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 555 Towner St, Ypsilanti**
OR
Virtually at https://zoom.us/j/91439970796
April 25, 2025
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 Quality-Finance Committee Meeting Minutes and Actions 2/10/25 (Attachment #1A)
- B. WCCMH Millage Advisory Committee Meeting Minutes and Actions 2/10/25 (Attachment #1B)
- C. WCCMH Board Meeting Minutes and Actions-2/21/25 (Attachment #1C)
- D. Contracts and Leases (recommended approval by Quality-Finance Committee on 4/14/25 (Attachment #1D)
- E. Executive Director Authorizations (recommended approval by Quality-Finance Committee on 4/14/25 (Attachment #1E)
- F. Program Committee Dashboard FY25, Quarter 1 (Attachment 1F)
- G. WCCMH Advisory Council Meeting Minutes and Actions- 2/12/25 (Attachment #1G)
- H. CMHPSM Policy – Reviewed and Recommended for Approval by Regional Operations Committee
    - Ability to Pay Policy 2025 (Attachment #1H)
    - Consent to Treatment and Services 2025 (Attachment #1I)
    - Corporate Compliance Policy 2025 (Attachment #1J)
    - Emergency Post-Stabilization Services 2025 (Attachment #1K)
    - Financial Audits of Contractors 2025 (Attachment #1L)
    - Office of Recipient Rights 2025 (Attachment #1M)
    - Peer Review Policy 2025 (Attachment #1N)
    - Performance Improvement Policy 2025 (Attachment #1O)

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

VI. Executive Director Report - **T. Cortes** (15 minutes)

VII. CMHPSM Regional Update (5 minutes)

VIII. New Business (60 minutes)
- Michigan Medicaid Program Presentation (Attachment #4) **T. Cortes**
- Annual Recipient Rights Training for Board Members (Attachment #5) **K. Snay**
- Annual Conflict of Interest Policy (Attachment #6)
- Annual Ethics Statement (Attachment #7)
- Board of Commissioners – WCCMH Board member appointment resolution (Attachment #8)

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.

- WCCMH Board Officers for 4/1/25 – 3/31/26 discussion (Attachment #9 & #10)
  - Board Chair – Felicia Brabec
  - Vice Chair - Holly Heaviland
  - Secretary - Anna Dusbiber
  - Treasurer - Marianne Udow-Phillips

- WCCMH Committee assignments 4/1/25 - 3/31/26
  - WCCMH Quality-Finance Committee
  - WCCMH Millage Advisory Committee
  - WCCMH Executive Committee
  - CMHPSM Regional Board

IX. Old Business (0 minutes)
- None

X. Items for Future Discussions (5 minutes)
- Homelessness Updates

XI. Adjournment of Public Meeting (Next WCCMH Board Meeting: June 27, 2025)

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

VIRTUAL MEETING LINK IS:

Join from PC, Mac, iPad, or Android:
https://zoom.us/j/91439970796

Phone one-tap:
+12678310333, 91439970796# US (Philadelphia)
13126266799, 91439970796# +US (Chicago)

Join via audio:
+1 267 831 0333 US (Philadelphia)
+1 312 626 6799 US (Chicago)
+1 646 518 9805 US (New York)
+1 929 205 6099 US (New York)

Webinar ID: 914 3997 0796

International numbers available: https://zoom.us/u/abk70uTfPh

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

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) BOARD

APRIL 25, 2025

CONSENT AGENDA

A. WCCMH Quality-Finance Committee Meeting Minutes and Actions 2/10/25 (Attachment #1A)
B. WCCMH Millage Advisory Committee Meeting Minutes and Actions 2/10/25 (Attachment #1B)
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    - Peer Review Policy 2025 (Attachment #1N)
    - Performance Improvement Policy 2025 (Attachment #1O)

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)

WCCMH QUALITY-FINANCE COMMITTEE MEETING MINUTES

DRAFT

February 10, 2025
Learning Resource Center-Michigan Room (in person)
https://zoom.us/j/99980080251 (virtual)
2:00-3:30 pm

ROLL CALL: A. Dusbiber attending virtually
H. Heaviland attending in person
S. Petty attending in person
M. Tolstyka attending in person

MEMBERS ABSENT: M. Udow-Phillips, B. Higman

STAFF PRESENT: R. Avedisian, N. Phelps, M. Harding, T. Cortes, S. Amos O'Neal, L. Gentz, M. Taylor, L. Higle, S. Ray, T. Florence, E. Waddell, E. Montgomery

OTHERS PRESENT: T. Gavalier

H. Heaviland called the meeting to order at 2:06 pm.

I. Introductions
- None

II. Audience Participation
- None

III. Committee Response to Audience Participation
- None

IV. Quality-Finance Committee Meeting Minutes and Actions from 12/9/24 (Attachment #1)
- Quality-Finance Committee Meeting Minutes and Actions of 12/9/24 were reviewed.

MOTION BY S. PETTY SUPPORTED BY M. TOLSTYKATO RECOMMEND APPROVAL OF THE MINUTES AND ACTIONS FROM DECEMBER 9, 2024, QUALITY-FINANCE COMMITTEE MEETING AS PRESENTED.

ROLL CALL VOTE:

DUSBIBER	**Y**	**HEAVILAND**	**Y**
HIGMAN	**N/A**	**PETTY**	**Y**
TOLSTYKA	**Y**	**UDOW-PHILLIPS**	**N/A**

MOTION CARRIED

M. Tolstyka left the meeting.

V. Financial Status Report

- N. Phelps presented the Financial Status Report for the period ending February 2, 2025 (Attachment #2)
- Financial Status Report for the period ending February 2, 2025, was reviewed, and recommended for approval to the WCCMH Board on 2/21/25.

VI. Contracts and Leases
- None

VII. Executive Director Authorizations
- None

VIII. Regional Finance Update
- None

IX. Old Business
- None

X. New Business
- Program Committee Dashboard FY24, Quarter 4 (Attachment #3)
  - L. Higle presented the Program Dashboard FY24 Quarter 4 for the Committee.

MOTION BY S. PETTY SUPPORTED BY M. TOLSTYKA TO RECOMMEND APPROVAL OF THE PROGRAM COMMITTEE DASHBOARD FY24, QUARTER 4 AS PRESENTED.

ROLL CALL VOTE:

DUSBIBER	**Y**	**HEAVILAND**	**Y**
HIGMAN	**N/A**	**PETTY**	**Y**
TOLSTYKA	**Y**	**UDOW-PHILLIPS**	**N/A**

MOTION CARRIED

- Office of Recipient Rights Annual Report (Attachment #4)
  - L. Raehtz presented the results of the Recipient Rights Annual Report to the Committee.

MOTION BY S. PETTY SUPPORTED BY M. TOLSTKYA TO RECOMMEND APPROVAL OF THE OFFICE OF RECIPIENT RIGHTS ANNUAL REPORT AS PRESENTED.

ROLL CALL VOTE:

DUSBIBER	**Y**	**HEAVILAND**	**Y**
HIGMAN	**N/A**	**PETTY**	**Y**
TOLSTYKA	**Y**	**UDOW-PHILLIPS**	**N/A**

MOTION CARRIED

XI. Items for Future Discussions
- Accounts Receivable

- Cost Per Case Comparisons

XII. Meeting adjourned at 2:49 pm.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH MILLAGE ADVISORY COMMITTEE MEETING MINUTES *DRAFT*
February 10, 2025
Learning Resource Center-Michigan Room (in person)
https://zoom.us/j/98430383197 (virtual)
3:30–5:00 pm

H. Heaviland called the meeting to order at 3:33 pm.

ROLL CALL:	A. Dusbiber attending virtually A. Carlisle attending virtually H. Heaviland attending in person B. Higman attending S. Petty attending virtually R. Rion attending in person A. Rooks attending virtually A. Somerville attending virtually G. Waddles Jr attending in person
MEMBERS ABSENT:	M. Udow-Phillips, M. Radzik
STAFF PRESENT:	R. Avedisian, T. Cortes, M. Harding,T. Florence, L. Gentz, N. Phelps, E. Waddell, M. Tasker
OTHERS PRESENT:	L. Lutomski, K. Homan,

NO QUORUM

I. Introductions
- None

II. Audience Participation
- None

III. Committee Response to Audience Participation
- None

IV. Millage Advisory Committee Minutes and Actions from 12/9/24 (Attachment #1)
- Millage Advisory Committee Minutes and Actions from 12/9/24, was reviewed, and recommended for approval to the WCCMH Board on 2/21/25.

V. Discussion Items
- Millage Process, Investments and Progress Update
  - L. Gentz presented the Millage Process, Investment and Progress update to the Committee.
  - L. Gentz proposed to the Committee to change the meeting frequency of the Millage Advisory Committee Meeting now that the RFP has been completed for the next 3 years.
  - L. Gentz/T. Cortes suggested moving to quarterly and having funding recipients attend meetings to provide progress updates.
  - H. Heaviland and G. Waddles Jr supported quarterly meetings and inquired about virtual being allowed since recommendations are made and sent to full board.
- CARES/CCBHC Data Report
  - L. Gentz provided and update on the CARES/CCBHC Data Report to the Committee.

VI. Financial Budget Update
- Financial Budget Update (Attachment #2)
  - N. Phelps presented the Financial Budget update ending December 31, 2024, to the Committee.

VII. Old Business Washtenaw County Sheriff's Office (WCSO) Millage and Financial Status Update
- None

VIII. New Business –
- Overview of New Millage Funded Projects (Attachment #3)
  - L. Gentz provided an update on the New Millage Funded Projects to the Committee.

IX. Items for Future Discussions
- Millage Investment Plan
- Washtenaw Coordinated Funding Partnership Update
- CHRT gaps analysis

MOTION BY G. WADDLES JR, SUPPORTED BY R. RION TO ADJOURN THE WCCMH MILLAGE ADVISORY COMMITTEE MEETING.

Meeting adjourned at 3:55 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/94523717923
February 21, 2025
9:30am

H. Heaviland called the meeting to order at 9:37 am.

ROLL CALL:	H. Heaviland attending in person B. Higman attending in person A. LaBarre attending in person S. Petty attending in person A. Rooks attending in person M. Udow-Phillips attending in person
MEMBERS ABSENT:	A. Dusbiber, B. King, K. Scott, A. Somerville, M. Tolstyka
STAFF PRESENT:	R. Avedisian, M. Harding, T. Cortes, N. Phelps, L. Gentz, M. Taylor, S. Ray, K. Snay, M. Hershberger, E. Montgomery,
OTHERS PRESENT:	L. Lutomski, T. Gavalier, A. Allman, J. Yost

I. Introductions
- None

II. Audience Participation
- None

III. Board response to audience participation
- None

IV. Consent Agenda Actions (Attachment #1)
A. WCCMH Quality-Finance Committee Meeting Minutes and Actions 12/9/24 (Attachment #1A)
B. WCCMH Millage Advisory Committee Meeting Minutes and Actions 12/9/24 (Attachment #1B)
C. WCCMH Board Meeting Minutes and Actions-12/13/24 (Attachment #1C)
D. Program Dashboard FY24, Quarter 3, 2024 (Attachment #1D)
E. WCCMH Advisory Council Meeting Minutes and Actions- 10/9/24 (Attachment #1E)
F. WCCMH Advisory Council Meeting Minutes and Actions- 11/13/24 (Attachment #1F)
G. WCCMH Advisory Council Meeting Minutes and Actions- 12/11/24 (Attachment #1G)
H. WCCMH Advisory Council Meeting Minutes and Actions- 1/8/25 (Attachment #1H)

MOTION BY M. UDOW-PHILLIPS SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE FEBRUARY 21, 2025, WCCMH BOARD CONSENT AGENDA AS PRESENTED.

ROLL CALL VOTE:

DUSBIBER	**N/A**	**HEAVILAND**	**Y**
HIGMAN	**Y**	**KING**	**N/A**
LABARRE	**Y**	**PETTY**	**Y**
ROOKS	**Y**	**SCOTT**	**N/A**
SOMERVILLE	**N/A**	**TOLSTYKA**	**N/A**
UDOW-PHILLIPS	**Y**		

MOTION CARRIED

V. Treasurer's Report
- WCCMH Financial Status Report (Attachment #2)
  - N. Phelps presented the Preliminary Financial Status Report to the Board for the period ending December 31, 2024.

MOTION BY M. UDOW-PHILLIPS SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE OF THE FINANCIAL STATUS REPORT ENDING DECEMBER 31, 2024, AS PRESENTED.

ROLL CALL VOTE:

DUSBIBER	**N/A**	**HEAVILAND**	**Y**
HIGMAN	**Y**	**KING**	**N/A**
LABARRE	**Y**	**PETTY**	**Y**
ROOKS	**Y**	**SCOTT**	**N/A**
SOMERVILLE	**N/A**	**TOLSTYKA**	**N/A**
UDOW-PHILLIPS	**Y**		

MOTION CARRIED

- WCCMH Millage Financial Status Report (Attachment #3)
  - N. Phelps presented the Millage Financial Status Report for the period ending December 31, 2024.

MOTION BY M. UDOW-PHILLIPS SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE MILLAGE FINANCIAL STATUS REPORT FOR THE PERIOD ENDING DECEMBER 31, 2024, AS PRESENTED.

ROLL CALL VOTE:

DUSBIBER	**N/A**	**HEAVILAND**	**Y**
HIGMAN	**Y**	**KING**	**N/A**
LABARRE	**Y**	**PETTY**	**Y**
ROOKS	**Y**	**SCOTT**	**N/A**
SOMERVILLE	**N/A**	**TOLSTYKA**	**N/A**
UDOW-PHILLIPS	**Y**		

MOTION CARRIED

VI. Executive Director report
- T. Cortes presented the Executive Director report to the WCCMH Board
  - T. Cortes provided State and Local updates to the Board.
  - M. Udow-Phillips spoke about the Board tour and how great it was to meet some CMH teams doing what they do daily and how enlightening the tour was. Kudos to the CMH Teams on putting this tour together.

VII. CMHPSM Regional Update
- None

VIII. New Business
- Advisory Council
  - M. Hershberger provided the Advisory Council update to the Board.
- Board Appointment Update
  - T. Cortes provided updates on new board appointments to the Board.
  - A. LaBarre made a motion and H. Heaviland seconded the motion to appoint F. Braebec as the WCCMH Board Chair.

- WCCMH Board Onboarding Process
  - T. Cortes discussed the onboarding process for new board members with the Board.
- Millage RFP Update (Attachment #4)
  - L. Gentz presented the RFP update to the Board.

IX. Old Business
- None

X. Items for future discussion
- Homelessness Updates

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

Meeting adjourned at 11:14 am.

REQUEST: To approve recommendations to the board for the following contract(s) and lease(s):

BACKGROUND:

1. Camp Able: provides Respite Camp services.
2. First Day Home Care: provides Private Duty Nursing (PDN) services.
3. The Imagine Center, LLC: provides Skill Building services.
4. Alpha House: will provide emergency sheltering (hoteling) to families experiencing homelessness and homeless diversion assistance.

Service Contracts

Contractor	Funding	Estimated Budget	Contract Term	Service Description
1. Camp Able	Medicaid	As Authorized	May 1, 2025-September 30, 2025	Respite Camp Services
2. First Day Home Care	Medicaid	As Authorized	May 1, 2025-September 30, 2025	Private Duty Nursing Services
3. The Imagine Center, LLC	Medicaid	As Authorized	March 1, 2025-September 30, 2025	Skill Building Services
4. Alpha House	Millage	$35,000	March 1, 2025-February 28, 2025	Emergency Sheltering & Homeless Diversion Assistance

Executive Director Contract Authorizations
April 2025 Quality-Finance Committee Meeting

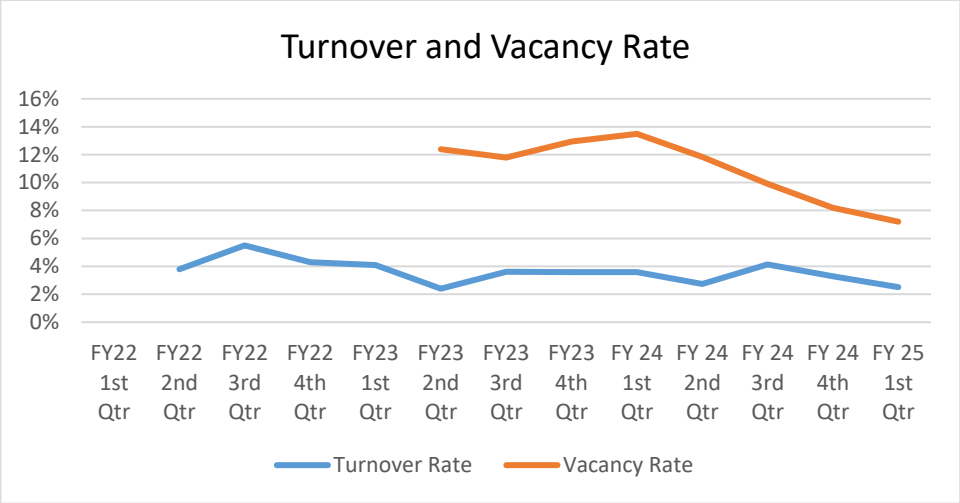
REQUEST: Recommend acceptance of the Executive Director's signature on contracts with a value of less than $25,000

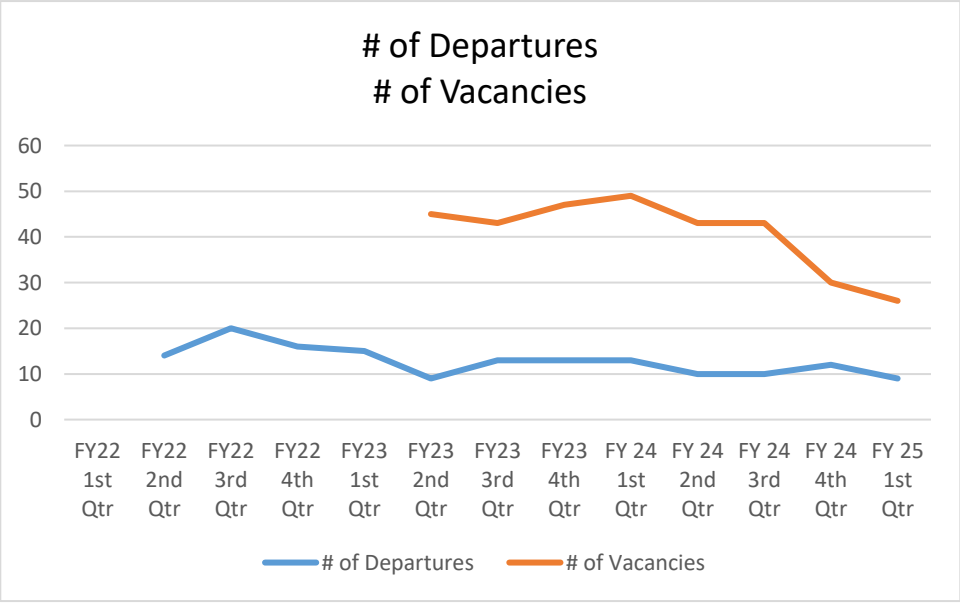
Contractor	Amount	Term	Purpose	Approval Date
Jewish Family Services	$450	March 11, 2025	Leadership Training	
Dr. Shanna Kattari	$2,000	April 1-16, 2025	LGBTQIA2S+, Inclusivity Mental Health & Healthcare Trainings	
Dr. Crystal Jackson	$12,000	April 1, 2025-March 31, 2026	Will provide monthly Supervision to a Temporary Limited Licensed Psychologist	

Quality-Finance Board Committee
Performance Improvement Dashboard 1st Qtr Data FY 2025 (Oct - Dec)

1st quarter Human Resources
Turnover Rate:
2.5%
9 staff left the organization with 363 active positions

Vacancy Rate:
7.2%
26 vacancies with 363 active positions

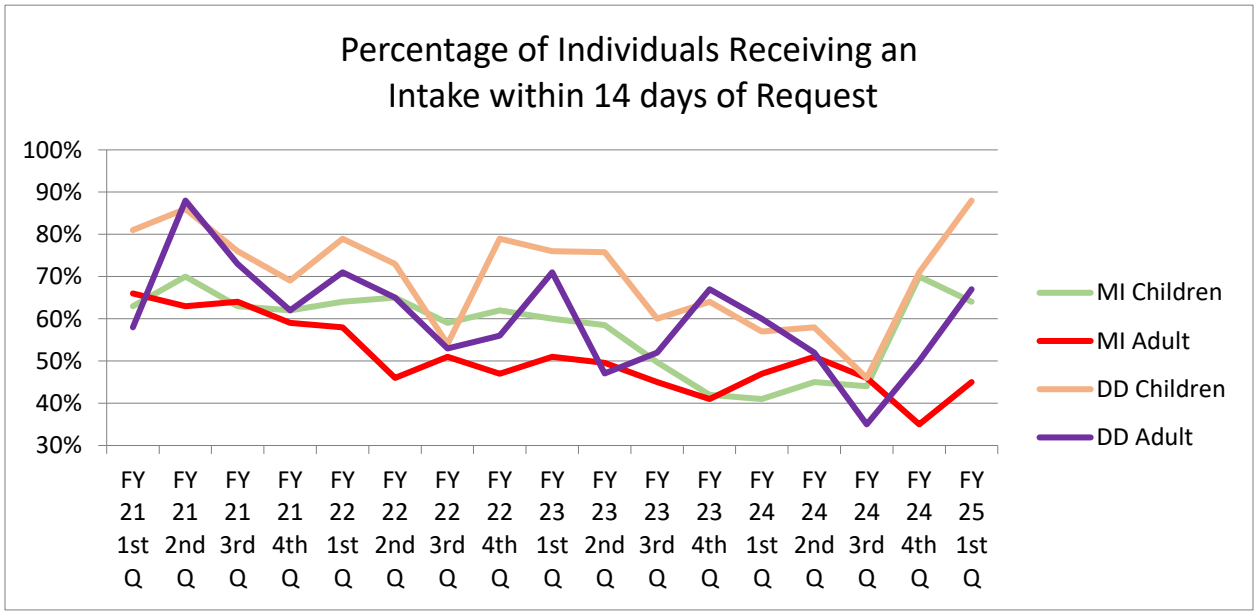




Michigan Department of Health and Human Services (MDHHS) Performance Indicators:
As of April 1, 2020, MDHHS changed the operational definitions for calculating Indicators #2 (14 days to Intake) and #3 (14 days to Ongoing Service) and removed the 95% historical expected goal.

The major change in the operational definition did not allow accounting for consumer choice. 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".

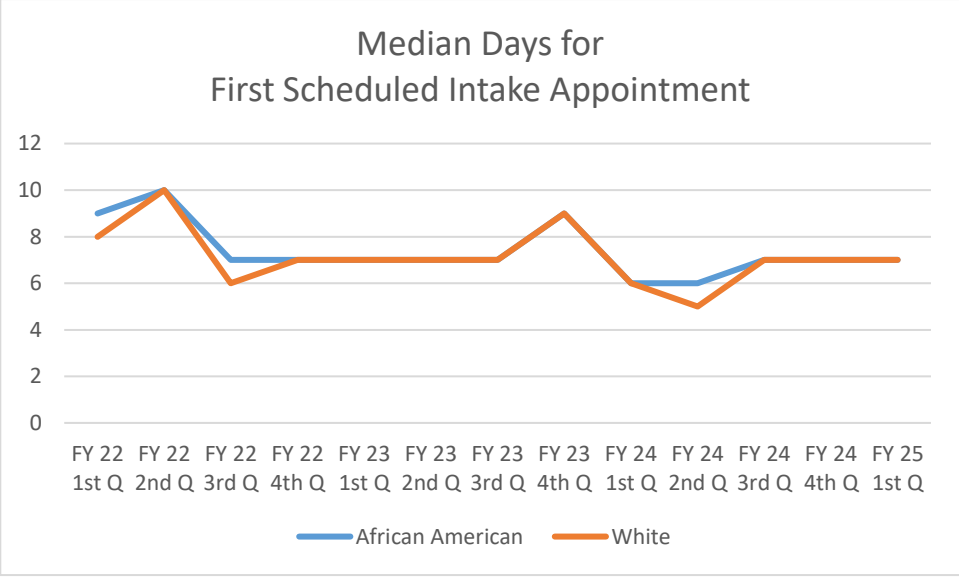
For fiscal year 2024, MDHHS expects each PIHP to move to either the statewide 50th or 75th percentile from FY 22 Regional (PIHP) baseline. For indicator 2 and 3, the PIHP baseline was 61.3% and 74.5% respectively which set an expectation of achieving the 75th percentile for both indicators. The 75th percentile for the indicators are 62% and 83.8% respectively.



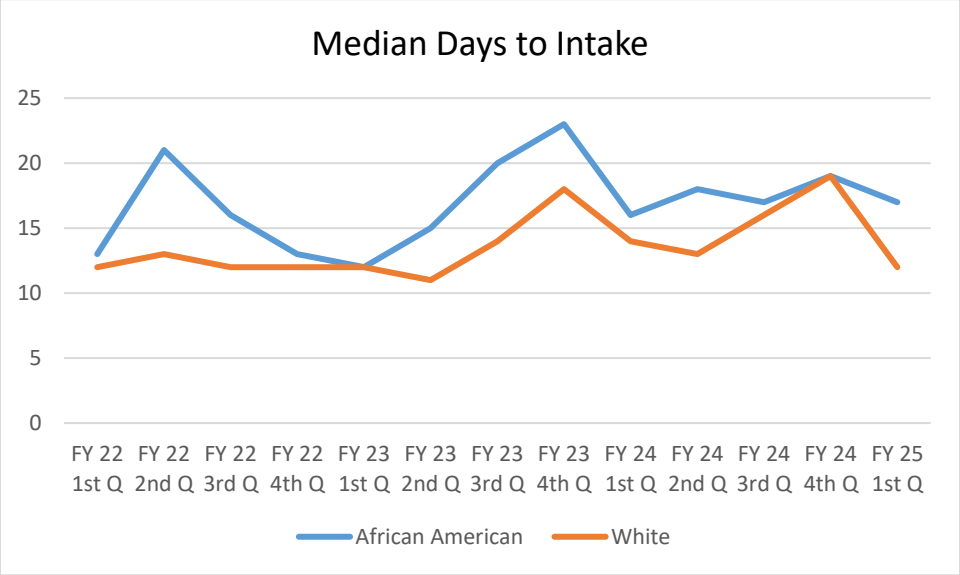
FY 25 1st Qtr Intake Appt within 14 days Detail						
Population	Total # of new persons requesting service	Number receiving appt. within 14 days of request	State defined as Out of Compliance	Consumer Preference (No Show, cancelled or Requested >14 days)- was formerly removed from the denominator	Percent Compliant by new State definition	Percent Compliant in previous definition
MI Child	157	100	57	56	64%	99%
MI Adult	504	225	279	262	45%	93%
DD Child	42	37	5	4	88%	97%
DD Adult	18	12	6	6	67%	100%

Recently the PIHP responded to a request for data graphs to help understand the dataset comparing the number of days from request for service to the first scheduled BPS date and the number of days from the request for service to the the actual BPS date. The median number of days was identified for both datapoints.

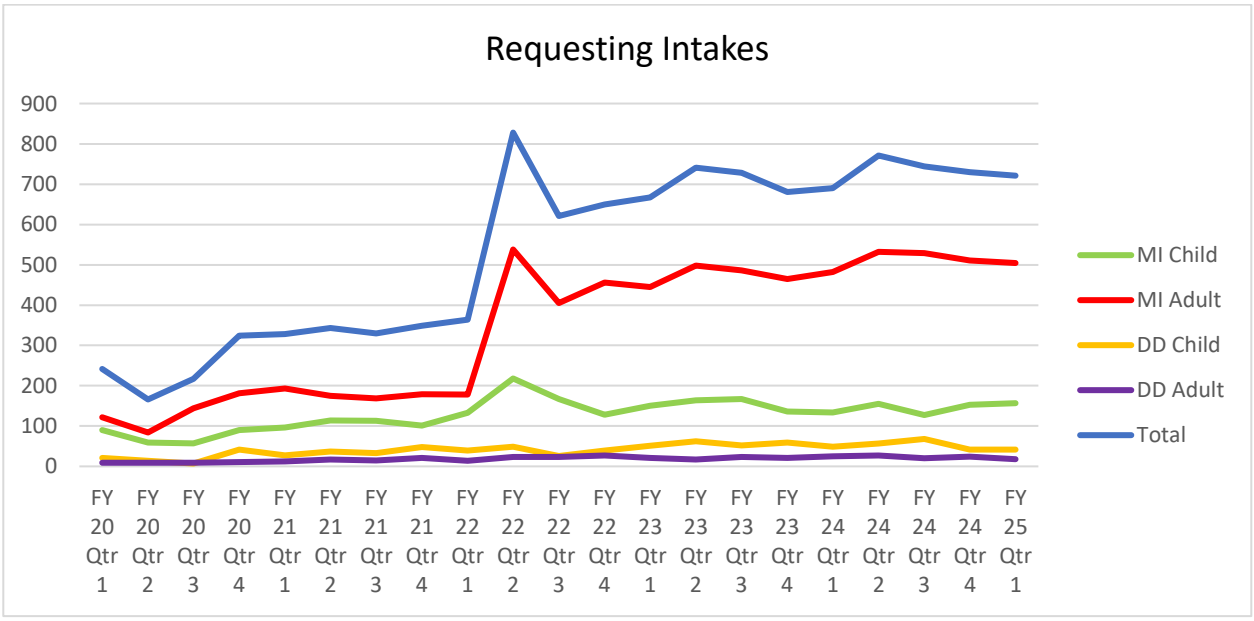
Below are graphs of the four counties in our region. The first graph identifies the median between the request for serivce and the first scheduled BPS date for both white (blue line) and black populations (red line).

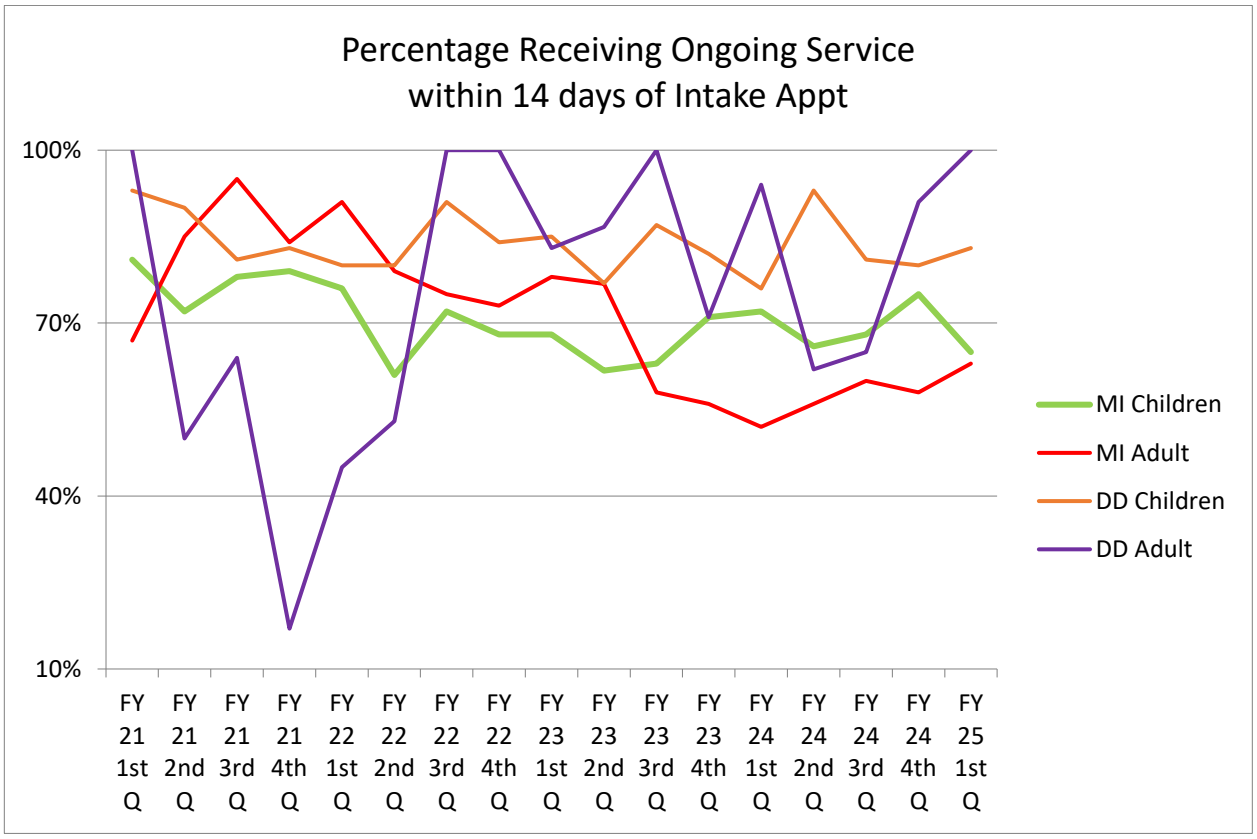


Consumers can have their first appointment scheduled and then can no show, call to reschedule or call to cancel. The first graph shows the median to the first appointment scheduled which are very impressive medians for Washtenaw. Each of those datapoints reflect a number where the dataset is 50% below (as well as 50% above) confirming our Access department tries very hard to schedule people quickly. We know that a large number of consumers end up receiving their intake/ BPS outside of 14 days. The graph below identifies the median number of days from the request for service to the actual BPS for the same populations and legend.



The graph displays when they actually received their appointment. This difference is due to a very high percentage of consumer no show, consumer canceled and consumer rescheduled appointments. The data clearly supports this.

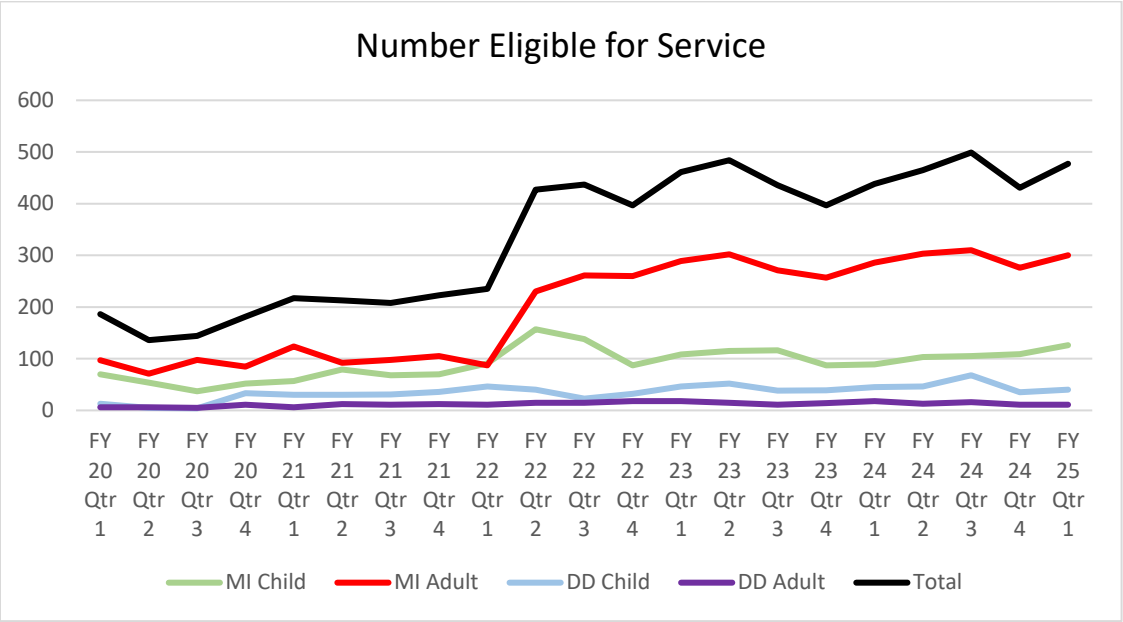


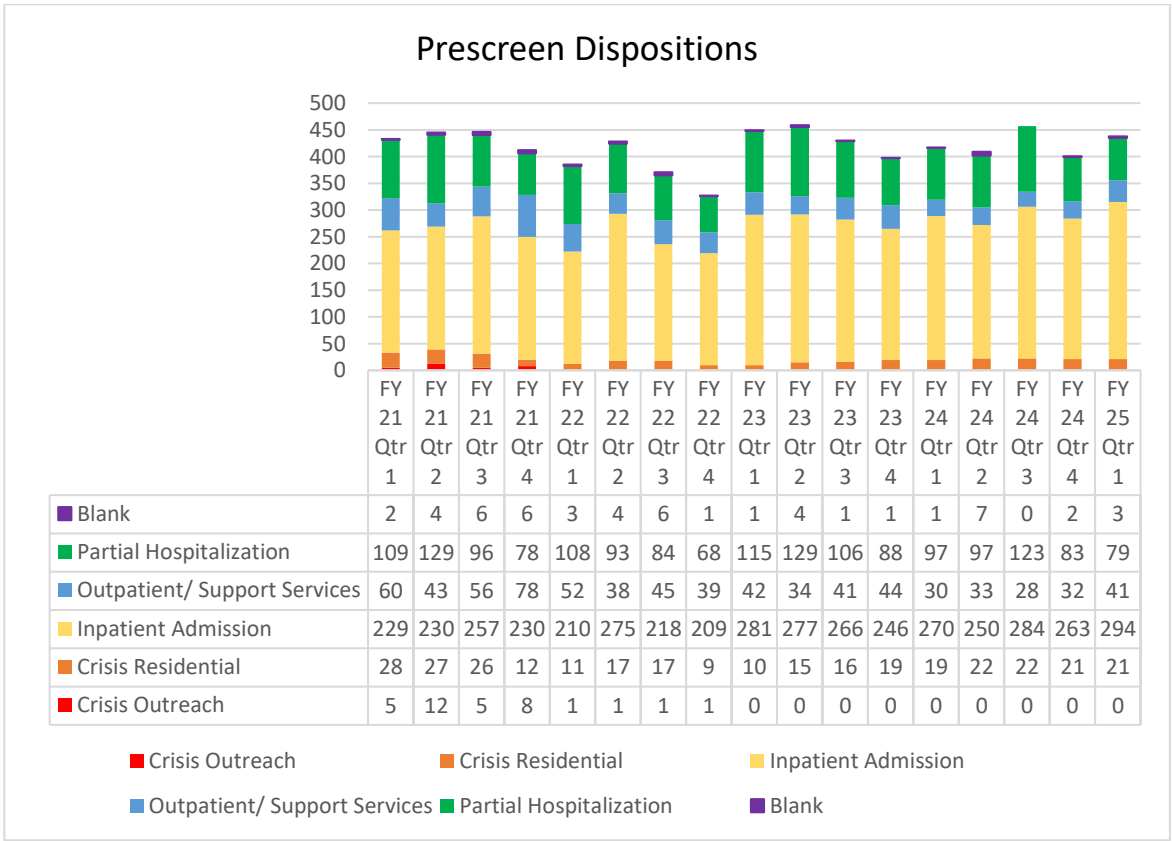


FY 25 1st Qtr Detail Ongoing Service						
Population	# of New Persons Eligible for Service	# of New Persons who started a new service within 14 days of eligibility	State Defined as Out of Compliance	Consumer Preference (No Show, cancelled, Requested >14 days or chose to go elsewhere)- used to be removed from the denominator	Percent Compliant under new definition	Percent Compliant under previous definition
MI Child	126	82	44	40	65%	95%
MI Adult	300	189	111	69	63%	82%
DD Child	40	33	7	7	83%	100%
DD Adult	11	11	0	0	100%	100%

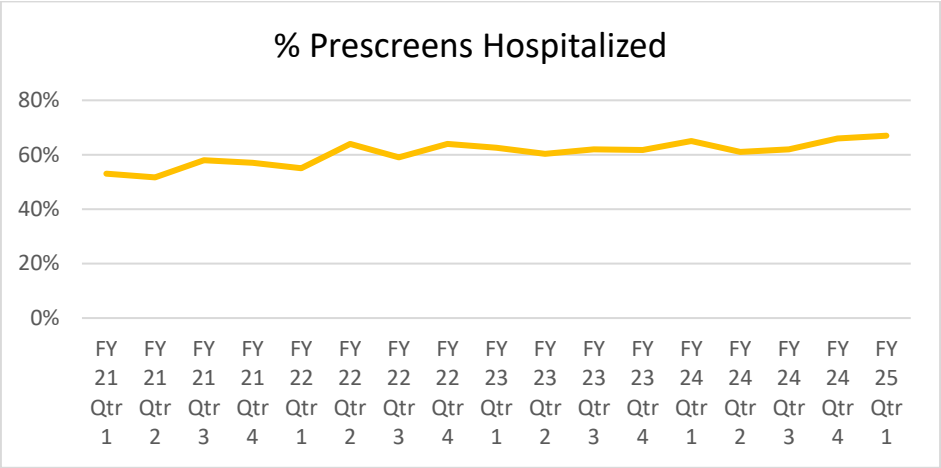
*We have found some individuals who attend their BPS appointment and are found eligible, do not wish to pursue our services. We share other resources with them. These cases still count as out of compliance. The breakdown of these numbers are listed below.

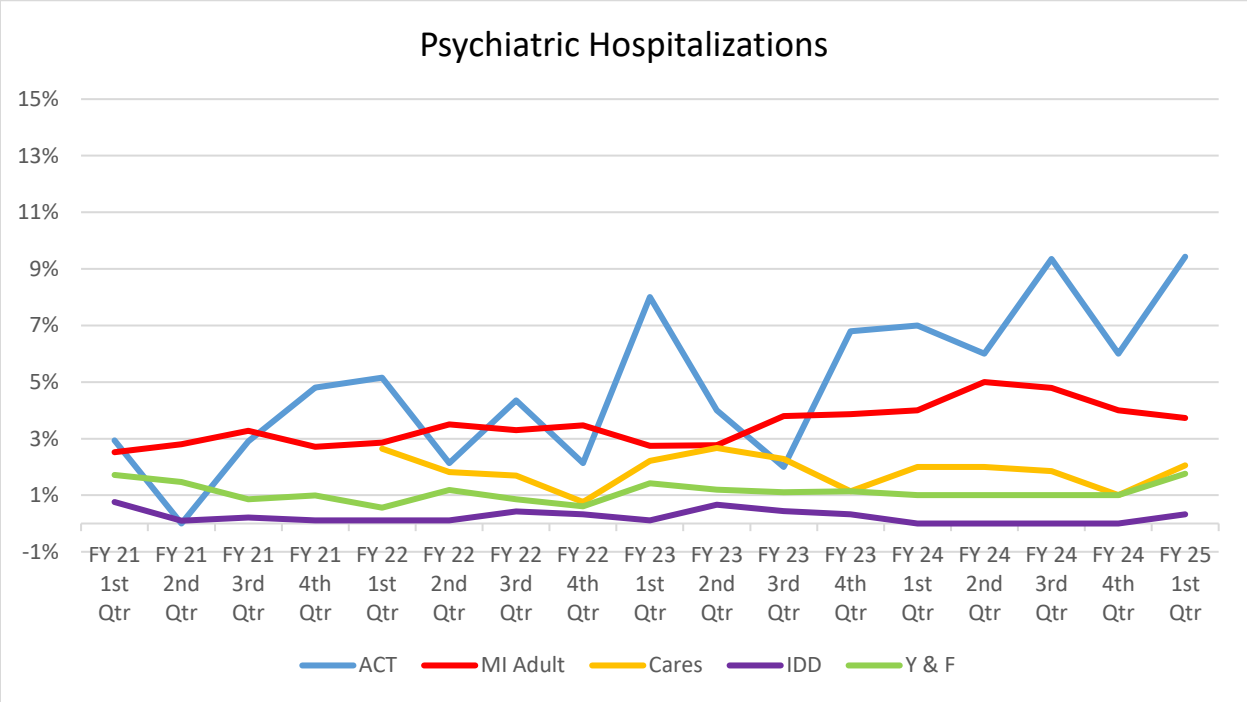
MI Child – 2/44
MI Adult – 26/111



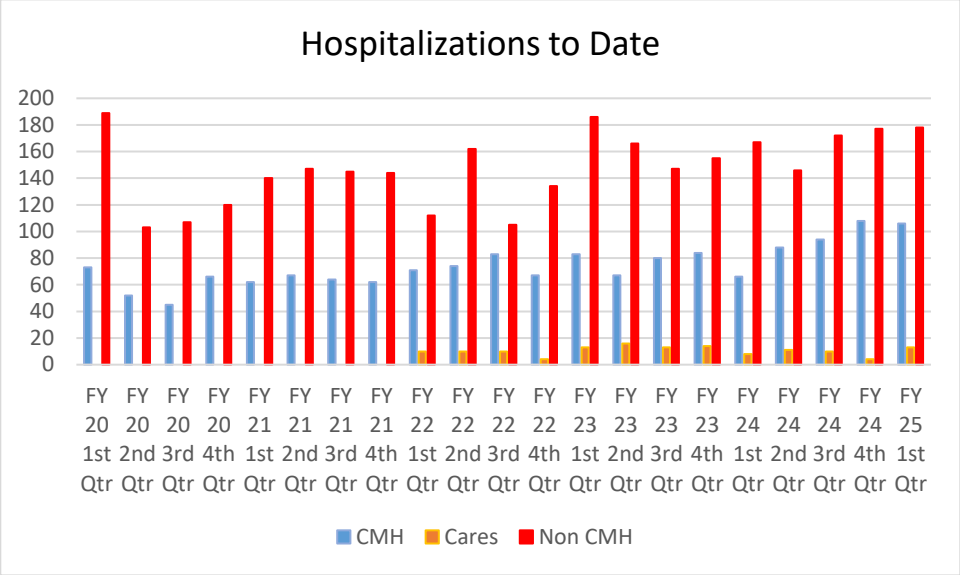


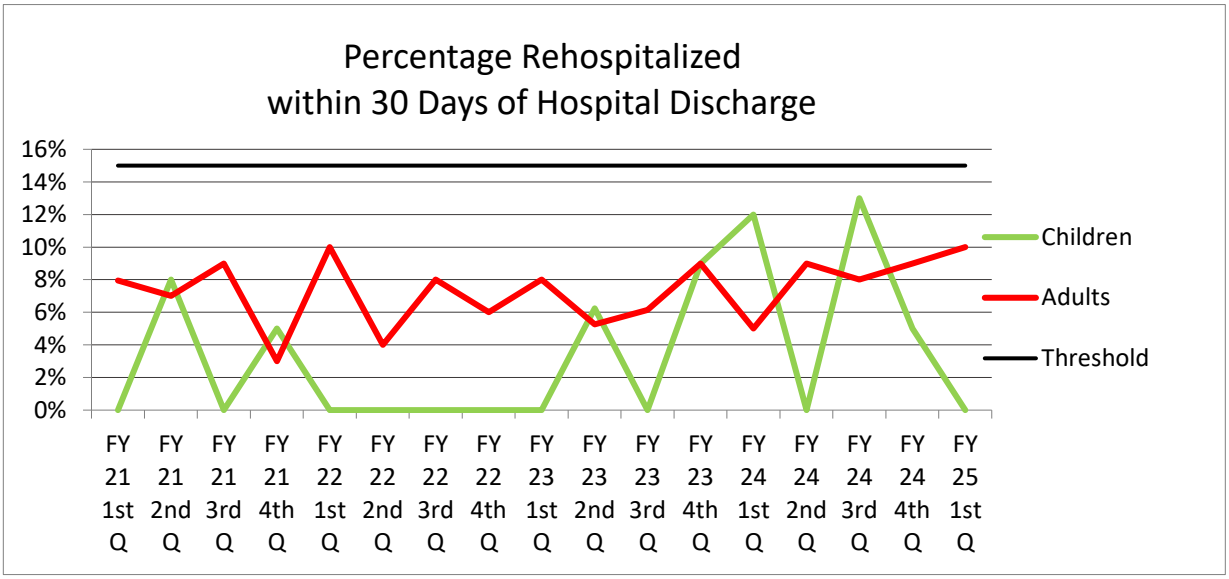
	FY 21 Qtr 1	FY 21 Qtr 2	FY 21 Qtr 3	FY 21 Qtr 4	FY 22 Qtr 1	FY 22 Qtr 2	FY 22 Qtr 3	FY 22 Qtr 4	FY 23 Qtr 1	FY 23 Qtr 2	FY 23 Qtr 3	FY 23 Qtr 4	FY 24 Qtr 1	FY 24 Qtr 2	FY 24 Qtr 3	FY 24 Qtr 4	FY 25 Qtr 1
Blank	2	4	6	6	3	4	6	1	1	4	1	1	1	7	0	2	3
Partial Hospitalization	109	129	96	78	108	93	84	68	115	129	106	88	97	97	123	83	79
Outpatient/ Support Services	60	43	56	78	52	38	45	39	42	34	41	44	30	33	28	32	41
Inpatient Admission	229	230	257	230	210	275	218	209	281	277	266	246	270	250	284	263	294
Crisis Residential	28	27	26	12	11	17	17	9	10	15	16	19	19	22	22	21	21
Crisis Outreach	5	12	5	8	1	1	1	1	0	0	0	0	0	0	0	0	0



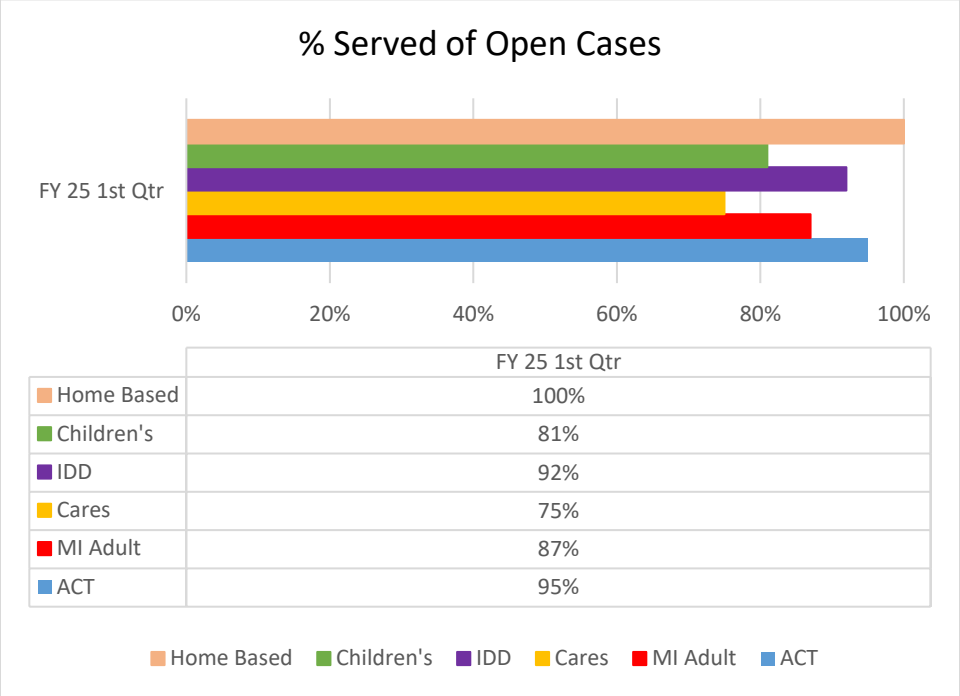


FY 25 1st Qtr Detail Hospitalizations			
Program	Number Served	Number Hospitalized (Multiple Admits)	% Consumers Hospitalized
ACT	106	10 (5)	9.43%
MI Adult	1502	56 (12)	3.73%
Cares	533	11 (2)	2.06%
IDD	948	3 (1)	0.32%
Y & F	964	17 (1)	1.76%





FY 25 1st Qtr Detail Readmit within 30 days of Discharge			
Population	# Discharged and Core Team Assignment	# Readmitted within 30 days of Discharge	% Readmit
Child	20	0	0%
Adult	155	16	10%



	FY 25 1st Qtr
Home Based	100%
Children's	81%
IDD	92%
Cares	75%
MI Adult	87%
ACT	95%

Critical Event Data Reported Thru Qtr 1 FY 2025

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	Non Suicide Death	2
	CARES	Non Suicide Death	1
	IDD	Non Suicide Death	3
	MI Adult	Non Suicide Death	9
Qtr 1 Total			15

Mortality Data Thru Qtr 1 FY 2025

Cause of Death	Number of Deaths FY 22	Number of Deaths FY 23	Number of Deaths FY 24	Number of Deaths FY 25
Aspiration Pneumonia	3	4	1	
Cancer	3	8	2	1
Cardiovascular	12	10	20	3
Dehydration				
Diabetes				
Drug Abuse	6	10	5	
Endocrine System (Diabetes)				
Environmental Hypothermia				
Fluid Electrolyte Disturbance		1		
Gastrointestinal		3	3	1
Hip Fracture Complications				
Homicide		3		
Hyponatremia	2			
Infection	4 (3 - COVID 19)		2	1
Kidney Disease		1	1	
Liver Disease	1	1	1	
Metabolic				
Medication Toxicity				1
Natural/Other				
Neurological	3	3	3	3
Respiratory	5	5	5	2
Suicide	2	6	1	
Trauma	3	2	1	
Unknown	10	8	3	3
Grand Total	**54**	**65**	**48**	**15**

Sentinel Events: There were no sentinel events in the first quarter.

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

February 12, 2024

Members Potentially Present/on the Call: Melissa Concannon (Chair), Lisa deRamos, Joy Duffy (Co-Chair), Leo Hanifin, Barb Higman, Alayna Manzanares, Alyssa Newsome, Pam Rathbun, Jason Zurawski (Secretary).
Staff: Mert Hershberger (Staff Liaison).
Guest: Melisa Tasker (Program Administrator)
Absent: Darren Beland, Anton Clark, Lisa Porzondek.

Meeting called to order at: _ 12:32 _ pm_. MOTION BY _ Pam _ - SUPPORTED BY _ Leo _: APPROVE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) ADVISORY COUNCIL (AC) CONSENT AGENDA. MOTION CARRIED.

I. **Regional Update:**
   A. **Arts & Crafts Show** – @Learning Resource Center -4135 Washtenaw Ave, Ann Arbor, MI 48108 https://bit.ly/cmhcraftshowsignup. Leo has a flyer. Listed deadline of March 28, 2025 while allowing people to register afterwards if there is still room and interest. Email Mert or Lisa deRamos with feedback or suggested changes for the form. Venmo is the recommended app for all who sign up for a table. Bottled water and snacks from the IDD Kitchen will be provided. Tables by Public Health & the Wish You Knew campaign, CMHs, NAMI and other groups promoting mental health.
   Proposed date and time 4/25/25 from 1pm-7pm. (Rooms reserved 2 hours early for set up and one hour later for cleanup.)
   Washtenaw County Learning Resource Center, 4135 Washtenaw Ave, Ann Arbor, Michigan
   If you are an artist/crafter who has received help from CMH in Lenawee, Livingston, Monroe, or Washtenaw County and are interested in showcasing your work, sign up!
   Any family friendly arts and crafts that the individual has created may be sold, unlike the Traveling Arts Show: Needlework, fabric arts, paintings, sketches, sculptures, mixed media, culinary arts, woodwork, metalwork, jewelry, greeting cards, etc.
   Open to the public for shopping and attendance. Please share the invitations.
   A link for signing up to attend: https://bit.ly/cmhcraftshowsignup
   Volunteers: Opening: Pam, Barb, Joy. Tear down & clean-up: Lisa deRamos and Melissa.
II. **Public Health Update: (Lisa deRamos)**
   A. Free WishYouKnew mental health resource materials order form: bit.ly/wykorderform
   B. Free It Is Possible substance use recovery/harm reduction materials order form: bit.ly/iiporder
   C. Sign up for Washtenaw County Health Department weekly updates newsletter: bit.ly/WCHD555
III. **Newsletter**: Nothing immediately available. Lisa reminded Mert to follow up again with Hayley Thompson about sharing the newsletters in some format in a shared file format publicly online: on Facebook or a website.

IV. **NAMI**: **Barb:** Arrangements with Carrie Reignans speaking. Upcoming Story Jam training. Advocacy training RE: Chelsea Hospital, with input on how hospitals operate. Advocacy committee meetings are ongoing.
Alayna: Shared how NAMI has a plan for a March 11 in person Family-To-Family-Class to start. On March 12, there will be a Zoom Family-To-Family Class starting. https://namiwc.org/about/mental-health-education/family-to-family/
Goal to have Peer-To-Peer Training in May.

V. **Legislators:** We need to get them to speak, but often it is only just before elections when they want to come. We have 2 years with the current legislators. Meanwhile we will invite Program Administrators.

VI. **New Business**:

A. **Fresh Start**: Joy reported that there is a new staff member at the clubhouse who is adapting well. She is trying to be earth friendly and is working on using donated sewing machines to sew cloth napkins with patterns with snaps to make cloth napkins that can hold silverware and can be reused rather than disposable paper napkins.

B. After a break, **Melisa Tasker** joined us at 1:30pm. She talked about: how she has been with the county more than a decade and in her current role since 2018. She oversees 4 Teams:

1. The ACCESS team which answers the 734-544-3050 line. This line is staffed by a team of 12 folks 24/7. They connect people to the appropriate services.
2. The Mobile Crisis Team is active 24/7 and meets the needs of anyone in crisis, usually not people opened to CMH. They authorize inpatient stays paid by Medicaid, partial hospitalizations. The Crisis Board keeps tabs on who will be seen when and what will be addressed during those outreaches.
3. The Hospital Liaison Team is active only during business hours and coordinates matters concerning those who are in hospitals.
4. The CARES team treats those who are mild to moderate in severity. Because of the CCBHC Washtenaw County CMH is able to treat anyone regardless of insurance type. But there are a lot of folks who are treated primarily by community partners as there are a lot of mental health workers who serve in the community. CARES has 3 Case Managers; 4 Mental Health Professionals; 3 Peers; 1 Service Coordinator; 1 Supervisor.
5. Mental Health Treatment in the Jail and Outpatient Treatment Orders are overseen by another P.A.

Lisa deRamos asked how many 988 calls had been routed to the ACCESS line. Melisa was unable to answer that and recommended contacting the service provider.

_ Melisa Tasker _ motioned to adjourn the meeting at _ 1:40 pm_, Supported by _ Mert _. The next meeting will be March 12, 2024 at 2140 E. Ellsworth or via Zoom at 12:30-2pm. Please arrive / join a few minutes early (as early as 12:15pm) if possible. NOTE: the room & calendar is reserved for Noon to 2pm to accommodate set-up for the meeting. However, the official meeting doesn't start until 12:30pm.

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy* *Ability to Pay***
Committee/Department: **Regional Finance 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	02/12/2025
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish a regional ability-to-pay policy in accordance with Michigan's Mental Health Code, Act 258, 1974 as amended.

II. REVISION HISTORY

DATE	MODIFICATION
5-3-2013	Revised to reflect the new regional entity effective January 1, 2014.
9-1-2019	Revised to update standards.
Will be Regional Approval Date	3-year review

III. APPLICATION

This policy applies:

☐ 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

No person shall be denied services due to an inability to pay. Fees for each service are provided in accordance with all applicable laws, regulations and the requirements of payers and in keeping with sound accounting practices. Reimbursement is sought for all services provided in accordance with all applicable laws, regulations and the requirements of payers.

V. DEFINITIONS

Ability to Pay – ability of a consumer/individual served or responsible party to pay for the cost of services.

Coordination of Benefits – process of payments by primary and secondary insurers that assures Community Mental Health Partnership of Southeast Michigan (CMHPSM) is the payer of last resort.

Customary rates for services – total amount to be paid for a unit of service as set by the CMHPSM**.**

Full financial determination – takes into consideration total financial status including but not limited to income, expenses, number and condition of dependents, assets and liabilities.

Income – responsible party's current annualized Michigan taxable income.

Insurance benefits – payment in accordance with insurance coverage for the cost of health care services provided to an individual.

Medicaid eligible – person who has applied for Medicaid and is determined to be eligible by the Michigan Department of Human Services (MDHS).

Residential services – 24-hour dependent care and treatment service provided by adult foster care facilities under contract by a community mental health services program or provided directly by a community mental health services program or substance use disorder residential treatment facilities

Responsible party – person who is financially liable for services provided to the consumer/individual served. This person includes the individual and, as applicable, the individual's spouse, guardian and parent, or parent of a minor.

VI. STANDARDS

A. The ability-to-pay determination will take place prior to starting services or, in the case of emergency, as soon as it is clinically appropriate.
B. Consumers/individuals served who either opt out of the ability to pay process or refuse to supply financial and/or insurance information shall be assessed full customary rate for service.
C. The total combined financial liability of the parties responsible shall not exceed the customary rate of the services.
D. Charges to consumers/individuals served for services provided by out of network providers will not exceed ability to pay for in network providers. When there is a discrepancy in cost for the same services the consumer/individual served will be charged the lower of the costs.
E. A responsible party shall only have one ability-to-pay determination in place at any given time.
F. A responsible party who is determined to be Medicaid eligible shall be assigned a zero ability to pay, unless otherwise provided for under Medicaid policy.
G. Respite ability-to-pay calculation is included in the over ability to pay monthly amount but is applied as a daily, 3-day (30) amount.

H. All consumers/individuals served shall be notified of their right to appeal an ability to pay determination.
I. Consumer/individual's ability to pay will be reassessed a minimum of once annually or upon significant changes in the responsible party's financial situation. A new ability to pay needs to be completed as soon as possible when there is a negative change in Medicaid eligibility (i.e.: HMP →MA(s), full MA → MA(s) or complete loss of Medicaid).
J. A parent shall not be determined to have an ability to pay for more than one (1) individual at any one time and a parent's total liability for two (2) or more individuals shall not exceed a combined total of eighteen (18) years.
K. Insurance benefits that cover services, either in part or whole are considered as part of the individual's ability to pay. Individual fees are assessed when insurance benefits are unavailable or pay for only part of the cost or have been depleted.
L. A **full** financial is required:
    1. For residential stays
    2. For inpatient stays of more than sixty-one (61) days
    3. When a consumer/individual served requests one and
    4. When a consumer/individual served states they are unable to pay the determined ability-to-pay amount.

VII. EXHIBITS

Public Mental Health System Ability-To-Pay Schedule

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)		
45 CFR Parts 160 & 164 (HIPPA)		
42 CFR Part 2 (Substance Abuse)		
Michigan Mental Health Code Act 258 of 1974	X	Chapters 2A, 8
The Joint Commission - Behavioral Health Standards		
MDCH Medicaid Contract	X	
MDCH Substance Abuse Contract		
Michigan Medicaid Provider Manual	X	
PA 500/501	X	
Substance Abuse Administrative Rules	X	R325.4151-325.4156

EXHIBIT A

The following scale is recommended for use in Region 6 with the understanding that each CMH may need to adjust the scale for its own situation.

[Provider Name]
Sliding Fee Scale

Sliding Fee Scale (SFS) for qualified people who are Uninsured or Under insured, for qualified Mental Health or SUD services:

Sliding Fee Scale daily visit amounts (SFSdva) are based on your ability to pay as established by State Law and Administrative Rules.
Annual Income Limits in the chart are based on the 2023 Federal Poverty Level guidelines and are updated annually.
Your SFSdva is determined at least annually and whenever your financial situation changes.
Documentation of your Annual Income and Family Size are required before a final, discounted SFSdva is approved.
The primary source of income documentation required is your State or Federal tax return (form 1040).

Sliding Fee Scale daily visit amount (SFSdva) Chart:

Income Category	A	B	C	D	E	F	G	
Family Size	<=133%	<=200%	<=250%	<=300%	<=350%	<=400%	>400%	FPL
1	$19,440	$29,160	$36,450	$43,740	$51,030	$58,320	>$58,320	$14,580.00
2	$26,293	$39,440	$49,300	$59,160	$69,020	$78,880	>$78,880	$19,720.00
3	$33,147	$49,720	$62,150	$74,580	$87,010	$99,440	>$99,440	$24,860.00
4	$40,000	$60,000	$75,000	$90,000	$105,000	$120,000	>$120,000	$30,000.00
5	$46,853	$70,280	$87,850	$105,420	$122,990	$140,560	>$140,560	$35,140.00
6	$53,707	$80,560	$100,700	$120,840	$140,980	$161,120	>$161,120	$40,280.00
7	$60,560	$90,840	$113,550	$136,260	$158,970	$181,680	>$181,680	$45,420.00
8	$67,413	$101,120	$126,400	$151,680	$176,960	$202,240	>$202,240	$50,560.00
Add for each additional family member:	$6,836	$10,280	$12,850	$15,420	$17,990	$20,560.00		
	133%	200%	250%	300%	350%	400%		

Sliding Fee Scale

Based on annual income and family size provided to ESM and applied to the SFSdva Chart above.

Your Income Category	A	B	C	D	E	F	G		Est Monthly Visits
Ability to pay % of Income (Not to publish)		6%	8%	10%	12%	14%	N/A		
CLS/Respite/Skill bldg/Clubhouse	$0	$5	$10	$17	$25	$35	₮	A	30
Other Excluding Residential/Inpatient S	$0	$15	$30	$50	$75	$105	₮	B	10
Specialized Residential/Inpatient Servic	$0	*	*	*	*	*	*	C	30

₮ - Full Feescreen is charged upto the monthly maximum calculated under Michigan Compiled Law 330.1818-1820 and Administrative Rule R330.8242

A Calculated based on this column. Assumes family size of 4. % of income based on administrative rule R330.8239(4) at this income level. Divided by the assumed number of daily visits per month. Rounded up to the nearest $1 in accordance with R330.8240(1)

B Calculated based on the midpoint between previous column and this column. Assumes family size of 4. % of income based on administrative rule R330.8239(4) at the midpoint. Divided by the assumed number of daily visits per month. Rounded down to the nearest $5 increment.

C *Actual cost of service is charged up to the monthly maximum calculated under Michigan Compiled Law 330.1818-1820 and Administrative Rule R330.8242

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	02/12/2025
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
09/28/2023	3 year review No content changes
Will be the Regional Approval Date	Revisions made per MDHHS ORR Policy 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:

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. Services provided to a minor will, to the extent possible, promote the minor's relationship to the parent, guardian, or person in loco parentis, and will not undermine the values that the parent, guardian, or person in loco parentis has sought to instill in the minor. The minor's parent, guardian, or person in loco parentis is not liable for the costs of services that are received by a minor.

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* *Corporate Compliance*
Committee/Department: **Regional Compliance 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	03/03/2025
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish policy that ensures the Community Mental Health Partnership of Southeast Michigan (CMHPSM) complies with all relevant federal, state, and local laws, rules, and regulations and other standards set forth by accrediting organizations and professional licensure requirements.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
01/27/2017	Revised to reflect regional compliance activities.
12/17/2021	Scheduled Review. Revised to reflect Compliance Plan.
06/03/2024	Revised to reflect Compliance Plan revisions. Approved by Compliance Committee 06/05/2024 (item J added)
[Enter Regional Approval Date]	Due for review.

III. APPLICATION

This policy applies to:

☒ 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. DEFINITIONS

Abuse: Practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the Medicaid payor, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.

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, 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.

Fraud: An intentional deception or misrepresentation by a person with the knowledge that the deception could result in an unauthorized benefit to him/herself or another person. This definition is not meant to limit the meaning of fraud as it is defined under applicable federal or state laws.

Healthcare Information: Any information, whether oral or recorded in any form or medium that: (a) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and that (b) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

Protected Health Information (a.k.a. confidential information): All personally identifiable information and material about a consumer/individual served in any form or medium, and the information that an individual is or is not receiving services.

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

Risk Assessment or Risk Analysis: The process of selecting appropriate measures to protect against particular dangers to computer systems, data, clinical records, and violations of regulatory and compliance standards.

Waste: Inappropriate utilization and/or inefficient use of resources.

V. POLICY

All staff, board members, students, volunteers, and providers with the CMHPSM network shall comply with all federal, state, and local laws, rules, and regulations applicable to the region's business lines, as well as other standards set forth by accrediting organizations and professional licensure requirements. Due to the collaborative nature amongst the CMHPSM members, including integrated elements of the data systems, all members of the region shall coordinate efforts to ensure the security and privacy of protected health information, and to ensure compliance with all other applicable regulations, laws, and standards.

VI. STANDARDS

A. CMHPSM and each CMHSP shall ensure the security, privacy, integrity, and confidentiality of all consumer/individual served-related information in accordance with professional ethics and legal requirements.

B. Policies and procedures necessary to ensure compliance with federal, state, and local laws, rules, and regulations are maintained by the regional entity, which issues these policies and procedures to providers within the CMHPSM network.

C. The CMHPSM and each CMHSP shall ensure that their staff, students, and board members receive compliance training that includes state and federal compliance standards and reporting requirements. Such training shall include at a minimum, standards and reporting requirements related to HIPAA, HITECH, federal Medicaid regulations, and state regulations.

D. No director or board member of the CMHPSM, or any person with an employment, consulting, or other arrangement with the CMHPSM, can be a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or anyone who is an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

E. All CMHPSM staff, board members, students, volunteers, and providers are expected to conduct themselves in an ethical manner while performing their duties.

F. Sanctions will be enacted against any employee, board member, student, or volunteer of the CMHPSM or its providers who violate this compliance policy. Sanctions are set forth in the CMHPSM Sanctions for Breaches of Security or Confidentiality policy and the CMHPSM Compliance Plan.

G. All board members shall adhere to the standards in this policy, the CMHPSM Compliance Plan, and other relevant state and federal compliance laws where it applies to their board duties. Any compliance-related issue and/or violation of a compliance standard by a board member shall be reported to the appointing entity. Alleged misconduct will be referred to both the relevant local and CMHPSM boards.

H. Any relevant issue of compliance by/with a board member will be addressed by the local CMH board or respective entity. Any necessary sanctioning of board members will be the responsibility of the appointing body.

I. All staff, students, volunteers, and providers within the CMHPSM network shall adhere to the standards in this policy, the CMHPSM Compliance Plan, and other relevant state and federal compliance laws where it applies to their duties. Any compliance-related issue and/or violation of a compliance standard shall be reported to the CMHSP and CMHPSM. The CMHPSM shall ensure relevant reporting is made to the required state and federal authorities. Alleged misconduct will be referred to both the relevant local boards.

J. CMHPSM and subcontractors must disclose protected health information to MDHHS-OIG or the Department of Attorney General upon their written request, without obtaining authorization from the beneficiary to disclose such information. This is required by OIG to prevent any interference with an OIG investigation.

K. To ensure compliance, the CMHPSM shall have an individual identified as the CMHPSM's Compliance Officer who reports directly to the Chief Executive Officer and the Board of Directors. The CMHPSM Compliance Officer shall ensure that the CMHPSM expediently investigates any reports of fraud/abuse, maintains data on compliance issues, and reports relevant data to state and federal entities where required. Such investigations shall be the role of the CMHPSM or the local CMHSP designee, as outlined by CMHSP contract/agreement. Investigations that result in suspected fraud shall be reported to the CMHPSM Compliance Officer using the Michigan Office of Inspector General Fraud Referral Form.

L. Each CMHSP shall have a designated Compliance coordinator identified to take local reports of alleged fraud/abuse, maintain local data, report compliance issues and data to the CMHPSM Compliance Officer, and serve on the CMHPSM Compliance Committee. This CMHSP Compliance role shall be assigned by the CMHSP Director.

M. Reports of alleged fraud/abuse shall be made in accordance with the CMHPSM Compliance Plan, and include at minimum:
- Persons involved (both those affected and those alleged)
- Source of complaint
- Type of provider and service(s) involved
- Nature of complaint
- Approximate dollars involved
- Legal & administrative disposition of the case including any finding(s) and action(s) taken

N. The CMHPSM Compliance Officer shall maintain and provide oversight to a CMHPSM Corporate Compliance Committee with membership appointed by the Regional Operations Committee (ROC). The Corporate Compliance Committee is charged with the development, coordination, and oversight of the CMHPSM's compliance efforts, including:
- Reviewing annual regional compliance audits to ensure adherence with established policies, procedures, and laws. If deficiencies are detected, requiring submission of corrective action plans and monitoring of said plans.
- Reviewing changes in law, regulations, or standards and identifying any areas of need in organizational policy, procedure, practice, and training.
- Reviewing risk analysis and risk management functions necessary to assure the privacy and security of protected health information.
- Reviewing risk analysis and risk management functions necessary to ensure areas of risk are assessed and corrected in compliance with laws, rules, and regulations.
- Monitoring regional plans of correction and making necessary recommendations, including performance improvement activities/recommendations as a result of assessed areas of need.

O. The Regional Corporate Compliance Committee is also given authority to assign ad hoc members or use specialized consultants to complete its work.

P. The responsibility for ensuring compliance with the security of health-related

information shall be assigned to the Regional Corporate Compliance Committee with membership appointed by the Regional Operations Committee (ROC). The director of each local CMHSP shall appoint a local Security Officer to provide local oversight in ensuring local compliance and information dissemination. Each local CMHSP member of the CMHPSM may also establish a local Compliance/Security committee at their discretion in ensuring local compliance with all laws, rules, regulations, and standards.

Q. Reports on the results of all annual compliance audits shall be shared with the ROC, which will assign further implementation of plans of correction to applicable committees.

R. Due to the collaborative nature amongst the CMHPSM members, including integrated elements of the data systems, all members of the region (the PIHP and the CMHSPs) shall coordinate efforts to ensure the security and privacy of protected health information, and shall ensure compliance with all other applicable regulations, laws, and standards. External application of standards shall be defined in Chain of Trust Agreements and/or contract language.

VII. EXHIBITS

None

VIII. REFERENCES

1. 42 CFR, Part 438 (Managed Care)
2. Balanced Budget Act
3. 45 CFR, Part 164 (Security and Privacy)
4. Health Information Portability and Accountability Act
5. The Joint Commission Standards
6. MDHHS/PIHP Contract
7. MDHHS/CMHSP Contract
8. CMHPSM Sanctions for Breaches of Security or Confidentiality Policy
9. CMHPSM Confidentiality and Access to Consumer Records Policy
10. Deficit Reduction Act of 2005
11. Patient Protection and Affordable Care Act of 2010
12. CMHPSM Compliance Plan
13. Federal False Claims Act, 31 U.S.C. §3729
14. Michigan Medicaid False Claims Act, Act 72 of 1977 §§400.601-.615 as amended through 2006

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* **Emergency and Post-Stabilization Services**
Committee/Department: **Clinical Performance Team**	**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	02/12/2025
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To provide clarity and definition to the scope of behavioral health and substance use disorder (SUD) emergency services and post-stabilization care services covered by Community Mental Health Partnership of Southeast Michigan (CMHPSM). To ensure behavioral health emergency and post-stabilization services are provided for all consumers/individuals served within the CMHPSM region operate consistently with all applicable federal requirements and how they apply to emergency services and post-stabilization care services in the CMHPSM system of care.

II. REVISION HISTORY

DATE	MODIFICATION
Will be Regional Approval Date	New policy

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. 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, intellectual and 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.

Emergency Medical Condition/Emergency Situation: The definition of emergency medical condition found in 42 CFR 438.114(a) is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or the unborn child) in serious jeopardy.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

For the purpose of this policy in the context of behavioral health emergencies, CMHPSM and its CMHSP partners use the definition of emergency situation found in Section 300.1100(a)(25) of the Michigan Mental Health Code to be synonymous with the Federal definition of emergency medical condition. An emergency situation means a situation in which an individual is experiencing a serious mental illness or an intellectual/developmental disability, or a minor is experiencing a serious emotional disturbance, and one (1) of the following applies:

a. The individual can reasonably be expected within the near future to physically injure themself, or another individual, either intentionally or unintentionally.
b. The individual is unable to provide themselves with food, clothing, or shelter or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
c. The individual's judgment is so impaired that they are unable to understand the need for treatment and, in the opinion of the mental health professional, their continued behavior as a result of the mental illness, intellectual/developmental disability, or serious emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

CMHPSM does not restrict what qualifies as an emergency based on specific diagnoses or symptoms. To fully understand the issue from the viewpoint of the person seeking assistance, the criteria for identifying emergencies must consider situations described as crises by the individual served or their family.

Emergency Intervention Services: Outpatient services provided to a person suffering from an acute problem of disturbed thought, behavior, mood, or social relationship which requires immediate intervention as defined by the client, the client's family or social unit, or a qualified staff. Emergency interventions are outlined in the Medicaid Provider Manual under the Intensive Crisis Stabilization Services benefit.

Emergency Services: Covered inpatient and outpatient services that are:

a) furnished by a provider that is qualified to provide these services, and
b) needed to evaluate or stabilize an emergency medical condition/emergency situation.

Post Stabilization Care Services: Covered services, related to an emergency medical

condition that are provided after a consumer/individual served is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the condition of the consumer/individual served.

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

V. POLICY

Federal and State legal authorities require Medicaid managed care entities, including Prepaid Inpatient Health Plans (PIHPs), to provide coverage and payment for emergency services and post-stabilization care services. The definition and descriptions of emergency medical conditions, emergency services, and care services focus heavily on physical health and serious bodily impairment. However, the same coverage provisions and requirements for emergency services and post-stabilization care services are still applicable to the PIHP for the scope of services which it is responsible to provide to consumers/individuals served by Medicaid and the Healthy Michigan Plan.

It is the policy of CMHPSM to ensure behavioral health emergency and post-stabilization services for its consumers/individuals served. CMHPSM shall operate consistent with all applicable federal requirements and how they apply to emergency room and hospital settings versus emergency services obtained through community provider locations.

VI. STANDARDS

A. Emergency Services

1. CMHPSM, per its contractual relationship to its CMHSP partners, ensures the provision of the following types of emergency services described in the Michigan Medicaid Provider Manual - Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter:
   - Crisis Intervention - Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy. Crisis intervention may occur in a variety of settings, including but not limited to the CMHSP offices, hospital emergency department, consumer/individual served home, schools, jails, and other community settings.
   - Pre-Admission Screening - Pre-admission screening to determine if an individual requires psychiatric inpatient hospitalization or whether alternative services are appropriate and available to treat the individual's needs. the screener must not only have thorough knowledge of and ability to schedule and authorize psychiatric hospitalization and all alternative services, but they must also have enough knowledge of the person and the present situation to make a sound decision. The state three-hour standard provides time for a thorough screening process, allowing the screener to evaluate the emergency medical condition. The completion of this screening process can frequently help stabilize the individual thereby resulting in post stabilization care services being able to be provided in a less restrictive setting than psychiatric hospitalization. The screening process is considered to be an emergency service as defined in 42 CFR 438.114. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Pre-screening services must be available 24 hours a day,7 days a week. Pre-admission screenings most often occur in hospital

emergency departments, although they can take place in other settings such as CMHSP offices, jails, or other community settings.

- Inpatient Psychiatric Hospital - Mental health services in licensed community-based psychiatric hospitals or psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area, for the treatment of individuals with serious mental illness or serious emotional disturbance. The CMHSPs/PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services.
- Intensive Crisis Stabilization Services - Intensive crisis stabilization services (ICSS) are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated. ICSS may be provided where necessary to alleviate the crisis situation, and to permit the consumer/individual served to remain in, or return more quickly to, their usual community environment. ICSS can also be used for post stabilization care once the immediate crisis situation has been addressed. Most ICSS are delivered by a mobile crisis team and typically occur at the consumer/individual's home or other community settings where the consumer/individual served is located.
- Outpatient Partial Hospitalization - Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services, and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the individual does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the individual's present treatment needs. The Severity of Illness/Intensity of Service criteria for admission assume that the individual is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments, and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

2. For consumers/individuals served enrolled in a Medicaid Health Plan (MHP), the MHP must be notified within 48 hours of the consumer/individual served utilizing an emergency intervention service.

B. Coverage and Payment: Emergency Services

1. The Michigan Mental Health Code 330.1206 (1) (a) requires that all Community Mental Health Service Programs must provide 24/7 crisis emergency service and stabilization for persons experiencing acute emotional, social, or behavioral dysfunctions. These services are funded through the per eligible per month (PEPM) sub capitation payment the CMHSP receives from the PIHP. There is never a cost to the consumer/individual served for emergency services provided by the PIHP and its CMHSP Participants. No prior authorization is needed.

2. When necessary, a consumer/individual served may seek services through the hospital emergency room. Disposition of the psychiatric emergency will be the responsibility of the

PIHP via delegation to its CMHSP Participants.

3. CMHPSM and its CMHSP partners are involved in resolving the psychiatric aspect of the emergency situation. Any medical treatment including medical clearance screening, stabilization, and emergency physician services needed by the consumer/individual served while in the emergency room is beyond the contractual requirements of the PIHP (Michigan Medicaid Provider Manual Hospital Chapter, Section 3.14.D Psychiatric Screening and Stabilization Services).

4. CMHPSM and its CMHSP partners adhere to the MDHHS County of Financial Responsibility (COFR) Technical Requirements when a consumer/individual served requires emergency services from a different PIHP or CMHSP provider outside of the CMHPSM PIHP region.

C. Post-stabilization Care Services

1. Post-stabilization care services means covered services, related to an emergency medical condition/emergency situation, that are provided after an individual is stabilized to maintain the stabilized condition or to improve or resolve the individual's condition. CMHPSM, per its contractual relationship to its CMHSP partners, provides the following types of post-stabilization care services as described in the Michigan Medicaid Provider Manual - Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter:
   - Inpatient Psychiatric Hospital Admission – Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness/Intensity of Service criteria for admission are based upon the assumption that the consumer/individual served is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.
   - Crisis Residential – Services are designed for individuals who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/Family-Driven, Youth-Guided, and recovery/resiliency-oriented approach. Services must be designed to resolve the immediate crisis and improve the functioning level of the individual to allow them to return to less intensive community living as soon as possible.
   - Outpatient Partial Hospitalization – Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly-coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services, and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the individual does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the individual's present treatment needs. The Severity of Illness/Intensity of Service criteria for admission assume that the individual is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or

educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments, and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

D. Coverage and Payment: Post-stabilization Care Services

1. The Michigan Medicaid Provider Manual requires prior authorization for post-stabilization psychiatric services from the PIHP or CMHSP for all Medicaid consumers/individuals served who reside within the service area covered by the PIHP. The following sections of the Michigan Medicaid Provider Manual - Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter contain specific prior authorization requirements and provider qualifications for each type of post-stabilization care service:
   Section 6.3 - Crisis Residential
   Sections 8.1 and 8.2 - Inpatient Psychiatric Hospital Admissions
   Section 9.1.A - Intensive Crisis Stabilization Services
   Section 10 - Outpatient Partial Hospitalization Services

2. CMHPSM and its CMHSP partners shall ensure post-stabilization care services are covered and paid for in accordance with 42 CFR 422.113, which state the CMHPSM and its CMHSP partners are financially responsible for Medicaid covered behavioral health post-stabilization care services obtained within or outside the PIHP region that are not pre-approved, but provided to maintain the consumer's/individual's served stabilized condition, within one-hour of a request to the PIHP organization for pre-approval of further post-stabilization care services.
   The one-hour time frame refers to when the PIHP/CMHSP receives the request from the provider to when they must provide pre-approval of the post-stabilization care service. This one-hour time frame does not include any time spent screening or stabilizing the individual. When considering how the state three-hour pre-screening requirement compares to the one-hour time frame cited in 42 CFR 422.113, the three-hour time frame is inclusive of both the screening and the authorization component. Whereas the one-hour time frame is solely for the authorization process.

3. The CMHPSM Claims Payment and Appeal Policy includes provision for reimbursement of claims for emergency and post-stabilization services provided to consumers/individuals served in the CMHPSM region if the provider is not contracted with the PIHP/CMHSP and/or if prior authorization was not obtained but it can be determined that, but for the urgency of the need, the service would have been pre-authorized by CMHPSM or the CMHSP.

VII. EXHIBITS

None

VIII. REFERENCES

A. 42 CFR §422.113
B. 42 CFR §422.214
C. 42 CFR §438.114
D. Medicaid Managed Specialty Supports and Services MDHHS/PIHP Contract
E. Michigan Medicaid Provider Manual, Behavioral Health and Intellectual and

Developmental Disability Supports and Services (BHIDDSS) Chapter F. Michigan Compiled Laws, Chapter 330. Mental Health Code

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* *Financial Audits of Contractors*
Committee/Department: **Regional Finance 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	02/12/2025
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish guidelines and standards regarding the financial audit obligations outlined in provider contracts, and to provide guidelines for exempting a contractual provider from the independent auditor requirements.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
2019	Revised to reflect updated deadlines.
09/28/2020	Revised contractor requirements
Will be the Regional Approval Date	3-year review, Consumer updated to Consumer/Individual Served

III. APPLICATION

This policy applies to:

☐ 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. DEFINITIONS

Annual Audit: An audit of the contractor's financial records performed annually by an independent auditor or audit firm. An annual audit shall include a separate section of all activities funded under the terms of the contract.

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.

Contractual Provider: Any agency or organization that provides direct support services to consumers/individuals served within CMHPSM, with the exclusion of hospitals. Also referred to as "contractor."

Financial Compilation: A compilation of the contractor's financial records presented in the format of financial statements regarding assets, liabilities, revenue and expenses.

Program Audit: An audit of the contractor's financial records that relate to the services provided on behalf of a CMHSP provided by an independent auditor or audit firm. A program audit shall report on the contractor's adherence to the terms of the contract between the contractor and the CMHSP, including the accuracy of expenses and revenue reported.

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, developmental disabilities, and substance use disorder needs.

V. POLICY

It is the policy of the CMHPSM that annual audits conform to Generally Accepted Auditing Standards (GAAS) and all applicable federal and state laws and regulations regarding accounting practices and standards.

VI. STANDARDS

A. Each contractor of CMHPSM is required to submit an annual audit performed by an independent auditor or accounting firm.
B. Each Contractor shall submit to the CMHSP the agency's Plan of Correction to address audit exceptions, comments, and/or recommendations, and submit progress reports periodically.
C. A Contractor may be permitted to waive the annual audit requirement if they meet the criteria for exemption and return an "Annual Audit Waiver Request" form to the CMHSP. The contractor must meet one of the following three criteria in order to be granted an Audit Waiver:

    1. Contractor provides services to 6 (six) or less CMHSP consumers/individuals served per year.
    2. Contractor receives $50,000 or less annually from entire CMHPSM to provide services to consumers/individuals served.
    3. Contractor employs fifteen (15) or fewer employees or full-time equivalents (FTE) throughout the entire organization of the provider.

D. Each Contractor may be required to submit to the CMHSP a program audit or financial compilation in lieu of or in addition to the annual audit.
E. If an Audit Waiver is approved, a Financial Compilation will be required.
F. A financial compilation does not need to be conducted by an independent auditor or audit firm; however, it must be attested to by the Contractor's Executive Director or Financial Officer. When the annual financial compilation is required, it must be submitted to PIHP within one hundred twenty (120) days of the close of Contractor's fiscal year or the termination of this Contract, whichever occurs first. Failure to provide this compilation may result in the imposition of a financial penalty.
G. Further requirements of this policy, including requirements for a single audit, are contained in the approved contract language of CMHPSM for each fiscal year, which is incorporated by reference here.

VII. EXHIBITS

None

VIII. REFERENCES

A. CMHPSM Provider Contract
B. Generally Accepted Accounting Principles (GAAP) http://www.fasab.gov/accepted.html
C. Generally Accepted Auditing Standards (GAAS)
D. 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards

IX. PROCEDURES

WHO	DOES WHAT
Contracting Agency	1. A new Audit Waiver Request must be submitted for each contract cycle. Contractor has until the end of the 3rd quarter to submit the Audit Waiver Request to the CMHSP. 2. Assures timely completion of all audits. 3. Submits Annual Audit or Financial Compilation to the CMHSP on or before 180 days after the close of the Contractor's fiscal year. 4. May submit in writing to the CMHSP up to two 30-day requests for extensions of the submission date. Request(s) shall include an explanation of extenuating circumstances for delay. "The audit is not yet completed" is not considered an extenuating circumstance.
CMHSP Designee	1. If an audit includes audit exceptions and/or auditor comments, it requires Contractor to submit a Financial Plan of Correction within thirty (30) days of the issuance of the audit. 2. If a Financial Compilation indicates a financial concern, requires Contractor to submit a Financial Plan of Correction within thirty (30) days of the submission of the Financial Compilation. 3. The following will occur if an audit or financial compilation is not submitted on or before the due date, the Contractor has not been approved for an extension, or extension has expired: a. Provider will be issued a reminder notice after requirement is 15 days past due b. After 30 days past due the Provider may be placed on provisional contract status until the requirement is met. c. After 45 days past due, additional sanctions may be imparted including a formal finance review, up to contract termination. 4. May approve up to two (2) 30-day extensions of the audit submission date if there are extenuating circumstances.

WHO	DOES WHAT
Contracting Agency	1. Submit to the CMHSP a Financial Plan of Correction for any audit exceptions, comments, and/or recommendations noted by the independent auditor or audit firm within thirty (30) days of issuance of the audit. 2. Submit status reports and products or other evidence of corrections as required under the Plan of Correction. 3. Failure to submit, comply with, or attain outcomes of a required Financial Plan of Correction may be cause for contract sanctions, up to and including contract termination. 4. The CMHSP may require the addition of concerns or issues in the Plan of Correction.
CMHSP Designee	1. If approved, verifies Contractor eligibility for Annual Audit Waiver at the end of contract cycle. 2. Notifies local Board of any Contractor that has a Plan of Correction. 3. Reviews Plan of Correction submitted by Contractor. May add additional requirements. 4. Makes recommendation about the feasibility of maintaining a Provider on the Network Panel regarding financial status. 5. Sends to Contractor regular invoices indicating amount withheld due to late audit submission. 6. Sends to Contractor written notification when a required Financial Plan of Correction has been successfully met.

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	02/12/2025
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.
09/28/2023	3 year review Removed mediation language to be consistent with MMHC updates.
Will be the Regional Approval Date	Updated per changes in required MDHHS policy standards

III. APPLICATION

This policy applies to:

☒ 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. The CMH shall ensure complainants, Rights Office staff, and any staff acting on behalf of a recipient are protected from harassment or retaliation as a result of contact with or participation with the Rights 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, in an understandable manner, a summary of recipient rights, as well as information regarding how to contact a Recipient Rights Officer. This shall occur at the initial

intake and annually thereafter at the Individual Plan of Service (IPOS) meeting. If a recipient is unable to understand the material provided, a reasonable attempt to assist the recipient in understanding the material shall be made. A statement describing the alternative methods utilized, as well as who provided the explanation, shall be included in the recipient's electronic health record.

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 workdays. Within 5 workdays 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 initiated 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, including official reprimand, demotion, suspension, reassignment, or dismissal.

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. A rights investigation may be reopened or reinvestigated by the rights office if there is new evidence that was not presented at the time of the investigation.

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 workdays 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 ensure 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) workdays 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 workdays 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 timeframe may be extended at the discretion of the Appeals Committee upon a showing of good cause by the Office. At no time shall the timeframe exceed 90 days.

Within 10 workdays 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 workdays 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.

An external investigation must be conducted within the timeframes outlined under Sec. 778 of the Code. The Department must submit an amended investigative report to the executive director and board of the CMHSP. Within 10 workdays of receipt of the Report of Investigative Findings from the Department, the CMH Director shall issue a Summary Report, in compliance with Sec. 782 of the Code. The Amended Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the parent of a minor recipient, the Office and the Appeals Committee. If the Appellant still disagrees with the conclusion of the rights investigation or asserts that the investigative findings of the Department are not consistent with the facts or with the law, rules, policies, or guidelines they may file an appeal under Sec. 786 of the Code. 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, respondent, and responsible mental health agency 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*** ***Peer Review***
Committee/Department: **Regional Compliance 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	03/03/25
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

This policy is to define peer review functions as it relates to practice of care of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity effective January 1, 2014
06/21/2017	Due for review
12/17/2021	Due for review
[Enter Regional Approval Date]	Due for review

III. APPLICATION

This policy applies to:

☒ 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. DEFINITIONS

Adverse Event: Events that do not qualify as Sentinel Events but are serious and could identify process improvements. During the process of reviewing an event, the

director/designee will determine if an event is an adverse event when it does not qualify as a Sentinel Event.

Clinical Supervision/Case Conferences: Team meetings and/or regular meetings held by clinical service staff where consumer/individual served care and clinical planning takes place, including peer/supervisor suggestions to assist in treatment.

CMHPSM Incident Reports: Written reports of unusual incidents related to consumer/individual served care that disrupts or adversely affects the course of treatment or care of an individual consumer/individual served or the program caring for others.

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, 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.

Peer: Any physician/psychiatrist, social worker, psychologist, nurse, nurse practitioner and/or other clinical professionals who meet basic qualifications with clinical experience and training to provide an evaluation of a specific significant issue or general case or process review. The peer(s) involved in the review shall have the same license/credentials as the person or persons involved in the event or service process.

Peer Review: A process in which mental health/substance use disorder professionals evaluate the clinical competence, quality and appropriateness of care/services provided to consumers/individuals served. The review may focus on an individual event or aggregate data and information on clinical practices. These processes are confidential in accordance with section 748(9) of the Mental Health Code Act 258 of 1974.

Performance Improvement: A systematic way of addressing improvement opportunities that involve the use of soft (facilitation techniques, problem solving processes) and hard (data analysis, statistical tests) skills to understand, recommend and implement change.

Regional and Internal Clinical Review Process: A process with identified and trained staff that performs case reviews of the consumer/individual served PCP and the clinical services being delivered.

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

Root Cause Analysis: A process for identifying the basic or causal factors that underlies variation in performance, including the occurrence, or possible occurrence, of a sentinel event.

Sentinel Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase ‘or risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome, i.e., if the event had continued or were to recur, the individual would risk death or major permanent loss of function.

Utilization Review: Analysis of the patterns of service authorization decisions and service usage to determine the means for increasing the value of services provided (minimize cost and maximize effectiveness/appropriateness).

V. POLICY

The CMHPSM will identify and correct processes or variations in care/services that may lead to undesirable or unanticipated events affecting consumers/individuals served or their care. Peer review will be utilized to establish evaluation mechanisms for clinical care and service delivery that identify opportunities for improving care.

VI. STANDARDS

A. The CMHPSM declares that the following business functions and analysis are all defined as Peer Review Functions:

1. Sentinel or Adverse Event Reports/Root Cause Analysis
2. CMHPSM Incident Reports and Data
3. Critical Event Data
4. Regional and Internal Clinical Reviews
5. Internal Ethics Consultation
6. Case Conferencing and Clinical Supervision or Team Meetings
7. Utilization Review

B. In accordance with the Michigan Mental Health Code 330.1143a and the Public Health Code Act 368 of 1978, Sections 333.20175 & 333.21515, all records and information obtained during Peer Review Functions are confidential and shall be used only for the purpose of reviewing the quality and appropriateness of care for improved practices. All documents created during and as a result of the Peer Review Functions shall not be public record or available through the Freedom of Information Act (FOIA) and are not subject to court subpoena.

C. Reports or Forms completed as a part of a peer review process shall be kept as peer review documents and shall not be kept as a part of a consumer/individual served clinical record. A summary of the incident (reported on the form/report) shall be included in the consumer/individual's clinical record for any consumer/individual served involved in accordance with the requirements of the Administrative Rules 330.7046.

D. Incident report information shall be maintained in a database and reports kept separate from the clinical record.

E. Peer Review Process analysis of events or clinical practices shall be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards, and/or national standards.

F. Risk Management and Corporate Counsel shall be consulted as needed during any peer review function.

G. Peer Review Functions/Processes shall adhere to all laws and policies including the reporting of any disciplinary action taken by an agency/organization against a health professional licensed or registered in the state that adversely affects the licensee's or registrant's clinical privileges for a period of more than 15 days. "Adversely affects" means the reduction, restriction, suspension revocation, denial or failure to review the clinical privileges of a licensee or registrant.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
Michigan Mental Health Code, Act 258 of 1974	X	330.1143a
Michigan Administrative Rules	X	R 330.7046
Michigan Compiled Laws, Public Health Code, Act 368 of 1978	X	333.20175 & 333.21515
The Joint Commission	X	Sentinel Events, Performance Improvement
MDHHS/PIHP Medicaid Contract	X	
Michigan Administrative Rules	X	R 400.14311
CMHPSM Critical Incident, Sentinel Event and Risk Event Policy	X	

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy and Procedure Performance Improvement***
Committee/Department: Compliance and Clinical Performance Team	**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	02/12/2025
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish and ensure an integrated region-wide Performance Improvement (PI) system is implemented and operating in accordance with applicable standards of the Community Mental Health Partnership of Southeastern Michigan (CMHPSM).

II. REVISION HISTORY

DATE	MODIFICATION
02/28/2012	
06/16/2014	Revised to reflect the new regional entity.
09/11/2017	Due for regional review.
02/25/2022	Due for regional review.
Will be Regional Approval Date	3-year review

III. APPLICATION

This policy applies to:

☒ 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

CMHPSM oversees the PI system and holds the overall responsibility for it. Each CMHSP Director ensures implementation within their agency and involvement of leadership at the regional level. PIHP Performance Improvement initiatives will be prioritized using decision making criteria covering high risk, high cost and problem prone areas and will be aligned with the strategic plan.

The designated Quality/Compliance/Program Integrity Manager is responsible for the implementation of this policy and ensuring the PI system operates in accordance with the Quality Assessment Performance Improvement Program (QAPIP) and other state/federal PI requirements. Central to the PI system is the Clinical Performance Team (CPT) as the regional PI committee, with CMHSP representation, standing committees, workgroups, and ad hoc PI teams.

This PI system is responsible for overseeing and ensuring the quality of consumer/individual served care. The PI system shall address any issue in need of performance improvement, performance assurance and performance planning.

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.

Performance Improvement System: The CMHPSM is responsible for addressing, implementing and resolving Performance Improvement, Performance Assurance and Performance Planning initiatives.

Performance Improvement Process (PIP): A systematic way of addressing improvement opportunities that involve the use of soft (facilitation techniques, problem solving processes) and hard (data analysis, statistical tests) skills to understand, recommend and implement change.

Quality Assessment: refers to a systematic evaluation process for ensuring compliance with specifications, requirements or standards and identifying indicators for performance monitoring and compliance with standards.

Quality Assessment and Performance Improvement Program (QAPIP): is an annual plan to establish goals for each fiscal year (FY) to meet the overall regional Quality Improvement (QI) framework for quality and accountability for consumer/individual served care. This occurs through the work of standing committees, ad hoc teams, and performance measures. The QAPIP establishes processes that promote ongoing systematic evaluation of important aspects of service delivery. The program promotes ongoing improvement and replication of strengths and focuses attention on ensuring that the safety of consumers/individuals served is addressed through the delivery of services

while addressing the requirements of network providers and CMHPSM staff and programs.

Quality Assurance: refers to a broad spectrum of evaluation activities aimed at ensuring compliance with minimum quality standards. The primary aim of quality assurance (QA) is to demonstrate that a service or product fulfills or meets a set of requirements or criteria. QA is identified as focusing on "outcomes," continuous quality improvement (CQI) identified as focusing on "processes" as well as "outcomes."

Quality/Compliance/Program Integrity Manager: The person responsible for ensuring that the implementation of the QAPIP is based on the agreed upon vision and values through the use of Learning Organization principles. The person is responsible for linking the activities of the CMHPSM committees with the QAPIP and providing oversight to CMHPSM performance improvement activities.

Quality Improvement: refers to ongoing activities aimed at improving performance as it relates to efficiency, effectiveness, quality, performance of services, processes, capacities, and outcomes. It is the continuous study and improvement of the processes of providing services to meet the needs of the consumer/individual served and others.

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, developmental disabilities, and substance use disorder needs.

VI. STANDARDS

A. Understanding root causes is the most effective means of ensuring lasting systemic change. When the need for such change has been identified, the use of qualitative and quantitative data will be reviewed to identify the specific areas that need improvement. These improvement efforts will ensure that high quality services are delivered across the entire CMHPSM.

B. The following values will be upheld in improvement processes based on the approved PI Program Description/Plan that include but are not limited to:
   - Organizational systems shared learning
   - Alignment with strategic planning
   - Stakeholder (consumers/individuals served, family members, providers, staff) involvement
   - Replication of successes by fostering and enabling both regional and local improvements.

C. The following outcomes shall be addressed:
   - The reductions of risk factors in service delivery.
   - The identification and resolution of specific service delivery and organizational opportunities for improvement.
   - Using established measures, evaluates specific program components. The data results will be used to modify, redesign, or otherwise improve that component.
   - Evidence of employee, consumer/individual served and community

stakeholder involvement in needs assessment, service planning and problem identification and resolutions.
- Evidence of service improvements and enhancements including innovative program designs based upon results of quality improvement activities.

D. The PI system shall adhere to all external and internal standards of governance, management and direct/support services.
E. The PI system shall be regularly monitored and evaluated to ensure quality components are being implemented along with any external or internal standards or regulation revisions are made.
F. The PI system program description/plan shall be approved annually by the PIHP board and be adopted by the CMHSPs.
G. The PI system shall operate within the annually approved PI program description/plan.
H. The PI system is a confidential peer review system where aggregate information is shared that is not subject to the Freedom of Information Act (FOIA) or other forms of disclosure.
I. The PI system shall include consumer/individual served and/or family representation, network provider representation, and have medical director consultation to assist the PI/CPT committee in addressing any medically significant related performance improvements.
J. The Clinical Performance Team shall serve as the regional Performance Improvement Committee. The Clinical Performance Team has representation from clinical and / or performance improvement staff from each of the four counties of the region as well as consumer/individual served representation from each county. The interim Medical Director or designee for the PIHP also sits on this committee as well as the PIHP Compliance/ Quality Manager. Some members of the Clinical Performance Team serve as liaisons to other regional committees such as the Utilization Review Committee, Regional Consumer Advisory Committee, Network Management and various population-specific administrators groups.
K. The PI system shall be responsible for approving, collecting, analyzing and monitoring organizational PI indicators to identify trends and reduce risk.
L. The PI system shall perform qualitative and quantitative improvement processes that obtain input from stakeholders to ensure high quality change efforts take place led by the Quality/Compliance/Program Integrity Director or other designated individual or body.
M. Led by the Quality/Compliance/Program Integrity Director or other designated individual or body, the PI system shall provide leadership, and will coordinate, collaborate, and/or participate in CMHPSM or regional programs', boards' and stakeholders' improvement efforts for the purpose of building upon strengths and reducing the frequency of improvement opportunities.
N. The PI system shall communicate the results of improvement efforts made to necessary relevant stakeholders by the Quality/Compliance/Program Integrity Director or other designated individual or body.
O. The PI system shall obtain PI reports and data on time within time frames based upon the agreed upon reporting schedule and in the agreed format established by the Quality/Compliance/Program Integrity Manager or other designated individual or body.
P. All CMHPSM network providers, including both CMHSPs and other contract providers, shall report all PI data at the specified timeframes as specified in the

signed contract with the applicable CMHPSM led by the Quality/Compliance/Program Integrity Director or other designated individual or body.

Q. The CMHPSM shall withhold payment as outlined in the signed contract to a CMHSP and or CMHPSM network provider should PI reports and data not be submitted within the necessary required timeframe established by the Quality/Compliance/Program Integrity Manager or other designated individual or body.

R. All CMHPSM network providers must operate within an approved performance improvement system as defined in the signed contract.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	x	43 8.206, 43 8.236, 43 8.240
45 CFR Parts 160 & 164 (HIPAA)	x	
42 CFR Part 2 (Substance Abuse)	x	
Michigan Mental Health Code Act 258 of 1974	x	
The Joint Commission - Behavioral Health Standards	x	Performance Improvement
Michigan Department of Health and Human Services(MDHHS) Medicaid Contract	x	
MDHHS Substance Abuse Contract	x	
Michigan Medicaid Provider Manual	x	
Quality Assessment Performance Improvement Program (QAPIP)	x	

IX. PROCEDURES

WHO	DOES WHAT
CMHPSM	1. Provides a written program description/plan. 2. Maintains and follows the guidelines as described in the program description and PI policy.
Clinical Performance Team	1. Makes recommendations for the Regional Operations Committee (ROC) to approve the functions/indicators and information for the PI system as described in the PI system Program Description/Plan. 2. Monitors the functions/indicators and information

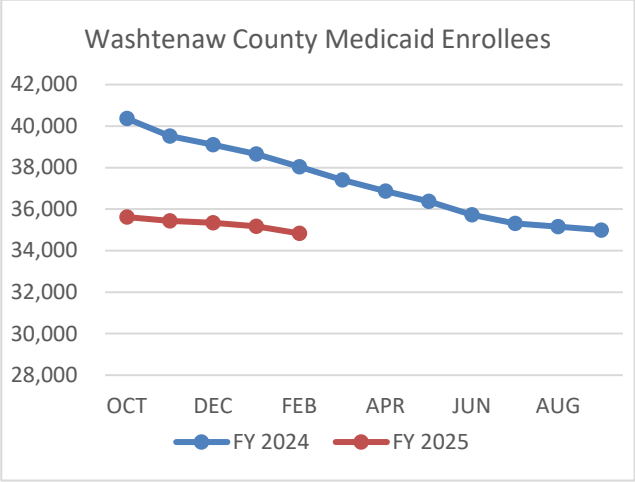
	for the PI system as described in the PI system Program Description/Plan. 3. Assigns improvement activities to the appropriate standing committee, workgroup, local CMHSP or create an Ad Hoc PI team as needed to address areas in need of improvement. 4. Makes recommendations for the ROC to approve the Regional Committee/Workgroup PI Ad Hoc Teams charge. 5. Reviews and provides input on periodic reports to the ROC and the CMHPSM Regional Board.
Quality/Compliance/Program Integrity Manager	1. Participates in the PI/CPT Committee. 2. Communicates necessary information across the CMHPSM. 3. Establishes, maintains and adheres to a reporting schedule. 4. Generates periodic PI reports 5. Reports PI system initiatives to the CMHPSM Regional Board.
PI Committee/CPT Chair/Coach	1. Reports PI system initiatives to the ROC.
Standing Committees, workgroups, local CMHSPs and Ad Hoc PI teams	1. Aligns work plan and functions with the CMHPSM strategic plan. 2. Use PI processes to implement functions and improvement efforts 3. Local CMHSPs use the PI processes to embed improvement efforts across the whole organization down to direct line staff. 4. Report periodically based on the reporting schedule and format to the PI Committee/CPT the work plan functions and indicators of performance and improvement activities. 5. Make recommendations to the PI committee/CPT for implementing PI processes to address areas needing improvement. 6. Relays information to and from committee, workgroups, or ad hoc teams.
CPT Members	1. Provide input and feedback on reports provided to the PI committee/CPT based on the roles of the members. 2. Relay information to and from the CMHSP.
Regional Operations Committee	1. Provides leadership across the CMHPSM and individual CMHSPs in promoting the values and principles of the PI system. 2. Reviews and provides input/feedback on the annual PI program description/Plan. 3. Reviews and provides input/feedback on periodic PI reports. 4. Reviews the PI reports prior to being presented to the CMHPSM Regional Board.
CMHSP	1. Receives and reviews reports and acts on any

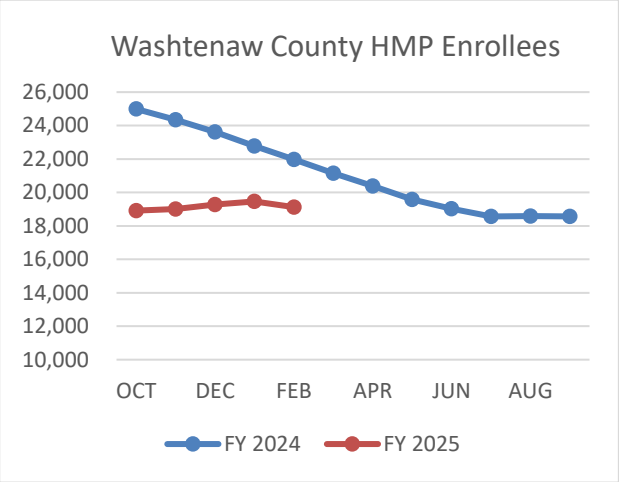
	identified PI related issues. 2. Provides leadership for CMHSP the values and principles in promoting the PI system. 3. Approves local PI projects. 4. Provides feedback on regional PI projects 5. Adopts the affiliation approved PI program description.
CMHPSM Regional Board	1. Provides input and feedback to Annual PI Program description/plan and periodic reports. 2. Approves the annual PI program description/plan and periodic reports.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
YEAR-TO-DATE FINANCIAL STATUS
FISCAL YEAR 2025: For the period ending February 28, 2025
Prepared: April 8, 2025

1. Washtenaw County Enrollees

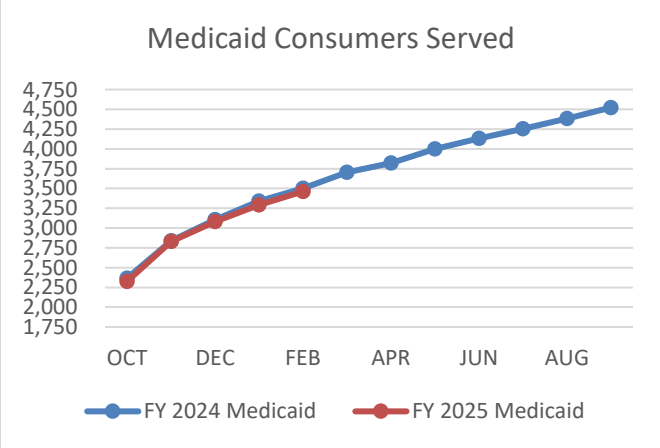
A summary of FY 2025 Washtenaw County Medicaid and Healthy Michigan Enrollees is shown below:

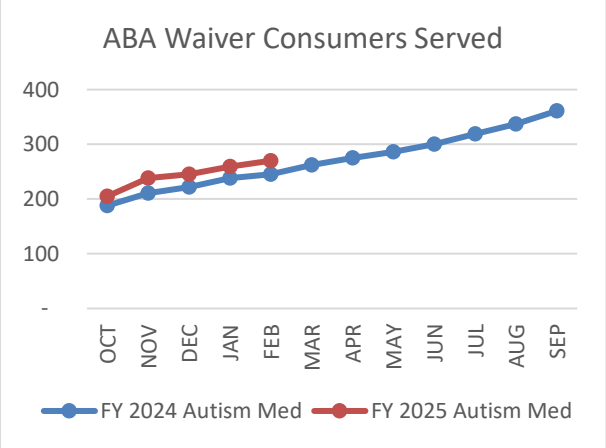




Washtenaw County Medicaid Enrollees were 34,829 in February 2025. This is a 8.45% decrease from the same time last year (3,215 less enrollees than in February 2024). Healthy Michigan enrollment in February 2025 was 19,129. This is a 12.97% decrease from the same time last year (2,852 less enrollees than in February 2024).

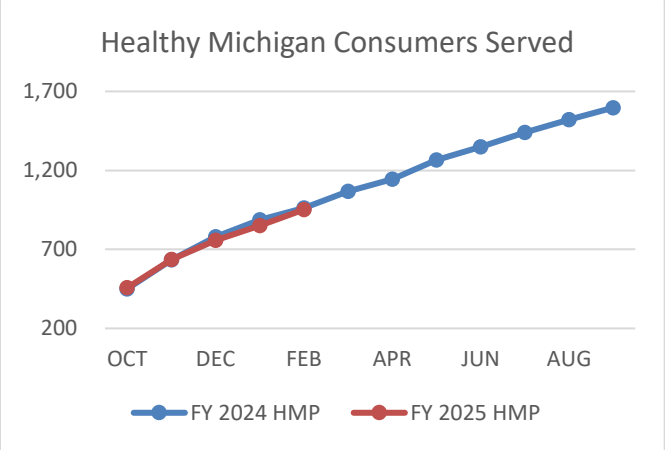
2. WCCMH Consumers Served to Date

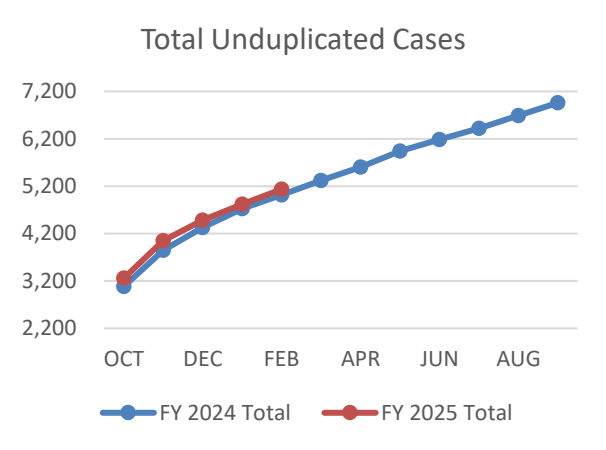




Medicaid consumers served through February 2025 are 3,463. This is 41 less consumers than the prior year (3,504 consumers were served through February 2024).

ABA Waiver consumers served through February 2025 are 270. This is the 25 more consumers than this same time as last year (245 consumers were served through February 2024).

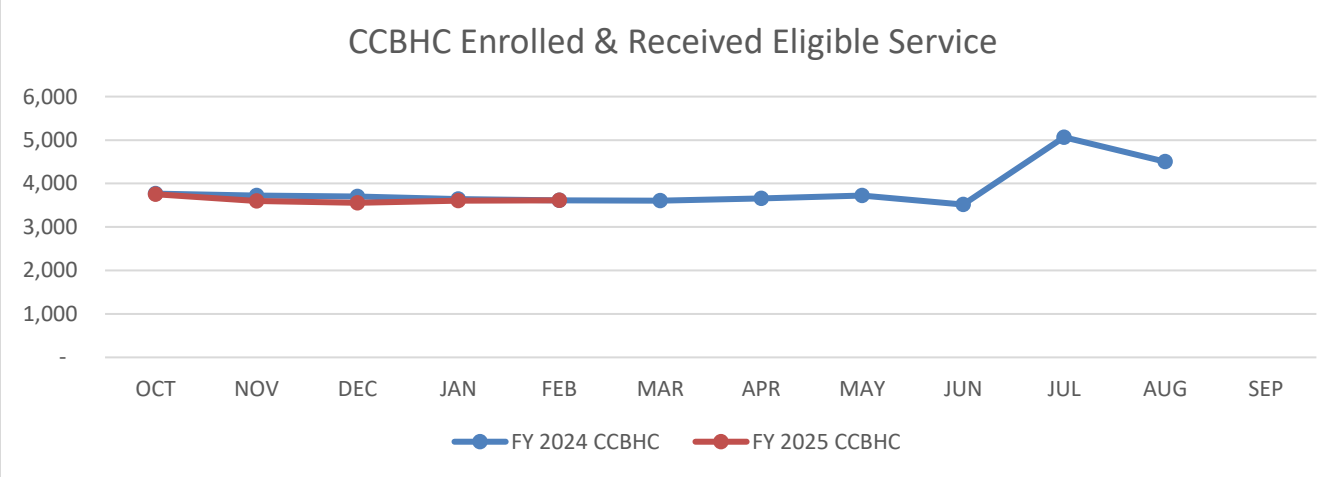




Healthy Michigan consumers served through February 2025 were 952. This is 11 less consumers than the same period last year.

The total unduplicated consumers served by WCCMH through February 2025 were 5,136. This is 118 more consumers than served last year for the same time period.

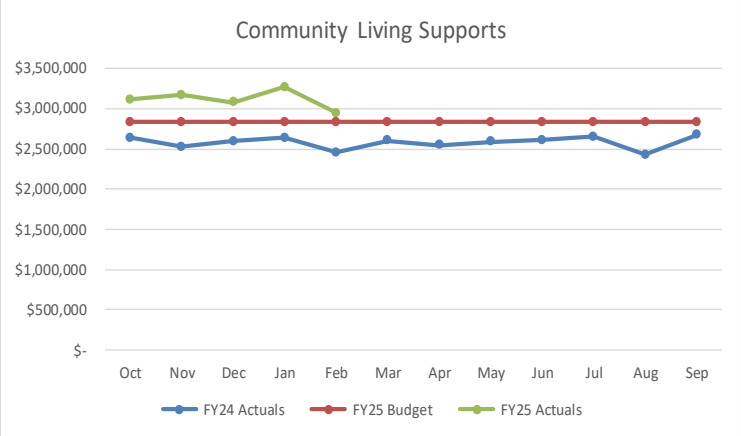
The YTD number of individuals CCBHC enrolled and received an eligible service for FY 2025 as of February was 3,612. This is 1 more consumer for the same time period last year.



3. Financial Statement Highlights

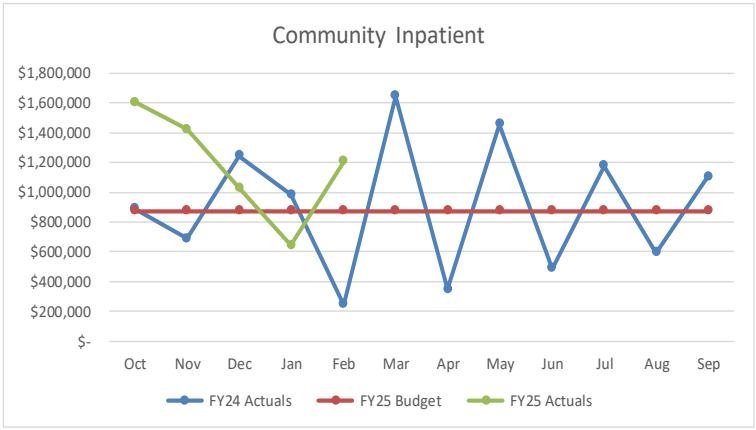
a. CLS service costs to date are estimated to be about $15.7 million and running over budget by about $1.6 million through February of FY 2025. The costs year to date are about 21% higher than last year at this time.

	FY24 Actuals	FY25 Budget	FY25 Actuals	YTD % Change
Oct	$ 2,637,767	$ 2,833,333	$ 3,110,404	17.92%
Nov	2,528,276	2,833,333	3,166,798	21.51%
Dec	2,596,104	2,833,333	3,077,601	20.52%
Jan	2,634,937	2,833,333	3,263,270	21.36%
Feb	2,452,584	2,833,333	2,946,981	21.13%
Mar	2,601,049	2,833,333		
Apr	2,544,132	2,833,333		
May	2,586,850	2,833,333		
Jun	2,607,943	2,833,333		
Jul	2,653,924	2,833,333		
Aug	2,425,501	2,833,333		
Sep	2,674,986	2,833,333		



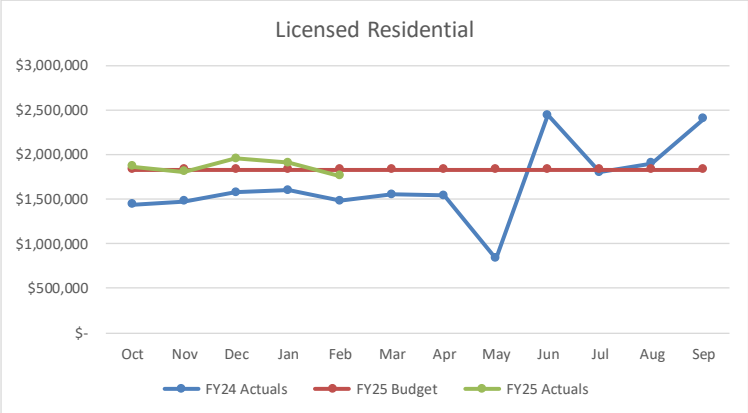
b. Community Inpatient costs to date are $5.9 Million. The costs year to date are 45% higher than this time last year and are about $1.5 million over budget.

	FY24 Actuals	FY25 Budget	FY25 Actuals	YTD % Change
Oct	$ 888,374	$ 873,000	$ 1,605,037	80.67%
Nov	686,783	873,000	1,420,600	92.08%
Dec	1,243,366	873,000	1,027,322	43.80%
Jan	981,798	873,000	643,501	23.58%
Feb	244,417	873,000	1,207,305	45.96%
Mar	1,643,710	873,000		
Apr	349,426	873,000		
May	1,457,597	873,000		
Jun	486,568	873,000		
Jul	1,175,601	873,000		
Aug	593,765	873,000		
Sep	1,104,616	873,000		



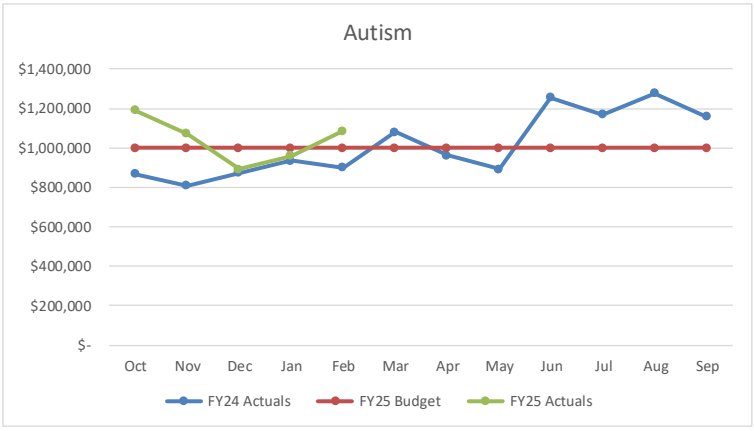
c. Licensed Residential costs to date are $9.3 Million and coming just slightly over budget. The costs year to date are about 23% more than this time last year.

	FY24 Actuals	FY25 Budget	FY25 Actuals	YTD % Change
Oct	$ 1,441,874	$ 1,833,333	$ 1,867,597	29.53%
Nov	1,476,079	1,833,333	1,810,965	26.07%
Dec	1,577,380	1,833,333	1,957,547	25.38%
Jan	1,601,609	1,833,333	1,909,077	23.75%
Feb	1,484,367	1,833,333	1,763,459	22.78%
Mar	1,553,224	1,833,333		
Apr	1,539,948	1,833,333		
May	835,708	1,833,333		
Jun	2,444,834	1,833,333		
Jul	1,805,435	1,833,333		
Aug	1,905,507	1,833,333		
Sep	2,401,479	1,833,333		



d. Applied Behavior Analysis/Autism service costs to date are $5.2 Million. The costs year to date are coming in right on budget although trending about 18.6% higher than this time last year.

	FY24 Actuals	FY25 Budget	FY25 Actuals	YTD % Change
Oct	$ 867,232	$ 1,000,000	$ 1,190,528	37.28%
Nov	808,887	1,000,000	1,073,749	35.09%
Dec	874,135	1,000,000	891,494	23.74%
Jan	936,517	1,000,000	960,952	18.07%
Feb	900,686	1,000,000	1,087,528	18.62%
Mar	1,081,448	1,000,000		
Apr	963,660	1,000,000		
May	892,941	1,000,000		
Jun	1,256,451	1,000,000		
Jul	1,170,401	1,000,000		
Aug	1,276,962	1,000,000		
Sep	1,160,236	1,000,000		



e. Internal staffing expenses are coming in line with budget after successful recruitment efforts as well as increased salary/fringe costs.

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 $4,321,939 through February.
c. By funding source, HMP is showing a deficit of $941,506 through February.
d. Overall, the PIHP surplus is $3,380,433 through February.

5. State General Fund Key Points

a. General Fund programs and funding redirected to other Risk-Based programs is showing a deficit of $685,970. The deficit is primarily resulting from CCBHC Non-Medicaid costs as well as covering Medicaid deductibles (spenddowns) for individuals served.

6. Local Key Points

a. The majority of Local Funding comes from Washtenaw County.

b. Local Funds are currently showing a deficit of $570,459 through February.

c. The purchase of two group homes totaling $890,000 occurred in February. A budget amendment is necessary to recognize the use the fund balance (local funds) for this purpose. Once complete, the local funds will show a surplus of approximately $300,000

d. 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

a. The final figures for FY24 fund balance are still in the works. At the end of FY 2023, WCCMH has a fund balance of $4,126,826.

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
FEBRUARY 25 FYTD

		Total
Medicaid **		
Revenue		
B & 1115i	$	22,731,815
HSW		14,511,241
Behavioral Health Home		258,940
Child Waiver/SED Waiver		443,504
Autism		3,325,063
Prior Year Adjustments		-
Care for Caid		16,224
Total Medicaid Revenue	$	41,286,787
Total Medicaid Expense	$	38,229,914
Medicaid Surplus/(Deficit)	$	3,056,873
CCBHC PIHP Section **		
Supplemental Revenue	$	8,638,090
CCBHC Capitation	$	3,807,292
Total CCBHC Revenue	$	12,445,382
CCBHC HMP Expense		2,075,933
CCBHC Medicaid Expense		9,093,861
Total CCBHC Expense	$	11,169,795
CCBHC Surplus/(Deficit)	$	1,275,587
CCBHC Local Section		
GF/Local Redirect	$	(669,934)
CCBHC Non-Medicaid Expense		669,934
CCBHC Surplus/(Deficit)	$	-
Healthy Michigan **		
Revenue	$	3,280,880
Expense		4,222,386
Healthy MI Surplus/(Deficit)	$	(941,506)
General Fund		
Revenue		
CMH Operations	$	1,881,704
CMH Operations Contra		-
GF Carryforward		-
Categorical		-
Redirect To Injectable Meds.		-
Redirect To CCBHC Non-Medicaid		(669,934)
Funding Fr. Other Local Sources		229,874

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
FEBRUARY 25 FYTD

		Total
Total General Fund Revenue	$	1,441,645
Total General Fund Expense	$	2,127,615
General Fund Surplus/(Deficit)	$	(685,970)
Injectable Meds		
Revenue	$	36,104
Expense		46,625
Inj. Meds. Surplus/(Deficit)	$	(10,521)
Grants And Contracts		
Revenue	$	921,803
Expense		921,803
Grants & Cont. Surplus/(Deficit)	$	-
CMHSP To CMHSP		
Revenue	$	449,106
Redirect to GF		(41,155)
Expense		407,951
CMHSP to CMHSP Surplus/(Deficit)	$	-
Local		
Revenue	$	714,296
Expense		1,284,755
Local Surplus/(Deficit)	$	(570,459)
Private Grant & All NOR		
Revenue	$	109,785
Expense		102,312
Priv. Grant & NOR Surplus/(Deficit)	$	7,474
Grand Total		
Revenue	$	60,644,633
Expense		58,513,155
Grand Total Surplus/(Deficit)	$	2,131,478

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit)	$	3,380,433
WCCMH Surplus/(Deficit)		(1,248,955)
	$	2,131,478

Washtenaw County Community Mental Health
Budget to Actuals
For Five Months Ending February 28, 2025

	Current Fiscal Year				
	FY 2025 Amended Budget	FY 2025 Amended Budget YTD	FY 2025 YTD Actuals	YTD Actuals Over/(Under) YTD Budget	% O(U)
Operating Revenue					
PIHP Revenue					
Medicaid Capitation:					
Medicaid (b) & 1115i	$ 54,524,586	$ 22,718,578	$ 22,731,815	$ 13,238	0.06%
HSW	31,656,289	13,190,120	14,511,241	1,321,121	10.02%
Children & SED Waivers	1,335,478	556,449	443,504	(112,945)	-20.30%
Healthy Michigan Capitation	7,874,111	3,280,880	3,280,880	0	0.00%
Autism Capitation	7,980,152	3,325,063	3,325,063	(0)	0.00%
CCBHC Medicaid/HMP	9,137,500	3,807,292	3,807,292	0	0.00%
CCBHC Supplementary	12,936,000	5,390,000	8,638,089	3,248,089	60.26%
Behavioral Health Home	572,073	238,364	258,940	20,576	0.00%
TOTAL PIHP Revenue	$ 126,016,189	$ 52,506,745	$ 56,996,824	$ 4,490,079	8.55%
MDHHS Revenue					
State General Funds	$ 4,461,704	$ 1,859,043	$ 1,881,704	$ 22,661	1.22%
Grants & Earned Contracts	2,392,867	997,028	986,411	(10,617)	-1.06%
All Other Revenue					
County Appropriation	$ 1,751,761	$ 729,900	$ 369,190	$ (360,710)	-49.42%
Project Revenue	939,998	391,666	209,657	(182,009)	-46.47%
All Other	1,917,652	799,022	1,415,393	616,371	77.14%
TOTAL Operating Revenue	**$ 137,480,171**	**$ 57,283,405**	**$ 61,859,179**	**$ 4,575,774**	7.99%
Operating Expenses					
Administrative Expenses					
General Administration	$ 8,329,146	$ 3,470,478	$ 3,405,717	$ (64,761)	-1.87%
Program Administration	4,608,587	1,920,245	1,874,797	(45,448)	-2.37%
Residential Services					
Community Living Supports	$ 34,000,000	$ 14,166,667	$ 15,768,832	$ 1,602,165	11.31%
Licensed Residential	22,000,000	9,166,667	9,308,645	141,978	1.55%
Outpatient Services					
Autism Services	$ 12,000,000	$ 5,000,000	$ 5,204,251	$ 204,251	4.09%
Case Management	6,340,214	2,641,756	2,812,833	171,077	6.48%
Supports Coordination	3,576,188	1,490,078	1,442,513	(47,565)	-3.19%
Skill Building	4,905,514	2,043,964	1,726,424	(317,540)	-15.54%
Supported Employment	2,174,459	906,025	643,250	(262,775)	-29.00%
Psychiatry	5,063,666	2,109,861	2,029,434	(80,427)	-3.81%
Nursing Services	2,892,534	1,205,223	1,345,133	139,911	11.61%
Therapy Services	3,157,108	1,315,462	1,318,662	3,200	0.24%
All Other	14,583,888	6,076,620	4,816,817	(1,259,803)	-20.73%
Other Expenses					
Community Inpatient	$ 10,476,000	$ 4,365,000	$ 5,903,000	$ 1,538,000	35.23%
Local Matches & Shelter	980,000	408,333	378,292	(30,041)	-7.36%
Grants & Earned Contracts	2,392,867	997,028	944,965	(52,063)	-5.22%
TOTAL Operating Expenses	**$ 137,480,171**	**$ 57,283,405**	**$ 58,923,565**	**$ 1,640,160**	2.86%
Revenue Over/(Under) Expenses	-	-	2,935,614	2,935,614	

Washtenaw County Community Mental Health
Budget to Actuals
For Five Months Ending February 28, 2025

	Prior Year Comparison			
	FY 2025 YTD Actuals	FY 2024 Prior YTD Actuals	YTD Actuals Over/(Under) Prior YTD Actuals	% O(U)
Operating Revenue				
PIHP Revenue				
Medicaid Capitation:				
Medicaid (b) & 1115i	$ 22,731,815	$ 20,691,077	$ 2,040,738	9.86%
HSW	14,511,241	12,873,419	1,637,822	12.72%
Children & SED Waivers	443,504	489,856	(46,352)	-9.46%
Healthy Michigan Capitation	3,280,880	2,564,690	716,190	27.93%
Autism Capitation	3,325,063	3,093,082	231,981	7.50%
CCBHC Medicaid/HMP	3,807,292	9,106,061	(5,298,769)	0.00%
CCBHC Supplementary	8,638,089	-	8,638,089	0.00%
Behavioral Health Home	258,940	233,642	25,298	0.00%
TOTAL PIHP Revenue	$ 56,996,824	$ 49,051,827	$ 7,944,997	16.20%
MDHHS Revenue				
State General Funds	$ 1,881,704	$ 1,881,704	$ -	0.00%
Grants & Earned Contracts	986,411	763,086	223,325	29.27%
All Other Revenue				
County Appropriation	$ 369,190	$ 311,529	$ 57,661	18.51%
Project Revenue	209,657	207,809	1,848	0.89%
All Other	1,415,393	4,037,671	(2,622,278)	-64.95%
TOTAL Operating Revenue	**$ 61,859,179**	**$ 56,253,626**	**$ 5,605,553**	9.96%
Operating Expenses				
Administrative Expenses				
General Administration	$ 3,405,717	$ 3,157,698	$ 248,019	7.85%
Program Administration	1,874,797	4,320,682	(2,445,885)	-56.61%
Residential Services				
Community Living Supports	$ 15,768,832	$ 12,567,537	$ 3,201,295	25.47%
Licensed Residential	9,308,645	7,581,309	1,727,336	22.78%
Outpatient Services				
Autism Services	$ 5,204,251	$ 4,387,457	$ 816,794	18.62%
Case Management	2,812,833	2,281,152	531,681	23.31%
Supports Coordination	1,442,513	1,240,211	202,302	16.31%
Skill Building	1,726,424	1,689,770	36,654	2.17%
Supported Employment	643,250	741,031	(97,781)	-13.20%
Psychiatry	2,029,434	1,502,228	527,206	35.09%
Nursing Services	1,345,133	1,088,344	256,789	23.59%
Therapy Services	1,318,662	1,101,027	217,635	19.77%
All Other	4,816,817	4,471,025	345,792	7.73%
Other Expenses				
Community Inpatient	$ 5,903,000	$ 4,044,737	$ 1,858,263	45.94%
Local Matches & Shelter	378,292	450,355	(72,063)	-16.00%
Grants & Earned Contracts	944,965	730,206	214,759	29.41%
TOTAL Operating Expenses	**$ 58,923,565**	**$ 51,354,769**	**$ 7,568,796**	14.74%
Revenue Over/(Under) Expenses	2,935,614	4,898,857	(1,963,243)	

CMH Millage Fund Income Statement 2023 & 2024

	2023	2024
Revenue	$8,163,415.75	$8,660,423.39
22245100 - CMH MH Millage Operations	$8,163,415.75	$8,660,423.39
401000 - Current Property Tax	$7,294,432.96	$7,745,774.32
660000 - Interest Earnings	$565,929.03	$828,791.69
661000 - GASB 31 Adjustment	$229,508.60	$2,928.67
690000 - Transfers In	$73,545.16	$82,928.71
Expense	$6,865,386.50	$8,629,045.05
22245100 - CMH MH Millage Operations	$6,865,386.50	$8,629,045.05
702000 - Salaried Permanent	$2,067,871.31	$2,802,077.31
703000 - Part Time Temporary	$11,741.01	$26,736.23
703010 - On Call	$13,633.68	$18,303.09
704000 - Overtime	$168,073.86	$196,249.61
706000 - Shift Premium	$14,437.36	$13,783.63
715200 - Fringe Benefits	$1,274,759.20	$1,444,338.72
752000 - Printing	$708.27	$155.14
753000 - Postage	$214.47	$288.70
754000 - Operating Supplies	$774.15	$703.28
801300 - Subscriptions and Dues	$315.90	$1,082.50
801500 - Consultants and Contracts	$1,976,261.58	$2,696,451.41
803000 - Telephone	$26,366.96	$25,252.93
805000 - Travel	$4,742.59	$7,461.30
805500 - Employee Development	$12,228.63	$16,984.18
815900 - Client Transportation	$5,371.11	$821.21
816700 - Reallocated Expense	$810,555.40	$756,644.69
817200 - Client Care	$13,433.04	$26,433.57
817300 - Housing Assistance	$146,311.78	$235,170.72
951000 - Cost Allocation Plan	$267,233.67	$344,447.03
952100 - Fleet Fuel	$2,727.78	$4,231.89
952200 - Fleet Maintenance	$1,250.43	$7,627.41
952300 - Fleet Administration	$2,374.32	$3,800.50
990000 - Transfers Out	$44,000.00	$0.00
Net Income:	**$1,298,029.25**	**$31,378.34**

Fund balance as 12/31/2024 $9,075,554

Michigan's Medicaid Program

Meghan Groen, Senior Deputy Director

March 20, 2025

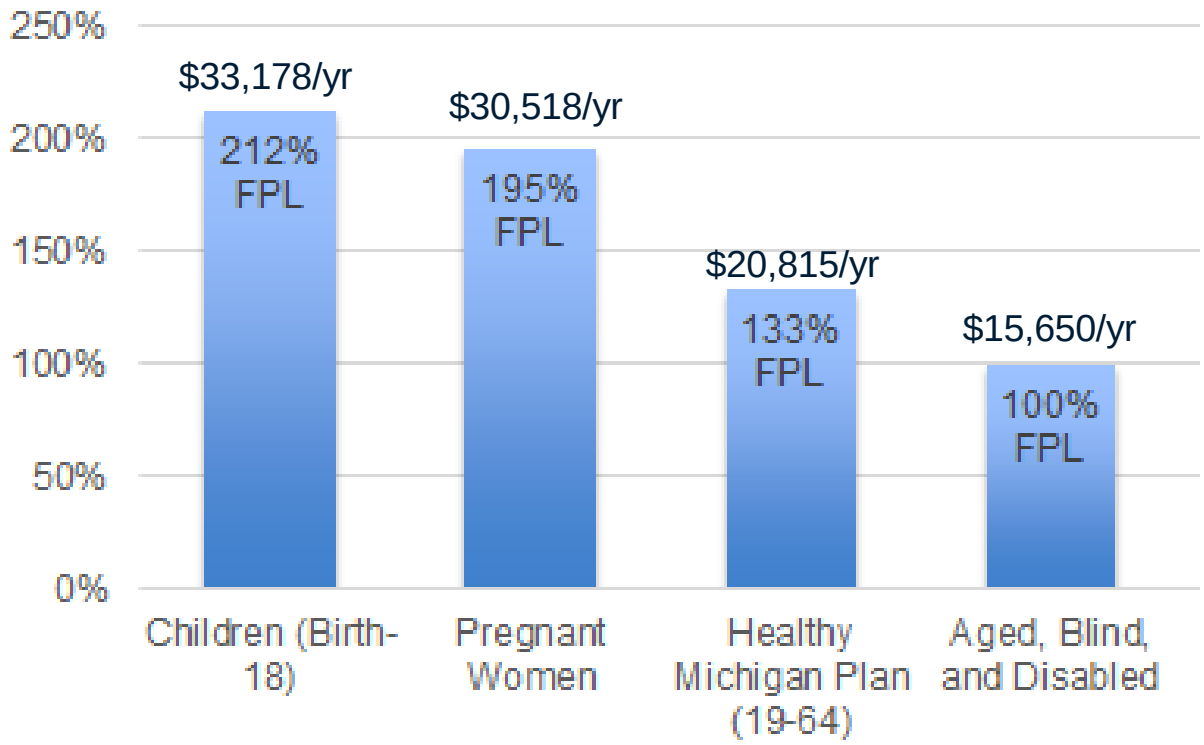
MDHHS
Michigan Department of Health & Human Services

Medicaid Background

Medicaid Program Background

- Medicaid is the **largest health insurance program** in the U.S.
- A means-tested entitlement program providing **comprehensive health coverage for eligible populations**, including:
  - Low-income children and families.
  - Elderly and disabled individuals.
  - Pregnant women.

Medicaid Income Limit by Population



Michigan's Medicaid Program has a Vast Reach

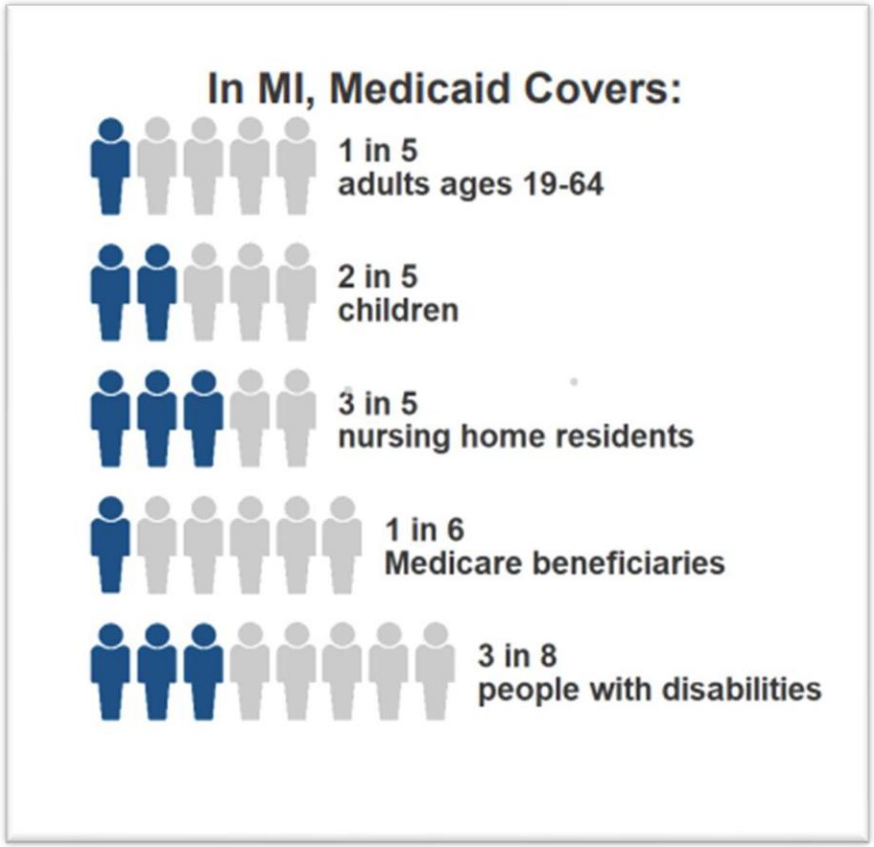
Medicaid covers 1 in 5 individuals living in the U.S.

In Michigan, the coverage rate is even higher — **1 in 4 Michiganders**.

Michigan's Medicaid program affords health coverage to more than **2.6 million Michiganders** each month, including:

- **1 million children**;
- **300,000 people** living with **disabilities**;
- **168,000 seniors**; and,
- Nearly **725,000 adults** in the **Healthy Michigan Plan**.

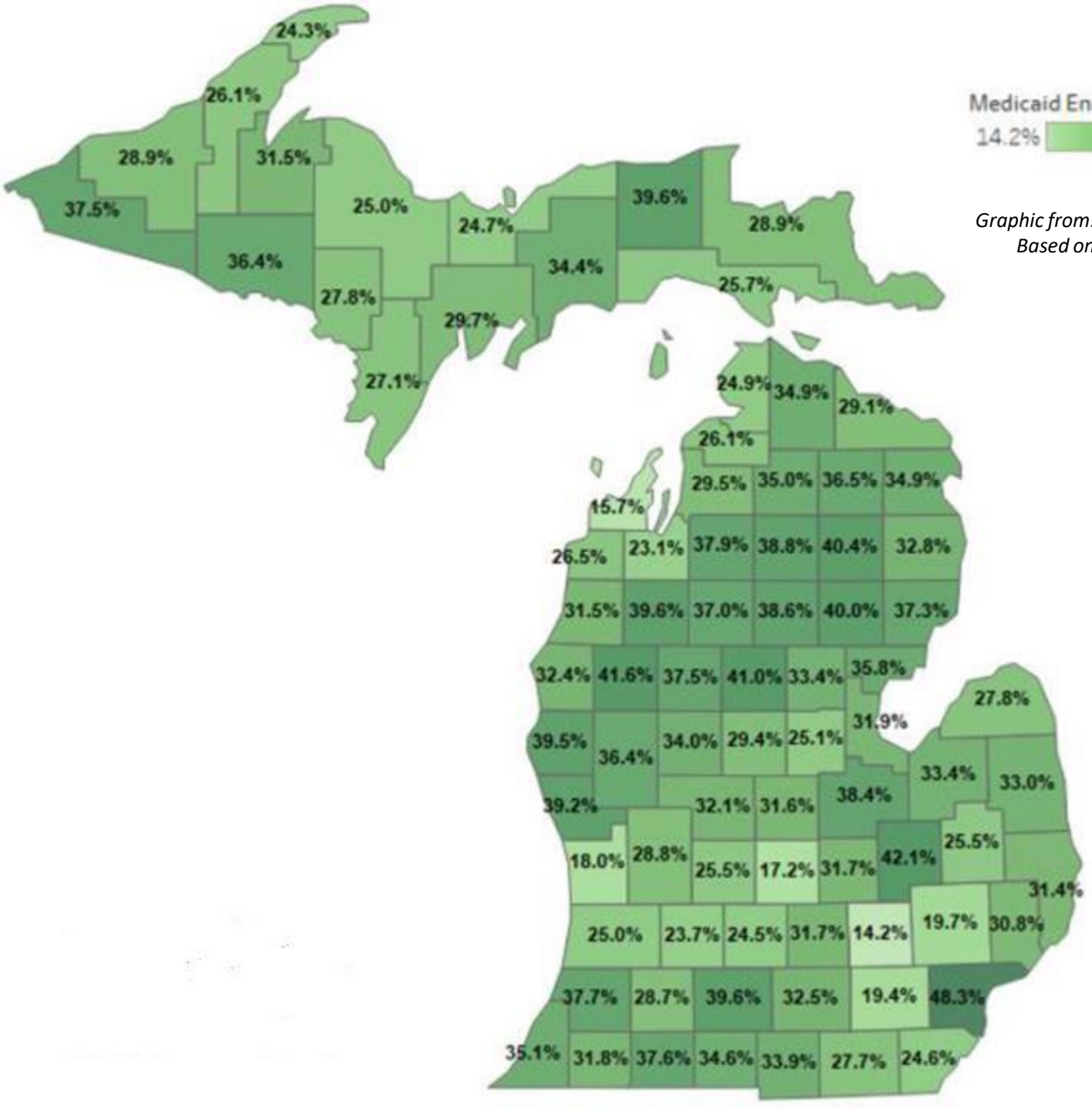
45% of births in Michigan are covered by Medicaid.



Graphic from: Kaiser Family Foundation
August 2024 Michigan Fact Sheet

Medicaid Enrollment

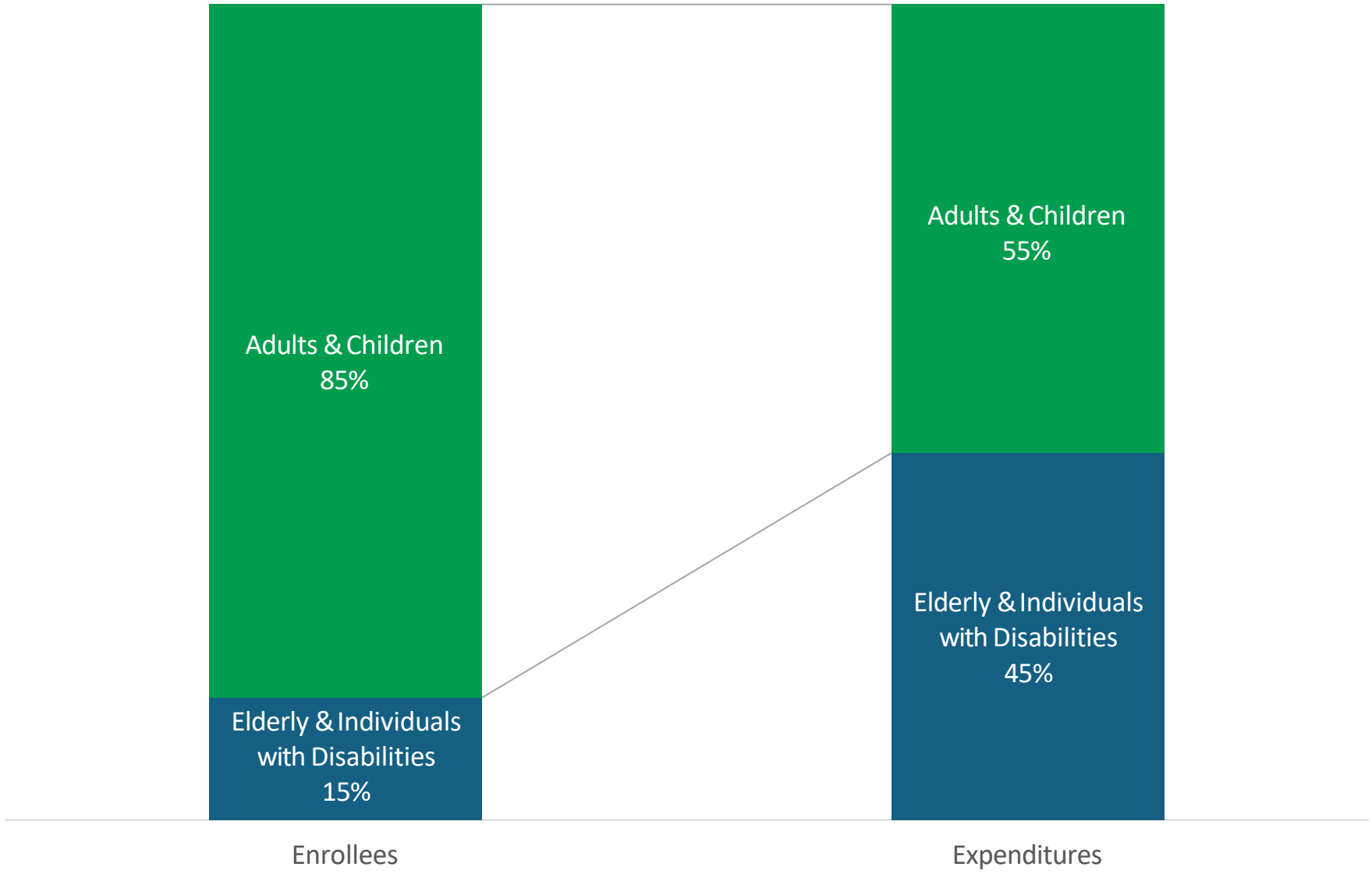
Percentage of County Population



Graphic from: Michigan Health & Hospital Association
Based on January 2023 Medicaid Enrollment

Medicaid Enrollees and Expenditures

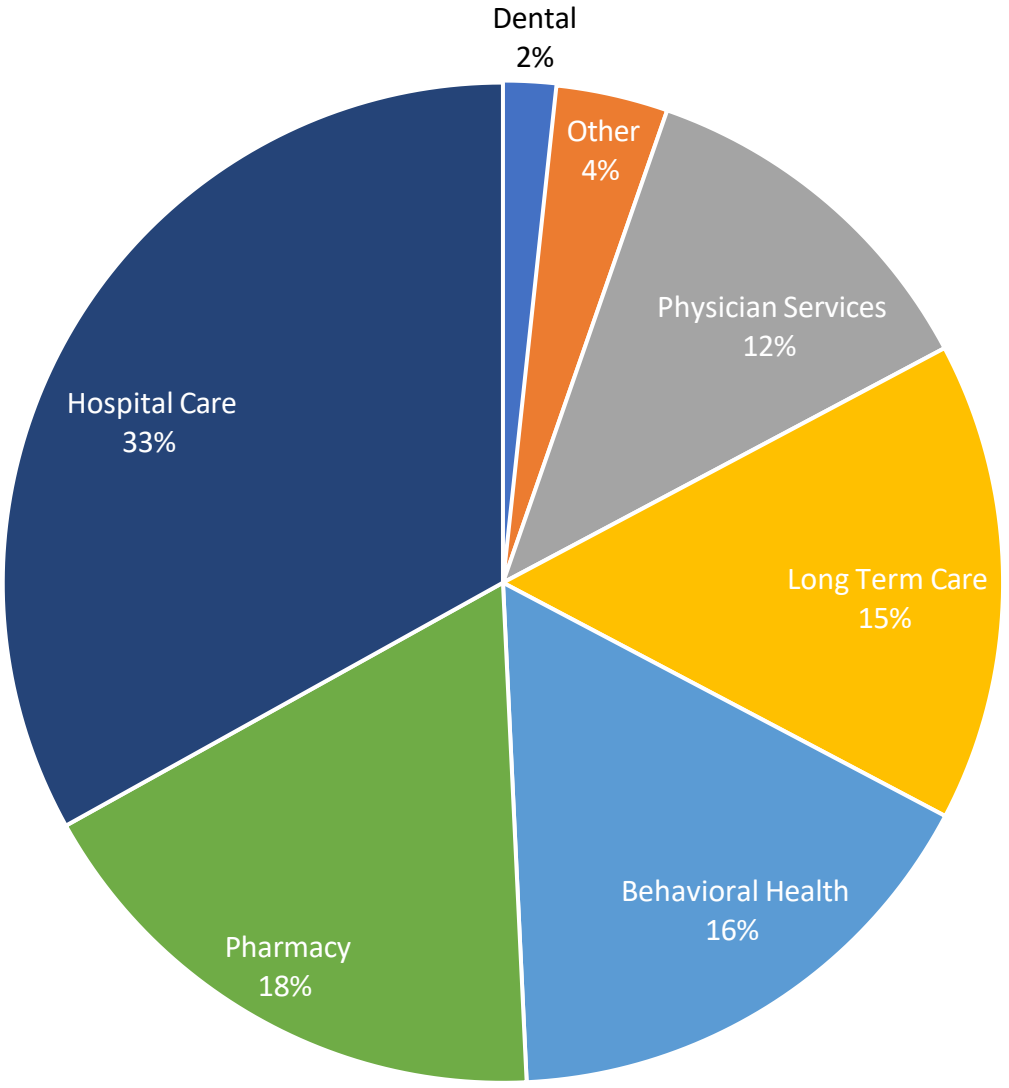
MDHHS Michigan Department of Health & Human Services



Medicaid is a Major Payer in the Health Care System

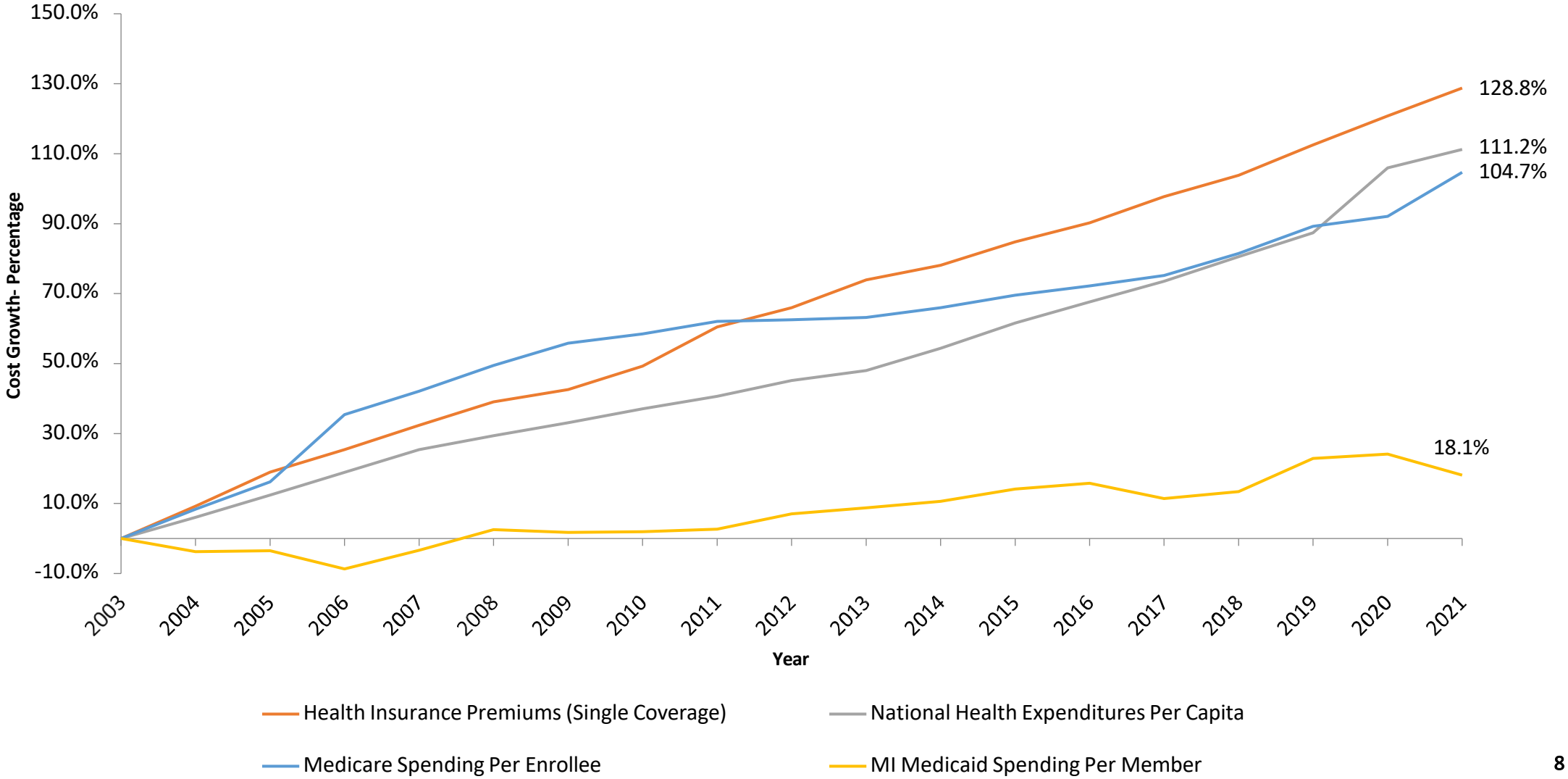
- Nationally, Medicaid accounts for one-fifth of all health care spending, and over half of spending on long-term care.
- It is largest payer of mental health services, long-term care services, and births.
- As such, it plays a critical role in assuring the sustainability of hospitals, community health centers, physicians, and nursing homes.

Michigan Medicaid Expenditures by Service



Medicaid is Cost Effective

MDHHS Michigan Department of Health & Human Services



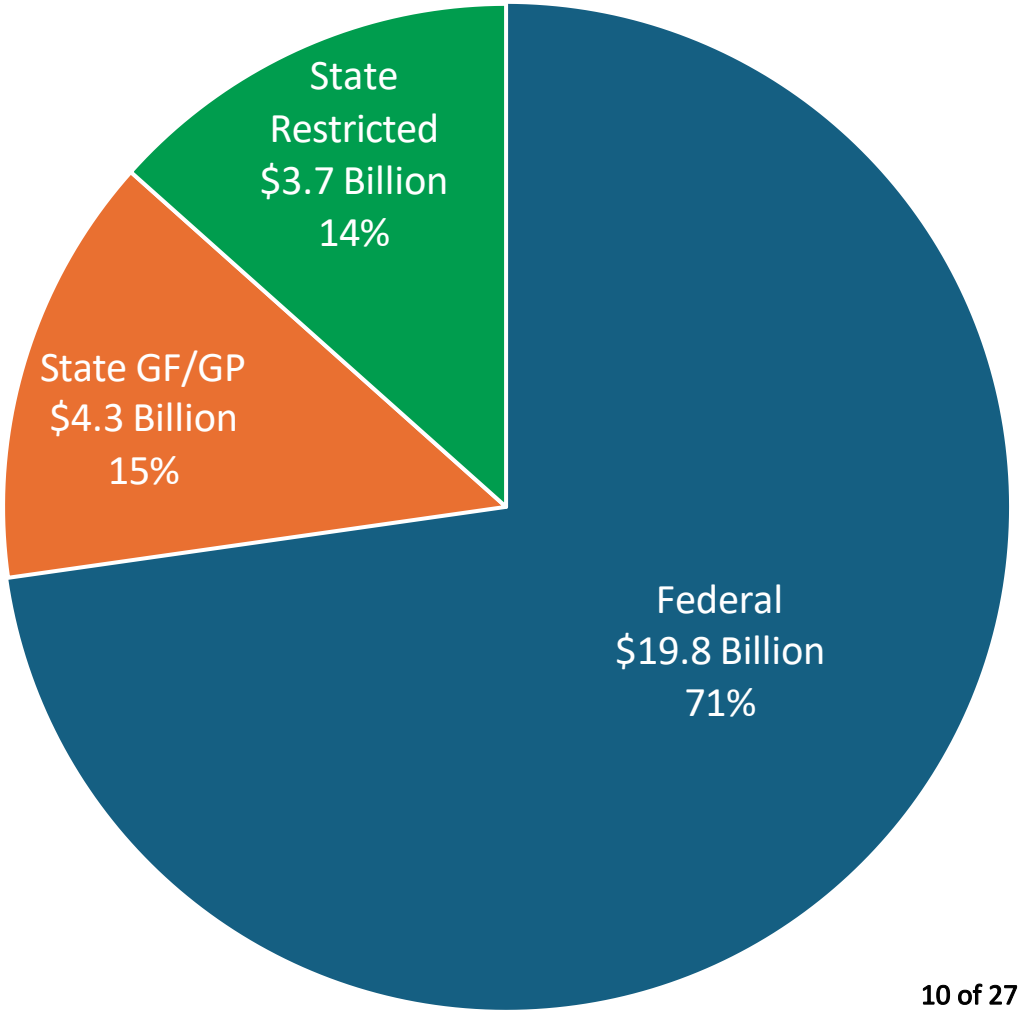
How Michigan Medicaid is Financed

MDHHS Michigan Department of Health & Human Services

- Medicaid is **jointly funded** by the state and federal governments.
- The federal match rates for most Medicaid enrollees vary by state following a federal formula that provides a **higher federal match rate for states with lower per capita income**.
  - Michigan's FY25 **federal match rate is ~65%**.
  - The remaining **~35% is covered by the state** through a combination of state appropriations, provider taxes and local revenue.
- **Healthy Michigan Plan**, Michigan's Medicaid expansion program, qualifies for **90% federal match**.
- Medicaid **administrative expenditures** are covered by the federal government at **50%, 75% or 90%, depending on the type of expenditure**.

Michigan Medicaid Budget

- Michigan's FY25 Medicaid budget is approximately $27.8 billion.
  - 34% of the state's overall budget.
- More than 70% of the Medicaid budget comes from federal funding.
- The state share is comprised of:
  - State General Fund/General Purpose Revenue: $4.3 billion.
  - Provider Taxes: $2.32 billion.
  - Insurance Provider Assessment: $651.1 million.
  - Tobacco Taxes/Settlement: $335.0 million.
  - Public/University Hospital and Long-Term Care Special Financing: $246.8 million.



Medicaid Helps Hospitals

- With Medicaid covering a quarter of the state's population, Michigan's **uninsured rate** continues to improve and is now **among the best in the country** (4.4% in Michigan compared to 8% nationally).
- Since the launch of Medicaid expansion in 2014, **hospital uncompensated care** has fallen dramatically – **decreasing by more than 50%.**
- Michigan's hospitals receive **nearly $7 billion** in Medicaid funding annually, which accounts for **almost one-fifth of the net patient revenue for hospitals in the state.**

Medicaid Helps Rural Communities

MDHHS Michigan Department of Health & Human Services

- **37.3% of small town and rural** Michiganders are covered by Medicaid.
- States that did not expand Medicaid experienced **more hospital closures, especially in rural communities**. Hospitals are six times more likely to close in non-expansion states.
- If Medicaid payments are reduced, rural hospitals will struggle to keep **labor and delivery** units open.
- The local hospital is often the **largest employer in many of Michigan's rural communities.**

Medicaid Helps the Economy

MDHHS
Michigan Department of Health & Human Services

- According to the Michigan Health and Hospital Association, Michigan's health care industry has a total economic impact of **$77 billion** per year — **greater than any other industry in the state.**
- A University of Michigan study found that Medicaid expansion alone sparked the creation of **more than 30,000 new jobs every year**.
  - One-third in health care and 85% in the private sector.
- These jobs boost the **personal spending power** for Michigan residents by about **$2.3 billion each year** and result in an additional **~$150 million in tax revenue annually.**

Medicaid is Good for our Future

Medicaid Kids ➡ *High Earners*

- Medicaid enrollment for children has been shown to:
  - Increase **positive health outcomes**.
  - Increase **educational attainment**.
  - Increase **wages** in adulthood.
  - Increase **future tax revenue** from increased earnings.

- Increasing the proportion of low-income pregnant women on Medicaid improved the **economic mobility outcomes** of their children in adulthood.
- The Congressional Budget Office estimates that **long-term** fiscal effects of Medicaid spending on children could **offset half or more** of the program's initial outlays.

Potential Federal Medicaid Changes

MDHHS
Michigan Department of Health & Human Services

Impact of Potential Federal Cuts to Michigan's Medicaid Program

- **Reducing the 90% federal match rate for Medicaid expansion (HMP)**:
  - Aligning the expansion match rate with Michigan's traditional federal match of ~65% would cost the state $1.1 billion annually. Absent this additional state investment, 30% of Michigan's Medicaid population would lose their health coverage.
- **Limiting provider taxes:**
  - Would result in cuts to hospital, nursing facility and ambulance reimbursement. The loss of federal revenue would also likely necessitate broad-based cuts to benefits or already low reimbursement rates.
- **Imposing work requirements:**
  - Would add administrative costs to the state and a burden on beneficiaries, and it would lead to unnecessary coverage losses including for individuals who are already working.
- **Ending enhanced federal match for certain administrative expenditures:**
  - Would result in the need for considerable additional state dollars to backfill loss of funds for administrative activities such as IT maintenance and operations, nursing home certification and survey activities, and program integrity efforts.
- **Per capita caps or block grants:**
  - Would cap federal funding available to support the state's Medicaid program over time. National estimates modeled to date project that Michigan could see a reduction in federal funding of $16 billion between FY2025 and FY2034.

Questions?

MDHHS
Michigan Department of Health & Human Services

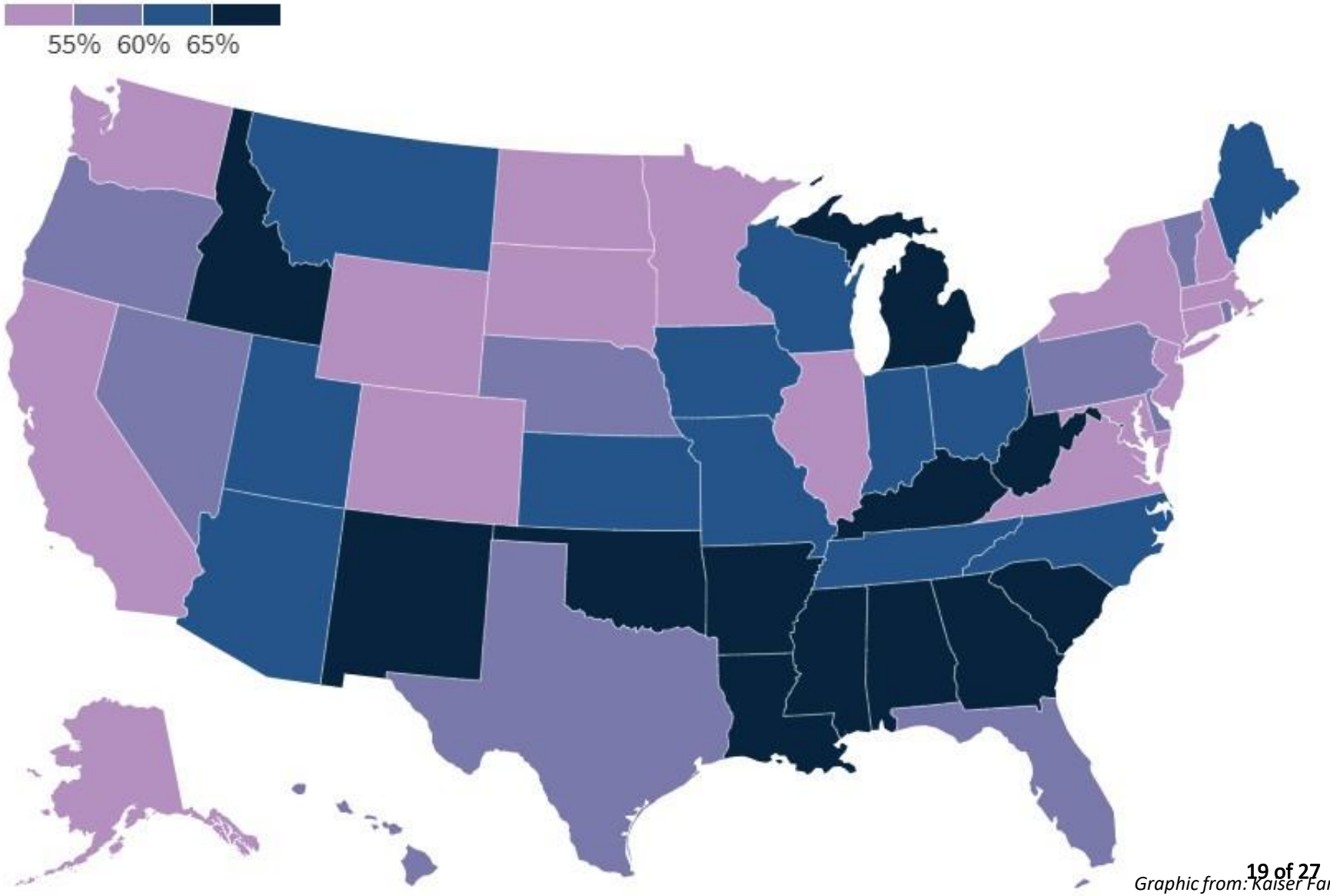
Supplemental Materials

MDHHS
Michigan Department of Health & Human Services

Michigan Brings in More Federal Dollars

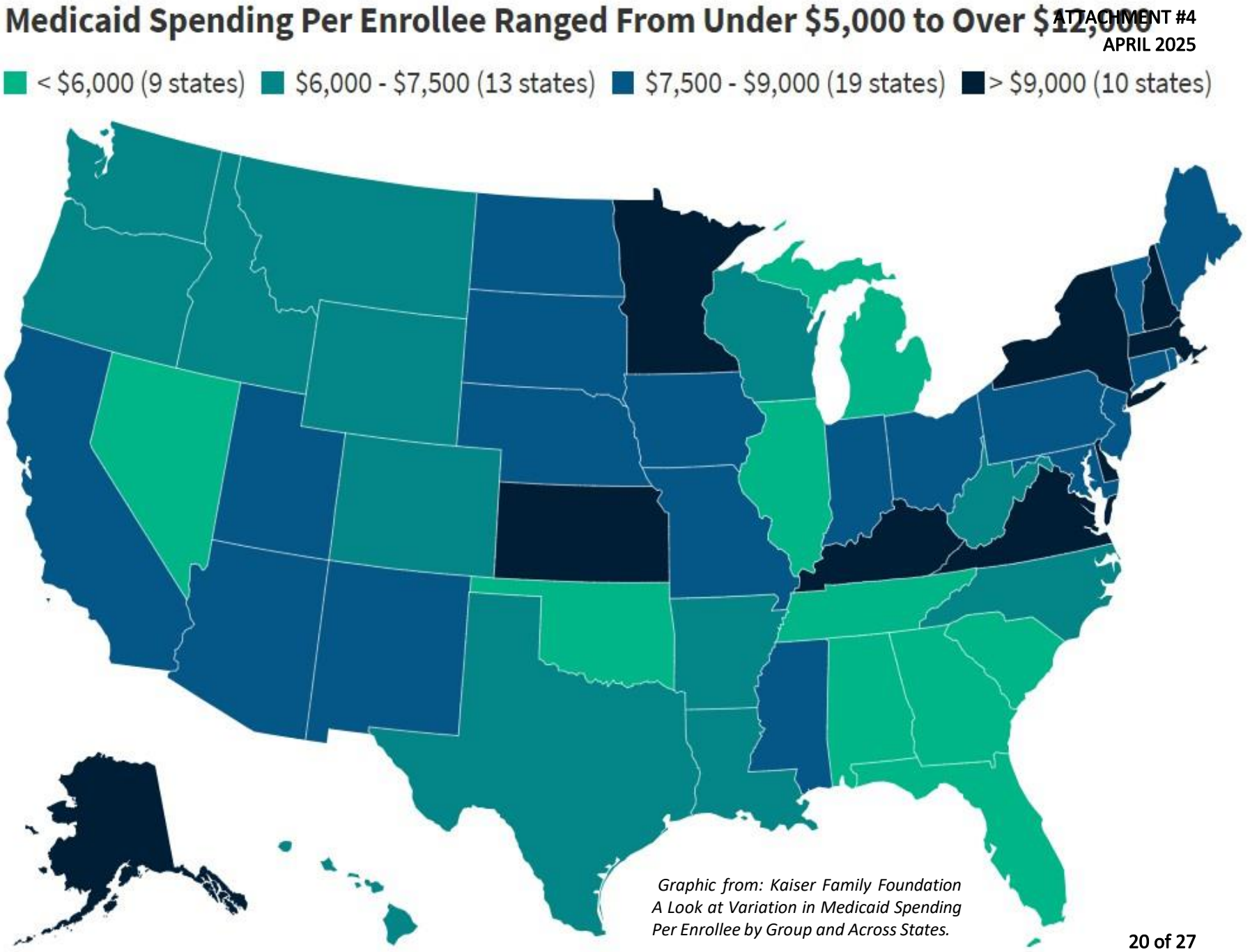
States With Lower Per Capita Incomes Have a Higher Federal Matching Rate for Medicaid

Federal Medicaid Assistance Percentages (FMAPs) for Traditional Medicaid Spending Effective for FFY 2026



Graphic from: Kaiser Family Foundation Medicaid Financing: The Basics.

Michigan Spends Less per Medicaid Enrollee



Graphic from: Kaiser Family Foundation
A Look at Variation in Medicaid Spending Per Enrollee by Group and Across States.

Mandatory Medicaid Populations and Benefits

MDHHS Michigan Department of Health & Human Services

Who must be covered under federal law?

- Older adults (age 65 and older) who receive Medicare and also qualify for Medicaid.
- Individuals who are blind.
- Individuals with disabilities.
- SSI recipients.
- Pregnant women.
- Children under age 1.
- Children in foster care.
- Very low-income families with children.
- Non-citizens for limited emergency services only.

What services must be covered under federal law?

- Inpatient and outpatient hospital services.
- Nursing facility services.
- Physician services.
- Lab and X-ray services.
- Home health services.
- Non-Emergency Medical Transportation (NEMT).
- Federally Qualified Health Centers & Rural Health Centers.
- Family planning services.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (under 21).
- Medication Assisted Treatment (MAT).

Changing Federal Matching Assistance Percentage (FMAP) Rates

- There are several potential policy changes under consideration relative to changing the current FMAP structure:
  - **Reducing the 90% federal match rate for Medicaid expansion population to the traditional Medicaid match rate (~65% for MI).**
    - CBO estimate: $561 billion reduction nationally over the next 10 years.
    - Michigan impact: $1.1 billion annual cost to the state.
    - Puts at risk the health coverage of ~725,000 individuals or 30% of Michigan's Medicaid population.
  - **Ending the enhanced federal match for certain administrative expenditures.**
    - CBO estimate: $69 billion reduction nationally over the next 10 years.
    - Michigan impact: Minimum of $115 million in state funds needed simply to maintain current IT operations/projects.
  - **Removing the 50% FMAP floor.**
    - No impact to Michigan absent broader FMAP formula adjustments.

Limiting Provider Taxes

- Michigan has three provider taxes today:
  - Hospitals.
  - Nursing homes.
  - Ambulance providers.
- We also have a Managed Care Organization tax – the Insurance Provider Assessment.
- Together, these taxes are leveraged to make up **nearly $3 billion** of Michigan's state share of Medicaid costs.
- The tax dollars fund both the base Medicaid program and broader state budget (through state retention) and increased reimbursement to the taxed provider classes.

Limiting Provider Taxes

- There are several options rumored to be under consideration relative to limiting provider taxes:
  - Reducing the provider tax limit from 6% of providers' net patient revenue to 3% or 4%.
  - Capping provider taxes as a share of state general funding.
  - Eliminating entirely the state's ability to leverage provider tax revenue to finance their Medicaid program.
  - Taking administrative action through rulemaking to require wholesale restructuring of managed care organization taxes.
- CBO estimate: $48-612 billion reduction nationally over the next 10 years.

Imposing Work Requirements

- U.S. House and Senate Republicans have begun introducing legislative proposals to impose work requirements in Medicaid.
- When Michigan implemented Healthy Michigan Plan (HMP) work requirements in 2020, MDHHS incurred more than **$30 million** in administrative costs.
- Before a federal court blocked Michigan's work requirements in March 2020, MDHHS was on track to lose **~80,000 HMP enrollees** in the first month that coverage terminations were to occur and **more than 100,000** in the first year.
- The estimated impacts of work requirements and how these may or may not align with Michigan's prior experience are highly dependent on policy details that have yet to be released.
- CBO estimate: $110 billion reduction nationally over the next 10 years.

Capping Medicaid Funds to States

MDHHS Michigan Department of Health & Human Services

- Medicaid is currently an entitlement program wherein states must cover all eligible individuals, and the federal government must provide the federal share of funding for the costs of that coverage.
- Per capita caps and block grants are mechanisms to shift financial costs and risk to states.
  - **Per-capita caps:** Limits federal funding to a fixed amount per enrollee. This amount would be adjusted annually by a set amount/inflationary factor. Because funding is set on a per enrollee basis, federal funding available to states under this model would adjust for enrollment fluctuations.
  - **Block grants:** Limits federal funding to a fixed amount for the entire Medicaid program. This amount would be adjusted annually by a set amount/inflationary factor but would not adjust for enrollment fluctuations.

Capping Medicaid Funds to States

- The estimated impacts of a per capita cap or block grant structure are highly dependent on policy details that have yet to be released, which limits the ability of the state to effectively model such a shift.
- CBO estimate – Per-capita Caps: $588-$893 billion reduction nationally over the next 10 years.
- CBO estimate – Block Grants: $459-$742 billion reduction nationally over the next 10 years.

Recipient Rights Board of Directors Training

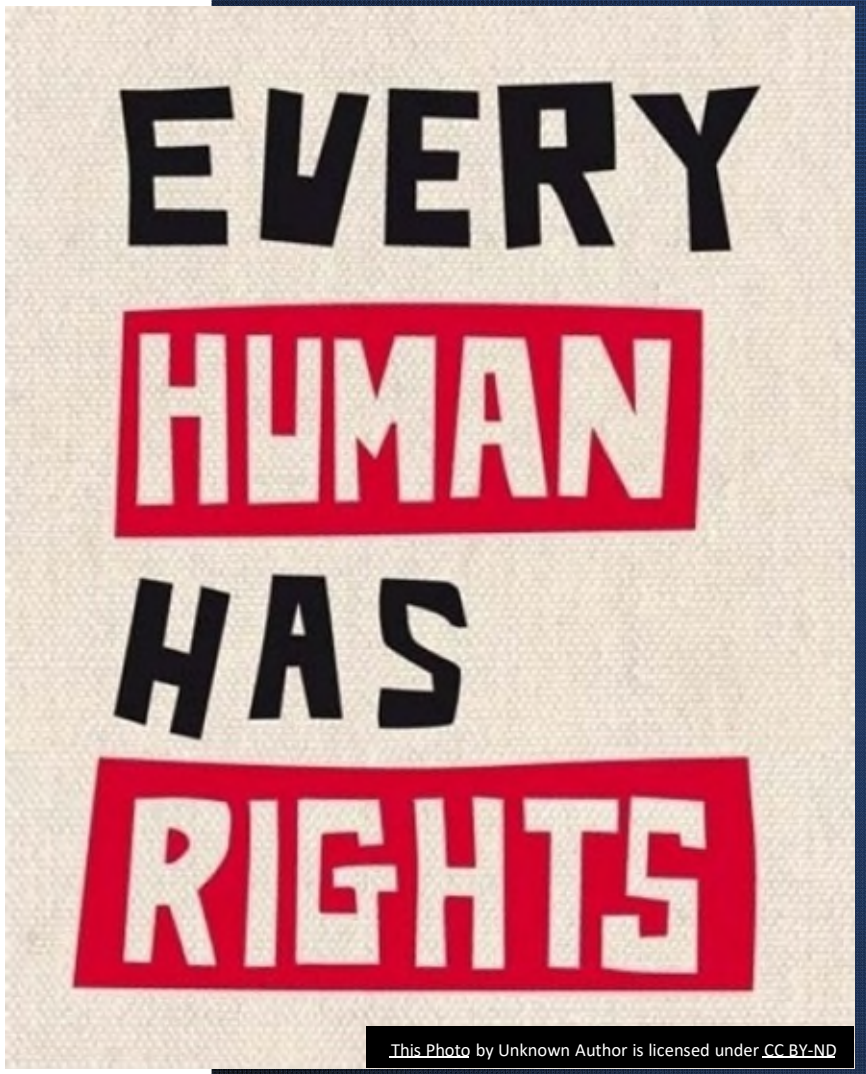
Office of Recipient Rights Overview

- The Office of Recipient Rights (ORR) is a department of the local CMH that is responsible for investigating, resolving and assuring remediation of apparent or suspected rights violations

- ORR works to ensure 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.

Functions of the Rights Office

- Prevention
- Monitoring
- Education/Training
- Complaint resolution



Overview of Code Protected Rights

The Mental Health Code guarantees certain rights for recipients of public mental health services in Michigan. These rights include, among others:

- To be free from abuse and neglect
- To be treated with dignity and respect
- To be treated in a safe, sanitary, and humane treatment environment
- To have information kept confidential (in compliance with the Code and HIPAA)

Overview of Code Protected Rights

The Mental Health Code also guarantees certain rights for family members of recipients of public mental health services in Michigan. These rights include:

- To be treated with dignity and respect
- The opportunity to provide information to treating professionals
- The opportunity to request and receive educational information about the nature of disorders, medications and their side effects, available support services, advocacy and support groups, financial assistance, and coping strategies

All employees, students, volunteers, contractors, and board members are required to **immediately** (by the next business day) verbally **report** to the Office all apparent or **suspected violations** of recipient rights and maintain recipients' confidentiality.

Investigative Process

- A recipient (or someone on their behalf) may file a Recipient Rights Complaint
- Within 90 days, the Rights Office will investigate the complaint and determine whether a violation occurred
- If the complaint is substantiated, the provider of services will take appropriate remedial action to correct the violation
- The CMH Director will issue a Summary Report to the recipient, complainant, and parent of a minor recipient or guardian (if applicable)

Recipient Rights Advisory and Appeals Committee (RRAC)

The RRAC is a committee appointed by the CMH Board comprised of primary recipients, secondary recipients, and community members. The committee meets quarterly and has the following functions:

- Protects the office from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions
- Serves in an advisory capacity to the executive director, the ORR director and the ORR
- Consults with the executive director regarding any proposed dismissal of the director of the Office of Recipient Rights
- Assures that Rights staff receive training in Rights protection and that the head of the Office has sufficient training, education, and experience to fulfill the responsibilities of the Office
- Annually reviews the funding for the Office
- Monitors the Office by reviewing and providing comments on data reports, including the Semi-Annual and Annual Reports submitted to MDHHS ORR
- Acts as the Appeals Committee

Appeal Process

- After receiving the Summary Report, the recipient, complainant, or parent of a minor recipient/guardian may file an appeal within 45 days
- Grounds for appeal include:
  - The investigative findings of the Rights Office are not consistent with the facts, law, rules, policies, or guidelines
  - The action taken or proposed by the provider does not provide an adequate remedy
  - The investigation was not initiated or completed on a timely basis
- The Recipient Rights Appeals Committee will review the appeal
- If accepted, the committee will make a decision within 30 days
- The Appeals Committee shall do one of the following:
  - Uphold the investigative findings of the Office and the action taken or plan of action proposed by the provider
  - Return the investigation to the Office and request that it be reopened or reinvestigated (If appeal is related to investigating findings)
  - Recommend that the local CMH Board request an external investigation by the Department of Health and Human Services (MDHHS) (If appeal is related to investigating findings)
  - Recommend that the provider take additional or different action to remedy the violation (If appeal is related to action taken)
  - Recommend the MDHHS ORR director or CMH Director address the cause of the lack of timeliness (If appeal is related to investigation not being timely)
- If the appeal was because the findings were inconsistent with the facts, law, rules, policies, or guidelines, the Appellant can file a second level appeal with MDHHS

Responsibilities of the CMH Director

- Directly supervises the Recipient Rights Director
- Issues Summary Reports
- Submits the Recipient Rights Annual Report to the CMH Board and MDHHS

Responsibilities of the CMH Board

- Approves the Recipient Rights Annual Report
- Approves new members of the RRAC
- The RRAC may also make additional recommendations to the CMH Board outside of the Annual Report, based on any concerns noted in the bullets on the prior slide.
- If a Rights complaint is received regarding the conduct of the CMH Director, the Board shall request MDHHS or another CMH's Rights Office complete the investigation
- If recommended by the RRAC, the Board can request an external investigation related to a Recipient Rights Appeal

Monitoring of the Rights Office

The Rights Office is monitored in the following ways:

- **Internal review**- The Director of the Office oversees the daily operations of the Office. Complaint data is reviewed quarterly during management meetings and at the RRAC.

- **Regional review**- Affiliate partners complete peer reviews of the Office. Complaint data is reviewed annually during the regional Clinical Performance Team Committee.

- **State review**- Complaint data and additional information are submitted to MDHHS semi-annually. The MDHHS Office of Recipient Rights completes a tri-annual assessment and certification of the Office. The internal and regional monitoring is preparation for this assessment. Certification of the Office of Recipient Rights is required for an agency to be certified as the CMH. Washtenaw's MDHHS ORR assessment will take place in 2027.

Contact your WCCMH Rights Officers

Leah Raehtz

Jessica Krefman

Sarah Starkey

Jody Marsh

Officer of the day phone number:

734-219-8519

Katie Snay, Director of Recipient Rights:

734-544-2958

Community Mental Health Partnership of Southeast Michigan	***Policy:*** ***Conflict of Interest***	
CMHPSM Board Governance		
Original Board Approval Date 12/09/2020	Date of Board Approval 6/14/2023	Date of Implementation 6/14/2023

I. POLICY / PURPOSE

It shall be the policy of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) to require any Covered Person to identify and disclose to CMHPSM's Board of Directors (the Board), any financial or personal Conflict of Interest. Covered Persons should avoid even the appearance of a perceived conflict of interest while fulfilling their required duties to ensure public trust in all CMHPSM processes, remain in compliance with federal and state laws and CMHPSM policy.

The purpose of this Conflict of Interest Policy is to protect the CMHPSM's interest when it contemplates entering a transaction or arrangement that might benefit the private interest of a Covered Person. To achieve this objective, this Policy defines Conflict of Interest, identifies individuals covered by this Policy, provides a means for those individuals to disclose information, and outlines procedures for managing conflicts of interest. This policy is intended to supplement, not replace, any applicable state and federal laws governing Conflict of Interest applicable to the CMHPSM.

II. REVISION HISTORY

REVISION DATE	MODIFICATION
12/09/20	This Board Governance policy replaces a CMHPSM Operational Policy last approved on 9/13/2017, that operation policy was rescinded 12/22/2020.
4/14/2021	Annual Board review
4/12/2023	Combined policy/purpose, updated application table

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 DD Service Providers
☐ SUD Treatment Providers ☐ SUD Prevention Providers
☐ Other as listed:

IV. DEFINITIONS

Compensation. Compensation includes direct and indirect renumeration as well as gifts or favors that are not insubstantial.

Conflict of interest. A conflict of interest refers to a situation where a Covered Person has a real or seeming incompatibility between one's financial or personal private interests and the interest of the CMHPSM. This type of situation arises when a Covered person; the Covered Person's Family member; or the organization that the Covered Person serves as an officer, director, trustee, or employee, has a financial or personal interest in the entity in which the Covered Person participates or proposes to participate in a transaction, arrangement, proceeding or other matter.

Covered Person. A "Covered Person" refers to all persons covered by this policy and includes:

- Members of the CMHPSM's Board (Directors)
- Members of the CMHPSM's Oversight Policy Board
- Officers of CMHPSM
- Individuals to whom the board has delegated authority
- Employees, agents, or contractors of CMHPSM who have responsibilities or influence over CMHPSM similar to that of officers, directors, or trustees; or who have or share the authority to control $100 or more of CMHPSM's expenditures, operating budget, or compensation for employees.

Family Member means a spouse, parent, children (natural or adopted), sibling (whole or half-blood), father-in-law, mother-in-law, grandchildren, great-grandchildren, and spouses of siblings, children, grandchildren, great grandchildren, and all step family members, wherever they reside, and any person(s) sharing the same living quarters in an intimate, personal relationship that could affect business decisions of the Covered Person in a manner that conflicts with this Policy.

Financial Interest. A person has a financial interest if the person has, directly or indirectly, through business, investment, or family:

A. An ownership or investment interest in, or serves in a governance or management capacity for, any entity with which CMHPSM has a transaction or arrangement;

B. A compensation arrangement with CMHPSM or with any entity or individual with which CMHPSM is negotiating a transaction or arrangement; or

C. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which CMHPSM is negotiating a transaction or arrangement.
D. A financial interest is not necessarily a conflict of interest. Under Section VI of this Policy, a person who has a financial interest may have a conflict of interest only if the appropriate governing board or committee decides that a conflict of interest exists.

Interested Person. Any Covered Person, who has a direct or indirect Financial Interest, as defined below, is an interested person.

Public Officer. Public officer means a person who is elected or appointed to a position in the CMHPSM, a CMHSP, or some other public entity.

V. DUTIES OF COVERED PERSONS

Duty of Care. Covered Persons shall act in a reasonable and informed manner and perform their duties for CMHPSM in good faith and with the degree of care that an ordinarily prudent person would exercise under similar circumstances.

Duty of Loyalty. Covered Persons owe a duty of loyalty to act in the best interest of CMHPSM and those who CMHPSM serves. No Covered Person may personally take advantage of a business opportunity that is offered to CMHPSM unless the Board determines not to pursue that opportunity, after full disclosure and a disinterested and informed evaluation.

Conflicts of Interest. All Covered Persons shall comply with this Policy when engaging in a transaction or arrangement that involves a Conflict of Interest. All Covered Persons shall:

- Disclose to the Board Chairperson, or any committee chairperson with Board delegated powers, the existence of a Financial Interest in connection with any actual or possible Conflict of Interest.
- Unless a Conflict of Interest Waiver has been granted by the Board, recuse themselves from voting, and being present for deliberations and voting, on any transaction or arrangement involving CMHPSM in which they have a Financial Interest. The Interested Person may respond to Board inquiries necessary for its deliberations and/or decisions.
- Comply with any restrictions or conditions stated in any Conflict of Interest Waiver or within the Board's bylaws.

Duty to Disclose. In connection with any actual or possible Conflict of Interest, Interested Persons must disclose the existence of the Financial Interest. They must be given the opportunity to disclose all material facts and answer questions from the Board—and from members of committees with governing board delegated powers—who are considering the proposed transaction or arrangement.

VI. PROCEDURES

Determining a Conflict of Interest. After disclosure of the Financial Interest and all material facts, and after discussion with the Interested Person, the disinterested members of the Board or committee discuss and vote to determine whether a Conflict of Interest exists. The Interested Person must not participate in the discussion, or vote on, whether a Conflict of Interest exists.

Appointment of Disinterested Person. If appropriate, the chairperson of the governing board or committee shall appoint a disinterested person or committee to investigate alternatives to the proposed transaction.

Alternatives. After exercising due diligence, the CMHPSM Board or committee shall determine whether the CMHPSM can obtain, with reasonable efforts, a more advantageous transaction or arrangement from a person or entity that would not give rise to a conflict of interest.

Board Vote. If a more advantageous transaction or arrangement is not reasonably possible, under circumstances that would not produce a conflict of interest, the CMHPSM Board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in the CMHPSM's best interest, for its own benefit, and whether it is fair and reasonable. An Interested Person may make a presentation at the CMHPSM board or committee meeting. The Interested Person, however, must not participate in the discussion, or the vote on, the transaction or arrangement involving the conflict of interest.

VII. VIOLATIONS OF THE CONFLICT OF INTEREST POLICY

Notice to Interested Person. If the CMHPSM Board or committee has reasonable cause to believe a Covered Person has failed to disclose actual or possible Conflicts of Interest, it shall inform that person of the basis for such belief and afford the member an opportunity to explain the alleged failure to disclose.

Taking Appropriate Action. If, after hearing the member's response and after making further investigation as warranted by the circumstances, the governing board or committee determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

VIII. WAIVERS

Procedure for Waiving a Conflict of Interest. If, after exercising reasonable efforts, the board determines that it is not able to obtain a more advantageous transaction or arrangement not involving the Interested Person, then the Board may grant a Conflict of Interest waiver. A Conflict of Interest waiver may be granted only if the Board determines that the Financial Interest is not so substantial as to be deemed likely to affect the integrity

of the Interested Person's services (*see* 18 USC §208(b)(1)). A Conflict of Interest waiver further requires a majority vote by the Board to waive the Conflict of Interest and proceed with the proposed transaction or arrangement. A Conflict of Interest Waiver shall be in writing and signed by the chairperson of the Board on CMHPSM's Conflict of Interest Waiver Form (Exhibit B). All Conflict of Interest Waivers shall be issued prior to the Interested Person's participation in any transaction or arrangement with CMHPSM.

Content of a Waiver of Conflict of Interest (*See* 5 CFR 2640.301). If the Board votes to waive the Conflict of Interest and proceed with the proposed transaction or arrangement, the Waiver may still restrict the Interested Person's participation in the matter to the extent deemed necessary by the Board. The Conflict of Interest Waiver may cover all matters the Interested Person may undertake as part of his/her official duties with CMHPSM, without specifically enumerating those duties. The information contained in the waiver, however, should provide a clear understanding of the nature and identity of the Financial Interest, the matters to which the waiver will apply, and the Interested Person's role in such matters.

Factors for Consideration when Granting a Waiver (*See* 5 CFR 2640.301). In determining whether a Financial Interest is substantial enough to be likely to affect the integrity of the Interest Person's services to CMHPSM, the Board may consider, as applicable:

- **i.** The type of Financial Interest (e.g. stocks, bonds, real estate, cash payment, job offer or enhancement of a family member's employment);
- **ii.** The identity of the person whose Financial Interest is involved, and if the interest does not belong directly to the Interested Person, the Interested Person's relationship to that person;
- iii. The dollar value of the Financial Interest, if known and quantifiable (e.g. amount of cash payment, salary of job to be gained or lost, change in value of securities);
- iv. The value of the financial instrument or holding from which the disqualifying Financial Interest arises and its value in relationship to the individual's assets;
- v. The nature and importance of the Interested Person's role in the matter including the level of discretion which the Interested Person may exercise in the matter;
- vi. The sensitivity of the matter
- vii. The need for the Interested Person's services (e.g. consider alternatives); and
- viii. Adjustments which may be made in the Interested Person's duties that would eliminate the likelihood that the integrity of the Interested Person's services would be questioned by a reasonable person.

Waivers Supported by Michigan Law (*See* 1968 PA 317, MCL 15.321 to 15.330; 1978 PA 566 MCL 15.183(8))

- A Community Mental Health Services Program (CMHSP) Board member or employee may be a party to a contract with a CMHSP if the contract is between the CMHSP and the CMHPSM.
- A CMHSP Public Officer or public employee may also be a Public Officer or employee of the CMHPSM, even if the CMHPSM has a contract with the CMHSP.
- The CMHPSM Board may approve a contract with a CMHSP, even if a CMHSP Board member is also an employee or independent contractor of the CMHPSM.

IX. RECORDS OF PROCEEDINGS

The minutes of the CMHPSM board and committees with board delegated powers shall contain:

Names of Covered Persons. The names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or possible conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the CMHPSM's Board or committee's decision as to whether a conflict of interest in fact existed.

Names of persons present. The names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Waiver of conflict of interest. If the Board grants a waiver of a Conflict of Interest, the waiver shall be in writing and shall be signed by the Chairperson of the Board. The writing shall describe the financial Interest, the transaction or arrangement to which the Financial Interest applies, the Interested Person's role in the transaction or arrangement, and any restriction on the Interested Person's participation in the proceeding, transaction or matter.

X. COMPENSATION COMMITTEES

Precluded from voting. A voting member of the CMHPSM Board or of any committee whose authority includes compensation matters, and who receives compensation, directly or indirectly, from the CMHPSM for services is precluded from voting on matters pertaining to that member's compensation.

Providing information. No voting member of the CMHPSM Board or any committee whose authority includes compensation matters and who receives compensation, directly or indirectly, from the CMHPSM, either individually or collectively, is prohibited from providing information to the Board or any committee regarding compensation.

XI. ANNUAL FINANCIAL INTEREST DISCLOSURE STATEMENT

Annually, on a date to be determined by the Board, each Covered Person shall sign and date a statement which affirms that the signor:

- Has received a copy of this Conflict of Interest Policy;
- Has read and understands the Policy;
- Has agreed to comply with the Policy;
- Has disclosed on the CMHPSM Financial Interest Disclosure Statement (Exhibit A) all Financial Interests which the signor may currently have; and
- Will complete a new, updated, Financial Interest Disclosure Statement if the information changes and/or a new Financial Interest arises.

XII. REFERENCES/LEGAL AUTHORITIES

Federal:

- INTERNAL REVENUE SERVICE, *Instructions for Form 1023 (01/2020), Appendix A: Sample Conflict of Interest Policy*, last accessed October 2020 at https://www.irs.gov/instructions/i1023.
- SSA Section 1902(a)(4)(C) and (D)
- 41 USC Chapter 21 (formerly 41 USC 423 –ch. 27 of the Office of Federal Procurement Policy Act—restrictions on obtaining and disclosing certain information)
- 18 USC §208 (Federal Conflict of interest statute)
- 5 CFR §2540.201 (Waivers issued pursuant to 18 USC 208)
- 5 CFR Part 2640 (Interpretation, Exemptions and Waiver Guidance concerning 18 USC 208)
- 42 USC 1396a (Federal Medicaid statute- State plans for medical assistance)
- 42 CFR §438.58 (Conflict of Interest Safeguards)
- 45 CFR Part 74 (Administrative requirements for awards to non profit organizations and local governments)
- 45 CFR Part 92 (Federal procurement regulations)
- 42 CFR 455 Subpart B - Board disclosure of interest statement
- 42 CFR 1001.1001(a)(1) (Reporting to state)

Michigan:

- 1978 PA 566; MCL 15.181 to 15.185 (Incompatible public offices)
- Mental Health Code Act 258 of 1974, MCL 330.1222 (Board composition)
- 1968 PA 318, MCL 15.301 to 15.310 (Conflict of Interest in contracts between state officers and political subdivisions)
- 1968 PA 317, MCL 15.321 to 15.330 (contracts of public servants with public entities)
- 1973 Act 196 MCL 15.341 to 15.348 (code of ethics for public officers and employees)
- Michigan Medicaid State Plan
- 1972 PA 284, MCL 450.1541a (duties of care and loyalty)

EXHIBIT A

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN (CMHPSM)

FINANCIAL INTEREST DISCLOSURE STATEMENT

Definitions

Compensation. Compensation includes direct and indirect renumeration as well as gifts or favors that are not insubstantial.

Covered Person. A "Covered Person" refers to all persons covered by this policy and includes:

- Members of the CMHPSM's Board (Directors)
- Members of the CMHPSM's Oversight Policy Board
- Officers of CMHPSM
- Individuals to whom the board delegated authority
- Employees, agents, or contractors of CMHPSM who have responsibilities or influence over CMHPSM similar to that of officers, directors, or trustees; or who have or share the authority to control $100 or more of CMHPSM's expenditures, operating budget, or compensation for employees.

Conflict of interest. A conflict of interest refers to a situation where a Covered Person has a real or seeming incompatibility between one's financial or personal private interests and the interest of the CMHPSM. This type of situation arises when a Covered person; the Covered Person's Family member; or the organization that the Covered Person serves as an officer, director, trustee, or employee, has a financial or personal interest in the entity in which the Covered Person participates or proposes to participate in a transaction, arrangement, proceeding or other matter.

Family Member means a spouse, parent, children (natural or adopted), sibling (whole or half-blood), father-in-law, mother-in-law, grandchildren, great-grandchildren, and spouses of siblings, children, grandchildren, great grandchildren, and all step family members, wherever they reside, and any person(s) sharing the same living quarters in an intimate, personal relationship that could affect business decisions of the Covered Person in a manner that conflicts with this Policy.

Financial Interest. A person has a financial interest if the person has, directly or indirectly, through business, investment, or family:

A. An ownership or investment interest in, or serves in a governance or management capacity for, any entity with which CMHPSM has a transaction or arrangement;

B. A compensation arrangement with CMHPSM or with any entity or individual with which CMHPSM is negotiating a transaction or arrangement; or

C. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which CMHPSM is negotiating a transaction or arrangement;

D. A financial interest is not necessarily a conflict of interest. Under Article III, section 2, a person who has a financial interest may have a conflict of interest only if the appropriate governing board or committee decides that a conflict of interest exists.

Affirmation of Conflict of Interest Policy

By my signature below, I agree that I:

Have received a copy of the CMHPSM's Conflict of Interest Policy;

Have read and understand the CMHPSM's Conflict of Interest Policy;

Understand that I am a Covered Person under the Conflict of Interest Policy;

Agree to comply with the CMHPSM's Conflict of Interest Policy;

Have disclosed below all Financial Interests which I may have; and

Will update the information I have provided on this Statement in the event that the information changes and/or a new Financial Interest arises.

Disclosure of Financial Interests

By my signature below, I certify that I or one of my Family Members has the Financial Interest(s) described below. (Please attach additional pages, if necessary.) I understand that the CMHPSM's Board may request further information about the Financial Interests described below, and that I agree to cooperate with providing such information. If I have not disclosed any information below, it is because I am not aware that I or any of my Family Members has a Financial Interest.

Disclosure #1
Name and Contact Information for Individual with Financial Interest:

_____
_____

Individual's Relationship to You: [_____] Self
[_____] Other, specify:

_____

Description of Financial Interest:

Disclosure #2

Name and Contact Information for Individual with Financial Interest:

_____
_____

Individual's Relationship to You: [_____] Self
[_____] Other, specify:

_____

Description of Financial Interest:

_____
_____

Disclosure #3
Name and Contact Information for Individual with Financial Interest:

_____
_____

Individual's Relationship to You: [_____] Self
[_____] Other, specify:

_____

Description of Financial Interest:

_____
_____

I certify that the above information is accurate and complete to the best of my knowledge, information and belief.

_____
_____
Signature Date

_____
Typed or Printed Name

_____
Title/Position with Entity

Please return this form, signed and dated, to the Entity's Chief Executive Officer.

EXHIBIT B

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
CONFLICT OF INTEREST WAIVER

Review of the Disclosed Financial Interest

In accordance with the requirements of the Community Mental Health Partnership of Southeast Michigan's (the "Entity") Conflict of Interest Policy, the Entity Board has undertaken appropriate due diligence review and deliberation regarding the Financial Interest disclosed by [Interested Person] on the Financial Interest Disclosure Statement (the "Statement") attached as Exhibit A.

Board Resolution Granting Conflict of Interest Waiver

At the conclusion of such due diligence review and deliberation, at its meeting on [Date], the Board passed the resolution attached as Exhibit B in which it determined that it is not, with reasonable efforts, able to obtain a more advantageous arrangement from a person other than [Interested Person] and the Financial Interest disclosed on the Statement is not so substantial as to be likely to affect the integrity of services which the Entity may expect from [Interested Person] and granted this Conflict of Interest Waiver under the terms described below.

Conflict of Interest Waiver Terms and Conditions

Name of Interested Person:

Description of Financial Interest:

Description of the Transaction, Arrangement, Proceeding or Matter to which the Financial Interest Applies:

Interested Person's Role in the Transaction, Arrangement, Proceeding or Matter

Scope of Waiver and Restrictions, if any:
This Conflict of Interest Waiver shall cover all matters [Interested Person] may undertake as part of his/her official duties with the Entity concerning any matters arising between the Entity and the [the organization in which the Interested Person has an interest].

_____ Date: _____
Chairperson of the Board

_____
(Print Name)

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* *Ethics and Conduct*
Committee/Department: **Clinical Performance Team**	**Local Policy Number (if used)**
Implementation Date **08/19/2024**	**Regional Approval Date** **06/26/2024**

Reviewed by:	**Recommendation Date:**
ROC	05/06/2024
CMH Board:	**Approval Date:**
Lenawee	05/30/2024
Livingston	05/28/2024
Monroe	06/26/2024
Washtenaw	06/21/2024

I. PURPOSE

The policy establishes guidelines which ensure that all persons will perform ethically and professionally.

II. REVISION HISTORY

DATE	MODIFICATION
08/27/2007	Original document
03/29/2011	Re-formatted; Peer Support Specialists clarified; the authority and role of the Affiliation Ethics Committee; role of supervisor detailed; the Role of the Employee Exit Interviewer was added; Gift Giving/Receiving was expanded; Professional Boundaries section clarified
2014	Revised to reflect the new regional entity effective January 1, 2014.
05/16/2017	Scheduled Review
07/27/2020	Preferential treatment for board members, etc. prohibited
06/26/2024	Scheduled 3-year review

III. APPLICATION

This policy applies to

☒ 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. 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, 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.

V. POLICY

This policy establishes that all work shall be performed in an ethical and professional manner as determined by statute, code, accrediting organization standards, professional organizations' code of conduct standards, and the content of the policy itself. This includes engaging in courteous, respectful relationships with co-workers, other health care providers, educational institutions, payers, people served and their family members. Principles of consumer/individual served autonomy, compassion, safety, privacy, informed consent, competence and other related principles shall be demonstrated. Any and all ethical and relationship questions, issues or dilemmas arising from work relationships should be discussed proactively with a supervisor, and/or administrator

VI. STANDARDS

A. All consumers/individuals served, family members, community members, other treatment providers and internal colleagues shall be treated with the utmost respect, courtesy, compassion and dignity.

B. In making decisions, primary consideration shall be given to what is in the best interest of the consumer/individual served or what the consumer/individual served desires**.**

C. It is the responsibility of immediate supervisors to ensure the behavior of their employees is not in violation of the provisions of this policy.

D. All licensed and registered professional employees of any affiliation organization shall abide by their profession's Code of Ethics.

E. When in doubt about the ethical dimensions of a particular situation, a proactive approach shall be taken by discussing the situation with a supervisor or appropriate administrator.

F. Any staff member whose cultural, religious, or moral values conflict with aspects of a particular job responsibility or task may ask their supervisor to be excused from that responsibility or task. The supervisor shall seek other options for addressing that particular job responsibility by other staff and grant the request only if there is no negative impact on consumer/individual served care as a result of doing so.

G. Clinical decisions shall be based on the assessed needs and desires of the consumer/individual served, regardless of how leaders, managers and clinical staff are compensated.

H. Preferential treatment in the application and/or receipt of services for CMH Board members, CMH employees or consultants, or their family members or associates, is prohibited.

I. Service referrals given to current or past consumers/individuals served or service applicants shall not be influenced by any consideration of possible financial or personal gain for the referring person or their family members or the appearance thereof.

J. All new employees shall be informed during orientation of their obligation to follow this policy and shall provide written verification of having been thus informed. Any time there is a significant change made to this policy, all staff shall be informed, and new signatures shall be obtained and placed in the personnel file.

K. All staff, students and volunteers shall utilize their administrative chain of command and formal grievance procedure should they feel they are being asked to engage in an unethical activity.

L. Workers are encouraged to report observations of unethical conduct. There shall be no retaliation or repercussions for such good faith reporting

M. Violations of any of the provisions of this policy may be cause for disciplinary action up to and including immediate termination of employment.

VII. EXHIBITS

A. Ethical Guidelines for Consideration
B. Gift-Giving & Receiving Guidelines for Consideration
C. Ethical Practices Agreement
D. Request Not to Participate In Treatment

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
42 CFR Parts 400 et al. (Balanced Budget Act)		
45 CFR Parts 160 & 164 (HIPAA)		
42 CFR Part 2 (Substance Abuse)		
Michigan Mental Health Code Act 258 of 1974		
The Joint Commission - Behavioral Health Standards	X	
Michigan Department of Health and Human Services (MDHHS) Medicaid Contract		
MDHHS Substance Abuse Contract		
Michigan Medicaid Provider Manual		
PIHP Policy Review Schedule	X	
Policy Tracking Form		

EXHIBIT A

ETHICAL GUIDELINES FOR CONSIDERATION

1. Respect and Dignity

The ethical worker treats everyone, whether colleagues or consumers/individuals served, with courtesy, respect and dignity, always being open to their unique characteristics, their unique histories and to the person as a whole. This is evident in their speech, appearance, manner, attitude and behavior.

2. Worker as Guide, Support and Provider of Assistance

The ethical worker guides, empowers and advocates for the people they serve, maintaining a focus on their desired outcomes and on helping them find their own way.

The focus of the relationship is on the needs of the person being assisted, not those of the worker. However, the ethical worker does not allow the needs or desires of the person to lead to a loosening of professional relationship boundaries which are always respected and maintained.

People are supported in deciding for themselves if, when, where, and how to use professional and non-professional supports and services.

3. Gift Giving and Receiving

The ethical worker is aware of the multiple perceived meanings and underlying intents that receiving or giving a gift may have for a consumer/individual served and a worker, meanings and intents that may interfere with the maintenance of an ultimately effective working relationship. Thus, consultation with a supervisor is pursued before money or gifts are accepted from or given to a consumer/individual served – See Exhibit B, Gift-Giving and Receiving Guidelines for Consideration

4. Worker as Role Model

The ethical worker recognizes that their values, beliefs, actions, and problem-solving methods impact others, both consumers/individuals served and staff members and acts accordingly.

5. Autonomy and Shared Power

In providing services, the ethical worker promotes consumer/individual served autonomy and shared power, never exerting strong influence on a person unless there is a clear and immediate threat to the person's or others' safety or health.

Consumers/individuals served are given the freedom to make their own decisions. The ethical worker offers suggestions rather than directives, identifies

and explores options and choices and discusses possible consequences of the consumer/individuals' decisions.

6. Compassion

The ethical worker demonstrates compassion in dealing with others, appreciating their struggles, their pain, our common humanity, and protecting them from imminent risk of harm.

The ethical worker advocates for and with the person.

7. Fairness and Justice

The ethical worker provides fair and just access to services, as well as fair and just ongoing care, never discriminating on the basis of race, color, gender, sexual orientation, religion, national origin, marital status, disability or other personal characteristics.

The rights of consumers/individuals served are acknowledged and protected.

8. Honesty

The ethical worker is honest with consumers/individuals served and co-workers as well as with themselves.

To maximize consumer/individuals' ability to make service decisions based on full and accurate information, the ethical worker communicates frankly about their role, relevant capacities, intent, limitations and role boundaries.

The ethical worker does not lie, cheat, steal, or condone or associate with others who are involved in such activities. They do not use their position or relationship with consumers/individuals served for personal advantage or give the appearance of the same.

9. Communication

The ethical worker communicates with consumers/individuals served openly, clearly, and frequently, doing what is promised, meeting expectations and fulfilling commitments, including those related to appointments and telephone calls.

Ambiguity, confusion and difficulty with consumer/individual served situations are to be expected and do not deter the worker from persisting in seeking guidance or consultation.

10. Confidentiality

The ethical worker upholds standards of consumer/individual served confidentiality and privacy while being candid about information that cannot be kept confidential and about with whom it can be shared.

The ethical worker also respects the privacy and dignity of co-workers.

11. Competence

The ethical worker performs job duties to the best of their ability, being open with supervisors when lacking the skills needed for a particular task and making efforts to enhance skills and competencies through timely professional development activities.

12. Personal Awareness and Self-Care

To fully appreciate each consumer/individual's perspective and, thus, be able to address their unique needs and desires, the ethical worker strives to identify their own personal issues, preconceptions, biases and areas of vulnerability and is open to making personal changes.

To reduce stress, time and space is carved out for a variety of self-care activities.

13. Professional Boundaries

The ethical worker always behaves professionally with all consumers/individuals served who receive services from the CMHPSM, avoiding interactions that are or might be perceived as flirtatious, provocative, threatening, harassing or hurtful.

The ethical worker never engages in a dating relationship with a person whom the worker directly or indirectly currently supervises or has done so in the past. ("indirectly supervises" is defined as having supervisory authority over the person's supervisor as evidenced by the organizational chart), including students and interns.

The ethical worker does not enter into a dating relationship with a consumer/individual served of the CMHSP who is served by another worker

The ethical worker does not provide services directly to individuals with whom they currently have or have had a prior friendship or dating relationship. Previous infrequent social contact or acquaintanceship would not preclude the provision of services by the worker.

The ethical worker notifies their supervisor regarding any past or current personal relationship with a CMHSP consumer/individual served. The worker whose helping relationship is becoming personal or intimate notifies a supervisor, discontinues the relationship and maintains professional boundaries. Direct treatment or support services are not provided to a person if there is intent to develop a personal or intimate relationship with them.

The ethical worker is aware of a consumer/individual's perceived power imbalance with the worker and the effect it may have on the consumer/individual's freedom to make their own decisions

The ethical worker respects consumer/individuals' religious and spiritual views and preferences and never pressures them to accept the religious or spiritual views of the worker. When initiated by the consumer/individual served and agreed upon as being related to an issue in the Individual Plan of Service, the worker may ethically explore spiritual issues with a consumer/individual served.

Depending on the worker's comfort and based on a determination that it is in the best interest of the consumer/individual served, the ethical worker may choose to disclose their own religious or spiritual views when an inquiry is made by the consumer/individual served.

Any worker-consumer/individual served service activity of a spiritual or religious nature, e.g., praying with a consumer/individual served, calls for prior approval by the worker's supervisor as well as the consumer/individual served themselves.

14. Alcohol and Drugs

The ethical worker never works under the influence of alcohol or drugs (legal or illegal).

The worker never purchases illegal substances from consumers/individuals served, never uses them with a consumer/individual served and never sells or gives them to a consumer/individual served.

Prescription medication is not to be shared with or borrowed from another person.

15. Alternative Interventions

Before engaging in support or treatment activities that might depart from traditional or conventional practices, the ethical worker discusses them with their supervisor to ensure their consistency with current professional standards.

16. Consumer/individuals' Right to Know

The ethical worker ensures that consumers/individuals served know and understand the rights, risks, opportunities and obligations associated with being a recipient of services.

Service activities and interventions are explained in understandable terms as are the limits of their impact and the implications and potential consequences of choices made by consumers/individuals served during the course of service provision.

Consumers/individuals served are informed of the cost of services and any available financial resources that may help them meet this obligation.

17. Organizational Relationships

The ethical worker, while taking into account funding/financial constraints, bases service provision decisions on standard clinical practice and organization criteria, regardless of how the agency compensates or shares financial risk with leaders, managers, clinicians, or licensed individual practitioners.

The ethical worker does not market or sell outside products or services to consumers/individuals served or engage in any non-job related activity with them that might result in or give the appearance of financial gain for the worker.

18. Equipment Use

The ethical worker only uses CMHPSM office equipment for CMHPSM business unless otherwise approved by their supervisor. Home use of equipment is authorized in advance by the appropriate supervisor or designee.

19. Service Provision and Documentation

The ethical worker ensures that all service~~s~~ types, amount, scope and duration are medically necessary and that their justification is clearly and thoroughly documented.

The ethical worker ensures that all services provided are in accordance with the Individual Plan of Service and with what has been authorized.

Documentation of a provided service is accurate, thorough and clear.

Assistance is obtained when there is uncertainty regarding the documentation requirements of service or financial information.

The ethical worker reports any suspected financial abuse or fraud to the Compliance Officer or designee and follows any other reporting requirements mandated by state or federal law.

20. Political Activity

The ethical worker ensures that any of their partisan political activities are conducted separately from their job responsibilities.

These activities never occur during those hours when the worker is being compensated for the performance of their work duties.

CMHPSM office supplies and equipment are not used for partisan political purposes.

The ethical worker never uses the authority or influence inherent in their CMHPSM position to interfere with or influence the results of an election or nomination for office.

The worker never requires contributions for political or partisan purposes as a duty or condition of employment, promotion or tenure and never coerces or

compels another CMHSPM employee to make contributions for political or partisan ends for any reason.

21. Self-Disclosure

The ethical worker only discloses personal information when it is consistent with the outcomes and interventions contained in the consumer/individual's Individual Plan of Service (IPOS).

These disclosures are intended to provide hope. They are intended to provide personal information as a means to facilitate consumer/individual served outcome achievement. Thus, the ethical worker does not self-disclose without considering the consumer/individual's service needs and current capacity to apply the information to their own life.

EXHIBIT B

GIFT GIVING & RECEIVING GUIDELINES FOR CONSIDERATION

Part One

1. The decision to accept or refuse a gift from a consumer/individual served should be given serious consideration as should the decision to give or not give a gift to a consumer/individual served. For the purposes of these Guidelines, "gift" is defined as a concrete object.

2. Like the majority of ethical decisions we face, we need to be fully aware of their possible positive and negative effects, both short and long term ones. This often takes a little time and involves the assistance of a supervisor and / or other staff with expertise in behavioral health ethics.

3. These effects might include a change in the consumer/individual's understanding of the nature of their relationship with the worker. For example, it might blur the difference between the worker as a professional and the worker as a friend, thereby interfering with the consumer/individual's progress toward outcome achievement.

4. Thus, accepting a gift from or giving a gift to a consumer/individual served may initially appear natural, innocent and without important consequences. Further analysis is often needed to confirm or bring into question this initial impression. A full understanding may involve consideration of the following:

   a. **What is the consumer/individual's intent in giving the gift?**

      - To express thanks for being helpful?
      - To express hope that the worker will be gentler in the future?
      - To express an apology for missing a contact or not achieving goals more quickly?
      - To express a wish to be personal friends?
      - To comply with the request of a parent or guardian?
      - To demonstrate good judgment in selecting the given item?
      - To express an interest in ending the work together via this thank-you gift?
      - To divert the worker's attention from the consumer/individual's anger or disappointment or misbehavior?
      - To express appreciation for sticking with the consumer/individual served through a crisis?
      - No intent, it's just what I do?
      - To express a wish for a gift in return?

   b. **Based on the intent, what might it mean to the consumer/individual served if the gift is graciously accepted without further discussion**?

      - I can expect better treatment?
      - The worker was so pleased; I will give more gifts in the future so as not to disappoint?
      - I am less uncertain about being seen as special by my worker?
      - I've found a nice way to make friends?
      - This is a good and easy way to show my private thoughts and feelings?

c. **What might it mean to the consumer/individual served if the gift is refused by the worker or there is some hesitation about accepting it?**

- My worker just makes things more complicated than they are?
- I can't do anything right? My worker doesn't understand my feelings?
- I have bad taste in gifts?
- My worker doesn't understand my cultural traditions and I am hurt and offended?
- This is interesting – I wonder why my worker won't accept it?
- My feelings are hurt – I'm sure other gifts are accepted?

d. What behavior or personal quality does accepting a consumer/individual served gift reinforce?

- Dependency?
- Subordination?
- Pleasing people in authority?
- Generosity?
- Sociability?
- Comfort with social norms?
- Need for social bonding?

e. **What impact might accepting a gift or giving a gift to a consumer/individual served have on the worker?**

- What personal needs does it satisfy?
- To what extent is the worker's self-esteem related to receiving the gift?
- Are those needs reducing the worker's focus on the consumer/individual's needs?
- How might the worker's objectivity be affected?
- Feelings of being appreciated, accepted?
- Increased sense of competence?

d. **What might it communicate to the consumer/individual served if the worker starts a discussion about gift giving in general or about the consumer/individual's thoughts and feelings behind the particular gift?**

- This is different; I wonder how it will help me to talk about my decisions and actions?
- I guess there are special rules at CMH?
- The worker thinks it's important to stick to how I'm doing with my outcomes?
- Pausing to talk before making a decision is something my worker values?
- Why is my worker making a mountain out of a molehill?

5. In summary, our natural inclination to graciously accept a gift might reduce consumer/individuals' hurt feelings in the short term but might not be the best response. More important may be the need to focus on providing a steady, predictable unambiguous professional relationship as well as on the consumer/individual's longer-term service goals. A lack of clarity about the relationship being more personal or professional can instill additional stress and distract the consumers/individuals served from the main purpose of the service provision.

It can be advisable to delay a decision until thoughtful consideration is given, often involving some timely and sensitive discussion with the consumer/individual served and / or a supervisor.

Guidelines for Consideration – Part Two

1. When feasible, discuss issues related to gift-giving in the early part of the consumer/individual served-worker relationship.

    - Opportunities can arise when expectations / logistics / parameters are being addressed, when the roles / tasks of those involved in implementing the IPOS are being discussed.
    - Talking about "working together" can provide an opportunity for elaborating on the meaning of the "working" part of the term, on what constitutes a working relationship.
    - Although some overlap exists, the uniqueness of the mental health working relationship, as distinct from those with friends, family members, religious officials, probation officers, judges, teachers and others can be spelled out.
    - For consumers/individuals served who have behavioral challenges or otherwise have difficulties with verbal emotional expression, the issue of gifts might be worked into an early conversation, as appropriate, when discussing more useful ways of expressing thoughts and feelings both in the community or with the mental health worker.
    - The consumer/individual's cultural background and resulting perspective on gift-giving can be discussed as a bridge to understanding later gift-related behavior and reactions.

2. Many consumers/individuals served can benefit from hearing the message from their workers that what is of greatest importance is "our work together," in outcome achievement and the satisfaction it can bring to the consumer/individual served. Other "gifts" might pale in comparison.

3. Although the meaning(s) given to gift giving and receiving is always an important thing to take into consideration or discuss before accepting or giving a gift, examples of less potentially impactful gifts can include:

    - Holiday cards
    - Very inexpensive gifts
    - Drawings or other artwork from children
    - Poems or songs composed or found by the consumer/individual served treated as an expression of something to be discussed and understood
    - Inexpensive food or decorative items that will be shared or displayed for a whole team or staff group.
    - Items created by the consumer/individual served as a result and demonstration of successful IPOS outcome achievement.
    - Anonymous staff donations to organized holiday gift-giving arrangements, e.g., "The Giving Tree."
    - Gifts given to young children on special occasions, like birthdays.

EXHIBIT C

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
ETHICAL PRACTICES AGREEMENT

I, (print name) _____ have read and understand the Ethics and Conduct policy of CMHPSM and I agree to follow its requirements including but not limited to the following:

I will not discuss or reveal consumer/individual served information to non-agency staff unless required by law and will only discuss or reveal it to agency staff on a need-to-know basis.

I will treat all consumers/individuals served with dignity and respect.

I will avoid any conflict of interest activities.

I do not have a mental or physical impairment that would interfere with my ability to carry out the requirements of the aforementioned policy.

In situations where my cultural values, ethics or religious beliefs conflict with those of a consumer/individual served to the extent that it influences my ability to provide appropriate services, I understand that I have the right and obligation to discuss this with my supervisor (EXHIBIT D).

I agree to be bound by applicable state laws including any / all reporting requirements

I agree to meet relevant accreditation standards.

Further, I agree to review the Recipient Rights policies, to be accountable for conducting myself in accordance with them, and to report any care concerns to my supervisor or to the Recipient Rights Officer.

_____ _____
Employee Signature Date

Employee to turn in signed form to Supervisor

_____ _____
Supervisor Signature Date

EXHIBIT D

Ethical Practices Agreement
Request Not to Participate in Treatment

Complete the following form and submit to your supervisor if there is an aspect of care that conflicts with your cultural values, ethics or religious beliefs:

Employee Name:

Date:

Consumer/Individual Served Name:

Aspect of Care requesting not to participate in:

Reason why (include the cultural values, ethic or religious beliefs that treatment conflicts with):

Resolution (to be completed by supervisor or Program Administrator) (include your conclusion as to whether the request, if granted, will or will not negatively affect treatment)

_____ _____
Supervisor's Signature Date

AGENDA
WASHTENAW COUNTY
BOARD OF COMMISSIONERS
February 19, 2025

7:00 PM
Board Room
Washtenaw County Administration Building
220 N. Main Street
Ann Arbor, Michigan

Remote Participation via Zoom: https://washtenaw.me/BOCZoom
Remote Participate via Phone: dial 1 (312) 626-6799
Webinar ID: 818 7669 6577, Passcode: 591694
www.washtenaw.org

I. PLEDGE OF ALLEGIANCE

II. ROLL CALL

III. PUBLIC PARTICIPATION

1. Public Comment through February 19, 2025

IV. COMMISSIONER FOLLOW-UP TO PUBLIC PARTICIPATION

V. LIAISON REPORTS

VI. REPORT FROM THE COUNTY ADMINISTRATOR

VII. REPORT FROM THE CHAIR OF THE BOARD OF COMMISSIONERS

VIII. SPECIAL ORDER OF BUSINESS

1. A Public Hearing on an amendment to the Washtenaw County Historic District Ordinance and amendments to various Historic District Ordinances

IX. APPOINTMENTS

25-025 Comm. LaBarre, seconded by Comm. Hodge moved to approve a resolution appointing members to the Washtenaw County Community Mental Health Board. Motion passed via roll call vote. **Approved. Resolution #25-025**

X. CONSENT AGENDA - **Approved**

1. Approval of Minutes of Previous Meeting February 5, 2025
2. Communications
3. Report of Standing Committees
4. Report of Special Committees
5. Other Reports

A. A report on contracts in the amount of $25,000 and under from January 30, 2025, through February 11, 2025

B. A report from the Washtenaw County Road Commission on the summary of service requests for the month of January, 2025

6. Report of the Treasurer

XI. RESOLUTIONS

1. First Reading

A. Comm. LaBarre, seconded by Comm. Hodge, moved to approve a resolution to approve the above midpoint hire of Dr. Thomas Atkins as a Psychiatrist from Community Mental Health. **Approved. Moved to 3/5 meeting for Final Reading.**

B. Comm. LaBarre, seconded by Comm. Hodge, moved to approve a resolution to pledge full faith and credit for the Portage Base Line Lake, Lake Level District from Water Resources. **Approved. Moved to 3/5 meeting for Final Reading.**

C. Comm. LaBarre, seconded by Comm. Hodge, moved to approve a resolution to approve assessments for Portage Base Line Lake, Lake Level District from Water Resources. **Approved. Moved to 3/5 meeting for Final Reading.**

D. Comm. LaBarre, seconded by Comm. Hodge, moved to approve a resolution to authorize the creation of 1.0FTE for the Board of Commissioners Constituent Outreach Coordinator position from Administration. **Approved. Moved to 3/5 meeting for Final Reading.**

2. Final Reading

A. **25-026** Comm. Hodge, seconded by Comm. LaBarre, moved to approve a resolution for two group home purchases from Community Mental Health. **Approved. Resolution #25-026**

B. **25-027** Comm. Hodge, seconded by Comm. LaBarre, moved to approve a resolution authorizing a grant application to the Michigan Health Endowment Fund from the Health Department. **Approved. Resolution #25-027**

C. **25-028** Comm. Hodge, seconded by Comm. LaBarre, moved to approve a resolution authorizing the Health Department's midyear budget adjustment and revised Environmental Health Fees from the Health Department. **Approved. Resolution #25-028**

D. **25-029** Comm. Hodge, seconded by Comm. LaBarre, moved to approve a resolution adopting the amended Washtenaw County Historic Preservation Ordinance and local Historic District Ordinances from the Office of Community and Economic Development. **Approved. Resolution #25-029**

E. **25-030** Comm. Hodge, seconded by Comm. LaBarre, moved to approve a resolution ratifying the signature of the Chair of the Board of Commissioners on the grant application for the continuation of the Secondary Road Patrol Program, from the Sheriff's Office. **Approved. Resolution #25-030**

F. **25-031** Comm. Hodge, seconded by Comm. LaBarre, moved to approve a resolution ratifying the signature of the Chair of the Board of Commissioners on the application of the Strategic Enforcement and Traffic Accident Prevention Program, from the Sheriff's Office. **Approved. Resolution #25-031**

3. Single Reading

A. **25-032** Comm. LaBarre, seconded by Comm. Hodge, moved to approve a resolution ratifying the 2025 Marine Safety Grant through the State of Michigan Department of Natural Resources, from the Sheriff's Office. **Approved. Resolution #25-032**

B. **25-033** Comm. LaBarre, seconded by Comm. Hodge, moved to approve a resolution to approve a $3M Community Project Fund grant with HUD to support the City of Ypsilanti Water Street Redevelopment from Administration. **Approved. Resolution #25-033**

C. **25-034** Comm. LaBarre, seconded by Comm. Hodge, moved to approve a resolution celebrating Black History Month and declaring February 2025 as Black History Month in Washtenaw County. **Approved. Resolution #25-034**

4. Approval of Claims

A. **25-035** Comm. LaBarre, seconded by Comm. Hodge, moved to approve a resolution authorizing the payment of claims commencing with the last previously approved claim and continuing through the date of February 10, 2025. **Approved. Resolution #25-035**

XII. ITEMS FOR CURRENT/FUTURE DISCUSSION

1. Closed Session to discuss Negotiation Strategy

XIII. PENDING

XIV. ADJOURN TO NEXT SESSION

Next Board Meeting
March 5, 2025
Board Room, Administration Building *and* via Zoom
7:00 PM

WCCMH BOARD AND BOARD COMMITTEE MEMBERS FOR 4/1/24-3/31/25

WCCMH Board

Name	Term expiring
Felicia Brabec (Board Chair)	3/31/27
Holly Heaviland (Vice-Chair)	3/31/26
Marianne Udow-Phillips (Treasurer)	3/31/27
Anna Dusbiber (Secretary)	3/31/27
Barbara Higman	3/31/26
Bob King	3/31/28
Andy LaBarre	3/31/28
Steve Petty	3/31/27
Alfreda Rooks	3/31/28
Judy Gardner	3/31/28
Annie Somerville	3/31/26
Melissa Tolstyka	3/31/26

*** The WCCMH Board includes representation from primary and secondary WCCMH consumers, the community and the Washtenaw County Board of Commissioners.**

WCCMH Executive Committee Members

Felicia Brabec (Chair)
Anna Dusbiber
Holly Heaviland
Bob King
Andy LaBarre
Marianne Udow-Phillips

WCCMH Quality-Finance Committee Members

Marianne Udow-Phillips (Co-Chair)
Holly Heaviland (Co-Chair)
Anna Dusbiber
Barb Higman
Steve Petty
Vacant
Melissa Tolstyka

Community Mental Health Partnership of Southeast Michigan (CMHPSM) Board Representatives

Bob King
Alfreda Rooks
Annie Somerville

WCCMH Millage Advisory Committee Members

Name	Term Expiring
Annie Somerville (Chair)	3/31/26
Barb Higman	3/31/26
Amanda Carlisle	3/31/25
Anna Dusbiber	3/31/27
Holly Heaviland	3/31/26
Steve Petty	3/31/27
Marlene Radzik	3/31/25
Ray Rion	3/31/25
Alfreda Rooks	3/31/28
Marianne Udow-Phillips	3/31/27
George Waddles, Jr.	3/31/25

*** The WCCMH Millage Advisory Committee includes representation from the WCCMH Board, Washtenaw County Board of Commissioners, housing partners, education, law enforcement and the community.**

Please email wccmhboard@washtenaw.org for questions and/or concerns. Revised 4/21/25 rla

ATTACHMENT #10
APRIL 2025

2025 WCCMH Board and Board Committees/Officers
4/1/25-3/31/26

	term expires	Executive (meets bi-monthly)	Quality-Finance (meets bi-monthly)	CMHPSM (meets monthly)	Officers
Anna Dusbiber	3/31/2027	X	X		Board Secretary
Felicia Brabec	3/31/2027	X	X		Board Chair/Executive Committee Chair
Judy Gardner	3/31/2028				
Holly Heaviland	3/31/2026	X	X		Board Vice Chair
Barbara Higman	3/31/2026		X		
Bob King	3/31/2028	X		X	
Andy LaBarre	3/31/2028	X			
Steve Petty	3/31/2027		X		
Alfreda Rooks	3/31/2028			X	
Annie Somerville	3/31/2026			X	
Melissa Tolstyk	3/31/2026		X		
Marianne Udow-Phillips	3/31/2027	X	X		Board Treasurer

Total CMH Board members assigned to Committees		6	7	3
# members required for committee-per Bylaws		6 (4 officers, 2 additional board members and immediate past board chair) (Executive Director is an ex-officio member)	5 (Vice Chair &Treasurer and not less than 3 other Board members)	3 (per PIHP)
Quorum for committees		4/6	4/7	

Quorum for Board is 7/12

2025 WCCMH Board and Board Committees/Officers
4/1/25-3/31/26

Millage Advisory Committee (MAC) (meets monthly)		
Annie Somerville (Chair)	3/31/2026	WCCMH Board Representative /Board of C
Barb Higman	3/31/2026	WCCMH Board Representative
Amanda Carlisle	3/31/2025	Washtenaw Housing Alliane Representativ
Anna Dusbiber	3/31/2027	Primary Consumer
Holly Heaviland	3/31/2026	Washtenaw Intermediate School District
Steve Petty	3/31/2027	Community Member
Marlene Radzik	3/31/2025	Washtenaw County Sheriff's Office Repres
Alfreda Rooks	3/31/2028	WCCMH Board Representative
Ray Rion	3/31/2025	Packard Health Representative
Marianne Udow-Phillips	3/31/2027	WCCMH Board Representative
George Waddles, Jr.	3/31/2025	Community Member

Quorum for Millage Advisory Committee		6/11

Please email wccmhboard@washtenaw.org for questions and/or concerns