.
ii. Assure that service providers who participate in an appeal process on behalf of a consumer/individual served are free from discrimination or retaliation.
iii. Assure that a consumer/individual served/legal representative who files an appeal is free from discrimination or retaliation.

V. DEFINITIONS

Access Staff – Staff designated to provide intake and/or assessment of an applicant's/consumer/individual's eligibility and/or medical necessity for requested services. Staff provide screenings and referrals using diagnostic criteria for mental health and substance abuse services. Staff also assess the needs of callers, make appropriate referrals, and provide authorization of mental health and substance use disorder services based on consumer/individual served need, eligibility, and available funding resources.

Action (also referred to as adverse action) – A benefit/service determination related to Non-Medicaid/General Funds by which the CMHSP determines any of the following covered by Non-Medicaid/General Funds:

- Denial of inpatient psychiatric hospitalization or denial of a requested alternate service if inpatient is denied.
- Denial of services where there are rights to a second opinion.
- Suspension, reduction, or termination of reduction of existing supports/services.

Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

Adequate Notice - Written notice to an applicant/consumer/individual served/ legal representative that a service is being approved or an adverse benefit determination (ABD) has occurred that is not a suspension, reduction or termination.

Administrative Law Judge (ALJ) - A person designated by the state to serve as a judge for the Michigan Administrative Hearing System to conduct Medicaid State Fair Hearings.

Advance Notice - Written notice of an ABD or action to a consumer/individual served/legal representative that a service is being suspended, reduced, or terminated. For Medicaid consumers/individuals, this notice must be mailed at least 10 days before the effective date of the service change. For Non-Medicaid consumers/individuals, this notice must be mailed at least 30 days before the effective date of the service change.

Adverse Benefit Determination (ABD) – A benefit/service determination specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following for Medicaid services:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or part, of a payment for service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) of this chapter is not an adverse benefit determination.
4. The failure to provide services within 14 calendar days of the start date agreed upon during the person-centered planning process and as authorized by the PIHP/CMHSP.
5. The failure of a PIHP/CMHSP to resolve grievances and provide notice within 90 calendar days of the date of the request.
6. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a consumer/individual’s request to exercise his or her right under 438.52(b)(2)(ii) to obtain services outside the network.
7. The denial of a consumer/individual’s request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other consumer/individual served financial liabilities.
8. The failure of the PIHP/CMHSP to act within the required timeframes regarding standard resolution of appeals.

Alternative Dispute Resolution Process - A program of the Michigan Department of Health & Human Services with responsibility for conducting an appeal which was not resolved at the local level through the LDRP. This process may occur after the LDRP review has

been exhausted and Community Mental Health (CMH) upholds the adverse action at the local appeal.

Applicant - A consumer/individual served, or his/her legal representative, who makes an initial request for mental health or substance use disorder services, including services provided by agencies under contract to the PIHP.

Authorized Hearing Representative (AHR) - Any person designated in writing by a consumer/individual served (or the consumer/individual's legal representative) to stand in for or represent the consumer/individual served during a local/internal or state level appeal, or a representative/parent of a minor, or the consumer/individual's spouse, widow, or widower, if there is no one else with authority to represent the consumer/individual served.

Community Mental Health Partnership of Southeast Michigan (CMHPSM) - The Regional Entity that serves as the Pre-Paid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe and Washtenaw for mental health, intellectual/developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP) - A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Consumer/individual served - A consumer/individual served who is receiving mental health or substance use disorder services, including services provided by entities under contract with the PIHP.

Core Provider - A local provider of substance use disorder services utilizing the ROSC model that provides for and/or coordinates all levels of care for consumers/individuals with substance use disorders.

Denial - An action taken by the CMHSP with Non-Medicaid/General Funds services, by which a service is denied in whole, denied in part, or currently authorized services or supports are to be suspended, terminated, or reduced. This is also known as an Action or Adverse Action.

Delay – An action specific to Medicaid, by which the Pre-Paid In-Patient Health Plan (PIHP)/ Community Mental Health Service Provider (CMHSP) determines any of the following and for which Medicaid consumers/individuals have a right to file a grievance:

1. A delay in making a standard/routine service authorization decision of a service request within 14 calendar days from the date of receipt of the request. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
2. A delay in making a decision regarding a request for an expedited service authorization decision within 72 hours from the receipt of the request. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.
3. A delay in resolving standard internal appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. The resolution timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance.

4. A denial of a request for an expedited appeal. The request for an expedited appeal within 72 hours can be denied and extended (hence delayed) to the standard 30-day appeal time frame if the consumer/individual served is notified of the right to file a grievance.
5. The failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal.

Expedited Appeal – The prompt review of an ABD or action, requested by a consumer/individual served/legal representative or a provider on behalf of the consumer/individual served, when the time necessary for the normal/standard review process could seriously jeopardize the consumer/individual's life or health or ability to attain, maintain or regain maximum function. If the consumer/individual served/legal representative requests the expedited review, the PIHP/CMHSP determines if the request is warranted. If the consumer/individual's provider makes the request or supports the consumer/individual's request, the PIHP/CMHSP must grant the request.

Fair Hearings Officer (FHO) –Person assigned by the CMHSP Board for mental health appeals, or by PIHP for Substance Use Disorder (SUD) appeals, to handle state level appeals, maintain appeals-related data, and report this data to the PIHP.

Grievance – An expression of dissatisfaction about any matter related to PIHP/CMHSP service issues, other than an adverse benefit determination or action, which does not involve a Recipient Rights complaint. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the consumer/individual served. Grievances not completed according to time frames are also considered a Medicaid ABD and are appealable.

Grievance Process - Impartial local level review of a consumer/individual's grievance.

Grievance and Appeal System – Processes the PIHP implements to handle appeals, grievances and the collecting and tracking of appeal and grievance information.

Internal Appeal – A request for the PIHP/CMHSP to review a Medicaid ABD at the local level.

Legal Representative – The representative, parent of a minor, or other person authorized by law to represent an applicant/consumer/individual served.

Local Appeal – A request for the PIHP/CMHSP to review a denial, suspension, termination or reduction of Non-Medicaid/General Funds services and/or supports at the local level.

Local Dispute Resolution Process (LDRP) - A review of a Non-Medicaid/General Funds local appeal convened by the local entity (either the CMHSP or the ROSC Core Provider). The LDRP for mental health services is chaired by the designee of the CMHSP Director; the LDRP for substance use disorder services is chaired by the SUD Director. The LDRP has the responsibility for reviewing local appeals regarding mental health or substance use disorder services covered with Non-Medicaid/General Funds by the PIHP/Core Provider and those of its contract agencies.

Medicaid Services – Services provided to a consumer/individual served under the authority of the Medicaid State Plan, EPSDT coverage, 1915(i) waiver, the 1115 demonstration waivers, and/or the 1915(c) program waivers (Habilitation Supports, SED or Children's Waivers.

Mediation - An informal dispute resolution process in which an impartial, neutral individual who has no authoritative decision-making power assists parties to reach their own settlement of issues in a confidential setting.

Michigan Office of Administrative Hearings and Rules (MOAHR) - The entity charged by the state with responsibility for conducting Medicaid State Fair Hearings.

Notice of Resolution – Written statement of the PIHP/CMHSP resolution of a grievance or appeal, which must be provided to the consumer/individual served as described in *42 CFR 438.408*.

Recipient Rights Complaint – A written or verbal statement by a consumer/individual served or anyone acting on behalf of a consumer/individual served alleging a violation of a consumer/individual's legally protected rights, including rights cited in the Michigan Mental Health Code, Chapter 7, which is resolved through the processes established in Chapter 7A.

Regional Entity - The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, intellectual/developmental disabilities, and substance use disorder needs.

Service Authorization – PIHP/CMHSP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*

State Fair Hearing – (Also called a Medicaid Fair Hearing). An Administrative Law Judge (ALJ) from MOAHR completes an impartial state level review of a decision made by the PIHP or the local CMHSP, or one of its contract agencies, regarding Medicaid services.

Utilization Review (UR) - Process in which established criteria are used to recommend or evaluate services provided in terms of cost effectiveness, medical necessity, and efficient use of resources.

VI. STANDARDS

A. General Standards

1. Both grievance and appeals systems shall have processes in place for consumers/individuals served, promote the resolution of concerns, and support and enhance the goal of improving the quality of services.
2. Consumers/individuals served/legal representatives shall be informed of their right to access grievance and appeal processes if they are dissatisfied or concerned at any point during the delivery of mental health services or supports.
3. Customer Services and the Office of Recipient Rights (ORR) shall assist applicants/consumers/individuals served/legal representatives of their legal rights to

access all grievance and/or appeal processes which they are eligible.

4. Providers shall be informed of their right to access the provider appeal process when they are denied or limited authorization for services, or when they wish to file an expedited appeal on behalf of a consumer/individual served.
5. Providers, acting on behalf of a consumer/individual served/applicant and with the consumer/individual's/legal representative's written consent, may file an appeal as the consumer/individual's Authorized Hearing Representative (AHR).
6. If an external/contractual provider makes a service request on behalf of a consumer/individual served, and that request results in an adverse benefit determination/action, both the provider and the consumer/individual served/guardian will be notified of the adverse benefit determination/action. Notice to the provider can be verbally or in writing. Notice to the consumer/individual served/guardian shall follow written notice requirements as outlined in this policy.
7. If the consumer/individual served/legal representative is not aware of the provider's service request, and the matter warrants involving the consumer/individual served/legal guardian in the request process (i.e., will warrant a change in the Individual Plan of Service (IPOS) that the consumer/individual served/legal representative would need to agree to), CMHSP staff will inform the consumer/individual served/legal representative regarding the request.
8. The PIHP/CMHSP will ensure no retaliatory or punitive action is taken with providers that request an expedited appeal review or support the appeal of a consumer/individual served in any other way.
9. The PIHP/CMHSP may only have one local level of appeal for consumers/individuals served.
10. Individuals served/legal representatives will be informed of their right to request mediation services per MDHHS requirements

B. Timeliness of Authorization/Service Decisions

1. State and federal regulations require that specific service decisions shall be made within certain time frames. If these times frames (described below) are not met they are considered appealable denials/Adverse Benefit Determinations (ABD) or decisions with grievance rights, and staff shall follow the same processes for providing consumers/individuals served/legal representatives with notices of their appeal or grievance rights as outlined in this policy.
2. Authorization decisions at the initial request for services, or request for hospitalization shall be made within 14 days of when the consumer/individual served, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent.
3. Authorization decisions for Medicaid consumers/individuals served currently receiving services shall be made within 14 days of when the consumer/individual served, legal representative, or provider made the request. If a decision is not made within 14 days and an extension allowable by policy is not pursued, the delay is considered an ABD and notice must be sent. The decision timeframe can be extended another 14 days if the consumer/individual served is notified of the right to file a grievance for this delay.
4. A standard service authorization decision may be extended an additional 14 calendar days if the consumer/individual served or legal representative requests an extension or if the PIHP/CMHSP/Core Provider justifies a need for additional information and the extension is in the consumer/individual's interest.

5. If a standard service authorization timeframe is extended, the CMHSP/PIHP/ ROSC Core Provider must:
    i. make attempts to give prompt oral/verbal notification of the delay to the individual served/legal representative
    ii. within two calendar days, provide the consumer/individual served written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served of the right to file a grievance if he/ she disagrees with that decision;
    iii. issue and carry out the determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).
6. Medicaid covered services shall begin within 14 days from when the authorization was completed, except in cases where the consumer/individual served agrees to a start date outside the 14-day timeframe. If services cannot begin within the 14-day time frame and the consumer/individual served does not agree to an extension, this shall be considered an ABD and staff shall provide the consumer/individual served/legal representative with notice of the denial and their appeal rights.
7. Expedited authorization decisions shall be made in urgent cases where the provider indicates, the consumer/individual served/legal guardian requests, or the PIHP/CMHSP determines that following the standard timeframe could seriously jeopardize the consumer/individual served/applicant's life or health or ability to attain, maintain, or regain maximum function. In these cases, a decision must be made, and written/electronic notice provided no later than 72 hours from receipt of the request for service.
8. The PIHP/CMHSP may extend the 72-hour time period by up to 14 calendar days if the consumer/individual served/legal representative requests an extension, or if the PIHP/CMHSP justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer/individual's interest. If the PIHP/CMHSP extends the timeframe, it must:
    i. give the consumer/individual served/legal representative written notice of the reason for the decision to extend the timeframe,
    ii. inform the consumer/individual served/legal representative of the right to file a grievance if he/she disagrees with the decision to extend, and
    iii. make a determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires.
9. Consumer/individual served requests for an expedited review of an authorization decision can be denied. If it is denied the consumer/individual served shall receive notice of denial for an expedited review, including the right to file a grievance, and standard 14-day timeframes for an authorization decision shall still be met.
10. <u>If a provider requests an expedited review of an authorization decision, such a request from a provider cannot be denied;</u> the review shall follow the expedited process and the provider shall be informed within 72 hours on whether the service request will be approved or denied.

C. Filing and Timeliness Requirements

1. **Grievances:** A consumer/individual served/legal representative may file a grievance at any time. The PIHP/CMHSP/SUD Core Provider shall resolve grievances and send written notice of the grievance outcome within 60 days of receipt.

2. **Appeals:**

a) Medicaid Appeals: Following receipt of notification of an Adverse Benefit Determination (ABD) by a PIHP/CMHSP/ROSC Core Provider/SUD provider, a consumer/individual served/legal representative has 60 calendar days to request an internal appeal with the entity that provided the ABD. An internal appeal must be resolved within 30 days of receipt.

   i. The 30-day timeframe for an internal appeal may be extended by up to 14 calendar days if a consumer/individual served/legal representative requests an extension or if the CMHSP/PIHP/ROSC Core Provider/SUD provider finds that there is a need for additional information that would be in the best interest of the consumer/individual served. If the timeframe for an internal appeal is extended, the consumer/individual/legal representative must be given notice of the right to file a grievance about the decision.
   ii. A consumer/individual served/legal representative may request a State Fair Hearing within 120 calendar days after receiving notice that the ABD was upheld by the internal appeal.
   iii. If the PIHP/CMHSP does not meet the notice or internal appeal timing requirements, the consumer/individual served has the immediate right to file a State Fair Hearing.

b) Non-Medicaid/General Fund Appeals: Following receipt of an action by the PIHP/CMHSP/ROSC Core Provider, a consumer/individual served/legal representative has 30 calendar days to request a local appeal with the CMHSP. A consumer/individual served/legal representative may request an Alternative Dispute Resolution Process with the state within 10 calendar days after receiving notice that the action was upheld by the local appeal/LDRP.

D. Approved Services

Approval of services is not considered an ABD, and therefore does not require notice of appeal rights. State regulation requires that consumers/individuals served/legal representatives receive an estimated cost of services as part of their Individual Plan of Service.

E. Second Opinion Process

1. All applicants/consumers/individuals served/legal representatives may request a second opinion for a denial of access to services and/or denial of an inpatient psychiatric hospitalization within 30 days of the denial. A second opinion will be provided within the PIHP/CMHSP, at no cost to applicants/consumers/individuals served, by a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist.
2. All consumers/individuals served may request a second opinion when denied a request for routine/non-urgent/non-emergent service. The CMHSP/PIHP/ROSC Core Provider/contractual provider will ensure a second opinion is provided at no cost to the consumer/individual served, and by a clinical staff that meets the MDHHS criteria for the service in question.
3. Non-urgent requests for a second opinion will be completed for applicants/consumers/individuals served within five (5) business days from the receipt of the request.
4. Upon completion of the second opinion, the applicant/consumer/individual served will be provided verbal notification of the outcome within one (1) business day from the completion of the second opinion, and written notification provided within five (5)

business days from the completion of the second opinion.
5. Urgent requests for a second opinion will be provided to consumer/individual served with Medicaid within 72 hours.
6. Urgent requests for a second opinion will be provider to Non-Medicaid consumer/individual served within three (3) business days.
7. Emergent requests for a second opinion will be provided on an immediate basis where applicable, based on clinical judgment of consumer/individual served clinical need, and no later than 24 hours of when the service was requested.
8. If the second opinion upholds the original denial, the notification to the applicant/consumer/individual served shall include the next steps available to them, including filing a grievance, and appeal, and/or a recipient rights complaint.
9. If the second opinion reverses the original denial, staff (Access, Psychiatric Emergency Services, or the local designee) shall arrange for services to be provided per the appropriate required timeframes for authorization decisions.

F. Timeliness of Providing Notice of an Adverse Benefit Determination/Adverse Action

Consumers/individuals served/legal representatives shall receive written notice of an ABD/action that meets federal and state requirements for timeliness.

1. Timeliness of Notice for Medicaid Beneficiaries:

a. For a Service Authorization decision that denies or limits services, notice must be provided to the consumer/individual served within 14 days following receipt of the request for service for standard authorization decisions, or within 72 hours after receipt of a request for an expedited authorization decision.

b. The CMHSP/PIHP/ROSC Core Provider may be able to extend the standard Service Authorization timeframe up to 14 additional calendar days, if:
   i. The consumer/individual served, or the provider, requests extension; or
   ii. The CMHSP/PIHP/ROSC Core Provider justifies (to the State agency upon request) a need for additional information and how the extension is in the consumer's/individual's interest.

c. If a standard service authorization timeframe is extended, the CMHSP/PIHP/ROSC Core Provider must:
   i. provide the consumer/individual served written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served of the right to file a Grievance if he or she disagrees with that decision; and
   ii. issue and carry out its determination as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires. 42 CFR 438.404(c)(4).

d. Advance Notice of Adverse Benefit Determination is required for service authorization decisions that are reductions, suspensions, or terminations of previously authorized/currently provided Medicaid Services. Advance Notice of an ABD must be provided to the consumer/individual served/legal representative at least ten (10) calendar days prior to the proposed effective date.
e. If Advance Notice of Adverse Benefit Determination is not provided within required timeframes, the CMHSP/PIHP/ROSC Core Provider/SUD provider provider must reinstate services to the level before the action if services have been reduced,

terminated, or suspended.

f. Limited Exceptions to Advance Action Notice of an ABD:
The PIHP may mail an adequate notice of action instead of advance action notice, not later than the date of action to terminate, suspend or reduce previously authorized services, if:

i. The entity providing notice has factual information confirming the death of a consumer/individual served/applicant;
ii. The entity providing notice receives a clear written statement signed by a consumer/individual served/legal representative that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the consumer/individual served/legal representative understands that this must be the result of supplying that information;
iii. The consumer/individual served has been admitted to an institution where he/she is ineligible under the plan for further services;
iv. The consumer/individual's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address;
v. The entity providing notice establishes that the consumer/individual served/applicant has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
vi. A change in the level of medical care is prescribed by the consumer/individual's physician;
vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act;
viii. The date of action will occur in less than 10 calendar days.
ix. The entity providing notice has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the consumer/individual served (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

g. If the PIHP/CMHSP/ROSC Core Provider/SUD Provider does not meet the requirements of providing notice or of internal appeal timing requirements, the consumer/individual served with Medicaid has the immediate right to file a State Fair Hearing.

2. Timeliness of Notice for Non-Medicaid/General Funds Consumers Beneficiaries:

a. Whenever a currently authorized service or support or currently authorized services are to be suspended, terminated, or reduced, whether through a utilization review (UR) function, or when the action is taken outside of the person-centered planning process when there is not an identifiable UR unit, the CMHSP/PIHP/ROSC Core Provider/SUD Provider must inform the consumer/individual served with written notification of the change at least 30 days prior to the effective date of the action.

b. Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

G. Content of Notice

1. Consumers/individuals served/legal representatives shall receive written notice of an

ABD/action with content that meets federal and state requirements.

a. **Content of a Medicaid Notice shall explain the following**:
   i. The ABD the PIHP/CMHSP intends to make or has already made.
   ii. The reasons for the ABD.
   iii. The consumer/individual's right to request an appeal of the PIHP's/CMHSP's ABD, including information on exhausting the PIHP's/CMHSP's one level of appeal and the right to request a State Fair Hearing.
   iv. The right for consumers/individuals served/legal representatives to have an AHR and the timeframes for requesting appeals.
   v. Before and during the appeal, the right of the consumer/individual served/legal representative and/or AHR to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the consumer/individual's ABD. This shall occur in a timely manner sufficient for preparation of their case for the appeal.
   vi. How to submit written comments or information relevant to the appeal.
   vii. The procedure for exercising their appeal rights.
   viii. The circumstances under which an appeal process can be expedited and how to request it.
   ix. The consumer/individual's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the consumer/individual served may be required to pay the cost of these services. A consumer/individual served may be required to pay the cost of the services if:
      1) The decision was upheld.
      2) The consumer/individual served/legal representative/AHR withdraws their appeal request.
      3) The consumer/individual served/legal representative/AHR does not attend the appeal.
   x. Notice of denials given to providers/practitioners shall include information on the opportunity for providers to discuss any denial decision with the reviewer and how to contact the reviewer.

b. **Content of a Non-Medicaid/General Funds Notice** shall explain the following:
   a. A statement of what action the CMHSP intends to take.
   b. The reasons for the intended action.
   c. The specific justification for the intended action.
   d. An explanation of the LDRP.

H. Handling of Appeals:

1. All PIHP/CMHSP/Provider entities handling appeals will:
   a. Ensure that written materials will be provided to consumers/individuals served, legal representatives and AHRs in a language and format that is easily understood.
   b. If an applicant/consumer/individual served requires written materials in alternative formats (i.e., visual/hearing impairments or limited English proficiency), materials will be provided free of charge and in ways to meet their needs. Large print materials must be typed in a font large enough and no less than an 18-point font for the consumer/individual served to read. (See the Regional Customer Services Policy for further information about written materials).
   c. Give consumers/individuals served/legal representatives reasonable assistance in

completing forms and taking other procedural steps related to an appeal. This includes but is not limited to auxiliary aids and services upon request, such as providing free interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. This shall occur in accordance with PIHP policies on interpreters and/or limited English proficiency.

2. Any staff/designee handling appeals of ABDs/actions shall:

   a. Acknowledge the receipt of each internal/local appeal in writing within 5 calendar days to the consumer/individual served/legal representative and when applicable, the AHR.
      i. Requests for internal/local appeals received orally will be treated as a formal appeal request to establish the earliest possible filing date for a local appeal.
      ii. An oral request for an appeal will stand as an appeal request. Staff cannot ask or require the requestor of a local appeal to submit any type of written appeal following the oral request for an appeal
      iii. Staff receiving oral requests for an appeal will ensure this request is documented in consumer/individual served and appeals records to ensure compliance with required timeframes are met in both responding to the appeal request and data reporting of appeals.
   b. Ensure that the individuals who make decisions on appeals are individuals who:
      i. Were not involved in any previous level of review or decision making nor a subordinate of any such individual.
      ii. If deciding any of the following, are individuals who have the appropriate clinical expertise in treating the consumer/individual's condition:
         (i) An appeal of a denial that is based on lack of medical necessity.
         (ii) A grievance regarding denial of expedited resolution of an appeal
         (iii) A grievance or appeal that involves clinical issues.
   c. Take into account all comments, documents, records and other information submitted by the consumer/individual served/legal representative without regard to whether such information was submitted or considered in the initial ABD/action.
   d. Provide the consumer/individual served/legal representative a reasonable opportunity, in person or in writing, to present evidence and testimony and make legal and factual arguments. The PIHP/CMHSP must inform the consumer/individual served/legal representative of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and in the case of expedited resolution.
   e. Provide the consumer/individual served/legal representative, upon their request, the consumer/individual's case file, including medical records, other documents, records, and any new or additional evidence considered, relied upon, or generated by the PIHP/CMHSP/Provider in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
      i. The means by which this information is provided will be discussed to ensure they are provided a copy of the case file sufficiently in advance of an appeal resolution, and in accordance with whether the appeal is to be conducted within standard or expedited timeframes.
      ii. Especially in the case of expedited appeals, options such as overnight mail, in-person drop-off, secure email with member permission will be provided.
      iii. In all cases, whether a standard or expedited appeal, documentation of the options discussed and means by which the case file is provided will be

maintained in the appeal record of the CMHPSM EHR Appeals module.

f. Include, as parties to the appeal, the consumer/individual served/legal representative; or the legal representative of a deceased consumer/individual's estate.
g. Ensure Medicaid consumers/individuals served with a Medicaid spend down receive Medicaid notices of appeal. MOAHR, in conjunction with the designated FHO, will determine whether the consumer/individual served had active Medicaid during the time of the decision and is eligible for a State Fair Hearing. If a consumer/individual served with a Medicaid spend down is not eligible for a State Fair Hearing, he/she shall be given the rights to Non-Medicaid appeals processes.
h. Ensure services continue to be provided for consumers/individuals served where applicable during a local/internal or state appeal process without interruption and regardless of the original authorization period if the consumer/individual served requests to continue to receive the services during this process within the required timeframes.
i. Ensure Medicaid consumers/individuals served may continue services, if the appeal request is received within 10 days of the notice of the ABD and includes a written request to continue services. If the ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP/ROSC Core Provider may recover against the consumer/individual served for services provided during the appeal and State Fair Hearing. Recoupment must be consistently applied.
   If Advance Notice of Adverse Benefit Determination is not provided within required timeframes, the CMHSP/PIHP/Provider must reinstate services to the level before the action if services have been reduced, terminated, or suspended.
   If the PIHP/CMHSP continues or reinstates the consumer/individual's benefits/services, at the consumer/individual's/legal representative's request, while the internal Appeal or State Hearing is pending, the PIHP/CMHSP/Provider must continue those benefits/services until one of the following occurs:
   i. The consumer/individual served/legal representative withdraws the internal appeal or request for State Fair Hearing.
   ii. The consumer/individual served/legal representative fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the PIHP/CMHSP sends the consumer/individual served notice of an adverse resolution to the consumer/individual's/legal representative's internal appeal.
   iii. A State Fair Hearing office issues a decision adverse to the consumer/individual served/legal representative.
j. If the Administrative Law Judge reverses a CMHSP/PIHP/Provider decision to deny, limit, or delay services that were not furnished while the appeal was pending the CMHSP/PIHP must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.
k. Ensure Non-Medicaid/General Funds may continue at the discretion of the CMHSP until the outcome of the local appeal is completed, if a consumer/individual served requests a local appeal of a reduction, suspension, or termination within 30 days of the date of the notice and in that request includes a written request to continue services. If the local appeal is upheld, the PIHP/CMHSP/ROSC Core Provider may recover against the consumer/individual served for services provided during the local appeal and MDHHS Alternative Dispute Resolution Process. Recoupment must be consistently applied.
l. Ensure that staff provide notice of appeal rights through the use of/entry into the Consumer Notice Module in the regional electronic record, which will generate the

appropriate forms as described in this policy, or use of notice of grievance rights in the Letters module of the regional electronic record. The only exception to this standard is in cases where staff/providers do not have access to the electronic record. In these cases, staff will provide paper/manual notice that meets current state and federal requirements. Resources are available at the PIHP website https://www.cmhpsm.org/sudtraining.

I. Resolution and Notification: General Standards

1. The Internal/Local Appeal Coordinator will follow the receipt process for requests for internal/local appeals.
2. PIHP/CMHSP/Provider person(s) reviewing internal/local appeals will follow processes for conducting internal/local appeals.
3. Review of all internal/local appeals will include:
    a. A full investigation of the substance for the appeal and any aspects of clinical care involved.
    b. The opportunity for the consumer/individual served/legal representative/Authorized Hearing Representative to be present at the internal/local appeal and bring anyone they wish to testify on their behalf.
    c. The opportunity for the consumer/individual served/legal representative to submit written comments, documents, or other information before or during the internal/local appeal meeting.
4. Expedited resolution of internal/local appeals shall be carried out in cases when, by request from the consumer/individual served/legal representative, the PIHP/CMHSP determines or the provider indicates (in making the request on the consumer/individual's behalf or supporting the consumer/individual's request) that following the standard timeframe could seriously jeopardize the consumer/individual served/applicant's life, physical or mental health or ability to attain, maintain, or regain maximum function.
5. A consumer/individual's request for an expedited appeal can be denied by the PIHP/CMHSP in cases that do not meet the criteria for an expedited appeal.
6. A provider's request for an expedited appeal cannot be denied by the PIHP/CMHSP. In cases where the provider is requesting an expedited appeal the appeal review must be expedited.

H. Medicaid Internal/ Appeal Process:

1. Medicaid internal appeals shall be completed (including the disposition sent out) within 30 calendar days of receipt of the request for an internal appeal with exception of expedited appeals. The 30-day timeframe may be extended by up to 14 calendar days if the consumer/individual served/legal representative request the extension or the PIHP shows that there is need for additional information and the delay is in the consumer/individual's best interest. If the PIHP extends the timeframe not at the request of the consumer/individual served, it must:
    a. Make reasonable efforts to give the consumer/individual served/legal representative prompt oral notice of the delay,
    b. Within 2 calendar days give the consumer/individual served/legal representative written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served/legal representative of the right to file a grievance if he or she disagrees with that decision, and

c. Resolve the appeal as expeditiously as the consumer/individual's health condition requires and no later than the date the extension expires.

2. **Medicaid Expedited Appeals:** The expedited internal appeals for Medicaid beneficiaries must be resolved and notice of disposition given no later than 72 hours from the request. In emergent situations, the timeframe to make expedited decisions will be made on an immediate basis where applicable, based on clinical judgment of a consumer/individual's needs. As with appeals of reductions, suspensions or terminations, the consumer/individual's services will continue until a decision is made, if requested within 10 days of ABD.

a. For expedited resolution of Medicaid internal/local appeals**,** the PIHP/CMHSP may extend the 72-hour notice of disposition time frame by up to 14 calendar days if the consumer/individual served/legal representative requests an extension or, if the PIHP/CMHSP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the consumer/individual's best interest. (Justification for the extension must be documented).

b. If PIHP, CMHSP, or ROSC Core Provider extends the timeframes not at the request of the enrollee, it must complete all of the following:
   i. Make reasonable efforts to give the enrollee prompt oral notice of the delay.
   ii. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
   iii. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

c. If the request for an expedited resolution of a Medicaid internal appeal is denied, the PIHP/CMHSP must:
   i. Transfer the internal appeal to the timeframe for standard resolution or no longer than 30 calendar days from the date the PIHP/ CMHSP received the appeal;
   ii. Make reasonable efforts to give the consumer/individual served/legal representative prompt oral notice of the denial for and expedited appeal; send the consumer/individual served/legal representative written notice of the denial for an expedited appeal within two (2) calendar days;
   iii. Inform the consumer/individual served/legal representative of their right to file a grievance for denial of an expedited appeal.

d. For Medicaid internal appeals, if the CMHSP/PIHP reverses a decision to deny authorization of services that the consumer/individual served received while the appeal was pending, the CMHSP/PIHP must pay for those services

3. **Medicaid Internal Appeal – Notice of Resolution**: A written letter of resolution shall be provided to the consumer/individual served/legal representative/AHR within 30 calendar days of the receipt of the request for internal appeal. The written resolution must include:

a. The results of the resolution and the date it was completed.

b. When the appeal is not resolved wholly in favor of the consumer/individual served, the notice of disposition must also include notice of the following:
   i. The consumer/individual's right to request a State Fair Hearing and how to do

so.
ii. The Right to request to receive benefits while the State Fair Hearing is pending and how to make the request.
iii. The potential liability for the cost of those benefits, if the hearing decision upholds the PIHP's ABD.
iv. The right to contact Customer Services or the Office of Recipients Rights.

c. If the consumer/individual served/legal representative continues to receive the service pending the appeal, the consumer/individual served may have to repay the cost of the service. This may happen if:
   i. The proposed suspension, reduction or termination of services is upheld in the appeal decision.
   ii. The consumer/individual served/legal representative/AHR withdraws their appeal request.
   iii. The consumer/individual served/legal representative/AHR does not attend the appeal.

I. Non-Medicaid Local Appeal Process:

1. Non-Medicaid/General Fund local appeals shall be completed within 45 days of the receipt of the request for a local appeal with exception of expedited appeals.

2. Non-Medicaid/General Fund Expedited Appeal

a. If psychiatric inpatient services are denied for Non-Medicaid/General Fund consumers/individuals served, the consumer/individual served/legal representative must be informed of their right to the LDRP, with the decision from that process to be reached within 3 business days.
b. If the CMHSP does not recommend hospitalization and an alternative service requested by the consumer/individual served/legal representative is denied, the CMHSP must inform the consumer/individual served/legal representative of his/her ability to access the LDRP. The decision from that process for these consumers/individuals served must be reached within 3 business days.
c. The CMHSP must communicate the decision of the LDRP and inform the consumer/individual served/legal representative of the right to access the MDHHS Alternative Dispute Resolution Process, if unsatisfied with the outcome of the LDRP.

1. **Non-Medicaid/General Fund Local Appeal – Notice of Resolution:**
   At the completion of a LDRP, the CMHSP must provide the consumer/individual served/legal representative written notification of the LDRP decision and subsequent avenues available, if he/she is not satisfied with the result, including the rights of consumers/individuals served without Medicaid coverage to access the MDHHS Alternative Dispute Resolution Process after exhausting the local dispute resolution procedures.

J. State Level Appeal Process:

1. State level appeal processes for Medicaid and Non-Medicaid consumers/individuals served will be followed in accordance with federal and state requirements, per the current Michigan Administrative Hearing System Pamphlet and the MDHHS contract.

2. State Medicaid Fair Hearings:

a. After the internal appeal has been exhausted, a Medicaid consumer/individual served may request a State Fair Hearing, if the PIHP/CMHSP upholds the ABD. If the PIHP/CMHSP does not adhere to the notice and timing requirements in 42CFR 438.408, the consumer/individual served is deemed to have exhausted the internal appeal process and may initiate a State Fair Hearing.
b. A consumer/individual served must request a State fair hearing not later than 120 calendar days from the date of the PIHP's/CMHSP's notice of resolution.
c. The parties to the State Fair Hearing include the PIHP/CMHSP as well as the consumer/individual served/legal representative or the representative of a deceased consumer/individual's estate.
d. If ABD is upheld at the State Fair Hearing level, the PIHP/CMHSP may recover against the consumer/individual served for services provided during the internal appeal and State Fair Hearing.
e. If the Administrative Law Judge at the State Fair Hearing level reverses a CMHSP/PIHP decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CMHSP/PIHP must authorize, pay for, and/or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

3. Non-Medicaid State Appeals:
   a. After exhausting the local dispute resolution procedures, a Non-Medicaid consumer/individual served may request the MDHHS Alternative Dispute Resolution Process (ADRP) if the CMHSP upholds the action.
   b. A consumer/individual served must request the MDHHS ADRP within 10 days from the written notice of the LDRP outcome.
   c. MDHHS shall review all requests within two business days of receipt.
   d. If MDHHS agrees with the CMHSP/PIHP/Provider decision, the consumer/individual served may be required to pay for the extended services.

K. Family Support Subsidy Appeals

1. All Family Support Subsidy appeals are handled by the local CMHSP.
2. If a Family Support Subsidy Application is denied or services are terminated, the CMHSP will send the consumer/individual's parent or legal representative a memorandum stating the reason for ineligibility and timeline for an appeal.
3. If the parent or representative had an income increase that resulted in the family exceeding the statutory limit, and the parent or representative did not notify the CMH within two weeks of the change, the CMHSP shall send the parent or representative a memorandum explaining that the subsidy will be terminated, and any amount illegally received will be repaid together with interest as provided in Administrative Rule 330.1621. Repayment of these services will be arranged through the state FSS program.
4. The parent/legal representative has 60 days to file an appeal from the date of the notice of ineligibility or termination. This may be done by letter or by a local Non-Medicaid appeal form available from the local CMHSP.
   If the parent/legal representative requests an FSS appeal within 60 days, the CMHSP shall conduct an FSS hearing in the manner provided for a contested case hearing under Chapter 4 of the Administrative Procedures Act of 1969

5. Using a “reasonable person” standard, the CMHSP determines if the denial or termination of the subsidy will pose an immediate and adverse impact upon the consumer/individual’s health and safety. If so, the CMHSP hears the appeal within one business day. If not, the CMHSP follows the steps below.
    a. Sends parent or legal representative notice of receipt of appeal, indicating the following information about the scheduled hearing:

        i. Date, hour, place, and nature of hearing.
        ii. Statement of legal authority and jurisdiction under which the hearing is to be held.
        iii. Reference to statues and rules involved, and
        iv. Short and plain statement of the matters asserted.
        v. If the timeline for an appeal was exceeded, sends a response indicating that the appeal was not received within two months of the action, and no further appeal rights are warranted.

L. Record Keeping and Retention Requirements:

1. PIHPs shall ensure the maintenance of records for second opinions, local appeals, and copies of State appeals. The PIHP must review the information as part of its ongoing monitoring procedures. The record of each appeal must contain, at a minimum, all of the following information:
    a. If the consumer/individual served is a Medicaid beneficiary or is served with Non-Medicaid/General Funds.
    b. A general description of the reason for the appeal.
    c. The date and time the appeal was received.
    d. Date and type of adverse benefit determination associated with the appeal.
    e. Whether ABD timeframes were met in providing notice
    f. Service(s) related to the appeal.
    g. Date of the service request; if an expedited appeal is request the time of the request needs to also be included.
    h. Whether an expedited appeal review was requested
    i. Whether and expedited appeal request was approved or denied.
    j. Whether expedited appeal timeframes were met (where applicable)
    k. The date of each review or, if applicable, review meeting.
    l. Evidence that individuals who made the decisions on appeals were not involved in any previous level of review or decision making, nor are subordinates of any such individual.
    m. Resolution at each level of the appeal, if applicable, including whether original ABD was upheld or not, in full or in part.
    n. Date and time of resolution at each level, where applicable.
    o. Name of the covered person for whom the appeal was filed.
    p. If the person had an AHR, and the name of the AHR where applicable.
    q. Whether the Medicaid beneficiary involved is using or has used at least one LTSS service at any point during the reporting year.
    r. Whether the Medicaid beneficiary is enrolled in a health home
2. All CMHSP and CMHPSM staff will use the CMHPSM EHR Appeals Module for all documentation of appeals records, data, and the provision of appeal-related notices/ letters to persons served, legal guardians, and/or AHRs.
3. Appeal records must be retained for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

4. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.

M. Performance Improvement

1. Each local board will maintain a log of second opinion requests, Family Support Subsidy appeals, LDRC requests/resolutions, MOAHR Administrative Hearing requests/resolutions, and MDHHS Alternative Dispute Resolution requests/resolutions. This information will be reported and reviewed by the PIHP UM Committee quarterly and maintained by the PIHP Compliance/Quality Manager.
2. Quarterly aggregate reports of appeals data shall be provided by the PIHP Compliance Manager /PIHP Utilization Management Committee Chair to the PIHP Clinical Performance Team and the PIHP Customer Services Committee as the PIHP Quality Assurance and Performance Improvement Program (QAPIP) entity for their review and recommendations on any trends or improvement opportunities.
3. The PIHP Compliance/Quality Manager will ensure PIHP reporting of service denial decisions, local/internal appeals, and grievances to MDHHS in accordance with the current MDHHS/PIHP contract.

VII. PROCEDURES

CMHPSM Procedure for Documentation of Appeals

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Medicaid Managed Care Rule 42 CFR Parts 432, 433, 438 et al.	X	
Michigan Mental Health Code Act 258 of 1974 as amended	X	Section 100b,409(4),705
MDHHS/PIHP Medicaid Contract and Attachments	X	4.4.1.1 Person Centered Planning Practice Guideline; 6.3.1.1 Grievance & Appeal Technical Requirement Process
MDHHS Medical Services Administration (MSA) Bulletin: Medicaid Eligibility Manual - Beneficiary Hearings.	X	
MDHHS/CMHSP General Funds Contract	X	3.1.1 Access System Standards; 6.3.2.1 CMHSP Local Dispute Resolution Process; 6.3.2.2 Family Support Subsidy Program
Family Support Subsidy Act, Public Act 249 of 1983, as amended.	X	
Administrative Procedures Act of 1969, Public Act 306 of 1969	X	Sec. 24.271-24.287.

MDHHS Administrative Rules	X	
MDHHS Policy Hearing Authority Decision #01-0358CMH, and subsequent MDHHS clarifications	X	
CMHPSM Office of Recipient Rights Policy	X	
CMHPSM Culturally and Linguistically Relevant Services Policy	X	
CMHPSM /Limited English Proficiency Policy	X	
CMHPSM Utilization Management Policy	X	
CMHPSM Customer Services Policy	X	
MI Medicaid Provider Manual	X	Coordination of Benefits Chapter; Behavioral Health and Intellectual and Developmental Disabilities Supports & Services Chapter
MOAHR Administrative Hearings Pamphlet	X	
Section 942 of PA 268 of 2016	X	

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy*** ***Customer Services Policy***
Committee/Department: Customer Services Committee	**Local Policy Number (if used)**
Implementation Date	**Regional Approval Date**

Reviewed by:	**Recommendation Date:**
ROC	06/14/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To ensure satisfaction with services for consumers/individuals served and to enhance the relationship between consumers/individuals served and the community.

II. REVISION HISTORY

DATE	MODIFICATION
01/14/2009	
2013	Updated process to remove references to PRU and disbanded committees. Also included language on barrier free services.
2014	Revised to reflect the new regional entity
06/05/2015	Revised to include recommendations made by the External Quality Review (EQR) audit.
2017	Revised to reflect Medicaid Managed Care Regulations Final Rule 2016
08/12/2020	Revisions related to HSAG CAP on significant change timeframes
06/24/2022	Revisions related to HSAG Compliance review on
Will be the Regional Approval Date	Revisions related to HSAG Compliance review on record keeping, reference of new regional grievance procedure, updated consumer/individual served language, updated data/PI reporting.

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:

☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☒ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

The focus of Customer Services includes problem prevention, removal of barriers to consumers/individuals served, grievance resolution, and advocacy for consumers/individuals served so that their voices are heard, respected, and included in organizational decisions and service provision. It is the responsibility of Customer Services to ensure that the community mental health system provides care that is respectful, available to all consumers/individuals served, informs consumers/individuals served of their choices in the system, and is free of stigma.

V. DEFINITIONS

Accessible – Services are located near the population group likely to utilize the service(s) and on/near public transportation routes where available.

Community Mental Health Partnership of Southeast Michigan (CMHPSM) – The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, intellectual/developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP) – A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

CMHPSM Confidential Record of Consumer Treatment (CRCT) – the electronic health record used by the PIHP and CMHSP partners in the CMHPSM region.

Consumer/Individual Served – An individual who is receiving Community Mental Health or Substance Use Disorder services, including services provided by mental health service providers and substance use disorder agencies under contract with the PIHP.

Customer Services – The department or staff members who provide a link between consumers/individuals served, their service network, and their community. The Customer Services staff respond to any inquiries made by consumers/individuals served /potential consumer/individual served/family members/legal representatives/community members/staff and responds to grievances made by consumers/individuals served/legal representatives. Customer Services staff orient consumers/individuals served to the Service Network, provides information on benefits and availability of services, and assists consumers/individuals served in pursuing services as needed.

Grievance – An expression of dissatisfaction about any matter related to services, other than an adverse action or a rights complaint. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the consumer/individual served.

Grievance System – Processes in place to handle appeals, grievances and the collecting and tracking of appeal and grievance information.

Inquiry – a contact made to the Customer Services department (via phone, mail, e-mail or in person) from consumers/individuals served, legal representatives, family members, providers, or anyone in the community seeking information and assistance. Inquiries can include (but are not limited to): information on benefits, services, providers, transportation, and reasonable accommodations available to consumers/individuals served.

Legal Representative – Legal Representative - A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor consumer/individual served,
3. In the case of a deceased consumer/individual served, the executor of the estate or court appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Local Dispute Resolution Committee – (LDRC) An ad hoc committee, convened by the local entity (either the CMHSP or the ROSC Core Provider). The LDRC for mental health services is chaired by the designee of the CMHSP Director; the LDRC for substance use disorder services is chaired by the SUD Director. The LDRC has the responsibility for reviewing local appeals regarding mental health or substance use disorder services of the CMHPSM/Core Provider and those of its contract agencies.

Mediation – a process wherein parties meet with an impartial and neutral person (mediator) that assists them in the negotiation of their differences. For the purposes of this policy, MDHHS has contracted with a specific entity to provide facilitative mediation when disagreements occur between a consumer/individual served/legal representative and the CMHSP/PIHP about the consumer/individual's services and supports. A mediator guides the parties through a confidential information-sharing and decision-making process, ensuring there is a power balance and that all parties have a voice. If a settlement is reached the mediator assists in writing an enforceable agreement created by the parties. A consumer/individual served/legal representative does not lose any due process rights (i.e., a grievance or an appeal) by participating in mediation.

Michigan Department of Health and Human Services (MDHHS) Alternative Dispute Resolution Process – A program of the Michigan Department of Health & Human Services with responsibility for conducting state level reviews for Non-Medicaid local appeals that were not resolved at the local level through the Local Dispute Resolution Committee.

Medicaid State Fair Hearing – The state level process by which a consumer/individual served/their legal representative can request a hearing to MOAHR related to an adverse benefit determination of Medicaid covered services. This process may occur after the local appeal review has been exhausted and the

adverse benefit determination related to the local appeal has been upheld. A hearing may also be requested if a responsible entity of the CMHPSM did not uphold the notice and timing requirements noted in CFR 438.408.

Regional Entity – The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, intellectual/developmental disabilities, and substance use disorder needs.

Rights Complaint – A written or verbal statement by a consumer/individual served or anyone acting on behalf of a consumer/individual served alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Service Network – The group of providers and practitioners with which the CMHPSM contracts or makes arrangements to furnish specialty support services to consumers/ individuals served through the CMHPSM network panel.

Significant Change – expected and unexpected changes in services received by consumers/individuals served that dictate the need for consumers/individuals served/families to be formally notified of these changes, including changes in: all types of provider/contractual arrangements, program, law and/or compliance requirements, staff, and other changes deemed by Customer Service staff as meeting the criteria.

VI. STANDARDS

In order to achieve the goals of this policy, Customer Service staff shall:

A. Orient new consumers/individuals served to the services and benefits available to them, including how to access services, also any fees and co-pays for which they are responsible.
B. Provide consumers/individuals served with information on accessing services, service authorization, and the provider network, including providers who are accepting new consumers/individuals served. Additionally, provides information on how to access primary health and other community services.
C. Provide consumers/individuals served with information on the recipient rights protection processes and how to file a rights complaint.
D. Provide consumers/individuals served with information on other rights to which they are entitled, including freedom to exercise those rights without retaliation, harassment, or discrimination.
E. Help consumers/individuals served /applicants with problems and inquiries regarding benefits.
F. Oversee and assist consumers/individuals served /legal representatives with the grievance process, including assuring the grievance process is conducted in a timely manner in accordance with the Balanced Budget Act requirements and the Regional Consumer Appeals policy.
G. Ensure translator services will be provided to consumers/individuals served /applicants in accordance with the Culturally and Linguistically Relevant Services Policy at no charge to the consumer/individual served/legal representative.
H. Notify and ensure a consumer/individual served has written information is available in alternative formats and in an appropriate manner that considers

special needs. Ensure that available resources include oral interpretation services; that written information is available in prevalent languages in the region's service area; and that such services will be free of charge to the consumer/individual served. Ensure that consumers/individuals served are given an explanation of how to access these services or information.

I. Ensure that all notices and written communication provided to consumers/individuals served /applicants (12-point font) are available in an easily understood format, including large print (minimum 18-point font) when needed.

J. Ensure written materials for potential applicants/consumers/individuals served that are critical to obtaining services must also be made available in alternative formats upon request at no cost, that they include:
- taglines in the prevalent non-English languages in Michigan,
- are in a conspicuously visible font size
- explain the availability of written translation or oral interpretation to understand the information provided,
- provide information on how to request auxiliary aids and services, and
- include the toll-free and TTY/TDY telephone number of the PIHP's member/customer service unit.

K. Ensure that consumers/individuals served /applicants are informed that electronic information (i.e., Guide to Services, etc.) is available in paper format without charge. Paper information must be provided within 5 business days of the request. Requests will be tracked in the CRCT Customer Service and Grievance system.

L. Address needs or barriers related to cultural sensitivity, reasonable accommodation for consumers/individuals served with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communication.

M. Track and report trends and problem areas to the organization locally and regionally.

N. Provide a readily available system of customer services that quickly assists consumers/individuals served.

O. Address the need for cultural sensitivity and reasonable accommodation for consumers/individuals served with physical disabilities, hearing and/or visual impairments.

P. Track the effectiveness and efficiency of Customer Services functions through documented and periodic reports that show performance.

Q. Assist consumers/individuals served and family members to find mechanisms within the CMHPSM to provide their input and insight into the operation of the CMHPSM. These mechanisms include soliciting membership and participation on advisory councils and Performance Improvement (PI) activities, development of new service programs and community awareness outreach initiatives, or provision or facilitation of arrangements for advocacy when requested, such as mentoring or developing informational material, newsletters, and customer satisfaction inquiries.

R. Maintain and make available to consumers/individuals served /applicants/legal representatives written information on benefits, access to services, services available, service authorization, provider network information, the grievance system, and Customer Services functions. This shall include annual review and revision of this information.

S. Ensure that consumers/individuals served /applicants are provided with the information described above at the time they enter services and are informed of

their right to request and obtain this information at least once a year, in accordance with the Balanced Budget Act of 1997.

T. Be available to consumers/individuals served during normal business hours and assist consumers/individuals served on the first contact.

U. Clearly identify hours of operation.

V. Ensure facilitation of phone access from the consumer/individual served, legal representatives, the community, and service providers throughout normal business hours (voice mail and answering machines are not considered phone access). It is expected that the customer services unit or function will operate for a minimum of eight hours daily, Monday through Friday, except for holidays. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized.

W. Enhance the relationship between the community mental health service provider/agency and the community.

X. Ensure information about mediation is available to consumers/individuals served /legal representatives and assist them in how to contact mediation services upon request.

Y. Include requests/referrals to mediations services in all inquiry and grievance data where applicable.

Z. Ensure that consumers/individuals served are notified of any Significant Changes within the required time frame of at least 30 days before the intended effective date of change and by means of the Regional process (see Exhibit A). All staff shall inform their local Customer Services representative immediately if they become aware of a potential Significant Change for consumers/individuals served. Such communication will include taglines for any potential language assistance needed.

AA. Ensure consumers/individuals served are given written notice of termination of a contracted provider to each consumer/individual served who received his or her primary care from, or was seen regularly by, the terminated provider. Notice must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. Such communication will include taglines for any potential language assistance needed.

BB. Ensure that written notice will be provided to consumers/individuals served and guardians as applicable when a contracted provider's services are terminated for whatever reason.

CC. Assist consumers/individuals served in accessing transportation services needed for medically necessary services, including specialty services identified by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines.

DD. Inform consumers/individuals served of any Significant Change in providers or benefits.

EE. Ensure that a copy of the Bill of Rights and Responsibilities shall be posted at each Community Mental Health Service Provider (CMHSP) network site in a location where it is easily visible to all people coming to the site, and update the Consumer Bill of Rights and Responsibilities periodically to ensure that the document continues to reflect state/federal standards, and the values of consumers/individuals served and the CMHPSM. All consumers/individuals served shall receive a brochure version of the Bill of Rights and Responsibilities, along with an explanation of the contents, at the time that services begin.

FF. Ensure there is annual review and update of all Customer Service brochures to ensure documents continue to reflect the values of recovery/resiliency, provide

value to consumers/individuals served, as well as those of network staff members and members of the Community Mental Health Service Provider (CMH)SP Board. Ensure that these materials are available in the prevalent language in the region's service area. Tag lines will be provided in the Guide to Services.

Customer Services shall coordinate efforts locally with the Office of Recipient Rights (ORR) to ensure that ORR is informed of potential rights violations, and Customer Services is informed of grievances in the course of daily operations.

All consumers/individuals served shall receive a brochure version of the Bill of Rights and Responsibilities, along with an explanation of the contents, at the time that services begin.

Customer Service staff shall be knowledgeable regarding different methods used per population served for orienting consumer/individual served into the general community based on the eligibility criteria and availability of services offered through the network.

Customer Service staff shall have up-to-date knowledge regarding benefits, the provider network, applicant and network policies/procedures regarding access, service authorization, and grievance/appeal procedures and are skilled in customer relations. Customer Services staff shall be trained on this information at the time of hire and refresher training therein annually.

Customer Services staff shall ensure compliance with any applicable Federal or State laws that pertain to consumer/individuals' informational rights and ensure that information is disseminated through the region on how staff and subcontract providers need to include those rights in the provision of services to consumers/individuals served. The CMHSP shall review any areas of need with applicable state and federal laws on a regular basis, and report these needs and any recommendations to the Clinical Performance Team (CPT) when needed.

VII. DATA COLLECTION AND REPORTING

A. All CMHSP Customer Services staff will collect and maintain data related to the experiences and satisfaction with services and supports in the CMH system of care through the follow means at minimum:
   i. satisfaction surveys representative of all populations served
   ii. feedback through focus groups, town halls, etc.
   iii. grievance data
   iv. general inquiry data
   v. significant changes

B. The Regional Customer Services Committee will review this data on a quarterly basis, including the reporting of this data to local Consumer Advisory Committees and Regional Consumer Advisory Committee for feedback and potential recommendations.

C. Analysis of consumers'/individuals' experiences and satisfaction with services and supports shall include an annual assessment and report that includes at minimum:
   i. All activities to assess member experience with services such as all member satisfaction surveys, focus groups, member interviews,

feedback from the consumer advisory council, member grievances, appeals etc.

ii. National surveys and how the PIHP compares to national benchmarks.
iii. Identifying an area (or areas) of focus across all activities to target action steps and interventions to improve satisfaction.
iv. An evaluation of the previous year's action steps and interventions to determine if they led to improved satisfaction.
v. Challenges or barriers in achieving member satisfaction goals.
vi. Year-to-year comparison of activity results. An area (or areas) of focus could be directed toward a year-to-year decrease in member satisfaction in a particular area.
vii. Should the PIHP achieve and sustain its member satisfaction goals over a period of time, revise the mechanisms for assessing member experience, such as identifying new member satisfaction surveys or developing new satisfaction questions; revise sampling methodology; and initiate new activities to assess satisfaction.
viii. Activities and findings specific to members receiving LTSS or home- and community-based services (HCBS).
ix. National Core Indicators (NCI) survey results. While these results are not specific to PIHPs, the PIHP could use the results to identify and investigate areas of dissatisfaction and implement interventions for improvement.

D. The Regional Customer Services Committee will report grievance data to the Regional CPT Committee, including trends related to:
   i. Grievances per 1000 served
   ii. Outcomes and types of interventions
   iii. Specific needs or differences within consumer/individual served care populations, including identification of consumers/individuals served using Long Term Services and Supports (LTSS).
   iv. Trends in quality-of-care provision over different locations/providers
   v. Compliance with timeframes
   vi. Compliance with documentation standards

E. The CMHPSM will report customer services related data to the CMHPSM Board as the governing body, through reporting of the current CMHPSM Quality Assessment and Performance Improvement Plan (QAPIP) and QAPIP status reports, for board input and feedback on planned interventions.

Record Retention/Maintenance

A. All CMHSP and CMHPSM staff will use the CMHPSM EHR Customer Service and Grievance Module for all documentation of grievance records, data, and the provision of grievance-related notices/ letters to consumers/individuals served and/or legal guardians.
B. All CMHSP and CMHPSM staff will use the CMHPSM EHR Customer Service and Grievance Module for all documentation of inquiries and outcomes of inquiries.
C. Grievance records must be retained for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

VIII. EXHIBITS

A. Procedures
B. Significant Change Process Flowchart

IX. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
42 Code of Federal Regulation, Parts 400 et al. (Balanced Budget Act of 1997)	X	42CFR438.100 & 42CFR438.10
Michigan Department of Health and Human Services (MDHHS) "PIHP" Medicaid Contract	X	
MDHHS Community Mental Health Authority (CMHA) Medicaid Contract	X	
MDHHS CMHA General Funds Contract	X	
CMHPSM Consumer Appeals Policy	X	
CMHPSM Culturally Linguistically Relevant Services Policy	X	
Health Insurance Portability and Accountability Act of 1996	X	
CMHPSM Office of Recipient Rights Policy	X	
CMHPSM Organization Credentialing and Monitoring Policy	X	
CMHPSM Procedure for Documentation of Grievances in the CRCT EHR Grievance Module	X	

EXHIBIT A

X. PROCEDURES

GRIEVANCES

The grievance process is for any expression of dissatisfaction with service provision that is not related to an adverse action and is not a Rights complaint. A grievance may be filed by a consumer/individual served or the consumer/individual's legal representative. If the consumer/individual served requires assistance in filing a grievance, the Customer Services or Office of Recipient Rights will assist as needed. Grievances may be filed orally or in writing.

WHO	DOES WHAT
Person Served or Legal Representative	May contact the community mental health agency or Customer Service department directly to file a grievance orally or in writing
Customer Services Staff	1. Logs receipt of oral or written grievance and enters relevant information In CRCT Customer Service and Grievance system. 2. Consults with the Office of Recipient Rights (ORR) to determine if the grievance is a legally protected right (Rights Complaint). If so, informs consumer/individual served/legal representative filing grievance of the need to refer the matter to ORR; refers person to the local ORR for follow-up, and logs ORR referral on Grievance Report Form. (Skip to "Office of Recipient Rights Staff" under "Who" to follow this procedure.) 3. If the grievance is not a legally protected right, sends written acknowledgement of receipt of the grievance within five days and explains the process to consumer/individual served/legal representative and includes taglines in this communication. Contacts consumer/individual served/legal representative by phone, if needed, to review the grievance. 4. Completes the data in the CMHPSM Customer Service and Grievance module and works with the appropriate staff and local/PIHP administrator(s) who were not involved in the initial determination that led to the grievance and who have the clinical expertise and the authority to recommend and implement any required corrective action. 5. Includes which staff were consulted about the grievance and determinations made in the documentation of the grievance. 6. Any grievances that Customer Services staff have the authority to respond to will be signed off by the Customer Services Supervisor prior to the disposition notification being sent to the person served.
Assigned Administrator or Customer Services Staff	1. Takes necessary action to ensure the grievance is resolved as expeditiously as the consumer/individual's health condition requires, but no later than ninety (90) calendar days of the receipt of the grievance. Ensures corrective action is taken, when necessary. 2. If the grievance involves clinical issues or issues of medical necessity, ensures that professional(s) who have the appropriate clinical expertise in treating the consumer/individual's condition or disease are involved in review of the grievance. 3. While not a state or federal requirement, seeks to resolve grievances as soon as possible, and within 10 calendar days where possible.

	However this internal standard agreed upon by the CMHPSM Customer Services staff is not required and only grievances not met within the state requirements will be considered out of compliance with required timeframes. 4. Whether or not the disposition is in favor of the consumer/individual served, the grievance must be addressed within the required time frame. 5. If the grievance filed by a consumer/individual served with Medicaid and is not disposed of within ninety (90)calendar days, notifies the consumer/individual served/legal representative of applicable appeal rights. 6. Ensures the consumer/individual served, guardian or parent of a minor child receives written notification of the disposition within ninety (90) calendar days from the date of the request for a grievance. The notice of the disposition shall include: i. the results of the grievance process; ii. the date the grievance process was conducted; iii. the consumer/individual's right to request a state-level fair hearing, if the notice is more than ninety (90) calendar days from the date of the request for a grievance; and iv. how to access the state level fair hearings process. 7. **Extension of Grievances**: Staff managing the grievance may extend the grievance resolution and notice timeframe by up to 14 calendar days if the consumer/individual served requests an extension, or if the PIHP/CMHSP/SUD provider documents that there is a need for additional information and how the delay is in the interest of the consumer/individual served. A. If an extension is needed, applicable staff must: i. Make reasonable efforts to give the consumer/individual served prompt oral notice of the delay; ii. Within 2 calendar days, give the consumer/individual served written notice of the reason for the decision to extend the timeframe and inform the consumer/individual served of their right to file a Grievance if they disagree with the decision; and iii. Resolve the Grievance as expeditiously as the consumer's/individual's health condition requires and not later than the date the extension expires. 8. Ensures taglines are included in grievance related letters. 9. Ensures the data in the CMHPSM EHR Customer Service and Grievance module is completed. 10. Provides quarterly grievance summary data to the CMHPSM Clinical Performance Team Committee as the oversight entity of the CMHPSM QAPIP, and to the Regional Customer Services Committee.
Office of Recipient Rights Staff	When providing consultation to Customer Services, or when triaging a call to the ORR, makes the final determination whether: • A received rights complaint involves a grievance. • A grievance involves a legally protected right. • Follows ORR policies and procedures for a rights complaint when ORR staff determines that a grievance also involves a legally

	protected right. • Refers any grievance portion of rights complaint to Customer Services department.
Regional Customer Services Committee/Customer Services Staff	1. Follows the CMHPSM Procedure for Documentation of Grievances in the CRCT EHR Grievance Module 2. Maintains grievance report database in the CMHPSM EHR Customer Service and Grievance module. 3. Reviews data on a quarterly basis and reports regional summary of grievance data to the CMHPSM Clinical Performance Team Committee. 4. Identifies any trends from grievance data and makes recommendations to the CMHPSM Clinical Performance Team Committee

INQUIRIES

The inquiry process is used for contacts made to the Customer Services Department (via phone, mail, e-mail or in person) from consumers/individuals served, legal representatives, family members, providers or anyone in the community seeking information and assistance. Inquiries can include but are not limited to: information on benefits, services, providers, transportation, and reasonable accommodations available to consumers/individuals served.

WHO	DOES WHAT
Consumer/Individual Served, Legal Representative, Family Member, Provider, or other Community Member, or staff	Contacts Customer Services for information or assistance.
Customer Services Staff	Takes contact (including inquiries and suggestions). 1. Logs receipt of inquiry in CMHPSM EHR Customer Service and Grievance system. 2. Consults with ORR as needed to clarify whether an inquiry may be a legally protected right (Rights Complaint) or a grievance. If ORR determines the contact is a potential rights issue, refers to ORR and logs in CMHPSM EHR Customer Service and Grievance system. If a grievance, follows the grievance procedure above. 3. Determines if contact is a suggestion that would be relevant feedback to provide to the PIHP via the Regional Clinical Performance Team Committee in the Customer Service Quarterly Report. 4. Determines if contact is a request for information or assistance. If so, provides information or assistance to contact or refers contact person to other resources, when appropriate. 5. Ensures the Customer Service Form Letter is completed in CRCT. 6. Maintains local Customer Service data in the CMHPSM EHR Customer Services and grievance system. 7. Reports local data, including relevant suggestions to Regional Customer Services Committee and the local Consumer Advisory

	Committee.
Regional Customer Services Committee	Maintains inquiry and grievance report database regionally. Reviews data on a quarterly basis and reports regional summary of inquiry data to the Clinical Performance Team. Identifies any trends from inquiry data, including relevant suggestions, and makes recommendations to the Clinical Performance Team when needed.

NOTIFYING CONSUMERS/INDIVIDUALS OF SIGNIFICANT CHANGES

The significant change process allows Customer Services to proactively respond to expected and unexpected changes in services received by consumers/individuals served. Utilization of the significant change process facilitates the prevention of grievances and inquiries, and provides a way for Customer Service to work collaboratively and systematically to ensure service delivery is provided in the best means possible for consumers/individuals served and families.

WHO	DOES WHAT
All Staff/Providers	Notifies Customer Services staff of potential or actual significant change.
Customer Services Staff	1. Checks definition of "Significant Change" to be sure the reported change meets the parameters of a Significant Change. 2. Ensures consumers/individuals served are notified of any Significant Changes at least 30 days before the intended effective date of change, and that taglines are included with the communication. 3. Ensures appropriate Administrative Staff is informed of Significant Change. 4. Informs Chairperson of Regional Customer Services Committee of Significant Change. 5. Works with core team to determine impact of change including: 6. Whether change will have a local or regional impact. 7. Whether a local or regional process needs to be implemented.
Customer Services Staff	1. Contacts key Department Heads and Administrative Staff of upcoming change. 2. Ensures a Core Team is identified that will work on the development and implementation of notifying consumers/individuals served of the Significant Change (will vary depending on the type and scope of change).
Identified Core Team	1. Develops and executes plan to notify consumers/individuals served of Significant Change using parameters identified in Exhibit C. 2. Develops and executes a communication/public relations plan for staff and consumers/individuals served using parameters identified in Exhibit C 3. Assures Customer Services staff (local or the Regional Chairperson depending on the type of change) is informed of the plan and the outcome of the plan.
Local Customer Services Staff	If the notification of a Significant Change was local, assures that the Regional Customer Services Committee is informed of the plan and its outcome.
Regional Customer Services Committee	Maintains data across the region on Significant Changes that occurred and their resolution.

EXHIBIT B

Process Flow to Notify Consumers/Individuals Served of Significant Changes

This process flow identifies standard parameters to be followed when developing and implementing a plan to notify consumers/individuals served/family members of a Significant Change. The specifics of the plan and implementation will be led by the Identified Core Team and will depend on the type and scope of the change involved.

Customer Services will be the lead in assuring the appropriate local or regional entities are made aware of a Significant Change that will require this process.

Customer Services may or may not be members of the Identified Core Team for the actual development and implementation of a notification plan (as per the process flow), depending on the type of Significant Change involved.

1. **The Definition of Significant Change Process for Consumers/Individuals Served**
   Significant Changes that would require staff to notify Customer Services include:

   a. <u>All Types of Potential Provider/Contractual Changes</u>
      CMH staff needs to be notified of any of these changes. Consumers/individuals served need to be notified in writing within 15 days of any of the changes below with an asterisk (*) next to them.
      i. Contract added
      ii. Provider in provisional status
      iii. Service added in provider contract*
      iv. Service removed from provider contract*
      v. Contract terminated by CMH or by the provider*

   b. <u>Program Changes</u>
      CMH staff and consumers/individuals served need to be notified of any of these changes.
      i. New program and services
      ii. Removed program
      iii. Changes in Medicaid Provider Manual (changes in services covered)
      iv. Change in programming (change in location, change in how service provided and scope of service)
      v. Reduction in services or a particular service (due to budget cuts)

   c. <u>Law/Compliance Change</u>
      CMH staff, consumers/individuals served and providers need to be notified of any of these changes.
      i. Advance Directives (within 90 days of change in law)
      ii. Michigan Mental Health Code
      iii. 42 CFR (including the Balanced Budget Act and other Medicaid law that affects consumers/individuals served)
      iv. HIPAA/Privacy Changes – either in the law or in our privacy practices.

   d. <u>Other</u>
      Customer Service staff will determine notification of any of these changes.

i. Change in leadership (from Program Administrators/Department Heads to Executive Directors)
ii. Change with clinical staff (the level of communication to be determined by the process)

Significant Change Notification of Identified Stakeholders

Identified Stakeholders that need to be considered, notified, and/or involved in the process of notifying consumer/individual of significant change include:

e. Consumers/individuals/families/guardians
f. Clinical/case management staff
g. Customer Services Department (CMHSP and Regional Committee)
h. Providers affected by the change
i. Regional Network Management Committee
j. Contract Holder in individual CMHSP
k. Office of Recipient Rights
l. Administrative/Fair Hearings Officer
m. CMHPSM Regional Substance Use Disorder Services
n. CMHSP's Finance Departments, Regional Finance Committee
o. Regional Operations Committee
p. Community Mental Health Service Provider (CMHSP) Administrative Teams
q. Board (Regional, CMHSP Boards)
r. Community (Association for Community Advocacy, Intermediate School District, etc.)
s. Partners (i.e. National Alliance on Mental Illness, Friends of Developmentally Disabled, Michigan Rehabilitative Services, Association for Retarded Citizens, Housing Authorities)
t. Reception and Clerical staff in the CMHSPs and CMHPSM
u. MDHHS (when applicable)
v. Consumer Advisory Committees (local & regional)

2. Minimum Standards for a Written Communication Plan (<u>Specifically for Consumers/Individuals Served/Families)</u>

a. <u>Impact Assessment</u> - Make a thorough assessment of which consumers/individuals served and other identified stakeholders* will be affected by this change.
    i. Is it all consumers/individuals we serve?
    ii. Is it consumers/individuals served in a specific program/department?
    iii. Is it consumers/individuals served who receive a particular service?
    iv. Is it consumers/individuals served receiving service from a particular provider?

b. Seek consumer/individual served involvement and feedback from consumers/individuals served before notice goes out if possible.
c. Notify consumers/individuals served/families to clinical/case management staff involved.
d. Explain what the Significant Change is using parameters of definitions of Significant Change above.
    i. Give the most direct information possible in the least complicated language.
    ii. Explain clearly what is expected of consumers/individuals served/families and any timeframes they need to commit to in order to make the change/ transition successful.
    iii. Explain simply and clearly what it means for consumers/individuals served/guardians/family - how will it affect them.
    iv. Plan for any continuity of care needs – clarify whether it will or will not be a change in service.

e. Provide a letter with information on any meetings that are happening related to this change consumers/individuals served/families can attend. Include the date, location, and time of meeting. If the meeting is a standing meeting and there is a schedule (i.e. a Board meeting), provide a copy of that schedule.
    i. Double check the correct addresses of the consumers/individuals served/family members receiving a letter.
    ii. Give clinical/case management staff lead time (two weeks) to make sure the correct address is in the system.
    iii. Include staff names and contact numbers that consumers/individuals served/families can access in the letter.
    iv. Make sure guardian gets copy if they are not in the same home as consumer/individual served;
    v. Make sure family members get a copy even if they are not the guardian when there is a return on investment that allows it.
    vi. Include any information (copies of documents) consumers/individuals served/families may need to explain the change, when possible.
    vii. If information can't be included in the communication, then explain where consumers/individuals served/families can access it.
    viii. Provide a chronology of how the change happened/how we got here, whenever appropriate.
    ix. Note any changes/alterations in the change or the plan for change will be communicated as soon as possible.

f. Consider alternate forms of communication for general changes such as newsletters, the web, multimedia information at different locations, etc.
    i. General changes are changes that do not adversely affect consumers/individuals served.
    ii. The timeframe would be longer, i.e. Advance Directives.

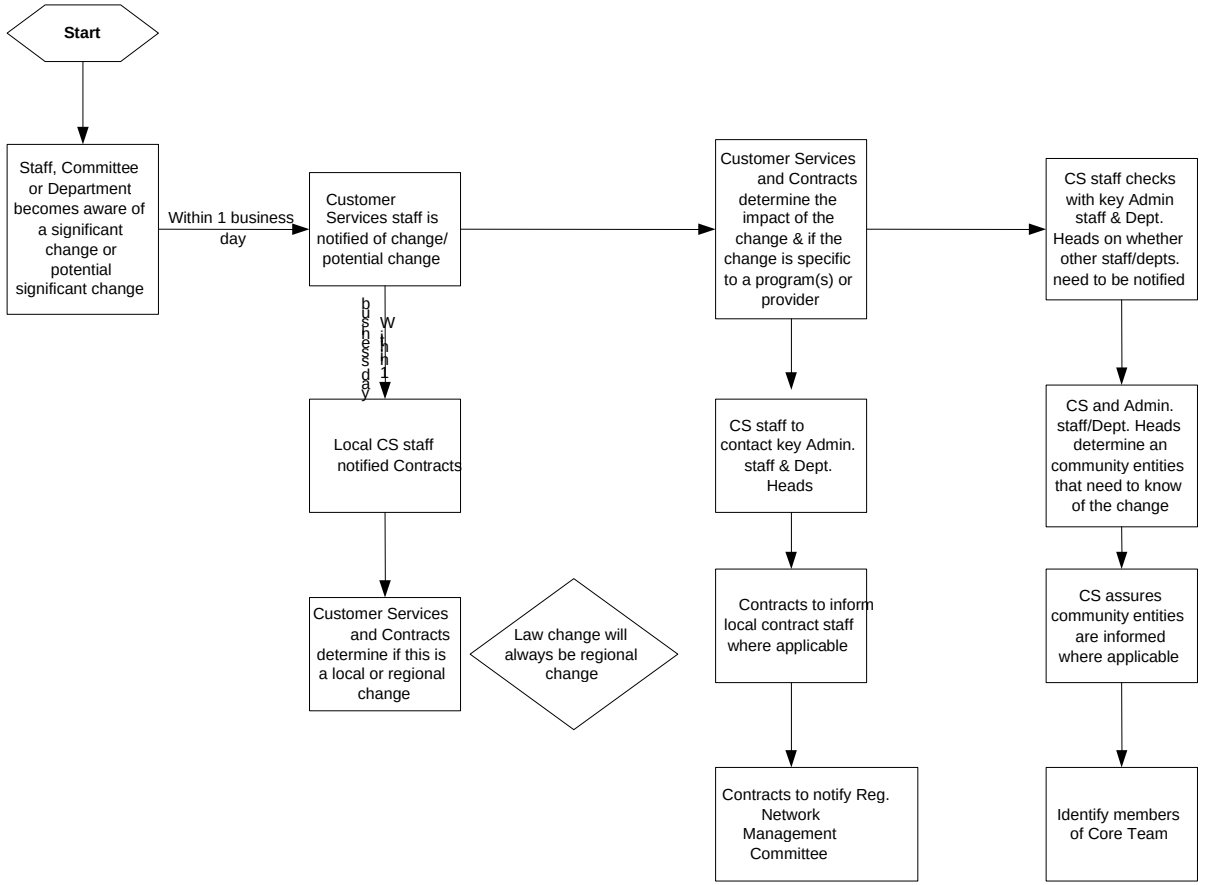
g. Include any information (copies of documents) they may need to explain the change, when possible.

h. Ensure taglines are included in the communication.

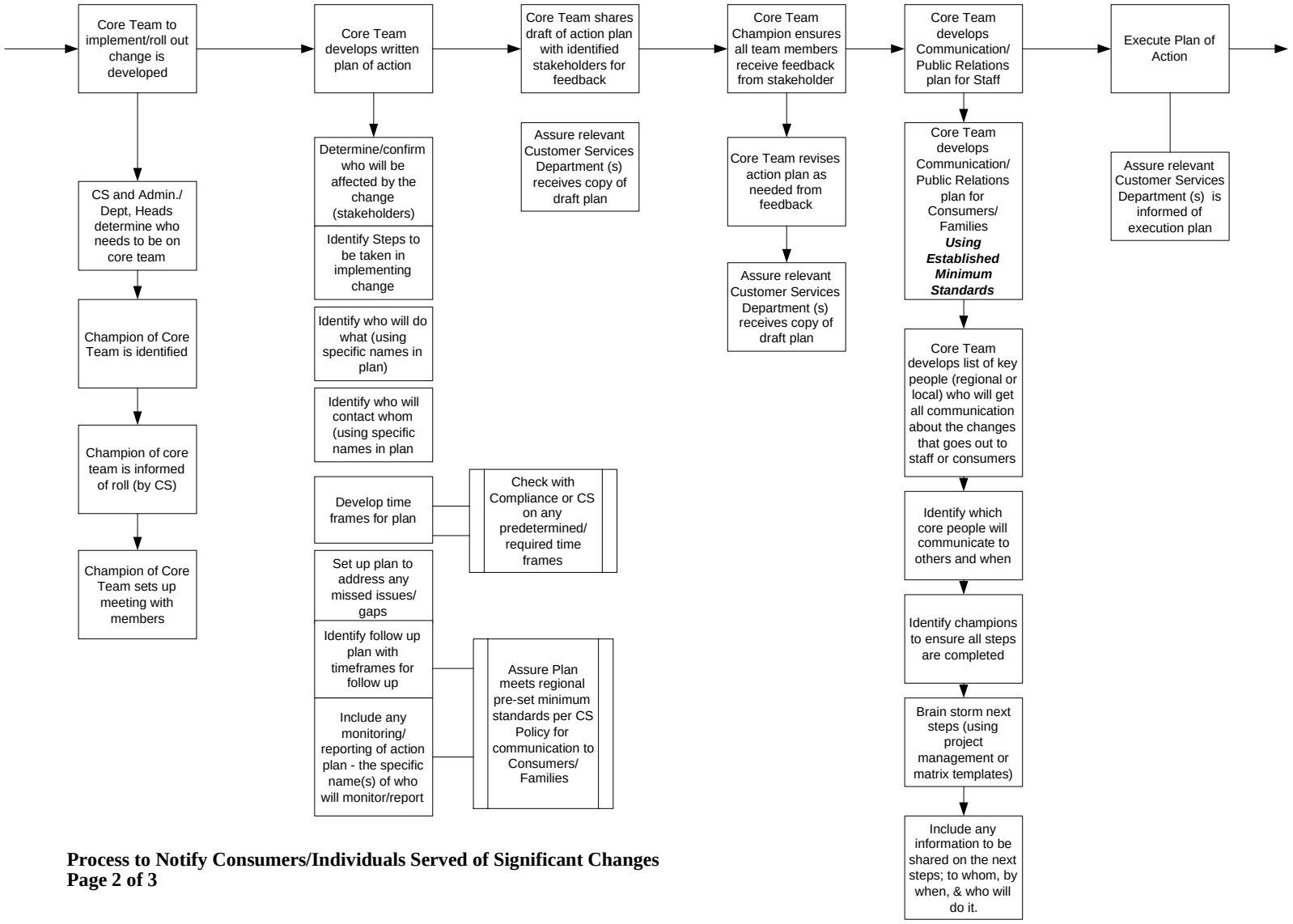
i. Ensure follow up post letter is created and distributed.

j. Explain what we are doing about the change (our action plan) to the extent we can share this information.

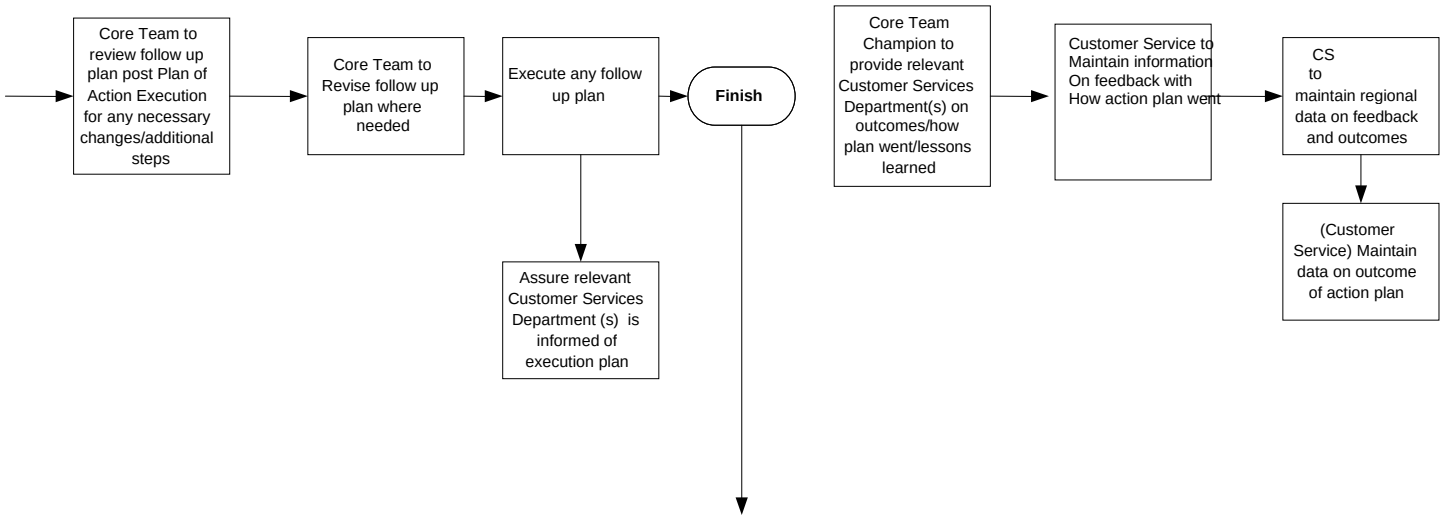
* Notification of other identified stakeholders who could or could not follow this communication plan depending on what the identified core team decided. These standards were set to note what minimally needs to be included about a Significant Change as a requirement for the region in how communication to consumers/individuals served/families occurred, but it could be used for other identified stakeholders when applicable.



Process to Notify Consumers/Individuals Served of Significant Changes
Page 1 of 3



Process to Notify Consumers/Individuals Served of Significant Changes
Page 2 of 3



Process to Notify Consumers/Individuals served of Significant Changes
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Figure 1

Community Mental Health Partnership of Southeastern Michigan/PIHP	***Policy*** ***Notice of Privacy Practices and Consumer Complaints for Protected Health Information***
Committee/Department: **Clinical Performance Team (CPT)**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	06/14/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish guidelines for informing consumers/individuals served in the CMHPSM region of the circumstances under which Protected Health Information will be used and disclosed, and their rights regarding their protected health information.

II. REVISION HISTORY

DATE	MODIFICATION
1/12/2015	Revised to reflect the new regional entity effective January 1, 2014.
5/17/2018	Revised to reflect updates to the Mental Health Code (330.1748)
6/09/2021	Revised to reflect EQR requirements, regulations, and updates to notification requirements.
Will be the Regional Approval Date	Revised to reflect EQR requirements, regulations, and updates to notification requirements.

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☒ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

All consumers/individuals served receiving CMHPSM services have the right to notice of the uses and disclosures of protected health information that may be made in the course of providing services to consumer/individual served. Furthermore, a consumer/individual served has the right to know the CMHPSM and service providers' legal duties with respect to the use and disclosure of confidential information.

V. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves and is comprised of the four-county affiliation of Lenawee, Livingston, Monroe and Washtenaw for mental health, intellectual/developmental disabilities, and substance use services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Complaint: Any written documentation received that expresses concern that a consumer's/individual's right to confidentiality and security of protected information has been violated.

Complainant: A consumer/individual served or anyone acting on behalf of a consumer/individual served who files a complaint that the consumer's/individual's right to confidentiality and security of protected information has been violated.

Protected Health Information (PHI): Medical, mental health, and substance abuse information that is individually identifiable and that is transmitted in any form or medium.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, intellectual/developmental disabilities, and substance use disorder needs.

VI. STANDARDS

A. All CMHPSM Board members, employees, students and volunteers shall be apprised of its policies and procedures protecting the confidentiality and integrity of consumer's/individual's protected health information of consumers/individuals served and be required to sign a Confidentiality Statement.

B. Each CMHSP will designate a Privacy Officer to receive complaints concerning the CMHSP's compliance with policies and procedures related to protecting the confidentiality and security of protected health information.

C. In the CMHSPs, the Rights Office appoints a local Privacy Officer for each county. The Rights Office Contact will ensure that the Privacy Officer is informed and begins necessary follow-up and/or actions as needed.

D. The CMHPSM will designate a Privacy Officer at the regional entity level to receive complaints concerning substance use service providers' compliance with policies and procedures related to protecting the confidentiality and security of protected health information.

E. The Notice of Privacy Practices and policy shall be reviewed annually at a minimum or otherwise updated as needed.

F. The CMHPSM Compliance Officer shall oversee any regulatory changes with notice of privacy practices, and ensure the regional notice is revised and redistributed to the local CMHSPs.

NOTICE OF PRIVACY

G. All Notice of Privacy Practices shall comply with sections 164.520 and 164.508 of the Health Insurance Portability and Accountability Act of 1996, the Michigan Mental Health Code, 42 C.F.R. (Code of Federal Regulations) Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records Final Rule, and any other applicable laws, explaining the allowable uses of protected health information.

H. A Notice of Privacy Practices (Exhibit A) shall be posted at all CMHPSM service delivery sites, and the service delivery sites of all contractual providers. Notice must be posted in a clear and prominent location where it is reasonable to expect consumers/individuals served and those seeking services from the CMHPSM to be able to read it.

I. CMHPSM and the CMHSPs shall ensure the Norice of Privacy Practices is prominently posted on entity websites.

J. Copies of the Notice of Privacy Practices shall be available at each service delivery location to be given to consumers/individuals served or others upon their request.

K. A Notice of Privacy Practices shall be given to each new consumer/individual served, guardian, or parent of a minor during their initial visit along with a brief explanation of the Notice and an opportunity to have questions answered.

L. If services are provided in an emergency situation, a good faith effort must be made to provide the consumer/individual served with a copy of the Notice Privacy Practices. Such efforts must also be documented in the consumer's/individual's record. A copy of the Notice of Privacy Practices shall be given to the consumer/individual served and documented as soon as reasonably practical after treatment of the emergency situation.

M. Each consumer/individual served who receives a Notice of Privacy Practices shall be asked to sign an Acknowledgement of Receipt (Exhibit B), which will be included in the consumer's/individual's record. If the t consumer/individual served cannot or will not sign the Acknowledgment of Receipt, a good faith effort to obtain such signature must be documented in the t consumer/individual served record, as well as the reason why the acknowledgement was not obtained.

N. Whenever the Notice of Privacy Practices is revised, the revised Notice of Privacy Practices must be promptly posted at all CMHSP and CMHPSM service delivery sites and made available upon request on or after the effective date of the revision.

O. For entities that post Notice of Privacy Practices on its website, the revised Notice of Privacy Practices must be prominently posted on its website by the effective date of the material change to the notice, AND provide the revised notice, or information about the material change and how to obtain the revised notice, in its next annual mailing to members then covered by the plan.

P. If the CMHSP/CMHPSM does not post its notice on a website, it must provide the revised notice, or information about the material change and how to obtain the revised notice, to consumers/individuals served within 60 days of the material revision to the notice.

CONSUMER/INDIVIDUAL SERVED COMPLAINTS

Q. A consumer/individual served who feels that their confidentiality has been violated, or their protected health information has been improperly used, has the right to a thorough and confidential investigation.

R. A consumer/individual served, or anyone acting on behalf of a consumer/individual served, who feels that any Board member, employee, student, volunteer or those of organizations under contract with the CMHPSM, has violated the confidentiality and security of their protected health information should contact the Privacy Officer to file a complaint.

S. There shall not be any retaliation or reprisals against any consumer/individual served, or any person acting on behalf of a consumer/individual served, who reports a suspected violation of its policies protecting the confidentiality and integrity of protected health information. Nor will the CMH require consumers/individuals served to waive their right to a complaint to the Secretary of Health and Human Services as a condition of receiving treatment.

T. The Privacy Officer/designee will conduct a thorough and confidential investigation of the allegation in a timely manner and will recommend corrective action to the CMHSP Executive Director. Investigations will be conducted in a manner that will not violate employee rights, e.g., the Bullard-Plawecki Employee Right to Know Act.

U. The Privacy Officer will inform their CMHSP Risk Manager and/or Compliance Officer at the time a complaint is received and notify the Risk Manager and/or Compliance Officer of the results of the investigation and any corrective action taken.

V. The Privacy Officer/designee will inform the complainant in writing of the results of the investigation and any corrective action taken and will ensure the complainant understands that he/she also has the option of contacting the Office of Civil Rights to file a complaint against the CMH.

W. The Privacy Officer/designee will maintain a system for logging all complaints received and for the secure storage of all investigative documents and evidence.

X. The Privacy Officer will provide a quarterly aggregate report of complaints and investigations to the Regional Compliance Committee for the purpose of trend analysis.

Y. The Privacy Officer will maintain documentation related to an investigation, and any corrective action taken, for a minimum of six years from the date of its creation or the date it was last in effect, whichever is later.

Z. The CMHSP Compliance Liaison will ensure compliance with all notification requirements made to consumers/individuals served and collaborate with the CMHPSM Compliance Officer to ensure all notification requirements are provided to the media, HHS, and legal entities where applicable.

VII. EXHIBITS

A. Notice of Privacy Practices
B. Acknowledgement of Receipt of Notice of Privacy Practices
C. Documentation of Good Faith Efforts
D. Security And Confidentiality Agreement

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
42 CFR Parts 400 et al.	X	
45 CFR §164.520(c)(1)(v),	X	
45 CFR Parts 160 & 164 (HIPPA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Mental Health Code Act 258 of 1974	X	

CMHPSM Confidentiality and Access to Records Policy	X	
CMHPSM Sanctions for Breaches of Security or Confidentiality Policy	X	
CMHPSM Ethics and Conduct Policy	X	
CMHPSM Corporate Compliance Policy	X	

Exhibit A

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
NOTICE OF PRIVACY PRACTICES
(Insert Name of Organization)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective Date: January 2023

The Community Mental Health Partnership of Southeast Michigan (CMHPSM) is part of a region that includes the following organizations:

- Lenawee County Community Mental Health Authority
- Livingston County Mental Health Authority
- Monroe Community Mental Health Authority
- Washtenaw County Community Mental Health

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy practices in this notice apply to all staff, students and volunteers and to all contract providers in our region. CMHPSM and its providers are required under the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, to protect your privacy, follow the privacy practices described in this Notice, and give you a copy of this Notice.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION

We understand that health information about you is personal. We are committed to protecting it. When you contact or receive services from an agency within our provider network, a record is typically created. We create this record to provide you with quality care and to comply with certain legal and payment requirements. This record contains “demographic information” such as; name, telephone number, social security number, birth date, and health insurance information. This record also contains other information related to your services such as; any health problems you may have, your plan of care, and information about your treatment, including diagnosis, goals for treatment, progress, etc. We refer to this information as “Protected Health Information” or “PHI.”, and it is used for many purposes.

This notice will tell you about the ways in which physical and behavioral health information about you may be used and disclosed. It tells you what our responsibilities are and what your rights are regarding the use and disclosure of your health information.

We are required by law to:

- make sure that PHI that identifies you is kept private,
- notify you if there is a breach of your PHI,
- give you this notice or our legal duties and privacy policies concerning your PHI and

- follow the terms of the notice that are currently in effect.

General Information About Privacy
Community Mental Health Partnership of Southeast Michigan and its providers, who are a part of our region, are able to share health information about you for the purpose of healthcare coordination without a release. Under the rules of HIPAA and the Michigan Mental Health Code, CMHPSM can also use and disclose protected health information, with certain limits and protections, for treatment, payment and health care operations without a release. If you give us permission to disclose your medical record, or parts of it, you may change your mind about this at any time and cancel (revoke) your permission, but you must let us know this in writing, either by signing a revocation form or giving us a signed written statement that cancels your permission. If you revoke your authorization, this will only apply to future disclosures and not ones that have already been disclosed.
CMHPSM and its providers do not release any information regarding substance use disorder treatment records or HIV/AIDS status without your signed permission, unless required to do so by law. Disclosures regarding these areas are subject to additional federal and state laws. Substance use treatment records are specifically protected under Federal Law 42 CFR Part 2.

There are additional laws that may further protect your private information such as the Michigan Mental Health Code.

In the event that a breach of your PHI is discovered, you will be notified as required by law. A breach occurs when your PHI has been used or disclosed in ways not permitted by law.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU WITHOUT YOUR AUTHORIZATION:

The following categories describe different ways that we may use and disclose mental health and/or medical information.

For Treatment. We may use and disclose information about you to coordinate, provide and manage your health care and any other related services. This may include coordination of management with another person, like a doctor or therapist. Information about you may be shared with staff, students or volunteers, and with contract providers or regional staff who may be involved in your or your family's treatment. For example, a staff person may need to review your record in order to respond to your emergency. We may also use your health information to remind you about an appointment or to provide information about treatment options or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about the treatment you receive so that your health plan will pay us or reimburse you for treatment. We may also tell your health plan

about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose information about you in order to maintain or improve services. These uses and disclosures are necessary to make sure that all our consumers receive quality care. For example, we may use information to review our treatment and services and to evaluate the performance of our staff. We may also combine information about many consumers to decide what additional services should be offered, what services are not needed and whether certain new treatments are effective. We may also disclose information to clinicians, doctors, nurses, students and other personnel who work for the agency for review and learning purposes.

Business Associates. There are some services provided in our organization through contracts with business associates. For example, the nurse may have to send your blood to a laboratory for testing prior to giving you a medication. The lab is not a part of the agency, but we will have a business relationship with the lab. When any services are contracted, we may disclose your health information so they may perform the job we've asked them to do and bill you or your health plan. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Coordination of Care. Your health information may be used and disclosed, as needed, to coordinate and manage your mental health and related services by one or more providers involved in your treatment. For example, a staff of community mental health may provide information about you when submitting referrals to providers related to your services.

Research. Under certain circumstances, CMHPSM may disclose your health information to researchers in ways usually related to public health and research only if their research proposal includes protocols to hide your identify and to ensure the privacy of your health information. The research project and its procedures must be approved by a CMHPSM review board where we must meet many more conditions under the law before we can use your information for those purposes. For more information on this, go to the following website: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

CMHPSM has a research policy that can be accessed at the following location:

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

As Required by Law: We are sometimes required to disclose some of your information without your signed authorization if state or federal laws say we must do so. Such disclosures are usually related to one of the following:

- **Medical Emergency.** In the event of a medical emergency, we may not be able to give you a copy of this Privacy Notice until after you receive care.
- **Public Health Activities**. To a public health authority that is required by law to receive the information in order to prevent, control or report disease, injury, disability, or death.
- **Medical Examiner**. To help identify a deceased person or to determine the cause of death.
- **Abuse or Neglect.** To alert state or local authorities if we believe you or another person are a victim of child or adult abuse, neglect, or domestic violence
- **Serious Threat to Health or Safety.** To give information about you to alert authorities or medical personnel to prevent a serious threat to your health and safety or that of another person or of the public.
- **Health Oversight.** To comply with health oversight agencies for things like audits, civil or administrative reviews, proceedings, inspections, investigations, licensing activities or to prove we are complying with federal privacy laws or other healthcare oversight activity.
- **Judicial or Administrative Proceedings.** To respond to a court or administrative order, or a subpoena or for risk management purposes.
- **Law Enforcement.** To disclose your health information in connection with a criminal investigation by a federal, state or local law enforcement agency or disclose it to authorized federal officials who provide protective services for the President or other persons or report crime on agency premises.
- **Organizations Involved in Your Care.** If you are a Medicaid enrollee, we may disclose PHI about you to another service provider involved in your care. This would include healthcare data available to providers through the state database.
- **Research.** We may disclose your health information to researchers only if their research proposal includes protocols to hide your identity and to ensure the privacy of your health information. The research project and its procedures must be approved by a CMHPSM review board.
- **Business Associates.** There are some services provided in our organization through contracts with business associates. To protect your health information, however, we require these business associates to appropriately safeguard your information.
- **Food and Drug Administration (FDA).** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- **Special Situations.** As law requires, we may disclose health information to funeral directors, coroners and medical examiners, as required by military command authorities,

and for national security activities. Your mental health services information will be disclosed only as allowed by law.

MEDICAL INFORMATION THAT CAN ONLY BE SHARED WITH YOUR AUTHORIZATION

There is information about your physical and behavioral health that we can only share about you if you have given us your consent in writing to share it, and we can only share the types of information you have given us permission to share.

You can cancel this permission in writing at any time by contacting your local agency or customer services staff.

- **Individuals Involved in Your Life.** We may disclose PHI about you to a family member or other persons you designate if you give permission to do so.

- **For Health Information Exchanges (HIE).** Along with other healthcare providers in our area, we may participate in a health information exchange. An HIE is a community-wide information system used by participating healthcare providers to share health information about you for treatment coordination purposes. Should you require treatment from a participating healthcare provider who does not have your medical records or health information, that healthcare provider can use the system to gather needed health information to treat you. For example, he or she may be able to get laboratory or other test results that have already been performed or find out about the treatment that you have already received. We will include your PHI in this system only if you give us special written permission to do so. You can cancel this permission at any time by contacting your case manager or local customer services staff.

- **Psychotherapy Notes.** We may disclose psychotherapy notes only with your permission unless an exception applies. For example, we may disclose these notes without your permission if required or permitted by law for reasons such as preventing or lessening an imminent threat to someone's health and safety, a state or federal audit of our organization, to defend a legal action brought by you

- **Marketing.** CMHPSM is not allowed and does not participate in marketing practices. Marketing does not include our communication to you about our own products and services, or communication described above about allowable disclosures for treatment or case management purposes. If CMHPSM is ever allowed and decides to participate in marketing practices, we only if you give us special written permission to do so. You can cancel this permission at any time by contacting your case manager or local customer services staff.
- **Sale of PHI.** CMHPSM is not allowed and will not sell your protected health information (PHI). If CMHPSM is ever allowed and decides to participate in such selling practices, we

only if you give us special written permission to do so. You can cancel this permission at any time by contacting your case manager or local customer services staff.

YOUR RIGHTS REGARDING YOUR PHYSICAL/BEHAVIORAL HEALTH INFORMATION

You have the following rights regarding physical and behavioral health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and receive a copy of information from your record that may be used to make decisions about your care. You have the right to request that the copy be provided in an electronic form or format. If the form and format you request are not readily producible, we will work with you to provide it in a reasonable electronic form or format. Usually, this includes medical and billing records, but may not include psychotherapy notes.

To review and have a copy of information from your record you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by contacting your case manager or local customer services staff. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

Right to Amend Your Record: If you believe that your personal health information or treatment record is incorrect or that an important part of it is missing, you have the right to ask us to amend your treatment record including adding your own statement in you record. You must submit your request and your reason for the request in writing.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures that we made, other than those covered in this notice, of information about you.

To request this list of accounting of disclosures, you must submit your request in writing. Your request must state a time period which may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, on paper or electronically). Disclosures you authorized in writing, routine internal disclosures such as those made to staff when providing you services, and/or disclosures made in connection with payment are examples of disclosures not included in the accounting. The accounting will give the date of the disclosure, the purpose for which your PHI was disclosed, and a description of the information disclosed. If there is a fee for the accounting, you will be informed what the fee is before the accounting is done.

Right to Request Restrictions. You have the right to ask that your protected health information not be shared or request a restriction or limitation on the information we use or

disclose about you. We are not required to agree to your request, but if we do agree to it, we will honor your request unless the information is needed to provide treatment to you or required by law.
If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree unless a law requires us to share that information.

Right to Request Confidential Communications. You have the right to request that we communicate with you in a certain way or at a certain location to keep your confidentiality. For example, you can ask that we contact you only at work or only by mail. To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Request Someone to Act on Your Behalf. You have the right to choose someone to act on your behalf. If you have given someone medical power of attorney, or if someone is your legal guardian, that person can act on your rights and make choices about your health information just as you would. We will make sure the person has this authority and can legally act for you before we respond to any such request.

Receiving Notice of Privacy Practices. You have the right to agree to receive this notice electronically or a paper copy. If you choose to receive this notice electronically you are still entitled to a paper copy. You can request either option from your case manager or your local customer services staff at your agency.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. When we change this notice, the revised notice will be posted at all agency locations and on CMHPSM and CMHSP websites. This notice will contain, on the first page, on the top left side, the effective date. In addition, when you begin treatment or receive your annual information with your plan of service, we will offer you a copy of the current notice in effect and how you can access it or request more copies.

If the CMHPSM or any of the CMHSPs do not post this Notice of Privacy Practice on its website, you will be given information about what changes occurred with this notice and how to get a copy of the revised notice, within 60 days of when the changes were completed.

COMPLAINTS ABOUT PRIVACY PRACTICES
If you believe your rights have been violated, you may contact your local agency, CMHPSM, or the U.S Department of Health and Human Services Office of Civil Rights
Your services cannot and will not be affected in any way if you file a complaint.
To file a complaint with you can call or write:

Local Agency Information
(insert name, address and phone number of your organization).

CMHPSM Attention: Privacy Officer
3005 Boardwalk Dr., Suite #200
Ann Arbor, MI 48108
Local Telephone: 1-734-344-6079
Toll Free Telephone: 1-855-571-0021
Fax Number: 1-734-222-3844

To file a complaint with the Health and Human Services Office of Civil Rights you can call, write, fax, or submit through their website complaint portal:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
1-877-696-6775
Toll Free Call Center: 1-800-368-1019
TTD Number: 1-800-537-7697
Email: OCRComplaint@hhs.gov
Complaint Portal: https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf
For more information see the HHS OCR website: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

Exhibit B

(Insert name of organization)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices.

My signature below indicates that I have received the notice, that I have been provided an opportunity to ask questions, and that I understand the organization's privacy practices as they pertain to my protected health information.

_____

Signature *Date*

_____

Witness *Date*

Exhibit C

(Insert name of organization)

DOCUMENTATION OF GOOD FAITH EFFORTS

Consumer/Individual Served Name: _____

Date: _____

The consumer/individual served presented for services on this date and was provided with a copy of the Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of receipt of the Notice; however, an acknowledgement was not obtained because:

_____ Consumer/Individual Served refused to sign

_____ Consumer/Individual Served was unable to sign or initial because:

_____

_____

_____ There was a medical emergency. Staff will attempt to obtain acknowledgement at the next available opportunity.

_____ Other reason:

_____

_____

_____

Signature of Employee completing form:

_____

Exhibit D

(**Insert name of organization)**

SECURITY AND CONFIDENTIALITY AGREEMENT

As an employee of (Insert name of organization) and as a condition of my employment, I agree to the following:

1. I understand that I am responsible for complying with the HIPAA policies which were provided to me.
2. I will treat all information received in the course of my employment with (Insert name of organization), related to the consumers of services, as confidential and privileged information.
3. I will not access consumer information unless I have a need to know this information in order to perform my job.
4. I will not disclose information regarding (insert name of organization) consumers to any person or entity other than as necessary to perform my job and as permitted under the Community Mental Health Partnership of Southeast Michigan (CMHSPM) HIPAA/Confidentiality policies.
5. I will not log on to any of the computer systems that currently exist or may exist in the future using a password other than my own.
6. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my ID badge.
7. I will not allow anyone, including other employees, to use my password to log on to the computer.
8. I will log off of the computer as soon as I have finished using it.
9. I will not use e-mail to transmit consumer information outside of the CMHPSM, unless I am instructed to do so by the Privacy Officer.
10. I will not take consumer information from the premises in paper or electronic form without first receiving permission from my supervisor and ensuring it is secure.
11. Upon cessation of my employment, I agree to continue to maintain the confidentiality of any information I learned while an employee, and agree to turn over any keys, key fobs, or any other device that would provide access to the agency or its information.

I understand that violation of this agreement could result in disciplinary actions.

_____

Employee Printed Name *Date*

_____

Employee Signature *Supervisor Signature*

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** **Organizational Credentialing/Recredentialing and Monitoring**
Department: Network Management	**Local Policy Number (if used)**
Implementation Date (2 weeks from Regional Approval Date)	**Regional Approval Date (date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	06/14/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish guidelines that ensure all organizational contractors who provide behavioral health and/or substance use disorder services to consumers of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), meet the minimum standards as described in this policy.

II. REVISION HISTORY

DATE	MODIFICATION
1/25/11	
11/30/11	Updated to reflect local practice, changes in delegated functions, and new policy format
8/20/2013	Updated to comply with requirements for OIG exclusions VII.C. Procedures removed. Procedures will be available in the Provider Manual.
6/11/2014	Revised to reflect the new regional entity.
8/24/2018	Rewrite
2/1/2021	Policy updates to meet EQR requirements and HSAG EQR review
Will be Regional Approval Date	Updates based on HSAG EQR Review corrective action plan

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers

☒ SUD Treatment Providers	☐ SUD Prevention Providers
☐ Other as listed:	

IV. POLICY

The CMHPSM will ensure that all organizations providing behavioral health and/or substance use disorder services to consumers in the CMHPSM continuously meet the standards set forth in this policy.

V. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the Pre-Paid Inpatient Health Plan (PIHP) for Region Six (Lenawee, Livingston, Monroe and Washtenaw Counties) for mental health, intellectual/developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Credentialing (or credentials review): The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide mental health or substance use disorder services based on established criteria.

Credentialing Criteria: The minimum qualifications expected for network providers such as: licensure, education, experience, training, current competence, malpractice/liability insurance limitations and claims history, and ability to perform clinical responsibilities.

National Practitioner Data Bank (NPDB): A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers.

Pre-Paid Inpatient Health Plan (PIHP): Organizations in Michigan that manage designated geographic areas for the Medicaid mental health, developmental disabilities, and substance use disorder services outlined in the 1915(b) and 1915(c) waivers that created the CMHSP managed care model in the State.

Regional Operations Committee (ROC): The Regional Operations Committee (“ROC”) is comprised of the CMHPSM Chief Executive and the four CMHSP Executive Directors. The CMHPSM Chief Executive Officer participates as a voting member only for issues related to the CMHPSM operations and all Medicaid services and requirements. The ROC, in collaboration with the CMHPSM Board and CMHPSM Chief Executive Officer, creates the vision, mission and long-term plans for the CMHPSM. The ROC and the CMHPSM Chief Executive Officer establish and coordinate the priorities for the CMHPSM Board consideration and approval.

Substance Use Disorder Oversight Policy Board (OPB): Responsibilities for this board include planning for substance use disorder prevention and treatment services, as well as providing advice and consultation to the CMHPSM Board of Directors, the ROC, and the staff of the CMHPSM and the partners.

VI. STANDARDS – The standards within this policy are organized into base categories, and more specific requirements for those categories based upon the payer-provider relationship that exists.

For all payer-provider relationships, the PIHP retains the right to approve, suspend, or terminate providers from participation in Medicaid funded services including when a provider is selected/contracts/subcontracts with a delegated entity.

A. Base Requirements by Category

The following establishes base standards or definitions related to regional organizational credentialing, re-credentialing and monitoring.

1. **CMHPSM Payer/Provider Relationships** – A number of relationships are in place to meet the needs of the CMHPSM region related to behavioral health and/or substance use disorder service provision. The following relationships exist related to this policy:
   a) **PIHP Payer - CMHSP Relationship:** covers the credentialing, recredentialing, monitoring of a CMHSP by the PIHP as payer. The PIHP contracts with CMHSPs to provide mental health services within their respective geographic county.
   b) **CMHSP Payer - CMHPSM Mental Health Organizational Provider Relationship:** covers the credentialing, recredentialing, monitoring relationship of a potential or current behavioral health service provider and a CMHSP as payer. (Note: this policy only applies to organizational providers, Licensed Individual Practitioners (LIPs) should follow the Credentialing and Clinical Responsibilities of LIPs policy.)
   c) **PIHP Payer - SUD Core Provider Relationship:** covers the credentialing, re-credentialing and monitoring relationship of a potential or current SUD Core Provider and the PIHP as payer. The PIHP contracts with SUD Core Providers to provide substance use disorder services, and/or perform one or more functions as delegated by the PIHP.
   d) **SUD Core Provider Payer - SUD Organizational Provider Relationship:** covers the credentialing, recredentialing, monitoring relationship of a potential or current substance use disorder service provider and a SUD Core Provider as payer.
   e) PIHP Payer - SUD Organizational Provider Relationship: covers the credentialing, recredentialing, monitoring relationship of a potential or current substance use disorder service provider and the PIHP as payer.
   f) PIHP Payer - Non-Federally Funded SUD Service Providers: covers the credentialing, recredentialing, monitoring relationship of a potential or current substance use disorder service provider and the PIHP as payer, where only non-Federal funds are utilized.

2. **Provider Procurement**
   a) Payers this policy applies to (CMHPSM as PIHP Payer, CMHSP Payers or SUD Core Provider) will follow all federal, state and or local rules and regulations when

entering into payer/provider relationships for services funded by or through the CMHPSM.

b) All CMHPSM procurement requirements can be found in the CMHPSM Procurement, RFPs and Bid Review policy.

3. Organizational Credentialing / Re-Credentialing Application

a) When required by the CMHPSM Payer / Provider Relationship standards within this policy the provider will complete and submit the Organizational Credentialing application. Organizational credentialing applications can be found on the CMHPSM website.

(1) Mental Health Application: http://www.cmhpsm.org/provider-manual
(2) SUD Application: http://www.cmhpsm.org/sudserviceprovidermanual

4. Organizational Credentialing/Re-Credentialing File Management

a. Initial Credentialing Files

The timeframes for completion of the initial credentialing process will be no more than 90 days, for which verification or credentialing requirements is acceptable. If the timeframe is not met, the initial credentialing application will need be declined with clear reasons as to what was not complete in the response to the provider and the steps to take in re-starting the application process.

Initial credentialing applications will be considered complete once the items in the application packet are received.

The decision to approve or deny an initial credentialing application will be made and the decision sent to the applicant by the 90th day of receiving a completed application.

An on-site review will be completed within this 90-day initial credentialing timeframe.

Verification of provider staff meeting federal and state requirements is a post initial credentialing activity and will be completed within 90 days of a completed contract.

All initial credentialing files will have the following information where applicable:

(1) The start date (receipt of a complete initial application) and the end date (when the credentialing decision is sent to the provider)
(2) The initial credentialing application.
(3) Attestation and disclosure questions.
(4) Review of any Medicare/Medicaid sanctions.
(5) License verification
(6) Screen shots of verification sources in each credentialing file
(7) Once the completed application is received, documentation that an on-site review was completed during the initial pre-contracting process when a provider is not accredited, or acceptance of an on-site review from CMS or licensing in lieu of an on-site review completed by the PIHP should that

review align with the credentialing time frame and meet the PIHP's on-site review requirements.

(8) Confirmation that the results on the on-site review were considered when rendered a contracting decision.
(9) Documentation in credentialing files will clarify the scope of service included in the application.
(10) Identification of whether any of the above criteria would be waived based on the payer-provider relationship identified in Standard B of this policy.
(11) If the initial completed application notes the provider will have licensed staff rendering services, the PIHP/CMHSP will ensure, then prior to contracting with the provider that the provider has a credentialing process that meets MDHHS requirements. While the initial credentialing file will have this information, the review of the provider's credentialing process will take place post completed application yet prior to contracting with the provider.

b. Recredentialing Files

The timeframe for completion of the re-credentialing process will be no more than 90 days, for which verification or credentialing requirements is acceptable. If the timeframe is not met, the re-credentialing application will need be declined with clear reasons as to what was not complete in the response to the provider and the steps to take in re-starting the application process.

Initial credentialing applications will be considered complete once the items in the application packet are received.

The decision to approve or deny an initial credentialing application will be made and the decision sent to the applicant by the 90th day of receiving a completed application.

All re-credentialing files will have the following information where applicable:

(1) The start date (receipt of a complete application) and the end date (when the credentialing decision is sent to the provider)
(2) The initial credentialing and all subsequent recredentialing applications,
(3) A review of member grievances and appeal for that provider during the 2-year recredentialing cycle, including if there was no activity to review.
(4) Attestation and disclosure questions.
(5) Review of any Medicare/Medicaid sanctions.
(6) License verification
(7) Evidence the provider was recredentialed within two years, any approved extensions.
(8) The initial credentialing and all subsequent recredentialing applications,
(9) Screen shots of verification sources in each credentialing file
(10) An on-site review was completed during the recredentialing process when a provider is not accredited, or acceptance of an on-site review from CMS or licensing in lieu of an on-site review completed by the PIHP should that review align with the credentialing time frame and meet the PIHP's on-site review requirements.
(11) Confirmation that the results on the on-site review were considered when rendered a re-credentialing decision.

(12) Documentation in re-credentialing files will clarify the scope of service under each contract and whether licensed staff are providing services under that contract. Should licensed staff render services, the PIHP/CMHSP will ensure the provider has a credentialing process that meets the requirements under its contract with MDHHS.
(13) Identification of `whether any of the above criteria would be waived based on the payer-provider relationship identified in Standard B of this policy.

5. CMHPSM Regional Provider Network Statuses:

a. Credentialed In-Network Status: An organizational provider that has an approved current credentialed status as determined by the PIHP, CMHSP or SUD Core Provider. There is no requirement that a payer identified within this policy be mandated to enter into a contract with an organization that obtains credentialed or In-Network status. Organizations may be credentialed for future capacity or backup capacity. Contract relationships will be determined by the appropriate applicable payer.
b. Contracted In-Network Status: A credentialed organizational provider that is currently contracted with one or more of the following payers: PIHP, CMHSPs or SUD Core Providers.
c. Out of Network Contracted Status: In certain situations, the PIHP, CMHSPs or SUD Core Providers may determine it is necessary to contract with an entity that is unwilling, or unable to join the CMHPSM Provider Network. Examples include but are not limited to:
    1. Single Case Agreements;
        (a) Emergency Placements;
        (b) Limited Duration Placements;
        (c) Clinically determined placement for individual consumer with unique clinical need.
    2. Out of Region and Network
        (a) Specialty service not delivered within CMHPSM region for a limited number of consumers; (Providers located outside of the CMHPSM region geographically are not required to be In-Network with the CMHPSM, however these providers are encouraged to participate as CMHPSM In-Network or obtain CMHPSM credentialing status through a reciprocity relationship with another PIHP/CMHSP region.

6. Deemed Status

The PIHP, CMHSP or SUD Core Provider may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where the CMHPSM LIP Committee chooses to accept the credentialing decision of another PIHP, the CMHPSM must maintain copies of the credentialing PIHPs decisions in the organizational provider's credentialing file.

7. Organizational Monitoring

When required by the CMHPSM Payer / Provider Relationship the payer will monitor the provider as required by the standards within this policy. Once a contract is issued to an organization, the payer will monitor to ensure that the organization maintains the contractual agreement in good standing and complies with relevant local, state, and federal requirements.

8. Medicaid Service Verification Policy
All providers delivering Medicaid funded services will follow all requirements outlined within the CMHPSM Medicaid Service Verification policy.

9. Significant Change Notification
All payers and providers must follow the timeliness standards identified within this policy related to notifying the PIHP of any incidents, planned or unplanned changes that would impact the CMHPSM Provider Network capacity, so the PIHP can notify MDHHS (spell out or define) within the seven (7) day standard.

10. Network Adequacy /Sufficiency
The PIHP and CMHSP will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the PIHP.

The Regional Network Management Committee will assess the Regional Provider Network on an ongoing basis.

11. Reciprocity
Payers will comply with all statewide reciprocity efforts as required by the PIHP/MDHHS service contract.

12. Debarment
All payers/providers will follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

13. Notification of Adverse Credentialing Decision
An organizational provider that is denied credentialing or recredentialing by the PIHP must be informed of the reasons for the adverse credentialing decision in writing by the PIHP within 30 days of the decision.

14. Appeal Process for Organizational Providers

a. Organizational providers may appeal adverse CMHPSM credentialing decisions. Providers will be notified of their right to appeal adverse decisions, during initial credentialing and re-credentialing processes.

b. Information relevant to an organizational provider's ability, suitability or appropriateness to fulfill CMHPSM's credentialing requirements will be considered by the credentialing body during the initial credentialing and subsequent re-credentialing processes, and at any other time that such information comes to the attention of CMHPSM/CMHSP/SUD Core Provider. Additional information from the organizational provider or from other sources, when available, will be included for consideration. Criteria to terminate or deny credentialing may include:
   i. Failure to maintain appropriate insurance as required by contract;
   ii. Failure to maintain an active license and failure to inform the CMHPSM of any changes in licensure status, pending investigations relating to licensure or malpractice suits being filed;
   iii. Falsifying information on initial or renewal application;
   iv. Falsifying any documents submitted with the initial or renewal application;
   v. Failure to abide by the terms of the contract;

vi. Illegal or fraudulent billing practices;
vii. Exclusion from participation in Federal health care programs;
viii. Clinical performance outside acceptable standards.

c. The organizational provider may request to appeal an adverse decision regarding credentialing by contacting the entity designee with which they have a contractual agreement within 10 business days of the date of the written notification. The appeal must be in writing and must specify the nature of the disagreement or the facts in dispute.

d. The CMHPSM/CMHSP/SUD Core Provider entity designee will schedule a hearing within 10 business days of the LIP's request for appeal. The designee will convene an appeal committee which may include: network managers, clinical staff, board members, consumers, the CMHPSM, CMHSP regional partners, and/or others based on their relevance to the nature of the appeal.

e. The CMHPSM/CMHSP/SUD Core Provider designee will preside over the hearing. The agenda will include: a restatement of the adverse recommendation; an opportunity for the organizational provider requesting the appeal to present reasons why the adverse recommendation should be changed and to present any supporting information in oral and/or written form; and an opportunity for the appeal committee members to ask questions.

f. Following the hearing the CMHPSM/CMHSP/SUD Core Provider designee will consult with the appeal committee members, make a final decision about the appeal and notify the organizational provider in writing. A copy of all appeal documentation will be retained in the provider's CMHPSM credentialing file.

15. Reporting

The CMHPSM and CMHSPs shall ensure that provider misconduct is reported to the appropriate authorities (i.e., MDHHS, the provider's regulatory board or agency, the Attorney General, and/or the Office of the Inspector General, etc.), if such conduct results in the termination or denial of credentialing status. Reporting procedures will be consistent with current federal and state requirements, including those specified in the MDHHS Medicaid Managed Specialty Supports and Services Contract.

The CMHPSM and CMHSPs will ensure MDHHS data reporting requirements for credentialing and recredentialing of organizations by CMHPSM is completed in compliance with MDHHS-PIHP contractual requirements.

B. Variable Standards

1. Payer **/** Provider Relationships Specific Standards
   a. PIHP Payer – CMHSP Relationship

1.	**Payer:**	CMHPSM as PIHP
	Provider:	CMHSP

2. Provider Procurement:	N/A
3. Organizational Credentialing / Re-Credentialing Application Required:	No application required, the CMHSP's MDHHS certification/re-certification status and CMHSP's National Accreditation status allow deemed status for this requirement.
4. Provider Network Status Participation:	CMHSP is required to hold an In-Network CMHPSM Network Status. PIHP may only contract with fully credentialed In-Network CMHSPs.
5. Organizational Monitoring:	CMHPSM/PIHP will monitor CMHSPs on a recurring two-year basis. Every two years the CMHSP will be monitored by the CMHPSM/PIHP through a Full CMHSP Review. A Full CMHSP Review includes a delegated function, clinical chart and CMHSP organizational responsibility review. If the CMHSP achieves a score of 95% or higher on the Full CMHSP Review, the PIHP in the following year will forego the Full CMHSP review and instead will conduct a corrective action verification and delegated function review.
6. Medicaid Service Verification:	CMHSP will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:	CMHSP must immediately notify PIHP of any incidents, planned or unplanned changes that would impact the CMHSP's status within the CMHPSM region. The PIHP will notify MDHHS immediately when becoming aware of a CMHSP which becomes ineligible to participate in federal funding, or if the PIHP/CMHSP relationship is threatened for any reason.
8. Network Sufficiency	The PIHP and CMHSP will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the PIHP.
9. Reciprocity	N/A, the PIHP will not accept reciprocity arrangements for CMHSPs.
10. Debarment	The PIHP and CMHSP must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

b. CMHSP Payer – CMHPSM Mental Health Organizational Provider Relationship:

1.	**Payer:**	Regional CMHSP
	Provider:	Organizational Provider Delivering Behavioral Health Services within CMHPSM region.
2. Provider Procurement:		Each CMHSP will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with Mental Health Service Providers.

3. Organizational Credentialing / Re-Credentialing Application Required:	All organizational providers delivering behavioral health services within the region will complete and submit an organizational credentialing application initially when applying to the network and at minimum once every two years thereafter to the CMHSP. New organizational providers may be required by the CMHSP to submit additional credentialing application materials or information. Organizational providers may also be required to submit verification or supplemental documentation to support the credentialing application. Organizational providers are only required to submit credentialing documentation to one CMHSP to obtain regional CMHPSM network status. CMHSPs may require supplemental or additional credentialing information.
4. Provider Network Status Participation:	CMHSPs must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region's preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by CMHSPs to meet service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b. CMHSPs are not required to contract with every organizational provider that is regionally credentialed and considered In-Network within the CMHPSM Provider Network.
5. Organizational Monitoring:	Organizational providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the CMHSP on a biennial basis (once every two years.) Organizational providers that are contracted to one or more CMHSPs typically will receive reciprocal status from one CMHSPs review. CMHSPs may withhold the right to review each contracted organizational provider individually if it the CMHSP determines. Organizational providers that **do not** hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored annually by the CMHSP. In addition to administrative reviews the CMHSP will monitor a sample of service sites of both accredited and non-accredited organizational providers on an ongoing basis. Organizational providers delivering service at more than one location will have at least 25% of active service sites reviewed during a site review.
6. Medicaid Service Verification:	The CMHSP and Organizational Provider will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:	The CMHSP will notify the PIHP within three (3) business days of any incident or situation with a contracted provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a CMHSP, and seven (7) business days of the original incident or situation.
8. Network Adequacy	The CMHSP and Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.

9. Reciprocity	Organizational providers will be credentialed, re-credentialed, and monitored on a reciprocal basis within the CMHPSM region. Providers typically will not be required to submit multiple applications when affiliated with multiple CMHSPs, a single credentialing determination can be made by one CMHSP and provide in-network status for the entire region. CMHSPs reserve the right to conduct additional monitoring or require additional information from providers when the CMHSP determines it necessary. CMHSPs will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. CMHSPs reserve the right to conduct additional monitoring or require additional information from providers when the CMHSP determines it necessary.
10. Debarment	All In-Network and Out-of-Network Organizational Providers delivering mental health services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

c. PIHP – SUD Core Provider Relationship

1.	**Payer:**	PIHP
	Provider:	SUD Core Providers
2. Provider Procurement:		The PIHP will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Core Providers.
3. Organizational Credentialing / Re-Credentialing Application Required:		SUD Core Providers within the region will complete and submit an organizational credentialing application initially when applying to the network, at minimum once every two years to the PIHP thereafter.
4. Provider Network Status Participation:		SUD Core Providers are required to hold an In-Network CMHPSM Network Status.
5. Organizational Monitoring:		SUD Core Providers will be monitored on an annual basis by the PIHP.
6. Medicaid Service Verification:		The PIHP and SUD Core Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:		The SUD Core Providers will notify the PIHP within three (3) business days of any incident or situation with a contracted provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a SUD Core Provider, and seven (7) business days of the original incident or situation.
8. Network Adequacy		The PIHP and SUD Core Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.
9. Reciprocity		N/A, the PIHP will not accept reciprocity arrangements for SUD Core Providers.
10. Debarment		The PIHP and SUD Core Providers must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

d. SUD Core Provider- SUD Organizational Provider Relationship

1.	**Payer:**	SUD Core Provider
	Provider:	SUD Organizational Provider
2. Provider Procurement:		Each SUD Core Provider will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Organizational Service Providers.
3. Organizational Credentialing / Re-Credentialing Application Required:		All organizational providers delivering SUD services within the region will complete and submit an organizational credentialing application initially when applying to the network at minimum once every two years thereafter to the SUD Core Provider. New providers may be required by the SUD Core Provider to submit additional credentialing application materials or information. Providers may also be required to submit verification or supplemental documentation to support the credentialing application.
4. Provider Network Status Participation:		SUD Core Providers must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region's preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by SUD Core Providers to meet service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b. SUD Core Providers are not required to contract with every organizational provider that is regionally credentialed and considered In-Network within the CMHPSM SUD Provider Network.
5. Organizational Monitoring:		SUD Organizational Service Providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the SUD Core Provider on a biennial basis (once every two years.) Organizations that are contracted to one or more SUD Core Providers typically will receive reciprocal status from one SUD Core Provider's review. SUD Core Providers withhold the right to review each contracted provider organization individually if the SUD Core Provider determines.
6. Medicaid Service Verification:		The SUD Core Provider and SUD Organizational Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:		The SUD Core Provider will notify the PIHP within three (3) business days of any incident or situation with a contracted SUD provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a SUD Core Provider, and within seven (7) business days of the original incident or situation.
8. Network Adequacy		The SUD Core Provider and SUD Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.

9. Reciprocity	Organizational providers will be credentialed, re-credentialed, and monitored on a reciprocal basis within the CMHPSM region. Providers typically will not be required to submit multiple applications when affiliated with multiple SUD Core Providers, a single credentialing determination can be made by one SUD Core Provider and provide in-network status for the entire region. SUD Core Providers reserve the right to conduct additional monitoring or require additional information from providers when the SUD Core Provider determines it necessary. SUD Core Providers will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. SUD Core Providers reserve the right to conduct additional monitoring or require additional information from providers when the SUD Core Provider determines it necessary.
10. Debarment	The SUD Core Provider and all SUD Organizational Providers delivering SUD services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

e. PIHP - SUD Organizational Provider Relationship:

1.	**Payer:**	PIHP
	Provider:	SUD Organizational Provider
2. Provider Procurement:		The PIHP will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Organizational Providers.
3. Organizational Credentialing / Re-Credentialing Application Required:		SUD Organizational Providers within the region will complete and submit an organizational credentialing application initially when applying to the network at minimum once every two years thereafter to the PIHP.
4. Provider Network Status Participation:		The PIHP must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region's preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by the PIHP to meet SUD service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b.
5. Organizational Monitoring:		SUD Organizational Service Providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the PIHP on a biennial basis (once every two years.)
6. Medicaid Service Verification:		The PIHP and SUD Organizational Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:		The PIHP will notify MDHHS within seven (7) business days of any incident or situation involving a SUD Organizational Provider which would induce a significant change on the regional provider network.
8. Network Sufficiency		The SUD Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.

9. Reciprocity	The PIHP will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. The PIHP reserves the right to conduct additional monitoring or require additional information from providers when determined to be necessary.
10. Debarment	All In-Network and Out-of-Network Organizational Providers delivering SUD services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

f. PIHP – Non-Federally Funded SUD Service Provider.

1.	**Payer:**	PIHP
	Provider:	Non-Federally Funded SUD Service Provider
2. Provider Procurement:		The PIHP will follow the CMHPSM PA2 Procurement for non-federally funded SUD service provider procurement to ensure the fair and efficient utilization of local and state tax dollars.
3. Organizational Credentialing / Re-Credentialing Application Required:		N/A
4. Provider Network Status Participation:		N/A
5. Organizational Monitoring:		The PIHP will determine all necessary organizational monitoring requirements for non-federally funded SUD service providers.
6. Medicaid Service Verification:		N/A
7. Provider Network Significant Change Notification:		N/A
8. Network Sufficiency		N/A
9. Reciprocity		N/A
10. Debarment		N/A

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 and 438 et al. (Medicaid Managed Care Rules)		438.230(b)
Public Law 109-171, Deficit Reduction Act of 2005,		Title VI
Public Law 111 – 148:Patient Protection & Affordable Care Act of 2010		

Public Law 111 – 152: Health Care & Education Reconciliation Act of 2010		Title I, Subtitles C and D
45 CFR Parts 160 & 164 (Health Information Portability and Accountability Act (HIPAA) and HITECH Act of 2010		
42 CFR Part 2 (Substance Abuse)		
Michigan Mental Health Code Act 258 of 1974		
The Joint Commission - Behavioral Health Standards		
Michigan Department of Health and Human Services (MDHHS) Medicaid Contract		
Michigan Department of Health and Human Services (MDHHS) General Funds Contract		
MDHHS Substance Abuse Contract		
Michigan Medicaid Provider Manual		

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN/PIHP	*Policy and Procedure* **Employee Competency & Credentialing Policy**
Committee/Department: **Network Management Committee**	**Local Policy Number (if used)**
Implementation Date	**Regional Approval Date**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To ensure that staff competencies are at a high level through ongoing assessment of their capacity to provide safe, effective, high-quality mental health and substance use disorder (SUD) care to Community Mental Health Partnership of Southeast Michigan (CMHPSM) consumers/individuals served.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
10/27/2021	3-year review
Will be Regional Approval Date	Revisions related to state credentialing reporting requirements HSAG EQR FY22 CAP

III. APPLICATION

This policy applies to the individuals or groups identified with a checkmark in the table below.

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☒ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

All employees will be competent to perform the responsibilities and duties assigned to them.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the Prepaid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe and Washtenaw for mental health, intellectual/developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.
Competence: The knowledge, skills, and abilities a person possesses to perform tasks correctly and effectively.

Credentials Review: The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide the mental health services based on established criteria.

Integrated Care: Bringing together inputs, delivery, management, and organization of services related to diagnosis, treatment, care, rehabilitation, and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency (World Health Organization).

Primary Source Verification: The source from which the applicant obtained written documentation of licensure, education, or other qualifications. Primary source includes federal and state licensing boards, letters from professional schools and letters from postgraduate education or postdoctoral programs for completion of training or designated equivalent sources.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. Competence shall be assessed at time of hire and at least annually.
B. Credentials for staff required to have state licensure or certification in order to provide clinical services will be reviewed at time of hire and at least every two years per MDHHS credentialing reporting requirements.
C. The CMHSP/SUD Core Service Provider shall have a process to assign clinical responsibilities that includes review of licensure, certification, and/or registration.
D. The CMHSP/SUD Core Service Provider shall establish program/service-specific criteria for each clinical responsibility. These criteria include the following:
    - Current licensure and/or certification as appropriate, verified with the primary source
    - Successful completion of required training
    - Peer or faculty recommendation
    - Evidence of the ability to perform the assigned clinical responsibilities

E. Initial Reviews of Competency and Credentialing
   1. Before assigning initial clinical responsibilities, the CMHSP/SUD Core Service Provider shall verify the identity of staff seeking clinical responsibilities by viewing a valid picture identification issued by a state or federal agency (for example, a driver's license or passport).
   2. Initial competencies will be verified during the hiring process, via interviews, review of education, and the orientation process. Training needs will be identified, as applicable to the staff role.
   3. Before assigning initial clinical responsibilities for employees whose jobs require state licensure/certification/registration, the CMHSP/SUD Core Service Provider shall:
      - Use primary sources when documenting the training specific to the clinical responsibilities requested.
      - For all employees whose jobs require a baccalaureate degree or higher, confirmation of degree will be obtained and verified from the primary source at the initial review as part of the hiring process.
      - Verify and maintain documentation that professional prescribers directly employed by CMHSPs have active DEA registration.
      - Verify and maintain documentation prescribers directly employed by CMHSPs have current Board Certification or Board Eligibility.
      - Assure staff being reviewed for clinical competencies do not have issues with licensure, certification, sanctions, or criminal activity that would affect their ability to perform their clinical responsibilities. This includes
        - State of Michigan criminal background check
        - DHS Central Registry Clearance
        - Michigan Medicaid Sanctioned Provider check per the CMHPSM Debarment, Suspension and Exclusion Policy
        - OIG/HHS Sanctioned Provider check per the CMHPSM Debarment, Suspension and Exclusion Policy
        - NPI Registry Provider verification
        - For renewed reviews, verification in the last two years of:
          a. Lack of present illegal drug use,
          b. No history of loss of license and/or felony convictions,
          c. No history of loss or limitation of licensing/certification privileges or disciplinary action,
      - Queries the National Practitioner Data Bank (NPDB), or a review that meets NPBD standards, at the time of initial assigning of clinical responsibilities, as well as at least every two years thereafter for information on licensed professional staff who are assigned clinical responsibilities.
      - If the CMHSP/SUD Core Service Provider does not use the NPBD system, in lieu of the NPDB/HIPDB query, all of the following must be completed and documented:
        - Minimum five- year history of professional liability claims resulting in a judgment or settlement, disciplinary status with regulatory board or agency, Medicare/Medicaid sanctions.
        - Minimum five-year history of professional liability claims resulting in a judgment or settlement; (this can include an attestation)
        - Disciplinary status with regulatory board or agency; (license/accreditation review, with screenshot included) and

- Review of any Medicare/Medicaid sanctions per the debarment review done by PIHP (with screenshots included)

F. Ongoing Review of Staff Credentials/Competencies
1. The CMHSP/SUD Core Service Provider shall ensure that staff with the educational background, experience, or knowledge related to the skills being reviewed are assessed for competence.
2. Employees shall receive supervision, including clinical supervision as appropriate to their position, on a regular basis.
3. Supervisors shall assess the competency of employees through supervision, observation, and performance evaluation. Performance evaluations for clinical staff who are supervised by another discipline will include peer review by their own discipline.
4. On-going competencies will be monitored through supervision and documented on annual performance evaluations.
5. Clinical staff competencies will be documented on the Employee Competencies Checklist (Exhibit A).
6. Nonclinical staff competencies will be documented through performance evaluations based on employee job descriptions.
7. All employees are expected to display cultural sensitivity and awareness of the role of culture in the delivery of services.
8. All employees are expected to have competence in integrated healthcare.
9. All employees are expected to have competence in applicable principles and practices of recovery and recovery-oriented systems of care.
10. All employees are expected to meet the applicable provider requirements of the Medicaid Provider Manual and MDHHS provider qualifications.
11. Programs which employ the use of glucometer, breathalyzer or other waived tests will ensure and document employee competency on those tests during orientation and annual performance reviews.
12. Before assigning renewed, or revised clinical responsibilities for employees whose jobs require state licensure/certification/registration, the CMHSP/SUD Core Service Provider shall assure the following occurs:
    - Reviews information from any of the organization's performance improvement activities pertaining to professional performance, judgment, and clinical or technical skills.
    - Evaluates the results of any peer review of the individual's clinical performance.
    - Reviews any clinical performance in the organization that is outside acceptable standards.
    - Evaluates the staff member's written statement that no health problems exist that could affect his or her ability to perform the requested clinical responsibilities, including consideration of the applicability of the Americans with Disabilities Act and/or the Rehabilitation Act of 1974.
    - Evaluates any challenges to licensure or registration.
    - Evaluates any voluntary and involuntary relinquishment of license or registration.
    - Evaluates any voluntary or involuntary limitation, reduction, or loss of clinical responsibilities.
    - Evaluates any professional liability actions that resulted in a final judgment against the staff member.

- Queries the National Practitioner Data Bank (NPDB), or a review that meets NPBD standards, at the time of initial assigning of clinical responsibilities, as well as at least every two years thereafter for information on licensed professional staff who are assigned clinical responsibilities.
- If the CMHSP/SUD Core Service Provider does not use the NPBD system, in lieu of the NPDB/HIPDB query, all of the following must be completed and documented:
  - Minimum five- year history of professional liability claims resulting in a judgment or settlement, disciplinary status with regulatory board or agency, Medicare/Medicaid sanctions.
  - Minimum five-year history of professional liability claims resulting in a judgment or settlement; (this can include an attestation)
  - Disciplinary status with regulatory board or agency; (license/accreditation review, with screenshot included) and
  - Review of any Medicare/Medicaid sanctions per the debarment review done by PIHP (with screenshots included)
- Evaluates whether the requested clinical responsibilities are consistent with the population(s) served by the organization.
- Evaluates whether the requested clinical responsibilities are consistent with the program or site-specific care, treatment, or services provided.
- Confirms the staff has completed required training since the last review.
- Confirms the staff's adherence to organization policies, procedures, rules, and regulations.

G. Reporting Requirements

CMHSPs will ensure data is reported to CMHPSM as the PIHP that meets MDHHS credentialing reporting requirements for the following directly hired staff:

- Staff newly hired who are required to have professional licensure/certification to perform clinical services.
- Review of current staff every two years who are required to have professional licensure/certification to perform clinical services.

Note: the state requires review and reporting of CMH professional staff every two years regardless of expiration/renewal dates of their state licensure/certification.

VII. EXHIBITS

A. Employee Competency Checklist

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
MDHHS Behavioral Health Code Charts and Provider Qualifications (link)	X	
MDHHS Medicaid Provider Manual – Staff		

Provider Qualifications		
The Joint Commission- Behavioral Health Human Resources Standards	X	Staffing (HRM.01.01) Qualifications (HRM.01.02) Supervision (HRM.01.04) Education and Training (HRM.01.05) Competence (HRM.01.06) Performance Evaluation (HRM.01.07)
CMHPSM PIHP-CMHSP Agreement - / Delegated Functions	x	CSSN Review; Contract Language
Culturally and Linguistically Appropriate Services Policy	X	
CMHPSM Debarment, Suspension and Exclusion Policy		
CMHPSM CMH Staff Initial Credentialing Checklist		
CMHPSM CMH Staff Recredentialing Checklist		

EXHIBIT A

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Employee Name: _____ Date: _____

Part I – Population-Specific Competencies

□ 1. Children with intellectual/developmental disability

Demonstration of knowledge of the following:

- □ Childhood & adolescent development
- □ Specific conditions/syndromes associated with intellectual/developmental disabilities
- □ Resources and supports available to persons with intellectual/developmental disabilities & families
- □ Principles of Person-Centered Planning/Family-Centered Planning
- □ Special education/school system
- □ Integrated Healthcare

□ 2. Adults with intellectual/developmental disability

Demonstration of knowledge of the following:

- □ Human development across the lifespan
- □ Specific conditions/syndromes associated with intellectual/developmental disabilities
- □ Resources and supports available to persons with intellectual/developmental disabilities & families
- □ Principles of Person-Centered Planning
- □ Special education/school system
- □ Integrated Healthcare

□ 3. Children with serious emotional disturbance

Demonstration of knowledge of the following:

- □ Childhood & adolescent development
- □ Emotional disorders/mental illnesses of childhood & adolescence
- □ Family Dynamics
- □ Parenting skills/strategies
- □ Human service system for children (Court, Schools, Spec. Ed., Child Welfare, etc.)
- □ Principles of Person-Centered Planning/Family-Centered Planning
- □ Stages of change
- □ Motivational Interviewing
- □ Integrated Healthcare

□ 4. Adults with serious & persistent mental illness

Demonstration of knowledge of the following:

- □ Signs & symptoms of major mental illness
- □ Acute symptoms of mental illness
- □ Medications used to treat symptoms of mental illness & common side effects

- □ Supports/resources available in the community for persons with SPMI & their families
- □ Principles of Person-Centered Planning & Recovery Model
- □ Stages of change
- □ Motivational Interviewing
- □ Integrated Healthcare

□ 5. Older adults with serious & persistent mental illness

Demonstration of knowledge of the following:

- □ Mental illness unique to the elderly population
- □ Special needs of the elderly
- □ Medication issues/concerns unique to older adults with SPMI
- □ Community resources available to older adults with SPMI & their families
- □ Principles of Person-Centered Planning & Recovery Model
- □ Stages of change
- □ Motivational Interviewing
- □ Integrated Healthcare

□ 6. Co-Occurring Disorders: mental illness and substance abuse

Demonstration of knowledge of the following:

- □ Theories of addiction and recovery
- □ Stages of change
- □ Motivational Interviewing
- □ Signs & symptoms of substance abuse
- □ Signs & symptoms of major mental illness
- □ Issues unique to co-occurring mental illness & substance abuse
- □ Medication used to treat mental illness, side effects, interaction with street drugs/alcohol
- □ Community resources & supports available to persons with mental illness & substance abuse and their families
- □ Integrated Healthcare

Part II – Competencies Needed to Deny, Reduce, Suspend or Terminate Services

□ Emergency Services (Inpatient, Crisis Residential and Partial Hospital) for the following populations:

□ DD-C	□ DD-A	□ SED	□ MI-A	□ MI-OA	□ Co-Occ	□ Sub. Ab

Demonstration of knowledge of the following:

- □ Evaluation of Mental Health Service Needs
- □ Evaluation of Substance Abuse Service Needs
- □ Treatment Planning Process (Crisis Planning, Diversion Planning)
- □ Service Authorization Process
- □ Service Eligibility Criteria
- □ CMH and Community Services, Supports and Other Resources
- □ Treatment (Crisis Intervention, Inpatient, Crisis Residential, Other Alternative Services)

□ Non-Emergency Services (all other) for the following populations:

□ DD-C □ DD-A □ SED □ MI-A □ MI-OA □ Co-Occ □ Sub. Ab

Demonstration of knowledge of the following:

- □ Evaluation of Mental Health Service Needs
- □ Evaluation of Substance Abuse Service Needs
- □ Treatment Planning Process
- □ Service Authorization Process
- □ Service Eligibility Criteria
- □ CMH and Community Services, Supports and Other Resources
- □ Treatment

Part III – Competency Assessment Methods

□ **After-Hire**	□ **New-Hire**
□ Annual Staff Evaluation	□ Resume
□ Clinical Case Record Review	□ Primary Source
□ Peer Review	□ Interview Results
□ Observation	□ Reference Check
□ Supervision Discussions	□ Other: _____
□ Consultation with other supervisors/directors	□ Consumer/Individual Served Feedback

Part IV – Training Needs & Plan

_____

_____

_____

_____ _____

Supervisor's signature Date

_____ _____

Employee's signature Date

Community Mental Health Partnership of Southeastern Michigan/PIHP	***Policy and Procedure Training Policy***
Committee/Department: Compliance/Network Management	**Local Policy Number (if used)**
Approval Date	**Implementation Date**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To ensure providers within the region meet training requirements in accordance with all regulatory entities. that all the necessary training resources based on functions and responsibilities are made available in order to provide quality service to consumers/individuals served in accord with all regulatory bodies.

II. REVISION HISTORY

DATE	MODIFICATION
1-28-11	
Will be Regional Approval Date	Updated to address all provider types

III. APPLICATION

This policy applies to the individuals or groups identified with a checkmark in the table below.

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☒ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

The CMHPSM, CMHPSM CMHSP partners, and all sub contractual providers shall ensure that staff meet training requirements relevant to their provider qualifications and job functions. It is the policy of the Community Mental Health Partnership of Southeastern Michigan (CMHPSM) to have training resources available in order for providers and staff to meet regional agreements and state and federal regulatory, contractual and accreditation requirements.

V. DEFINITIONS

Employer of Record: the individual in self-directed services who is the legal employer. An individual who is self-directing will be considered the employer of record or a managing employer unless the individual has a guardian, in which case the guardian is considered the employer of record.

Qualified Provider: A qualified provider is an individual or agency that meets the federal and state requirements in their contract to provide mental health services and supports.

Responsible Entity: Any organization or agency within or in a contractual relationship with the CMHPSM or CMHSP, that directly hires staff or independent practitioner.

Self-Direction or Self Directed Services: Self-direction is an alternative method for obtaining supports and services. It is the act of selecting, directing and managing one's services and supports, including the hiring and management of staff to provide their services. Individuals who self-direct their services are able to decide how to spend their CMH services budget with support, as desired.

VI. STANDARDS

A. The CMHPSM shall have consistent guidelines that the PIHP and each CMHSP will use for the content, implementation and tracking of training for their staff, volunteers, students and board members.
B. Where applicable, more than one version of each training topic may be developed to meet the needs of different staff groups, e.g. administrative vs. clinical staff.
C. Where possible or available, responsible entities will use the training resources provided by the CMHPSM or vetted trainings in the state Improving MI Practices platform (link).
D. Entities that develop local trainings will ensure they meet the PIHP, state and federal requirements, and complete the vetting process as outlined in this policy if a current vetted training program does not currently exist for the local training.
E. Responsible entities will ensure local trainings meet state requirements by following either of the following procedures:
    a. Use a training on the state Improving MI Practices platform that has been vetted by the MI Statewide Training Guidelines Workgroup (STGW). link
    b. Submit the training to the regional entity with which they contract, to request review and approval of the use of the training to meet the requirements of this policy.
F. Staff, volunteers, students and board members may attend trainings offered by any CMHPSM regional partner in order to meet time frame requirements.
G. The CMHSPs and PIHP may adjust the timeframes for the initial training to be more conservative/earlier than but shall not exceed the required timeframe.

H. The entity responsible to ensure their staff are trained shall be also responsible to ensure they are following the current training requirements.
I. The CMHPSM Clinical Practice Committee shall oversee this policy, including holding the authority to delegate aspects of training requirements to relevant regional committees or workgroup as applicable to ensure content experts are used in training development and/or monitoring.
J. Trainers of in-person trainings are responsible for distributing and collecting course evaluations and using that data for performance improvement purposes.
K. Each responsible entity will track the implementation of required trainings for all staff, volunteers, students in the following areas:
    - Completion of initial training per time frames.
    - Completion of refresher training per time frames.
    - Completion of any attestations or quizzes and scores
    - Sign off of supervisor or trainer in cases where in-person/virtual training is provided by a trainer.
    - Identification of individual staff that are out of compliance, and supervisory oversight.
L. Each responsible entity that has a board of directors will develop a plan to ensure that all board members have received the appropriate trainings, according to local practice.
M. Wherever possible CMHSPM and the CMHSPs will accept reciprocity of completed trainings that have been vetted and approved by the MDHHS Statewide Training Guidelines Work-group (STGW).

Training Requirements for CMHSP Directly Hired Staff

N. All CMHSPs and CMHSP staff shall ensure they meet the training requirements for their specific professional licensure or credentials where applicable.
O. Case managers working with consumers/individuals served/ with an intellectual/developmental disability must be a Qualified Intellectual Disability Professional (QDIP) or supervised by a supervisor with a QDIP if the case manager does not yet meet QDIP qualifications.
P. Case managers working with consumers/individuals served with a mental illness diagnosis must be a Qualified Mental Health Professional (QMHP) or supervised by a supervisor with a QMHP if the case manager does not yet meet QMHP qualifications.
Q. All CMHSPs shall ensure staff are trained and documentation of training is maintained as in order to meet credentialing and recredentialing requirements. Below is the minimum basic required training for CMHSP staff providing clinical services. Specific programs, services, or service types may require additional training:

Training	**Applies To:**	**Initial Training Timeframes**	**Refresher Timeframes**
Recipient Rights	All staff Executive team Student Interns Volunteers	30 days from hire	Every 2 years

Person Centered Planning (PCP) 1. training for facilitators or 2. training for non-facilitators	All staff Executive team Student Interns Volunteers	30 days from hire	Annually for clinical staff or facilitators. Other staff at the discretion of the CMHSP
Due Process (Grievance & Appeals) 1. Training for clinical staff or 2. Training for non – clinical staff	All staff Executive team Student Interns Volunteers	90 days from hire	2 years for clinical staff. Other staff at the discretion of the CMHSP
Cultural Competency	All staff Executive team Student Interns Volunteers	90 days from hire	As needed (based on job performance /supervisor determination)
Limited English Proficiency	All staff Executive team Student Interns Volunteers	90 days from hire	As needed (based on job performance /supervisor determination)
Comprehensive Health & Safety (includes universal precautions/blood borne pathogens, infection control, workplace safety)	All staff Executive team Student Interns Volunteers	60 days from hire	Annually
Confidentiality (HIPAA Privacy and Security, 42CFR Part 2)	All staff Executive team Student Interns Volunteers	30 days from hire	Annually
Corporate Compliance (including Medicaid Fraud Abuse and Waster)	All staff Executive team Student Interns Volunteers	90 days from hire	Annually
Ethics	All staff Executive team	1 year	As needed (based on job performance /supervisor determination)
Customer Service/Anti Stigma	Customer Services Staff Recommended for all staff	1 year	Yearly for Customer Services staff
PI– Quality Improvement / Learning Organization	All staff Executive team	90 days from hire	As needed (based on job performance /supervisor determination)

Population/Program Specific Required training for CMHSP Staff

Training	Applies To:	Initial Training Timeframes	Refresher Timeframes
Child/Adolescent SED Specific Training	Clinical staff working w/children, in SED-W program	24 Hours - Annually	Annually
Co-Occurring Disorders	Clinical staff	1 year	As needed (based on job performance /supervisor determination)
Parent Management Training – Oregon	Staff working with PMTO children and families	As needed	As needed (based on job performance /supervisor determination)
Multi-Family Group / Family Psycho education	Staff working with Psycho Ed family groups	As needed	2 years
Assertive Community Treatment (ACT)	ACT staff	When hired?	As needed (based on job performance /supervisor determination)
Supported Employment	Job Coaches	When hired?	As needed (based on job performance /supervisor determination)
Peer Supports Certificate Training	Peer Support Staff	When hired?	As needed (based on job performance /supervisor determination)
Children's Waiver Program Category of Care Training (CWP only)	Staff working within the CWP	Prior to completing CWP COC assessments without supervisor with CWP COC training	Annually? One time?

Training Requirements for SUD Treatment Providers

R. All SUD staff shall ensure they meet the training requirements for their specific professional licensure or credentials.
S. All SUD providers shall ensure staff are trained and documentation of training is maintained as in order to meet credentialing and recredentialing requirements.

Training Requirement	Initial Requirements	Renewal Requirements	Resource
SUD Recipient Rights	Prior to providing service	Annually	https://www.improvingmipractices.org/ under Focus Areas, Substance Use Disorders (SUD), Recipient Rights – SA
Medicaid Integrity/ Corporate Compliance	Within 90 days of hire	Every 2 years	https://www.improvingmipractices.org/ under Focus Areas, Workplace Essentials (WE)
Confidentiality (HIPAA Privacy and Security, 42CFR Part 2)	Within 30 days of hire	Annually	
Cultural Competency	Within 90 days of hire	Every 2 years	https://www.improvingmipractices.org/ under Focus Areas, Workplace Essentials (WE)
Limited English Proficiency	Within 90 days of hire	Every 2 years	https://www.improvingmipractices.org/ under Focus Areas, Workplace Essentials (WE)
Level 1 Communicable Diseases	Prior to providing service	Annually	https://www.improvingmipractices.org/ under Focus Areas, Substance Use Disorders (SUD)
Grievances and Appeals *See Training 1 and training 2 descriptions on website*	Within 90 days of hire	Every 2 years	CMHPSM website (See below) https://www.cmhpsm.org/sudtraining PowerPoint presentation and Attestation
Fetal Alcohol Syndrome Screening – *Women's Specialty Services (WSS) Providers Only*	Within 90 days of hire	As needed	*There is not a state specific training for this. Provider are expected to train their staff on screening process and use of the screening tool, to ensure they know how to complete an FASD Prescreen, and document that staff were trained.* For more information see: https://www.michigan.gov/documents/mdch/FASD_Prescreen_form_Feb-10_314457_7.pdf https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4912_21220---,00.html

Behavioral Health CMHSP Contractual Providers
This includes direct care providers working as individuals or for an organization, or for consumers/individuals served with self-directed arrangements.

T. All staff shall:
- Be at least 18 years of age

- Able to prevent transmission of communicable disease
- Able to communicate effectively to follow IPOS requirements, beneficiary-specific emergency procedures, and to report on activities performed
- Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien)

U. All contractual providers or employers of record of self-directed staff shall ensure they meet the training requirements for their specific professional licensure or credentials where applicable.
V. All contractual providers shall ensure staff are trained and documentation of training is maintained as in order to meet credentialing and recredentialing requirements.
W. All employers of record of self-directed staff shall ensure staff are trained and documentation of training is maintained.

Staff Training Requirements **R = Required** **IR = Individually Required by** consumer/**individual's IPOS** **HR = Highly Recommended**	**Administrative & Non-Service Staff**	**Aide Level Staff:** CLS, Respite, Skill Building & Sup. Emp.	**Aide Level:** Licensed Residential	**ABA Behavior Technician Staff**	**Clubhouse and Drop-In Staff**	**Licensed Clinical Practitioners***	**Initial Requirement**	**Renewal of Requirement**
Basic First-Aid & MDHHS Approved In-Person CPR		R	R	R	R	R	Prior to Service Delivery	Per Training Body
Medication Administration Initial		IR	R	IR			Prior to Service Delivery	N/A, unless lapsed
Medication Administration Refresher		IR	R	IR			Prior to Service Delivery	Annual
Individualized Training on each Consumer/Individual's CMH IPOS		R	R	R		R	Prior to Service Delivery	Upon every new or revised IPOS
Universal Precautions / Blood-borne Infectious Disease Training		R	R	R	R	R	Prior to Service Delivery	Annual
Person Centered Planning	R	R	R	R	R	R	Within 30 days of hire	Annual
Recipient Rights/Confidentiality Day One Orientation	R	R	R	R	R	R	Within 30 days of hire & prior to service delivery.	N/A, eligible only once
Recipient Rights/Confidentiality	R	R	R	R	R	R	Within 90 days of hire (in-person)	Annual (online or in-person)
Registered Behavior Technician Task List				R			Prior to Service Delivery	N/A, unless notified

Staff Training Requirements **R = Required** **IR = Individually Required by** consumer/**individual's IPOS** **HR = Highly Recommended**	**Administrative & Non-Service Staff**	**Aide Level Staff:** CLS, Respite, Skill Building & Sup. Emp.	**Aide Level:** Licensed Residential	**ABA Behavior Technician Staff**	**Clubhouse and Drop-In Staff**	**Licensed Clinical Practitioners***	**Initial Requirement**	**Renewal of Requirement**
LEP Training	R	R	R	R	R	R	Within 60 days of hire	Biennial (Every 2 Years)
Cultural Competency	R	R	R	R	R	R	Within 60 days of hire	Biennial (Every 2 Years)
Due Process, Grievance and Appeals	R	R	R	R	R	R	Within 90 days of hire	Biennial (Every 2 Years)
Medicaid Integrity (HIPAA,HITECH)	R	R	R	R	R	R	Within 90 days of hire	N/A, unless notified
Non-aversive techniques training documented in Behavior Treatment Plan		IR	IR	IR	IR	IR	Prior to Service Delivery	Per Training Body
Licensed Residential Training Bundle: 1. Working with People with DD/MI 2. Role of Direct Care Workers 3. Emergency Preparedness 4. Nutrition 5. Health			R				Within 180 days of hire	N/A, required only once
Staff Qualification Requirements **R = Required** **IR = Individually Required by consumer/individual's IPOS** **HR = Highly Recommended**	**Administrative & Non-Service Staff**	**Aide Level Staff:** CLS, Respite, Skill Building & Sup. Emp.	**Aide Level:** Licensed Residential	**ABA Behavior Technician Staff**	**Clubhouse and Drop-In Staff**	**Licensed Clinical Practitioners***	**Initial Requirement**	**Renewal of Requirement**
Staff is 18 years of age or older		R	R	R	R	R	Prior to Hire Date	N/A
Criminal Background Check	HR	R	R	R	R	R	Prior to Hire Date	Annual
Recipient Rights Background Check	R	R	R	R	R	R	Prior to Hire Date	N/A
Motor Vehicle Driving Record Check (If transporting CMH consumers/individual(s) served	IR	IR	IR	IR	IR	IR	Prior to Service Delivery	Annual
Additional SED Waiver Covered Services Staff Requirement: Tuberculosis Test results documenting staff is clear from TB.		R	R	R		R	Prior to Service Delivery	Biennial (Every 2 Years)
Additional SED Waiver Covered Services Staff Requirement: Child & Adolescent Mental Health Training is required for all LIP's who work with children w/serious emotional disturbance: Content must focus on the identification, diagnosis, and treatment of mental health issues specific to children.				R				Annually (24 Hour Annual Requirement)

Staff Training Requirements **R = Required** **IR = Individually Required by** consumer/**individual's IPOS** **HR = Highly Recommended**	**Administrative & Non-Service Staff**	**Aide Level Staff:** CLS, Respite, Skill Building & Sup. Emp.	**Aide Level:** Licensed Residential	**ABA Behavior Technician Staff**	**Clubhouse and Drop-In Staff**	**Licensed Clinical Practitioners***	**Initial Requirement**	**Renewal of Requirement**
May include seminars, conferences, in-house trainings, independent study/reading. Verification should include training dates, descriptions, and hours attended. Trainings should be approved by supervising staff.								
Additional Habilitation Services Waiver (HSW) Perform emergency procedures as evidenced by completion of emergency procedures training course, or other method determined by the PIHP to demonstrate competence.		R	R					

VII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPAA)	X	
Michigan Mental Health Code Act 258 of 1974	X	
Joint Commission- Behavioral Health Standards	X	
MDHHS Medicaid Contract	X	
Michigan Medicaid Provider Manual	X	
MDHHS Behavioral Health Code Charts and Provider Qualifications	X	
Public Health Act 125	X	

VIII. PROCEDURES

None

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Abuse and Neglect***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines for:

1. Protecting recipients from abuse and neglect.
2. Investigating and remediating allegations of abuse and neglect.

II. REVISION HISTORY

DATE	MODIFICATION
05/18/2010	Full policy revision
04/29/2013	Template updated
01/13/2017	Template Updated
02/13/2020	3-year review Definition Changes
03/22/2021	Definition additions
Will be Regional Approval Date	3 year review Typos corrected

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that recipients shall be protected from abuse and neglect during the provision of mental health services.

V. DEFINITIONS

Abuse Class I: A non-accidental act or provocation of another to act by an employee, contract employee or volunteer that caused or contributed to the death, serious physical harm, or sexual abuse of a recipient.

Abuse Class II: Abuse Class II is defined as any of the following:

1. A non-accidental act or provocation of another to act by an employee, contract employee or volunteer that caused or contributed to the non-serious physical harm of a recipient;
2. The use of unreasonable force on a recipient by an employee, contract employee or volunteer with or without apparent harm;
3. Any action, or provocation of another to act, by an employee, contract employee or volunteer which causes or contributes to, emotional harm to a recipient;
4. An action taken on behalf of a recipient by a provider who assumes the recipient is incompetent, despite the fact that a guardian has not been appointed, that results in substantial economic, material, or emotional harm to the recipient;
5. Exploitation of a recipient by an employee, contract employee or volunteer.

Abuse Class III: The use of language, or other means of communication by an employee, contract employee or volunteer to degrade, threaten, or sexually harass a recipient.

Bodily Function: The usual action of any region or organ of the body.

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Criminal Abuse: Assault, criminal homicide, criminal sexual conduct, vulnerable adult abuse or child abuse as defined in the Michigan Penal Code, Act 328 of Public Acts of 1931.

Degrade: Degrade is defined as any of the following:

1. To treat humiliatingly: to cause somebody a humiliating loss of status or reputation or cause somebody a humiliating loss of self-esteem; make worthless; to cause a person to feel that they or other people are worthless and do not have the respect or good opinion of others. (syn) degrade, debase, demean, humble, humiliate. These verbs mean to deprive of self-esteem or self-worth; to shame or disgrace.
2. Any language or epithets that insult the person's heritage, mental status, race, sexual orientation, gender, intelligence, etc.

Examples of behavior that is degrading and must be reported as abuse include but is not limited to:

a. Swearing at recipients
b. Using foul language at recipients
c. Using racial or ethnic slurs at recipients
d. Causing or prompting others to commit the actions listed above.

Emotional Harm: Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.

Exploitation: Any action by an employee, contract employee, or volunteer that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian;
2. A parent with legal custody of a minor recipient;
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative;
4. A patient advocate under a durable power of attorney or other advanced directive.

Neglect Class I: Neglect Class I is defined as either of the following:

1. Acts of commission or omission by an employee, contract employee or volunteer, which result from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, procedures, written directives, or individual plan of service, and which causes, or contributes to the death or serious physical harm to or sexual abuse of a recipient; or,
2. The failure to report apparent or suspected Abuse Class I or Neglect Class I of a recipient.

Neglect Class II: Neglect Class II is defined as either of the following:

1. Acts of commission or omission by an employee, contract employee or volunteer which result from noncompliance with a standard of care required by law, rules, policies, guidelines, procedures, written directives, or individual plan of service which cause, or contribute to, non-serious physical harm, or emotional harm, to a recipient; or,
2. The failure to report apparent or suspected Abuse Class II or Neglect Class II of a recipient.

Neglect Class III: Neglect Class III is defined as either of the following:

1. Acts of commission or omission by an employee, contract employee or volunteer, which result from noncompliance with a standard of care required by law, rules, policies, guidelines, procedures, written directives or individual plan of service which either placed or could have placed, a recipient at risk of physical harm or sexual abuse; or,
2. The failure to report apparent or suspected Abuse Class III or Neglect Class III of a recipient.

Non-Serious Physical Harm: Physical damage or what could reasonably be construed

as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact in order to prevent the recipient from harming himself, herself, or others.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Serious Physical Harm: Physical damage suffered by a recipient that a physician or registered nurse determine caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.

Sexual Abuse: Sexual Abuse is defined as any of the following:

1. Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, being 750.520b to MCL 750.520e involving an employee, contract employee, volunteer, or agent of a provider and a recipient.
2. Any sexual contact or sexual penetration involving an employee, contract employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act, or an adult foster care facility and a recipient.
3. Any sexual contact or sexual penetration of a recipient involving an employee, contract employee, or volunteer and a recipient for whom the employee, contract employee, or volunteer provides direct services.

Sexual Contact: The intentional touching of the recipient's, employee's, contract employee's or volunteer's intimate parts (genitals, buttocks, breasts, groin, inner thigh, or rectum); or the touching of the clothing covering the immediate area of the recipient's, employee's, contract employee's or volunteer's intimate parts, if that intentional touching can be reasonably construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following:

1. Revenge.
2. To inflict humiliation.
3. Out of anger.

Sexual Harassment: Any action, by any person, which can be construed as:

1. Sexual advances toward a recipient.
2. Requests for sexual favors from a recipient.
3. Conduct or communication of a sexual nature toward a recipient.

Sexual Penetration: Sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or any object into the genital or anal openings of another person's body, but emission of semen is not required.

Threaten: To tell someone that you will hurt them or cause problems if they do not do what you want.

Examples of threatening behavior:

a. Language or other means of communication that implies intentions of injury or punishment against a recipient.
b. To express a deliberate intention to deny the well-being, safety, or happiness of somebody unless the person does what is being demanded.

Unreasonable Force: Physical management or force that is applied by an employee, contract employee, or volunteer, to a recipient in one or more of the following circumstances:

1. There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.
2. The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
3. The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service.
4. The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.

VI. STANDARDS

A. All staff members are responsible for safeguarding recipients from abuse and neglect.

B. Any staff member who has knowledge of apparent or suspected recipient abuse or neglect shall ensure that it is immediately verbally reported to the Office of Recipient Rights and other appropriate entities as required by law and in accordance with the Michigan Mental Health Code. This includes any and all incidents that the staff, students, volunteers and/or contractual agencies have either witnessed or received reports of that constitute or may constitute abuse or neglect as defined in this policy, whether or not the staff believes the allegation to be true.

C. Failure to report abuse and neglect shall subject the employee to administrative and disciplinary action, up to and including termination.

VII. EXHIBITS

A. Report on Recipient Abuse
B. Report of Actual or Suspected Child Abuse or Neglect – DHS 3200

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code, Public Act 258 of 1974 as amended	X	330.1700(a), 330.1722, 330.1723, 330.1778
MDHHS Administrative Rules	X	330.7001, 330.7035
Michigan Penal Code, Act 328 of Public Acts of 1931	X	
CMHSP Provider Contract – Attachment A	X	

P.A. 519 of 1982, Adult Protective Services	X	
Child Protection Law, Public Act 238 of 1975, as amended	X	
42 C.F.R. (Code of Federal Regulations) Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, Final Rule	X	
MDHHS Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans	X	

IX. PROCEDURES

WHO	DOES WHAT
All CMH or contractual agency staff, students, and volunteers	1) Upon discovery of apparent or suspected abuse or neglect, takes immediate action to protect, comfort and ensure treatment of the recipient as necessary. 2) Ensures that emergency medical personnel are notified immediately if necessary due to any injury. 3) If sexual abuse is suspected, ensures that the recipient is offered to be taken to a hospital for an examination, which may include a Sexual Assault Kit. 4) Immediately verbally reports apparent or suspected abuse or neglect to direct supervisor, recipient's Supports Coordinator/Client Services Manager and the legal representative, if applicable. 5) Immediately verbally reports apparent or suspected abuse or neglect to the Rights Officer. This shall occur by no later than the next business day. 6) Immediately verbally notifies the appropriate public agency as required by law regarding any apparent or suspected abuse, neglect, sexual abuse, or death of any recipient. 7) Immediately verbally notifies or ensures that immediate verbal notification is made to Protective Services in accordance with PA 238, Child Protection Law or PA 519. Immediately notifies or ensures that

	Licensing is notified if the incident occurred in a licensed residential setting. 8) If there is reasonable cause to suspect that criminal abuse has occurred, immediately notifies or ensures immediate verbal notification to the appropriate law enforcement agency with a written report (Report on Recipient Abuse) to follow within 72 hours. 9) Distributes the Report on Recipient Abuse as follows: a) Original copy to applicable law enforcement agency. b) Copies to: i) Recipient record (with names of alleged abuser(s) and reporting person redacted). ii) Adult/Child protective services, as applicable. iii) Licensing consultant, as applicable. iv) Office of Recipient Rights 10) Recipient to recipient simple assault is not required to be reported to law enforcement. It is not required to make a report to law enforcement of alleged abuse that: a) Occurred more than one year prior to being revealed, or b) Did not occur at a CMHPSM or provider site nor was committed by an employee, contract employee, student or volunteer. 11) Provides assistance to Protective Services and/or police agency if requested. However, 42 C.F.R. (Code of Federal Regulations) Part 2 prohibits disclosure of any alcohol or drug abuse treatment information after the initial report of child abuse or neglect has been made unless there is either an appropriate court order or consent. 12) Documents on an Incident Report Form the death, serious injury, suspected abuse, neglect, or sexual abuse of a recipient. For recipients under the age of 18, attaches a copy of the Report of Actual or Suspected

	Child Abuse or Neglect, DHS-3200 to the Incident Report Form. Submits the Incident Report and if applicable, the DHS-3200 to the Rights Officer immediately if possible, but by no later than the next business day. Writing an Incident Report does not meet the requirement of making a verbal report of apparent or suspected abuse/neglect to the Rights Office.
Recipient Rights Officer	1) Upon receipt of abuse or neglect allegation: a) Determines if there is reasonable cause to suspect abuse or neglect. b) Ensures that the recipient is protected from further mistreatment. c) Ensures that all of the procedures have been followed as outlined in this policy. d) Informs local Director/Designee. 2) If abuse or neglect allegation involves a CMH or contractual agency staff, student, or volunteer, immediately initiates an independent investigation in compliance with CMHPSM Policy: Office of Recipient Rights. 3) Upon substantiated allegations of abuse or neglect: a) Requests remediation that will prevent future recurrence. b) Requests firm and fair discipline against the perpetrator of abuse/neglect in compliance with agency policy.

Exhibit A: Report on Recipient Abuse

Report on Recipient Abuse
CONFIDENTIAL

Community Mental Health
Partnership of Southeast Michigan

REPORT ON RECIPIENT ABUSE
(as required by Public Act 224 of 1986)

IN THE MATTER OF:
Name of Recipient:
Person/Agency Responsible for Recipient:
Street Address:
City, State, Zip Code:
Telephone Number:
TO:
Law Enforcement Agency:
Street Address:
City, State, Zip Code:
Telephone Number:
Follow-up to an oral report given to your agency on:

REPORT OF SUSPECTED ABUSE

Alleged abuser(s):	
Please indicate cause and manner of abuse where incident occurred:	

Signature/Title of Reporting Person Date

Cc: Office of Recipient Rights
Clinical File, with alleged abuser's and reporting person's names blacked out
CMH Director/Designee
MDHHS Adult Protective Services/Child Protective Services
Office of Children and Adult Licensing (LARA) if applicable

REPORT ON RECIPIENT ABUSE – FILE IN RELEASE OF INFO SECTION

Exhibit B: Report of Actual or Suspected Child Abuse or Neglect - DHS 3200

REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT
Michigan Department of Health and Human Services

Was complaint phoned to MDHHS?
☐ Yes ☐ No ▶ If yes, Log # _____ ▶ If no, contact Centralized Intake (855-444-3911) immediately

INSTRUCTIONS: REPORTING PERSON: Complete items 1-19 (20-28 should be completed by medical personnel, if applicable). Send to Centralized Intake at the address list on page 2.

1. Date

2. List of child(ren) suspected of being abused or neglected (Attach additional sheets if necessary)

NAME	BIRTH DATE	SOCIAL SECURITY #	SEX	RACE
3. Mother's name				
4. Father's name				

5. Child(ren)'s address (No. & Street)	6. City	7. County	8. Phone No.

9. Name of alleged perpetrator of abuse or neglect	10. Relationship to child(ren)
11. Person(s) the child(ren) living with when abuse/neglect occurred	12. Address, City & Zip Code where abuse/neglect occurred

13. Describe injury or conditions and reason for suspicion of abuse or neglect

14. Source of Complaint (Add reporter code below)

01 Private Physician/Physician's Assistant	11 School Nurse	42 MDHHS Facility Social Worker
02 Hosp/Clinic Physician/Physician's Assistant	12 Teacher	43 DMH Facility Social Worker
03 Coroner/Medical Examiner	13 School Administrator	44 Other Public Social Worker
04 Dentist/Register Dental Hygienist	14 School Counselor	45 Private Agency Social Worker
05 Audiologist	21 Law Enforcement	46 Court Social Worker
06 Nurse (Not School)	22 Domestic Violence Providers	47 Other Social Worker
07 Paramedic/EMT	23 Friend of the Court	48 FIS/ES Worker/Supervisor
08 Psychologist	25 Clergy	49 Social Services Specialist/Manager (CPS, FC, etc.)
09 Marriage/Family Therapist	31 Child Care Provider	56 Court Personnel
10 Licensed Counselor	41 Hospital/Clinic Social Worker	

15. Reporting person's name	Report Code (see above)	15a. Name of reporting organization (school, hospital, etc.)			
15b. Address (No. & Street)		15c. City	15d. State	15e. Zip Code	15f. Phone No.
16. Reporting person's name	Report Code (see above)	16a. Name of reporting organization (school, hospital, etc.)			
16b. Address (No. & Street)		16c. City	16d. State	16e. Zip Code	16f. Phone No.
17. Reporting person's name	Report Code (see above)	17a. Name of reporting organization (school, hospital, etc.)			
17b. Address (No. & Street)		17c. City	17d. State	17e. Zip Code	17f. Phone No.
18. Reporting person's name	Report Code (see above)	18a. Name of reporting organization (school, hospital, etc.)			
18b. Address (No. & Street)		18c. City	18d. State	18e. Zip Code	18f. Phone No.
19. Reporting person's name	Report Code (see above)	19a. Name of reporting organization (school, hospital, etc.)			
19b. Address (No. & Street)		19c. City	19d. State	19e. Zip Code	19f. Phone No.

DHS-3200 (Rev. 10-15) Previous edition may be used. 1

TO BE COMPLETED BY MEDICAL PERSONNEL WHEN PHYSICAL EXAMINATION HAS BEEN DONE

20. Summary report and conclusions of physical examination (Attach Medical Documentation)		
21. Laboratory report	22. X-Ray	
23. Other (specify)	24. History or physical signs of previous abuse/neglect ☐ YES ☐ NO	
25. Prior hospitalization or medical examination for this child DATES	PLACES	
26. Physician's Signature	27. Date	28. Hospital (if applicable)

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	AUTHORITY: P.A. 238 of 1975. COMPLETION: Mandatory. PENALTY: None.

INSTRUCTIONS

GENERAL INFORMATION:
This form is to be completed as the written follow-up to the oral report (as required in Sec. 3 (1) of 1975 PA 238, as amended) and mailed to Centralized Intake for Abuse & Neglect. Indicate if this report was phoned into MDHHS as a report of suspected CA/N. If so, indicate the Log # (if known). The reporting person is to fill out as completely as possible items 1-19. Only medical personnel should complete items 20-28.

Mail this form to:
Centralized Intake for Abuse & Neglect
5321 28th Street Court S.E.
Grand Rapids, MI 49546

OR

Fax this form to 616-977-8900 or 616-977-8050 or 616-977-1158 or 616-977-1154
OR
email this form to MDHHS-CPS-CIGroup@michigan.gov

1. Date – Enter the date the form is being completed.
2. List child(ren) suspected of being abused or neglected – Enter available information for the child(ren) believed to be abused or neglected. Indicate if child has a disability that may need accommodation.
3. Mother's name – Enter mother's name (or mother substitute) and other available information. Indicate if mother has a disability that may need accommodation.
4. Father's name – Enter father's name (or father substitute) and other available information. Indicate if father has a disability that may need accommodation.

5.-7. Child(ren)'s address – Enter the address of the child(ren).

8. Phone – Enter phone number of the household where child(ren) resides.
9. Name of alleged perpetrator of abuse or neglect – Indicate person(s) suspected or presumed to be responsible for the alleged abuse or neglect.
10. Relationship to child(ren) – Indicate the relationship to the child(ren) of the alleged perpetrator of neglect or abuse, e.g., parent, grandparent, babysitter.
11. Person(s) child(ren) living with when abuse/neglect occurred – Enter name(s). Indicate if individuals have a disability that may need accommodation.
12. Address where abuse / neglect occurred.
13. Describe injury or conditions and reason of suspicion of abuse or neglect – Indicate the basis for making a report and the information available about the abuse or neglect.
14. Source of complaint – Check appropriate box noting professional group or appropriate category.

Note: If abuse or neglect is suspected in a hospital, also check hospital.

MDHHS Facility – Refers to any group home, shelter home, halfway house or institution operated by the Department of Health and Human Services. Refers to any institution or facility operated by the Department of Health and Human Services.

15.-19 - Reporting person's name - Enter the name and address of person(s) reporting this matter.

DHS-3200 (Rev. 10-15) Previous edition may be used. 2

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Communication by Mail, Telephone, and Visits***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines which ensure that recipients are able to communicate with individuals of their choice by mail, telephone, and visits.

II. REVISION HISTORY

DATE	MODIFICATION
04/20/2010	Full policy revision
03/20/2013	Template updated
01/13/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be Regional Approval Date	3 year review Made language consistent

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that recipients are entitled to unimpeded, private and uncensored communication by mail and telephone, and to visit with persons of their choice, except in instances allowable by law and further defined in policy.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Consent: Consent is defined as either of the following:

1. A written agreement signed by a recipient, unless the recipient has a designated legal representative with authority to execute consent. If the recipient has a designated legal representative, the legal representative must provide written agreement.
2. A verbal agreement of a recipient, unless the recipient has a designated legal representative with authority to execute a consent, that is witnessed and documented by an individual other than the individual providing treatment. If the recipient has a designated legal representative, the legal representative must provide verbal agreement.

   Additionally, consent must include the elements of competency, comprehension, knowledge, and voluntariness (see Consent to Treatment and Services Policy).

Legal Inquiry: Any matter concerning civil, criminal, or administrative law.

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Mail: Letters, magazines, packages and other material sent or received through the U.S. Postal Service, Federal Express or other carriers.

Mental Health Professional: A Mental Health Professional is defined as any of the following:

1. A physician who is licensed to practice medicine or osteopathic medicine and surgery in this state under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
2. A psychologist licensed to practice in this state under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
3. A registered professional nurse licensed to practice in this state under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
4. A licensed master's social worker licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.
5. A licensed professional counselor licensed to practice in this state under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

6. A marriage and family therapist licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Uncensored: Without rebuke, reproach or disapproval; free from criticism; not judged or condemned.

Unimpeded: Not slowed or prevented; unblocked.

VI. STANDARDS

A. Recipients are entitled to unimpeded, private and uncensored communication by mail and telephone, and to visit with persons of their choice, except in the circumstances set forth in this policy. This standard is inclusive of electronic mail and other forms of electronic communication.

B. Recipients' right to communicate by mail or telephone, or to receive visitors, shall not be limited except as indicated in their Individual Plan of Service, or as indicated in program rules of licensed residential settings.

C. Individual limitations on communication must be:

   a. Clinically justified and documented in the recipient's record.
   b. Implemented in compliance with CMHPSM policies Limitation of Rights and Behavior Treatment Committee.
   c. Removed when no longer clinically justified.

D. A recipient's communication regarding matters of legal inquiry shall not be limited under any circumstances. This may include communication with an attorney, a court, or the CMHPSM's Recipient Rights Officer, Customer Service Representative, or Fair Hearings Officer.

E. If a recipient secures the services of a Mental Health Professional or other licensed professional, the recipient shall be allowed to see that person at any reasonable time. A time is reasonable as long as it does not affect the functioning of the program.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
CMHPSM Policy: Behavior Treatment Committee	X	

CMHPSM Policy: Consent to Treatment and Services	X	
CMHPSM Policy: Limitation of Rights	X	
MDHHS Administrative Rules	X	330.7199(2) (g)
Michigan Mental Health Code Act 258 of 1974	X	Sec. 330.1715, 330.1726
Licensing Rules for Adult Foster Care Small Group Homes	X	R400.14304
MDHHS Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans	X	

IX. PROCEDURES

A. Mail, Incoming

WHO	DOES WHAT
Assigned Clinical staff	1) Ensures that any need or limitation regarding incoming mail is documented in the recipient's Individual Plan of Service. 2) Ensures that any limitations regarding incoming mail, including the opening or destruction of mail by staff, are in compliance with agency policy.
Licensed Residential Services Provider Non-Licensed Residential Service Provider	1) Ensures that a postal box is available for the delivery of mail. 2) Ensures that incoming mail can be conveniently and confidentially received. 3) Does not open a recipient's mail unless authorized in the recipient's Individual Plan of Service. 4) Completes an Incident Report for any instance of opening, withholding, or destruction of recipient mail.

B. Mail, Outgoing

WHO	DOES WHAT
Assigned Clinical staff	1) Ensures that any need or limitation regarding outgoing mail is documented in the recipient's Individual Plan of Service.

	2) Ensures that any limitations regarding outgoing mail are in compliance with agency policy.
Licensed Residential Services Provider	1) Ensures that a postal box is available for the deposit of outgoing mail. 2) Ensures that outgoing mail can be conveniently and confidentially sent. 3) Ensures that writing materials, non-letterhead stationery and postage are provided in reasonable amounts for recipients unable to procure such items.
Non-Licensed Residential Service Provider	1) Ensures that a postal box is available for the deposit of outgoing mail. 2) Ensures that outgoing mail can be conveniently and confidentially sent.

C. Telephone Calls

WHO	DOES WHAT
Assigned Clinical staff	1) Ensures that any need or limitation regarding telephone usage is documented in the recipient's Individual Plan of Service. 2) Ensures that any limitations regarding telephone usage are in compliance with agency policy.
Licensed Residential Services Provider	1) Ensures that a telephone is reasonably accessible to recipients. 2) Provides a reasonable amount of telephone usage funds for those unable to provide their own. 3) Ensures that recipients are afforded privacy during telephone usage. 4) If limits are set regarding the length of telephone calls, ensures that the limit is no less than five (5) minutes. 5) Ensures that any limitations regarding telephone usage, including length or

	hours of usage, are posted in a conspicuous area for both residents and guests.
Non-Licensed Residential Service Provider	1) Ensures that recipients are afforded privacy during telephone usage.

D. Visits

WHO	DOES WHAT
Assigned Clinical staff	1) Ensures that any need or limitation regarding visits is documented in the recipient's Individual Plan of Service. 2) Ensures that any limitations regarding visits are in compliance with agency policy.
Licensed Residential Services Provider	1) Ensures that adequate space and privacy is provided for recipients to receive visitors. 2) Ensures that any limitations regarding visits, including visiting hours, are posted in a conspicuous area for both residents and guests.
Non-Licensed Residential Service Provider	1) Ensures that adequate space and privacy is provided for recipients to receive visitors.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Consent to Treatment and Services***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines which ensure that recipients receive notification of their rights, and that informed consent is obtained for all services provided.

II. REVISION HISTORY

DATE	MODIFICATION
04/20/2010	Full policy revision
04/11/2013	Template updated
01/13/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be Regional Approval Date	3 year review No content changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that informed consent shall be obtained, as defined in this policy, prior to the provision of services.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Competency: The legal capacity of an individual to provide informed consent. An adult recipient shall be considered competent unless a court has determined that the recipient is not competent or is legally incapacitated and has been appointed a legal representative. If a legal representative has been appointed, the recipient shall be presumed competent regarding matters that are not within the legal representative's scope and authority.

Comprehension: The ability to understand the personal implications of providing consent, based on the basic information that has been provided.

Consent: Consent is defined as either of the following:

1. A written agreement signed by a recipient, unless the recipient has a designated legal representative with authority to execute consent. If the recipient has a designated legal representative, the legal representative must provide written agreement.
2. A verbal agreement of a recipient, unless the recipient has a designated legal representative with authority to execute a consent, that is witnessed and documented by an individual other than the individual providing treatment. If the recipient has a designated legal representative, the legal representative must provide verbal agreement.

   Additionally, consent must include the elements of competency, comprehension, knowledge, and voluntariness.

Knowledge: Possession of the basic information needed to consent to services, including an understanding of the services being proposed, as well as the risks, benefits, consequences and other relevant information of consenting to those services.

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Rights: Protections for recipients of mental health services as defined by state and federal laws and agency policy.

Voluntariness: The ability to provide informed consent without force, fraud, deceit, duress or coercion, with the understanding that consent can be withdrawn at any time without prejudice.

VI. STANDARDS

A. All applicants and their legal representatives shall be notified of their rights as recipients of mental health services. This shall be done at the time services are first requested, and annually thereafter, by providing each applicant, recipient and legal representative with a copy of the Your Rights brochure, the Bill of Rights and Responsibilities brochure, the HIPAA Privacy Notice, and the Person Centered Planning brochure, and by having a complete copy of Chapters 7 and 7a of the Mental Health Code available for review at each service site.

B. Informed consent shall be obtained prior to:
   1. Providing mental health services to a recipient,
   2. Providing a prescription for psychotropic medication to a recipient,
   3. Disclosing confidential information which requires consent,
   4. Photographing, recording, or using one-way glass to observe a recipient.

C. Informed consent for services shall be obtained at least annually, or sooner if changes in circumstances substantially change the risks, other consequences, or benefits that were previously expected.

D. Exceptions to this policy are:
   1. Civil Commitment Assessments
   2. Court ordered treatment
   3. Emergency Services Procedures

   Applicants for, or recipients of services provided under exceptions 1-3 above shall be informed regarding the services to be provided, but written informed consent is not required.

E. Applicants/recipients and their legal representatives shall be given the following information at the time of the request for services:
   1. A description of services and their purpose,
   2. Risks, benefits, and other consequences reasonably to be expected,
   3. A disclosure of appropriate alternatives advantageous to the recipient,
   4. An offer to answer further questions.

F. Consent to service participation is voluntary. The consenting individual is free to withdraw consent and discontinue participation in services at any time without prejudice to the recipient.

G. The ability of each applicant or recipient to give informed consent shall be evaluated and shall precede any guardianship proceedings.

H. A minor who is fourteen years of age or older may request and receive mental health services, and a mental health professional may provide such services on an outpatient basis (excluding pregnancy termination referral services and the use of psychotropic drugs), without the consent or knowledge of the minor's parent, guardian or person in loco parentis unless there is a compelling need for disclosure

based on a substantial probability of harm to the minor or another individual, and if the minor is notified of the mental health professional's intent to disclose. These outpatient sessions shall be limited to not more than twelve sessions or four months for each request for services. After that time, the mental health professional shall terminate the services or, with the consent of the minor, shall notify the parent, guardian, or person in loco parentis to obtain consent to provide further outpatient services.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code, Public Act 258 of 1974, as amended	x	330.1100a (19); 330.1706, 330.1707
MDHHS Administrative Rules	x	330.7003; 330.7011
CMHPSM Policy: Confidentiality and Access to Clinical Records	x	
CMHPSM Policy: Customer Services	x	
CMHPSM Policy: Fingerprints, Photographs, Recordings, or Use of 1-Way Glass	x	
CMHPSM Policy: Psychotropic Medication Orders and Consents	x	
CMHPSM Policy: Services Suited to Condition	x	

IX. PROCEDURES

A. Notification of Rights

WHO	DOES WHAT
Assigned Program Staff	1) Gives the applicant/recipient and legal representative a copy of the Your Rights brochure, the Bill of Rights and Responsibilities brochure, the Person Centered Planning brochure, and HIPAA Privacy Notice at the initial request for service, and annually thereafter. Documents this in the clinical record. 2) Provides a brief verbal explanation of the brochures as well as a description of the Rights Procedures. 3) Asks the applicant/recipient/legal representative to review the Your Rights brochure.

	4) Reiterates the content of the brochures in accordance with the applicant/recipient/legal representative's ability to comprehend, if the individual(s) appear to be: a) Illiterate b) A person with an intellectual/developmental disability. c) Non-English speaking (verbal explanation should be in a language that the individual(s) understand and may be delayed until a translator is available). d) Blind (the information shall be read to the individual(s)). e) Hearing impaired (the information shall be communicated in an understandable manner, or may be delayed until a qualified translator is available). f) Emotionally upset (the verbal explanation may be delayed until a more clinically suitable time, if, because of emotional status, the individual is unable to comprehend or is non-receptive to the explanation. The delay should be for a period of no more than two (2) weeks from the time of consent). 5) Documents in the clinical record if the applicant/recipient/legal representative is assisted in reading or understanding the brochures.

B. Informed Consent to Services

WHO	DOES WHAT
Assigned Program Staff	1) Provides a verbal explanation of services, risks, benefits, other consequences, and provides other relevant information to the applicant/recipient/ legal representative. 2) Evaluates the applicant/recipient's ability to give informed consent based on the individual's ability to understand the explanation of services, risks, benefits, other consequences, and other relevant information. Informs supervisor/manager if individual appears to lack the ability to give consent. If further evaluation confirms an inability to make a decision or to rationally understand a situation, as required for informed consent, the supervisor/manager will take administrative action to ensure the individual's

	rights are protected and appropriate services are made available. This shall include a determination as to whether guardianship proceedings should be considered. 3) Ensures that services being consented to are accurately documented on the Service Participation Consent form. 4) Assists consenting individual with completing and signing the Service Participation Consent form at the initial request for services, prior to implementing any services, and annually thereafter. Gives applicant/recipient/legal representative a copy of the signed Service Participation Consent form. 5) If consent is being given verbally, obtains verbal consent from consenting individual and documents on the Service Participation Consent form. Ensures that verbal consent is also witnessed and documented by a non-treating individual.
Consenting Individual	1) If consenting in writing, signs Service Participation Consent form. 2) If consenting verbally, verbally consents to services to the assigned program staff and second non-treating witness.
Additional non-treating staff	1) Witnesses verbal consent given by consenting individual to the assigned program staff. 2) Documents witnessed consent on Service Participation Consent form.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Dignity and Respect***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines that ensure that all recipients and their family members are treated with dignity and respect.

II. REVISION HISTORY

DATE	MODIFICATION
03/05/2010	Full policy revision
05/22/2013	Template updated
01/11/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be Regional Approval Date	3 year review No content changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that all recipients and their family members will be treated with dignity and respect during the provision of services.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Dignity: To be treated with esteem, honor, politeness; to be addressed in a manner that is not patronizing or condescending; to be treated as an equal; to be treated the way any individual would like to be treated.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Respect: To show deferential regard for; to be treated with esteem, concern, consideration or appreciation; to protect an individual's privacy; to be sensitive to cultural differences; to allow an individual to make choices.

VI. STANDARDS

A. All recipients of mental health services and their family members shall be treated with dignity and respect.

B. Staff within the CMHPSM shall protect and promote the dignity and respect to which recipients are entitled.

C. Examples of treating a person with dignity and respect include, but are not limited to: calling a person by his or her preferred name; knocking on a closed door before entering; using positive language; encouraging a person to make choices instead of making assumptions about their preferences; taking a person's opinion seriously; including a person in conversations; allowing a person to do things independently or to try new things.

D. Family members shall be given an opportunity to provide information to the treating professionals.

E. Family members shall be given an opportunity to request and receive general educational information about the nature of disorders, medications and their side effects, available support services, advocacy and support groups, financial assistance, and coping strategies.

F. Information shall be provided to family members within the confidentiality constraints of Section 748 of the Mental Health Code.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check	Standard Numbers:

	if applies:	
Michigan Mental Health Code Act 258 of 1974	X	330.1704, 330.1708, 330.1711

IX. PROCEDURES

None

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Family Planning***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines for notifying recipients and their legal representatives of the availability of family planning and health information services.

II. REVISION HISTORY

DATE	MODIFICATION
04/20/2010	Full policy revision
04/11/2013	Template updated
01/11/2017	Template Updated
02/13/2020	3-year review No content changes
Will be the Regional Approval Date	3 year review No content changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that recipients and their legal representative will be notified of the availability of family planning and health information services.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Family Planning: Planning of the number of one's children through the use of birth control techniques.

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. Recipients and their legal representatives shall be provided with notice of the availability of family planning and health information services.

B. This notice shall include a statement that mental health services are not contingent on the request or decision to engage in family planning or health information services.

C. Recipients and their legal representatives shall be provided with a referral to family planning or health information services upon request.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code, Act 258 of 1974	X	330.1752
MDHHS Administrative Rules	X	330.7029
MDHHS Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans	X	

IX. PROCEDURES

WHO	DOES WHAT
Case Manager, Supports Coordinator, or designated staff	1) Informs recipient and their legal representative, if applicable, of the

	availability of family planning and health information services. 2) Provides referral assistance for family planning or health information services upon request of the recipient or their legal representative. 3) Referrals for pregnancy termination services shall not be provided for a minor recipient without consent from the recipient's legal representative.
Recipient/Legal Representative	1) Maintain sole responsibility for all decisions related to family planning.

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy and Procedure* *Fingerprints, Photographs, Recordings, or Use of 1-Way Glass*
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines regarding the recording, photographing, and fingerprinting of recipients, and the use of one-way glass to observe recipients.

II. REVISION HISTORY

DATE	MODIFICATION
02/04/2010	Full policy revision
03/20/2013	Renamed; updated per changes to MHC
01/10/2017	Updated Template
07/17/2018	Exhibit: Consent Form added
02/13/2020	3-year review No content changes
03/22/2021	Updated per changes in required MDHHS policy standards.
Will be the Regional Approval Date	3 year review Made standards more consistent with the MMHC

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that informed consent shall be obtained prior to the recording, photographing, or observing of recipients through one-way glass. Fingerprinting of recipients is prohibited.

V. DEFINITIONS

Audio Recording: A recording of the voice alone.

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Consent: Consent is defined as either of the following:

1. A written agreement signed by a recipient, unless the recipient has a designated legal representative with authority to execute consent. If the recipient has a designated legal representative, the legal representative must provide written agreement.
2. A verbal agreement of a recipient, unless the recipient has a designated legal representative with authority to execute a consent, that is witnessed and documented by an individual other than the individual providing treatment. If the recipient has a designated legal representative, the legal representative must provide verbal agreement.

   Additionally, consent must include the elements of competency, comprehension, knowledge, and voluntariness.

Film: See photograph.

Fingerprint: An inked and/or digital impression of the finger used as a means of identification.

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Photograph: A visual image reproduced as a photographic still, film, video or digital image on any device.

Recording: Any reproduction, audio or visual.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Video Recording: A recording of the voice and image.

Video Surveillance: Surveillance, with or without recording, in a recipient's home for the purpose of safety, security, or quality improvement.

VI. STANDARDS

A. Recipients may be recorded, photographed, and/or observed through one-way glass only when prior written consent has been obtained, and only for the following purposes:
   1. Supervision of staff, students, or volunteers,
   2. In order to provide services,
   3. Evaluation of the treatment process,
   4. Staff development or training,
   5. Community education,
   6. Research,
   7. Personal or social purposes,
   8. To determine the identification of a recipient.

B. The consent form must indicate all of the following:
   1. The intended use of the material,
   2. The right to terminate the consent at any time,
   3. That there will be a review at least annually regarding the need to continue to retain the material.

C. Fingerprinting and video surveillance of recipients is prohibited.

D. Recordings or photographs of recipients taken during the provision of services, and any copies of them, shall be maintained as part of the clinical record.

E. Photographs of a recipient may be taken for personal or social purposes and shall be maintained as the recipient's personal property. A photograph of a recipient shall not be taken or used if the recipient has objected.

F. Recordings or photographs may not be used by any person, group or organization outside of the CMHPSM unless the following have been obtained:
   1. Written consent to release information
   2. Permission of the local CMH Director or designee.

G. If it is necessary to send photographs or recordings to an outside individual or agency for assistance in determining the identification of a recipient, the individual/agency shall be informed that such photographs or recordings must be returned, along with any copies that were made. Upon their return, the photographs or recordings, along with any copies, shall be part of the clinical record.

H. There will be a review at least annually to determine if there is an essential need to maintain recorded or photographic material in order to achieve one of the objectives

set forth in Standard A. If not, the photographs or recordings in the recipient's record, and any copies, shall be given to the recipient or destroyed.

I. Recorded or photographic material will be returned to the recipient or destroyed upon the recipient's discharge from services.

VII. EXHIBITS

Consent for Photographing, Filming and/or Audio/Videotaping

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code Act 258 of 1974	X	330.1724
MDHHS Administrative Rules	X	330.7003
MDHHS Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans	X	
CMHPSM Policy: Consent to Treatment and Services	X	

IX. PROCEDURES

WHO	DOES WHAT
Assigned clinical staff	1) Discusses need to record, photograph, or use one-way glass for observation with supervisor. 2) Reviews need to record, photograph, or use one-way glass with recipient and/or legal representative, and obtains consent.
Consenting individual	1) Consents or objects to being recorded, photographed, or viewed through one-way glass. 2) May object to being photographed for social purposes.
Client Services Manager/Supports Coordinator	1) Maintains copy of written consent in the recipient's record. 2) Affords an opportunity for recipient to object, immediately prior to the recording, photographing or observation through one-way glass. A recipient shall

	not be observed through one-way glass, nor shall a recording or photograph be made or transmitted if the recipient indicates objection, even if prior written consent has been obtained. 3) Securely maintains original and copies of photographs or recordings in recipient's clinical record. 4) In conjunction with annual Person Centered Planning process, determines whether there is an essential need to retain photograph or recording. 5) Returns copies of recorded or photographic materials to recipient or destroys when: a) It is determined that there is no longer an essential need to maintain materials, or b) Consent is withdrawn, or c) Discharge of the recipient.
Director or Designee	1) Grants or denies permission before a recording/photograph may be removed from the premises and a recipient's record.

CONSENT FOR PHOTOGRAPHING, FILMING AND/OR AUDIO/VIDEOTAPING

Community Mental Health Partnership of Southeast Michigan

I, _____, Birthdate_____,

hereby authorize_____ to:

1. Photograph me _____
2. Record my voice _____
3. Record my voice and image ____

I understand that these photographs and/or recordings may be used for:

1. Personal or social purposes _____
2. Providing services _____
3. Community Education _____
4. Supervision of staff, students or volunteers _____
5. Research _____

I authorize my name to be associated with the photograph/recording: Yes ____ No _____

I understand that at least once a year there will be a review to determine whether there continues to be a need to keep the photograph, film or audio/videotape. I also understand that I may revoke my consent at any time by notifying my Case Manager/Supports Coordinator. I have no objection to the use of my picture and/or voice for the purposes described.

_____ _____
RECIPIENT SIGNATURE DATE

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Freedom of Movement***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines which ensure that recipients are entitled to maximum freedom of movement, and to clarify conditions for any limitation of movement.

II. REVISION HISTORY

DATE	MODIFICATION
02/18/2010	Full policy revision
04/10/2012	Policy section updated
06/03/2013	Template updated
01/06/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be the Regional Approval Date	3 year review No content changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) that recipients will receive mental health services in the least restrictive setting that is appropriate and available to ensure the safety of people and property.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. Recipients' freedom of movement shall not be restricted more than is necessary to provide mental health services, to prevent injury to the recipient or others, or to prevent substantial damage to property.

B. Security precautions may be taken if an individual is admitted by order of a criminal court or transferred as a sentence-serving convict of a penal institution, as determined appropriate to the condition and circumstance.

C. If a limitation on the right to freedom of movement is imposed pursuant to an order of the court and the limitation substantially restricts the ability to carry out treatment or habilitation specified in the Individual Plan of Service, the court shall be so informed during the hearing process.

D. Recipients shall have free access to areas suited for vocational, recreational or social activities unless limited by general restrictions or individual limitation of rights.

E. Any individual limitation of recipients' freedom of movement shall be:
   a. Justified in the clinical record.
   b. Time-limited.
   c. Removed when the circumstance that justified its implementation ceases to exist.
   d. Implemented in compliance with CMHPSM policies Behavior Treatment Committee and Limitation of Rights.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
Michigan Mental Health Code Act 258 of 1974	X	330.1744
CMHPSM Policy: Behavior Treatment Committee	X	
CMHPSM Policy: Limitation of Rights	X	

IX. PROCEDURES

WHO	DOES WHAT
Licensed Residential Service Provider Specialized group setting provider Clinical/residential program provider	1) Ensures that any general restrictions are implemented in compliance with CMHPSM policy: Limitation of Rights.
Client Service Manager/Supports Coordinator	1) Ensures that any individual restriction of a recipients' freedom of movement is implemented in compliance with CMHPSM policies: Limitation of Rights and Behavior Treatment Committee.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Limitation of Rights***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines for limiting the rights of recipients.

II. REVISION HISTORY

DATE	MODIFICATION
03/04/2010	Full policy revision
05/22/2013	Template updated
01/06/2017	Template Updated
02/13/2020	3-year review No content changes
Will be the Regional Approval Date	3 year review No content changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that recipients' rights shall not be limited more than is essential to ensure the health and safety of recipients and others.

V. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Consent: Consent is defined as either of the following:

1. A written agreement signed by a recipient, unless the recipient has a designated legal representative with authority to execute consent. If the recipient has a designated legal representative, the legal representative must provide written agreement.
2. A verbal agreement of a recipient, unless the recipient has a designated legal representative with authority to execute a consent, that is witnessed and documented by an individual other than the individual providing treatment. If the recipient has a designated legal representative, the legal representative must provide verbal agreement.

   Additionally, consent must include the elements of competency, comprehension, knowledge, and voluntariness.

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Limitation: A restriction; something that confines or restricts.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. Recipients' rights shall be limited only as essential for the safety and welfare of recipients and others.

B. Any restriction of a right guaranteed by state or federal law shall be imposed with due regard for the recipient's basic human dignity.

C. General restrictions may be imposed in the form of house rules of licensed residential facilities, program rules of other specialized groups settings (i.e. clubhouses, drop-in centers, vocational programs, directly operated CMH service sites), or entrance agreements of clinical/residential programs. Such restrictions must be conspicuously posted at the service site, and implemented in a manner to promote a least restrictive setting.

D. Any individual limitation of a recipient's rights must be reviewed and approved by the Behavior Treatment Committee and implemented in compliance with CMHPSM policy: Behavior Treatment Committee.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
DCH Administrative Rules	X	330.7119(g)
Michigan Mental Health Code Act 258 of 1974	X	330.1728
CMHPSM Policy: Behavior Treatment Committee	X	
CMHPSM Policy: Consent to Treatment and Services	X	

IX. PROCEDURES

A. General Restrictions

WHO	DOES WHAT
Licensed Residential Services Provider Specialized group setting provider Clinical/residential program provider	1) Develops general restrictions only as necessary for the safety and welfare of recipients and others. 2) Includes recipients and family members when developing general restrictions. 3) Ensures general restrictions are compliant with: a) The contract for services between CMHPSM and the service provider. b) The established needs of the recipients of the residence. c) Person centered practices and principles. 4) Consults with the Office of Recipient Rights as needed. 5) Explains general restrictions to recipients, legal representatives, and interested family members prior to the recipient entering the facility, and provides them with a written copy of the restrictions. 6) Posts general restrictions in a conspicuous location at each service site, where they may be easily seen by recipients and visitors.

	7) Removes general restrictions when they are no longer essential to achieve the objectives which justified their application.
Assigned Clinical Staff	1) Monitors implementation of general restrictions in licensed settings. 2) Follows-up with supervisor, service provider, or Office of Recipient Rights regarding any concerns.
Office of Recipient Rights	1) At least annually, reviews general restrictions of each licensed residential setting for compliance with state and federal law, and to ensure the promotion of a least restrictive setting.

B. Individual Limitations of Recipients' Rights

Assigned Clinical Staff	1) Guided by the condition and/or behavior of the recipient, determines if an individual limitation of rights is necessary. 2) Discusses the need for a limitation of rights with recipient and legal representative. 3) With the concurrence of the person-centered planning team, brings the following documentation to the Behavior Treatment Committee for review and approval: a) Description of the limitation and a rationale for its imposition, including evidence to support expected mental or physical harm, violation of law or harassment of others if a limitation was not imposed. b) Date of initiation. c) Expiration date of the limitation. d) Justification that the limitation is the least restrictive necessary to achieve the purpose proposed, including steps that have been taken to avoid restrictions, and action to be taken to ameliorate or eliminate the need for the restriction in the future. 4) Ensures that the limitation, as well as consent for the limitation, is clearly documented in the recipient's Individual Plan of Service. 5) Monitors at least quarterly during regular reviews of the Individual Plan of Service to determine whether there continues to be a need for a limitation of rights. When no longer essential to achieve the

	objectives which prompted its imposition, the limitation shall be removed.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Non-Discrimination in Provision of Service***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines that prohibit discrimination in the provision of services.

II. REVISION HISTORY

DATE	MODIFICATION
04/20/2010	Full policy revision
04/11/2013	Template updated
01/06/2017	Template/References/Language Updated
02/13/2020	3-year review Policy section updated
Will be the Regional Approval Date	3 year review No content changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that no qualified person shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination in any services or activities of the CMHPSM solely on the basis of race, color, religion, national origin, ancestry, age, sex, gender, gender expression, gender identity, height, weight,

marital status, sexual orientation, physical or mental disability, political belief, Medicaid, Medicare or CHIP status, or ability to pay for services.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Discrimination: The negative treatment, either intentional or unintentional, of a person or group based on the factors specified in Section IV above.

Disability: A determinable physical or mental characteristic of an individual or a history of the characteristic which may result from disease, injury, congenital condition of birth, or functional disorder which is unrelated to the individual's ability to utilize and benefit from a service.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

None

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
Michigan Mental Health Code Act 258 of 1974	X	Sec. 330.1705
The Rehabilitation Act of 1973	X	Sec. 504
The Persons With Disabilities Civil Rights Act of 1976, P.A. 220, as amended by P.A. 478 of 1990.	X	
The Americans with Disabilities Act (1990)	X	
CMHPSM Policy: Customer Services	X	
CMHPSM Policy: Consumer Appeals	X	
CMHPSM Policy: Office of Recipient Rights	X	
MDHHS Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans	X	

IX. PROCEDURES

WHO	DOES WHAT
Applicant or Recipient of Services	1) Informs any staff if it is believed that services have been denied for a reason which is defined as discriminatory under this policy.
Any staff	1) Contacts the Office of Recipient Rights to report alleged discrimination. 2) Informs the applicant or recipient of services of their right to file a complaint with the Office of Recipient Rights. 3) Informs the applicant or recipient of services of their right to file a grievance with Customer Services.
Program Supervisor/Designee	1) After being informed by staff, reviews the complaint and determines, in consultation with her/his Program Administrator, how to resolve the situation.
Applicant or Recipient of Services	1) May make a request for a second opinion regarding a denial of services to the Director. The Director shall secure the second opinion from a physician, licensed psychologist, registered professional nurse, master's level social worker or master's level psychologist. 2) May file a complaint with the Office of Recipient Rights at any time if the matter has not been satisfactorily resolved.
Office of Recipient Rights	1) When informed of an allegation of discrimination, provides appropriate follow-up in matters concerning any protected right under state or federal law, and decides on proper disposition as indicated in the CMHPSM policy: Office of Recipient Rights.
Customer Services	1) When contacted by an applicant or recipient of services regarding an allegation of discrimination, provides appropriate follow-up and decides on proper disposition as indicated in the CMHPSM policy: Customer Services.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Office of Recipient Rights***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines regarding the development and function of an Office of Recipient Rights.

II. REVISION HISTORY

DATE	MODIFICATION
05/18/2010	Full policy revision
04/29/2013	Template updated
03/03/2014	Updated Application, Definitions, and Standard D
01/13/2017	Template Updated; training requirements clarified
09/04/2018	Updated per changes in required MDHHS policy standards
02/13/2020	Updated per changes in required MDHHS policy standards. Updated training standards. Updated Complaint Form.
03/22/2021	Updated per changes in required MDHHS policy standards.
Will be the Regional Approval Date	3 year review Removed mediation language to be consistent with MMHC updates.

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that an Office of Recipient Rights shall be established and maintained to protect the rights of recipients in compliance with the Mental Health Code and Department of Health and Human Services Administrative Rules. The Office shall respond to any query or complaint submitted by or on behalf of recipients of CMHPSM Programs and contract agencies.

V. DEFINITIONS

Appeals Committee: A committee appointed by the Community Mental Health (CMH) board to hear appeals of recipient rights investigations. The governing board of a licensed private psychiatric hospital/unit (LPH/U) shall designate the CMH Appeals Committee to hear appeals brought by or on behalf of a recipient of that CMH.

Appellant: The recipient, complainant, parent of a minor or guardian who appeals a recipient rights finding or a respondent's action to an appeals committee.

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Complainant: An individual who files a rights complaint.

Department: For the purpose of this policy, Department shall refer to the Michigan Department of Health and Human Services, Office of Recipient Rights.

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Mediation: A private, informal dispute resolution process in which an impartial, neutral individual, in a confidential setting assists parties in reaching their own settlement of issues in a dispute and has no authoritative decision-making power.

Office: For the purpose of this policy, Office shall refer to the local CMHSP Office of Recipient Rights as established under section 755 of the Mental Health Code.

Office of Recipient Rights: An office of the local CMH that is responsible for investigating, resolving and assuring remediation of apparent or suspected rights violations and assuring that mental health services are provided in a manner which respects and promotes the rights of recipients as guaranteed by Chapter 7 and 7A of the Mental Health Code, P.A. 258, as amended.

Preponderance of the evidence: A standard of proof which is met when, based upon all the available evidence, it is more likely that a right was violated than not; not as to quantity (number of witnesses), but as to quality (believability and greater weight of important facts).

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Respondent: The service provider that had responsibility at the time of an alleged rights violation for the services with respect to which a rights complaint has been filed.

VI. STANDARDS

A. The Office will report to the local Community Mental Health (CMH) Director for coordination of work and access to resources, and to the local Recipient Rights Advisory Committee for oversight. At least semi-annual meetings will be held with the Recipient Rights Advisory Committee to review reports of rights activities. As needed, other meetings with the Recipient Rights Advisory Committee will be held to discuss issues or concerns which affect the rights of recipients of service.

B. Funding for the Office shall be reviewed annually by the Recipient Rights Advisory Committee and shall be included in the annual operating budget approved by the local CMH Board.

C. The Director of the Office shall have the education, training and experience to fulfill the responsibilities of the Office. Qualifications and training for the Rights Officer position shall be specified in a formal job description. The employee holding this position will be entitled to the rights and privileges afforded all exempt employees, except in the areas of employment and termination. Employment and termination of the Recipient Rights Officer will be subject to review by the Recipient Rights Advisory Committee. In the absence of a Rights Officer, rights services shall be provided by a person designated by the local CMH Director and/or the Recipient Rights Director.

D. The Office shall be accessible at all times. Individuals who access the Office shall be ensured due process and protection from harassment or retaliation as a result of contact with or participation with the Office. Allegations of retaliation or harassment of any recipient, complainant, Office staff, or any person based on their contact or participation with the Office shall be investigated by the Office. In the event of an actual or perceived conflict of interest, the allegations shall be investigated by another CMHPSM Office at the discretion of the Office Director. The respondent shall take appropriate disciplinary action if there is evidence of retaliation or harassment.

E. All employees, students, volunteers and contractors are required to:
   1. Immediately (by the next business day) verbally report to the Office all apparent or suspected violations of recipient rights, even if they did not witness it directly, do not have proof or believe it may be a rumor or "hearsay." Failure to report suspected violations of rights shall require that appropriate administrative action be taken, up to and including firm and fair disciplinary action.

2. Ensure rights complaints filed by recipients or anyone on their behalf are submitted to the Office in a timely manner.
3. Be oriented to Recipient Rights within 30 days of hire by using the curriculum developed by the Office titled: "Recipient Rights Day One Orientation." Employees shall not work alone with recipients until they have completed this training.
4. Attend a recipient rights training designated by a Rights Officer within the CMHPSM or an approved Recipient Rights Office within 90 days of the date of hire. The CMHSP ORR shall provide rights training for employees on a schedule determined by the CMHSP ORR. All employees are to retake the rights training, offered by an approved Recipient Rights Office, at least annually.

F. The Office shall be protected from pressures that could interfere with the impartial, even-handed, and thorough performance of its duties. The Office shall have unimpeded access to all programs and staff employed by or under contract to the CMHPSM and to any evidence necessary to conduct a thorough investigation or fulfill its monitoring function. The Office shall ensure that appropriate remedial action is taken to resolve violations of rights and that investigations are conducted in a manner that does not violate employee rights.

G. Recipient Rights Officers shall not have direct service responsibilities and shall receive annual training in recipient rights protection as guaranteed by the Mental Health Code and MDHHS Administrative Rules.

H. Recipient Rights Officers, Rights Advisors, and alternate Rights Officers will attend the Department's ORR Basic Skills Training within 90 days of hire. Any providers under contract with the CMHPSM that are allowed/required to establish their own rights system will also attend all initial and ongoing/update trainings as required by the Department.

I. Recipient Rights Officers will comply with the continuing education requirements identified in the MDHHS Contract Attachment. A minimum of 36 contact hours of continuing education or training will be obtained by Recipient Rights Officers over a three-year period subsequent to the completion of the Basic Skills Training, and in every three year period thereafter. A minimum of 12 of the 36 contact hours will be in Category I or II. Recipient Rights Officers will acquire at least 3 continuing education credits each calendar year.

J. The Office will participate in the development and review of all policies pertinent to the rights of recipients and serve as a consultant to the Local Director in matters related to recipient rights.

K. The Office shall conduct an independent review of all treatment plans presented to the Behavior Treatment Committee.

L. The Office ensures that all recipients and their legal representatives are given a summary of recipient rights, as well as information regarding how to contact a Recipient Rights Officer.

M. The Office, together with Customer Services, shall:

1. Ensure that available resources include interpretation services; that written information is available in prevalent languages; and that such services will be free of charge to the recipient/applicant.
2. Notify recipients of, and ensure that written information is available in, alternative formats and in an appropriate manner that considers special needs.
3. Ensure recipients are given an explanation of how to access these services or information.
4. Address needs or barriers related to cultural sensitivity, reasonable accommodation for persons with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communication.

N. The Office shall ensure that complaint forms are accessible to recipients, parents of minors, guardians, staff and others who wish to act on behalf of a recipient, when requested.

O. Each rights complaint shall be accurately recorded upon receipt by the Office, and acknowledgment of the recording shall be sent along with a copy of the complaint to the complainant within 5 work days. Within 5 work days after the Office receives a complaint, it shall notify the complainant if it determines that no investigation of the rights complaint is warranted. The Office shall ensure that all complaints and investigative evidence are accurately recorded and securely stored.

P. The Office shall advise the complainant that there are advocacy organizations available to assist in preparation of a written rights complaint and shall offer to refer the complainant to those organizations. In the absence of assistance from an advocacy organization, the Office shall assist in preparing a written complaint, including a statement of the allegation, the right(s) allegedly violated, and the outcome(s) desired by the complainant.

Q. The Office shall coordinate with Customer Services to ensure that during the course of daily operations, Customer Services is informed of potential grievances and the Office is informed of potential rights violations. When providing consultation to Customer Services or when triaging a call, the Office shall make the final determination whether (a) a rights complaint involves a grievance, and (b) a grievance involves a code-protected right. When the Office determines that a rights complaint involves a grievance, the complaint shall be referred to the Customer Services Department. When the Office determines that a grievance also involves a legally-protected right, procedures for a rights complaint shall be followed by the Office.

R. If a rights complaint is made regarding the conduct of the local CMH Director, the investigation shall be conducted by another CMH Board's Office of Recipient Rights, or by the Department, as decided by the local CMH Board.

S. Rights investigations shall be initiated immediately in cases involving abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation. All other apparent or suspected violations shall be investigated in a timely and efficient manner. All investigations shall be completed within 90

days of receiving the complaint, with written status reports to the complainant, respondent and responsible mental health agency every 30 days during the course of the investigation. Issuance of the written Report of Investigative Findings may be delayed pending completion of investigations that involve external agencies, including law enforcement agencies and the Department of Human Services.

T. The Office shall recommend that the respondent take disciplinary action against those who have engaged in abuse or neglect. The CMH and each service provider shall ensure that appropriate disciplinary action is taken against those who engage in abuse or neglect.

U. All rights investigations shall be documented in written form using a Report of Investigative Findings format. The preponderance of evidence standard of proof shall be used to determine whether a right was violated. Investigations shall be conducted in a manner that will not violate employee rights, e.g., Bullard-Plawecki Employee Right to Know Act. Upon completion of the investigation, the Report of Investigative Findings shall be submitted to the local CMH Director and the respondent(s) with any applicable recommendations, and a Remedial Action Verification form to be returned to the Office specifying the remedial actions taken or planned.

V. In response to substantiated rights violations, respondents shall take remedial action that does all of the following:
   1. Corrects or provides remedy to the rights violation
   2. Is implemented in a timely manner
   3. Attempts to prevent recurrence of the rights violation.

W. After completion of the investigation and receipt of the Remedial Action Verification form, if applicable, the Office shall forward their findings to the local CMH Director. Within 10 work days of issuance of the Report of Investigative Findings, the Director shall submit a written Summary Report to the complainant, the recipient, if different than the complainant, parent of a minor recipient and guardian. Information in the Summary Report shall be provided within the constraints of the confidentiality/privileged communications sections of the Mental Health Code, and shall not violate the rights of any employee.

X. A complainant/recipient/minor's parent/guardian shall be advised that an appeal of an investigative finding may be made in writing to the local Recipient Rights Advisory Committee, which has been designated by the Board to act as an Appeals Committee, in care of the local CMH Director, within 45 days after receipt of the Summary Report. They shall further be advised that there are advocacy agencies available to assist with filing an appeal, and that the Office can assist in making a referral. In the absence of assistance from an advocacy organization, the Office is available to assist in meeting the procedural requirements of a written appeal.

Y. A Summary Report which contains a plan of action shall indicate a date the action is to be completed. The CMH Director shall assure that the complainant, recipient (if different than the complainant), the recipient's legal guardian, (if any), and the Office are provided written notice that the action described in the plan has been completed. If the action taken differs from the original plan, a

description of that action shall be provided. Within 45 calendar days after receipt of the Summary Report, or 45 days from the mailing of a notice regarding the action that was taken when the Summary Report provided only a plan of action, the appellant may file a written appeal with the Appeals Committee. The only ground for appeal of a notice of action taken is that the action failed to provide adequate remedy.

Z. Within five (5) work days of receipt of the request for appeal, members of the Appeals Committee shall review the request for appeal to determine if the appellant has standing to appeal and if the appeal request meets the timeframe and grounds. This review may be conducted by the full Committee, or by a subcommittee consisting of at least two (2) members designated by the full Committee to fulfill this responsibility. The Committee or subcommittee:
   1. Shall review the grounds for the appeal to determine whether it meets one of the following criteria:
      i. The investigative findings of the rights office are not consistent with the facts, law, rules, policies or guidelines.
      ii. The action taken or plan of action proposed by the respondent does not provide an adequate remedy.
      iii. An investigation was not initiated or completed on a timely basis.
   2. Shall provide written notice to the appellant that the appeal has either been accepted or denied based on the criteria set forth above. A copy of the appeal shall also be provided to the respondent, CMH Director and the Office.

AA. Within 30 days after receipt of a written appeal, the Appeals Committee shall meet in closed session and review the facts as stated in the complaint investigative documents. Any member of the Appeals Committee who has a personal or professional relationship with an individual involved in the appeal shall abstain from participating in that appeal as a member of the Committee. The Committee shall not consider additional allegations that were not part of the original complaint but shall inform appellant of his/her right to file an additional complaint with the Office. The Appeals Committee may request consultation and technical assistance from the Department.

BB. At the meeting, the Appeals Committee shall do one do one of the following:
   1. Uphold the investigative findings of the Office and the action taken or plan of action proposed by the respondent.
   2. Return the investigation to the Office and request that it be reopened or reinvestigated.
   3. Uphold the investigative findings but recommend that the respondent take additional or different action to remedy the violation.
   4. Recommend that the local CMH Board request an external investigation by the Department.

CC. The Appeals Committee shall document its decision in writing and within 10 work days provide copies of the decision to the respondent, appellant, recipient, minor's parent, and guardian, as well as to the local CMH Director and the Office. Documentation shall include justification for the decision made by the Committee. The Committee's decision shall include a statement of the appellant's right to appeal to the Department within 45 days from

receipt of the decision, when the original grounds for the appeal were that the investigative findings of the Office were inconsistent with the facts, or with law, rules, policies, or guidelines. An appeal to the Department may be taken only when the original grounds for appeal were that the investigative findings of the Office were inconsistent with the facts, law, rules, policies or guidelines and only after a decision on the original appeal has been made by the local Appeals Committee.

DD. If the Appeals Committee directs that the Office reopen or reinvestigate the complaint, the Office shall submit another investigative report in compliance with section 778(5) of the Code, within 45 calendar days of receipt of the written decision of the committee to the local CMH Director. The 45 calendar day time frame may be extended at the discretion of the Appeals Committee upon a showing of good cause by the Office. At no time shall the time frame exceed 90 days.

Within 10 work days of receipt of the re-investigative report, the CMH Director shall issue a new Summary Report in compliance with section 782 of the Code. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the Office and the Appeals Committee. If the Summary Report indicates the decision in the case remains unsubstantiated, the Summary Report shall contain information regarding the appellant's right to further appeal, the time frame for the appeal and the grounds for appeal. The report shall also inform the appellant of advocacy organizations that may assist in filing the written appeal or, in the absence of an advocacy organization, offer the assistance of the Office. If the reinvestigation results in the substantiation of a previously unsubstantiated rights violation but the appellant disagrees with the adequacy of the action or plan of action proposed by the respondent, the appellant shall be advised that they may file an appeal on such grounds to the Appeals Committee.

EE. If the Appeals Committee upholds the findings of the ORR but directs that the respondent take additional or different action, that direction shall be based on the fact that appropriate remedial action has not been taken in compliance with section 780 of the Code. The Appeals Committee shall base its determination upon any or all of the following:

1. Action taken or proposed did not correct or remedy the rights violation.
2. Action taken or proposed was/will not be taken in a timely manner.
3. Action taken or proposed did not/will not prevent a future recurrence of the violation.

Within 30 calendar days of receipt of the determination from the Appeals Committee, the Respondent shall provide written notice to the Appeals Committee that the action has been taken or justification as to why it was not taken. The written notice shall also be sent to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the CMH Director if different than the respondent, and the Office. If the action taken by the respondent is determined by the Appeals Committee and/or the appellant still to be inadequate to remedy the violation, the appellant shall be informed

by the Appeals Committee of his/her right to file a recipient rights complaint against the local CMH Director.

FF. If the Appeals Committee recommends that the CMH Board request an external investigation by the Department, the CMH Board shall make the request to the Department, in writing, within 5 work days of receipt of the request from the Appeals Committee. If an appeal request is made to the Department, the Office shall ensure that the Department has access to all requested documentation. The Department will not consider additional evidence or information that was not available during the initial appeal, although it may return the matter to the local CMH Board, requesting an additional investigation.

Within 10 work days of receipt of the Report of Investigative Findings from the Department, the CMH Director shall issue a Summary Report, in compliance with section 782 of the Code. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the Office and the Appeals Committee. The complainant, recipient if different than the complainant and the recipient's legal guardian, if any, shall be informed of the right to appeal to the Department's Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 784(2), the time frame for submission of the appeal, advocacy organizations that may assist with filing the written appeal, and an offer of assistance by the Office in the absence of assistance from an advocacy organization. Not later than 45 calendar days after receipt of the Summary Report, the appellant may file a written appeal with the Department's Appeals Committee.

GG. If the appeal concerns the timeliness of the investigation and the Appeals Committee confirms that the investigation was not initiated or completed in a timely manner, the Committee shall recommend that the CMH Director address the root cause of the lack of timeliness with the Recipient Rights Officer.

HH. The Office shall ensure that all service sites are visited at the frequency necessary to assess right protection, but at least annually.

II. On a semiannual basis, the Office shall provide summary complaint data, together with a summary of remedial actions taken on substantiated complaints by category, to the local Recipient Rights Advisory Committee. This data shall also be forwarded to the Department semiannually.

JJ. The local CMH Director shall submit to the local CMH Board and to the Department an annual report prepared by the Office on the current status of recipient rights protection and a review of the operations of the office. The report shall be submitted to the Department not later than December 30 of each year for the preceding fiscal year, and shall include, at a minimum, all of the following:

1. Summary data by category including complaints received, number of reports filed, and number of reports investigated by provider.
2. Number of substantiated rights violations by category and provider.
3. Remedial actions taken by category and provider.
4. Training received by the Office.
5. Training provided by the Office to contract providers.
6. Desired outcomes established for the Office and progress toward these outcomes.
7. Recommendations made to the local CMH Board.

VII. EXHIBITS

Recipient Rights Complaint Form

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code Act 258 of 1974	X	330.1722, 330.1757, 330.1774, 330.1776, 330.1778, 330.1780, 330.1782, 330.1784, 330.1786, 330.1788
Bullard-Plawecki Right to Know Act, Public Act 397 of 1978	X	
Michigan Whistleblowers' Protection Act P.A. of 1980	X	
MDHHS Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans	X	3.1.1.1

IX. PROCEDURES

A. Complaint Resolution

WHO	DOES WHAT
Individual makes inquiry or complaint with the Office.	1) Request is referred in a timely manner to the following (in order): a) Office of Recipient Rights b) Alternate Recipient Rights staff c) Director d) Director's designee
Rights Officer/Designee	1) Determines if the person who is making the call is safe. If hazards to safety exist

	or are suspected, makes arrangements to ensure individual will be protected. 2) Assesses and initiates the appropriate response, e.g., formal investigation, intervention, or consultation. Ensures that all complaints are accurately recorded. 3) Within 5 work days notifies complainant that complaint has been received and will either be investigated or reason why an investigation is not warranted. Encloses a copy of the complaint. 4) Offers to assist the complainant with the complaint process. 5) Advises the complainant that there are advocacy organizations available to assist in preparation of a written rights complaint, and offers to refer the complainant to those organizations. . 6) In the absence of assistance from an advocacy organization, assists in preparing a written complaint containing a statement of the allegation, the right allegedly violated and the outcome desired by the complainant. 7) Conducts independent investigation of the complaint. 8) If investigation is not completed within each 30 calendar day interval after receiving the complaint, submits a written Status Report to the complainant and respondent including: a) Statement of the allegation(s) b) Statement of issues involved c) Citations of relevant provisions of the Mental Health Code, rules, policies and guidelines d) Investigative progress to date e) Expected date for completion of the investigation. 9) Completes the Report of Investigative Findings, including:

	a) Statement of the allegation(s) b) Statement of issues involved c) Citations of relevant provisions of the Mental Health Code, rules, policies and guidelines d) Investigative findings e) Conclusions f) Recommendations, if any 10) Forwards report and applicable recommendations to the respondent and CMH Director. Requests completion and return of Remedial Action Verification form by date specified to ensure that action has been taken or is planned. 11) Reviews Remedial Action Verification form to determine if remedial actions taken or proposed are appropriate and: a) Correct or provide a remedy for the rights violation(s) b) Are implemented in a timely manner c) Attempt to prevent a recurrence of the rights violation(s). 12) Files the Remedial Action Verification form in the Investigative File. 13) Submits a copy of the Report of Investigative Findings and remedial action taken or proposed the CMH Director along with names and addresses of the complainant, recipient, parent of a minor and guardian.
CMH Director	1) Within ten (10) work days after issuance of the Report of Investigative Findings, submits a Summary Report to the complainant, recipient, parent of a minor and guardian, with a copy also to the Office. The Summary Report shall include: a) Statement of the allegation(s) b) Statement of issues involved c) Citations of relevant provisions of the Mental Health Code, rules, policies and guidelines d) Investigative findings e) Conclusions f) Recommendations, if any g) Action taken or planned by the

	respondent, including specific disciplinary action taken. 2) Advises complainant, recipient, parent of minor and guardian, of: a) Right to appeal. b) Timeline for appeal (no later than 45 days after receipt of the Summary Report). c) Grounds for an appeal as follows: i) Investigative findings of the rights office are not consistent with the facts, law, rules, policies, or guidelines. ii) Action taken or plan of action proposed by the respondent does not provide an adequate remedy. iii) Investigation was not initiated or completed on a timely basis. d) Advocacy organizations available to assist with an appeal, and availability of the Office to assist.

B. Appeals

WHO	DOES WHAT
Recipient Rights Appeals Committee	1) Within 5 work days of receiving the appeal: a) Reviews the appeal to determine if it meets the required criteria. b) If the appeal is denied, notifies appellant in writing, and provides a copy to the respondent, Local Director and the Office. c) If the appeal is accepted, notifies appellant in writing, and provides a copy of the appeal to the respondent, Local Director and the Office. 2) Within 30 days of receipt of a written appeal, meets to make a decision on the appeal and does one of the following:

	a) Upholds the findings of the Office and the action taken or plan of action proposed by respondent. b) Returns the investigation to the Office, requesting that it be reopened or reinvestigated. c) Upholds the investigative findings of the Office but recommends that the respondent take additional or different action to remedy the violation. d) Recommends that the Board request an external investigation by the Department. 3) Documents its decision in writing and within 10 days after reaching its decision, provides copies of the decision to: a) Appellant b) Respondent c) Recipient, parent of minor and legal guardian d) CMH Director e) The Office. 4) Includes a statement of appellant's right to appeal to the Department within 45 days of receipt of decision, only on the grounds that the investigative findings were inconsistent with facts, rules, policies or guidelines.
Appellant	1) Accepts decision or files appeal with the Department within 45 days.

RECIPIENT RIGHTS COMPLAINT

Michigan Department of Health and Human Services

Complaint Number

INSTRUCTIONS:
If you believe that one of your rights has been violated, you (or someone on your behalf) may use this form to make a complaint. A rights officer/advisor will review the complaint and may conduct an investigation. Send this form to the rights office at the Community Mental Health (CMH) or hospital where you are receiving (or received) services at: Enter your agency address here.

Keep a copy for yourself. If you send your complaint to Michigan Department of Health and Human Services, Office of Recipient Rights (MDHHS-ORR), it will be forwarded to the appropriate rights office. The MDHHS-ORR address is: Michigan Department of Health and Human Services, Office of Recipient Rights, Lewis Cass Building, 320 South Walnut Street, Lansing, MI 48933.

Complainant's Name	Recipient's Name (if different from complainant)
Complainant's Address	Where did it occur (name or address of hospital/agency)?
Complainant's Telephone Number	When did the alleged violation occur (indicate date and time)?

What right was violated?

Describe what happened:

What would you like to see happen in order to correct the violation?

Complainant's Signature	Date	Name of person assisting complainant

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	**Authority:** PA 258 of 1974 as amended

Original to ORR
Copy to complainant (with acknowledgement letter)

DCH-0030 (Rev. 4-17) 1

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy and Procedure* *Personal Property and Funds*
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines for the protection of, and access to recipients' personal property and funds.

II. REVISION HISTORY

DATE	MODIFICATION
11/24/2010	Full policy revision
06/03/2013	Template updated
01/13/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be the Regional Approval Date	3 year review No Content Changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that the personal property and funds of recipients shall be protected and accessible during the provision of mental health services.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Personal Funds: Any money that belongs to a recipient.

Personal Property: Any possession that belongs to a recipient.

VI. STANDARDS

A. Recipients are entitled to receive, possess, and use all personal property and funds, except in the circumstances and conditions set forth in this policy.
B. Licensed residential settings shall provide a reasonable amount of storage space to each recipient for clothing and other personal property. The recipient shall be permitted to inspect personal property at reasonable times.

C. Licensed residential settings may implement general restrictions of personal property, including weapons, sharps, explosives, drugs, and alcohol. Any excluded items must be:
    a. Listed in writing.
    b. Conspicuously posted at each residential setting.
    c. Implemented in compliance with CMHPSM policy Limitation of Rights.

D. Individual limitations of personal property may be implemented to prevent:
    a. Theft, loss, or destruction of the property, unless a waiver is signed by the recipient.
    b. Physical harm to the recipient or others.

E. Individual limitations of personal property must be:
    a. Clinically justified and documented in the recipient's record.
    b. Implemented in compliance with CMHPSM policies Limitation of Rights and Behavior Treatment Committee.
    c. Removed when no longer clinically justified.

F. A recipient's property or living area shall not be searched by a provider unless the search is authorized in the recipient's plan of service, or there is reasonable cause to suspect that the recipient is in possession of contraband or property that is excluded from the recipient's possession by written policies, procedures, or rules of the licensed residential provider. The following conditions apply to all searches:
    a. A search of the recipient's living area or property shall occur in the presence of a witness. The recipient shall also be present unless he or she declines.
    b. The circumstances surrounding the search shall be documented in the recipient's record, and shall include the following:
        i. The reason for initiating the search.
        ii. The names of the individuals performing and witnessing the search.
        iii. Any results of the search, including a description of the property seized.

G. A receipt shall be given to a recipient and a recipient's designee for any personal property taken for safekeeping. Any personal property taken for safekeeping shall be returned to the recipient upon discharge from the program.

H. Provider agencies shall promptly reimburse a recipient for any discrepancies in client funds, either from theft or simple error.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code Act 258 of 1974, as amended	X	330.1728, 330.1730
MDHHS Administrative Rules	X	330.7009
CMHPSM Policy: Behavior Treatment Committee	X	
CMHPSM Policy: Limitation of Rights	X	

IX. PROCEDURES

A. Personal Property

WHO	DOES WHAT
Assigned Clinical Staff	1) Based on clinical assessment, determines if an individual limitation of personal property is necessary. Implements any individual limitation in compliance with CMHPSM Policies: Limitation of Rights and Behavior Treatment Committee.
Licensed Residential Service Provider	1) Provides a reasonable amount of storage space for each recipient's clothing and other personal property. 2) Ensures that recipients have unimpeded access to inspect their personal property. 3) May adopt general exclusions of personal property that are: a) Listed in writing. b) Conspicuously posted at service sites. c) Implemented in compliance with CMHPSM Policy: Limitation of Rights.

Licensed Residential Service Provider Non-Licensed Residential Service Provider	1) Implements recipient's Individual Plan of Service, including any individual limitations of personal property. 2) May search a recipient's personal property if there is reasonable cause to suspect that a recipient possesses an item excluded by general or individual limitations. The following conditions must apply: a) The search shall be conducted in the presence of a witness. The recipient shall also be present, unless they decline. b) The circumstances of the search shall be documented in the recipient's record, including the reason for the search, names of staff conducting/witnessing the search, and the results of the search, including any property seized. 3) Provides a receipt to a recipient and a recipient's designee for any personal property taken for safekeeping. Any personal property taken for safekeeping shall be returned to the recipient upon discharge from the program

B. Personal Funds

WHO	DOES WHAT
Assigned Clinical Staff	1) Based on clinical assessment, determines if an individual limitation of personal funds is necessary. Implements any individual limitation in compliance with CMHPSM Policies: Limitation of Rights and Behavior Treatment Committee. 2) In the event that a recipient requires support in the management of their personal funds, ensures that these supports are outlined in the recipient's Individual Plan of Service (IPOS). Monitors the services at the frequency outlined in the IPOS.
Licensed Residential Service Provider Non-Licensed Residential Service Provider	1) Implements recipient's Individual Plan of Service, including any individual limitations of personal funds as applicable.

	2) If providing support with the management of a recipient's personal funds, ensures that the support is provided consistent with any licensing rules (as applicable), laws, agency policy, or other guidelines. 3) Ensures that recipients have maximum control and choice in the use of their funds. 4) Promptly reimburse a recipient for any discrepancies in client funds, either from theft or simple error.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Physical Management and Restraint***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines regarding the use of physical management, restraint, seclusion, and protective devices during the provision of services.

II. REVISION HISTORY

DATE	MODIFICATION
03/05/2010	Full policy revision
05/22/2013	Template updated
01/13/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be the Regional Approval Date	3 year review No content changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that physical management shall only be used in emergent situations to prevent harm to recipients or others.

V. DEFINITIONS

Anatomical Support: The body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient's physical functioning.

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact in order to prevent the recipient from harming himself, herself, or others.

Protective Device: A device or physical barrier used to prevent a recipient from causing serious self-injury associated with documented and frequent behavioral incidents. A protective device as defined and incorporated into the Individual Plan of Service shall not be considered a form of restraint.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Restraint: The use of a physical device to restrict an individual's movement. Restraint does not include the use of a protective device, or a device primarily intended to provide anatomical support.

Seclusion: The temporary placement of a recipient in a room, alone, where egress is prevented by any means. Seclusion does not include the use of time outs or therapeutic de-escalation programs as defined in this policy.

Therapeutic De-escalation – An intervention, the implementation of which is incorporated in the Individual Plan of Service, in which a recipient is placed in an area or room, accompanied by staff who shall therapeutically engage the recipient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

Time Out: A voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.

VI. STANDARDS

A. Physical management may only be used in situations when a recipient is presenting an imminent risk of serious or non-serious physical harm to self or others, and lesser restrictive interventions have been unsuccessful in reducing or eliminating the imminent risk of serious or non-serious harm.

B. Physical management shall not be included as a component in a behavioral treatment plan.

C. Prone immobilization of a recipient for the purpose of behavior control is prohibited unless implementation of physical management techniques other than prone immobilization is medically contradicted and documented in the recipient's record.

D. Restraint and/or seclusion shall not be used by any staff, provider, or directly operated program, except as permitted by state or federal law and agency policy (such as in a contracted inpatient psychiatric hospital or Child Caring Institution).

E. Contracted inpatient settings and child caring institutions utilizing restraint and/or seclusion shall develop and maintain policies regarding their use in compliance with applicable state and federal rules and regulations. Contractual providers shall submit their policies to the local CMHSP Office of Recipient Rights for review as they are developed and as revisions occur.

F. A time-out or therapeutic de-escalation program shall not be considered a form of seclusion.

G. The use of a protective device shall not be considered a form of restraint. The use of a protective device shall be:
   a. Incorporated in the recipient's Individual Plan of Service.
   b. Clinically justified in the recipient's record, including a review of least-restrictive measures.
   c. Implemented in a manner that promotes the safety, welfare, and dignity of the recipient.
   d. Discontinued when no longer necessary to achieve the objective that justified its application.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
Michigan Mental Health Code Act 258 of 1974	X	330.1700, 330.1740
MDHHS Administrative Rules	X	330.7001, 330.7243
CMHPSM Policy: Behavior Treatment Committee	X	

IX. PROCEDURES

A. Physical Management

WHO	**DOES WHAT**
All staff	1) Utilizes physical management only in situations when a recipient is

	presenting an imminent risk of serious or non-serious physical harm to himself, herself or others and lesser restrictive interventions have been unsuccessful in reducing or eliminating the imminent risk of serious or non-serious physical harm. 2) Documents any use of physical management on an Incident Report. 3) Ensures safety, welfare, and dignity of recipient and others.

B. Protective Devices

WHO	DOES WHAT
Assigned Clinical Staff	1) Incorporates use of protective device into recipient's Individual Plan of Service. 2) Ensures that use of a protective device is clinically justified and least restrictive. Documents evidence in recipient's clinical record. 3) Ensures device is utilized in a manner that promotes the safety, welfare, and dignity of the recipient. 4) Discontinues use of safety device when no longer clinically justified.

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy and Procedure* *Recipient Payment for Damage to Property*
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines for recipient responsibility for payment of purposeful damage to property during the provision of services.

II. REVISION HISTORY

DATE	MODIFICATION
04/22/2010	Full policy revision
05/31/2013	Template updated
01/05/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be the Regional Approval Date	3 year review No Content Changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM to promote recipients' assumption of responsibility for purposeful damage of property during the provision of services.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Purposeful damage: Any intentional or deliberate impairment of the usefulness or value of facilities and property.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. Recipients will not be charged for accidental damage to property. Ongoing maintenance funds from program budgets shall be accessed for repairs due to accidental damage.

B. The clinical treatment team, in consultation with the Office of Recipient Rights, as needed, shall make a determination as to the purposeful nature of the action, and the recipient's ability to understand the connection between their action and the damage incurred. In addition, any actions or omissions by staff, which may have contributed to the incident, will be evaluated. A recipient shall not be asked to pay for damages if staff action or omission was a determining factor in the property damage.

C. The clinical treatment team will determine an appropriate charge for the damage. Charges will not exceed the cost of repair or the actual value of the damaged property. Charges will not affect a recipient's ability to meet basic needs. Payment plans may be arranged as appropriate. Any restrictions placed on a recipient's access to funds shall be implemented in compliance with CMHPSM policies Limitation of Rights, Personal Property and Funds, and Behavioral Treatment Committee.

D. Should the recipient not consent to payment, the clinical treatment team shall determine whether it is appropriate for legal charges to be filed. This determination shall be made in consultation with the Office of Recipient Rights.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code Act 258 of 1974	X	
CMHPSM Policy: Behavioral Treatment Committee	X	

CMHPSM Policy: Limitation of Rights	X	
CMHPSM Policy: Personal Property and Funds	X	

IX. PROCEDURES

WHO	DOES WHAT
All Program Staff	1) Maintains familiarity with recipients' Individual Plans of Service/Behavior Plans regarding interventions used to address property destruction. In the event a recipient engages in destructive behavior, intervenes as soon as possible to prevent harm to individuals and property. 2) Ensures that all recipients are safe and that their needs have been addressed. 3) Assesses any property damage. 4) Encourages recipient to assist with cleanup of any debris or damage if appropriate, and if it will not further escalate the recipient, resulting in additional damage. 5) Inventories damaged property. Initiates any immediately needed repairs. 6) Follows emergency and Incident Reporting procedures and any previously identified treatment plan. 7) Notifies Program Supervisor.
Program Supervisor	1) Ensures that all recipients are safe, that their needs have been addressed, and that Incident Reporting procedures have been followed. 2) Informs assigned clinical staff of incident, and notifies them if consideration should be given to assessing recipient with cost of damages. 3) Secures information on costs of repairs/replacement to damaged

	property, and forwards to assigned clinical staff.
Assigned clinical staff	1) Reviews incident, consults with recipient and legal representative, program staff and other professionals to determine appropriateness of assessing recipient for cost of damage. 2) Determines amount recipient will be charged based on the cost of repair or the cost of the damaged item's actual value, with consideration of the recipient's financial resources and appropriateness of staff action during the incident. 3) Consults with the Office of Recipient Rights before making a final determination of recipient costs. 4) Notifies Program Supervisor and recipient of results of review. 5) If recipient agrees to repayment, assists recipient in making payment arrangements. 6) If recipient refuses to make payment, consults with other involved professionals, supervisor and Office of Recipient Rights to determine appropriateness of any additional action. 7) Ensures that recipient is aware of grievance and recipient rights complaint processes.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Religious Freedom and Treatment by Spiritual Means***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines which ensure that recipients are entitled to religious freedom and choice regarding worship, religious activities, and treatment by spiritual means.

II. REVISION HISTORY

DATE	MODIFICATION
04/2020/2010	Full Policy Revision
04/11/2013	Template Update
01/13/2017	Template/References Updated
02/13/2020	3-year review No Content Changes
Will be the Regional Approval Date	3 year review No Content Changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that recipients shall be ensured reasonable access to their choice of religious services, worship, and treatment by spiritual means.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Consent: Consent is defined as either of the following:

1. A written agreement signed by a recipient, unless the recipient has a designated legal representative with authority to execute consent. If the recipient has a designated legal representative, the legal representative must provide written agreement.
2. A verbal agreement of a recipient, unless the recipient has a designated legal representative with authority to execute a consent, that is witnessed and documented by an individual other than the individual providing treatment. If the recipient has a designated legal representative, the legal representative must provide verbal agreement.

   Additionally, consent must include the elements of competency, comprehension, knowledge, and voluntariness.

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Treatment by Spiritual Means: A spiritual discipline or school of thought that a recipient relies on to aid in physical or mental recovery.

VI. STANDARDS

A. Recipients shall have access to treatment by spiritual means upon the request of the recipient or their legal representative.

B. Recipients shall not be coerced into engaging in and/or observing religious activities or events.

C. Recipients shall be provided with the opportunity for contact with agencies providing treatment by spiritual means in the same manner that they have contact with private mental health professionals.

D. Requests for printed, recorded, or visual material essential or related to treatment by spiritual means, and to a symbolic object of similar significance, shall be honored and made available at the recipient's expense.

E. Treatment by spiritual means includes the right of recipients and their legal representatives to refuse medication or other treatment on spiritual grounds that predate the current allegations of mental illness or disability, but does not extend to circumstances where either of the following provisions apply:
   1. A legal representative or the provider has been empowered by a court to consent to or provide treatment and has done so.
   2. A recipient poses harm to himself, herself, or others and treatment is essential to prevent physical injury.

F. The right to treatment by spiritual means does not include the right to any of the following:
   1. To use mechanical devices or chemical/organic compounds that are physically harmful.
   2. To engage in activity prohibited by law.
   3. To engage in activity that physically harms the recipient or others.
   4. To engage in activity that is inconsistent with court-ordered custody or voluntary placement by a person other than the recipient.

G. CMHPSM reserves the right to engage in recourse to a court if a legal representative of a minor or adult recipient refuses to consent to treatment or medication that is determined to be essential.

H. Recipients and their legal representatives shall be informed of any denial of treatment by spiritual means, including the reasons for the denial.

I. A decision to deny a request for treatment by spiritual means may be appealed in writing to the local CMH Director or Designee. Additionally, a complaint may be filed with the Office of Recipient Rights.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code Act 258 of 1974	X	330.1704(2)
MDHHS Administrative Rules	X	330.7001(r), 330.7135
MDHHS Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans	X	3.1.1.1
CMHPSM Policy: Consent to Treatment and Services	X	

IX. PROCEDURES

WHO	DOES WHAT
Assigned Program Staff	1) Ensures that recipients are provided contact with agencies providing treatment by spiritual means in the same manner that they are provided contact with private mental health professionals. 2) If treatment by spiritual means is denied: a) Documents denial and justification in the clinical record. b) Provides notification to recipient and legal representative of denial and reasons for denial. c) Informs recipient and legal representative of their right to appeal denial to CMH Director or designee. d) Informs recipient and legal representative of their right to file a complaint with the Office of Recipient Rights. 3) May seek court-ordered treatment if a minor or adult recipient's legal representative refuses to consent to treatment or medication determined to be essential.

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy and Procedure* *Report and Review of Recipient Death*
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines for the reporting and review of all recipient deaths.

II. REVISION HISTORY

DATE	MODIFICATION
06/04/2010	Full policy revision
05/31/2013	Template updated
01/13/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be the Regional Approval Date	3 year review No Content Changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that all recipient deaths are reviewed for quality of care and recipient rights issues.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. All recipient deaths shall be reviewed for quality of care and recipient rights issues.

B. Data regarding recipient deaths shall be reported to the Michigan Department of Health and Human Services in compliance with their reporting requirements.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
Michigan Mental Health Code Act 258 of 1974	X	330.1778(1)
MDHHS Medicaid Contract	X	
CMHPSM Policy: Confidentiality and Access to Consumer Records	X	
CMHPSM Policy: Office of Recipient Rights	X	
CMHPSM Policy: Critical Incident, Sentinel Event, and Risk Event	X	

IX. PROCEDURES

WHO	**DOES WHAT**
Any staff notified of a recipient death	1) Secures as much information as available regarding the circumstances of the death. 2) Verbally reports death to immediate supervisor, assigned clinical staff, and Office of Recipient Rights, no later than the next business day. 3) Completes an Incident Report by the end of shift.

Assigned Clinical Staff	1) Ensures the following: a) Notification of death to Office of Recipient Rights, Clinical Supervisor, and Department Head, no later than the next business day. b) Completion of an Incident Report. 2) Ensures completion of the Report of Death form. Forwards a copy of the completed form to supervisor for review. 3) Ensures that a final copy of the Report of Death form is forwarded to the Office of Recipient Rights and filed in the recipient's medical record. 4) Ensures that the recipient's medical record is complete, up-to-date, and closed. 5) Ensures notification of guardian/next of kin as appropriate, and in compliance with confidentiality standards.
Clinical Supervisor/Designee	1) Ensures notification of death to Department Head and Office of Recipient Rights, no later than the next business day. 2) Ensures the following: a) Incident Report has been accurately completed. b) Report of Death has been accurately completed, filed in the medical record, and forwarded to the Office of Recipient Rights. c) Recipient's medical record is complete, up-to-date, and closed. d) Notification of next of kin, in compliance with confidentiality standards. 3) Consults with the CMH Director to determine if any additional action is necessary, including Adverse Event or Sentinel Event review.

Local CMH Director	1) Determines if any additional action is necessary, including Adverse Event or Sentinel Event Review. 2) Coordinates, or designates coordination, of additional action as appropriate.
Recipient Rights Officer	1) Conducts and documents a review of all recipient deaths, including review of the medical record and Report of Death form. 2) Forwards copy of the Recipient Rights death review to: a) CMH Director b) Department Head c) Medical Director 3) In the event that staff action/lack of action may have contributed to the recipient's death, or if there is an appearance of a lapse in quality of care, conducts an investigation in compliance with CMHPSM Policy: Office of Recipient Rights. 4) In the event that an investigation is completed in response to a recipient's death, the Investigative Report shall take the place of the Recipient Rights death review. A copy of the report shall be forwarded to: a) CMH Director b) Department Head c) Medical Director
Designated PIHP Staff	1) Ensures accurate reporting of deaths to the Michigan Department of Health and Human Services, in compliance with their data reporting requirements.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Right to Entertainment Materials, Information and News***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines which ensure that recipients have access to reading, viewing and listening material of their choice.

II. REVISION HISTORY

DATE	MODIFICATION
02/09/2010	Full policy revision
05/31/2013	Template Updated
01/13/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be the Regional Approval Date	3 year review Made language consistent

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that recipients shall have access to reading, viewing, and listening materials of their choice.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Consent: Consent is defined as either of the following:

1. A written agreement signed by a recipient, unless the recipient has a designated legal representative with authority to execute consent. If the recipient has a designated legal representative, the legal representative must provide written agreement.
2. A verbal agreement of a recipient, unless the recipient has a designated legal representative with authority to execute a consent, that is witnessed and documented by an individual other than the individual providing treatment. If the recipient has a designated legal representative, the legal representative must provide verbal agreement.

Additionally, consent must include the elements of competency, comprehension, knowledge, and voluntariness (see Consent to Treatment and Services Policy).

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. A recipient shall not be prevented from obtaining reading/viewing/listening material at his/her expense for reasons of, or similar to, censorship.

B. A recipient's access to entertainment materials, information, or news shall not be limited unless specifically approved in the recipient's Individual Plan of Service.

C. Each instance of a limitation shall be:
    1. Clinically justified and documented in the recipient's record.
    2. Implemented in compliance with CMHPSM policies Limitation of Rights and Behavior Treatment Committee.
    3. Removed when no longer clinically justified.

D. Material not prohibited by law may be read or viewed by a minor recipient, unless there is objection by the minor recipient's legal representative. Staff may attempt to

persuade a minor's legal representative to withdraw objection to material desired by the minor, as allowable by law.

E. Licensed residential providers may impose general restrictions on access to material if necessary for the safety and welfare of the group as a whole, or for the therapeutic benefit of the group. Any general restrictions shall be implemented in accordance with CMHPSM policy Limitation of Rights.

F. Licensed residential providers shall determine recipients' interest in a daily newspaper, and ensure access to a newspaper as applicable.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
CMHPSM Policy: Behavior Treatment Committee	X	
CMHPSM Policy: Limitation of Rights	X	
MDHHS Administrative Rules	X	330.7139
Joint Commission- Behavioral Health Standards	X	
MDHHS Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans	X	3.1.1.1
CMHPSM Policy: Consent to Treatment and Services	X	

IX. PROCEDURES

WHO	DOES WHAT
Licensed Residential Services Provider	1) Does not censor or limit recipients' access to entertainment materials of their choice any more than consented to in the Individual Plan of Service. 2) Considers recipient interest in providing newspapers and other reading, viewing and listening material. 3) Provides for a daily newspaper upon expressed interest and request.

	4) Ensures that all general restrictions are implemented in compliance with CMHPSM policy: Limitation of Rights.
Non-Licensed Residential Services Provider	1) Does not censor or limit recipients' access to entertainment materials of their choice any more than consented to in the Individual Plan of Service. 2) Considers recipient interest in providing newspapers and other reading, viewing and listening material.
Clinical Treatment Team	1) Ensures that any individual limitations are implemented in compliance with CMHPSM policies: Limitation of Rights and Behavior Treatment Committee. 2) Ensures that individual limitations are removed when no longer clinically justified. 3) May consult with a minor recipient's legal representative regarding objections that they may have made to reading, listening or viewing material which is desired by the minor. However, the right of access shall not entitle a minor to obtain and keep written material, or to view television programs or movies, over the objection of minor's legal representative, or if prohibited by law.
CMH Supervisor/Director/Designee	1) Reviews recipients' written or verbal appeals of limitations of access to entertainment materials. 2) Ensures that wrongful limitations of recipients' access to entertainment materials are remedied.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Services Suited to Condition***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines for the development of an Individual Plan of Service that will ensure that each recipient receives services suited to his or her condition.

II. REVISION HISTORY

DATE	MODIFICATION
05/07/2010	Full policy revision
06/03/2013	Template updated
01/05/2017	Template Updated
02/13/2020	3-year review No Content Changes
Will be the Regional Approval Date	3 year review No Content Changes

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that all recipients shall receive services suited to their condition, and that these services are provided in a safe, sanitary, and humane treatment environment.

V. DEFINITIONS

Applicant: An individual or his or her legal representative who makes a request for mental health services.

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Humane: Characterized by kindness, mercy or compassion.

Individual Plan of Service: A written individualized plan of service developed with a recipient as required by section 712 of the Mental Health Code.

Legal Representative: A legal representative is defined as any of the following:

1. A court-appointed guardian,
2. A parent with legal custody of a minor recipient,
3. In the case of a deceased recipient, the executor of the estate or court-appointed personal representative,
4. A patient advocate under a durable power of attorney or other advanced directive.

Person-centered planning: A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Support plan: A written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.

Treatment plan: A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services that are to be developed with and provided for a recipient.

VI. STANDARDS

A. A person-centered planning process shall be used to develop a written Individual Plan of Service in partnership with each recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release.

B. The Individual Plan of Service shall consist of a treatment plan, support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient.

C. The Individual Plan of Service shall assess and address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care,

employment opportunities, educational opportunities, legal services, transportation, and recreation.

D. The Individual Plan of Service shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.

E. The Individual Plan of Service shall identify a specific date or dates when the overall plan and any of its subcomponents will be reviewed for possible modification or revision.

F. Recipients shall receive verbal and written notice of their clinical status and progress at reasonable intervals established in the Individual Plan of Service, and in a manner that is clinically appropriate.

G. If a recipient is not satisfied with their Individual Plan of Service, the recipient or their legal representative may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the governing body.

H. An individual may be excluded from participation in the person-centered planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient, or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the clinical record.

I. A comprehensive assessment/analysis shall be conducted if a recipient exhibits challenging behaviors.

J. The Individual Plan of Service shall identify any restrictions or limitations of the recipient’s rights. This shall include documentation of attempts to avoid such restrictions, as well as action that will be taken to eliminate the need for future restrictions.

K. Restrictions, limitations, or any intrusive behavior management techniques shall be reviewed by a formally constituted committee of mental health professionals with specific knowledge, training, and expertise in applied behavioral analysis. This shall occur in compliance with CMHPSM Policy: Behavior Treatment Committee.

L. A recipient shall be given a choice of physician or other mental health professional within the limits of available staff.

M. If an applicant for community mental health services has been denied mental health services, the applicant or their legal representative may request a second opinion of the Executive Director. The Executive Director shall secure the second opinion from a physician, licensed psychologist, registered professional nurse, master's level social worker, or master's level psychologist. If the individual providing the second opinion determines that the applicant has a serious mental illness, serious emotional disturbance, developmental disability, or is experiencing an emergency situation or urgent situation, the community mental health services program shall direct services to the applicant.

N. Individuals requesting admission to a hospital under contract with the local CMH shall be informed of their right to request a second opinion from the Executive Director if hospitalization is denied. The Executive Director shall arrange for a second opinion by a psychiatrist, other physician, or licensed psychologist within three days, excluding Sundays and holidays. If the conclusion of the second opinion is different from the original opinion, the Executive Director, with the Medical Director, shall make a decision based on all clinical information available within one business day. The Executive Director's decision shall be confirmed in writing to the individual who requested the second opinion, and the confirming document shall include the signature of the Executive Director and Medical Director or verification that the decision was made in conjunction with the Medical Director. If an individual is assessed and found not to be clinically suitable for hospitalization, appropriate referral services shall be provided.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
Michigan Mental Health Code Act 258 of 1974	X	330.1100, 330.1700, 330.1712, 330.1713, 330.1714
MDHHS Administrative Rules	X	330.7199
Michigan Medicaid Provider Manual	X	Chapter 3, Section 3
CMHPSM Policy: Behavior Treatment Committee	X	

IX. PROCEDURES

None

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure*** ***Work Performed by Recipients***
Committee/Department: **Recipient Rights**	**Local Policy Number (if used)**
Implementation Date **(2 weeks from Regional Approval Date)**	**Regional Approval Date** **(date of last CMH board's approval)**

Reviewed by:	**Recommendation Date:**
ROC	08/09/2023
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

The purpose of this policy is to establish guidelines regarding the performance of labor by recipients in residential settings and vocational services.

II. REVISION HISTORY

DATE	MODIFICATION
04/20/2010	Full policy revision
04/29/2013	Template updated
01/05/2017	Template Update
02/13/2020	Standards update 3-year review
Will be the Regional Approval Date	3 year review Typos corrected

III. APPLICATION

☒ CMHPSM PIHP Staff, Board Members, Interns & Volunteers
☒ Regional Partner CMHSP Staff, Board Members, Interns & Volunteers
Service Providers of the CMHPSM and/or Regional CMHSP Partners:
☒ Mental Health / Intellectual or Developmental Disability Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. POLICY

It is the policy of the CMHPSM that the performance of labor by recipients, whether paid or unpaid, shall be voluntary.

V. DEFINITIONS

Community Mental Health Partnership Of Southeast Michigan (CMHPSM): The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

VI. STANDARDS

A. The performance of labor by recipients, whether paid or unpaid, shall be voluntary.

B. Recipients shall be compensated appropriately and in accordance with federal and state labor laws when performing labor which results in an economic benefit to another person or organization.

C. A recipient may perform volunteer activities on behalf of an organization with a recognized volunteer program.

D. A recipient shall not be paid for performing their own personal housekeeping chores, except as indicated in the recipient's Individual Plan of Service.

E. A recipient may perform labor that contributes to the operation and maintenance of the residential facility for which the facility would otherwise employ someone only if all of the following apply:
   a. The recipient voluntarily agrees to perform the labor.
   b. Engaging in the labor would not be inconsistent with the recipient's Individual Plan of Service.
   c. The amount of time or effort necessary to perform the labor would not be excessive
   d. In no event is discharge or privileges conditioned upon the recipient's performance of the labor.
   e. The recipient is compensated appropriately and in accordance with federal and state labor laws.

F. One-half of any compensation to a recipient for work performed shall be exempt from collection as payment for mental health services.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code Act 258 of 1974	X	330.1736
MDHHS Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans	X	

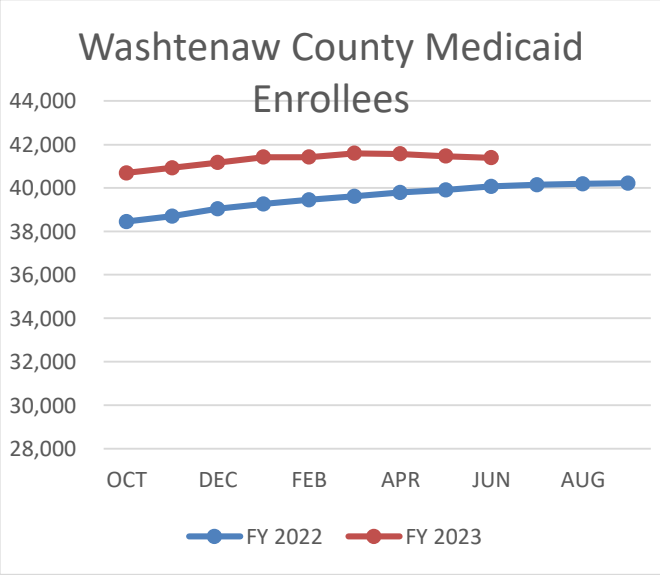
IX. PROCEDURES

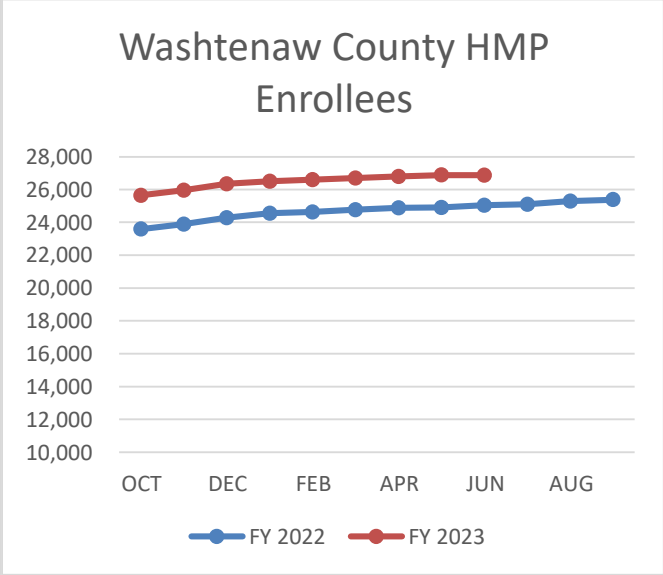
WHO	DOES WHAT
Client Services Manager/Supports Coordinator	1) Ensures that recipient voluntarily agrees to perform the labor. 2) Ensures that labor performed by a recipient is consistent with both the therapeutic needs of the recipient and the dignity to which a recipient is entitled. 3) Ensures that the recipient's preferences regarding labor are addressed in the Individual Plan of Service, if applicable. 4) Ensures that the number of hours worked by the recipient is in compliance with all known and applicable labor laws and regulations. 5) Ensures that recipient's labor does not interfere with other ongoing treatment or habilitation programs.
Local Director/Designee	1) Ensures that compensation for a recipient's labor is made in accordance with applicable federal and state laws.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
YEAR-TO-DATE FINANCIAL STATUS
FISCAL YEAR 2023: For the period ending June 30, 2023
Prepared: August 7, 2023

1. Washtenaw County Enrollees

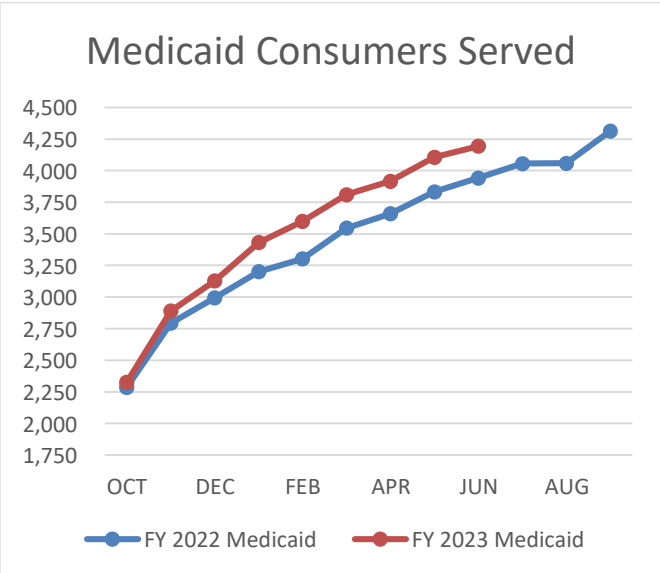
A summary of FY 2023 Washtenaw County Medicaid and Healthy Michigan Enrollees is shown below:

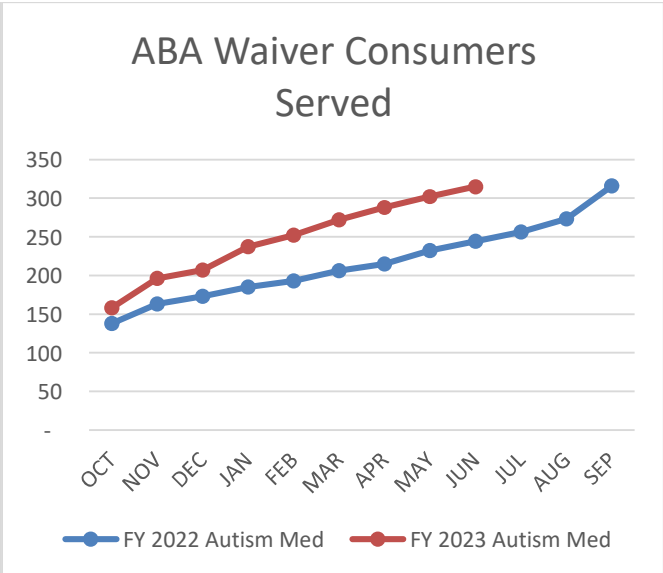




Washtenaw County Medicaid Enrollees were 41,385 in June 2023. This is a 3.29% increase from the same time last year (1,317 more enrollees than in June 2022). Healthy Michigan enrollment in June 2023 was 26,864. This is a 7.30% increase from the same time last year (1,828 more enrollees than in June 2022).

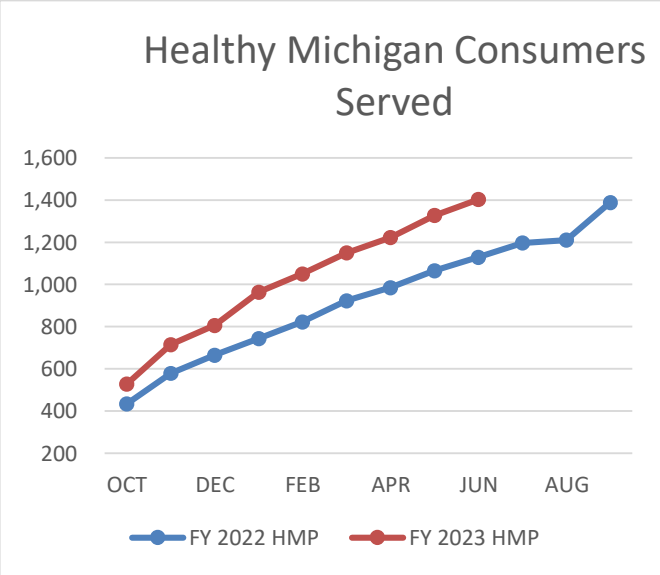
2. WCCMH Consumers Served to Date

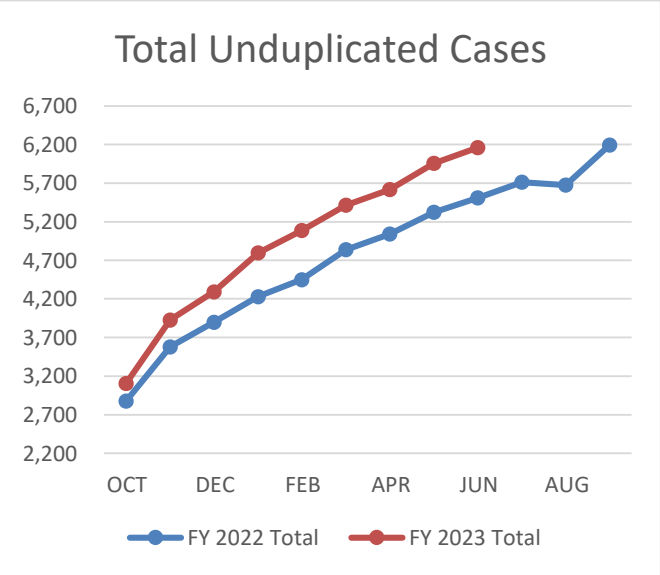




Medicaid consumers served through June 2023 are 4,195. This is 254 more consumers than the prior year (3,941 consumers were served through June 2022).

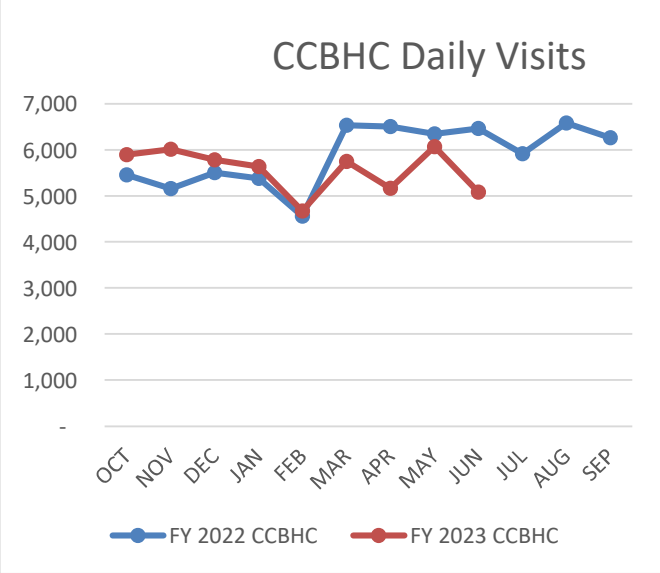
ABA Waiver consumers served through June 2023 are 315. This is 71 more consumers than prior year (244 consumers were served through June 2022).

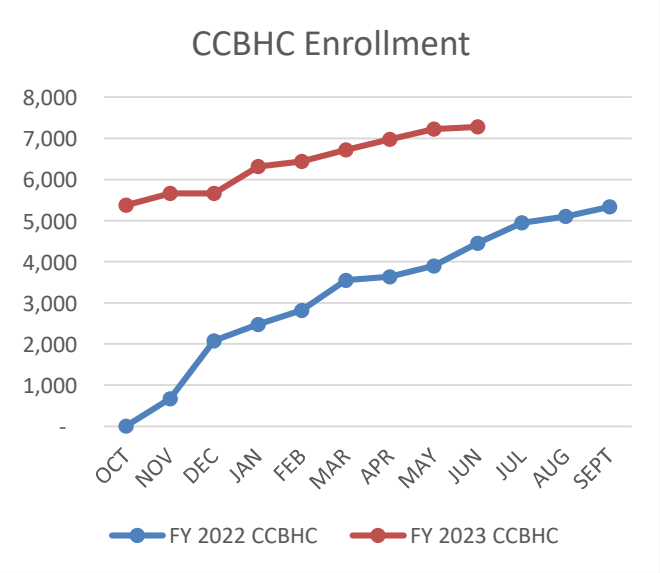




Healthy Michigan consumers served through June 2023 were 1,403. This is 273 more consumers than the same period last year.

The total unduplicated consumers served by WCCMH through June 2023 were 6,160. This is 649 more consumers than served last year.





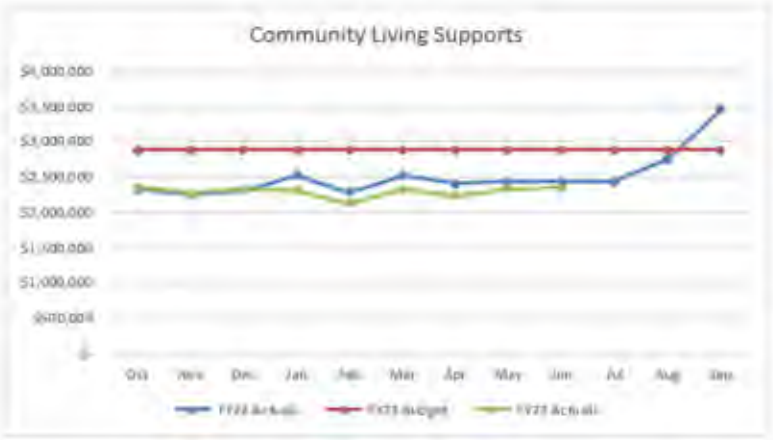
The CCBHC daily visit count for June 2023 were 5,085.

The YTD CCBHC Enrollment for FY 2023 as of June was 7,282.

3. Financial Statement Highlights

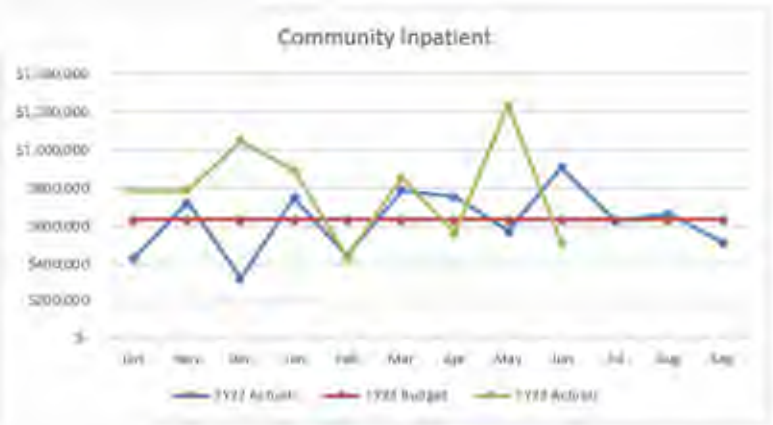
a. CLS service costs to date are estimated to be $21.4 Million. The costs year to date are 1.29% more than this time last year. A 5% increase to CLS rates has been implemented as of 10/1/2022.

	FY22 Actuals	FY23 Budget	FY23 Actuals	YTD % Change
Oct	$ 2,325,336	2,883,333	$ 2,349,683	1.05%
Nov	2,240,096	2,883,333	2,268,391	1.15%
Dec	2,317,212	2,883,333	2,325,087	0.88%
Jan	2,524,996	2,883,333	2,316,463	-1.57%
Feb	2,285,682	2,883,333	2,127,806	-2.62%
Mar	2,529,180	2,883,333	2,324,151	-3.59%
Apr	2,406,148	2,883,333	2,231,213	-4.12%
May	2,431,396	2,883,333	2,339,572	-4.08%
Jun	2,431,870	2,883,333	2,357,899	-3.96%
Jul	2,436,133	2,883,333		
Aug	2,746,122	2,883,333		
Sep	3,451,817	2,883,333		



b. Community Inpatient costs to date are $7.0 Million. The costs year to date are 25.17% more than this time last year and $1.4 Million over budget.

	FY22 Actuals	FY23 Budget	FY23 Actuals	YTD % Change
Oct	$ 428,747	$ 629,167	$ 783,838	82.82%
Nov	719,608	629,167	786,506	36.75%
Dec	318,967	629,167	1,046,711	78.36%
Jan	745,851	629,167	890,910	58.50%
Feb	438,634	629,167	428,822	48.46%
Mar	785,399	629,167	851,148	39.30%
Apr	751,136	629,167	558,658	27.65%
May	572,488	629,167	1,233,470	38.21%
Jun	904,625	629,167	511,519	25.17%
Jul	624,231	629,167		
Aug	661,279	629,167		
Sep	508,767	629,167		



c. Licensed Residential costs to date are $12.4 Million and $7,000 over budget. The costs year to date are 6.21% more than this time last year. A 5% increase was implemented as of 10/1/2022 for local providers.

	FY22 Actuals	FY23 Budget	FY23 Actuals	YTD % Change
Oct	$ 1,386,550	$ 1,383,333	$ 1,348,498	-2.74%
Nov	1,038,733	1,383,333	1,351,230	11.32%
Dec	1,304,777	1,383,333	1,371,021	9.13%
Jan	1,429,675	1,383,333	1,456,672	7.13%
Feb	1,325,725	1,383,333	1,244,640	4.42%
Mar	2,048,936	1,383,333	1,466,361	-3.47%
Apr	1,451,576	1,383,333	1,292,818	-4.55%
May	1,437,448	1,383,333	1,529,546	-3.17%
Jun	1,454,128	1,383,333	1,396,384	-3.26%
Jul	1,995,132	1,383,333		
Aug	2,141,085	1,383,333		
Sep	1,952,399	1,383,333		

d. Applied Behavior Analysis/Autism service costs to date are $7.5 Million. The costs year to date are 47.39% more than this time last year and $1.7 Million over budget.

	FY22 Actuals	FY23 Budget	FY23 Actuals	YTD % Change
Oct	$ 602,553	$ 641,667	$ 648,805	7.68%
Nov	479,479	641,667	694,140	24.11%
Dec	534,172	641,667	765,065	30.43%
Jan	580,372	641,667	776,181	31.30%
Feb	453,979	641,667	737,877	36.65%
Mar	672,143	641,667	939,566	37.29%
Apr	674,225	641,667	948,251	37.85%
May	587,988	641,667	939,851	40.67%
Jun	508,069	641,667	1,056,440	47.38%
Jul	670,422	641,667		
Aug	643,331	641,667		
Sep	658,111	641,667		

e. Internal staffing expenses are trending under budget due to the difficulty recruiting for budgeted vacant positions.

4. PIHP Revenue Key Points

a. Medicaid, CCBHC and Healthy Michigan Plan revenues are collected from the PIHP.
b. By funding source, Medicaid and CCBHC is showing a surplus of $3,830,603 through June.
c. By funding source, HMP is showing a surplus of $286,627 through June.
d. Overall, the PIHP surplus is $6,194,592 through June.

5. State General Fund Key Points

a. General Fund programs and funding redirected to other Risk-Based programs is showing a surplus of $1,747,527.

6. Local Key Points

a. The majority of Local Funding comes from Washtenaw County.

b. Local Funds are showing a surplus of $278,327 through June.

c. Uses of Local Funding include:

i. The 10% GF Match of non-residential services
ii. Local contribution – required by MDHHS
iii. Local share for State Facilities
iv. Shelter expenses and other Local needs

7. Fund Balance

WCCMH currently has no fund balance available for fiscal year 2023.

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
JUNE 2023 FYTD

		Total
Medicaid **		
Revenue		
B & B3	$	43,389,711
HSW		20,653,594
DCW		-
Behavioral Health Home		281,994
Child Waiver/SED Waiver		875,514
Autism		4,856,546
Prior Year Adjustments		-
Care for Caid		169,318
Total Medicaid Revenue	$	70,226,678
Total Medicaid Expense	$	55,100,811
Medicaid Surplus/(Deficit)	$	15,125,867
CCBHC **		
Supplmental Revenue	$	5,754,818
CCBHC Non-Medicaid Expense	$	948,440
CCBHC HMP Expense		3,013,497
CCBHC Medicaid Expense		13,088,145
Total CCBHC Expense	$	17,050,082
CCBHC Surplus/(Deficit)	$	(11,295,264)
Healthy Michigan **		
Revenue	$	5,184,458
Expense		4,897,830
Healthy MI Surplus/(Deficit)	$	286,627
General Fund		
Revenue		
CMH Operations	$	3,448,251
CMH Operations Contra		-
GF Carryforward		211,753
Categorical		-
Redirect To Injectable Meds.		-
Funding Fr. Other Local Sources		(4,262)
Total General Fund Revenue	$	3,655,742
Total General Fund Expense	$	1,908,215
General Fund Surplus/(Deficit)	$	1,747,527

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
JUNE 2023 FYTD

		Total
Injectable Meds		
Revenue	$	113,312
Expense		74,233
Inj. Meds. Surplus/(Deficit)	$	39,079
Grants And Contracts		
Revenue	$	1,231,538
Expense		1,231,538
Grants & Cont. Surplus/(Deficit)	$	-
CMHSP To CMHSP		
Revenue	$	749,544
Redirect to GF		(48,301)
Expense		701,243
CMHSP to CMHSP Surplus/(Deficit)	$	-
Local		
Revenue	$	1,276,109
Expense		997,782
Local Surplus/(Deficit)	$	278,327
Private Grant & All NOR		
Revenue	$	72,289
Expense		59,860
Priv. Grant & NOR Surplus/(Deficit)	$	12,429
Grand Total		
Revenue	$	88,259,619
Expense		82,065,027
Grand Total Surplus/(Deficit)	$	6,194,592

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit)	$	4,156,309
WCCMH Surplus/(Deficit)		2,038,283
	$	6,194,592

Washtenaw County Community Mental Health
Budget to Actuals
For Nine Months Ending June 30, 2023

	Current Fiscal Year				
	FY 2023 Approved Budget	FY 2023 Approved Budget YTD	FY 2023 YTD Actuals	YTD Actuals Over/(Under) YTD Budget	% O(U)
Operating Revenue					
PIHP Revenue					
Medicaid Capitation:					
Medicaid (b) & 1115i	$ 48,979,046	$ 36,734,285	$ 43,389,711	$ 6,655,427	18.12%
HSW	30,058,737	22,544,053	20,653,594	(1,890,459)	-8.39%
Children & SED Waivers	1,200,000	900,000	918,948	18,948	2.11%
Healthy Michigan Capitation	6,913,368	5,185,026	5,184,458	(568)	-0.01%
Autism Capitation	6,475,395	4,856,546	4,856,546	(0)	0.00%
Direct Care Worker Pass-Through	9,263,483	6,947,612	-	(6,947,612)	-100.00%
CCBHC Supplementary	4,059,000	3,044,250	5,754,818	2,710,568	89.04%
Behavioral Health Home	-	-	281,994	281,994	0.00%
TOTAL PIHP Revenue	$ 106,949,029	$ 80,211,772	$ 81,040,069	$ 828,297	1.03%
MDHHS Revenue					
State General Funds	$ 4,597,669	$ 3,448,252	$ 3,660,004	$ 211,752	6.14%
Grants & Earned Contracts	1,790,168	1,342,626	1,223,238	(119,388)	-8.89%
All Other Revenue					
County Appropriation	$ 1,751,761	$ 1,313,821	$ 419,166	$ (894,655)	-68.10%
Project Revenue	847,984	635,988	431,399	(204,589)	-32.17%
All Other	1,917,652	1,438,239	2,368,913	930,674	64.71%
TOTAL Operating Revenue	**$ 117,854,263**	**$ 88,390,697**	**$ 89,142,789**	**$ 752,092**	0.85%
Operating Expenses					
Administrative Expenses					
General Administration	$ 7,733,373	$ 5,800,030	$ 5,382,864	$ (417,166)	-7.19%
Program Administration	4,150,194	3,112,646	2,732,497	(380,149)	-12.21%
Residential Services					
Community Living Supports	$ 34,600,000	$ 25,950,000	$ 21,478,830	$ (4,471,170)	-17.23%
Licensed Residential	16,600,000	12,450,000	12,457,170	7,170	0.06%
Outpatient Services					
Autism Services	$ 7,700,000	$ 5,775,000	$ 7,506,315	$ 1,731,315	29.98%
Case Management	5,750,761	4,313,071	3,632,879	(680,192)	-15.77%
Supports Coordination	3,243,708	2,432,781	2,054,132	(378,649)	-15.56%
Skill Building	5,004,548	3,753,411	2,908,894	(844,517)	-22.50%
Supported Employment	1,556,862	1,167,647	1,288,084	120,438	10.31%
Psychiatry	4,134,073	3,100,555	3,060,779	(39,776)	-1.28%
Nursing Services	2,659,925	1,994,944	1,722,142	(272,802)	-13.67%
Therapy Services	2,758,751	2,069,063	1,796,169	(272,894)	-13.19%
All Other	11,339,062	8,504,297	7,749,161	(755,136)	-8.88%
Other Expenses					
Community Inpatient	$ 7,550,000	$ 5,662,500	$ 7,091,582	$ 1,429,082	25.24%
Local Matches & Shelter	1,282,838	962,129	917,733	(44,396)	-4.61%
Grants & Earned Contracts	1,790,168	1,342,626	1,168,966	(173,660)	-12.93%
TOTAL Operating Expenses	**$ 117,854,263**	**$ 88,390,697**	**$ 82,948,197**	**$ (5,442,500)**	-6.16%
Revenue Over/(Under) Expenses	-	-	6,194,592	6,194,592	

Washtenaw County Community Mental Health
Budget to Actuals
For Nine Months Ending June 30, 2023

	Prior Year Comparison			
	FY 2023 YTD Actuals	FY 2022 Prior YTD Actuals	YTD Actuals Over/(Under) Prior YTD Actuals	% O(U)
Operating Revenue				
PIHP Revenue				
Medicaid Capitation:				
Medicaid (b) & 1115i	$ 43,389,711	$ 35,118,937	$ 8,270,774	23.55%
HSW	20,653,594	19,679,724	973,870	4.95%
Children & SED Waivers	918,948	1,336,265	(417,317)	-31.23%
Healthy Michigan Capitation	5,184,458	4,713,662	470,796	9.99%
Autism Capitation	4,856,546	4,415,042	441,504	10.00%
Direct Care Worker Pass-Through	-	6,015,249	(6,015,249)	0.00%
CCBHC Supplementary	5,754,818	3,015,897	2,738,921	0.00%
Behavioral Health Home	281,994	-	281,994	0.00%
TOTAL PIHP Revenue	$ 81,040,069	$ 74,294,776	$ 6,745,293	9.08%
MDHHS Revenue				
State General Funds	$ 3,660,004	$ 3,369,909	$ 290,095	8.61%
Grants & Earned Contracts	1,223,238	1,194,939	28,299	2.37%
All Other Revenue				
County Appropriation	$ 419,166	$ 869,570	$ (450,404)	-51.80%
Project Revenue	431,399	553,948	(122,549)	-22.12%
All Other	2,368,913	1,807,287	561,626	31.08%
TOTAL Operating Revenue	**$ 89,142,789**	**$ 82,090,429**	**$ 7,052,360**	8.59%
Operating Expenses				
Administrative Expenses				
General Administration	$ 5,382,864	$ 4,705,582	$ 677,282	14.39%
Program Administration	2,732,497	3,208,521	(476,024)	-14.84%
Residential Services				
Community Living Supports	$ 21,478,830	$ 21,206,129	$ 272,701	1.29%
Licensed Residential	12,457,170	11,728,288	728,882	6.21%
Outpatient Services				
Autism Services	$ 7,506,315	$ 5,092,979	$ 2,413,336	47.39%
Case Management	3,632,879	3,191,686	441,193	13.82%
Supports Coordination	2,054,132	1,722,834	331,298	19.23%
Skill Building	2,908,894	2,735,162	173,732	6.35%
Supported Employment	1,288,084	1,095,339	192,745	17.60%
Psychiatry	3,060,779	2,305,373	755,406	32.77%
Nursing Services	1,722,142	1,629,226	92,916	5.70%
Therapy Services	1,796,169	1,379,287	416,882	30.22%
All Other	7,749,161	6,043,870	1,705,291	28.22%
Other Expenses				
Community Inpatient	$ 7,091,582	$ 5,665,456	$ 1,426,126	25.17%
Local Matches & Shelter	917,733	962,548	(44,815)	-4.66%
Grants & Earned Contracts	1,168,966	1,165,189	3,777	0.32%
TOTAL Operating Expenses	**$ 82,948,197**	**$ 73,837,469**	**$ 9,110,728**	12.34%
Revenue Over/(Under) Expenses	6,194,592	8,252,960	(2,058,368)	

Washtenaw County Community Mental Health - Millage Advisory Committee
Millage Financial Update - For Six Months Ending June 30, 2023

	Budget to Actuals				Commitments		
	Annual Budget	Budget YTD	Actuals YTD	Actuals YTD Over/(Under) Budget YTD	Committed Current Fiscal Year	Remaining Uncommitted Current Fiscal Year	Committed FY 2024
Community Wide Service Expansion							
CARES Team							
Access & Triage	$ 577,500	$ 288,750	$ 289,508	$ 758	$ 577,500	$ -	$ 606,375
Treatment & Stabilization Services	577,500	288,750	282,115	(6,635)	577,500	-	606,375
Crisis Response	787,500	393,750	374,152	(19,598)	787,500	-	826,875
Crisis Stabilization Center	367,500	183,750	162,999	(20,751)	367,500	-	385,875
Other CARES Team	417,480	208,740	208,647	(93)	417,480	-	438,354
Criminal Justice Diversion & Deflection							
WCCMH Staffing - LEADD/Jail Services	$ 450,000	$ 225,000	$ 156,009	$ (68,991)	$ 400,000	$ 50,000	$ 450,000
Prosecutting Attorney Office	$ 122,779	$ 61,390	49,050	$ (12,340)	$ 122,779	$ -	$ 127,690
Supportive Housing							
Supportive Housing RFP	$ 400,000	$ 200,000	$ 200,000	$ -	$ 400,000	$ -	$ -
Supportive Housing Other	460,000	230,000	150,000	(80,000)	460,000	-	70,000
Avalon - Permanent Supportive Housing	180,000	90,000	90,000	-	180,000	-	180,000
Emergency Housing	50,000	25,000	39,716	14,716	50,000	-	50,000
Youth Initiatives and Support							
Washtenaw Intermediate School District	$ 940,716	$ 470,358	$ 192,849	$ (277,509)	$ 940,716	$ -	$ 795,843
Student Advocacy Center	193,643	96,822	96,821	(1)	193,643	-	-
Health Dept - Anti Stigma Campaign	170,000	85,000	21,543	(63,457)	170,000	-	56,667
WCCMH - Wraparound Staff	95,000	47,500	39,541	(7,959)	95,000	-	100,000
Other Youth Initiatives and Support	350,000	175,000	31,250	(143,750)	140,000	210,000	-
Other Service Expansion							
Washtenaw Health Plan	$ 165,000	$ 82,500	$ 82,500	$ -	$ 165,000	$ -	$ 165,000
Other	250,000	125,000	-	$ (125,000)	125,000	125,000	-
TOTAL Community Wide Service Expansion	$ 6,554,618	$ 3,277,309	$ 2,466,700	$ (810,609)	$ 6,169,618	$ 385,000	$ 4,859,054

	Budget to Actuals				Commitments		
	Annual Budget	Budget YTD	Actuals YTD	Actuals YTD Over/(Under) Budget YTD	Committed Current Fiscal Year	Remaining Uncommitted Current Fiscal Year	Committed FY 2024
Education & Prevention							
Education & Outreach							
NAMI Contract	$ 169,425	$ 84,713	$ 84,713	$ 1	$ 169,425	$ -	$ 169,425
MHFA Trainings	25,000	12,500	-	(12,500)	25,000	-	25,000
TOTAL Education & Prevention	$ 194,425	$ 97,213	$ 84,713	$ (12,500)	$ 194,425	$ -	$ 194,425
Evaluate & Communicate							
Evaluate							
CHRT Contract	$ 51,970	$ 25,985	$ 19,716	$ (6,269)	$ 51,970	$ -	$ -
Communicate							
CHRT Contract	$ 261,890	$ 130,945	$ 188,986	58,041	$ 261,890	$ -	$ -
TOTAL Evaluation & Communication	$ 313,860	$ 156,930	$ 208,702	$ 51,772	$ 313,860	$ -	$ -
Administration of the Millage							
WCCMH	$ 555,000	$ 277,500	$ 283,479	$ 5,979	$ 540,000	$ -	$ 555,000
CHRT Contract	150,000	75,000	37,186	(37,814)	140,000	-	150,000
Grand Totals	**$ 7,767,903**	**$ 3,883,952**	**$ 3,080,780**	**$ (803,172)**	**$ 7,357,903**	**$ 385,000**	**$ 5,758,479**

Washtenaw County Community Mental Health
WCCMH

Fiscal Year 2024
Annual Operating Budget

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget

	FY 2024 Proposed Budget	FY 2023 Final Budget	FY 2024 Budget Over / (Under) FY 2023 Budget	FY 2023 Projected YE	FY 2024 Budget Over / (Under) FY 2023 Projections
Revenues					
Medicaid (b) & 1115i	$ 50,222,609	$ 48,979,046	$ 1,243,563	$ 48,979,046	$ 1,243,563
Habilitation Supports Waiver	30,015,227	30,058,737	(43,510)	30,058,737	(43,510)
Children's & SED Waivers	1,335,478	1,200,000	135,478	1,200,000	135,478
Direct-Care Worker Pass-Through	-	9,263,483	(9,263,483)	9,263,483	(9,263,483)
Healthy Michigan Plan	6,155,256	6,913,368	(758,112)	6,913,368	(758,112)
Autism Medicaid	6,819,980	6,475,395	344,585	6,475,395	344,585
CCBHC Medicaid/HMP	8,500,000	-	8,500,000	-	8,500,000
CCBHC Supplementary	8,500,000	4,059,000	4,441,000	4,059,000	4,441,000
Behavioral Health Home	390,000	-	390,000	-	390,000
State General Funds	4,597,669	4,597,669	-	4,597,669	-
Funding From Washtenaw County	1,751,761	1,751,761		1,751,761	-
Grants and Earned Contracts Incl. OBRA	3,100,646	1,790,168	1,310,478	1,790,168	1,310,478
CMHPSM/Affiliate & U of M Billings	893,227	847,984	45,243	847,984	45,243
All Other	1,917,652	1,917,652	-	1,917,652	-
Total Revenues	**$ 124,199,505**	**$ 117,854,263**	**$ 6,345,242**	**$ 117,854,263**	**$ 6,345,242**
Expenses					
Administrative Expenses					
WCCMH Administration	$ 8,329,146	$ 7,733,373	$ 595,773	$ 6,755,000	$ 1,574,146
Total Administrative Expenses	$ 8,329,146	$ 7,733,373	$ 595,773	$ 6,755,000	$ 1,574,146
Direct Services					
WCCMH Direct Services	$ 37,254,441	$ 34,765,450	$ 2,488,991	$ 33,580,000	$ 3,674,441
Total Direct Services	$ 37,254,441	$ 34,765,450	$ 2,488,991	$ 33,580,000	$ 3,674,441
Contracted Services					
WCCMH Contracted Services	$ 74,424,000	$ 72,474,000	$ 1,950,000	$ 69,250,000	$ 5,174,000
Total Contracted Services	$ 74,424,000	$ 72,474,000	$ 1,950,000	$ 69,250,000	$ 5,174,000
Other Non-Service Costs					
Medicaid Local Match	$ 411,272	$ 411,272	$ -	$ 411,272	$ -
State Facilities Local Contribution	600,000	600,000	-	900,000	(300,000)
Shelter	80,000	80,000	-	80,000	-
Total Other Non-Service Costs	$ 1,091,272	$ 1,091,272	$ -	$ 1,391,272	$ (300,000)
Grants And Contracts	$ 3,100,646	$ 1,790,168	$ 1,310,478	$ 1,790,168	$ 1,310,478
Total Expenses	**$ 124,199,505**	**$ 117,854,263**	**$ 6,345,242**	**$ 112,766,440**	**$ 11,433,065**
Revenue Over/(Under) Expenses	0	0	0	5,087,823	$ (5,087,823)

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget

WCCMH Administrative Expenses

		FY 2024 Budget	FY 2023 Final Budget	FY 2024 Budget Over / (Under) FY 2023 Budget	FY 2023 Projected YE	FY 2024 Budget Over / (Under) FY 2023 Projections
	Administration	$ 844,965	$ 764,444	$ 80,521	$ 815,000	$ 29,965
(a)(b)	Compliance	166,000	154,668	11,332	150,000	16,000
(a)	Finance	1,410,294	1,410,294	-	1,095,000	315,294
	Human Resources	278,590	185,726	92,864	150,000	128,590
(a)	Information Management	218,504	189,073	29,431	110,000	108,504
(a)	Intake/Enrollment	915,870	867,730	48,140	575,000	340,870
(a)	Member Services	287,286	243,088	44,198	235,000	52,286
(a)	Network Management	742,849	742,849	-	565,000	177,849
(a)	Quality/Performance Imp.	548,700	404,696	144,004	260,000	288,700
(b)	Recipient Rights	1,638,000	1,492,715	145,285	1,530,000	108,000
(a)	Utilization Review	1,278,089	1,278,089	-	1,270,000	8,089
	TOTAL	$ 8,329,146	$ 7,733,373	$ 595,774	$ 6,755,000	$ 1,574,146

(a) All or a portion of this administrative category is a delegated function of the PIHP.

(b) Revenue contracts exist with Affiliate Partner CMH's for the purchase of these administrative functions.

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget

WCCMH Direct Service Expenses

	FY 2024 Budget	FY 2023 Final Budget	FY 2024 Budget Over / (Under) FY 2023 Budget	FY 2023 Projected YE	FY 2024 Budget Over / (Under) FY 2023 Projections
Program Support	$ 4,373,800	$ 4,150,194	$ 223,607	$ 4,850,000	$ (476,200)
ACT	1,901,270	1,728,427	172,843	1,800,000	101,270
Autism	760,000	510,000	250,000	200,000	560,000
Behavior Management	736,914	669,922	66,992	725,000	11,914
Crisis Stabilization	2,824,313	2,598,368	225,945	2,600,000	224,313
Health Home	390,000	307,418	82,582	300,000	90,000
Home Based	1,615,103	1,480,511	134,592	1,250,000	365,103
Jail Services	716,534	656,823	59,711	630,000	86,534
Jail Diversion	122,000	119,261	2,739	110,000	12,000
Nursing	2,624,013	2,509,925	114,088	2,450,000	174,013
Nursing Home Services	160,625	146,023	14,602	138,000	22,625
Outpatient	2,883,563	2,746,251	137,313	2,650,000	233,563
Peer Supports	796,848	664,040	132,808	762,000	34,848
Psychiatric Services	4,678,306	4,134,073	544,233	4,200,000	478,306
Skill Building	1,894,775	1,804,548	90,227	1,350,000	544,775
Specialty Services	315,000	282,493	32,507	380,000	(65,000)
Supported Employment	1,277,327	1,021,862	255,465	1,375,000	(97,673)
Supports Coordination	3,405,893	3,243,708	162,185	2,750,000	655,893
Targeted Case Management	5,513,230	5,250,695	262,535	4,850,000	663,230
Wraparound	264,928	240,844	24,084	210,000	54,928
TOTAL	$ 37,254,441	$ 34,265,383	$ 2,989,058	$ 33,580,000	$ 3,674,441

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget

WCCMH Contracted Service Expenses

	FY 2024 Budget	FY 2023 Final Budget	FY 2024 Budget Over / (Under) FY 2023 Budget	FY 2023 Projected YE	FY 2024 Budget Over / (Under) FY 2023 Projections
Access/Assessments	$ 150,000	$ 150,000	$ -	$ 150,000	$ -
Autism Services	11,400,000	7,700,000	3,700,000	10,250,000	1,150,000
Community Inpatient	9,700,000	7,550,000	2,150,000	9,170,000	530,000
Community Living Supports	29,800,000	34,600,000	(4,800,000)	28,700,000	1,100,000
Licensed Facilities	18,000,000	16,600,000	1,400,000	16,740,000	1,260,000
Nursing	150,000	150,000	-	180,000	(30,000)
Outpatient	12,500	12,500	-	130,000	(117,500)
Peer Supports/Drop-In	346,500	346,500	-	200,000	146,500
PERS	150,000	150,000	-	150,000	-
PSR/Clubhouse	495,000	495,000	-	280,000	215,000
Respite	715,000	715,000	-	580,000	135,000
Skill Building	2,700,000	3,200,000	(500,000)	2,300,000	400,000
Specialty Services	150,000	150,000	-	150,000	-
Supported Employment	535,000	535,000	-	150,000	385,000
All Other Contracted Services	120,000	120,000	-	120,000	-
TOTAL	$ 74,424,000	$ 72,474,000	$ 1,950,000	$ 69,250,000	$ 5,174,000

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget by Fund Source

		Total
Medicaid **		
Revenue		
Medicaid (b), 1115i, Waivers, Autism, CCBHC & DCW	$	105,783,294
Total Medicaid Revenue	$	105,783,294
Expense		
Service Costs	$	105,783,294
Total Medicaid Expense	$	105,783,294
Medicaid Surplus/(Deficit)	$	-
Healthy Michigan Plan **		
Revenue		
Healthy Michigan Plan	$	6,155,256
Total Healthy Michigan Revenue	$	6,155,256
Expense		
Service Costs	$	6,155,256
Total Healthy Michigan Expense	$	6,155,256
Total Healthy Michigan Surplus/(Deficit)	$	-

** Denotes PIHP Medicaid Subcontracting Agreement Funds

General Fund		
Revenue		
CMH Operations	$	4,597,669
Funding from Other Sources		-
Total General Fund Revenue	$	4,597,669
Total General Fund Expense	$	4,597,669
General Fund Surplus/(Deficit)	$	-
Grants and Contracts		
Revenue	$	5,018,298
Expense		5,018,298
Grants & Cont. Surplus/(Deficit)	$	-
Local		
Revenue	$	1,751,761
Expense		1,751,761
Local Surplus/(Deficit)	$	-
CMHSP to CMHSP		
Revenue	$	893,227
Expense		893,227
All Other Surplus/(Deficit)	$	-
Grand Total		
Revenue	$	124,199,505
Expense		124,199,505
Grand Total Surplus/(Deficit)	$	-

ATTACHMENT #5
AUGUST 2023

ANNUAL BUDGET

FISCAL YEAR 2024

Table of Contents

MISSION, VISSION AND VALUES

MISSION

To promote hope, recovery, resilience, and advance health equity in Washtenaw County by providing, high quality, integrated behavioral health services to adults and youth with intellectual/developmental disabilities, mental health and/or substance use needs.

VISION

All residents can secure supports to improve their quality of life and reach their full potential.

VALUES

Excellence

We provide the highest level of service to promote recovery, quality of life and self-sufficiency through proven and innovative practices. We recognize that the foundation of excellent service is our relationships.

Growth

We believe in the capacity for change at every stage of development. We grow through shared learning, lived experiences and mentoring.

Well-being

We cultivate well-being through a commitment to physical and emotional safety, active listening, and a culture of appreciation.

Inclusion

Together we build a welcoming, respectful environment for all people. Through active engagement and shared decision-making, we build a stronger community.

Community

We develop strong, trusting partnerships with the people we serve, in our broader community, and within our own organization while advancing health equity.

Accountability

We are accountable to those we serve, to the larger community, and to each other for the equitable, effective, and efficient use of our resources.

Equity

Services will be delivered with a focus on eliminating health inequities by addressing and reducing the racial and economic disparities frequently impacting Black, Indigenous and People of Colors' health status, access, and outcomes.

GUIDING DEFINITIONS

Wellness is not the absence of disease, illness, or stress but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness.

SAMSHA, Wellness Overview, 2016

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential**.**

SAMSHA, Recovery defined, August 2010

People with intellectual and/or developmental disabilities must be able to live the lives they choose and have a good quality of life.

The ARC, Quality of Life Position Statement, November 2009

STRATEGIC PLAN

Environmental Drivers

Access to Care

- There is a shortage of staff statewide with long waiting times, difficulty in accessing care or needs not getting met
- CMH system reform efforts are being driven by concerns about access and inconsistent statewide availability of services - encouraged to find ways to increase/improve access
- There is a lack of access to youth behavioral health services
- A severe statewide psychiatric hospital bed shortage with long waits for care
- A lack of a single point of access for all behavioral health services including substance use disorders

Performance/Quality

- Uneven metrics/performance by PHIPs and pressure from MCOs to shift payment from PIHPs to MCOs with competing bills in the legislature from Shirkey and Whiteford bills
- Current CMH system collects a lot of data but lacks a clear dashboard of metrics for accountability and performance
- State rate setting efforts expected to put emphasis on cost efficiency and effectiveness etc.

Expansion of Services

- Federal expansion of mental health funding through the designation of Michigan as a CCBHC state
- Passage of millage since the last strategic plan has shifted focus from exclusively mandated services for “eligible” individuals to comprehensive services for the general community
- Greater need for focus on prevention, early intervention, and community education

Other Drivers

- Inconsistency of support for Behavioral Health services by the State of Michigan
- Importance of telemedicine and the infrastructure to support it (i.e., broadband internet, county infrastructure and internet)
- Workforce recruitment and retention challenges
- The pandemic has forced isolation and created other stresses

- Racial and economic disparities in health status and in access to health care have become more obvious as people of color and lower income people bore disproportionate risks from COVID
- Excessive use of force and underutilization of behavioral science principles on the part of police officers and especially in interactions of white officers and citizens of color have led to a growing public chorus for reform of how society deals with people in crisis

STRATEGIC GOALS

Ensure availability of behavioral health services through a single point of entry.

Tactic:

- Create a single point of entry for behavioral health services for individuals with substance use disorder, mental illness, or intellectual/developmental disabilities
  Completed by: January 2023
  Responsible Party: Melisa Tasker
  Measurement: TBD work with PIHP on evaluation criteria
- Establish and strengthen care coordination agreements to develop a behavioral health network of safety net providers in Washtenaw County
  Completed by: January 2025
  Responsible Party: Trish Cortes, Heather Linky, Dr. Florence
  Measurement: Care Coordination with key stakeholders. Examples may include Packard Health, Corner Health, Ozone, Catholic Social Services, Jewish Family Services, etc.

Promote wellness through the integration of physical and behavioral health.

Tactic:

- Achieve successful implementation of State of Michigan Behavioral Health Home
  Completed by: October 2023
  Responsible Party: Brandie Hagaman, Michael Harding
  Measurement: 200 Washtenaw County individuals enrolled through the State of Michigan, ongoing qualitative measure TBD in partnership with the State of Michigan

- Complete and successfully implement State of Michigan Certified Community Behavioral Health Clinic (CCBHC)
  Completed by: October 2023
  Responsible Party: Michael Harding
  Measurement:
  1. Successful State certification
  2. 95% of individuals receiving qualified CCBHC services are enrolled in in the State Demonstration

3. Percent of the number of individuals requesting services that are assessed for medical necessity are provided services either through community partnerships or directly

Provide an array of crisis services that promotes care in the least restrictive setting.

Tactic:

- Complete full implementation of crisis 23 Hour Observation site
  Completed by: January 2023
  Responsible Party: Melisa Tasker
  Measurement: Maintain monthly capacity of 80%
- Partner in the development of a community plan to establish a youth assessment center
  Completed by: January 2024
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Presentation of the community plan to the WCCMH board
- Implementation of Law Enforcement Assisted Diversion/Deflection (LEADD) in partnership with community stakeholders
  Completed by: January 2022
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: TBD CHRT Evaluation
- In partnership with Washtenaw County Sherriff's office, develop protocols for metro dispatch to deploy a mobile mental health crisis team as an alternative to law enforcement response
  Completed by: January 2024
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: TBD Chicago Health Labs evaluation

Break down the barriers for all to reduce mental health disparities in access to care and improve health equity within Washtenaw County.

Tactic:

- Utilize existing studies and reports to identify health inequities within Washtenaw County. These studies will be utilized to develop a workplan that is specific to how WCCMH can impact health inequities within Washtenaw County
  Completed by: January 2024
  Responsible Party: Trish Cortes, Lisa Gentz, BLM Taskforce, Public Health
  Measurement: Work plan finalized and presented to key stakeholders

- Create interventions based on the work plan that target stigma, increase health education and trainings that aid in reducing health inequities
  Completed by: January 2025
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Measurements will be developed based on the workplan and will identify the impact the interventions that WCCMH has implemented to reduce health inequities

Braid diversified revenue streams to support prevention, treatment, outreach, and equitable access to behavioral health services.

Tactic:

- Expand youth services through outreach and partnerships by leveraging all funding streams
  Completed by: January 2025
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Either directly or through agreements increase youths served by 25%
- Expand the adult service array through primary care agreements
  Completed by: January 2024
  Responsible Party: Trish Cortes, Dr. Florence
  Measurement: Agreements with primary care safety net clinics
- Implement 31N WISD School Mental Health Project to expand services within Washtenaw School districts
  Completed by: January 2023
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Number of schools receiving mental health resources
- Prioritize available resources to broaden outreach, education, and prevention efforts to address health inequities
  Completed by: January 2025
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Number of community events and trainings in geographic areas of need. No show rates for African Americans

Improve recruitment and retention of the behavioral health workforce.

Tactic:

- Advocate with MDHHS leadership and legislators to address behavioral health workforce shortages
  Completed by: January 2025
  Responsible Party: Trish Cortes
  Measurement: Additional funding allocated from the State for behavioral health staffing or decrease vacancies from 10% to 5%
- Collaborate with Washtenaw County administration and labor partners to strategize local efforts
  Completed by: January 2025
  Responsible Party: Trish Cortes, Nicole Phelps, Sally Amos O'Neal
  Measurement: County Implementation of MAG Study
- Partner with provider network to address direct care workforce challenges
  Completed by: January 2022
  Responsible Party: Heather Linky
  Measurement: Implementation of direct care worker training reciprocity and/or increased funding for direct care workers

Thank you to the following groups that contributed to the WCCMH Strategic Plan:

Consumer Advisory Group
WCCMH All Staff
WCCMH Board
WCCMH Millage Advisory Group
WCCMH Black Lives Matter Taskforce
WCCMH Recipient Rights Committee
WCCMH Provider Network

The Following reports informed the WCCMH Strategic Plan:

CHRT Behavioral Health Environmental Analysis
Unite Report
WCCMH Staff Survey
Millage Advisory Committee Survey Results

WCCMH ENABLING LEGISLATION

Washtenaw County Community Mental Health (WCCMH)

The WCCMH has been designated by the State of Michigan as the Community Mental Health Services Program (CMHSP) as an agency model for Washtenaw County in accordance with Section 232a of the Michigan Mental Health Code.

Certified Community Behavioral Health Clinic (CCBHC)

The WCCMH is a Michigan Certified CCBHC Demonstration Site. A CCBHC is a new provider type in Medicaid and designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations.

State Innovation Model (SIM)

The WCCMH is an approved hublet site through the Washtenaw/Livingston Community Health Innovation Region (CHIR). CHIRs (pronounced “shires”) are intended to build community capacity to drive improvements in population health. The Care Delivery component includes the Patient-Centered Medical Home (PCMH) Initiative and the promotion of alternative payment models.

Behavioral Health Home (BHH)

The BHH provides comprehensive care management and coordination services to Medicaid beneficiaries with a select serious mental illness/serious emotional disturbance (SMI/SED) diagnosis. For enrolled beneficiaries, the BHH functions as the central point of contact for directing patient-centered care across the broader health care system.

FUNDING SOURCES

State General Funds

- The Michigan Department of Health and Human Services (MDHHS) authorizes State General Funds for community services. These authorizations may be adjusted throughout the year and may also include transfers pursuant to section 236 and section 307 of the Mental Health Code (MH Code). Funding is also contingent upon the funding contained in the current year state legislative Appropriations Act.

- The CMHSP is also obligated to provide local matching funds as stipulated in the MH Code.
    - Revenue sources for this local obligation include
        - County Appropriations
        - Appropriations from other local governments such as cities and townships
        - Gifts and donations
        - Earned interest
        - First and third-party reimbursement reported under the Special Fund Account pursuant to section 226a of the Michigan Mental Health Code qualify as local matching funds
    - The local obligation is ten percent of service costs. The following exclusions apply:
        - Residential programs, including mental health services provided in the residency of the recipient and are part of a comprehensive individual plan of services (IPOS).
        - Services provided to people whose residency is transferred according to section 307 of the MH Code.
        - Programs that are State responsibilities and that the State has transferred to the CMHSP.
        - Services provided to an individual under criminal sentence to a state prison.

- At the conclusion of the fiscal year, the CMHSP may carry forward up to 5% of the State General Funds into the next fiscal year. The succeeding fiscal year budget will include planned expenditures of the full amount carried forward. Unexpended funds in that succeeding year must be returned to MDHHS.

- No Internal Services Fund (risk protection) may be maintained with State General Fund dollars.

Medicaid

- MDHHS administers the Medicaid Managed Specialty Supports and Services 1115 Medicaid Demonstration Waiver. Under this waiver, select state plan specialty services related to mental health and intellectual/developmental disability services as well as certain covered substance abuse services, have been carved out (removed) from Medicaid primary physical health care plans and arrangements. The 1115 Waiver includes Michigan's 1915(c) Habilitation Supports Waiver (HSW) for persons with intellectual/developmental disabilities, Children's Waiver Program (CWP), Children with Serious Emotional Disturbance Waiver (SED) and 1915(i) Waiver (previously identified as 1915(b)(3)). The concurrent 1915(i)/(c) programs are managed on a shared risk basis by Prepaid Inpatient Health Plans (PIHP) that have been selected through the Application for Participation (AFP) process.

- Medicaid funding is a shared risk arrangement whereby the PIHP may set aside a risk pool (Internal Service Fund - ISF) to cover potential future shortfalls of Medicaid funding and to cover unforeseen Medicaid expenses. The PIHP's shared risk is up to 7.5% of the total deficit: the first 5% is the PIHP's responsibility, the second 5% is shared equally with the state, and the remaining deficit is borne totally by the state.

- Capitated payments are set by the state and issued to the PIHP a monthly basis. The rate of payment is based on numerous factors relating to Medicaid beneficiaries developed by the actuary agency, Milliman, Inc. **[APPENDIX A]**

  Factors Include but not limited to:
  - Number of TANF (Temporary Assistance for Needy Families) beneficiaries
  - Number of DAB (Disabled, Aged & Blind) beneficiaries
  - Number of HMP (Healthy Michigan Plan) beneficiaries
  - Age
  - Gender
  - Entity Specific Factor
  - Autism
  - Enrollment in the Habilitation Supports Waiver
  - Enrollment in the Children's Model Waiver

Children's Model and SED Waivers

MDHHS determines if an individual meets the criteria to participate in these Waiver's. Up until 2019, the programs operated as a fee-for-service arrangement between the CMHSP and MDHHS. The Waiver programs have since been incorporated into the PIHP's Medicaid contract and are funded through the capitated funding model.

Grants and Earned Contracts

- The WCCMH actively seeks additional funding through grants and earned contracts. In addition to Block Grants from the state, the WCCMH has been awarded several million dollars in other Federal and Private grants. These grants allow the WCCMH to be innovative and provide additional behavioral health services to individuals in Washtenaw County.

Appropriation from Washtenaw County

- An annual appropriation is provided to WCCMH by Washtenaw County to meet the local match requirements of the CMHSP.

Other Revenue

- WCCMH participates in several contractual arrangements for which staff time is reimbursed to provide supports within the community. For many years, the Washtenaw County Sheriff's Office has contracted with WCCMH to provide mental health services to individuals within the jail. Other arrangements exist with partners such as Packard Health and Washtenaw County Courts.

WHO WE SERVE

Who We Serve

- Services are provided to individuals who have a mental illness, emotional disturbance, intellectual/developmental disability, or have a co-occurring disorder.
- An individual shall not be denied service because an individual is unable to pay for the service.
- Crisis and stabilization behavioral health services are provided to individuals who are under/uninsured.

Medicaid Eligible

- Medicaid beneficiaries whose needs render them eligible for specialty services and supports are served through the PIHP/CMHSP, its Provider Network and/or its Lead Agency. Those who are experiencing or demonstrating mild or moderate psychiatric symptoms are not eligible for specialty services and are covered through the State's fee-for-service Medicaid Program.
- The number of Medicaid beneficiaries in Washtenaw County has averaged 34,000 plus or minus every month. The number of Healthy Michigan Plan beneficiaries averages 17,000 plus or minus each month.

Numbers Served

- 4386 Medicaid covered individuals were served in 2022.
- 1428 Healthy Michigan Plan (HMP) covered individuals were served in 2022.
- 605 individuals not covered by Medicaid/HMP were served in 2022.

PURPOSE AND SERVICES

State General Fund Supports and Services

- The purpose of the Community Mental Health Services Program (CMHSP) is to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area regardless of an individual's ability to pay.
- The array of services includes the following:
    - Crisis stabilization and emergency services that can respond to persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment
    - Assessment and diagnosis
    - Planning, linking, coordinating, follow-up, and monitoring
    - Specialized mental health services
        - Training, treatment, support
        - Therapeutic clinical interactions
        - Socialization and adaptive skill and coping skills training
        - Health and rehabilitative services
        - Pre-vocational and vocational services
    - Recipient Rights
    - Mental Health advocacy
    - Prevention action

Medicaid Supports and Services

- Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the Individual Plan of Services (IPOS) must meet medical necessity criteria, be appropriate to the individual's needs, and meet the standards set forth in the Medicaid Provider Manual.
- Services selected and included in the IPOS must be determined through the persons-centered planning process in accordance the state guidelines.
- Medical Necessity is the determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology, and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with the clinical standards of care. Medical necessity shall be documented in the IPOS. **[APPENDIX B]**

1915 (i)

- Services are aimed at providing a wider, more flexible, and mutually negotiated set of supports and services that will enable individuals to exercise and experience greater choice and control over their individual plan of services.
- Services are intended to be more individualized and cost-effective and in accordance with the beneficiary's needs and requests.
- Services are outlined in detail in the Michigan Provider Manual
    - Inpatient Psychiatric Services
    - Psychiatric Partial Hospitalization
    - Mental Health Clinic Services
    - Community Rehabilitation Services
    - Crisis Residential and Crisis Stabilization Services
    - Psychosocial Rehabilitation Program
    - Substance Abuse Rehabilitative Services
    - Targeted Case Management
    - Personal Care in Specialized Residential Settings
    - Specialty services to treat, correct or ameliorate an illness

1915 (c) Services

- Covered services in this waiver include:
    - Chore Service
    - Community Living Supports
    - Enhanced Dental
    - Enhanced Pharmacy
    - Enhanced Medical Equipment and Supplies
    - Environmental Modifications
    - Family Training
    - Out of home Non-Vocational Habilitation
    - Personal Emergency Response System
    - Pre-Vocational Habilitation
    - Private Duty Nursing
    - Respite Care
    - Supports Coordination
    - Supported Employment
    - Assertive Community Treatment Programs (ACT)
    - Clubhouse Psychosocial Rehabilitation Programs
    - Crisis Residential Programs
    - Day Program Sites
    - Crisis Observation Care
    - Home-Based Services

- Intensive Crisis Stabilization
- Wraparound

CCBHC Services

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
- Screening, assessment, and diagnosis, including risk assessment.
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support and counselor services and family supports.
- Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

SERVICE DELIVERY SYSTEM

Basic Organization Structure

- Administrative Functions are intended to support the Service Delivery System and to meet all the legal and regulatory requirements of a Managed Care and Clinical Delivery System.
  - Executive and Managing Levels of Operations
  - Budget and Finance
  - Provider Acquisition, Requirements, Compliance
  - Policy, Risk, Quality
  - Recipient Rights, Customer Services, Fair Hearings
  - Information Management
  - Service System Management
- Services are provided through WCCMH and the network of contracted providers.
- The Service Delivery System needs to meet the changing needs of the individuals served. Healthcare delivery and funding across the nation and state are ever changing and WCCMH must be flexible and able to adapt quickly to be sustainable.
- Utilization Management is a key component of management care system. It requires a systematic set of processes from prescreening and prior authorization for treatment as well as ongoing, retrospective service utilization review.

Access

- The Access System is available and accessible to all individuals seeking assistance or service. Access is by telephone or face-to-face. Access also includes a community outreach function.
- The basic philosophy of the organization is to provide a welcoming environment for consumers: person-centered, self-determined, and recovery oriented.
- Basic functions include screening, determination of eligibility for the various benefit packages, timely referral to the appropriate mental health or other community service, and outreach to under-served and hard-to reach populations.

Person-Centered Planning

- The Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a person-centered planning process regardless of age, disability, or residential setting. In this process, the individual directs the planning with a focus on what he/she wants and needs, including the identification of possible services. This interactive strategy is intended to ensure that individuals are provided with the most appropriate services necessary to achieve the desired outcomes.
- When an individual expresses a choice or preference for a support, service and/or treatment for which an appropriate alternative of lesser cost exists, and compromise fails, the individual may employ a process for dispute resolution and appeal.
- Self-determination incorporates a set of concepts and values that emphasize participation by the individual and achievement of personal control over his/her life. Person-centered planning is a central element of a self-determination.
- The person-centered planning process is highly individualized and designed to respond to the expressed needs/desires of the individual.
- The process encourages strengthening and developing natural supports by inviting family and friends to participate in the planning. Developing natural supports is an equal responsibility of the CMHSP and the individual.

Individual Plan of Services (IPOS)

- Services must be delivered according to an individual plan of service based on an assessment of immediate need. The plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the parent or guardian, the psychiatrist, and any other professionals involved in treatment planning as determined by the needs of the beneficiary. The Case Manager must be involved in the treatment as soon as possible and must be involved in the follow-up services.

- The IPOS must clearly state goals and measurable objectives derived from the assessment of immediate need and stated in terms of specific observable changes in behavior, skills, attitudes, and circumstances.
- The array of covered services to meet the needs and desires of the individual are addressed in at the planning meeting and a copy of the plan is provided to the individual within 15 business days after the meeting.

Provider Agencies [APPENDIX C]

- To meet service obligations, the WCCMH/CMHSP contracts with a number of provider agencies that provide a range of services.

Contract Services include:

- Psychiatric Inpatient Hospitals
- Partial Inpatient Hospitals
- Licensed Residential
- Community Living Supports
- Clubhouse Psychosocial Rehabilitation
- Peer-Operated Drop-In Center
- Vocational Services
- Applied Behavioral Analysis
- Miscellaneous Clinical Services

WCCMH DIRECT SERVICE DELIVERY

Assessments

- Health Assessments are provided by a registered nurse or nurse practitioner to determine the individual's need for medical services and to recommend a course of treatment within the scope of the practice of the nurse or dietician.
- Psychiatric Evaluations are comprehensive, face-to-face evaluations provided by a psychiatrist that includes current clinical status, historical psychiatric, physical, and medication information, relevant personal and family history, personal strengths and assets, and a mental status examination.
- Psychological testing includes standardized tests and measures rendered by full, limited-licensed, or temporary-limited-licensed psychologists.
- Another assessment used is the Child and Adolescent Functional Assessment Scale (CAFAS)

Case Management/Supports Coordination

- This covered service is to assist beneficiaries in designing and implementing strategies for obtaining the services and supports that are goal-oriented and individualized. To assist in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports, the responsibilities of the case manager include:
    - Assessment
    - Planning
    - Linkage
    - Advocacy
    - Coordinating and Monitoring
- The case manager must review services at intervals defined in the IPOS and update the IPOS as needed.
- The case manager must determine, on an ongoing basis, if the services and supports have been delivered and if they are adequate to meet the needs/wants of the beneficiary.
- Monitoring (frequency and scope of case management service) must reflect the intensity of the beneficiary's health and welfare needs identified in the IPOS.

Assertive Community Treatment Program (ACT)

- ACT is a set of intensive clinical, medical, and psychosocial services provided by a mobile multi-disciplinary treatment team.
- ACT provides basic services and supports essential to maintain the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources, such as food, housing, medical care and supports to allow beneficiaries to function in social, educational, and vocational settings.
    - Services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the individual.

Individual/Group Therapy

- Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functions, reality oriented, re-motivation and emotional adjustment.
- Expected treatment outcome is improved functioning and more appropriate interpersonal and social relationships.

Medication Review/Administration

- Medication administration is the process of giving a physician-prescribed oral medication, injection, intravenous or topical medication treatment to an individual.
- Medication review is the evaluation and monitoring of medications, their effects, and the need to continue or change the medication regimen.

Home-Based Services

- Mental health home-based services are designed to provide intensive services to children (birth through age 17) and their families with multiple service needs who require access to an array of mental health services.
- Primary goal of this program is to promote normal development, promotion healthy family functions, support and preserve families, reunite families who have been separated, reduce the use of, or shorten, the length of stay in psychiatric hospitals.

Health Services

- Health Services include assessment, treatment, and professional monitoring of health conditions that are related to or impacted by a person's mental health condition. A person's primary doctor will treat any other health conditions they may have.

Peer Delivered Services

- Peers offer help with food, clothing, socialization, housing, and support to begin or maintain mental health treatment. Peer Specialist services are activities designed to help persons with serious mental illness in their individual recovery journey and are provided by individuals who are in recovery from serious mental illness. Peer Mentors help individuals with developmental disabilities.

Skill Building Assistance

- Skill Building assistance includes supports, services, and training to help an individual participate actively at school, work, volunteer, or community settings, or to learn social skills they may need to support themselves or to get around in the community.

Supported/Integrated Employment Services

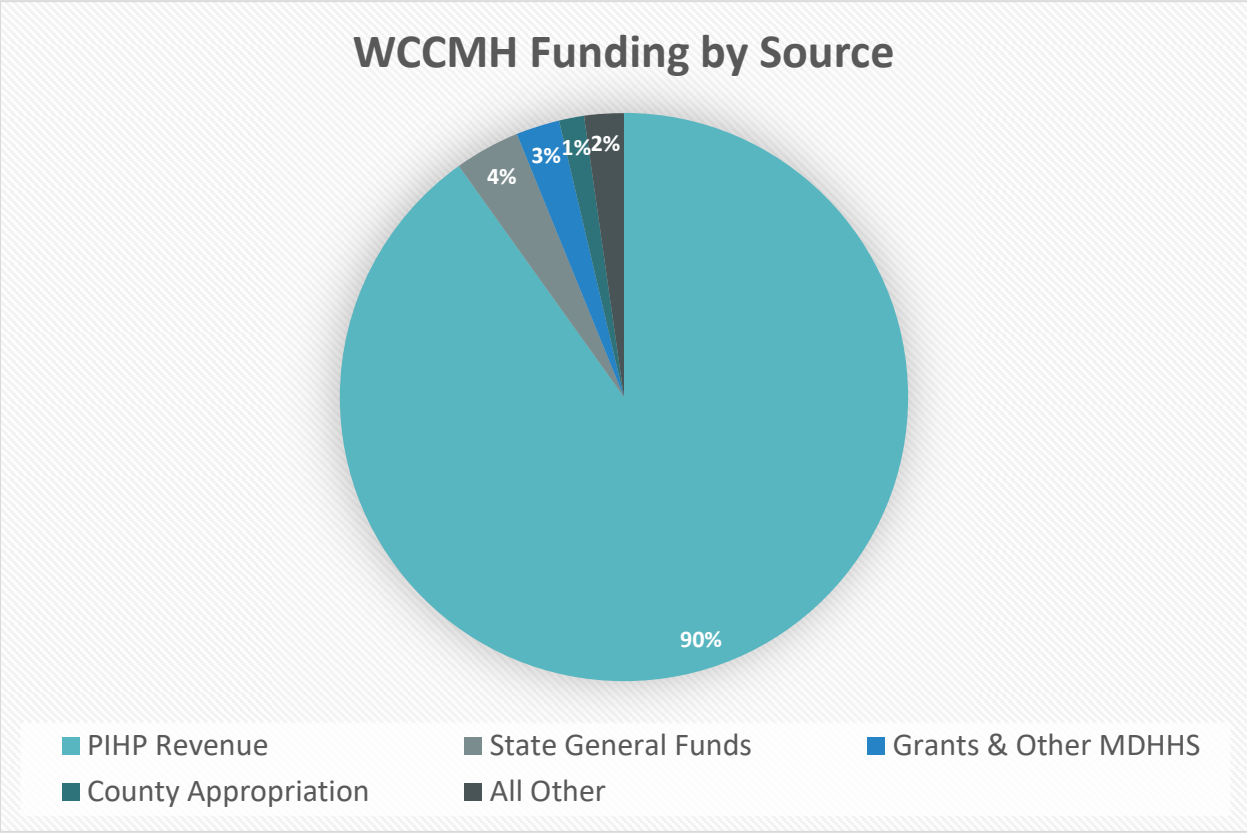
- Supported/Integrated employment services provide initial and ongoing supports, services, and training at the job site to help adults who are eligible for behavioral health services find and keep paid employment in the community.

Wraparound Services for Children and Adolescents

- Wraparound services are for individuals with serious emotional disturbance and their families that includes treatment and supports necessary to maintain the child in the family home.

BUDGET DEVELOPMENT

REVENUES:

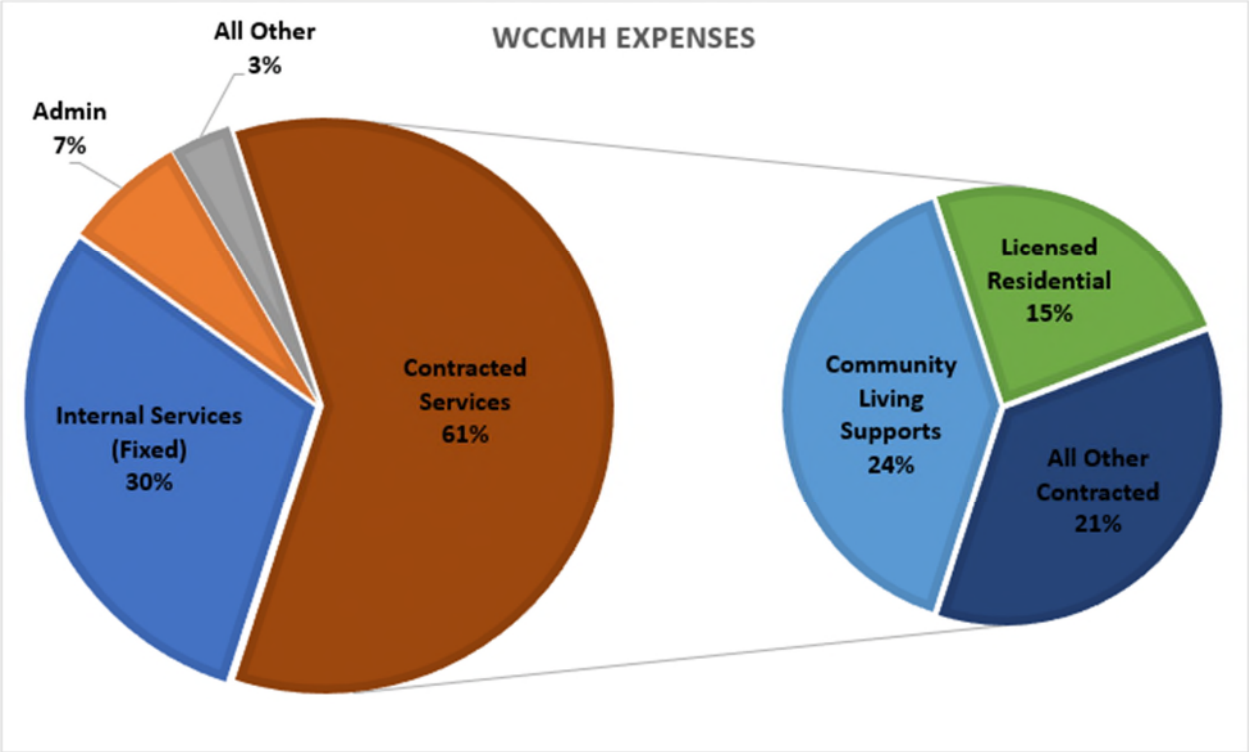


PIHP Revenue Assumptions:

- Community Mental Health Partnership of Southeast Michigan (CMHPSM/PIHP) prepared a FY 2024 Operating Budget assuming relatively flat Medicaid revenues and the use of the maximum allowed carryforward from surplus FY 2023 Medicaid revenues. At the regional level, the Internal Service Fund, which is the PIHPs Medicaid risk reserve is fully funded at the allowable level.

- The WCCMH FY 2024 Annual Operating Budget reflects a total of $112 million being distributed under the Medicaid Sub-Contracting Agreement from CMHPSM (PIHP) to WCCMH.

EXPENSES:



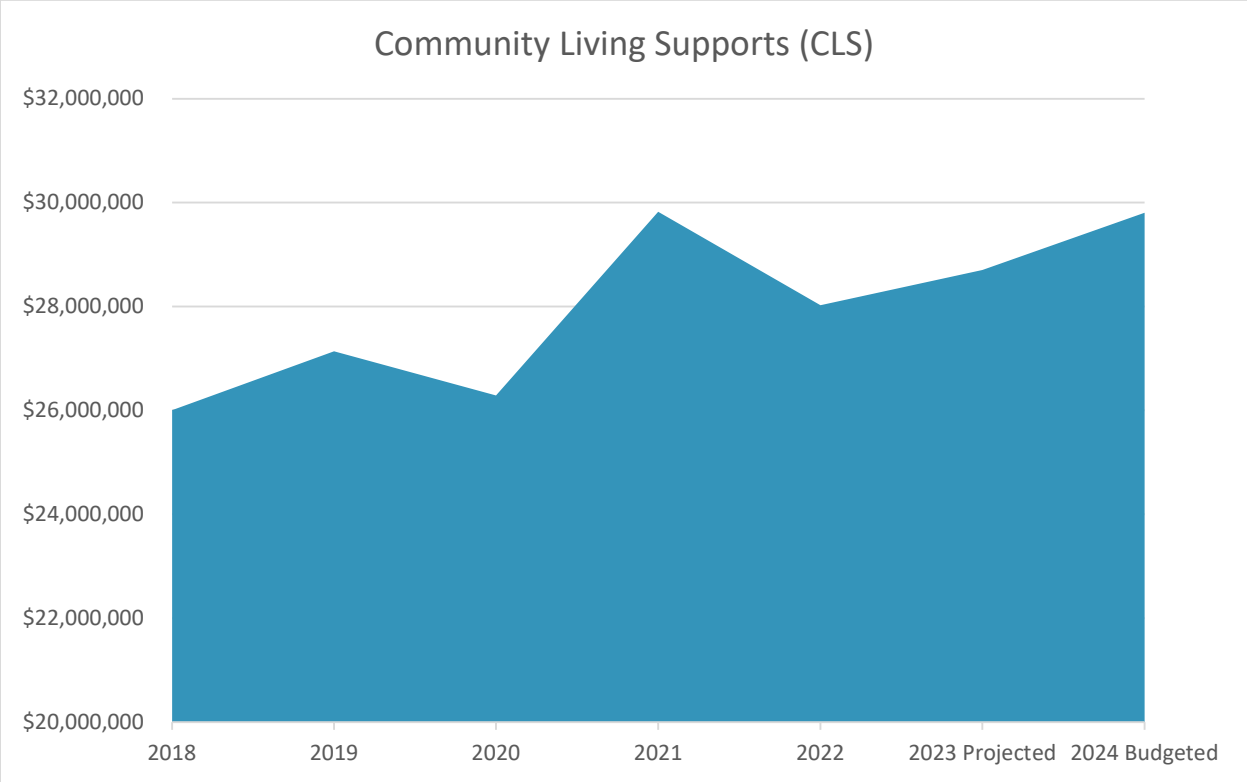
Internal Services and Administration Assumptions:

Internal services and administrative assumptions were built on current staffing levels and includes adequate resources to respond to growing service demands. There are also adequate resources accounted for in the budget for the implementation of the County compensation study.

Contracted Services Assumptions:

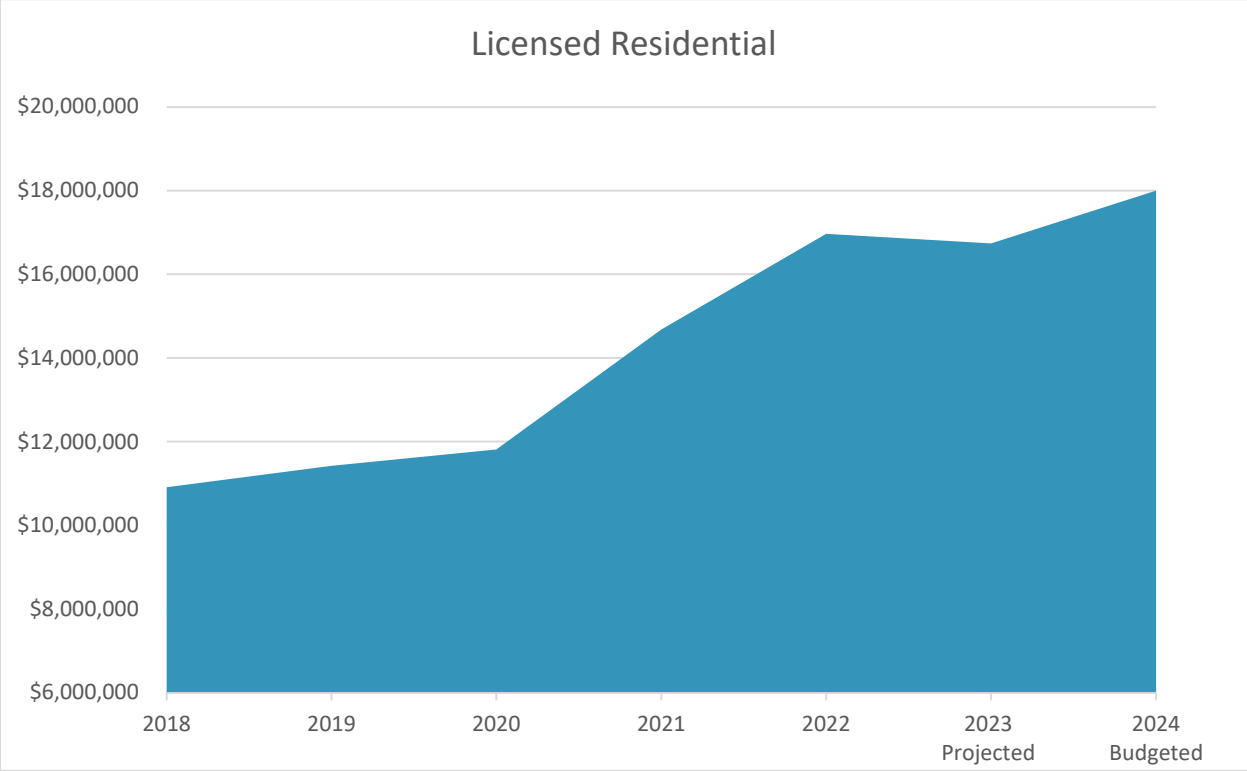
Contracted service costs are projected at prior-year utilization levels and known assumptions at the time of preparation. Residential and community support services include the continuation of the Direct Care Worker temporary wage increase.

Community Living Supports:



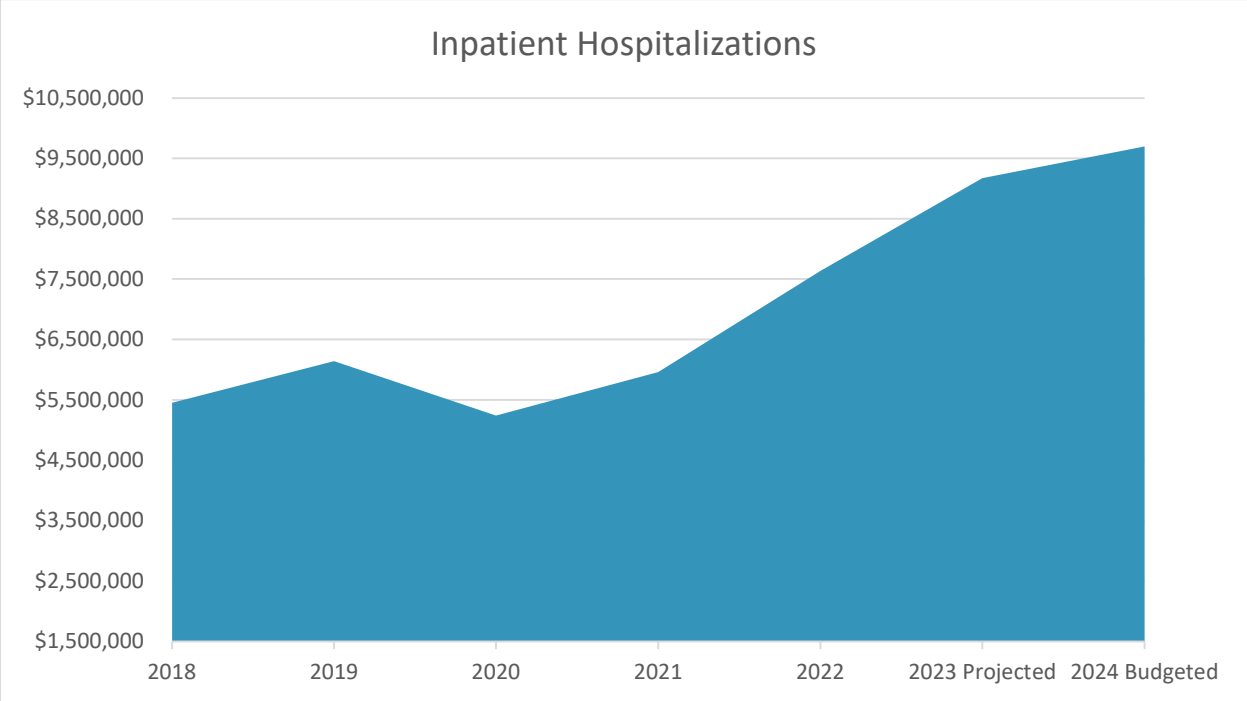
Community Living Supports (CLS) are a residential and community-based support provided to individuals in an unlicensed setting. A temporary direct care worker wage increase has been passed through to the CLS providers since the early onset of the COVID-19 pandemic. The continuation of this wage increase is assumed in the FY 2024 budget assumptions. At the regional level, over the past few years there has been additional support for the CLS providers through the mechanism of retrospective rate increases to aide in provider financial stability.

Specialized Residential:



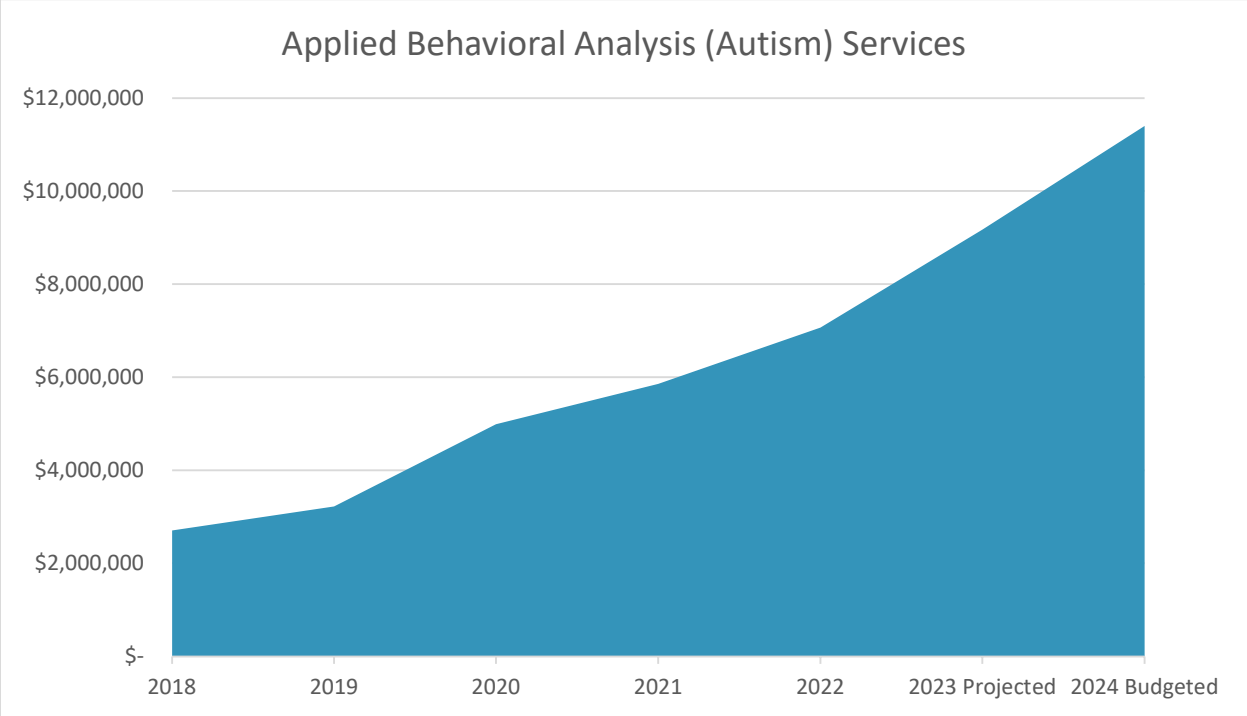
Specialized Residential services are a residential and community-based support provided to individuals in a licensed setting. A temporary direct care worker wage increase has been passed through to the residential providers since the early onset of the COVID-19 pandemic. The continuation of this wage increase is assumed in the FY 2024 budget assumptions. At the regional level, over the past few years there has been additional support for the residential providers through the mechanism of retrospective rate increases to aide in provider financial stability.

Inpatient Hospitalizations:



Inpatient Hospitalization costs have been on a steady increase since emerging from the COVID-19 pandemic. The budget assumes the projected growth in psychiatric hospitalization costs.

Applied Behavioral Analysis (Autism) Services:



Autism services and the number of individuals served has been on a steady increase since the inclusion of applied behavioral analysis in the CMH eligible service array. The FY 2024 budget assumes the continuing growth of these services.

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget

	FY 2024 Proposed Budget	FY 2023 Final Budget	FY 2024 Budget Over / (Under) FY 2023 Budget	FY 2023 Projected YE	FY 2024 Budget Over / (Under) FY 2023 Projections
Revenues					
Medicaid (b) & 1115i	$ 50,222,609	$ 48,979,046	$ 1,243,563	$ 48,979,046	$ 1,243,563
Habilitation Supports Waiver	30,015,227	30,058,737	(43,510)	30,058,737	(43,510)
Children's & SED Waivers	1,335,478	1,200,000	135,478	1,200,000	135,478
Direct-Care Worker Pass-Through	-	9,263,483	(9,263,483)	9,263,483	(9,263,483)
Healthy Michigan Plan	6,155,256	6,913,368	(758,112)	6,913,368	(758,112)
Autism Medicaid	6,819,980	6,475,395	344,585	6,475,395	344,585
CCBHC Medicaid/HMP	8,500,000	-	8,500,000	-	8,500,000
CCBHC Supplementary	8,500,000	4,059,000	4,441,000	4,059,000	4,441,000
Behavioral Health Home	390,000	-	390,000	-	390,000
State General Funds	4,597,669	4,597,669	-	4,597,669	-
Funding From Washtenaw County	1,751,761	1,751,761		1,751,761	-
Grants and Earned Contracts Incl. OBRA	3,100,646	1,790,168	1,310,478	1,790,168	1,310,478
CMHPSM/Affiliate & U of M Billings	893,227	847,984	45,243	847,984	45,243
All Other	1,917,652	1,917,652	-	1,917,652	-
Total Revenues	**$ 124,199,505**	**$ 117,854,263**	**$ 6,345,242**	**$ 117,854,263**	**$ 6,345,242**
Expenses					
Administrative Expenses					
WCCMH Administration	$ 8,329,146	$ 7,733,373	$ 595,773	$ 6,755,000	$ 1,574,146
Total Administrative Expenses	$ 8,329,146	$ 7,733,373	$ 595,773	$ 6,755,000	$ 1,574,146
Direct Services					
WCCMH Direct Services	$ 37,254,441	$ 34,765,450	$ 2,488,991	$ 33,580,000	$ 3,674,441
Total Direct Services	$ 37,254,441	$ 34,765,450	$ 2,488,991	$ 33,580,000	$ 3,674,441
Contracted Services					
WCCMH Contracted Services	$ 74,424,000	$ 72,474,000	$ 1,950,000	$ 69,250,000	$ 5,174,000
Total Contracted Services	$ 74,424,000	$ 72,474,000	$ 1,950,000	$ 69,250,000	$ 5,174,000
Other Non-Service Costs					
Medicaid Local Match	$ 411,272	$ 411,272	$ -	$ 411,272	$ -
State Facilities Local Contribution	600,000	600,000	-	900,000	(300,000)
Shelter	80,000	80,000	-	80,000	-
Total Other Non-Service Costs	$ 1,091,272	$ 1,091,272	$ -	$ 1,391,272	$ (300,000)
Grants And Contracts	$ 3,100,646	$ 1,790,168	$ 1,310,478	$ 1,790,168	$ 1,310,478
Total Expenses	**$ 124,199,505**	**$ 117,854,263**	**$ 6,345,242**	**$ 112,766,440**	**$ 11,433,065**
Revenue Over/(Under) Expenses	0	0	0	5,087,823	$ (5,087,823)

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget

WCCMH Administrative Expenses

		FY 2024 Budget	FY 2023 Final Budget	FY 2024 Budget Over / (Under) FY 2023 Budget	FY 2023 Projected YE	FY 2024 Budget Over / (Under) FY 2023 Projections
	Administration	$ 844,965	$ 764,444	$ 80,521	$ 815,000	$ 29,965
(a)(b)	Compliance	166,000	154,668	11,332	150,000	16,000
(a)	Finance	1,410,294	1,410,294	-	1,095,000	315,294
	Human Resources	278,590	185,726	92,864	150,000	128,590
(a)	Information Management	218,504	189,073	29,431	110,000	108,504
(a)	Intake/Enrollment	915,870	867,730	48,140	575,000	340,870
(a)	Member Services	287,286	243,088	44,198	235,000	52,286
(a)	Network Management	742,849	742,849	-	565,000	177,849
(a)	Quality/Performance Imp.	548,700	404,696	144,004	260,000	288,700
(b)	Recipient Rights	1,638,000	1,492,715	145,285	1,530,000	108,000
(a)	Utilization Review	1,278,089	1,278,089	-	1,270,000	8,089
	TOTAL	$ 8,329,146	$ 7,733,373	$ 595,774	$ 6,755,000	$ 1,574,146

(a) All or a portion of this administrative category is a delegated function of the PIHP.
(b) Revenue contracts exist with Affiliate Partner CMH's for the purchase of these administrative functions.

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget

WCCMH Direct Service Expenses

	FY 2024 Budget	FY 2023 Final Budget	FY 2024 Budget Over / (Under) FY 2023 Budget	FY 2023 Projected YE	FY 2024 Budget Over / (Under) FY 2023 Projections
Program Support	$ 4,373,800	$ 4,150,194	$ 223,607	$ 4,850,000	$ (476,200)
ACT	1,901,270	1,728,427	172,843	1,800,000	101,270
Autism	760,000	510,000	250,000	200,000	560,000
Behavior Management	736,914	669,922	66,992	725,000	11,914
Crisis Stabilization	2,824,313	2,598,368	225,945	2,600,000	224,313
Health Home	390,000	307,418	82,582	300,000	90,000
Home Based	1,615,103	1,480,511	134,592	1,250,000	365,103
Jail Services	716,534	656,823	59,711	630,000	86,534
Jail Diversion	122,000	119,261	2,739	110,000	12,000
Nursing	2,624,013	2,509,925	114,088	2,450,000	174,013
Nursing Home Services	160,625	146,023	14,602	138,000	22,625
Outpatient	2,883,563	2,746,251	137,313	2,650,000	233,563
Peer Supports	796,848	664,040	132,808	762,000	34,848
Psychiatric Services	4,678,306	4,134,073	544,233	4,200,000	478,306
Skill Building	1,894,775	1,804,548	90,227	1,350,000	544,775
Specialty Services	315,000	282,493	32,507	380,000	(65,000)
Supported Employment	1,277,327	1,021,862	255,465	1,375,000	(97,673)
Supports Coordination	3,405,893	3,243,708	162,185	2,750,000	655,893
Targeted Case Management	5,513,230	5,250,695	262,535	4,850,000	663,230
Wraparound	264,928	240,844	24,084	210,000	54,928
TOTAL	$ 37,254,441	$ 34,265,383	$ 2,989,058	$ 33,580,000	$ 3,674,441

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget

WCCMH Contracted Service Expenses

	FY 2024 Budget	FY 2023 Final Budget	FY 2024 Budget Over / (Under) FY 2023 Budget	FY 2023 Projected YE	FY 2024 Budget Over / (Under) FY 2023 Projections
Access/Assessments	$ 150,000	$ 150,000	$ -	$ 150,000	$ -
Autism Services	11,400,000	7,700,000	3,700,000	10,250,000	1,150,000
Community Inpatient	9,700,000	7,550,000	2,150,000	9,170,000	530,000
Community Living Supports	29,800,000	34,600,000	(4,800,000)	28,700,000	1,100,000
Licensed Facilities	18,000,000	16,600,000	1,400,000	16,740,000	1,260,000
Nursing	150,000	150,000	-	180,000	(30,000)
Outpatient	12,500	12,500	-	130,000	(117,500)
Peer Supports/Drop-In	346,500	346,500	-	200,000	146,500
PERS	150,000	150,000	-	150,000	-
PSR/Clubhouse	495,000	495,000	-	280,000	215,000
Respite	715,000	715,000	-	580,000	135,000
Skill Building	2,700,000	3,200,000	(500,000)	2,300,000	400,000
Specialty Services	150,000	150,000	-	150,000	-
Supported Employment	535,000	535,000	-	150,000	385,000
All Other Contracted Services	120,000	120,000	-	120,000	-
TOTAL	$ 74,424,000	$ 72,474,000	$ 1,950,000	$ 69,250,000	$ 5,174,000

Washtenaw County Community Mental Health
Fiscal Year 2024 Budget by Fund Source

	Total
Medicaid **	
Revenue	
Medicaid (b), 1115i, Waivers, Autism, CCBHC & DCW	$ 105,783,294
Total Medicaid Revenue	$ 105,783,294
Expense	
Service Costs	$ 105,783,294
Total Medicaid Expense	$ 105,783,294
Medicaid Surplus/(Deficit)	$ -
Healthy Michigan Plan **	
Revenue	
Healthy Michigan Plan	$ 6,155,256
Total Healthy Michigan Revenue	$ 6,155,256
Expense	
Service Costs	$ 6,155,256
Total Healthy Michigan Expense	$ 6,155,256
Total Healthy Michigan Surplus/(Deficit)	$ -

** Denotes PIHP Medicaid Subcontracting Agreement Funds

General Fund	
Revenue	
CMH Operations	$ 4,597,669
Funding from Other Sources	-
Total General Fund Revenue	$ 4,597,669
Total General Fund Expense	$ 4,597,669
General Fund Surplus/(Deficit)	$ -
Grants and Contracts	
Revenue	$ 5,018,298
Expense	5,018,298
Grants & Cont. Surplus/(Deficit)	$ -
Local	
Revenue	$ 1,751,761
Expense	1,751,761
Local Surplus/(Deficit)	$ -
CMHSP to CMHSP	
Revenue	$ 893,227
Expense	893,227
All Other Surplus/(Deficit)	$ -
Grand Total	
Revenue	$ 124,199,505
Expense	124,199,505
Grand Total Surplus/(Deficit)	$ -

FY 2018 & FY 2019 Deficit Update

As of: August 2023

Beginning in 2016 the State set forth a phased in approach to a new capitated rate development methodology. As a result, Medicaid funding for Southeast region had declined to an insufficient level. The historical experience of the CMH system is that as the health of the economy improves, generally the number of Medicaid eligible individuals decreases and can have a negative impact on the CMH system funding, even though the number of individuals qualifying for CMH services remains consistent. Theoretically, the risk-based funding model is designed to cover the challenging years with minimal service disruption.

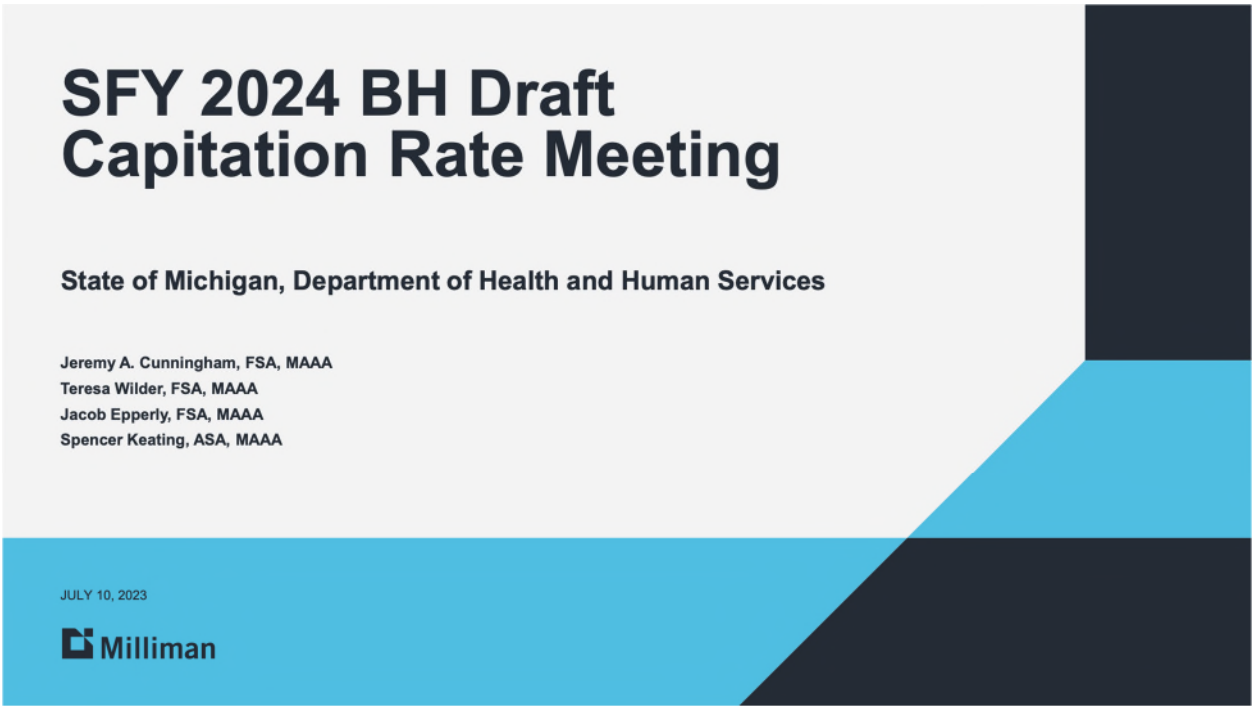
Regionally, the increased cost of service provision and insufficient revenue had ultimately put the PIHP into the shared-risk corridor with MDHHS. At the close of FY 2018, the PIHP had depleted their Medicaid risk reserve and faced an additional multi-million-dollar shortfall. As the revenue challenges continued into FY 2019 (October 1, 2018 – September 30, 2019) the PIHP had zero Medicaid reserves. Between FY 2018 and 2019 the total Medicaid deficit at the region was just over $30 million, $11 million attributable to the State share and the remaining $19 million the PIHP share.

The following chart outlines the amounts due to Washtenaw from the State and PIHP per the shared-risk model:

Fiscal Year 2018	TOTAL	Due from State	Due from PIHP
Washtenaw	$7,550,164	$4,381,480	$3,168,683
Fiscal Year 2019	**TOTAL**	**Due from State**	**Due from PIHP**
Washtenaw	$10,444,113	$2,055,622	$8,388,491
TOTAL FY18 & FY19	**TOTAL**	**Total Due from State**	**Total Due from PIHP**
	$17,994,277	$6,437,102	$11,557,174
Less Payments Received			-$3,821,592
Washtenaw Current Due:	$14,172,684	$6,437,102	$7,735,582

Appendices

APPENDIX A


SFY 2024 BH Draft
Capitation Rate Meeting
State of Michigan, Department of Health and Human Services
Jeremy A. Cunningham, FSA, MAAA
Teresa Wilder, FSA, MAAA
Jacob Epperly, FSA, MAAA
Spencer Keating, ASA, MAAA
JULY 10, 2023
Milliman

Limitations

This presentation is intended to facilitate live discussion and should not be relied upon as a stand-alone document.

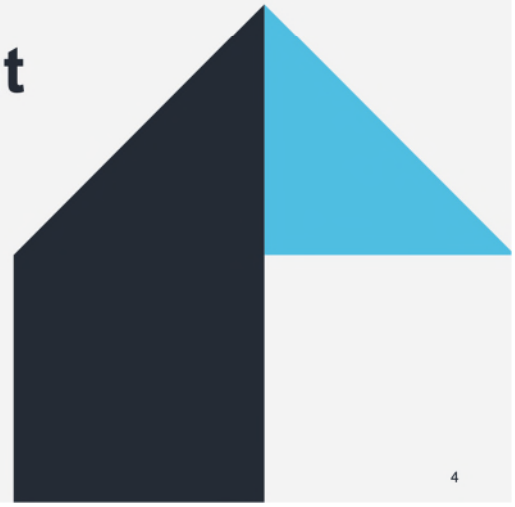
The draft capitation rates do not reflect all changes anticipated for SFY 2024, and therefore, results are expected to change. Known changes that will be accounted for in the final capitation rates include:

- Consideration of the continuous eligibility expiration
- Consideration of DCW policy changes
- Consideration of additional CAFAS assessment data
- Supplemental payment calculations for new CCBHC sites

Agenda

1	Summary of Draft SFY 2024 Rate Development
2	Key Capitation Rate Impacts
3	Area Factor Development
4	CCBHC Demonstration Program Approach
5	SFY 2024 CCBHC Supplemental Payment Calculation
6	Next steps and Q&A

Summary of Draft SFY 2024 Rate Development



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Introduction / Background: Key References

Federal Regulation 42 CFR 438.4(a). The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract.

Managed Care Rate Setting Consultation Guide. We will utilize the most recent guide published by CMS.

CMS 2390-F. Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective as of July 1, 2018.

Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance. Certified Community Behavioral Health Center (CCBHC) PPS rate setting guidance and managed care considerations.

Actuarial Soundness Definition from ASOP 49.

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

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Introduction / Background: Overview

State Fiscal Year (SFY) 2024 Capitation Rates

- October 1, 2023 through September 30, 2024

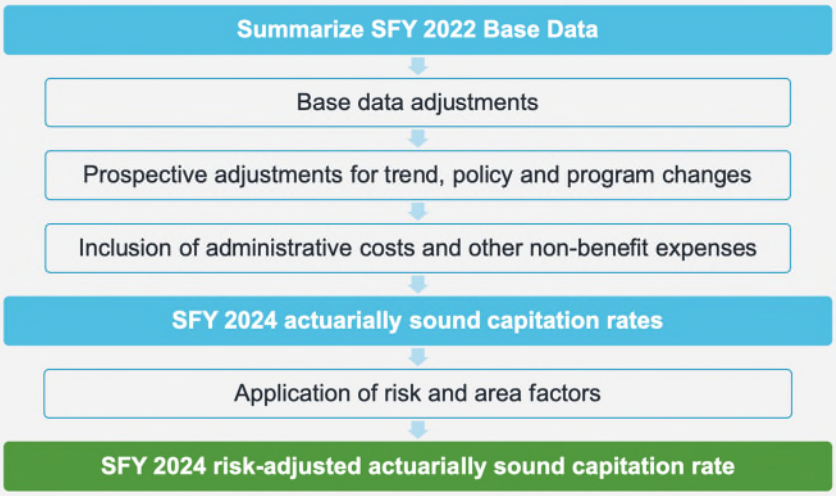
Medicaid Behavioral Health Managed Care Populations

- Temporary Assistance for Needy Families (TANF)
- Disabled, Aged, and Blind (DAB)
- Healthy Michigan Plan (HMP)
- 1915(c) Waivers
  - Habilitation Supports Waiver (HSW)
  - Children's Waiver Program (CWP)
  - Serious Emotional Disturbances (SED) Waiver

Primary Data Sources

- SFY 2022 eligibility data
- SFY 2022 PIHP encounter data
- SFY 2022 EQI Reports and FSRs
- SFY 2022 CCBHC submitted cost reports
- SFY 2022 LOCUS and CAFAS assessment data
- CCBHC supplemental mild-to-moderate data
- SFY 2022 provider service expense survey data
- January 2023 provider salary and benefits survey data

Capitation Rate Methodology Overview



SFY 2022 Base Experience
Comparison to SFY 2021 by Population

2021 EQI VS 2022 EQI ADJUSTED EXPERIENCE SUMMARY

POPULATION	AVERAGE MONTHLY			EXPENDITURES			PMPM		
	2021	2022	% CHANGE	2021	2022	% CHANGE	2021	2022	% CHANGE
DAB	519,016	534,183	2.9%	$ 1,768.7	$ 1,902.1	7.5%	$ 283.98	$ 296.73	4.5%
TANF	1,345,820	1,438,398	6.9%	415.4	460.3	10.8%	$ 25.72	$ 26.67	3.7%
HMP	867,756	959,211	10.5%	376.4	401.7	6.7%	$ 36.15	$ 34.90	(3.5%)
HSW	7,607	7,457	(2.0%)	468.6	502.2	7.2%	$ 5,133.84	$ 5,612.35	9.3%
CWP	423	488	15.3%	10.5	12.8	22.2%	$ 2,071.66	$ 2,195.38	6.0%
SED	447	451	0.9%	6.9	7.8	12.8%	$ 1,290.98	$ 1,443.55	11.8%
Total/Composite	**2,741,069**	**2,940,187**	**7.3%**	**$ 3,046.6**	**$ 3,286.9**	**7.9%**	**$ 92.62**	**$ 93.16**	**0.6%**

Note: Expenditures are illustrated in millions.

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Draft SFY 2024 Capitation Rates - Excluding HRA
Rates prior to application of CCBHC Program Adjustments

POPULATION	SFY 2023 AMENDED CAPITATION RATES	SFY 2024 CAPITATION RATES	INCREASE/DECREASE
Specialty Services			
DAB - Enrolled	$ 336.93	$ 355.85	5.6%
DAB - Unenrolled	342.16	361.38	2.6%
HMP - Enrolled	51.61	44.11	(14.5%)
HMP - Unenrolled	46.64	36.11	(22.6%)
TANF - Enrolled	33.93	37.29	9.9%
TANF - Unenrolled	23.14	23.54	1.7%
1915(c) Waiver			
Children's Waiver Program	2,871.21	2,614.55	(8.9%)
Habilitative Supports Waiver	6,047.90	6,734.05	11.3%
Serious Emotional Disturbances	1,654.85	1,958.92	18.4%
Composite Base Capitation Rates	**$ 110.27**	**$ 114.24**	**3.6%**

Notes:
1. **Reflects composite rates for all services (MH, SUD, Autism) based on SFY 2022 enrollment.**
2. **Excludes consideration of CCBHC mild-to-moderate service removal and CCBHC fee schedule application.**
3. **Expenditures are illustrated in millions.**

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Draft SFY 2024 Capitation Rates - Excluding HRA

Rates considering CCBHC Program Adjustments

POPULATION	SFY 2023 AMENDED CAPITATION RATES	SFY 2024 CAPITATION RATES	INCREASE/DECREASE
Specialty Services			
DAB - Enrolled	$ 336.93	$ 336.01	(0.3%)
DAB - Unenrolled	342.16	344.58	0.7%
HMP - Enrolled	51.61	40.87	(20.8%)
HMP - Unenrolled	46.64	33.40	(28.4%)
TANF - Enrolled	33.93	34.24	0.9%
TANF - Unenrolled	23.14	21.20	(8.4%)
1915(c) Waiver			
Children's Waiver Program	2,871.21	2,614.55	(8.9%)
Habilitative Supports Waiver	6,047.90	6,733.46	11.3%
Serious Emotional Disturbances	1,654.85	1,954.14	18.1%
Composite Base Capitation Rates	**$ 110.27**	**$ 108.45**	**(1.7%)**

Notes:
1. **Reflects composite rates for all services (MH, SUD, Autism) based on SFY 2022 enrollment.**
2. **Includes consideration of CCBHC mild-to-moderate service removal and CCBHC fee schedule application.**
3. **Expenditures are illustrated in millions.**

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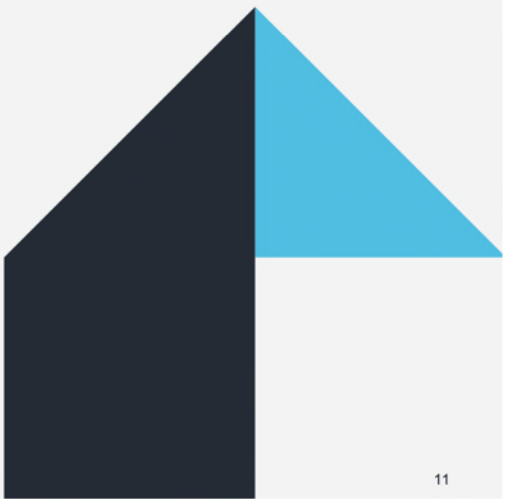
Key Capitation Rate Impacts



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Base Data Adjustments (Retrospective Adjustments)

- EQI Data Quality Adjustment (unit cost & utilization)
- Jail Services Removal
- CCBHC Mild-to-Moderate Removal
- IMD Stay Adjustment
- DCW Removal From Base
- Methadone Unit Cost Adjustment

Base Data Adjustments (Retrospective Adjustments)

CCBHC Mild-to-Moderate removal from base capitation

- MDHHS CCBHC Policy is for all CCBHCs to use the assessment-based approach for determining Mild-to-Moderate services
- CCBHC services identified as mild-to-moderate were removed from the SFY 2022 encounter data used to develop base capitation rates given 100% funded via supplemental
- **We have identified and removed mild-to-moderate services and their corresponding costs for each PIHP using:**
  - LOCUS assessment data for individuals 18 and older
  - Supplemental CCBHC data for individuals under 18 for existing CCBHC sites
  - **Preference to using CAFAS data for individuals under 18 for final capitation rates, but dependent on data availability.** CAFAS data from existing sites is being reviewed. Additional communication will be needed in some cases to gather appropriate data: one record per member (MDHHS Beneficiary ID), assessment date, and CAFAS score.
- **This experience will also be removed from the experience used for developing entity specific risk scores and is anticipated to reduce risk scores because of reduced behavioral health treatment prevalence**

Prospective Adjustments for Policy and Program Changes

Repeat Adjustments	New Adjustments	Adjustments to be included in Final Capitation Rates	Discontinued Adjustments
▪ Trend (Utilization and Unit Cost) ▪ Autism Fee Schedule ▪ DCW Adjustment	▪ CCBHC Fee Schedule Reprice	▪ Continuous eligibility expiration	▪ Autism Treatment Prevalence ▪ Additional Utilization Trend ▪ SUD Assessment

Trend Selection Methodology

Per Member Per Month (PMPM)

- Developed by evaluating rolling 12-PMPM trends
- Selected trend reflects blend of average trend from most recent six months and average trend from most recent eighteen months

Cost Per Unit

- Utilize Federal Reserve Economic Data
- Analyze June 2021 to May 2023 annualized wage trends
- Analyze emerging wage trends from the last 6 months
- Prospective trend utilizes an average of historic and emerging trends

Utilization per 1,000

- Utilization per 1,000 trend was calculated such that the product of the cost per unit and utilization per 1,000 trends equal the PMPM trend
- The utilization per 1,000 trend has a floor of zero

Prospective Trend Rate by Population and Service Category

Inclusive of both Utilization and Unit Cost

BENEFIT	DAB	TANF	HMP	1915(c) Waiver	COMPOSITE
Autism	7.6%	13.4%	3.8%		**10.2%**
Mental Health 1915(i)	3.8%	3.8%	3.8%		**3.8%**
Mental Health State Plan	4.4%	6.7%	3.8%		**4.8%**
Substance Abuse State Plan	4.6%	7.0%	3.8%		**4.6%**
Children's Waiver Program				5.0%	**5.0%**
Serious Emotional Disturbances				13.2%	**13.2%**
Habilitative Supports Waiver				5.3%	**5.3%**
Composite	**4.4%**	**8.2%**	**3.8%**	**5.4%**	**5.0%**

Insight Annual trend rates illustrated here are applied for 24 months to the midpoint of the SFY 2024 rating period

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DCW Wage Increase

KEY INSIGHTS	ADDITIONAL DETAIL
Assumptions	• Wage increase reflects $2.64 increase per hour inclusive of the corresponding 12% add-on for employer-related costs, consistent with SFY 2023 amended rates.
Changes from SFY 2023	• There are currently no modeled changes from the amended SFY 2023 capitation rates • We will incorporate DCW policy changes based on legislative language in the final capitation rates

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SFY 2024 CCBHC Fee Schedule Adjustment

General Approach

- A SFY 2024 CCBHC fee schedule amount was considered for **each procedure code and modifier combination** included within the SFY 2023 P2 EQI templates
- The fee schedule amount was developed using a combination of both our independent rate model (IRM) and historical EQI unit cost because the IRM is only available for the most highly utilized services
  - When developing an IRM for the EQI code sets, which excludes provider group modifiers, we used the provider group modifier that provides the most CCBHC units of a service based on the SFY 2022 encounter data

Base Capitation Rate Development

- CCBHC program encounter service utilization was identified and adjusted to align with EQI reported data
- SFY 2022 CCBHC program encounter data service utilization was then repriced to the SFY 2024 CCBHC fee schedule

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SFY 2024 CCBHC Fee Schedule Development by Case

CCBHC Services with associated SFY 2024 comparison rates	• The independent rate model (IRM) used to develop the SFY 2024 comparison rates was modified to reflect CCBHC service costs (these modifications are explained in the next slide) • This approach accounts for 92% of CCBHC demonstration expenditures
CCBHC services with CCBHC expenditures reported in the SFY 2022 EQI	• For services without an IRM, a fee schedule payment was developed by taking the 40th percentile SFY 2022 EQI CCBHC unit cost • SFY 2022 EQI CCBHC unit costs were trended to SFY 2024
CCBHC services with BH expenditures reported in the SFY 2022 EQI	• If SFY 2022 CCBHC expenditures were less than $100k for a given service, then a fee schedule payment was developed by taking the average SFY 2022 EQI BH unit cost • SFY 2022 EQI unit costs were trended to SFY 2024
CCBHC services with no BH expenditures reported in the SFY 2022 EQI	• A fee schedule payment was not developed for these CCBHC services • These services will be reviewed in future years and a payment will be developed if any of the above cases are applicable

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CCBHC Fee Schedule Independent Rate Model Development

Leverages SFY 2024 BH Comparison Rate Modeling as a starting point

- Key updates from SFY 2023 include utilization of January 2023 wage data, utilization of 2022 Provider Service Expense Template data for administrative assumptions, and an insurance buildup adjustment for the HM-less than bachelor's level provider modifier (assuming less than 100% of HM employees "take up" employer insurance)
- For SFY 2024, wages and ERE comparison rate assumptions reflect **non-CMHSP** costs

Modification #1 – Reflect CCBHC wage levels

- Wage adjustment factors were developed for the provider modifiers that had the most credible data in the 2023 Provider Salary and Wage Survey (HM, HN, HO, TD) by dividing average CMHSP wage levels for that modifier divided by the respective average non-CMHSP wage levels
- A composite CCBHC wage factor was developed to be used for all other provider modifiers by weighing the calculated wage adjustment factors by FTE count

Modification #2 – Reflect CCBHC benefits levels

- Benefit adjustment factors were developed for the provider modifiers that had the most credible data in the 2023 Provider Salary and Wage Survey (HM, HN, HO, TD) by dividing average reported CMHSP benefits (retirement and insurance) by average reported non-CMHSP benefits
- A composite CCBHC benefits factor was developed for all other provider modifiers by weighing the calculated ERE adjustment factors by FTE count

CCBHC Fee Schedule Independent Rate Model Modifications

Distribution of CCBHC Wage and Benefits by Provider Group Modifier

WAGE AND BENEFITS FACTORS BY PROVIDER MODIFIER

PROVIDER MODIFIER	WAGE ADJUSTMENT FACTOR	BENEFITS ADJUSTMENT FACTOR
HM	119%	220%
HN	108%	150%
HO	108%	149%
TD	94%	140%
Composite	**110%**	**165%**

Note: CMHSP HM employees are assumed to take-up employer insurance 76% of the time when offered, which is 9% higher than the non-CMHSP HM take-up percentage assumption of 67%

Continuous Eligibility Expiration Anticipated Impacts

- This adjustment is not considered in the draft rate presentation. Final 2024 capitation rates will include updated calculations for enrollment and an adjustment for changes in acuity
- **Effective July 2023, but most July 2023 disenrollments will be delayed until August 2023**
- We will review redetermination dates by rate cell and perform any rate adjustments at the rate cell level
- Assuming enrollment drops uniformly across 12-month period.
- **Current Assumption:** Targeting decrease of approximately 60% of the growth between pre-pandemic and current enrollment levels
- Intend to review changes in emerging Michigan enrollment to modify assumptions as necessary

Non-Benefit Expense Assumptions

Administrative Cost

- The SFY 2024 administrative allowance, inclusive of risk margin, was increased to approximately 7.00% in composite
  - HMP 6.75% variable administrative allowance
  - Non-HMP 5.00% variable administrative allowance
  - Fixed administrative component (limited to DAB and TANF populations)

Risk Margin

- The SFY 2024 risk margin for the behavioral health program reflects 0.75%, consistent with prior years

Summary of SFY 2024 Capitation Rate Development

DESCRIPTION	(MILLIONS)	PERCENTAGE	RATE IMPACT PMPM
SFY 2022 Base Encounter Experience	$ 3,123.3		$ 88.73
SFY 2022 Retrospective Adjustments			
EQI Repricing - Utilization	($ 31.3)	(1.0%)	$ (0.89)
EQI Repricing - Unit Cost	$ 222.4	7.2%	$ 6.32
Removal of Jail Services	($ 14.5)	(0.4%)	$ (0.41)
Removal of Mild-to-Moderate Services	($ 51.1)	(1.5%)	$ (1.45)
Removal of IMD Stays over 15 Days	($ 22.8)	(0.7%)	$ (0.65)
Direct Care Worker Increase	($ 169.9)	(5.3%)	$ (4.83)
Methadone Unit Cost	$ 25.5	0.8%	$ 0.72
SFY 2024 Prospective Adjustments			
Utilization and Unit Cost Trend	$ 318.8	10.3%	$ 9.06
Morbidity	$ 0.0	0.0%	$ 0.00
ABA Fee Schedule Repricing	($ 25.9)	(0.8%)	$ (0.74)
DCW Add Back	$ 238.9	7.1%	$ 6.79
CCBHC Fee Schedule	($ 135.6)	(3.8%)	$ (3.85)
Non-Benefit Expense Add-Ons			
Managed Care Administration	$ 273.5	7.9%	$ 7.77
Cap to Elig Ratio	$ 24.1	0.6%	$ 0.68
IPA	$ 42.2	1.1%	$ 1.20
HRA	$ 93.4	2.4%	$ 2.65
SFY 2024 Total Projected Expenditures	$ 3,910.9		$ 111.10

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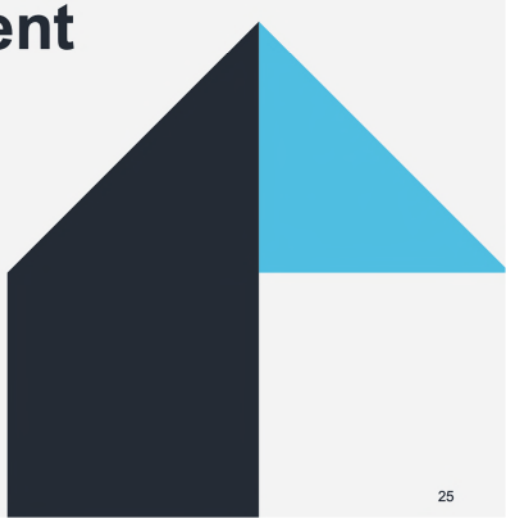
Area Factor Development



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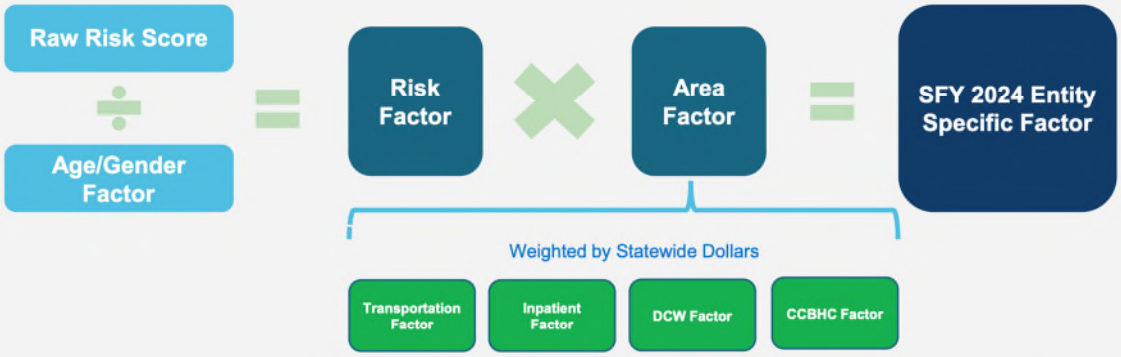
SFY 2024 Capitation Rate Methodology

Entity Specific Factor



Note the SFY 2024 entity factor is then blended 50/50 with the SFY 2023 entity specific factor and normalized for budget neutrality to create the SFY 2024 Effective Entity Specific Factor

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Area Factor Methodology

Approach and percentage weights for blending the area factor components

	Percent of Projected Expenditures	Inpatient Factor	DCW Factor	CCBHC Factor	Transportation Factor
Inpatient Psychiatric Hospital Expenditures	7.2%	X			
DCW Directed Payment Expenditures	5.7%		X		
CCBHC Service Expenditures	27.8%			X	X
All Other Expenditures	59.4%				X

Note: CCBHC service expenditures reflects the statewide percent of expenditures reflecting CCBHC services provided to MH and/or SUD diagnosed individuals.

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Area Factor Methodology

Inpatient and Transportation Factor Components

- Weighted approach accounting for total cost attributable to inpatient (based on unit cost variation) vs non-inpatient services (based on transportation factor), consistent with SFY 2023
- Transportation factor methodology
  - We are using the SFY 2024 comparison rates to estimate the impact of transportation by geographic region
  - We have continued to classify areas into one of three categories (urban, rural, and frontier) based on the population density at the county level, which is then composited to the PIHP by population
  - We will multiply statewide utilization by the rate for each service adjusted for transportation expense differences to get the expenditure difference and corresponding factor for each of the three areas

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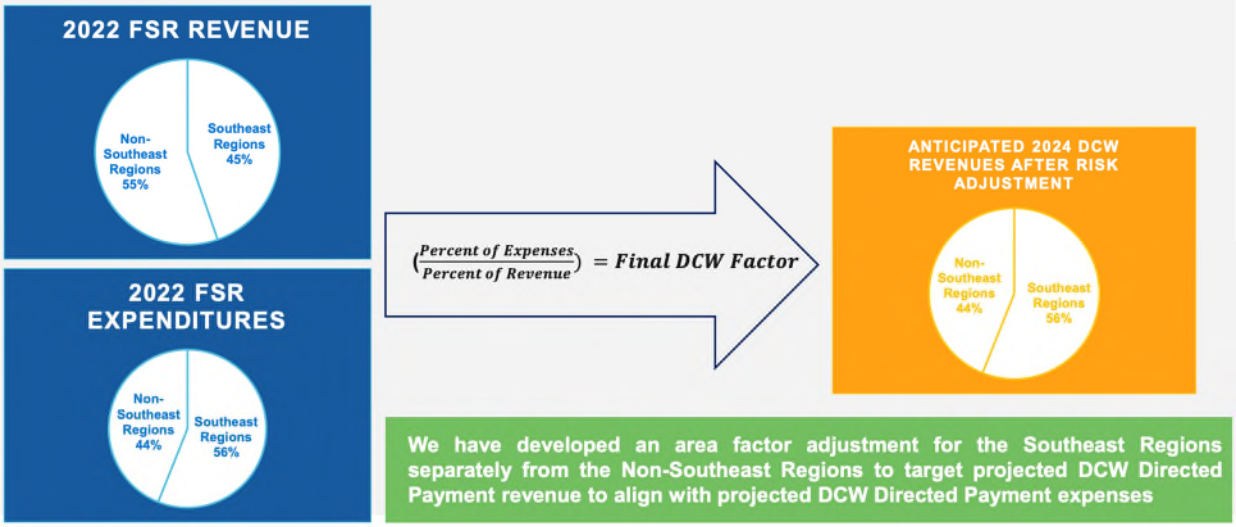
Area Factor Methodology

DCW Factor Component



We have developed an area factor adjustment for the Southeast Regions separately from the Non-Southeast Regions to target projected DCW Directed Payment revenue to align with projected DCW Directed Payment expenses

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Area Factor Methodology

CCBHC Factor Development

PIHP	ENTITY SPECIFIC FACTOR	CAPITATION RATE	CCBHC PROGRAM CHANGE ADJUSTED CAPITATION RATE	CCBHC AREA FACTOR	ENTITY SPECIFIC FACTOR WITH CCBHC AREA FACTOR	CCBHC FEE SCHEDULE ADJUSTED CAPITATION RATE WITH AREA	SUPPLEMENTAL PMPM
Statewide Capitation Rate		$ 100.00	$ 97.00			$ 97.00	**$3.00**
PIHP - No CCBHCs	0.98	$ 98.00	$ 95.06	1.03	1.01	$ 98.00	$ 0.00
PIHP - All CCBHC	1.02	$ 102.04	$ 98.98	0.97	0.99	$ 96.01	**$6.03**

- This is a simplified example with two PIHPs, one with all CCBHCs and another with no CCBHCs
- The CCBHC area factor is developed as the relativity between the statewide composite capitation rate with and without the CCBHC program changes
- CCBHC program changes include removal of CCBHC mild-to-moderate services and application of the CCBHC fee schedule
- CCBHC program changes reduce base capitation rates given these expenses will be paid through the CCBHC supplemental funding
- The intent of the CCBHC area factor is to not penalize PIHPs with few or no CCBHCs as a result of the CCBHC program changes
- **The CCBHC factor methodology is still under review and is therefore subject to refinements**

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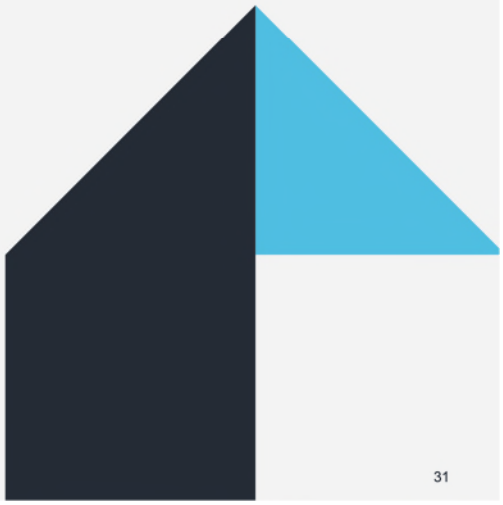
CCBHC Demonstration Program Approach



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SFY 2024 CCBHC Demonstration Program Expansion and Approach

- The CCBHC Demonstration Program is expected to expand from 13 CCBHCs participating in SFY 2023 to 31 CCBHCs participating in SFY 2024
  - *MDHHS expects additional sites to be added in future demonstration years*
- SFY 2024 rate methodology was developed with the expansion of sites as well as operational considerations and timing in mind, which lead to a similar structure to DY 1 and DY 2 with improvements made where possible
- **The rate methodology changes for SFY 2024 do not represent long-term decisions; changes for future DYs will be considered to best support demonstration goals and MDHHS's mission, vision, and values; as well as aligning with federal requirements.**
  - MDHHS future considers include – but are not limited to – valuing base cost per day on service utilization and supplemental payment mechanism changes

SFY 2024 CCBHC Payment Approach

SMI/SED/SUD Base Capitation	• Use of CCBHC fee schedule to develop CCBHC program portion of base capitation rate expenditures • **MDHHS will continue to assume a fixed base capitation cost per day set at the beginning of the year, similar to DY 1 and DY 2, but will base it on fee schedule costs**
SMI/SED/SUD Supplemental Capitation	• Supplemental capitation payments through the PIHP specific to each CCBHC reflecting **75%** of the annual estimated supplemental required. **MDHHS is proposing supplemental capitation payments which reflect 75% of the anticipated funding needed in order to avoid large payment recoupments at year-end**
Mild-to-Moderate PPS-1 Capitation	• Supplemental capitation payments through the PIHP specific to each CCBHC reflecting **75%** of the annual estimated supplemental required.
Reconciliation	• Continuation of current process – Quarterly PIHP-CCBHC reconciliation and MDHHS-PIHP reconciliation. CCBHCs will receive the remaining funding through this process

MDHHS Funding of CCBHC Services Illustration

Population	Behavioral health capitation rates	Supplemental revenue	Other funding
SMI, SED, SUD Medicaid beneficiaries	PPS-1 rate plus PIHP admin and quality incentive		
Mild-to-Moderate Medicaid beneficiaries		PPS-1 rate	
Non-Medicaid beneficiaries			$5M GF pool

Note: The $5M GF pool is subject to SFY 2024 legislative appropriations

PIHP Risk

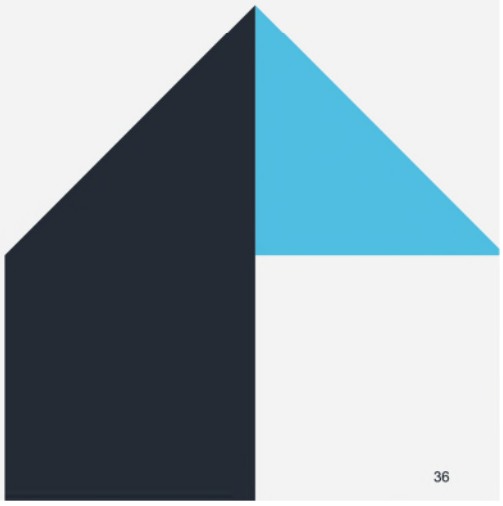
Base Capitation Rates

- Prior to the CCBHC demonstration, the PIHPs were at risk for the total cost of care for behavioral health services for individuals with SMI, SED, SUD, and/or I/DD diagnoses
- In SFY 2024, this risk continues to remain consistent for non-CCBHC services and CCBHC services provided outside the Section 223 Demonstration. For CCBHC Demonstration services, PIHP risk is limited to utilization at a pre-defined cost given the state is directing the PIHPs to pay at the state fee schedule.

Mild-to-Moderate Beneficiaries

- The PIHPs are not responsible for paying for mild-to-moderate beneficiary services. However, MDHHS requests that the PIHPs work with CCBHCs to submit $0 paid encounters to MDHHS for CCBHC Demonstration services provided to mild-to-moderate beneficiaries.

SFY 2024 CCBHC Supplemental Payment Calculation



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SFY 2024 CCBHC Supplemental Payment Calculation

SMI/SED/SUD Members

REFERENCE	DESCRIPTION	CCBHC 1	CCBHC 2
A	SFY 2024 PPS-1 rate developed using SFY 2022 cost reports	$350	$300
B	Projected SFY 2024 cost per day included within base capitation rates based on CCBHC Fee Schedule	$300	$200
C = A - B	CCBHC Supplemental cost per day	$50	$100
D	Projected SFY 2024 SMI/SED/SUD daily visits	20,000	15,000
E = A * D	Projected SFY 2024 CCBHC PPS-1 expenditures for SMI/SED/SUD members	$7,000,000	$4,500,000
F = C * D	Projected SFY 2024 CCBHC supplemental expenditures for SMI/SED/SUD members	$1,000,000	$1,500,000

SFY 2024 CCBHC Supplemental Payment Calculation

Miild-to-Moderate Members

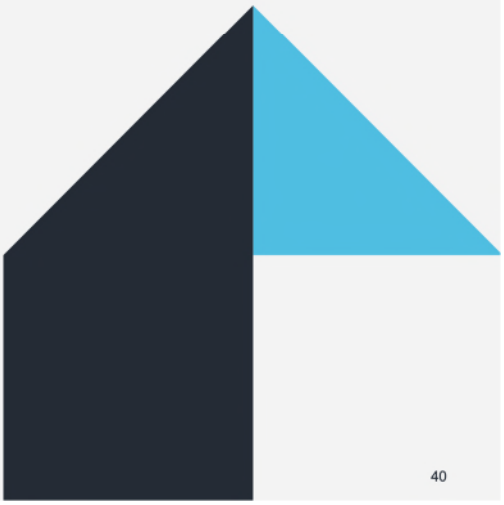
REFERENCE	DESCRIPTION	CCBHC 1	CCBHC 2
G = A	SFY 2024 PPS-1 rate developed using SFY 2022 cost reports	$350	$300
H	Projected SFY 2024 mild-to-moderate daily visits	10,000	5,000
I = G * H	Projected SFY 2024 CCBHC supplemental expenditures for mild-to-moderate members	$3,500,000	$1,500,000

Note: For mild-to-moderate members CCBHC supplemental expenditures are equivalent to CCBHC PPS-1 expenditures

SFY 2024 CCBHC Supplemental Payment Calculation

REFERENCE	DESCRIPTION	CCBHC 1	CCBHC 2
J = E + I	Projected SFY 2024 CCBHC PPS-1 expenditures	$10,500,000	$6,000,000
K = F + I	Projected SFY 2024 CCBHC supplemental expenditures	$4,500,000	$3,000,000
L = J / (100% - 1%) * 1%	PIHP administrative loading (1%)	$106,061	$60,606
M = J/ (100% - 5%) * 5%	Quality incentive (5%)	$552,632	$315,789
N = 75% * K + L + M	Projected SFY 2024 CCBHC supplemental funding paid through capitation payments	$4,033,692	$2,626,396
O	Projected SFY 2024 CCBHC supplemental capitation payments	300,000	200,000
P = N / O	Projected SFY 2024 supplemental capitation payment	$13.45	$13.13

Next steps and Q&A



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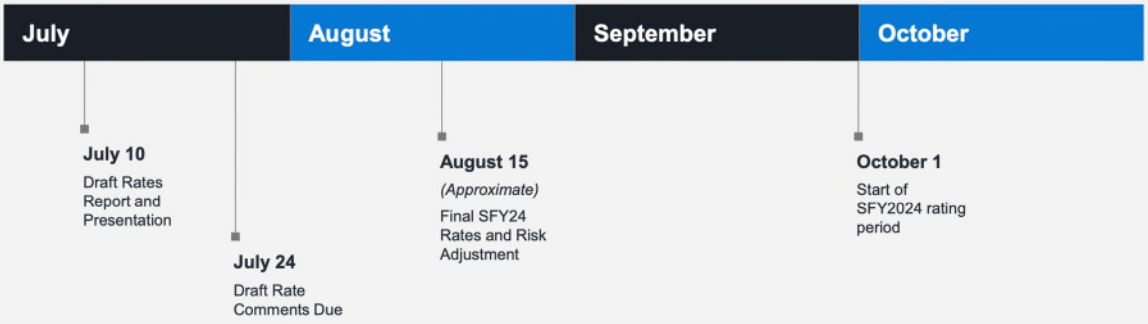
Timeline of Rating Activities

Comments on this presentation from the PIHPs are due by July 24, 2023.

Please Send Feedback To:
MDHHS-MSA-ACTUARIAL-DIVISION <MDHHS-MSA-ACTUARIAL-DIVISION@michigan.gov>



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Next Steps

- Additional meetings will be scheduled as needed to discuss the CCBHC fee schedule and rate impacts on sub-capitated payments
- MDHHS will work with new CCBHC sites to ensure complete and accurate SFY 2022 CCBHC cost report submissions
- Updates for known changes that will be accounted for in the final capitation rates include:
  - Consideration of the continuous eligibility expiration
  - Consideration of DCW policy changes
  - Consideration of additional CAFAS assessment data
  - Supplemental payment calculations for new CCBHC sites

Q&A

If you have a question, please add it to the chat.

Limitations and Qualifications

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved November 21, 2022.

The information contained in this presentation has been prepared for State of Michigan, Department of Health and Human Services (MDHHS), related Divisions, and their advisors to provide documentation of the methodology and data sources anticipated to be used for developing the certified state fiscal year (SFY) 2024 capitation rates for the behavioral health managed care program. The data and information presented may not be appropriate for any other purpose.

The information contained in this presentation has been prepared for MDHHS, related Divisions, and their advisors. To the extent that the information contained in this presentation is provided to any approved third parties, the presentation should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

We have developed certain models to estimate the information included in this presentation. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models, including all input, calculations, and output may not be appropriate for any other purpose.

In performing this analysis, we relied on data and other information provided by MDHHS. We did not audit or verify this data and other information. If the underlying data is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Milliman makes no representations or warranties regarding the contents of this presentation to third parties. Likewise, third parties are instructed that they are to place no reliance upon this presentation prepared for MDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this presentation must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

The presenters of this material are Members of the American Academy of Actuaries and meet the Qualification Standards of the Academy for performing the analyses contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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Thank you

Jeremy Cunningham
jeremy.cunningham@milliman.com

APPENDIX B

Michigan Medicaid Medical Necessity Criteria:

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability, or substance use disorder; and/or
- Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:
    - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
    - that are experimental or investigational in nature; or
    - for which there exists another appropriate, efficacious, less restrictive, and cost-effective service, setting or support that otherwise satisfies the standards for medically necessary services; and/or
- Employ various methods to determine amount, scope, and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

APPENDIX C

Service Contracts

Applied Behavioral Analysis Services	Start Date	End Date
ABA Insight	10/1/2023	09/30/2024
ABA Pathways, LLC	10/1/2023	09/30/2024
Advanced Therapeutic Concepts	10/1/2023	09/30/2024
Autism Spectrum Therapies, LLC dba Total Spectrum	10/1/2023	09/30/2024
BlueMind Therapy LLC	10/1/2023	09/30/2024
Centria Healthcare	10/1/2023	09/30/2024
Creating Brighter Futures	10/1/2023	09/30/2024
Early Autism Services, LLC	10/1/2023	09/30/2024
EMU Autism Collaborative Center	10/1/2023	09/30/2024
Illuminate ABA Services, LLC	10/1/2023	09/30/2024
IvyRehab Michigan, LLC	10/1/2023	09/30/2024
Judson Center	10/1/2023	09/30/2024
Metropolitan Speech, Sensory & ABA Centers	10/1/2023	09/30/2024
Michigan Learning Community, LLC	10/1/2023	09/30/2024
Residential Options, LLC	10/1/2023	09/30/2024
Strident Healthcare	10/1/2023	09/30/2024
Clubhouse/Drop-In Center		
Fresh Start	10/1/2023	09/30/2024
Full Circle Drop-In Center	10/1/2023	09/30/2024
Training & Treatment Innovations, Inc.	10/1/2023	09/30/2024
Community Inpatient Hospitals/Partial Hospitalizations		
BCA of Detroit, LLC dba StoneCrest Center	10/1/2023	09/30/2024
Beaumont Behavioral Health	10/1/2023	09/30/2024
Forest View Hospital	10/1/2023	09/30/2024
Harbor Oaks	10/1/2023	09/30/2024
Havenwyck Hospital	10/1/2023	09/30/2024
Havenwyck Hospital dba Cedar Creek Hospital	10/1/2023	09/30/2024
Hillsdale Medical Center	10/1/2023	09/30/2024
Madison Community Hospital dba Samaritan Behavioral Center	10/1/2023	09/30/2024
Mercy Memorial Hospital	10/1/2023	09/30/2024
New Oakland Family Center	10/1/2023	09/30/2024
Pontiac General	10/1/2023	09/30/2024
The Regents of The University of Michigan	10/1/2023	09/30/2024
Trinity Health-Michigan	10/1/2023	09/30/2024
Community Living Supports- Unlicensed		
CABB Community Supports, LLC	10/1/2023	09/30/2024
CHS Group, LLC	10/1/2023	09/30/2024
Community Residence Corporation	10/1/2023	09/30/2024
ExpertCare	10/1/2023	09/30/2024

Full Life Independence	10/1/2023	09/30/2024
His Eye Is on the Sparrow	10/1/2023	09/30/2024
Home Sweet Home Care Services	10/1/2023	09/30/2024
INI Group, Inc.	10/1/2023	09/30/2024
JOAK American Homes	10/1/2023	09/30/2024
JYB Homecare, LLC	10/1/2023	09/30/2024
Michigan Agency with Choice	10/1/2023	09/30/2024
Renaissance Community Homes, Inc.	10/1/2023	09/30/2024
Southeastern Michigan Nannies DBA Jovie of Ann Arbor	10/1/2023	09/30/2024
Specially Made Co. LLC	10/1/2023	09/30/2024
Spectrum Community Services	10/1/2023	09/30/2024
Synod Community Services	10/1/2023	09/30/2024

Crisis Residential

Beacon Specialized Living Services	10/1/2023	09/30/2024
Synod Community Services	10/1/2023	09/30/2024

Fiscal Intermediaries

Community Living Network	10/1/2023	09/30/2024
Guardian Trac LLC	10/1/2023	09/30/2024

Licensed Residential Services

Adult Learning Systems	10/1/2023	09/30/2024
Beacon Specialized Living Services	10/1/2023	09/30/2024
CBI Rehabilitation Services, Inc.	10/1/2023	09/30/2024
Christ Centered Homes, Inc.	10/1/2023	09/30/2024
Courtyard Manor of Wixom, Inc.	10/1/2023	09/30/2024
Elite AFC, LLC	10/1/2023	09/30/2024
Elite AFC II, LLC	10/1/2023	09/30/2024
Flatrock Manor	10/1/2023	09/30/2024
Henlyn Care	10/1/2023	09/30/2024
Heartland Autism Center	10/1/2023	09/30/2024
Hope Network Behavioral Health Services	10/1/2023	09/30/2024
Hope Network West Michigan	10/1/2023	09/30/2024
JOAK American Homes	10/1/2023	09/30/2024
Jodes Foster Family Home	10/1/2023	09/30/2024
Moriah Inc. DBA Eisenhower Center	10/1/2023	09/30/2024
NRMI, LLC DBA NeuroRestorative	10/1/2023	09/30/2024
PAL's Place	10/1/2023	09/30/2024
Prader Willi Homes of Oconomowoc, LLC	10/1/2023	09/30/2024
Progressive Residential Services	10/1/2023	09/30/2024
Renaissance Community Homes, Inc.	10/1/2023	09/30/2024
Renaissance House, Inc.	10/1/2023	09/30/2024
Saints, Inc.	10/1/2023	09/30/2024
Spectrum Community Services	10/1/2023	09/30/2024
St. Louis Center	10/1/2023	09/30/2024

Synod Community Services	10/1/2023	09/30/2024
Toepfer Home	10/1/2023	09/30/2024
Turning Leaf Behavioral Health Services	10/1/2023	09/30/2024
Umbrellex Behavioral Health Services	10/1/2023	09/30/2024
Pharmacy/Enhanced Pharmacy		
CareLinc Medical Equipment & Supply Co., LLC	10/1/2023	09/30/2024
Genoa Healthcare, LLC	10/1/2023	09/30/2024
Nutritional Healing of Ann Arbor	10/1/2023	09/30/2024
Pharmacy Solutions	10/1/2023	09/30/2024
Private Duty Nursing		
A Quality Staffing, LLC dba Elite Medical Staffing	10/1/2023	09/30/2024
Centria Healthcare	10/1/2023	09/30/2024
HealthCall of Detroit	10/1/2023	09/30/2024
Maxim Healthcare	10/1/2023	09/30/2024
Mercy Plus Healthcare Services	10/1/2023	09/30/2024
Respite/Respite Camps		
CABB Community Supports, LLC	10/1/2023	09/30/2024
Camp Fish Tales	10/1/2023	09/30/2024
CHS Group, LLC	10/1/2023	09/30/2024
Eagle Village	10/1/2023	09/30/2024
ExpertCare	10/1/2023	09/30/2024
Home Sweet Home Cares Services, LLC	10/1/2023	09/30/2024
Howell Nature Center	10/1/2023	09/30/2024
Indian Trails Camp dba IKUS Life Enrichment Services	10/1/2023	09/30/2024
Just Us Club	10/1/2023	09/30/2024
JYB Homecare	10/1/2023	09/30/2024
Methodist Children's Home Society	10/1/2023	09/30/2024
Michigan Agency with Choice, LLC	10/1/2023	09/30/2024
St. Francis Camp on the Lake	10/1/2023	09/30/2024
St. Louis Center	10/1/2023	09/30/2024
Skill Building Services		
CHS Group, LLC	10/1/2023	09/30/2024
Community Works Opportunities	10/1/2023	09/30/2024
Just Us Club	10/1/2023	09/30/2024
Life Enrichment Academy	10/1/2023	09/30/2024
Services to Enhance Potential (STEP)	10/1/2023	09/30/2024
Skills and Abilities Education	10/1/2023	09/30/2024
Work Skills Corporation	10/1/2023	09/30/2024
Specialty Services (OT/PT, Speech, Psychology, Treatment Planning, Supported Housing, etc.)		
ABA Insight	10/1/2023	09/30/2024
ABA Pathways, LLC	10/1/2023	09/30/2024

Advanced Therapeutic Solutions	10/1/2023	09/30/2024
Avalon Housing	10/1/2023	09/30/2024
Creating Brighter Futures	10/1/2023	09/30/2024
EMU Autism Collaborative Center	10/1/2023	09/30/2024
Guardian Medical Monitoring	10/1/2023	09/30/2024
HealthCall of Detroit	10/1/2023	09/30/2024
Metropolitan Speech, Sensory & ABA Centers	10/1/2023	09/30/2024
Psych Resolutions	10/1/2023	09/30/2024
Sharon O'Bryan	10/1/2023	09/30/2024
Therapeutic Concepts, LLC	10/1/2023	09/30/2024
Supported Employment Services		
CHS Group, LLC	10/1/2023	09/30/2024
Community Works Opportunities	10/1/2023	09/30/2024
Life Enrichment Academy	10/1/2023	09/30/2024
Services to Enhance Potential (STEP)	10/1/2023	09/30/2024
Skills and Abilities Education	10/1/2023	09/30/2024
Work Skills Corporation	10/1/2023	09/30/2024
County of Financial Responsibility (Revenue)		
Macomb County CMH	10/1/2023	09/30/2024
Pathways CMH	10/1/2023	09/30/2024
Saginaw CMH	10/1/2023	09/30/2024

*****The contracts listed above have no budget associated with them because they are contingent upon consumer utilization.**

WCCMH Vocational Contracts

Expense	Start Date	End Date	Budget
American Building Services	10/1/2023	09/30/2024	$20,720
Ann Arbor Rug & Carpet Cleaning	10/1/2023	09/30/2024	$9,200
Republic Waste	10/1/2023	09/30/2024	$3,500
Vertex System	10/1/2023	09/30/2024	$2,600
Revenue			
Arbor Bridge Church	10/1/2023	09/30/2024	***
Barr, Anhut & Associates	10/1/2023	09/30/2024	***
Chinmaya Mission	10/1/2023	09/30/2024	***
Full Circle Community Center	10/1/2023	09/30/2024	***
Shelter Association of Washtenaw County	10/1/2023	09/30/2024	***
Washtenaw County Facilities Management	10/1/2023	09/30/2024	***
Washtenaw County Parks and Rec	10/1/2023	09/30/2024	***
Ypsilanti Senior Center	10/1/2023	09/30/2024	***
Ypsilanti Thrift Shop	10/1/2023	09/30/2024	***

***** The revenue is contingent upon the frequency of services provided by consumer vocational groups.**

Administrative Contracts

Revenue Contracts	Start Date	End Date	Budget
15th District Court	10/1/2023	09/30/2024	Per Budget
Blue Care Network	10/1/2023	09/30/2024	Per Budget
CMHPSM Medicaid Revenue Contract	10/1/2023	09/30/2024	Per Budget
Corner Health	10/1/2023	09/30/2024	Per Actual Cost
Hope Clinic	10/1/2023	09/30/2024	Per Actual Cost
Lenawee County CMH	10/1/2023	09/30/2024	Per Actual Cost
Livingston County CMH	10/1/2023	09/30/2024	Per Actual Cost
MDHHS (GF Contract)	10/1/2023	09/30/2024	Per Budget
Michigan Rehabilitation Services	10/1/2023	09/30/2024	Per Budget
Monroe County CMH	10/1/2023	09/30/2024	Per Actual Cost
Packard Health	10/1/2023	09/30/2024	Per Actual Cost
Regents of the University of Michigan (ORR)	10/1/2023	09/30/2024	Per Actual Cost
Washtenaw County Children's Services	10/1/2023	09/30/2024	$330,714
Washtenaw County Sheriff's Office	10/1/2023	09/30/2024	$302,217
Washtenaw County Trial Court	10/1/2023	09/30/2024	$100,000

Medicaid/General Fund Expense Contracts	Start Date	End Date	Budget
Bromberg & Associates, LLC	10/1/2023	09/30/2024	$1,500
Crystal Jackson	10/1/2023	09/30/2024	$4,800
DHHS Liaison	10/1/2023	09/30/2024	$74,150
Drug and Laboratory Disposal	10/1/2023	09/30/2024	$5,000
Dummies on the Run	10/1/2023	09/30/2024	$5,000
Griffin Pest Solutions	10/1/2023	09/30/2024	$5,000
Human Resource Opportunities, Inc.	10/1/2023	09/30/2024	$700,000
Michigan Green Cabs Ann Arbor, LLC	10/1/2023	09/30/2024	$30,000
Michigan Rehabilitative Services	10/1/2023	09/30/2024	$10,000
Monroe County CMH	10/1/2023	09/30/2024	Per Actual Cost
NAMI of Washtenaw County	10/1/2023	09/30/2024	$31,000
PCE Systems	10/1/2023	09/30/2024	$12,000
Relias Learning	10/1/2023	09/30/2024	$44,883
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Roslund Prestage & Company	10/1/2023	09/30/2024	$14,420
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Toby's Instrument Shop	10/1/2023	09/30/2024	$2,000
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Zoom Video Communications, Inc.	10/1/2023	09/30/2024	$39,782

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Avalon	10/1/2023	09/30/2024	$180,000
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Full Circle Community Center	10/1/2023	09/30/2024	$25,000
NAMI	10/1/2023	09/30/2024	$225,900
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Student Advocacy Center	10/1/2023	09/30/2024	$193,643
Washtenaw County Prosecutor's Office	10/1/2023	09/30/2024	$143,114

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Catholic Social Services	10/1/2023	09/30/2024	$20,998
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RDBZ II, LLC	10/1/2023	09/30/2024	$38,400
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Renaissance House, Inc.	10/1/2023	09/30/2024	$25,704
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Spectrum Community Services	10/1/2023	09/30/2024	$11,259
Synod Community Services	10/1/2023	09/30/2024	$29,400

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D.J.'s Landscaping
Michigan State University Community Music School
Mobility Transportation Services, Inc.
Rose Hill Center, Inc.
Source America
Tender Hearts, Inc.
Underground Printing
Vintage Specialized Services, LLC dba Creekside West Residential
Vital Records Control
Y-PCS Group, Inc.

Service Contracts

Applied Behavioral Analysis Services	**Start Date**	**End Date**
ABA Insight	10/1/2023	09/30/2024
ABA Pathways, LLC	10/1/2023	09/30/2024
Advanced Therapeutic Concepts	10/1/2023	09/30/2024
Autism Spectrum Therapies, LLC dba Total Spectrum	10/1/2023	09/30/2024
BlueMind Therapy LLC	10/1/2023	09/30/2024
Centria Healthcare	10/1/2023	09/30/2024
Creating Brighter Futures	10/1/2023	09/30/2024
Early Autism Services, LLC	10/1/2023	09/30/2024
EMU Autism Collaborative Center	10/1/2023	09/30/2024
Illuminate ABA Services, LLC	10/1/2023	09/30/2024
IvyRehab Michigan, LLC	10/1/2023	09/30/2024
Judson Center	10/1/2023	09/30/2024
Metropolitan Speech, Sensory & ABA Centers	10/1/2023	09/30/2024
Michigan Learning Community, LLC	10/1/2023	09/30/2024
Residential Options, LLC	10/1/2023	09/30/2024
Strident Healthcare	10/1/2023	09/30/2024
Clubhouse/Drop-In Center		
Fresh Start	10/1/2023	09/30/2024
Full Circle Drop-In Center	10/1/2023	09/30/2024
Training & Treatment Innovations, Inc.	10/1/2023	09/30/2024
Community Inpatient Hospitals/Partial Hospitalizations		
BCA of Detroit, LLC dba StoneCrest Center	10/1/2023	09/30/2024
Beaumont Behavioral Health	10/1/2023	09/30/2024
Forest View Hospital	10/1/2023	09/30/2024
Harbor Oaks	10/1/2023	09/30/2024
Havenwyck Hospital	10/1/2023	09/30/2024
Havenwyck Hospital dba Cedar Creek Hospital	10/1/2023	09/30/2024
Hillsdale Medical Center	10/1/2023	09/30/2024
Madison Community Hospital dba Samaritan Behavioral Center	10/1/2023	09/30/2024
Mercy Memorial Hospital	10/1/2023	09/30/2024
New Oakland Family Center	10/1/2023	09/30/2024
Pontiac General	10/1/2023	09/30/2024
The Regents of The University of Michigan	10/1/2023	09/30/2024
Trinity Health-Michigan	10/1/2023	09/30/2024
Community Living Supports- Unlicensed		
CABB Community Supports, LLC	10/1/2023	09/30/2024
CHS Group, LLC	10/1/2023	09/30/2024
Community Residence Corporation	10/1/2023	09/30/2024
ExpertCare	10/1/2023	09/30/2024
Full Life Independence	10/1/2023	09/30/2024
His Eye Is on the Sparrow	10/1/2023	09/30/2024

Home Sweet Home Care Services	10/1/2023	09/30/2024
INI Group, Inc.	10/1/2023	09/30/2024
JOAK American Homes	10/1/2023	09/30/2024
JYB Homecare, LLC	10/1/2023	09/30/2024
Michigan Agency with Choice	10/1/2023	09/30/2024
Renaissance Community Homes, Inc.	10/1/2023	09/30/2024
Southeastern Michigan Nannies DBA Jovie of Ann Arbor	10/1/2023	09/30/2024
Specially Made Co. LLC	10/1/2023	09/30/2024
Spectrum Community Services	10/1/2023	09/30/2024
Synod Community Services	10/1/2023	09/30/2024

Crisis Residential

Beacon Specialized Living Services	10/1/2023	09/30/2024
Synod Community Services	10/1/2023	09/30/2024

Fiscal Intermediaries

Community Living Network	10/1/2023	09/30/2024
Guardian Trac LLC	10/1/2023	09/30/2024

Licensed Residential Services

Adult Learning Systems	10/1/2023	09/30/2024
Beacon Specialized Living Services	10/1/2023	09/30/2024
CBI Rehabilitation Services, Inc.	10/1/2023	09/30/2024
Christ Centered Homes, Inc.	10/1/2023	09/30/2024
Courtyard Manor of Wixom, Inc.	10/1/2023	09/30/2024
Elite AFC, LLC	10/1/2023	09/30/2024
Elite AFC II, LLC	10/1/2023	09/30/2024
Flatrock Manor	10/1/2023	09/30/2024
Henlyn Care	10/1/2023	09/30/2024
Heartland Autism Center	10/1/2023	09/30/2024
Hope Network Behavioral Health Services	10/1/2023	09/30/2024
Hope Network West Michigan	10/1/2023	09/30/2024
JOAK American Homes	10/1/2023	09/30/2024
Jodes Foster Family Home	10/1/2023	09/30/2024
Moriah Inc. DBA Eisenhower Center	10/1/2023	09/30/2024
NRMI, LLC DBA NeuroRestorative	10/1/2023	09/30/2024
PAL's Place	10/1/2023	09/30/2024
Prader Willi Homes of Oconomowoc, LLC	10/1/2023	09/30/2024
Progressive Residential Services	10/1/2023	09/30/2024
Renaissance Community Homes, Inc.	10/1/2023	09/30/2024
Renaissance House, Inc.	10/1/2023	09/30/2024
Saints, Inc.	10/1/2023	09/30/2024
Spectrum Community Services	10/1/2023	09/30/2024
St. Louis Center	10/1/2023	09/30/2024
Synod Community Services	10/1/2023	09/30/2024
Toepfer Home	10/1/2023	09/30/2024

Turning Leaf Behavioral Health Services	10/1/2023	09/30/2024
Umbrellex Behavioral Health Services	10/1/2023	09/30/2024
Pharmacy/Enhanced Pharmacy		
CareLinc Medical Equipment & Supply Co., LLC	10/1/2023	09/30/2024
Genoa Healthcare, LLC	10/1/2023	09/30/2024
Nutritional Healing of Ann Arbor	10/1/2023	09/30/2024
Pharmacy Solutions	10/1/2023	09/30/2024
Private Duty Nursing		
A Quality Staffing, LLC dba Elite Medical Staffing	10/1/2023	09/30/2024
Centria Healthcare	10/1/2023	09/30/2024
HealthCall of Detroit	10/1/2023	09/30/2024
Maxim Healthcare	10/1/2023	09/30/2024
Mercy Plus Healthcare Services	10/1/2023	09/30/2024
Respite/Respite Camps		
CABB Community Supports, LLC	10/1/2023	09/30/2024
Camp Fish Tales	10/1/2023	09/30/2024
CHS Group, LLC	10/1/2023	09/30/2024
Eagle Village	10/1/2023	09/30/2024
ExpertCare	10/1/2023	09/30/2024
Home Sweet Home Cares Services, LLC	10/1/2023	09/30/2024
Howell Nature Center	10/1/2023	09/30/2024
Indian Trails Camp dba IKUS Life Enrichment Services	10/1/2023	09/30/2024
Just Us Club	10/1/2023	09/30/2024
JYB Homecare	10/1/2023	09/30/2024
Methodist Children's Home Society	10/1/2023	09/30/2024
Michigan Agency with Choice, LLC	10/1/2023	09/30/2024
St. Francis Camp on the Lake	10/1/2023	09/30/2024
St. Louis Center	10/1/2023	09/30/2024
Skill Building Services		
CHS Group, LLC	10/1/2023	09/30/2024
Community Works Opportunities	10/1/2023	09/30/2024
Just Us Club	10/1/2023	09/30/2024
Life Enrichment Academy	10/1/2023	09/30/2024
Services to Enhance Potential (STEP)	10/1/2023	09/30/2024
Skills and Abilities Education	10/1/2023	09/30/2024
Work Skills Corporation	10/1/2023	09/30/2024
Specialty Services (OT/PT, Speech, Psychology, Treatment Planning, Supported Housing, etc.)		
ABA Insight	10/1/2023	09/30/2024
ABA Pathways, LLC	10/1/2023	09/30/2024
Advanced Therapeutic Solutions	10/1/2023	09/30/2024
Avalon Housing	10/1/2023	09/30/2024

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Guardian Medical Monitoring	10/1/2023	09/30/2024
HealthCall of Detroit	10/1/2023	09/30/2024
Metropolitan Speech, Sensory & ABA Centers	10/1/2023	09/30/2024
Psych Resolutions	10/1/2023	09/30/2024
Sharon O'Bryan	10/1/2023	09/30/2024
Therapeutic Concepts, LLC	10/1/2023	09/30/2024
Supported Employment Services		
CHS Group, LLC	10/1/2023	09/30/2024
Community Works Opportunities	10/1/2023	09/30/2024
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