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 Learning Resource Center-Michigan Room**
4135 Washtenaw Ave, Ann Arbor, MI
OR
Virtually at https://zoom.us/j/99586453935
August 28, 2026
9:30 – 11:30AM

I. Roll Call (5 minutes)

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

III. Board Response to Audience Participation (5 minutes)

IV. Consent Agenda (Attachment #1) (5 minutes) **ACTION**
- A. WCCMH Millage Advisory Committee Meeting Minutes and Actions 6/8/26 (Attachment #1A)
- B. WCCMH Quality-Finance Committee Meeting Minutes and Actions 6/8/26 (Attachment #1B)
- C. WCCMH Board Meeting Minutes and Actions – 6/26/26 (Attachment #1C)
- D. WCCMH Advisory Council Meeting Minutes and Actions – 6/10/26 (Attachment #1D)
- E. WCCMH Advisory Council Meeting Minutes and Actions – 7/8/26 (Attachment # 1E)
- F. Performance Improvement FY24 Report (Attachment #1F)
- G. Program Committee Dashboard FY26, Quarter 2 (Attachment #1G)
- H. CMHPSM Policy – Reviewed and Recommended for Approval by Regional Operations Committee
  - Medication Administration Storage & Other Medical Treatment (Attachment 1H)
  - Credentialing for Licensed Independent Providers (Attachment #1I)
  - Organizational Credentialing/Recredentialing and Monitoring (Attachment #1J)
  - Employee Competency & Credentialing Policy (Attachment #1K)

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

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

VII. CMHPSM Regional Update (5 minutes)

VIII. New Business (30 minutes)
- WCCMH FY27 Annual Operating Budget (Attachment #4) **N. Phelps ACTION**
- WCCMH FY27 Annual Budget Book (Attachment #5) **N. Phelps ACTION**
- WCCMH FY27 Master Contract List (Attachment #6) **M. Taylor ACTION**

IX. Old Business (5 minutes)
- None

X. Items for Future Discussions (5 minutes)
- Homelessness Updates
- Plans for upcoming Medicaid cuts and how to keep members enrolled

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.

- In person trainings with people
- Social Media roll outs
- Consistent documentation between organizations (one document that everyone is handing out)

XI. Adjournment of Public Meeting (Next WCCMH Board Meeting: October 23, 2026)

****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/99586453935

Phone one-tap:
+13126266799, 99586453935# US (Chicago)
+16465189805, 99586453935# US (New York)

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

Webinar ID: 995 8645 3935

International numbers available:
https://zoom.us/u/agoS2axK0

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

AUGUST 28, 2026

CONSENT AGENDA

A. WCCMH Millage Advisory Committee Meeting Minutes and Actions 6/8/26 (Attachment #1A)
B. WCCMH Quality-Finance Committee Meeting Minutes and Actions 6/8/26 (Attachment #1B)
C. WCCMH Board Meeting Minutes and Actions – 6/26/26 (Attachment #1C)
D. WCCMH Advisory Council Meeting Minutes and Actions – 6/10/26 (Attachment #1D)
E. WCCMH Advisory Council Meeting Minutes and Actions – 7/8/26 (Attachment # 1E)
F. Performance Improvement FY24 Report (Attachment #1F)
G. Program Committee Dashboard FY26, Quarter 2 (Attachment #1G)
H. CMHPSM Policy – Reviewed and Recommended for Approval by Regional Operations Committee
    - Medication Administration Storage & Other Medical Treatment (Attachment 1H)
    - Credentialing for Licensed Independent Providers (Attachment #1I)
    - Organizational Credentialing/Recredentialing and Monitoring (Attachment #1J)
    - Employee Competency & Credentialing Policy (Attachment #1K)

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH MILLAGE ADVISORY COMMITTEE MEETING MINUTES
June 8, 2026
Learning Resource Center-Michigan Room (in person)
https://zoom.us/j/97618604302 (virtual)
3:30–5:00 pm

A. Sommerville called the meeting to order at 2:30 pm.

ROLL CALL:
H. Heaviland attending in person
B. Higman attending in person
M. Radzik attending in person
R. Rion attending in person
A. Rooks attending in person
A. Somerville attending in person
G. Waddles, Jr attending in person

MEMBERS ABSENT: A. Carlisle, A. Dusbiber, S. Petty, M. Udow-Phillips

STAFF PRESENT: L Gentz, M. Harding, N. Phelps, R. Dornbos, T. Florence, M. Tasker

OTHERS PRESENT: L. Lutomski, M. Creekmore

I. Introductions
- None

II. Audience Participation
- None

III. Committee Response to Audience Participation
- None.

IV. Millage Advisory Committee Minutes and Actions from 4/13/26 (Attachment #1)
- Millage Advisory Committee Minutes and Actions from 4/13/26, were reviewed.

MOTION BY G. WADDLES JR., SUPPORTED BY H. HEAVILAND TO RECOMMEND APPROVAL OF THE MINUTES AND ACTIONS FROM THE APRIL 13, 2026, MILLAGE ADVISORY COMMITTEE MEETING AS PRESENTED.

ROLL CALL VOTE:

DUSBIBER	**NOT PRESENT**	**CARLISLE**	**NOT PRESENT**
HEAVILAND	**Y**	**HIGMAN**	**Y**
PETTY	**NOT PRESENT**	**RADZIK**	**Y**
RION	**Y**	**ROOKS**	**Y**
SOMERVILLE	**Y**	**UDOW-PHILLIPS**	**NOT PRESENT**
WADDLES JR.	**Y**		

MOTION CARRIED

V. Discussion Items
- Millage Process, Investments and Progress Update

- L. Gentz provided the Millage Process, Investments and Progress Update to the Committee.

- Millage Dashboard (Attachment #2)
  - M. Tasker presented the Millage Dashboard to the Committee.

VI. Financial Budget Update

- Financial Budget Update (Attachment #3)
  - N. Phelps presented the Millage Budget Update through April 30, 2026, to the Committee.

VII. Old Business

- None

VIII. New Business –

- Ann Arbor Co-Response Update
  - M. Tasker provided an update on the Ann Arbor Co-Response program to the Committee.
- Crisis System
  - CRU Expansion
    - M. Tasker provided an update on the CRU expansion to the Committee.
  - 911 / Dispatch
    - M. Tasker provided an update on the 911 / Dispatch to the Committee.
  - Crisis System Education
    - M. Tasker provided updates on Crisis System Education to the Committee.
- LEADD Updates
  - L. Gentz provided updates on the LEADD program to the Committee.

IX. Items for Future Discussions

-

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

Meeting adjourned at 3:49 pm.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)

WCCMH QUALITY-FINANCE COMMITTEE MEETING MINUTES

June 8, 2026
Learning Resource Center-Michigan Room (in person)
https://zoom.us/j/981409141864 (virtual)
2:30-3:30 pm

ROLL CALL:	H. Heaviland attending in person B. Higman attending in person S. Petty attending virtually M. Tolstyka attending in person
MEMBERS ABSENT:	A. Dusbiber, M. Udow-Phillips
STAFF PRESENT:	M. Harding, S. Ray, N. Phelps, L. Gentz, R. Dornbos, M. Taylor, L. Higle, S. Amos O'Neal, T. Florence, B. Hagaman, K. Hoener
OTHERS PRESENT:	L. Lutomski, M. Creekmore

H. Heaviland called the meeting to order at 2:37 pm.

I. Introductions
- None

II. Audience Participation
- None

III. Committee Response to Audience Participation
- None

IV. Quality-Finance Committee Meeting Minutes and Actions from 2/9/26 (Attachment #1)
- Quality-Finance Committee Meeting Minutes and Actions of 2/9/26, were reviewed.

MOTION BY B. HIGMAN SUPPORTED BY S. PETTY TO RECOMMEND APPROVAL OF THE MINUTES AND ACTIONS FROM THE FEBRUARY 9, 2026, QUALITY-FINANCE COMMITTEE MEETING AS PRESENTED.

V. Financial Status Report
- N. Phelps presented the Financial Status Report for the period ending April 30, 2026 (Attachment #2)

MOTION BY B. HIGMAN SUPPORTED BY M. TOLSTYKA TO RECOMMEND APPROVAL OF THE WCCMH FINANCIAL STATUS REPORT FOR THE PERIOD ENDING APRIL 30, 2026, AS PRESENTED.

VI. Contracts and Leases
- M. Taylor presented the Contracts and Leases to the Committee. (Attachment #3)

MOTION BY B. HIGMAN BY SUPPORTED BY M. TOLSTYKA TO RECOMMEND APPROVAL OF THE CONTRACTS AND LEASES AS PRESENTED.

VII. Executive Director Authorizations

- None

VIII. Regional Finance Update
- N. Phelps provided a status update on the status of the rate setting to the Committee.
- Starting to discuss the FY 2027 budget development.

IX. Old Business
- CCBHC Fee-For-Service Update
  - N. Phelps updated the Committee on progress being made regarding the CCBHC Fee-For-Service Payment processes.
- CCBHC/Mental Health Framework Updates
  - L. Gentz provided updates on the CCBHC/Mental Health Framework.
  - M. Harding is retiring in August and L. Gentz is taking over as the CCBHC Administrator.
- PIHP Procurement Update
  - L. Gentz provided an update on the PIHP Procurement Update to the Committee.

X. New Business
- 1st Quarter Dashboard (Attachment #4) **L. Higle/T. Florence ACTION**
  - L. Higle presented the Program Dashboard FY26 Quarter 1 to the Committee.
  - There were no sentinel events in the 1st quarter of FY 2026.

MOTION BY M. TOLSTYKA SUPPORTED BY B. HIGMAN TO RECOMMEND APPROVAL OF THE PROGRAM COMMITTEE DASHBOARD FY26, QUARTER 1, AS PRESENTED.

- IBH Medicare Application
  - L. Gentz discussed the progress of the IBH Application with the Committee.
  - The application has been submitted and waiting for an update.

XI. Items for Future Discussions
- Accounts Receivable
- Fee for Service

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

XII. Meeting adjourned at 3:15 pm.

WASHTENAW COUNTY CO:MMUNITY 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/93060465985
June 26, 2026
9:30am

F. Brabec called the meeting to order at 9:40 am.

ROLL CALL:	F. Brabec attending in person J. Gardner attending in person H. Heaviland attending in person B. Higman attending in person A. LaBarre attending in person A. Somerville attending in person M. Tolstyka attending in person M. Udow-Phillips attending in person
MEMBERS ABSENT:	A. Dusbiber, B. King, S. Petty, A Rooks
STAFF PRESENT:	R. Avedisian, T. Cortes, N. Phelps, K. Snay, S. Amos O'Neal, L. Gentz, M. Hershberger, N. Testorelli, M. Tasker. E. Montgomery, B. Hagaman, R. Rosenberg; E. Waddell, T. Florence
OTHERS PRESENT:	L. Lutomski

I. Introductions
- None

II. Audience Participation
- None

III. Board response to audience participation
- None

IV. Consent Agenda (Attachment #1) (5 minutes) **ACTION**
A. WCCMH Millage Advisory Committee Meeting Minutes and Actions 4/13/26 (Attachment #1A)
B. WCCMH Quality-Finance Committee Meeting Minutes and Actions 2/9/26 (Attachment #1B)
C. WCCMH Board Meeting Minutes and Actions – 4/24/26 (Attachment #1C)
D. WCCMH Advisory Council Meeting Minutes and Actions – 4/8/26 (Attachment #1D)
E. WCCMH Advisory Council Meeting Minutes and Actions – 5/13/26 (Attachment #1E)
F. Millage Dashboard 2026, Quarter 1 (Attachment #1F)
G. Contracts and Leases recommended approval by WCCMH Quality-Finance Committee 6/8/26 (Attachment #1G)
H. Program Committee Dashboard FY26, Quarter 1 (Attachment #1H)
I. CMHPSM Policy – Reviewed and Recommended for Approval by Regional Operations Committee
- Crisis Prevention and Safety Planning 2026 (Attachment #1I)
- Confidentiality and Access to Consumer Records 2026 (Attachment #1J)
- Artificial-Augmented Intelligence Policy 2026 (Attachment #1K)
- Consumer Appeals Policy 2026 (Attachment #1L)
- Customer Services Policy 2026 (Attachment #1M)
- Emergency Post-Stabilization Services 2026 (Attachment #1N)
- Utilization Management and Review Policy 2026 (Attachment #1O)

MOTION BY A. LABARRE SUPPORTED BY M. UDOW-PHILLIPS TO ACCEPT AND APPROVE THE JUNE 26, 2026, WCCMH BOARD CONSENT AGENDA AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

A. Somerville arrived at 9:43

V. Treasurer's Report
- WCCMH Quality-Finance Status Report (Attachment #2) **ACTION**
  - N. Phelps presented the Quality-Finance Status Report for the period ending April 30, 2026.

MOTION BY A. LABARRE SUPPORTED BY M. UDOW-PHILLIPS TO ACCEPT AND APPROVE THE WCCMH QUALITY-FINANCE FINANCIAL STATUS REPORT ENDING APRIL 30, 2026, AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

- WCCMH Millage Financial Status Report (Attachment #3) **ACTION**
  - N. Phelps presented the Millage Financial Status Report for the period ending April 30, 2026.

MOTION BY M.UDOW-PHILLIPS SUPPORTED BY A. SOMERIVLLE TO ACCEPT AND APPROVE THE WCCMH MILLAGE FINANCIAL STATUS REPORT ENDING APRIL 30, 2026, AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

VI. Executive Director report
- T. Cortes presented the Executive Director report to the WCCMH Board
  - T. Cortes provided updates on upcoming leadership changes at the State level.
  - T. Cortes provided updates for local level discussions with law enforcement partnerships to the Board.
  - T. Cortes informed the Board that G. Dill and M. Harding were retiring from the County.

VII. CMHPSM Regional Update
- N. Phelps provided regional financial updates to the Board.

VIII. New Business

- Advisory Council **M. Hershberger**
  - M. Hershberger provided Advisory Council updates to the Board.
  - Speakers Bureau training is coming up in August.
  - Walk-A-Mile will be on September 23rd in Ann Arbor.
  - Celebration of Success will be on October 20th at the LRC.
- Fee-For-Service Discussion **N. Phelps**
  - N. Phelps led a discussion regarding Fee-For-Service with the Board.
- Fiscal Year 2025 Financial Audit (Attachment #4) **D. Merritt – Rehmann**
  - D. Merritt provided results for the Fiscal Year 2025 Financial Audit to the Board

MOTION BY M. UDOW-PHILLIPS SUPPORTED BY A. LABARRE TO ACCEPT AND APPROVE THE FISCAL YEAR 2025 FINANCIAL AUDIT AS PRESENTED.

ROLL CALL VOTE:

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

MOTION CARRIED

- Law Enforcement Partnerships **T. Cortes**
  - T. Cortes discussed law enforcement partnerships with the Board

IX. Old Business

- CCBHC Update – **L. Gentz**
  - L. Gentz provided a CCBHC Update to the Board.

X. Items for future discussion

- Homelessness Updates
- Plans for upcoming Medicaid cuts and how to keep members enrolled
  - In person trainings with people
  - Social Media roll outs
  - Consistent documentation between organizations (one document that everyone is handing out)

MOTION BY XXX SUPPORTED BY XXX TO ADJOURN THE PUBLIC MEETING OF THE WCCMH BOARD.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY
WC-CMH ADVISORY COUNCIL MINUTES
June 10, 2026

Members Potentially Present/on the Call: Darren Beland (chair), Lisa deRamos, Joy Duffy (co-chair), Leo Hanifin, Barb Higman, Alayna Manzanares, Lisa Porzondek, Pam Rathbun, Jason Zurawski (Secretary).
Staff: Mert Hershberger (Staff Liaison).
Absent: Anton Clark, Melissa Concannon.

Meeting called to order at: _ 12:36 _ pm_.
MOTION BY _ Lisa _ - SUPPORTED BY _ Pam _: APPROVE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) ADVISORY COUNCIL (AC) CONSENT AGENDA. MOTION CARRIED.

I. **Regional Update:**
   a. We are shifting the picnic to June 25, 2026. People were reminded of what they would bring. Mert is coordinating with the regional admin staff Stacy P. to ensure that certain supplies are brought (meat, water, paper goods)
   b. November 12, 2026 for the regional training at the LRC. The day before, November 11 is Veteran's Day, so we will not have the regular meeting. We may coordinate a brief meeting on Thursday after the regional meeting/training.

II. **Legislators:** Does someone want to contact legislators? Pam offered to continue contacting Jimmie Wilson and Elissa Slotkin. Barb mentioned Felicia Brabec running for State Senate. Lisa P. offered to help when her time frees up some.

III. **Speaker's Bureau:** Darren said that some speakers are sharing their speaking outlines / summaries of their stories with Alex Mitrovich. Alex Mitrovich also inquired about participating in the council in the future. Mert also mentioned that Randen Ott is interested in the speaker's Bureau training in August.

IV. **Public Health updates:** Lisa deRamos:
   a. Save the Date: Summer Health Day event hosted by WCHD and MDHHS – Wednesday, August 5, 3-6pm at 555 Towner (rain or shine). Free and open to all community members. Flyer and more details to come.
   b. Hosting our annual Cannabis in Practice webinar series in late July. Geared toward health providers and professionals but open to all community members. Flyer and more details to come.
   c. Link to marijuana education campaign feedback survey: http:bit.ly/wchd25mm – **please submit feedback by end of day Monday, June 15**! Takes less than 5 minutes to complete.

V. **NAMI:** Barb and Alayna: There is a staff meeting coming up to discuss the Peer2Peer Coordinator role and plans, communications were coordinated between Barb and NAMI and Lisa dR. The NAMI Advocacy Group will be preparing for voter education running up to the August Elections. Also, NAMI is preparing for the NAMI Walk in Gallup Park on Saturday, October 17, 2026 at

noon. Family-To-Family is planned to start in the second week of September. Peer-To-Peer is not set yet. The Peer-To-Peer Coordinator is

VI. **Fresh Start:** Recently an award was given to James Naughton in Lansing for him holding a job for the longest time in his life (6 years). Fresh Start is seeking accreditation.

VII. **Newsletter:** Mert still waiting on from Anton and Lisa. Lisa is getting ready for a wedding to Darren, so Mert will be patient.

VIII. **Walk-A-Mile –** The date of the WAM is Wednesday, September 23, 2026. Meet @Ellsworth office at 9:30am. We are hoping for a 3-4 sentence speech.

IX. **All CMH – Regional Arts & Crafts Sale:** Mert will discuss this with Sally soon possibly for May 2027

X. **NEW BUSINESS:**

a. **Next Month:** https://umich.zoom.us/j/95184848573?from=addon
In July there will be a visit from folks @UM surveying how well CMH is doing, and they will be leading the first hour of the meeting in July. This is for the CCBHC.

_ Barb _ motioned to adjourn the meeting at _ 1:19 pm_, Supported by _ Pam _.

The next meeting will be July 8, 2026 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.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY
WC-CMH ADVISORY COUNCIL MINUTES
July 8, 2026

Members Present/on the Call: Darren Beland (chair), Anton Clark, Melissa Concannon, Joy Duffy (co-chair), Leo Hanifin, Barb Higman, Pam Rathbun, Jason Zurawski (Secretary).
Staff: Mert Hershberger (Staff Liaison).
Absent: Lisa deRamos, Lisa Porzondek, Alayna Manzanares,

Meeting called to order at: _ 12:30 _ pm_.
MOTION BY _ Pam _ - SUPPORTED BY _ Melissa _: APPROVE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) ADVISORY COUNCIL (AC) CONSENT AGENDA. MOTION CARRIED.
F

I. The first section of the session was spent discussing insurance and how accessing behavioral health services is impacted by insurance.
II. Fresh Start Clubhouse charges a fee for activities. There was a question about the legitimacy of this.
III. Limited numbers of therapy sessions was an issue.
IV. How would you describe your experience with site doctors?
V. Many emphasized the need for more peers and more therapists.
VI. After the meeting, Lisa deRamos shared a little information about Cannabis in Practice webinar series:
    a. Hosting our annual Cannabis in Practice webinar series in late July. Geared toward health providers and professionals but open to all community members. Flyer and more details to come..
VII. **NEW BUSINESS: None.**

_ Meeting adjourned at _ 1:38 pm_.
The next meeting will be August 12, 2026 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.

Washtenaw County Community Mental Health (WCCMH)
Annual Year End Performance Improvement Report
Fiscal Year 25 (October 1, 2024 – September 30, 2025)

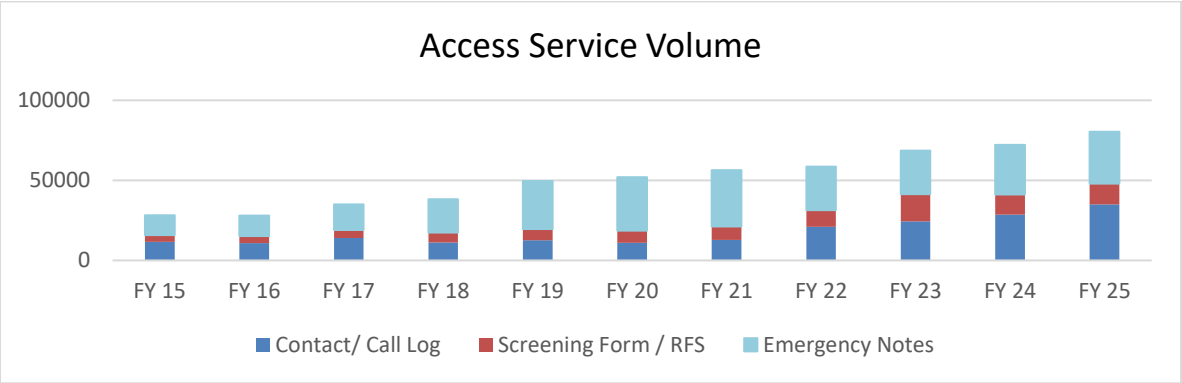
FY 25 Organizational Foci

- WCCMH continued to actively participate in the Certified Community Behavioral Health Clinic (CCBHC) programming (Cohort 1).
- Anticipating a change in the CCBHC funding model, WCCMH implemented systems and training intended to impact turnaround times on submitted claims and reimbursement.
- WCCMH, working with Community Partners, implemented and provided ongoing communication of Millage initiatives, results and outcomes.
- WCCMH Administration continued to work to increase funding levels by leading advocacy efforts at local and state levels for a diverse portfolio of funding opportunities, including, but not limited to: Medicaid, CCBHC, Managed Care, and grants.
- Continued focus on filling vacancies continues to result in fewer vacancies.
- Continued efforts to implement Zero Suicide Evidence Based Practices (EBP) throughout the organization. Project managed by Performance Improvement with Program Administrators, Directors, and front line staff creating content via committees of Care Path, Treatment Modalities and Training.
- Continued implementation of the Black Lives Matter (BLM) Task Force with twelve events and almost 2900 participants during 2025.
- Received full compliance from the Michigan Department of Health and Human Services (MDHHS) Office of Recipient Rights (ORR) during the triennial WCCMH ORR system assessment November 19-21, 2024.
- The Incident Review Committee authored multiple policies and procedures and continues to work to enhance and consolidate existing safety policies. Safety Tabletop Exercises began in 2025 and will continue in 2026 throughout the organization to better understand our current action steps during emergency incidents. The discussions during these exercises will be used to inform the development of new safety trainings, policies, and procedures with the aim of consistently prioritizing the safety of our staff, consumers, and community.
- Received re-accreditation by Joint Commission with an expiration of September 27, 2028.
- 2025 was the seventh year that the Public Safety and Mental Health Preservation Millage provided funding to expand access to mental health and substance use services across Washtenaw County. These dollars were used to support Washtenaw County youth, to assist unhoused people into stable housing, to provide services to people who would not otherwise qualify for them, and to divert low-level, low-risk offenders away from the criminal justice system and into much-needed mental health and substance use treatment.

This concludes a narrative overview of various activities conducted during FY 25. Additional information follows, which includes WCCMH's performance in some areas of efficiency and effectiveness as indicated by presenting various indicators monitored throughout the year. These indicators may reveal trends and patterns which assist our future foci. This is a summary review of our status in FY 25.

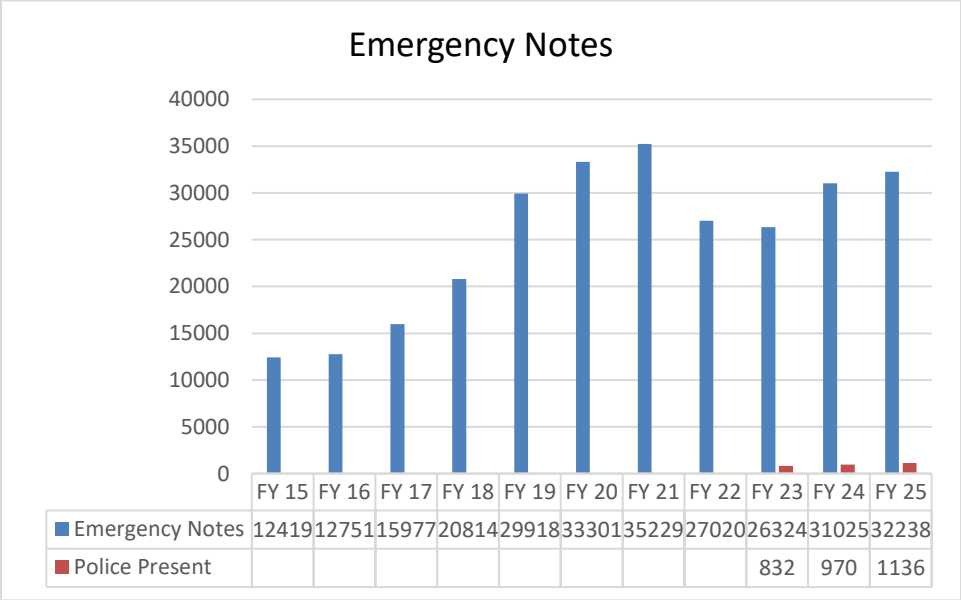
Access, Triage and Crises

Our indicator monitoring begins with a focus on access to our services. Typically, the process starts with a phone call. The phone call may result in a Call Log or Request for Services (RFS). If the phone call is considered urgent, the call will be routed to the Crisis Team which results in an Emergency Note. Below is a graph of Access Services from FY 15 – FY 25.



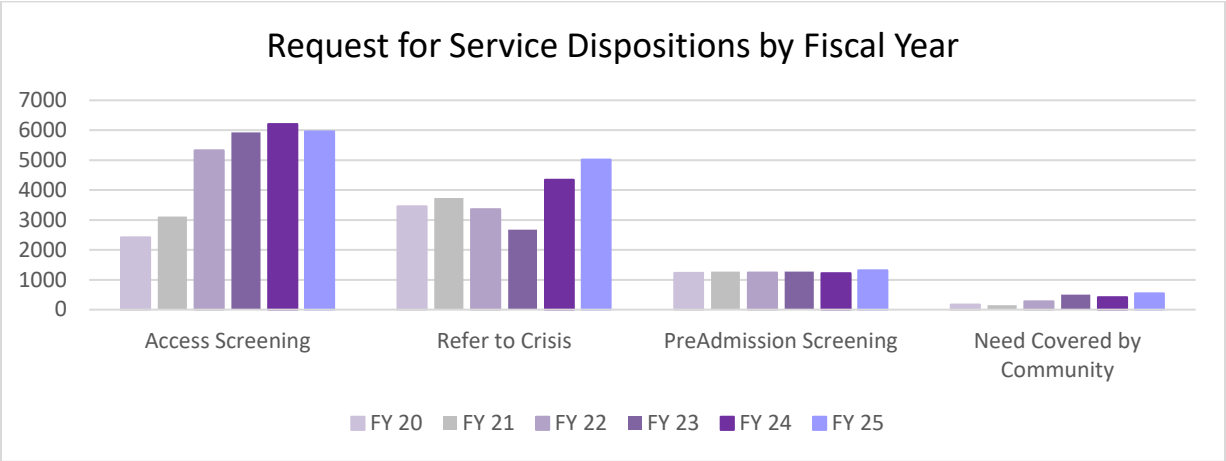
Monitoring the total number of services per fiscal year reveals a continued increase in services. This overall increase continues to be most likely due to millage services, increased collaborations with various law enforcement departments, marketing, and the ongoing Certified Community Behavioral Health Clinics (CCBHC) services. It is clear we continue to increase our ability to identify and respond to the needs in the community.

Continuing to monitor the flow of a request for service, individuals who contact us for services and present with an urgent situation are referred to the Crisis Team which then results in a service and a corresponding emergency note. The emergency note will also occur when a Prescreen is needed. Monitoring the volume of emergency notes by fiscal year reveals the relatively same number of emergency notes in FY 25 compared to FY 24. In FY 23, we also started capturing if police were present during the service. That detail is displayed below. The "police present" emergency notes is a subset of the overall emergency notes. We are seeing an increase in the number of services implemented with the collaboration of police presence.



	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	FY 25
Emergency Notes	12419	12751	15977	20814	29918	33301	35229	27020	26324	31025	32238
Police Present									832	970	1136

The RFS document produces dispositions identifying the type of requests. When an individual requests a service, the caller can be routed to an Access Screen, referred to the crisis team (for urgent issues), routed for a preadmission screening if there is an emergent situation or given information of options in the community. The graph below includes FY 20 – FY 25 RFS disposition data that pertain to a service request.

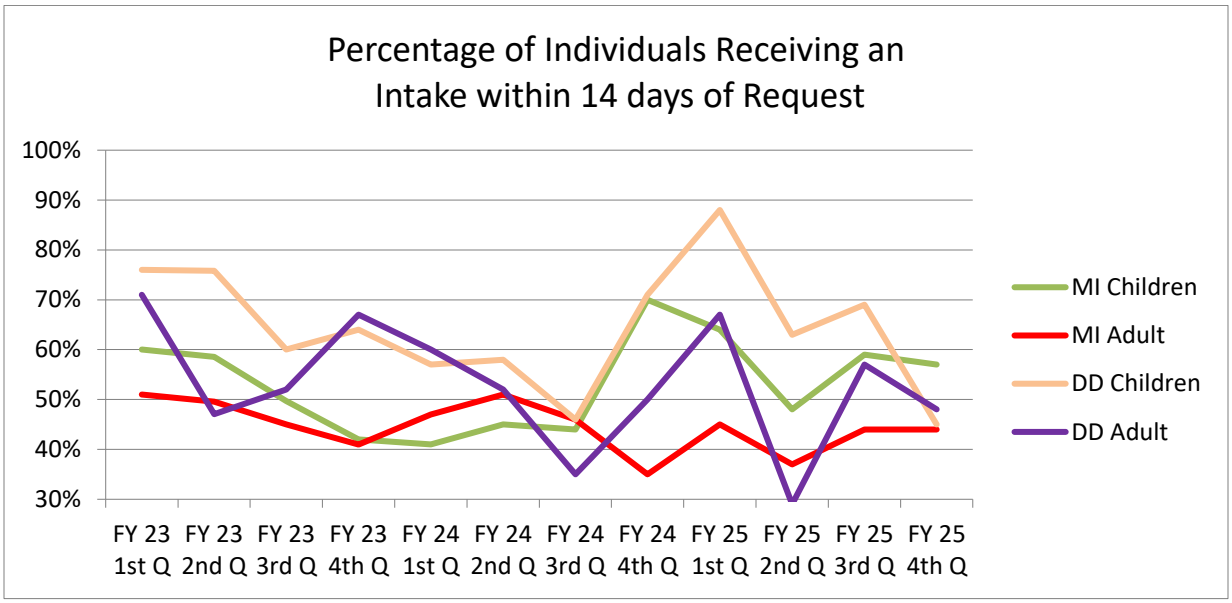


A summary of the data is as follows:

- Over the past six years, there was a trend identifying a significant increase in Access Screenings. This past year shows a small decrease though appears to help identify a baseline hovering at 6000 requests resulting in Access Screenings.
- In the past year, there continued to be a strong number of referrals to Crisis. This number continues to be much higher than it has been in the past.
- Conversely, we continue to see a minimal change in the number of calls that resulted in a preadmission screening. This has been stable in the past six years.
- Needs covered by community increased in FY 23 (which may be due to the millage impact on available services in the community). FY 24 and FY 25 suggest relative consistency and perhaps a new baseline.

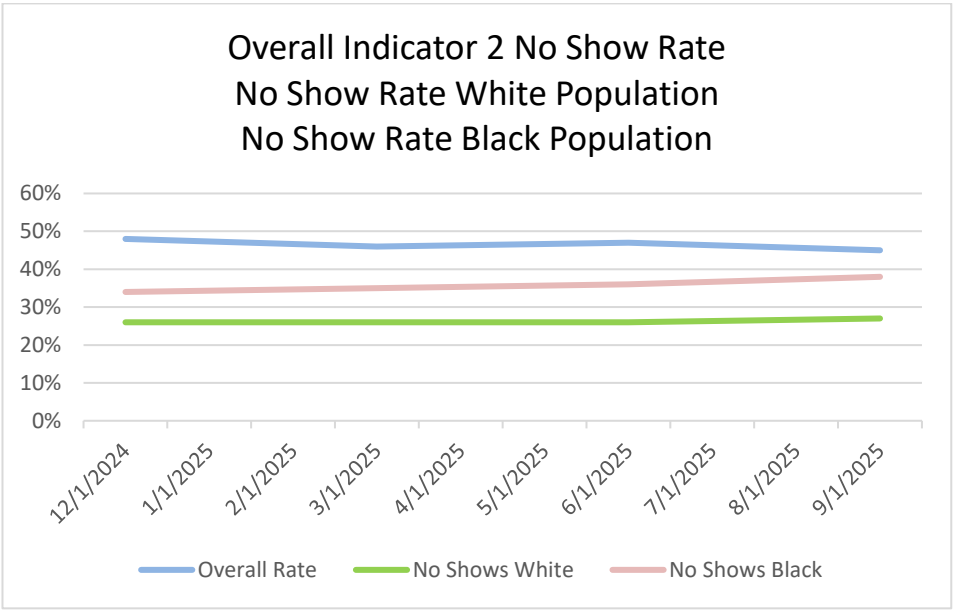
RFS dispositions, resulting in "Access Screening" leads to identifying if an intake is appropriate for the individual. If so, this results in the scheduling of a Biopsychosocial (BPS) appointment. (Please note, callers seeking substance use services may be routed to other organizations in the County).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

The graph below shows our performance on the indicator per the new definition. (Please note, for State Performance Indicators, all population naming follows the MDHHS population naming convention. MDHHS continues to identify adults who experience a developmental disability as "DD Adult" while our internal programming describes these individuals as experiencing an Intellectual and/or Developmental Disability (IDD)).

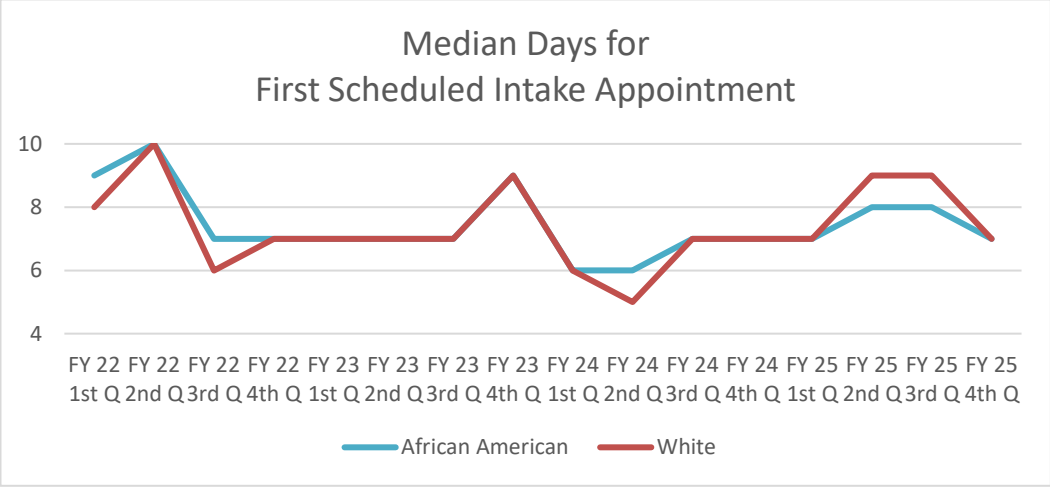


The Performance Improvement Department and Program Administrators evaluate each case out of compliance to identify trends and/or patterns and identify possible systemic improvements. This arduous process continually identifies that the individual's preference has a significant impact on the intake occurring within 14 days. This preference is indicated by the consumer scheduling the appointment outside of 14 days, rescheduling the appointment, or not attending the appointment (no show). Our Access Department offers appointments as close to the request as possible hoping this will help the consumer keep the appointment as a priority. However, consumers seeking services often have competing priorities or other variables that prohibit them from attending appointments within 14 days.

MDHHS has also mandated a Quality Assurance Performance Improvement Project to focus on reducing racial disparities specific to No-Shows for the Initial BioPsychoSocial Assessment (BPS). Previous years were considered baseline years with the project expecting an impact beginning January 2023. The graph below shows no show rates by each population (white and black) based on rolling year data from the Prepaid Inpatient Health Plan (PIHP).

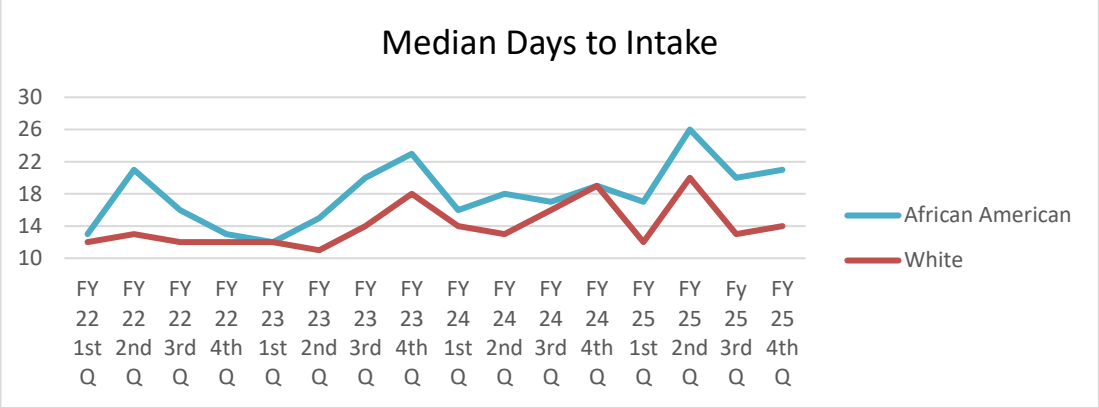


All quarters continued to show significant disparity. In FY 23, WCCMH accessed members of the Black Lives Matter (BLM) taskforce to review and revise our triage phone guide in hopes of establishing a warm and trusted connection with black callers seeking services. However, we continued to observe this disparity. We then focused on scheduling the intakes as soon as possible. Below are graphs displaying medians for the number of days the appointment is scheduled from the request and then the number of days the appointment actually occurs, both delineated for white and black consumers.



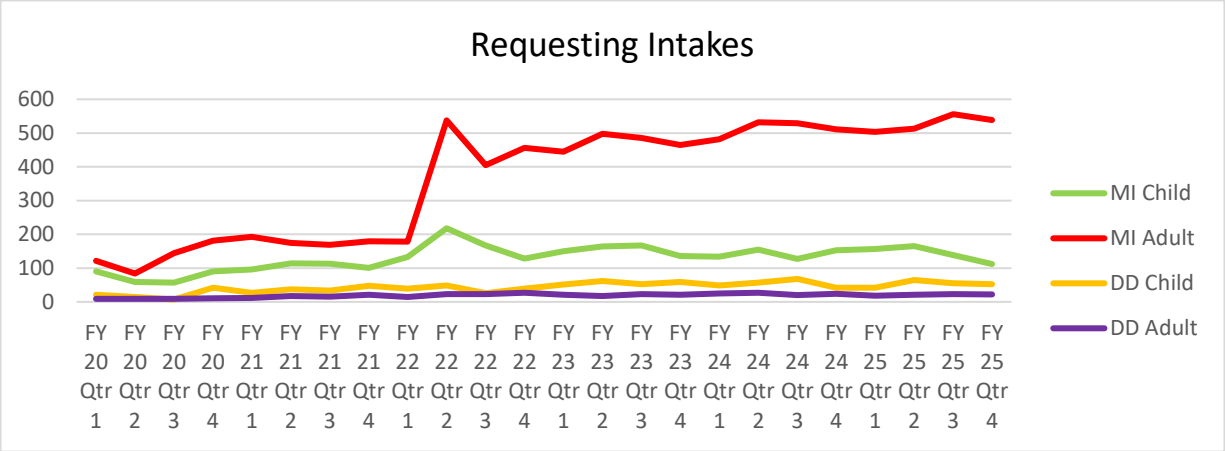
We are not seeing any difference in the scheduling of the appointment and the median is typically around 7 days with some variance.

However, the median for the number of days to intake is much different due to consumer preference.



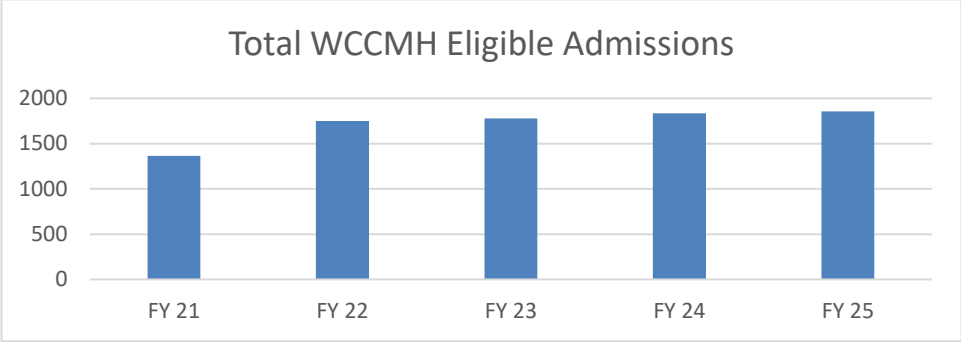
Both black and white consumers frequently no show or reschedule their appointments. The black population tends to have their actual appointment a higher number of days from the initial request. This is due to their requests and preferences. It is not known to us why their preference pushes the appointment farther out from the original request (when compared to the white population). WCCMH has hired the Research Leadership Institute which focuses on justice, equity, diversity and inclusion (JEDI). This institute is led by Dr. Daphne Watkins. The insititute is reviewing our organization and will be providing an analysis. The insights we gain will directly shape our strategic priorities and hopefully be able to impact this significant disparity.

With the implementation of CCBHC and the integration of CARES datasets, we experienced a significant increase of requests for intakes which continues to be present.

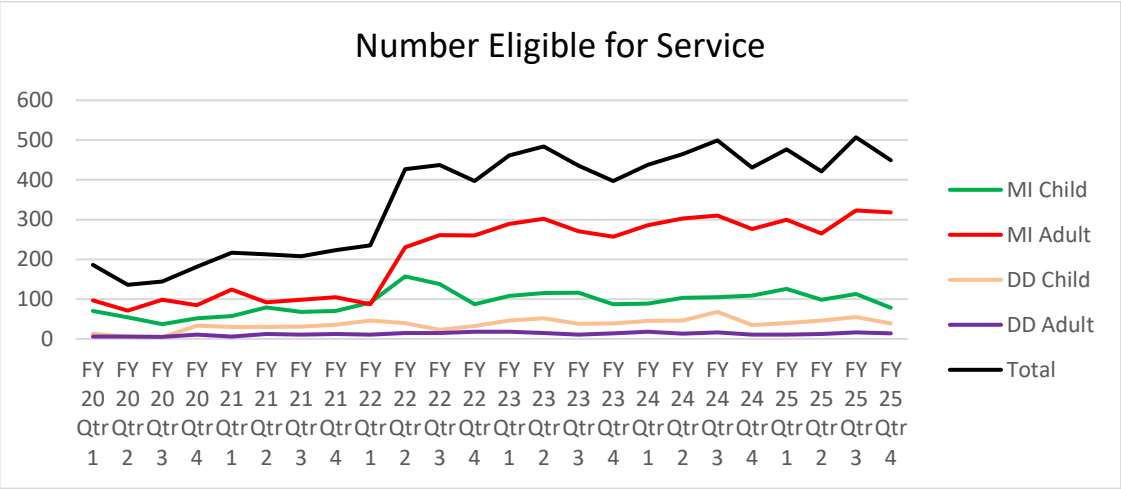


The increase in requests for Adults who experience mental health complications continues to be remarkable. Children with mental health complications seeking services remained relatively stable. These increases reflect CCBHC's ability to serve the individuals who experience mild to moderate symptoms which allows WCCMH to be able to identify and serve more individuals with mental health needs. This is a strength for the community.

The BPS (intake) results in identifying eligibility. With the increase in BPSes, it is not surprising the number of individuals identified as eligible has increased a great deal as well and remains consistent, again suggesting a new baseline.

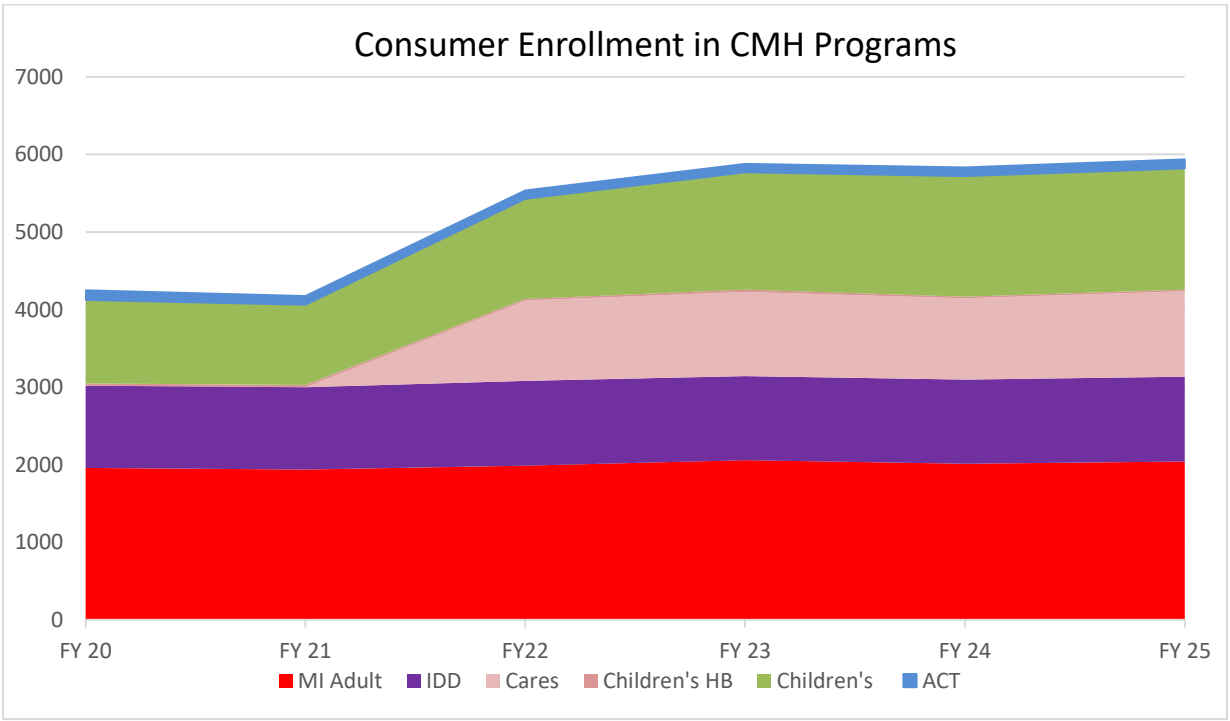


Admissions increased in FY 22 and have continued to remain about the same. This increase in admissions is due to eligibility expanding due to the CCBHC eligibility criteria. Those eligible for services are then admitted into one of our programs. Tracking these admissions into WCCMH core teams reveals the following graph:



Overall, MI Adult continues to experience a higher level of admissions (compared to pre CCBHC). Youth and Family experienced an increase in FY 22 and has since leveled off suggesting a new baseline.

The following graph identifies enrollment in the organization's program. The overall increased cumulative enrollment is mostly impacted by enrollment in the Cares and Youth and Family programs.

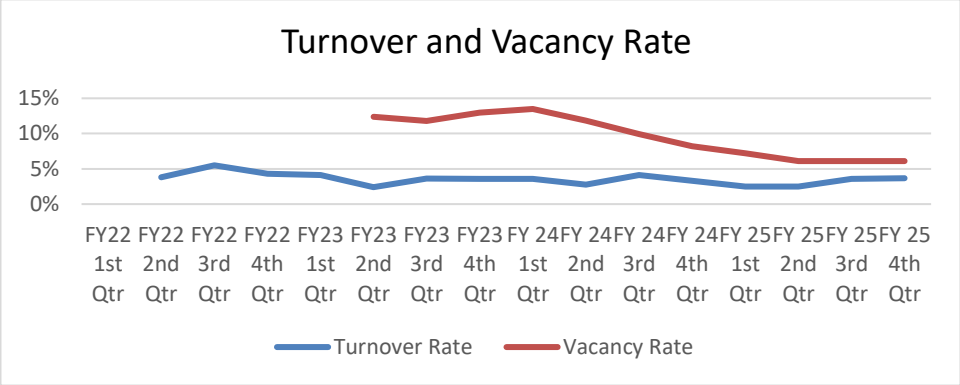


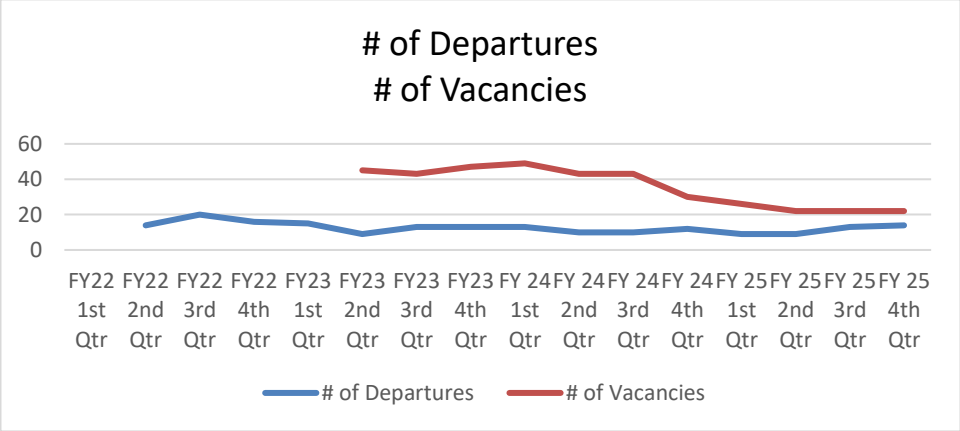
Cumulative enrollment from FY 20 to FY 25 shows an overall increase in admission to WCCMH services which is mostly impacted by the implementation of CCBHC and integration of the CARES dataset.

While experiencing higher enrollment, we continue to focus on decreasing our employee turnover and vacancies. The turnover rate is defined as the the number of terminations (voluntary, retiring and involuntary) divided by the average number of active positions during the quarter. The vacancy rate is defined by the number of vacancies divided by the number of active positions each quarter. FY 25 shows an overall decrease in both rates with minor variance. The rates for each quarter were:

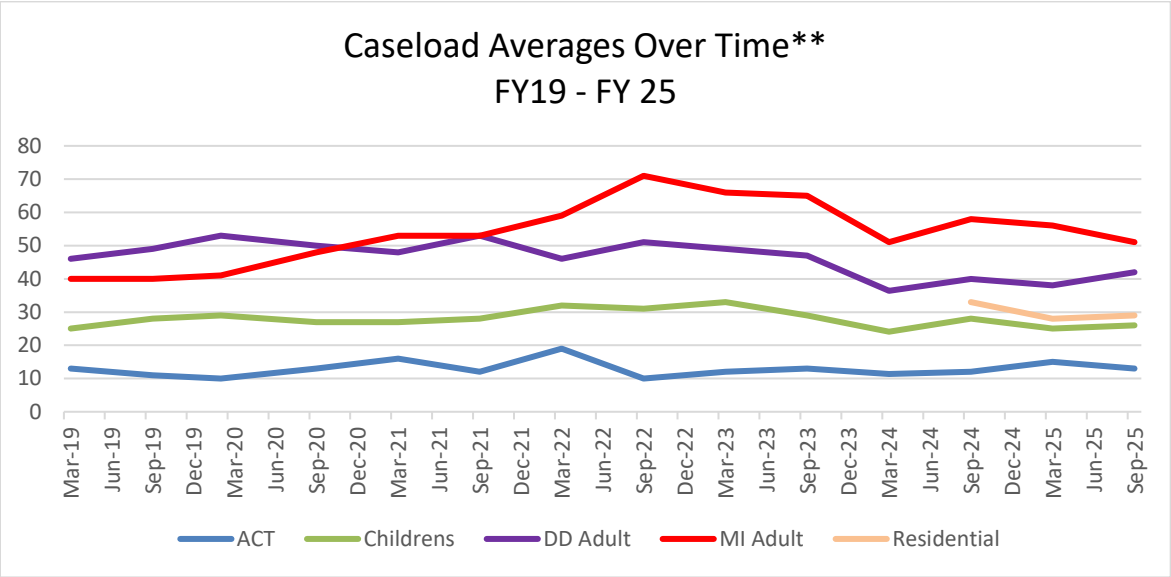
FY 25 Quarter	Average Number of Active Positions	Number of Employment Termination	Turnover Rate	Number of Vacancies	Vacancy Rate
1st	363	9	2.5%	26	7.2%
2nd	363	9	2.5%	22	6.1%
3rd	363	13	3.6%	22	6.1%
4th	363	14	3.9%	22	6.1%

The overall vacancy rate has decreased considerably since we began reporting this data in FY 23. The graphs for Turnover and Vacancy Rate and the number of turnovers and vacancies are below:





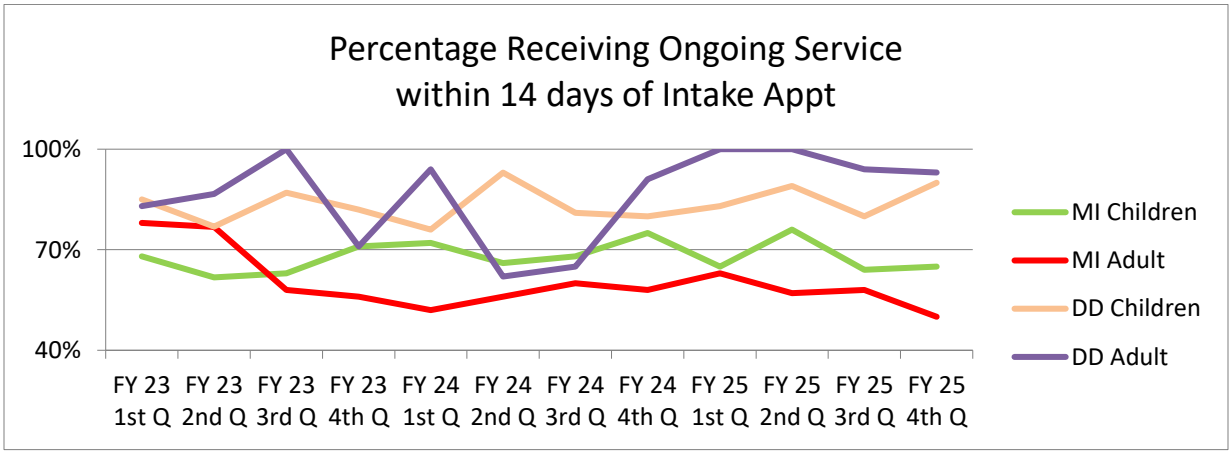
As individuals are found eligible for service, their case is opened, assigned to a program and then assigned to a caseload. The graphic below displays the average caseloads. The trending increase of caseload sizes began in FY 19 (due to a hiring freeze). Focusing on minimizing vacancies and reducing the turnover rate has impacted caseload averages in a positive manner.



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

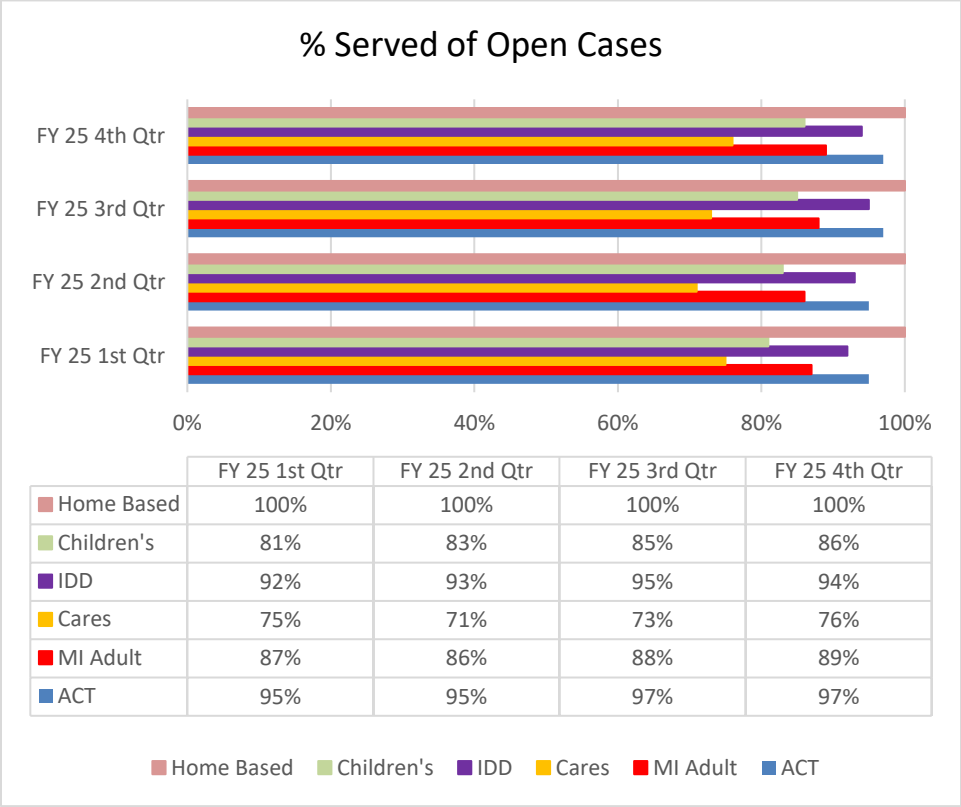
Average caseload sizes were the highest in FY 22. With the number of vacant positions decreasing, we saw a correlating decrease in caseload sizes for MI Adult, I/DD Adult and Youth and Family in FY 24 which continued through FY 25. I/DD Adult caseload sizes are lower than they were prior to the hiring freeze. Youth and Family are where they were in FY 19. MI Adult is still experiencing higher caseloads than before the hiring freeze. Cares no longer implements a program model of caseloads electing to implement a clinic model able to respond to clients as they arrive to the clinic.

For programs where a caseload is carried, once a case is assigned to a primary staff, ongoing services are initiated. Below is a graph showing the percentages of consumers who received their first ongoing appointment within 14 days, which is the MDHHS Performance Indicator #3. As in indicator #2, the definition of compliance changed for indicator #3 in FY 2020 and the new definition does not consider the consumer's preference (e.g. scheduled outside of 14 days, rescheduled by consumer, no show, found eligible but chose to pursue services elsewhere). The new compliance rate is much lower than prior to the definition change.



The DD Adult performance visually displays the greatest variance due to a low denominator which is then sensitive to numerator changes. MI Adult and MI Children's percentages are greatly impacted by the consumer's choice of not showing for their appointment or scheduling outside of the 14 days. DD Children (in the Youth and Family program) decreased then increased with a strong increase in the fourth quarter. MI Adult had an overall increase from FY 23 though remains much lower than in FY 22.

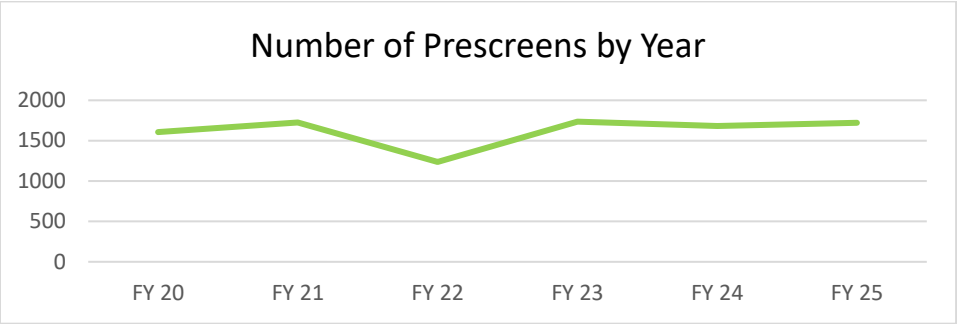
The organization's priority continues to focus on the individual receiving their services and that we remain in contact with them. Of those enrolled, it is helpful to monitor the percentage receiving a service in the designated time period as indicated below:



	FY 25 1st Qtr	FY 25 2nd Qtr	FY 25 3rd Qtr	FY 25 4th Qtr
Home Based	100%	100%	100%	100%
Children's	81%	83%	85%	86%
IDD	92%	93%	95%	94%
Cares	75%	71%	73%	76%
MI Adult	87%	86%	88%	89%
ACT	95%	95%	97%	97%

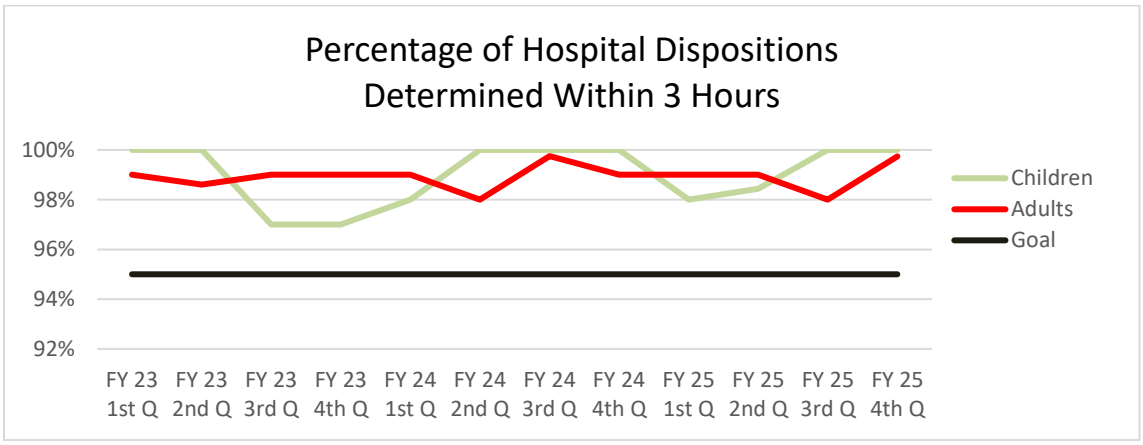
This graph displays the percentage of individuals receiving at least one service in the corresponding time period. It should be noted, engaging those enrolled in the Children's program can be quite challenging due to the complexity and competing priorities in the family's life. Also, medical necessity drives the frequency of service so not all consumers would be expected to be seen in a quarter. This graph does help us monitor if there are any trends or patterns to be aware of. Currently, we have not identified any.

Whether or not a consumer is open to our organization, they may experience a psychiatric crisis. The consumer is evaluated for the appropriate level of care during a prescreen. Below are the total number of prescreens over a five-year period.



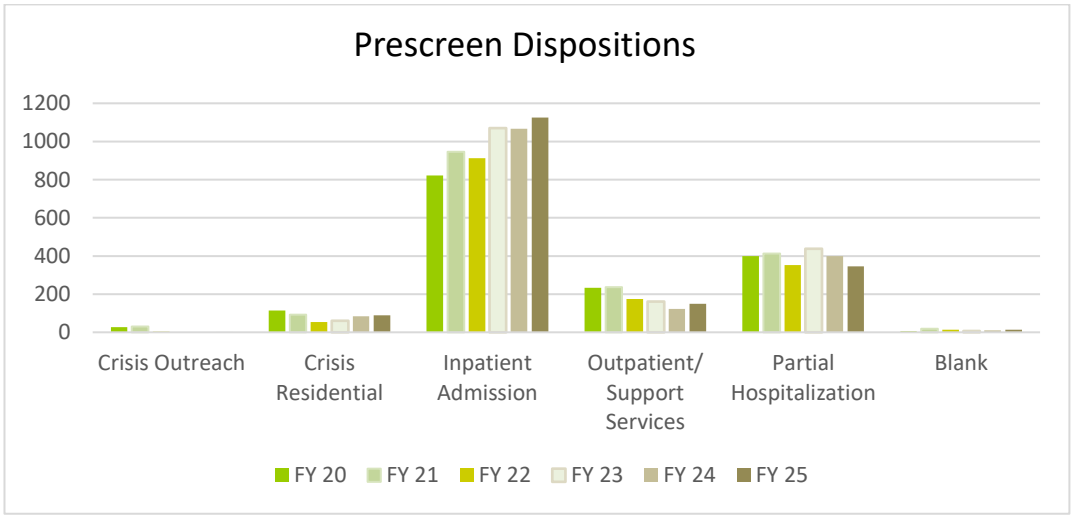
The number of prescreens is consistent with most previous years.

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



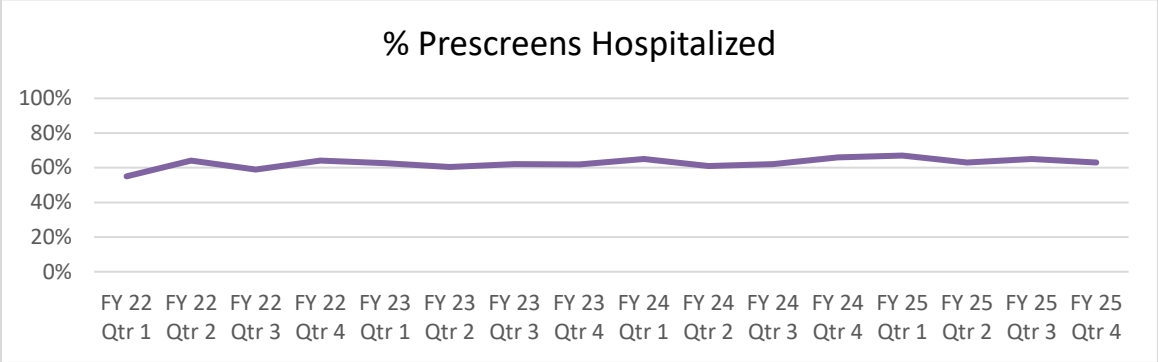
We continue to excel beyond expectations. (Please note, this does not indicate the amount of time a consumer waits for an available bed once the disposition is identified.)

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



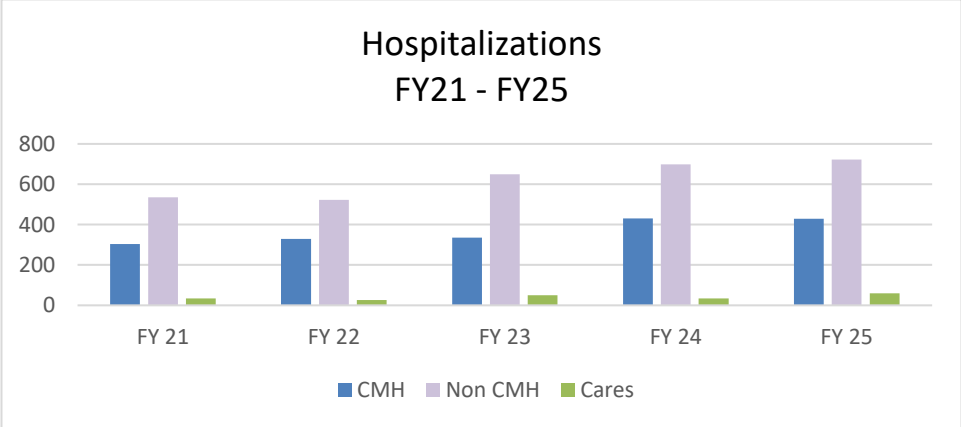
Partial hospitalizations decreased while Inpatient admissions increased in FY 25.

Monitoring the percentage of prescreens that result in dispositions of psychiatric hospitalizations reveals the following:



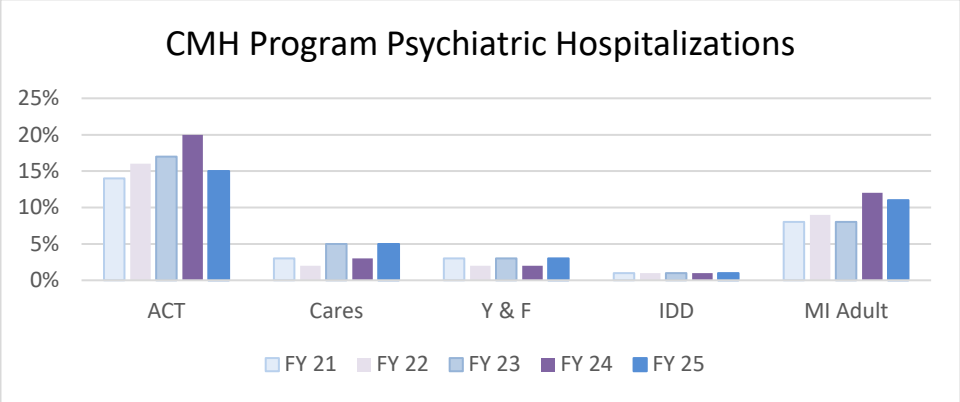
While the number of inpatient hospitalizations has increased, the percentage of psychiatric hospitalizations dispositions remains steady.

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



Psychiatric hospitalizations of CMH-served individuals (open CMH cases) remain stable. Non-CMH individuals show a slight increase in hospitalizations. Cares data for FY 25 seems to be like previous years.

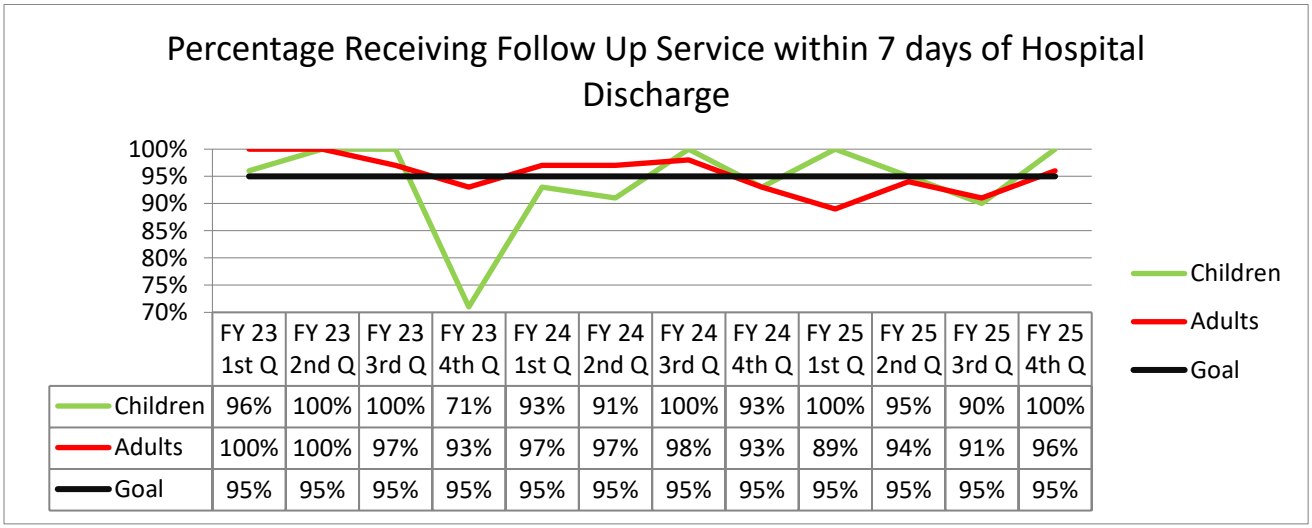
Considering a psychiatric hospitalization rate (number of individuals hospitalized compared to number of individuals served as an open case) can be a very useful measure to monitor as it helps identify the percentage of admissions per those served. The following graph helps depict these rates and possible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



The graph displays the percentage of CMH funded hospitalizations per the number of served individuals by the corresponding program. For the ACT program, it is important to note that the actual percentage of hospitalizations is higher due to Medicare funded hospitalizations and our inability to access that data. However, based on CMH funded hospitalizations, the previous trend of increasing hospitalization rate for ACT is no longer occurring with a substantial decrease in FY 25.

Cares hospitalization is a bit higher than FY 24 though negligible. Youth and Family (Y & F) is relatively stable. The IDD program remains steady. The MI Adult program saw a significant increase in hospitalizations in FY 24 with a slight decrease in FY 25. However, overall, the rate is relatively stable with no concerning trends.

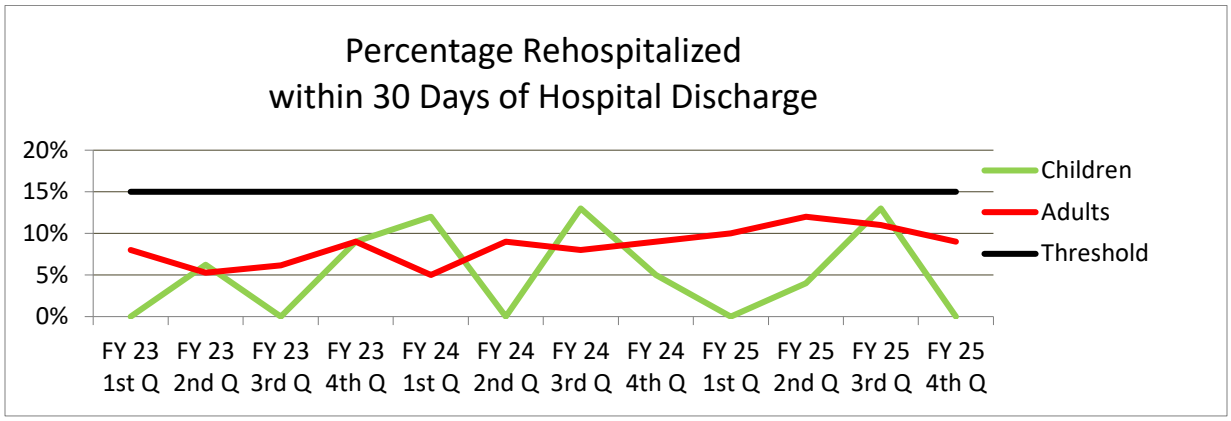
Below is a graph depicting the percentage of individuals who had a CMH funded psychiatric hospitalization that received a follow up service from CMH within 7 days of discharge.



	FY 23 1st Q	FY 23 2nd Q	FY 23 3rd Q	FY 23 4th Q	FY 24 1st Q	FY 24 2nd Q	FY 24 3rd Q	FY 24 4th Q	FY 25 1st Q	FY 25 2nd Q	FY 25 3rd Q	FY 25 4th Q
Children	96%	100%	100%	71%	93%	91%	100%	93%	100%	95%	90%	100%
Adults	100%	100%	97%	93%	97%	97%	98%	93%	89%	94%	91%	96%
Goal	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

For FY 25, Children were above the goal three of the four quarters while Adults were below the goal for three quarters. Each time we are below the goal, a corrective action plan is implemented.

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



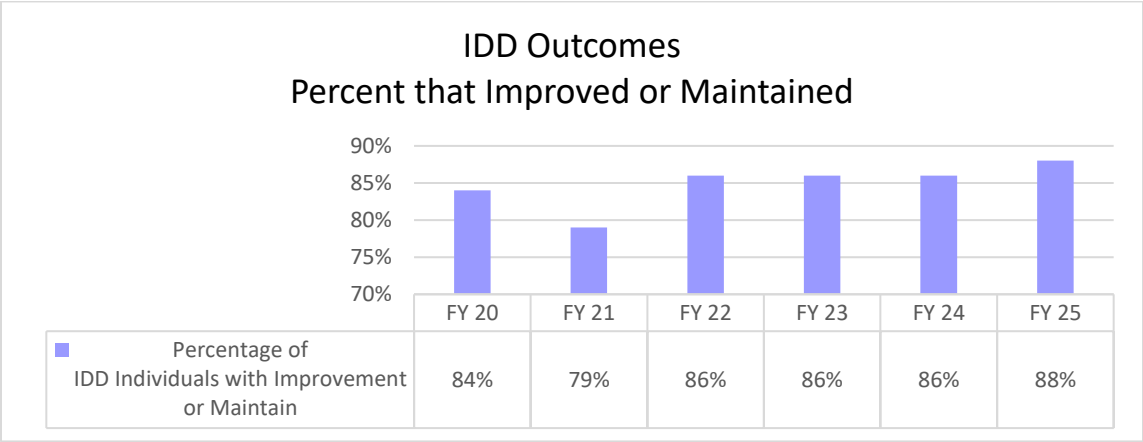
The organization continues to remain below the MDHHS threshold of 15%.

Program Outcomes

IDD Program Outcomes

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

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



The program increased the percentage of cases that improved or maintained to 88% in FY 25.

Youth and Family Program Outcomes

The Youth and Family program had used the Child, Adolescent Functional Assessment System (CAFAS) as the valid and reliable outcome measures for children who experience a serious emotional disorder. However, due to mandates from MDHHS, this outcome tool is no longer used. The Children's

program shifted to the Michicans tool in FY 25. All outcome measurements are based on comparing outcomes from two points in time and aggregating these outcomes. Since Michicans is a tool implemented on an annual basis and was first implemented in FY 25 with no second time point, there are no available outcome data for this year.

MI Adult Program Outcomes

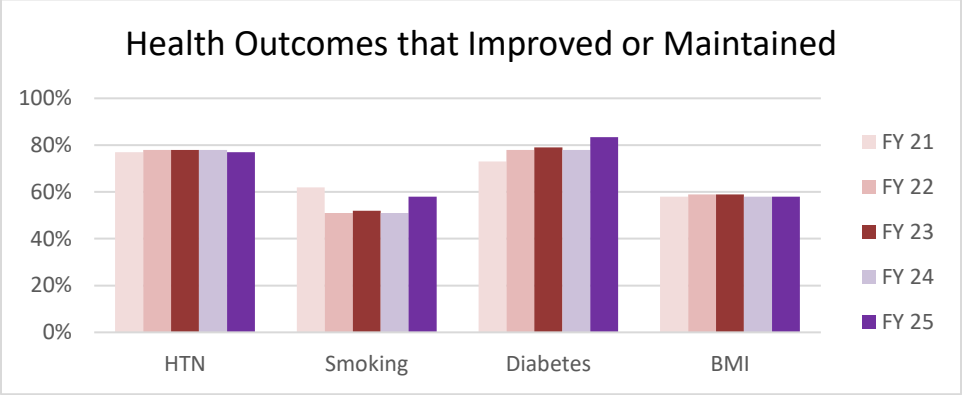
The MI Adult program's outcome tool was the Self Sufficiency Matrix which was identified as no longer being the outcome tool of choice. CCBHC required the implementation of the Social Determinants of Health (SDOH) tool to be implemented on an annual basis. This tool has been identified as the new outcome tool for the MI Adult program. As with the children's program, all outcome measurements are based on comparing outcomes from two points in time and aggregating these outcomes. The SDOH tool has data from the first point in time. The second point of time should occur in FY 26 and outcome data will be developed then.

Integrated Care

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

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

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



Smoking and Diabetes has an increase in the percentage improved or maintained while BMI remained steady and HTN had a very slight decrease.

Health and Mortality

Research and industry trends identify those individuals who experience a severe mental illness tend to die much younger than their counterparts. WCCMH monitors our mortality rate, as well as the average age of the individual at the time of death. The data below are commensurate with research identified trends. For every reported individual death, WCCMH process includes reviewing the chart, obtaining the death certificate

(if available) and presenting this information and the death report to the Medical Director. The Medical Director then classifies the cause of death. Below are the aggregated categories of cause of death and the average age at the time of death for each category.

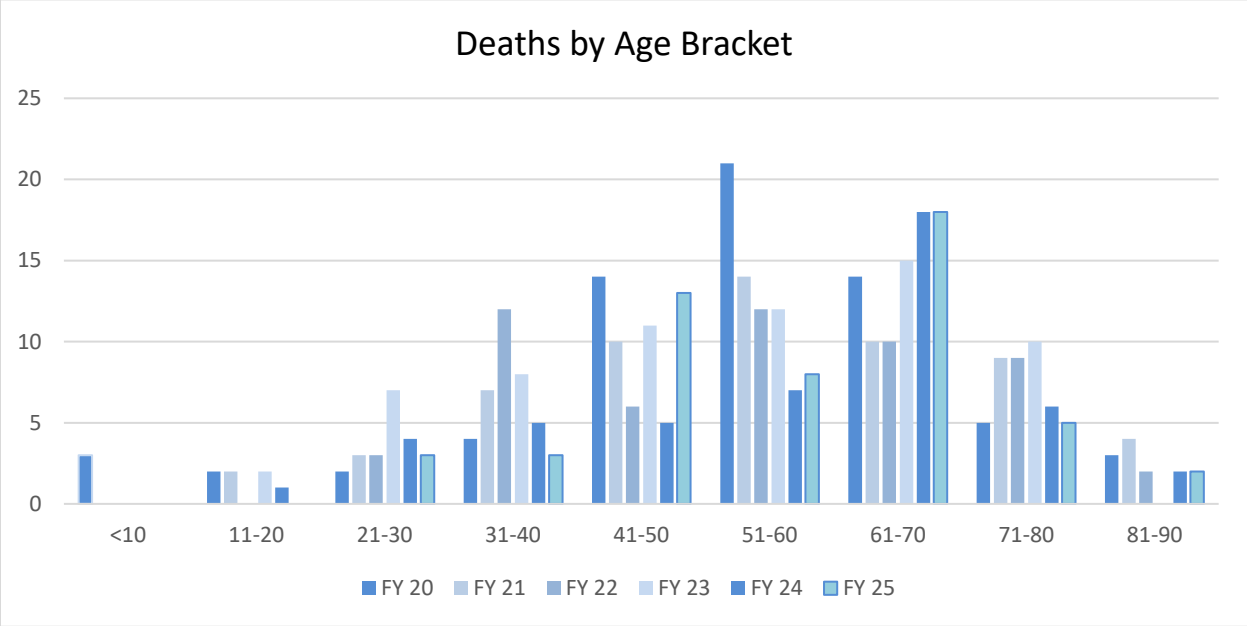
Mortality

Cause of Death	FY 21	Age FY 21	FY 22	Age FY 22	FY 23	Age FY 23	FY 24	Age FY 24	FY 25	Age FY 25
Aspiration Pneumonia	2	76	3	66	4	68	1	62	1	55
Cancer	10	62	3	51	8	65	2	68	7	56
Cardiovascular	6	69	12	64	10	67	20	68	11	65
Diabetes	1	50								
Drug Abuse	2	37	6	43	10	48	5	40	6	53
Endocrine System (Diabetes)										
Fluid Electrolyte Disturbance					1	49				
Gastrointestinal	1	65			3	42	3	46	3	50
Homicide					3	36				
Hyponatremia			2	43						
Inanition									1	63
Infection	5 (4 - COVID 19)	49	4 (3 - COVID 19)	49			2	27	3	66
Kidney Disease					1	54	1	49	1	34
Liver Disease	3	62	1	61	1	39	1	47	1	63
Medication Toxicity									1	49
Metabolic										
Natural/Other										
Neurological	7	60	3	69	3	55	3	43	4	47
Respiratory	4	40	5	60	5	44	5	61	4	62
Suicide	2	23	2	36	6	32	1	34	3	46
Trauma	2	40	3	50	2	73	1	43		
Unknown	15	49	10	38	8	44	3	49	6	54
Grand Total	**# of Deaths 60**	**Avg Age 54**	**# of Deaths 54**	**Ave Age 52**	**# of Deaths 65**	**Ave Age 52**	**# of Deaths 48**	**Ave Age 56**	**# of Deaths 52**	**Ave Age 56**

Mortality data is based on death certificates from the Washtenaw County Medical Examiner. If an individual dies out of county, we do not receive that death certificate, and it is coded as "unknown". The number of

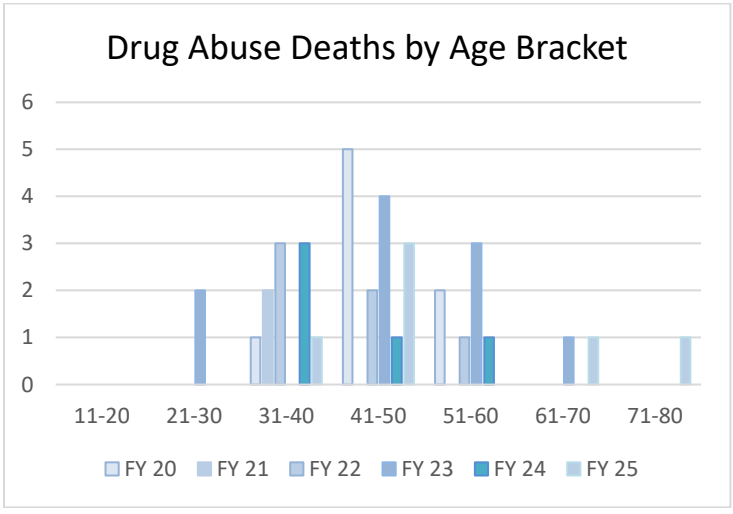
deaths tend to vary as indicated by the five-year dataset. The number of deaths in FY 25 is within the expected variance. The average age of deaths continues to be somewhat consistent.

Reviewing the number of individuals who were receiving services and passed away in FY 25 between frequency of deaths per bracketed age categories helps monitor and review baseline data and possible trends/ patterns.

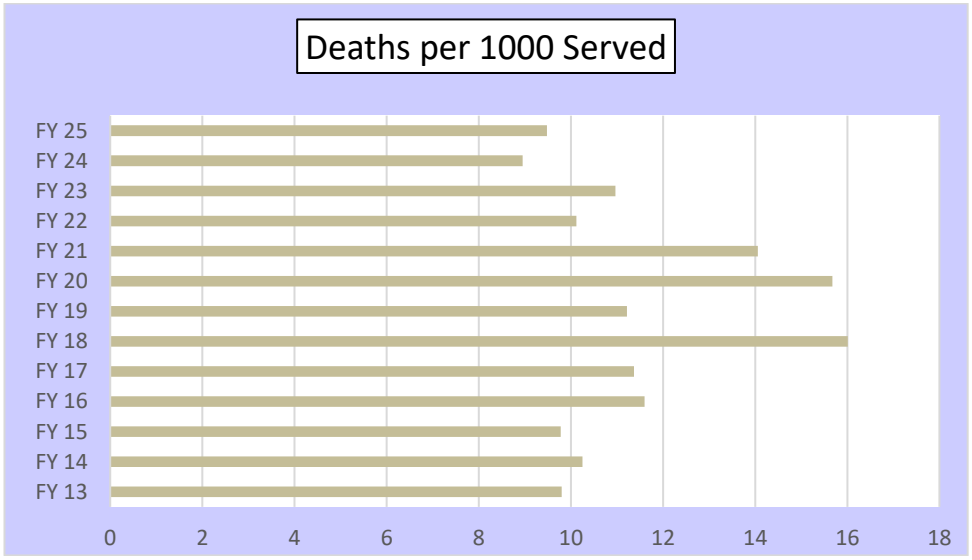


Overall, the number of deaths was the highest in the 61-70 decade for FY 24 and FY 25. The number of deaths in the 41-50 category continues to display variability while the 51-60 decade remains lower than in previous years.

The number of deaths that occurred due to accidental overdose (Drug Abuse) continue to show variance, though there was an increase in the age bracket of 41 - 50 from FY 24 reflecting variability.

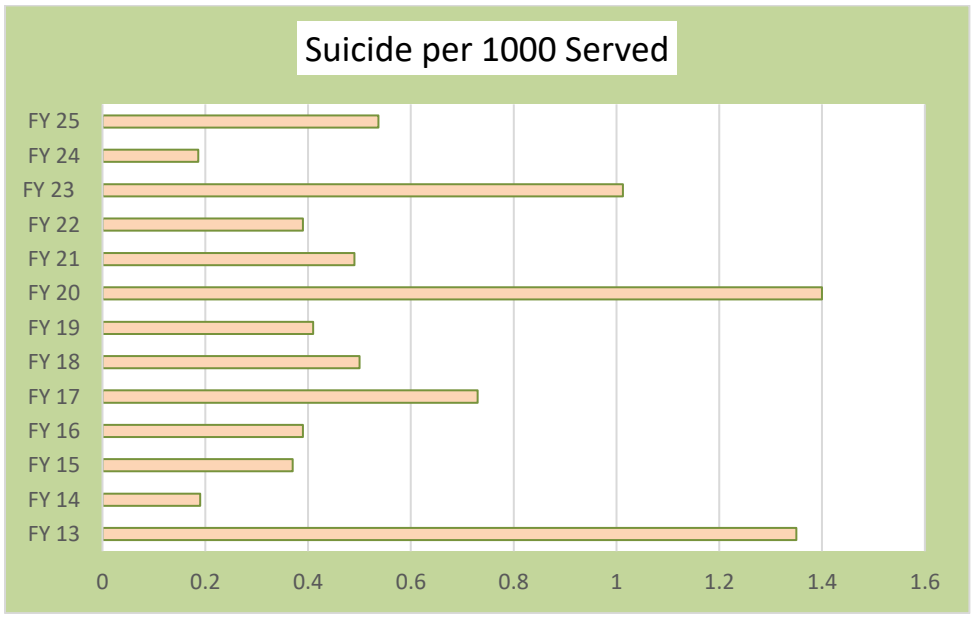


Reviewing deaths over the past thirteen years has helped us identify the number of deaths compared to the number of individuals served. There is a great deal of variance with no pattern identified.



The ratio of deaths/individuals served this past year remains lower than many previous years. There are no identified systemic mental health treatment factors contributing to these deaths.

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



The ratio for FY 25 increased from FY 24 though is not indicative of a concerning trend or pattern. All suicides are reviewed with a root cause analysis. This is a very thorough and thoughtful review process beyond the normal death review process.

Satisfaction Survey Results

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

N= 92

Survey Results from Those Who Receive Services

The survey assesses client experiences and perceptions of the services provided by Washtenaw County Community Mental Health in 2025.

- 92 responses collected.
- Participants received services for I/DD, Adult MI, or Youth & Family.
- Most respondents are aged 25-34, with responses spanning all age groups.
- Clients saw various staff members, including doctors, therapists, case managers, peers, and recovery coaches.
- High levels of safety and respect were evident; 95%-100% feel the agency is a safe place and are respected by staff.
- Most clients report their calls are returned the next day and that they see staff within 15 minutes of their appointment time.
- About 95% feel they can decide what is important when working with staff.
- Two responses expressed dissatisfaction, mainly due to past misdiagnoses or suggesting "mean what you say".
- A very high percentage of responses indicate that clients generally understand their staff and feel staff help achieve goals.
- Follow-up on physical health needs is reported positively by about 85%.
- 88% feel able to complain or disagree with staff; there is strong indication all know how to initiate a complaint while two respondents requested further follow up from the Customer Services staff.
- Overall, clients feel informed, respected, and able to communicate concerns effectively.

No scores indicate further review.

Summary

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

Quality-Finance Board Committee
Performance Improvement Dashboard
2nd Qtr Dashboard (Jan 1 – March 31, 2026)

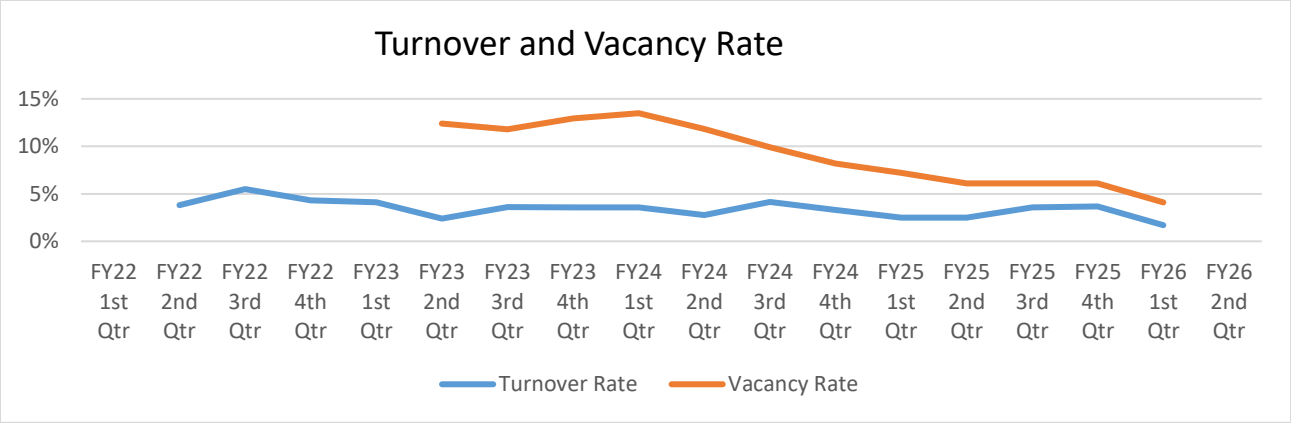
2nd Quarter Human Resources

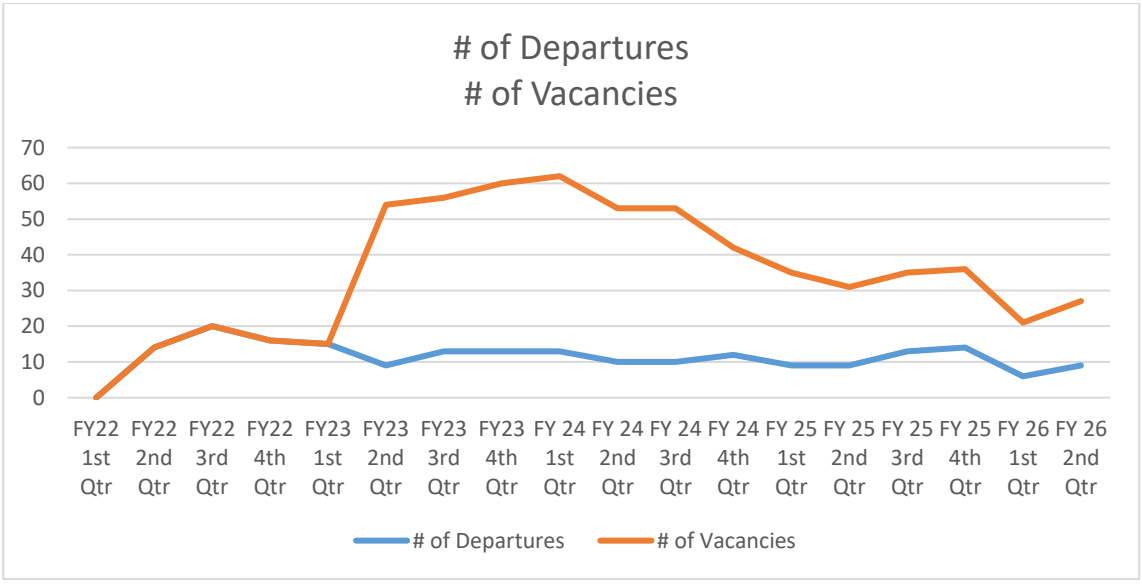
Turnover Rate:

9 staff resigned or were involuntarily terminated
363 positions
Turnover rate is 2.48%

Vacancy Rate:

18 vacancies
363 active positions
Vacancy rate 4.96%

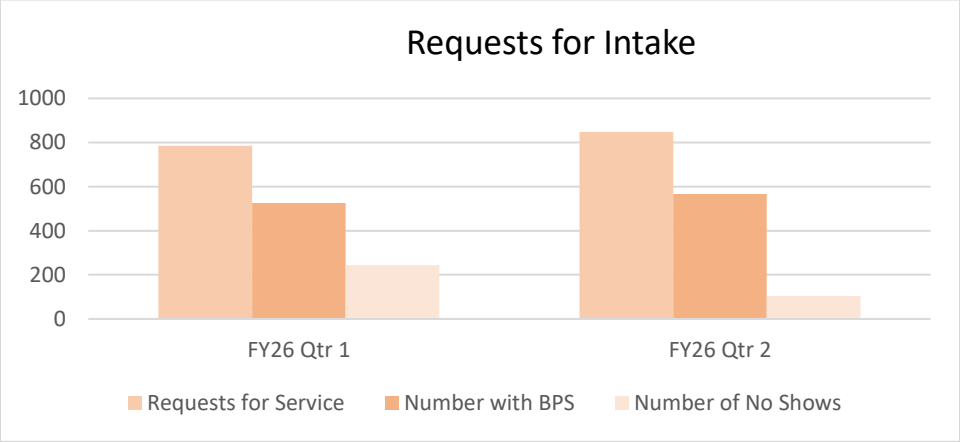




Michigan Department of Health and Human Services (MDHHS) Performance Indicator Hedis Measure Transition (Verbal Update)

Hedis Measures:
Initiation and engagement alcohol treatment (IET)
Follow up after psychiatric hospitalization (FUH)
Follow up after emergency room visit for mental illness (FUM)
Follow up after emergency room visit for substance use (FUA)
Follow up for children prescribed medications for ADHD (ADD)
Metabolic Monitoring for children prescribed antipsychotics (APM)
Psychosocial care for children and adolescents on antipsychotics (APP)

Access to Services



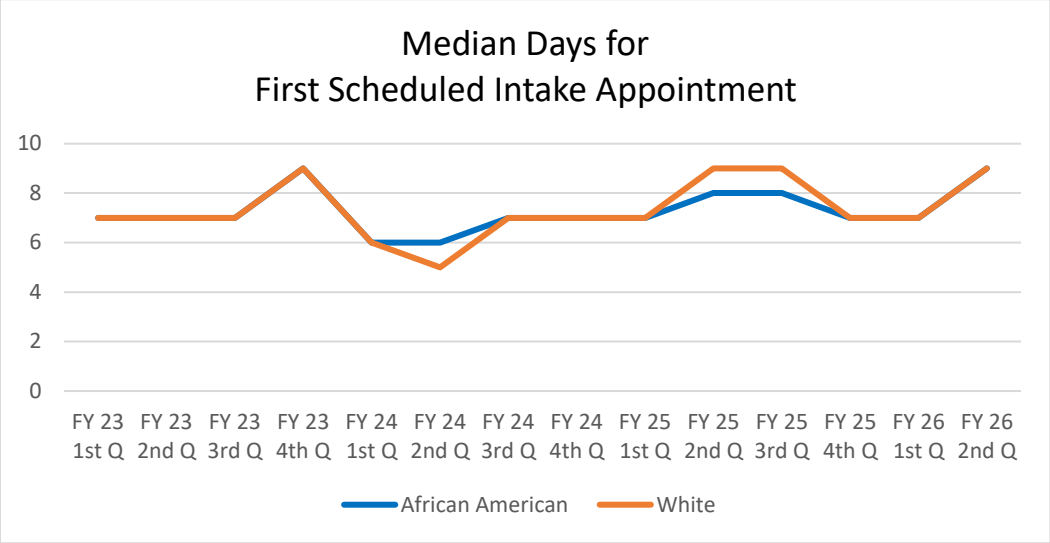
2nd Qtr Detail of Intake Data				
Time Frame	**Requests for Intake**	**Received BPS**	**Percentage receiving BPS**	**No Shows**
Jan	**272**	**184**	**68%**	**37**
Feb	**293**	**195**	**67%**	**31**
Mar	**283**	**187**	**66%**	**35**
Grand Total	**848**	**566**	**67%**	**103**

Median Days for Intake Appointment

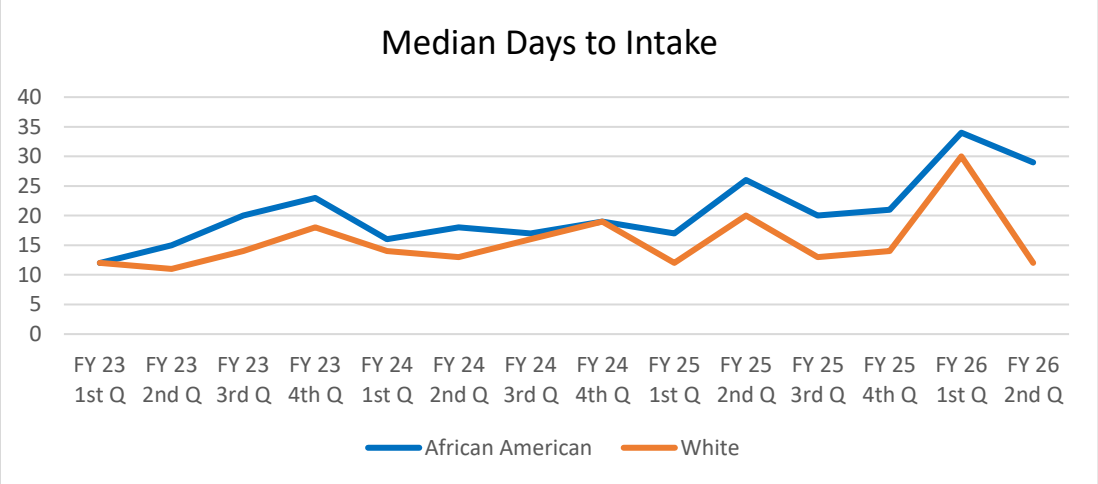
This dataset compares the number of days from request for service to the first scheduled BPS date and the number of days from the request for service to the the actual BPS date. The median number of days was identified for both datapoints.

The first graph identifies the median between the request for service and the first scheduled BPS date for both white (blue line) and black populations (red line). Each of those datapoints reflect a number where the

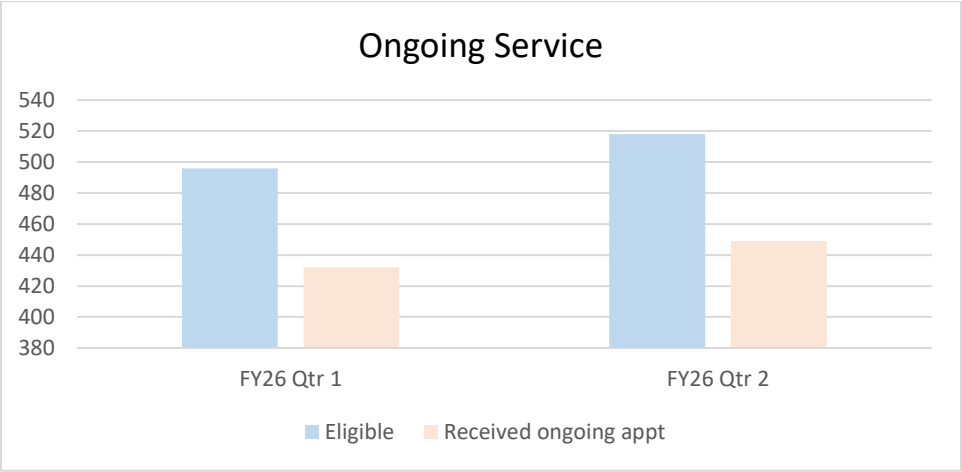
dataset is 50% below (as well as 50% above) confirming our Access department tries very hard to schedule people quickly.



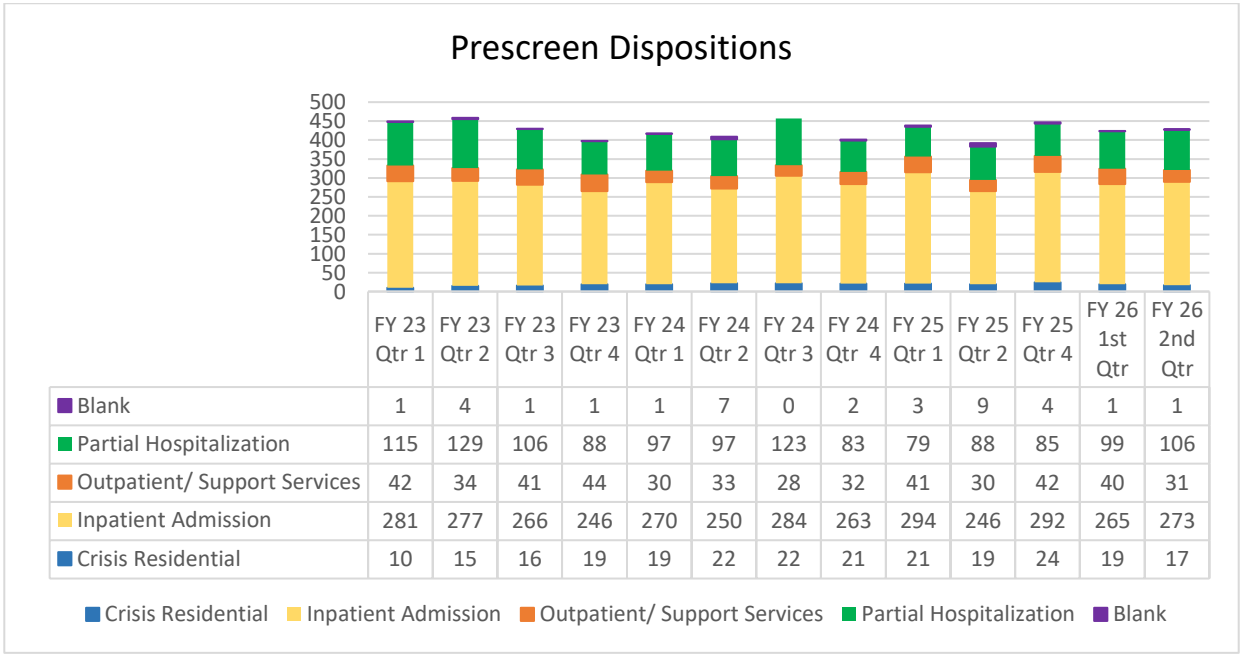
Consumers can have their first appointment scheduled and then can no show, call to reschedule, or call to cancel. We know that a large number of consumers end up receiving their intake/ BPS outside of 14 days. The graph below identifies the median number of days from the request for service to the actual BPS for the same populations and legend.



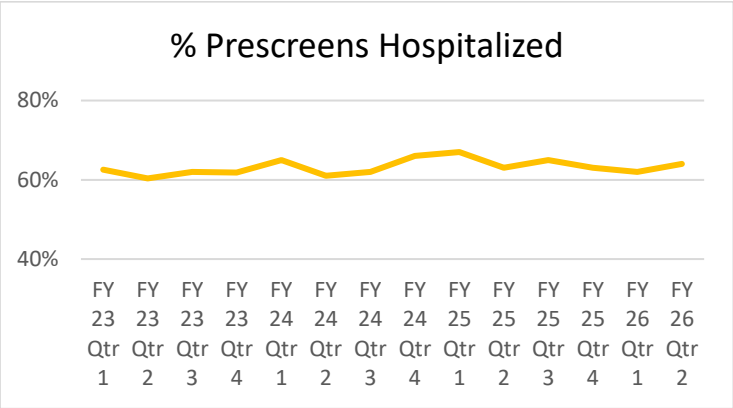
Ongoing Service

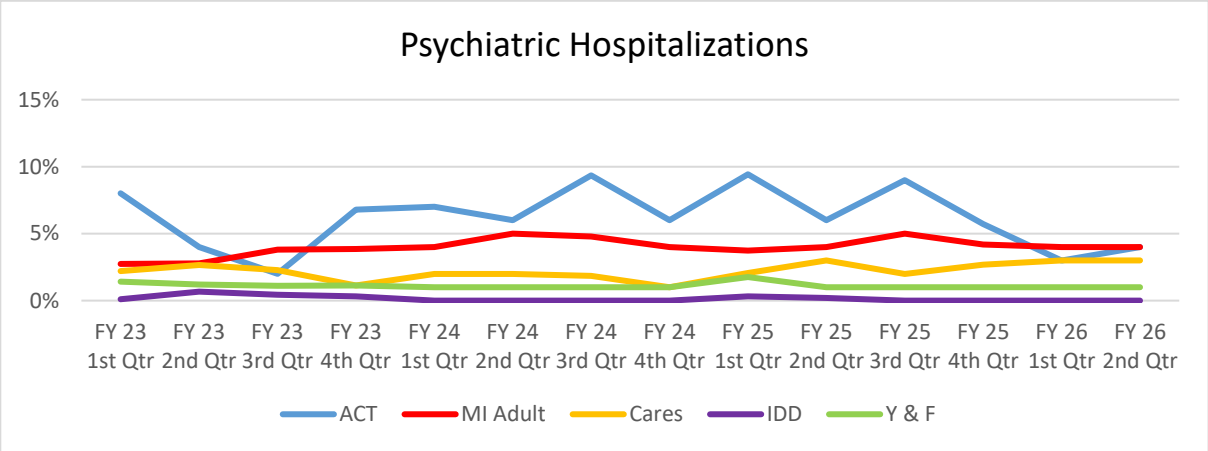


2nd Qtr Detail for ongoing appointment			
Month	**Eligible**	**Received ongoing appt**	**Percentage receiving ongoing appt**
Jan	**176**	**145**	**82%**
Feb	**180**	**159**	**88%**
Mar	**162**	**145**	**90%**
	518	**449**	**87%**

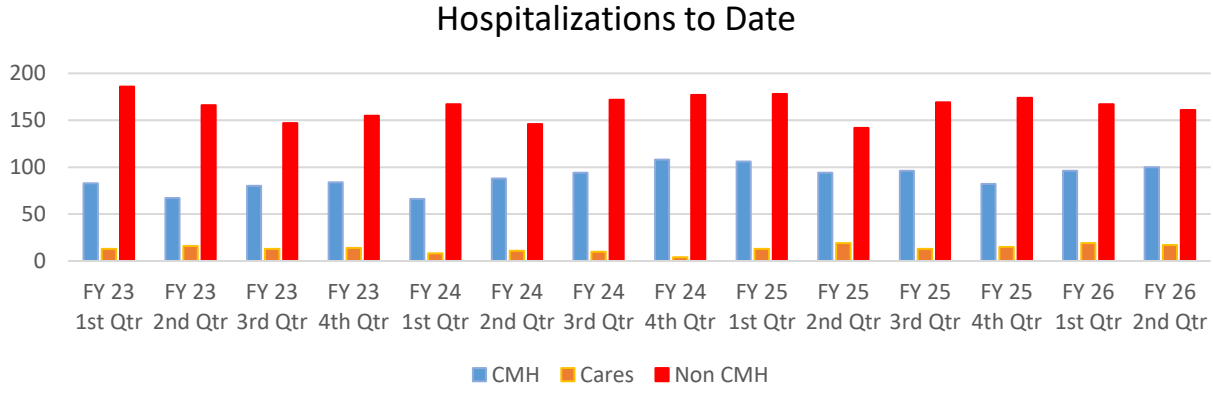


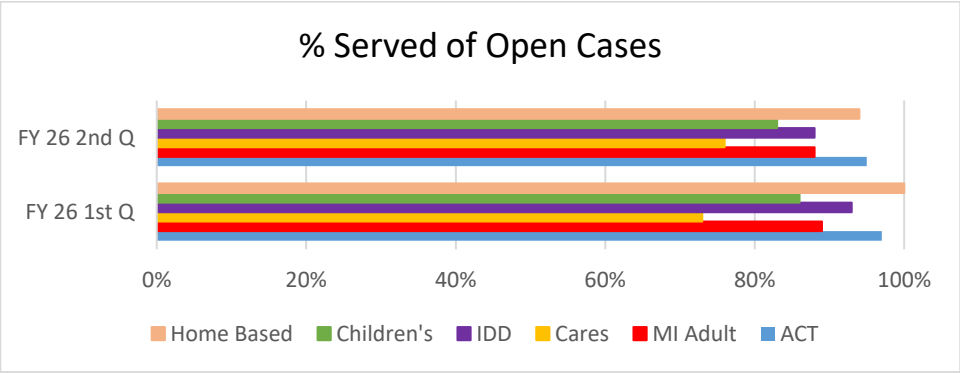
	FY 23 Qtr 1	FY 23 Qtr 2	FY 23 Qtr 3	FY 23 Qtr 4	FY 24 Qtr 1	FY 24 Qtr 2	FY 24 Qtr 3	FY 24 Qtr 4	FY 25 Qtr 1	FY 25 Qtr 2	FY 25 Qtr 4	FY 26 1st Qtr	FY 26 2nd Qtr
Blank	1	4	1	1	1	7	0	2	3	9	4	1	1
Partial Hospitalization	115	129	106	88	97	97	123	83	79	88	85	99	106
Outpatient/ Support Services	42	34	41	44	30	33	28	32	41	30	42	40	31
Inpatient Admission	281	277	266	246	270	250	284	263	294	246	292	265	273
Crisis Residential	10	15	16	19	19	22	22	21	21	19	24	19	17





FY 26 2nd Qtr Detail Hospitalizations			
Program	Number Served	Number Hospitalized (Multiple Admits)	% Consumers Hospitalized
ACT	105	4 (0)	4%
MI Adult	1843	63 (17)	4%
Cares	724	17 (3)	3%
IDD	1072	1 (0)	0%
Y & F	1275	11 (0)	1%





Critical Event Data Reported Thru Qtr 2 FY 2026

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, fall or medication error and involve iSPA, 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
1st Qtr	CARES	Non Suicide Death	1
	IDD	Non Suicide Death	7
		Emergency Medical Tx due to Fall	1
	MI Adult	Non Suicide Death	6
		Arrest	1
		Emergency Medical Tx due to Fall	1
Qtr 1 Total			17
Qtr 2	ACT	Non Suicide Death	1
	IDD	Non Suicide Death	10
		Emergency Med Tx due to fall	1
	CARES	Non-Suicide Death	1
	Crisis Team	Suicide	1
	MI Adult	Non Suicide Death	12
		Suicide Death	1
		Arrest	3
		Emergency Med Tx due to Injury	1
		Emergency Medical Treatment due to a Med Error	1
	Children's	Suicide	1
Qtr 2 Total			33

Mortality Data Thru Qtr 2 FY 2026

Cause of Death	Number of Deaths FY 22	Number of Deaths FY 23	Number of Deaths FY 24	Number of Deaths FY 25	Number of Deaths FY 26
Aspiration Pneumonia	3	4	1	1	
Cancer	3	8	2	7	4
Cardiovascular	12	10	20	11	6
Dehydration					
Diabetes					
Drug Abuse	6	10	5	6	2
Endocrine System (Diabetes)					
Environmental Hypothermia					
Fluid Electrolyte Disturbance		1			
Gastrointestinal		3	3	3	3
Hip Fracture Complications					
Homicide		3			
Hyponatremia	2				
Inanition				1	
Infection	4 (3 - COVID 19)		2	3	1
Kidney Disease		1	1	1	1
Liver Disease	1	1	1	1	
Metabolic					
Medication Toxicity				1	
Natural/Other					
Neurological	3	3	3	4	2
Respiratory	5	5	5	4	2
Suicide	2	6	1	3	3
Trauma	3	2	1		
Unknown	10	8	3	6	17
Grand Total	**54**	**65**	**48**	**52**	**41**

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

Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy and Procedure* *Medication Administration, Medication Storage & Other Medical Treatment*
Committee: **Clinical Performance Team**	**Local Policy Number (if used)**
Implementation Date	**Regional Approval Date**

Reviewed by:	**Recommendation Date:**
ROC	06/22/2026
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To establish regional guidelines regarding the administration of psychotropic and other medications, storage of medications, and medical treatment procedures for the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

II. REVISION HISTORY

DATE	MODIFICATION
02/04/2019	New regional policy
04/28/2023	Standard 3-year Review
Will be Regional Approval Date	Standard 3-year 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

Medication and medical treatments shall be administered only at the order of a physician, or a prescriber who is a medical professional with vested legal authority through professional licensing or certification to prescribe medications. ~~,~~ A provider will assure that medication use conforms to federal standards and the standards of the medical community.

V. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the Prepaid Inpatient Health Plan (PIHP) for Lenawee, Livingston, Monroe and Washtenaw for mental health, 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.

Delegated Prescribing Authority: When a licensed physician delegates the authority to prescribe medications and medical treatment procedures to a Nurse Practitioner, Clinical Nurse Specialist or Physician Assistant. The physician shall supervise the performance of this delegated function in accordance with the Michigan Public Health Code (1978 P.A. 368), including, but not limited to, Section 16109(2); 16215; 17076; 17210; 17708(2).

Medication Training Program: Training for the CMHPSM, CMHSPs, and contract provider staff on the standards for administering and maintaining medications. This training is conducted by a person qualified to train on this topic.

Medical Treatment Procedures: Treatment procedures that are ordered by a physician or prescriber with delegated prescribing authority prior to implementation by staff (e.g. hot wet soak to left foot). Exceptions include emergency situations where injury is apparent and first aid by trained individuals does not require orders from a physician or prescriber with delegated prescribing authority prior to initiation.

Medication: A drug or medical treatment prescribed by a physician or nurse practitioner, clinical nurse specialist or physician assistant with delegated prescribing authority for the therapeutic benefit of a patient.

Medication Administration: The provision of a prescribed and prepared dose of an identified medication to the individual for whom it was ordered to achieve its pharmacological effect. This includes directly introducing the medication into or onto the individual's body.

Medication Dispensing: Providing, furnishing, or otherwise making available a supply of medications to the individual for whom it was ordered or the individual's representative) by a licensed pharmacy according to a specific prescription or medication order, or by a licensed independent practitioner authorized by law to dispense. Dispensing does not involve providing a consumer/individual served with a dose of medication previously dispensed by the pharmacy.

Medication Order: A written direction provided by a prescribing practitioner for a specific medication to be administered to an individual. The prescribing practitioner may also give a medication order verbally to a **licensed person** such as a pharmacist or a nurse.

Examples of some different types of medication orders are:

- Copy of a written prescription
- Written order on a consultation form, signed by the practitioner
- Written list of medication orders, signed by the practitioner

- Copy of a pharmacy call-in order, given to you by the pharmacist
- A verbal order given to a licensed person
- Electronic prescriptions signed electronically via a secured system

Nurse Practitioner or Clinical Nurse Specialist: An individual licensed to practice as a registered nurse and certified in a nursing specialty by the State of Michigan.

Physician: An individual who is licensed to practice medicine or osteopathic medicine in the State of Michigan under article 15 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being sections 33.16101 to 333.18838 of the Michigan Compiled Laws. The "practice of medicine" means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical or mental condition, by attendance, advice, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts (MCL 333-1978-15-170).

Physician Assistant: An individual licensed to practice as a physician assistant by the State of Michigan.

Prescriber: A physician who is licensed to prescribe medications and medical treatment procedures, or nurse practitioner, clinical nurse specialist, or physician assistant with delegated prescribing authority who is licensed to prescribe medications and medical treatment procedures. A licensed physician may delegate the authority to prescribe medications to a nurse practitioner, clinical nurse specialist or physician assistant in accordance with the Michigan Public Health Code (1978 P.A. 368) Section 16109(2), 16215, 17076; 17210, 17708(2).

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.

Stop Order: An order by a physician or nurse practitioner, clinical nurse specialist, or physician assistant with delegated prescribing authority, to discontinue the administration of a medication or medical treatment procedure.

VI. STANDARDS

A. All licensed contract providers must:
   1. Adhere to licensing regulations related to the administration and management of medications.
   2. Follow all outlined responsibilities of the licensed setting as determined by the Individual Plan of Service.

B. Staff involved in providing medication administration or medical treatment-related services shall follow the standards in the Individual Plan of Service and/or any related documents.

C. Medication reviews should occur as specified in the Individual Plan of Service, or as required based on clinical status.

D. Staff administering medications must:

1. Satisfactorily complete a CMHPSM-approved medication training program that is provided by a qualified professional.
2. Demonstrate knowledge of the '5 rights' (correct dose, correct time, correct patient, correct route, correct order/medication/prescriber). expected actions, and side effects of medications administered.

E. Medication shall not be used as punishment, for the convenience of staff, or as a substitute for other appropriate treatment.

F. Any use of medication to solely address behavioral issues (and not as established practice for a physical or mental health condition) must be approved by the local CMHSP Behavior Treatment Plan Review Committee.

G. Current medication and medical treatment orders shall be maintained on-site.

H. The CMHSP is responsible for ensuring that medication reconciliation is done at least quarterly.

I. Controlled substances stored on-site will be documented on a controlled medication log and stored in a locked secured location.

J. The medication administration record must be updated whenever a medication is prescribed, changed, or discontinued, and should be signed or initialed by staff.

K. Discontinued, expired, recalled, or unused medications stored on the premises shall be destroyed according to the site procedure.

L. Any destroyed medications or medications returned to the pharmacy shall be documented on the Expired, Recalled or Discontinued Medication Inventory Sheet, and documented on an Incident Report if required in that county.

M. Staff will use at least two of the following identifiers whenever administering medication(s) or treatment(s):
   - Consumer/individual served photograph attached to the medication and treatment record or medication injection record.
   - Staff who knows the individual identifies the consumer/individual served.
   - Consumer/individual served states their name and staff compare the name to the medication and treatment record or medication injection record.
   - Consumer/individual served states their birth date and staff compare it to the medication and treatment record or medication injection record.

N. Each time a medication or medical treatment is administered, the administration shall be documented on the medication and treatment record and or the medication administration record (MAR).

O. Medication errors and adverse reactions must be:
   1. Reported immediately to the prescriber.
   2. Documented according to procedures for the completion of the medication and treatment record.
   3. Documented on an Incident Report.

4. Reviewed according to the CMHPSM Critical Incident, Sentinel Event, and Risk Event Policy if the medication error resulted in a medical emergency.

P. Medication errors that result in an adverse reaction will be reported according to the CMH's medication training.

Q. Only medications for which there is an active prescription shall be given to a consumer/individual served upon leave or discharge. Enough medication is to be made available to ensure the consumer/individual served has an adequate supply until the individual can become established with another provider, not to exceed a maximum supply of three (3) months.

R. If outlined in the Individual Plan of Service, a consumer/individual served may self-administer medication in a licensed contract provider setting or in an unlicensed setting where the consumer/individual served is receiving supports upon completion of an independent self-medication module. Staff will ensure the medications are safely stored and provide monitoring of an independent self-medication activity.

S. Medications that are stored at a CMH site or a licensed residential site shall be stored on the premises only to facilitate the delivery of services to consumer/individual served and shall be safeguarded as follows:
   - A "double-locked" system shall be employed, such as a locked medication box in a locked structure that is secured if the medication is classified as a controlled substance or is a reviewed and approved limitation documented in the record and IPOS of the individual/consumer served.
   - Keys to locked storage areas shall be available only to staff who are authorized to have access to medications.
   - The CMHSP will implement a process to record and review the medication inventory quarterly either through internal reviews or external provider audits, unless the CMHSP has an agreement with a pharmacy to do so.
   - If a consumer/individual served has received a recalled or discontinued medication, the consumer/individual served will be notified as soon as possible, and an Incident Report will be completed.
   - When a medication is recalled or discontinued outside of the standard inventory schedule, the consumer/individual served will be notified as soon as possible, and an Incident Report will be completed.
   - Medication requiring storage in a refrigerator is governed by the following standards for security, control and inspection.
   - Refrigerators used for medication storage shall be used exclusively for that purpose.
   - Refrigerated medications shall be secured in a locked container within the refrigerator, or the refrigerator shall be located in a locked medication room accessible only to authorized staff.
   - Medication refrigerator temperatures shall be maintained between 36°F and 46°F (2°C to 8°C). Any temperature excursion outside this range shall be documented immediately. Medication stability shall be verified with the manufacturer prior to use.
   - Temperature monitoring devices, including digital data loggers when utilized, shall be calibrated annually in accordance with NIST standards.

- Temperature monitoring shall be continuous, including weekends, holidays, and periods of facility closure, to ensure compliance with required temperature ranges.
- Automatic defrost cycles shall not result in temperatures outside the required range. Documentation shall be maintained to demonstrate compliance.
- A written procedure shall be followed for the disposal of medications compromised by temperature excursions.

T. Any consumer/individual served in their own home shall have medication administration or medication storage needs identified in the Individual Plan of Service.

U. All medication stored at CMH sites, or a licensed residential site must be in the original container which is labeled as follows:
- Name of recipient
- Name of prescriber
- Name of medication
- Strength of medication
- Dosage of medication
- Schedule of administration
- Dispensing pharmacy: lot number and expiration information.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	Check if applies:	Standard Numbers:
The Joint Commission	X	MM 03.01.01 4.10-5.20
MDHHS Administrative Rules	X	AR 7158;
MDHHS Policy	X	Psychotropic Medications, III-7158-R-GL
CMHPSM Training Policy	X	
CMHPSM Behavior Treatment Plan Review Committee Policy	X	
CMHPSM Critical Incident, Sentinel Event, and Risk Event Policy	X	
CMHPSM ORR Limitation of Rights Policy	X	

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy*** ***Credentialing for Licensed Independent Providers***
Department: **Network Management Committee**	**Local Policy Number (if used)**
Implementation Date	**Regional Approval Date**

Reviewed by:	**Recommendation Date:**
ROC	05/04/2026
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

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

II. REVISION HISTORY

DATE	MODIFICATION
03/2007	
10/2009	
08/2013	Revisions to PIHP language and modification to persons affected by this policy. Standards revised to align with current requirements.
10/2014	Updated regional entity language and made some EQR-related corrections.
05/2016	Revision based on updated standards from The Joint Commission.
07/2019	Scheduled Review
02/01/2021	Policy updates to meet EQR requirements and HSAG EQR review
08/25/2023	Policy updates to meet EQR requirements and HSAG EQR review
Will be Regional Approval Date	Policy updates to meet HSAG EQR findings from FY25 Compliance review

III. APPLICATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. Definitions

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

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

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

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

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

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

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

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

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

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

Peer Review: For the purposes of this policy, an assessment of the competence of an individual, performed by another individual of the same professional discipline, typically completed through reviewing clinical documentation and examples of the individual's work, against existing professional standards.

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

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

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

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

V. Policy

The CMHPSM ensures the following:

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

VI. STANDARDS

A. Delineation of CMHPSM and CMHSP Responsibilities

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

2. The CMHPSM will conduct the credentialing process for Licensed Independent Providers. This policy applies to professionals meeting the definitions under

section III.A who enter into a contract as an individual, not as an employee of an accredited provider organization.

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

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

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

B. Initial Credentialing Process

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

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

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

4. Credentialing of all LIPs will include verification of current competence by obtaining a written attestation by the applicant of their ability to perform the applicable duties and responsibilities and verified by at least two written peer recommendations from professionals of the same or equivalent discipline.

5. Collection, verification of credentialing information, and the retention of the completed file will be conducted by staff of the CMHPSM. A completed file for each applicant will contain:
   a. The start date (receipt of application) and the end date (when the credentialing/re-credentialing decision is sent to the applicant) is clearly documented.
   b. A standard timeframe of 90 calendar days for which verification or credentialing requirements is required, with the completion time calculated from receipt of a completed credentialing application and the end date being when the written communication is sent to the provider. If the timeframe is not met, the credentialing application will need to be declined with clear reasons as to what was not complete in the response to the provider.
   c. The individual or committee reviewing the provider includes reviewers with the same/similar credentials of that provider, especially for files considered adverse, including the names and credentials of the committee members/individuals who completed the review with either manual signatures on the review for or copies of email confirmation with the member's credentials saved in the file.
   d. A completed, signed, and dated credentialing application which includes attestation of:
      i. lack of current illegal drug use;
      ii. any history of loss of license and/or felony convictions;
      iii. any history of loss or limitations of privileges or disciplinary action;
      iv. correctness and completeness of the application;
      v. ability to perform duties and responsibilities.
   e. Verification of identity conducted by viewing a valid picture identification issued by a state or federal agency (e.g., driver's license or passport).
   f. Resume/curriculum vitae covering at least the last five years. Gaps in employment of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.
   g. Education – verification of highest degree awarded from an accredited school.
   h. Training – verification of residency completion and board certification (physician only).
   i. Licensure – verification of license/certification/registration including any actions against license/certification/registration.
   j. Sanctions/exclusions/restrictions – results of queries of Medicaid/Medicare sanctioned providers list; results of follow up on identified restrictions to clinical responsibilities/privileges; results of follow up on any disciplinary status with a regulatory board or agency; results of NPDB query for applicable disciplines.

k. Results of criminal background check and national and state sex offender registry checks.
l. Results of Child Abuse/Neglect Central Registry Check.
m. Minimum of two written peer recommendations of the same discipline or equivalent.
n. Professional liability insurance – verification of current & adequate coverage and history of professional liability claims resulting in a judgment or settlement.
o. Verification of Drug Enforcement Agency registration, and if applicable, controlled substance certificate. (Physicians, Physician Assistants, and Nurse Practitioners only)
p. Attestation and disclosure questions.
q. National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all the following with a minimum five-year review of:
    i. A minimum five-year history of professional liability claims resulting in a judgment or settlement.
    ii. A minimum five-year history that verifies the provider has no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgements within the last five years. Sources to very this would include the provider's attestation, criminal background checks w/convictions, licensure checks of misconduct, and checks with regulatory, accreditation, and professional organizations that would be involved in malpractice or misconduct investigations.
    iii. Disciplinary status with regulatory board or agency.
    iv. Medicare/Medicaid sanctions.
    v. Approval (or denial) of credentials by the credentialing committee or designee.
    vi. The initial credentialing and all subsequent recredentialing applications,
    vii. Information gained through PSV.
    viii. Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and recredentialing standards.
    ix. Screen shots of verification sources in each credentialing file including the date the verification was obtained
r. The Background Check Resource Guide required verification of a Drug Enforcement Administration (DEA) registration for physicians will be updated to ensure a DEA registration is verified for all prescribers including nurse practitioners (NPs) and physician assistances (PAs).
s. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association (AMA) or American Osteopathic Association (AOA) may be used to satisfy the primary source requirements of verifying: 1) the practitioner has a current and valid license or certification, 2) Board certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training., and 3) Official transcript of graduation from an accredited school and/or the Michigan Department of Licensing and Regulatory Affairs (LARA) license.

All verifications shall include the date the source was verified

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

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

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

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

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

C. Re-Credentialing

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

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

written notification of the appeal process. The LIP file will contain the appropriate documentation supporting the decision to deny re-credentialing of the LIP.

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

4. Collection, verification of re-credentialing information, and the retention of the completed file will be conducted by staff of the CMHPSM. A completed file for each applicant will contain:
   a. The start date (receipt of application) and the end date (when the re-credentialing decision is sent to the applicant) is clearly documented.
   b. A standard timeframe of 90 calendar days for which verification of re-credentialing requirements is required, with the completion time calculated from receipt of a completed re-credentialing application and the end date being when the written communication is sent to the provider. If the timeframe is not met, the re-credentialing application will need to be declined with clear reasons as to what was not complete in the response to the provider.
   c. The LIP Committee conducting the review includes reviewers with the same/similar credentials of that provider, especially for files considered adverse, including the names and credentials of the committee members/individuals who completed the review with either manual signatures on the review or copies of email confirmation with the member's credentials saved in the file.
   d. A completed, signed, and dated credentialing application which includes the LIP attestation of:
      i. lack of current illegal drug use;
      ii. any history of loss of license and/or felony convictions;
      iii. any history of loss or limitations of privileges or disciplinary action;
      iv. correctness and completeness of the application;
      v. ability to perform duties and responsibilities.
   e. Verification of identity conducted by viewing a valid picture identification issued by a state or federal agency (e.g., driver's license or passport).
   f. Resume/curriculum vitae covering at least the last five years.
   g. Education - verification of highest degree awarded from an accredited school.
   h. Training – verification of residency completion and board certification (physician only).
   i. Licensure – verification of license/certification/registration including any actions against license/certification/registration.

j. Sanctions/exclusions/restrictions – results of queries of Medicaid/Medicare sanctioned providers list; results of follow up on identified restrictions to clinical responsibilities/privileges; results of follow up on any disciplinary status with a regulatory board or agency; results of NPDB query for applicable disciplines.
k. Results of criminal background check, and national and state sex offender registry checks.
l. Results of Child Abuse/Neglect Central Registry Check.
m. Minimum of two written peer recommendations of the same discipline or equivalent.
n. Professional liability insurance – verification of current & adequate coverage and at least a five year history of professional liability claims resulting in a judgment or settlement.
o. Verification of Drug Enforcement Agency registration, and if applicable, controlled substance certificate. (Physicians, Physician Assistants, and Nurse Practitioners only)
p. Attestation and disclosure questions.
q. National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB) query **or, in lieu of the NPDB/HIPDB query, all the following**:
    i. A minimum five-year history of professional liability claims resulting in a judgment or settlement.
    ii. A minimum five-year history that verifies the provider has no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgements within the last five years. Sources to very this would include the provider's attestation, criminal background checks w/convictions, licensure checks of misconduct, and checks with regulatory, accreditation, and professional organizations that would be involved in malpractice or misconduct investigations.
    iii. Disciplinary status with regulatory board or agency.
    iv. Medicare/Medicaid sanctions.
    v. Approval (or denial) of credentials by the credentialing committee or designee.
    vi. The initial credentialing and all subsequent recredentialing applications,
    vii. Information gained through primary source verification PSV.
    viii. Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and recredentialing standards.
    ix. Screen shots of verification sources in each credentialing file including the date the verification was obtained.
r. The Background Check Resource Guide required verification of a Drug Enforcement Administration (DEA) registration for physicians to be updated to ensure a DEA registration is verified for all prescribers including nurse practitioners (NPs) and physician assistances (PAs).
s. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association (AMA) or American Osteopathic Association (AOA) may be used to satisfy the primary source requirements of verifying: 1) the practitioner has a current and valid license or certification, 2) Board certification, or highest level of credentials attained, if applicable, or completion of any required

internships/residency programs, or other postgraduate training., and 3) Official transcript of graduation from an accredited school and/or the Michigan Department of Licensing and Regulatory Affairs (LARA) license.

All verifications shall include the date the source was verified

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

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

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

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

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

10. The CMHPSM LIP Credentialing Committee will review the application and verify the information. A decision will be sent to the practitioner within 90 days of receipt of the applicant's completed recredentialing application, and prior to the LIPs credentialing expiration date. Based on this review, CMHPSM will advise the CMHSP Network Managers of the committee's decision to approve or deny the application, and for which populations if there is an approval.

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

D. Deemed Status

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

E. Temporary/Provisional Credentialing of Individual Practitioners

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

Temporary or provisional credentialing must not exceed 150 days.

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

1. A written application that is completed, signed, and dated by the individual practitioner and attests to the following elements:
   a. Lack of present illegal drug use.
   b. History of loss of license, registration, certification, and/or felony convictions.
   c. Any history of loss or limitation of privileges or disciplinary action.
   d. Attestation by the applicant of the correctness and completeness of the application.
2. An evaluation of the individual practitioner's work history for the prior five years. Gaps in employment of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.
3. Verification from primary sources of:
   a. Licensure or certification and in good standing.
   b. Board Certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training.
   c. Official transcript of graduation from an accredited school and/or LARA license.
   d. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, **in lieu of the NPDB/HIPDB query, all the following must be verified:**
      i. A minimum five-year history of professional liability claims resulting in a judgment or settlement.
      ii. A minimum five-year history that verifies the provider has no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgements within the last five years. **Sources to verify this would include:**
      iii. Disciplinary status with regulatory board or agency.
      iv. Medicare/Medicaid sanctions.
      v. Approval (or denial) of credentials by the credentialing committee or designee.
      vi. The initial credentialing and all subsequent recredentialing applications,
      vii. Information gained through primary source verification PSV.
      viii. Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and recredentialing standards.
      ix. Screen shots of verification sources in each credentialing file including the date the verification was obtained.
   e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association

or American Osteopathic Association may be used to satisfy the primary source requirements of verifying: 1) the practitioner has a current and valid license or certification, 2) Board certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training., and 3) Official transcript of graduation from an accredited school and/or the Michigan Department of Licensing and Regulatory Affairs (LARA) license.

All verifications shall include the date the source was verified

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

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

F. Additional Responsibilities of the CMHPSM LIP Credentialing Committee

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

1. Credentialing committee members shall sign off on a nondiscrimination attestation to demonstrate an understanding of nondiscriminatory practices in committee decisions; this attestation is required once for all decision-making members.
2. Make recommendations to the CMHPSM Network Management Committee regarding additions, deletions, or changes to the list of professions covered by this policy.
3. Review a LIP's documented performance between credentialing and re-credentialing time periods per the request of the CMHPSM and/or CMHSP. Make recommendations to the CMHSP whether to maintain credentialing status, withdraw, or deny credentialing status. If credentialing status is withdrawn, the CMHSP shall proceed with termination of the contract. The CMHPSM will provide notification to the LIP in writing of the recommendation and reason for the recommendation along with written notification of the appeal process.
4. Ensure members of the CMHPSM LIP Credentialing Committee have representation sufficient to review and make decisions regarding LIP credentialing and re-credentialing applications based on the professional discipline being reviewed.
5. Develop credentialing criteria and update these criteria, as needed. Criteria will be based on The Joint Commission standards, MDHHS, federal or other state requirements, and other relevant professional standards. CMHPSM & CMHSP approval for these criteria will be obtained as necessary.
6. Assist CMHPSM staff in creating provider applications and other forms or processes to assist in the implementation of this policy.

G. Reporting

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

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

H. Appeal Process for Licensed Independent Providers

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

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

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

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

5. The CMHPSM Chief Executive Officer/designee will schedule a hearing within 10 business days of the LIP's request for appeal. The CMHPSM Chief Executive Officer/designee will convene an appeal committee which may include: members of the CMHPSM LIP Credentialing Committee; another licensed independent

practitioner who has clinical responsibilities in the same discipline as the LIP requesting the hearing, clinical staff, board members, consumers/individuals served, and/or others based on their relevance to the nature of the appeal.

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

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

VII. Exhibits

None

VIII. References

A. 42 CFR Parts 400 and 438 et al. (Medicaid Managed Care Rules)
B. 42 CFR Parts 457.1233 and 42 CFR §457.1218
C. Public Law 109-171, Deficit Reduction Act of 2005,
D. Public Law 111 – 148: Patient Protection & Affordable Care Act of 2010
E. Public Law 111 – 152: Health Care & Education Reconciliation Act of 2010
F. 45 CFR Parts 160 & 164 (Health Information Portability and Accountability Act (HIPAA) and HITECH Act of 2010
G. 42 CFR Part 2 (Substance Abuse)
H. Michigan Mental Health Code Act 258 of 1974
I. The Joint Commission - Behavioral Health Standards
J. Michigan Department of Health and Human Services (MDHHS)-PIHP Medicaid Contract
K. Michigan Department of Health and Human Services (MDHHS)-CMHSP General Funds Contract
L. Michigan Medicaid Provider Manual
M. MDHHS Credentialing and Re-Credentialing Procedure
N. CMHPSM Organizational Credentialing/Recredentialing and Monitoring Policy
O. CMHPSM Employee Competency & Credentialing Policy

Community Mental Health Partnership of Southeast Michigan/PIHP	***Policy*** **Organizational Credentialing/Recredentialing and Monitoring**
Department: **Network Management**	**Local Policy Number (if used)**
Implementation Date	**Regional Approval Date**

Reviewed by:	**Recommendation Date:**
ROC	05/04/2026
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

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

II. REVISION HISTORY

DATE	MODIFICATION
01/25/2011	
11/30/2011	Updated to reflect local practice, changes in delegated functions, and new policy format
08/20/2013	Updated to comply with requirements for OIG exclusions VII.C. Procedures removed. Procedures will be available in the Provider Manual.
06/11/2014	Revised to reflect the new regional entity.
08/24/2018	Rewrite
02/01/2021	Policy updates to meet EQR requirements and HSAG EQR review
08/25/2023	Updates based on HSAG EQR Review corrective action plan
Will be Regional Approval Date	Policy updates to meet HSAG EQR findings from FY25 Compliance 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

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

V. DEFINITIONS

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

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

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

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

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

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

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

Substance Use Disorder Oversight Policy Board (OPB): Responsibilities for this board include planning for substance use disorder prevention and treatment services, as well as providing advice and consultation to the CMHPSM Board of Directors, the ROC, and the staff of the CMHPSM and the CMHSP partners.

VI. STANDARDS – The standards within this policy are organized into base categories, and more specific requirements for those categories based upon the payer-provider relationship that exists.

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

A. Base Requirements by Category

The following establishes base standards or definitions related to regional organizational credentialing, re-credentialing and monitoring.

1. **CMHPSM Payer/Provider Relationships** – A number of relationships are in place to meet the needs of the CMHPSM region related to behavioral health and/or substance use disorder service provision. The following relationships exist related to this policy:
   a) **PIHP Payer - CMHSP Relationship:** covers the credentialing, recredentialing, monitoring of a CMHSP by the PIHP as payer. The PIHP contracts with CMHSPs to provide mental health services within their respective geographic county.
   b) **CMHSP Payer - CMHPSM Mental Health Organizational Provider Relationship:** covers the credentialing, recredentialing, monitoring relationship of a potential or current behavioral health service provider and a CMHSP as payer. (Note: this policy only applies to organizational providers, Licensed Individual Practitioners (LIPs) should follow the Credentialing and Clinical Responsibilities of LIPs policy.)
   c) **PIHP Payer - SUD Core Provider Relationship:** covers the credentialing, re-credentialing and monitoring relationship of a potential or current SUD Core Provider and the PIHP as payer. The PIHP contracts with SUD Core Providers to provide substance use disorder services, and/or perform one or more functions as delegated by the PIHP.
   d) **SUD Core Provider Payer - SUD Organizational Provider Relationship:** covers the credentialing, recredentialing, monitoring relationship of a potential or current substance use disorder service provider and a SUD Core Provider as payer.
   e) **PIHP Payer - SUD Organizational Provider Relationship:** covers the credentialing, recredentialing, monitoring relationship of a potential or current substance use disorder service provider and the PIHP as payer.
   f) **PIHP Payer - Non-Federally Funded SUD Service Providers:** covers the credentialing, recredentialing, monitoring relationship of a potential or current substance use disorder service provider and the PIHP as payer, where only non-Federal funds are utilized.

2. **Provider Procurement**
   a) Payers this policy applies to (CMHPSM as PIHP Payer, CMHSP Payers or SUD Core Provider) will follow all federal, state and or local rules and regulations when entering into payer/provider relationships for services funded by or through the CMHPSM.
   b) All CMHPSM procurement requirements can be found in the CMHPSM Procurement, RFPs and Bid Review policy.

3. **Organizational Credentialing / Re-Credentialing Application**
   a) When required by the CMHPSM Payer / Provider Relationship standards within this policy the provider will complete and submit the Organizational Credentialing application. Organizational credentialing applications can be found on the CMHPSM website.

      (1) Mental Health Application: http://www.cmhpsm.org/provider-manual

(2) SUD Application: http://www.cmhpsm.org/sudserviceprovidermanual

4. Organizational Credentialing/Re-Credentialing File Management

a. Initial Credentialing Files

The timeframes for completion of the initial credentialing process will be no more than 90 days, for which verification or credentialing requirements is acceptable, with the completion time calculated from receipt of a completed credentialing application and the end date being when the written communication is sent to the provider. If the timeframe is not met, the initial credentialing application will need be declined with clear reasons as to what was not complete in the response to the provider and the steps to take in re-starting the application process.
Initial credentialing applications will be considered complete once the required application materials are received.

The decision to approve or deny an initial credentialing application will be made and the decision sent to the applicant by the 90th day of receiving a completed application.

An on-site review will be completed within this 90-day initial credentialing timeframe.

Verification of provider staff meeting federal and state requirements is a post initial credentialing activity and will be completed within 90 days of a completed contract.

All initial credentialing files will have the following information where applicable:

(1) The start date (receipt of a complete initial application) and the end date (when the credentialing decision is sent to the provider)
(2) The initial credentialing application.
(3) Attestation and disclosure questions.
(4) Review of any Medicare/Medicaid sanctions.
(5) License verification
(6) Screen shots of verification sources in each credentialing file
(7) Once the completed application is received, documentation that an on-site review was completed during the initial pre-contracting process when a provider is not accredited, or acceptance of an on-site review from CMS or licensing in lieu of an on-site review completed by the PIHP should that review align with the credentialing time frame and meet the PIHP's on-site review requirements.
(8) Confirmation that the results on the on-site review were considered when rendered a contracting decision.
(9) Documentation in credentialing files will clarify the scope of service included in the application.
(10) Identification of whether any of the above criteria would be waived based on the payer-provider relationship identified in Standard B of this policy.
(11) If the initial completed application notes the provider will have licensed staff rendering services, the PIHP/CMHSP will ensure, then prior to contracting with the provider that the provider has a credentialing process that meets MDHHS requirements. While the initial credentialing file will have this information, the review of the provider's credentialing process will take place post completed application yet prior to contracting with the provider.

b. Recredentialing Files

The timeframe for completion of the re-credentialing process will be no more than 90 calendar days for which verification or credentialing/re-credentialing requirements is required, with the acceptable completion time calculated from receipt of a completed credentialing application and the end date being when the written communication is sent to the provider. If the timeframe is not met, the credentialing/re-credentialing application will need to be declined with clear reasons as to what was not complete in the response to the provider, and the steps to take in re-starting the application process.

Re-credentialing applications will be considered complete once the required application materials are received.

The decision to approve or deny an initial credentialing application will be made and the decision sent to the applicant by the 90th day of receiving a completed application.

All re-credentialing files will have the following information where applicable:

(1) The start date (receipt of a complete application) and the end date (when the credentialing decision is sent to the provider)
(2) The initial credentialing and all subsequent recredentialing applications,
(3) A review of member grievances and appeal for that provider during the 3-year recredentialing cycle, including if there was no activity to review.
(4) Completed Disclosure of Ownership and Controlling Interesting Statement.
(5) Primary Source Verification of:
    i. LARA License
    ii. At least five-year history of organizational liability claims resulting in a judgement or settlement
    iii. Proof of Accreditation
    iv. On-Site Quality Assessment
    v. Disciplinary status with regulatory board or agency
    vi. Office of Inspector General Check of any Medicare/Medicaid exclusions/sanctions
    vii. MDHHS Sanctioned Provider Check of any Medicare/Medicaid exclusions/sanctions
    viii. SAM.gov Check of any Medicare/Medicaid exclusions/sanctions
(6) Screen shots of verification sources in each credentialing file.
(7) Evidence the provider was recredentialed within three years, any approved extensions.
(8) Quality Review of provider that includes the following data since the last credentialing completion date:
    i. Professional Liability
    ii. Commercial Liability
    iii. Workman's Compensation
    iv. Cyber Liability
    v. Facility Licenses
    vi. Service License
    vii. NPI Verification
    viii. G&A Database Information
    ix. Compliance F/W/A or other billing issues
    x. Customer Services Issues (Other than formal Grievances / Appeals

xi. Utilization Management Issues
xii. Incident/Event Reporting data

(9) Application was signed/dated no more than 180 days prior to credentialing committee review
(10) Primary/secondary source verification occurred no more than 6 months prior to credentialing committee review
(11) An on-site review was completed during the recredentialing process when a provider is not accredited, or acceptance of an on-site review from CMS, licensing, or another PIHP entity in the state, in lieu of an on-site review completed by the PIHP should that review align with the credentialing time frame and meet the PIHP's on-site review requirements.
(12) Confirmation that the results on the on-site review and quality review were considered when rendered a re-credentialing decision.
(13) Documentation in re-credentialing files will clarify the scope of service under each contract and whether licensed staff are providing services under that contract. Should licensed staff render services, the PIHP/CMHSP will ensure the provider has a credentialing process that meets the requirements under its contract with MDHHS.
(14) Identification of `whether any of the above criteria would be waived based on the payer-provider relationship identified in Standard B of this policy.

5. CMHPSM Regional Provider Network Statuses:

a. Credentialed In-Network Status: An organizational provider that has an approved current credentialed status as determined by the PIHP, CMHSP or SUD Core Provider. There is no requirement that a payer identified within this policy be mandated to enter into a contract with an organization that obtains credentialed or In-Network status. Organizations may be credentialed for future capacity or backup capacity. Contract relationships will be determined by the appropriate applicable payer.
b. Contracted In-Network Status: A credentialed organizational provider that is currently contracted with one or more of the following payers: PIHP, CMHSPs or SUD Core Providers.
c. Out of Network Contracted Status: In certain situations, the PIHP, CMHSPs or SUD Core Providers may determine it is necessary to contract with an entity that is unwilling, or unable to join the CMHPSM Provider Network. Examples include but are not limited to:
    1. Single Case Agreements;
        (a) Emergency Placements;
        (b) Limited Duration Placements;
        (c) Clinically determined placement for consumer/individual served with unique clinical need.
    2. Out of Region and Network
        (a) Specialty service not delivered within CMHPSM region for a limited number of consumers; (Providers located outside of the CMHPSM region geographically are not required to be In-Network with the CMHPSM, however these providers are encouraged to participate as CMHPSM In-Network or obtain CMHPSM credentialing status through a reciprocity relationship with another PIHP/CMHSP region.

6. **Deemed Status**
   The PIHP, CMHSP or SUD Core Provider may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where the CMHPSM LIP Committee chooses to accept the credentialing decision of another PIHP, the CMHPSM must maintain copies of the credentialing PIHPs decisions in the organizational provider's credentialing file.

7. **Organizational Monitoring**
   When required by the CMHPSM Payer / Provider Relationship the payer will monitor the provider as required by the standards within this policy. Once a contract is issued to an organization, the payer will monitor to ensure that the organization maintains the contractual agreement in good standing and complies with relevant local, state, and federal requirements.

8. **Medicaid Service Verification Policy**
   All providers delivering Medicaid funded services will follow all requirements outlined within the CMHPSM Medicaid Service Verification policy.

9. **Significant Change Notification**
   All payers and providers must follow the timeliness standards identified within this policy related to notifying the PIHP of any incidents, planned or unplanned changes that would impact the CMHPSM Provider Network capacity, so the PIHP can notify MDHHS (spell out or define) within the seven (7) day standard.

10. **Network Adequacy /Sufficiency**
    The PIHP and CMHSP will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the PIHP.

    The Regional Network Management Committee will assess the Regional Provider Network on an ongoing basis.

11. **Reciprocity**
    Payers will comply with all statewide reciprocity efforts as required by the PIHP/MDHHS service contract.

12. **Debarment**
    All payers/providers will follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

13. **Notification of Adverse Credentialing Decision**
    An organizational provider that is denied credentialing or recredentialing by the PIHP must be informed of the reasons for the adverse credentialing decision in writing by the PIHP within 30 days of the decision.

14. **Appeal Process for Organizational Providers**
    a. Organizational providers may appeal adverse CMHPSM credentialing decisions. Providers will be notified of their right to appeal adverse decisions, during initial credentialing and re-credentialing processes.

    b. Information relevant to an organizational provider's ability, suitability or appropriateness to fulfill CMHPSM's credentialing requirements will be considered

by the credentialing body during the initial credentialing and subsequent re-credentialing processes, and at any other time that such information comes to the attention of CMHPSM/CMHSP/SUD Core Provider. Additional information from the organizational provider or from other sources, when available, will be included for consideration. Criteria to terminate or deny credentialing may include:

i. Failure to maintain appropriate insurance as required by contract;
ii. Failure to maintain an active license and failure to inform the CMHPSM of any changes in licensure status, pending investigations relating to licensure or malpractice suits being filed;
iii. Falsifying information on initial or renewal application;
iv. Falsifying any documents submitted with the initial or renewal application;
v. Failure to abide by the terms of the contract;
vi. Illegal or fraudulent billing practices;
vii. Exclusion from participation in Federal health care programs;
viii. Clinical performance outside acceptable standards.

c. The organizational provider may request to appeal an adverse decision regarding credentialing by contacting the entity designee with which they have a contractual agreement within 10 business days of the date of the written notification. The appeal must be in writing and must specify the nature of the disagreement or the facts in dispute.

d. The CMHPSM/CMHSP/SUD Core Provider entity designee will schedule a hearing within 10 business days of the LIP's request for appeal. The designee will convene an appeal committee which may include network managers, clinical staff, board members, consumers, the CMHPSM, CMHSP regional partners, and/or others based on their relevance to the nature of the appeal.

e. The CMHPSM/CMHSP/SUD Core Provider designee will preside over the hearing. The agenda will include: a restatement of the adverse recommendation; an opportunity for the organizational provider requesting the appeal to present reasons why the adverse recommendation should be changed and to present any supporting information in oral and/or written form; and an opportunity for the appeal committee members to ask questions.

f. Following the hearing the CMHPSM/CMHSP/SUD Core Provider designee will consult with the appeal committee members, make a final decision about the appeal and notify the organizational provider in writing. A copy of all appeal documentation will be retained in the provider's CMHPSM credentialing file.

15. Reporting

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

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

B. Variable Standards

1. Payer / Provider Relationships Specific Standards
   a. PIHP Payer – CMHSP Relationship

1.	**Payer:**	CMHPSM as PIHP
	Provider:	CMHSP
2.	**Provider Procurement:**	N/A
3.	**Organizational Credentialing / Re-Credentialing Application Required:**	No application required, the CMHSP's MDHHS certification/re-certification status and CMHSP's National Accreditation status allow deemed status for this requirement.
4.	**Provider Network Status Participation:**	CMHSP is required to hold an In-Network CMHPSM Network Status. PIHP may only contract with fully credentialed In-Network CMHSPs.
5.	**Organizational Monitoring:**	CMHPSM/PIHP will monitor CMHSPs on a recurring two-year basis. Every two years the CMHSP will be monitored by the CMHPSM/PIHP through a Full CMHSP Review. A Full CMHSP Review includes a delegated function, clinical chart and CMHSP organizational responsibility review. If the CMHSP achieves a score of 95% or higher on the Full CMHSP Review, the PIHP in the following year will forego the Full CMHSP review and instead will conduct a corrective action verification and delegated function review.
6.	**Medicaid Service Verification:**	CMHSP will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7.	**Provider Network Significant Change Notification:**	CMHSP must immediately notify PIHP of any incidents, planned or unplanned changes that would impact the CMHSP's status within the CMHPSM region. The PIHP will notify MDHHS immediately when becoming aware of a CMHSP which becomes ineligible to participate in federal funding, or if the PIHP/CMHSP relationship is threatened for any reason.
8.	**Network Sufficiency**	The PIHP and CMHSP will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the PIHP.
9.	**Reciprocity**	N/A, the PIHP will not accept reciprocity arrangements for CMHSPs.
10.	**Debarment**	The PIHP and CMHSP must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

   b. CMHSP Payer – CMHPSM Mental Health Organizational Provider Relationship:

1.	**Payer:**	Regional CMHSP
	Provider:	Organizational Provider Delivering Behavioral Health Services within CMHPSM region.
2.	**Provider Procurement:**	Each CMHSP will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with Mental Health Service Providers.

3. Organizational Credentialing / Re-Credentialing Application Required:	All organizational providers delivering behavioral health services within the region will complete and submit an organizational credentialing application initially when applying to the network and at minimum once every three years thereafter to the CMHSP through the MDHHS Universal Credentialing CRM system. New organizational providers may be required by the CMHSP to submit additional credentialing application materials or information. Organizational providers may also be required to submit verification or supplemental documentation to support the credentialing/re-credentialing application. Organizational providers are only required to enter one file in the MDHHS UC CRM, and submit credentialing documentation to one entity to obtain regional CMHPSM network status. CMHSPs may require supplemental or additional credentialing information.
4. Provider Network Status Participation:	CMHSPs must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region's preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by CMHSPs to meet service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b. CMHSPs are not required to contract with every organizational provider that is regionally credentialed and considered In-Network within the CMHPSM Provider Network.
5. Organizational Monitoring:	Organizational providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the CMHSP on a biennial basis (once every two years.) Organizational providers that are contracted to one or more CMHSPs typically will receive reciprocal status from one CMHSPs review. CMHSPs may withhold the right to review each contracted organizational provider individually if it the CMHSP determines. Organizational providers that **do not** hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored annually by the CMHSP. In addition to administrative reviews the CMHSP will monitor a sample of service sites of both accredited and non-accredited organizational providers on an ongoing basis. Organizational providers delivering service at more than one location will have at least 25% of active service sites reviewed during a site review.
6. Medicaid Service Verification:	The CMHSP and Organizational Provider will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:	The CMHSP will notify the PIHP within three (3) business days of any incident or situation with a contracted provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a CMHSP, and seven (7) business days of the original incident or situation.
8. Network Adequacy	The CMHSP and Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.

9. Reciprocity	Organizational providers will be credentialed, re-credentialed, and monitored on a reciprocal basis within the CMHPSM region. Providers typically will not be required to submit multiple applications when affiliated with multiple CMHSPs, a single credentialing determination can be made by one CMHSP and provide in-network status for the entire region. CMHSPs reserve the right to conduct additional monitoring or require additional information from providers when the CMHSP determines it necessary. CMHSPs will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. CMHSPs reserve the right to conduct additional monitoring or require additional information from providers when the CMHSP determines it necessary.
10. Debarment	All In-Network and Out-of-Network Organizational Providers delivering mental health services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

c. PIHP – SUD Core Provider Relationship

1.	**Payer:**	PIHP
	Provider:	SUD Core Providers
2.	**Provider Procurement:**	The PIHP will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Core Providers.
3.	**Organizational Credentialing / Re-Credentialing Application Required:**	SUD Core Providers within the region will complete and submit an organizational credentialing application initially when applying to the network, at minimum once every two years to the PIHP thereafter.
4.	**Provider Network Status Participation:**	SUD Core Providers are required to hold an In-Network CMHPSM Network Status.
5.	**Organizational Monitoring:**	SUD Core Providers will be monitored on an annual basis by the PIHP.
6.	**Medicaid Service Verification:**	The PIHP and SUD Core Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7.	**Provider Network Significant Change Notification:**	The SUD Core Providers will notify the PIHP within three (3) business days of any incident or situation with a contracted provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a SUD Core Provider, and seven (7) business days of the original incident or situation.
8.	**Network Adequacy**	The PIHP and SUD Core Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.
9.	**Reciprocity**	N/A, the PIHP will not accept reciprocity arrangements for SUD Core Providers.
10.	**Debarment**	The PIHP and SUD Core Providers must meet all applicable CMHPSM Debarment and Exclusion Policy requirements.

d. SUD Core Provider- SUD Organizational Provider Relationship

1.	**Payer:**	SUD Core Provider
	Provider:	SUD Organizational Provider
2.	**Provider Procurement:**	Each SUD Core Provider will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Organizational Service Providers.
3.	**Organizational Credentialing / Re-Credentialing Application Required:**	All organizational providers delivering behavioral health services within the region will complete and submit an organizational credentialing application initially when applying to the network and at minimum once every three years thereafter to the CMHSP through the MDHHS Universal Credentialing CRM system. New organizational providers may be required by the CMHSP to submit additional credentialing application materials or information. Organizational providers may also be required to submit verification or supplemental documentation to support the credentialing/re-credentialing application. Organizational providers are only required to enter one file in the MDHHS UC CRM, and submit credentialing documentation to one entity to obtain regional CMHPSM network status. CMHSPs may require supplemental or additional credentialing information.
4.	**Provider Network Status Participation:**	SUD Core Providers must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region's preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by SUD Core Providers to meet service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b. SUD Core Providers are not required to contract with every organizational provider that is regionally credentialed and considered In-Network within the CMHPSM SUD Provider Network.
5.	**Organizational Monitoring:**	SUD Organizational Service Providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the SUD Core Provider on a biennial basis (once every two years.) Organizations that are contracted to one or more SUD Core Providers typically will receive reciprocal status from one SUD Core Provider's review. SUD Core Providers withhold the right to review each contracted provider organization individually as determined by the SUD Core Provider.
6.	**Medicaid Service Verification:**	The SUD Core Provider and SUD Organizational Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7.	**Provider Network Significant Change Notification:**	The SUD Core Provider will notify the PIHP within three (3) business days of any incident or situation with a contracted SUD provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a SUD Core Provider, and within seven (7) business days of the original incident or situation.
8.	**Network Adequacy**	The SUD Core Provider and SUD Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.

9. Reciprocity	Organizational providers will be credentialed, re-credentialed, and monitored on a reciprocal basis within the CMHPSM region. Providers typically will not be required to submit multiple applications when affiliated with multiple SUD Core Providers, a single credentialing determination can be made by one SUD Core Provider and provide in-network status for the entire region. SUD Core Providers reserve the right to conduct additional monitoring or require additional information from providers when the SUD Core Provider determines it necessary. SUD Core Providers will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. SUD Core Providers reserve the right to conduct additional monitoring or require additional information from providers when the SUD Core Provider determines it necessary.
10. Debarment	The SUD Core Provider and all SUD Organizational Providers delivering SUD services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

e. PIHP - SUD Organizational Provider Relationship:

1.	**Payer:**	PIHP
	Provider:	SUD Organizational Provider
2.	**Provider Procurement:**	The PIHP will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Organizational Providers.
3.	**Organizational Credentialing / Re-Credentialing Application Required:**	SUD Organizational Providers within the region will complete and submit an organizational credentialing application initially when applying to the network at minimum once every three years thereafter to the PIHP through the MDHHS Universal Credentialing CRM system.
4.	**Provider Network Status Participation:**	The PIHP must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region's preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by the PIHP to meet SUD service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b.
5.	**Organizational Monitoring:**	SUD Organizational Service Providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the PIHP on a biennial basis (once every two years.)
6.	**Medicaid Service Verification:**	The PIHP and SUD Organizational Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7.	**Provider Network Significant Change Notification:**	The PIHP will notify MDHHS within seven (7) business days of any incident or situation involving a SUD Organizational Provider which would induce a significant change on the regional provider network.
8.	**Network Sufficiency**	The SUD Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.

9. Reciprocity	The PIHP will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. The PIHP reserves the right to conduct additional monitoring or require additional information from providers when determined to be necessary.
10. Debarment	All In-Network and Out-of-Network Organizational Providers delivering SUD services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

f. PIHP – Non-Federally Funded SUD Service Provider.

1.	**Payer:**	PIHP
	Provider:	Non-Federally Funded SUD Service Provider
2.	**Provider Procurement:**	The PIHP will follow the CMHPSM PA2 Procurement for non-federally funded SUD service provider procurement to ensure the fair and efficient utilization of local and state tax dollars.
3.	**Organizational Credentialing / Re-Credentialing Application Required:**	N/A
4.	**Provider Network Status Participation:**	N/A
5.	**Organizational Monitoring:**	The PIHP will determine all necessary organizational monitoring requirements for non-federally funded SUD service providers.
6.	**Medicaid Service Verification:**	N/A
7.	**Provider Network Significant Change Notification:**	N/A
8.	**Network Sufficiency**	N/A
9.	**Reciprocity**	N/A
10.	**Debarment**	N/A

VII. EXHIBITS

None

VIII. REFERENCES

A. 42 CFR Parts 400 and 438 et al. (Medicaid Managed Care Rules)
B. 42 CFR Parts 457.1233
C. Public Law 109 – 171, Deficit Reduction Act of 2005,
D. Public Law 111 – 148: Patient Protection & Affordable Care Act of 2010
E. Public Law 111 – 152: Health Care & Education Reconciliation Act of 2010
F. 45 CFR Parts 160 & 164 (Health Information Portability and Accountability Act (HIPAA) and HITECH Act of 2010
G. 42 CFR Part 2 (Substance Abuse)
H. Michigan Mental Health Code Act 258 of 1974

I. The Joint Commission - Behavioral Health Standards
J. Michigan Department of Health and Human Services (MDHHS)-PIHP Medicaid Contract
K. Michigan Department of Health and Human Services (MDHHS)-CMHSP General Funds Contract
L. Michigan Medicaid Provider Manual
M. MDHHS Credentialing and Re-Credentialing Procedure
N. CMHPSM Credentialing and Competency for Licensed Independent Providers
O. CMHPSM Employee Competency & Credentialing Policy

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN/PIHP	*Policy and Procedure* Employee Competency & Credentialing Policy
Committee/Department: **Network Management Committee**	**Local Policy Number (if used)**
Implementation Date	**Regional Approval Date**

Reviewed by:	**Recommendation Date:**
ROC	05/04/2026
CMH Board:	**Approval Date:**
Lenawee	
Livingston	
Monroe	
Washtenaw	

I. PURPOSE

To ensure that staff competencies are at a high level through ongoing assessment of their capacity to provide safe, effective, high-quality mental health and substance use disorder (SUD) care to Community Mental Health Partnership of Southeast Michigan (CMHPSM) consumers/individuals served.

II. REVISION HISTORY

DATE	MODIFICATION
2014	Revised to reflect the new regional entity.
10/27/2021	3-year review
09/27/2023	Revisions related to state credentialing reporting requirements HSAG EQR FY22 CAP
Will be Regional Approval Date	Revisions related to HSAG EQR FY25 CAP

III. APPLICATION

This policy applies to the individuals or groups identified with a checkmark in the table below.

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

IV. POLICY

All employees will be competent to perform the responsibilities and duties assigned to them.

V. DEFINITIONS

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

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

Competence: The knowledge, skills, and abilities a person possesses to perform tasks correctly and effectively.

Credentials Review: The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide the mental health services based on established criteria.

Integrated Care: Bringing together inputs, delivery, management, and organization of services related to diagnosis, treatment, care, rehabilitation, and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency (World Health Organization).

Primary Source Verification: The source from which the applicant obtained written documentation of licensure, education, or other qualifications. Primary source includes federal and state licensing boards, letters from professional schools and letters from postgraduate education or postdoctoral programs for completion of training or designated equivalent sources.

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

VI. STANDARDS

A. Competence shall be assessed at time of hire and at least annually.

B. Credentials for staff required to have state licensure or certification in order to provide clinical services will be reviewed at time of hire and at least every three years per MDHHS credentialing requirements. (see Standard H. Reporting Requirements)

C. Credentialing and re-credentialing reviews for which verification or credentialing requirements are required shall be completed no later than 90 calendar days, with the completion time calculated from receipt of a completed credentialing application and the end date being when the written communication is sent to the staff or confirmed in staff files. If the timeframe is not met, the credentialing application will need to be declined with clear reasons as to what was not complete in the response to the provider. If the CMHSP/SUD Core provider's internal processes require

completion of the application process in less than 90 days, this internal timeframe would apply.

D. The CMHSP/SUD Core Service Provider shall have a process to assign clinical responsibilities that includes review of licensure, certification, and/or registration.

E. The CMHSP/SUD Core Service Provider shall establish program/service-specific criteria for each clinical responsibility. These criteria include the following:
- Current licensure and/or certification as appropriate, verified with the primary source
- Successful completion of required training
- Peer or faculty recommendation
- Evidence of the ability to perform the assigned clinical responsibilities

F. Initial Reviews of Competency and Credentialing

1. Before assigning initial clinical responsibilities, the CMHSP/SUD Core Service Provider shall verify the identity of staff seeking clinical responsibilities by viewing a valid picture identification issued by a state or federal agency (for example, a driver's license or passport).
2. Initial competencies will be verified during the hiring process, via interviews, review of education, and the orientation process. Training needs will be identified as applicable to the staff role.
3. Before assigning initial clinical responsibilities for employees whose jobs require state licensure/certification/registration, the CMHSP/SUD Core Service Provider shall:
   - Use primary sources when documenting the training specific to the clinical responsibilities requested.
   - For all employees whose jobs require a baccalaureate degree or higher, confirmation of degree will be obtained and verified from the primary source at the initial review as part of the hiring process.
   - Verify and maintain documentation that professional prescribers directly employed by CMHSPs have active DEA registration.
   - Verify and maintain documentation prescribers directly employed by CMHSPs have current Board Certification or Board Eligibility.
   - The Background Check Resource Guide required verification of a Drug Enforcement Administration (DEA) registration for physicians to be updated to ensure a DEA registration is verified for all prescribers including nurse practitioners (NPs) and physician assistances (PAs).
   - If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association (AMA) or American Osteopathic Association (AOA) may be used to satisfy the primary source requirements of verifying: 1) the practitioner has a current and valid license or certification, 2) Board certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training, and 3) Official transcript of graduation from an accredited school and/or the Michigan Department of Licensing and Regulatory Affairs (LARA) license.
   - Assure staff being reviewed for clinical competencies do not have issues with licensure, certification, sanctions, or criminal activity that would affect their ability to perform their clinical responsibilities. This includes:

- State of Michigan criminal background check
- National and state sex offender registry background checks
- DHS Central Registry Clearance including l. Results of Child Abuse/Neglect Central Registry Check
- Michigan Medicaid Sanctioned Provider check per the CMHPSM Debarment, Suspension and Exclusion Policy
- OIG/HHS Sanctioned Provider check per the CMHPSM Debarment, Suspension and Exclusion Policy
- NPI Registry Provider verification
- For renewed reviews, verification in the last two years of:
  a. Lack of present illegal drug use,
  b. No history of loss of license and/or felony convictions,
  c. No history of loss or limitation of licensing/certification privileges or disciplinary action,

- Queries the National Practitioner Data Bank (NPDB), or a review that meets NPBD standards, at the time of initial assigning of clinical responsibilities, as well as at least every two years thereafter for information on licensed professional staff who are assigned clinical responsibilities.
- If the CMHSP/SUD Core Service Provider does not use the NPBD system, in lieu of the NPDB/HIPDB query, all of the following must be completed and documented with a minimum five-year history review of:
  - History of professional liability claims resulting in a judgment or settlement.
  - Verification the staff has no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgements within the last five years. Sources to very this would include the provider's attestation, criminal background checks w/convictions, licensure checks of misconduct, and checks with regulatory, accreditation, and professional organizations that would be involved in malpractice or misconduct investigations.
  - Professional liability claims resulting in a judgment or settlement; (this can include an attestation)
  - Disciplinary status with regulatory board or agency; (license/accreditation review, with screenshot included) and
  - Any Medicare/Medicaid sanctions per the debarment review done by PIHP (with screenshots included)

The CMHSP/SUD Core provider shall ensure copies/screen shots of verification sources are maintained in each credentialing file including the date the verification was obtained.

G. Ongoing Review of Staff Credentials/Competencies

1. The CMHSP/SUD Core Service Provider shall ensure that staff with the educational background, experience, or knowledge related to the skills being reviewed are assessed for competence.
2. Employees shall receive supervision, including clinical supervision as appropriate to their position, on a regular basis.
3. Supervisors shall assess the competency of employees through supervision, observation, and performance evaluation. Performance evaluations for clinical staff who are supervised by another discipline will include peer review by their own discipline.

4. On-going competencies will be monitored through supervision and documented on annual performance evaluations.
5. Clinical staff competencies will be documented on the Employee Competencies Checklist (Exhibit A).
6. Nonclinical staff competencies will be documented through performance evaluations based on employee job descriptions.
7. All employees are expected to display cultural sensitivity and awareness of the role of culture in the delivery of services.
8. All employees are expected to have competence in integrated healthcare.
9. All employees are expected to have competence in applicable principles and practices of recovery and recovery-oriented systems of care.
10. All employees are expected to meet the applicable provider requirements of the Medicaid Provider Manual and MDHHS provider qualifications.
11. Programs which employ the use of glucometer, breathalyzer or other waived tests will ensure and document employee competency on those tests during orientation and annual performance reviews.
12. Before assigning renewed, or revised clinical responsibilities for employees whose jobs require state licensure/certification/registration, the CMHSP/SUD Core Service Provider shall ensure the following occurs:
    - Reviews information from any of the organization's performance improvement activities pertaining to professional performance, judgment, and clinical or technical skills.
    - Evaluates the results of any peer review of the individual's clinical performance.
    - Reviews any clinical performance in the organization that is outside acceptable standards.
    - Evaluates the staff member's written statement that no health problems exist that could affect his or her ability to perform the requested clinical responsibilities, including consideration of the applicability of the Americans with Disabilities Act and/or the Rehabilitation Act of 1974.
    - Results of criminal background check, and national and state sex offender registry checks.
    - Results of Child Abuse/Neglect Central Registry Check.
    - Evaluates any challenges to licensure or registration.
    - Evaluates any voluntary and involuntary relinquishment of license or registration.
    - Evaluates any voluntary or involuntary limitation, reduction, or loss of clinical responsibilities.
    - Evaluates any professional liability actions that resulted in a final judgment against the staff member.
    - Queries the National Practitioner Data Bank (NPDB), or a review that meets NPBD standards, at the time of initial assigning of clinical responsibilities, as well as at least every two years thereafter for information on licensed professional staff who are assigned clinical responsibilities.
    - If the CMHSP/SUD Core Service Provider does not use the NPBD system, in lieu of the NPDB/HIPDB query, all of the following must be completed and documented with a minimum five-year history review of:
        - History of professional liability claims resulting in a judgment or settlement.

  - Verification the staff has no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements, and/or judgements within the last five years. Sources to very this would include the provider's attestation, criminal background checks w/convictions, licensure checks of misconduct, and checks with regulatory, accreditation, and professional organizations that would be involved in malpractice or misconduct investigations.
  - Professional liability claims resulting in a judgment or settlement; (this can include an attestation)
  - Disciplinary status with regulatory board or agency; (license/accreditation review, with screenshot included) and
  - Any Medicare/Medicaid sanctions per the debarment review done by PIHP (with screenshots included)
- Verify and maintain documentation prescribers directly employed by CMHSPs have current Board Certification or Board Eligibility.
- The Background Check Resource Guide required verification of a Drug Enforcement Administration (DEA) registration for physicians to be updated to ensure a DEA registration is verified for all prescribers including nurse practitioners (NPs) and physician assistances (PAs).
- If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association (AMA) or American Osteopathic Association (AOA) may be used to satisfy the primary source requirements of verifying: 1) the practitioner has a current and valid license or certification, 2) Board certification, or highest level of credentials attained, if applicable, or completion of any required internships/residency programs, or other postgraduate training., and 3) Official transcript of graduation from an accredited school and/or the Michigan Department of Licensing and Regulatory Affairs (LARA) license.
- The CMHSP/SUD Core provider shall ensure copies/screen shots of primary verification sources are maintained in each credentialing file including the date the verification was obtained.
- Evaluates whether the requested clinical responsibilities are consistent with the population(s) served by the organization.
- Evaluates whether the requested clinical responsibilities are consistent with the program or site-specific care, treatment, or services provided.
- Confirms the staff has completed required training since the last review.
- Confirms the staff's adherence to organization policies, procedures, rules, and regulations.

H. Reporting Requirements

CMHSPs will ensure credentialing of staff is completed/maintained in the MDHHS Universal Credentialing CRM per MDHHS requirements, and that credentialing data is reported to CMHPSM where required by MDHHS for the following directly hired staff:

- Staff newly hired who are required to have professional licensure/certification to perform clinical services.
- Review of current staff every three years who are required to have professional licensure/certification to perform clinical services.

Note: the state requires review and reporting of CMH professional staff every three years regardless of expiration/renewal dates of their state licensure/certification.

VII. EXHIBITS

A. Employee Competency Checklist

VIII. REFERENCES

A. 42 CFR Parts 400 and 438 et al. (Medicaid Managed Care Rules)
B. 42 CFR Parts 457.1233 and 42 CFR §457.1218
C. Public Law 109-171, Deficit Reduction Act of 2005
D. Public Law 111 – 148: Patient Protection & Affordable Care Act of 2010
E. Public Law 111 – 152: Health Care & Education Reconciliation Act of 2010
F. 45 CFR Parts 160 & 164 (Health Information Portability and Accountability Act (HIPAA) and HITECH Act of 2010
G. 42 CFR Part 2 (Substance Abuse)
H. Michigan Mental Health Code Act 258 of 1974
I. The Joint Commission - Behavioral Health Standards
J. Michigan Department of Health and Human Services (MDHHS)-PIHP Medicaid Contract
K. Michigan Department of Health and Human Services (MDHHS)-CMHSP General Funds Contract
L. Michigan Medicaid Provider Manual
M. MDHHS Credentialing and Re-Credentialing Procedure
N. CMHPSM Organizational Credentialing/Recredentialing and Monitoring Policy
O. CMHPSM Employee Competency & Credentialing Policy

EXHIBIT A

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Employee Name: _____Date: _____

Part I – Population-Specific Competencies

□ 1. Children with intellectual/developmental disability

Demonstration of knowledge of the following:

- □ Childhood & adolescent development
- □ Specific conditions/syndromes associated with intellectual/developmental disabilities
- □ Resources and supports available to persons with intellectual/developmental disabilities & families
- □ Principles of Person-Centered Planning/Family-Centered Planning
- □ Special education/school system
- □ Integrated Healthcare

□ 2. Adults with intellectual/developmental disability

Demonstration of knowledge of the following:

- □ Human development across the lifespan
- □ Specific conditions/syndromes associated with intellectual/developmental disabilities
- □ Resources and supports available to persons with intellectual/developmental disabilities & families
- □ Principles of Person-Centered Planning
- □ Special education/school system
- □ Integrated Healthcare

□ 3. Children with serious emotional disturbance

Demonstration of knowledge of the following:

- □ Childhood & adolescent development
- □ Emotional disorders/mental illnesses of childhood & adolescence
- □ Family Dynamics
- □ Parenting skills/strategies
- □ Human service system for children (Court, Schools, Spec. Ed., Child Welfare, etc.)
- □ Principles of Person-Centered Planning/Family-Centered Planning
- □ Stages of change
- □ Motivational Interviewing
- □ Integrated Healthcare

□ 4. Adults with serious & persistent mental illness

Demonstration of knowledge of the following:

- □ Signs & symptoms of major mental illness
- □ Acute symptoms of mental illness
- □ Medications used to treat symptoms of mental illness & common side effects

- □ Supports/resources available in the community for persons with SPMI & their families
- □ Principles of Person-Centered Planning & Recovery Model
- □ Stages of change
- □ Motivational Interviewing
- □ Integrated Healthcare

□ 5. Older adults with serious & persistent mental illness

Demonstration of knowledge of the following:

- □ Mental illness unique to the elderly population
- □ Special needs of the elderly
- □ Medication issues/concerns unique to older adults with SPMI
- □ Community resources available to older adults with SPMI & their families
- □ Principles of Person-Centered Planning & Recovery Model
- □ Stages of change
- □ Motivational Interviewing
- □ Integrated Healthcare

□ 6. Co-Occurring Disorders: mental illness and substance abuse

Demonstration of knowledge of the following:

- □ Theories of addiction and recovery
- □ Stages of change
- □ Motivational Interviewing
- □ Signs & symptoms of substance abuse
- □ Signs & symptoms of major mental illness
- □ Issues unique to co-occurring mental illness & substance abuse
- □ Medication used to treat mental illness, side effects, interaction with street drugs/alcohol
- □ Community resources & supports available to persons with mental illness & substance abuse and their families
- □ Integrated Healthcare

Part II – Competencies Needed to Deny, Reduce, Suspend or Terminate Services

□ Emergency Services (Inpatient, Crisis Residential and Partial Hospital) for the following populations:

□ DD-C	□ DD-A	□ SED	□ MI-A	□ MI-OA	□ Co-Occ	□ Sub. Ab

Demonstration of knowledge of the following:

- □ Evaluation of Mental Health Service Needs
- □ Evaluation of Substance Abuse Service Needs
- □ Treatment Planning Process (Crisis Planning, Diversion Planning)
- □ Service Authorization Process
- □ Service Eligibility Criteria
- □ CMH and Community Services, Supports and Other Resources
- □ Treatment (Crisis Intervention, Inpatient, Crisis Residential, Other Alternative Services)

□ Non-Emergency Services (all other) for the following populations:

□ DD-C	□ DD-A	□ SED	□ MI-A	□ MI-OA	□ Co-Occ	□ Sub. Ab

Demonstration of knowledge of the following:

- □ Evaluation of Mental Health Service Needs
- □ Evaluation of Substance Abuse Service Needs
- □ Treatment Planning Process
- □ Service Authorization Process
- □ Service Eligibility Criteria
- □ CMH and Community Services, Supports and Other Resources
- □ Treatment

Part III – Competency Assessment Methods

□ After-Hire	**□ New-Hire**
□ Annual Staff Evaluation	□ Resume
□ Clinical Case Record Review	□ Primary Source
□ Peer Review	□ Interview Results
□ Observation	□ Reference Check
□ Supervision Discussions	□ Other: _____
□ Consultation with other supervisors/directors	□ Consumer/Individual Served Feedback

Part IV – Training Needs & Plan

_____

_____

_____

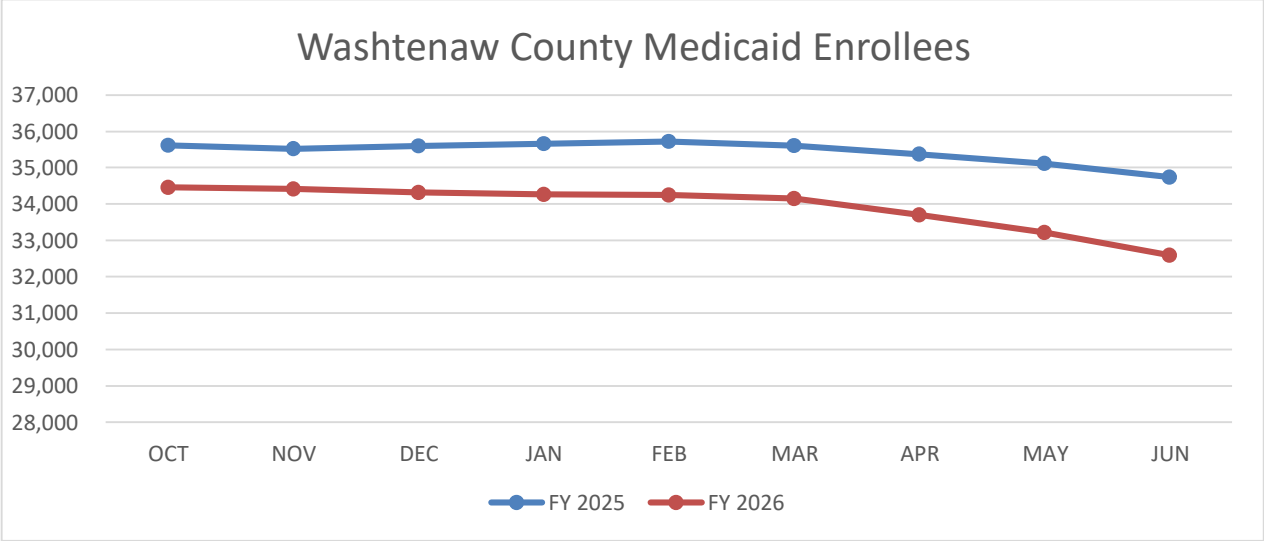
_____ _____
Supervisor's signature Date

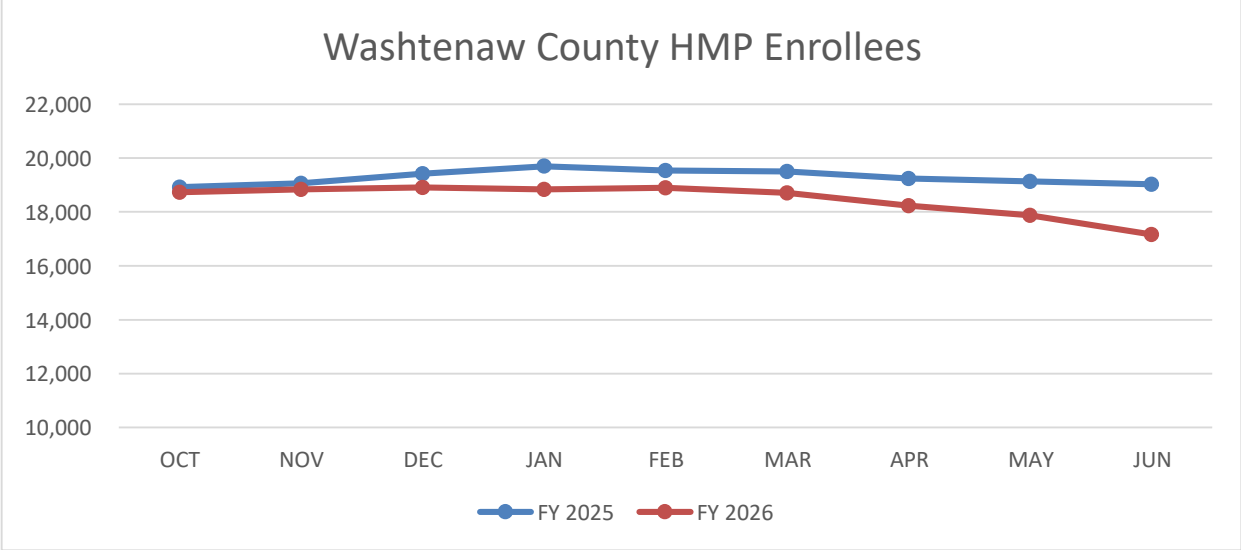
_____ _____
Employee's signature Date

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
YEAR-TO-DATE FINANCIAL STATUS
FISCAL YEAR 2026: For the period ending June 30, 2026
Prepared: August 2, 2026

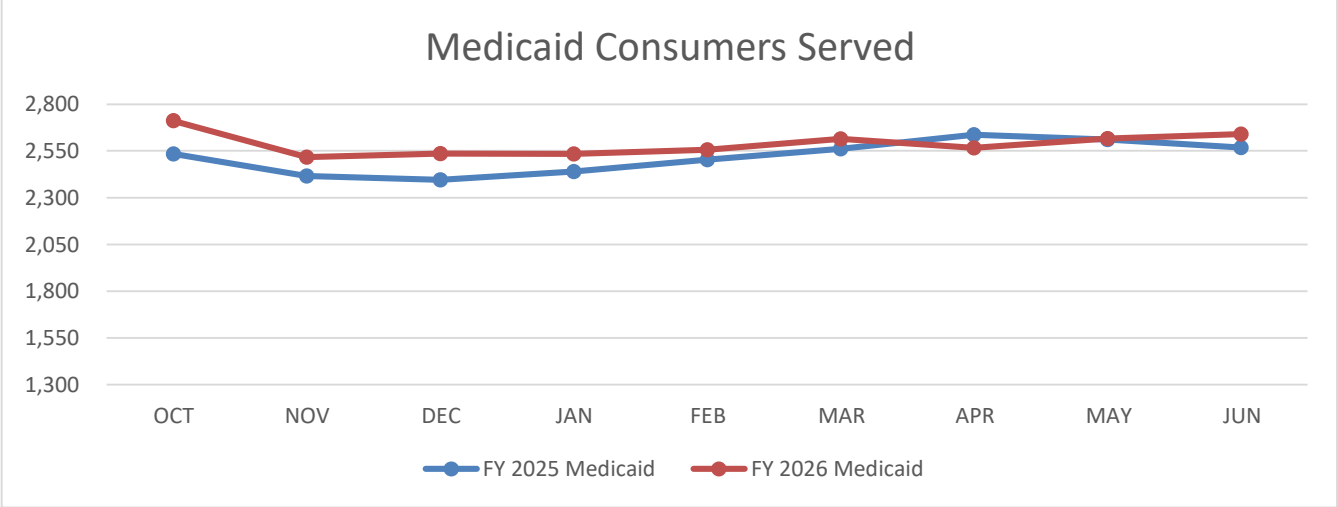
1. Washtenaw County Enrollees

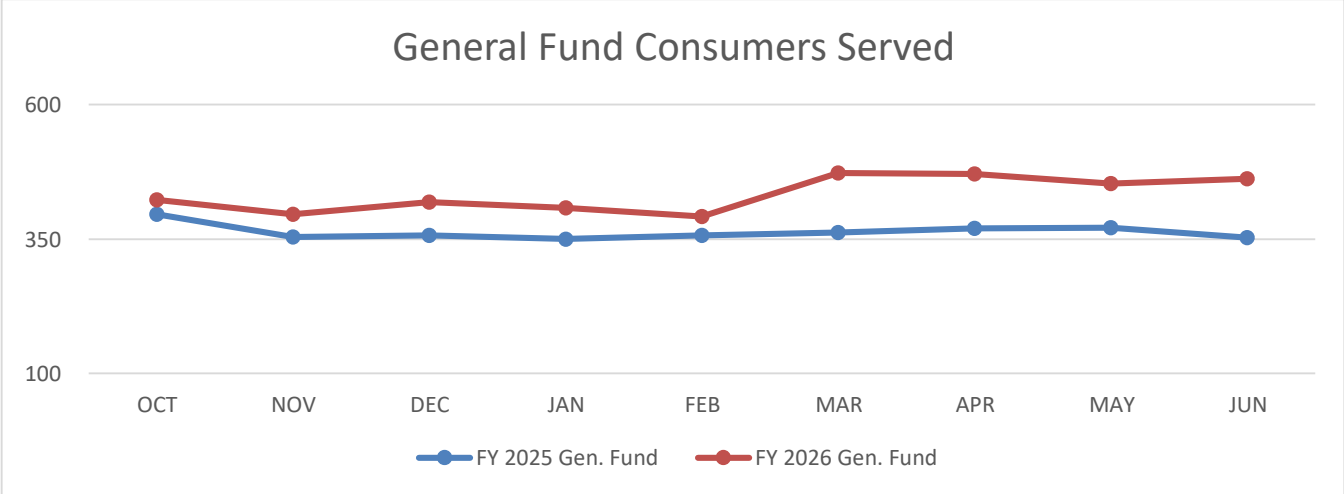
A summary of FY 2026 Washtenaw County Medicaid and Healthy Michigan Enrollees is shown below:



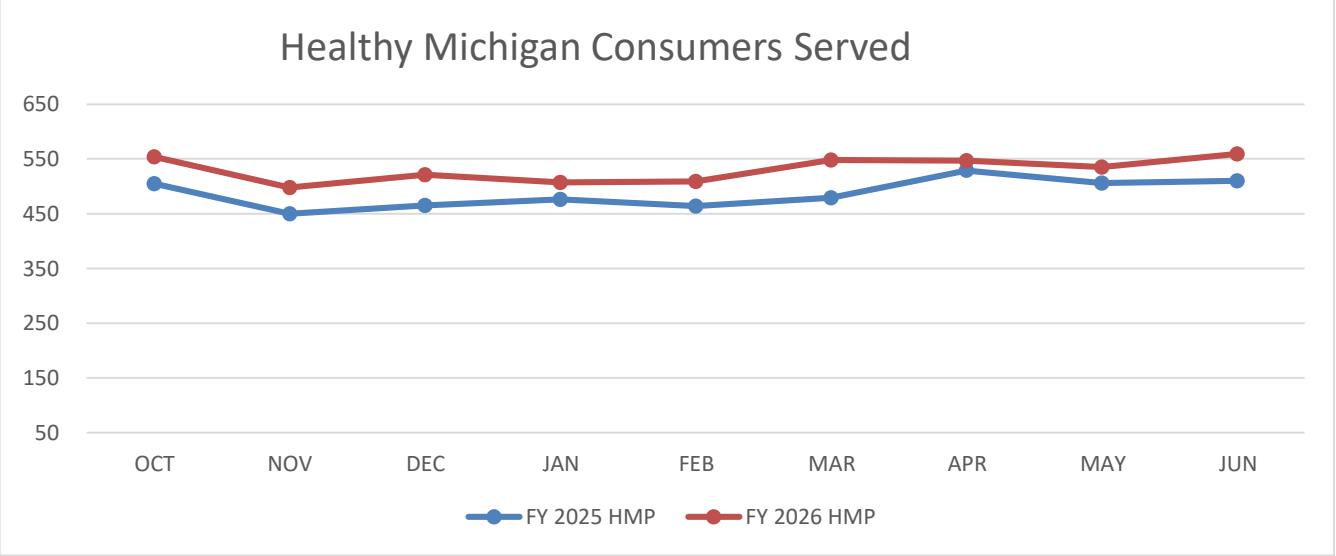


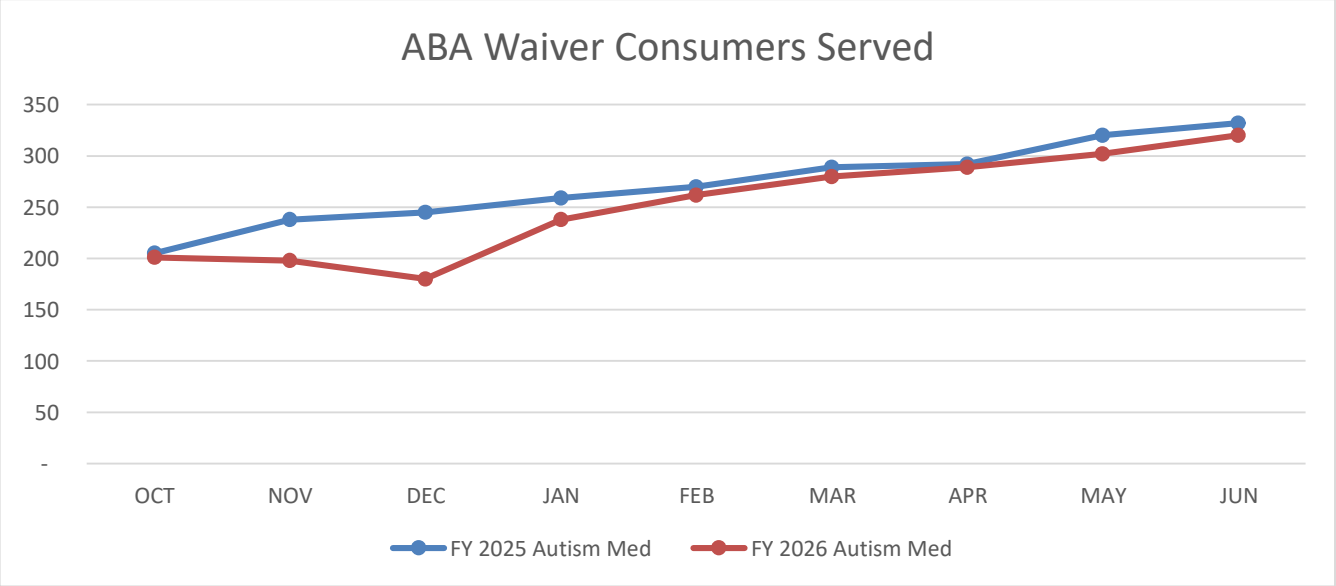
Washtenaw County Medicaid Enrollees were 32,597 in June 2026. This is a 6.17% decrease from the same time last year (2,143 less enrollees than in June 2025). Healthy Michigan enrollment in June 2026 was 17,166. This is a 9.80% decrease from the same time last year (1,865 less enrollees than in June 2025).





Medicaid consumers served were 2,640 in June 2026. This is 72 more consumers served from the same time last year (2,568 served in June 2025). General Fund consumers served in June 2026 was 462. This is 109 more consumers served from the same time last year (353 served in June 2025).



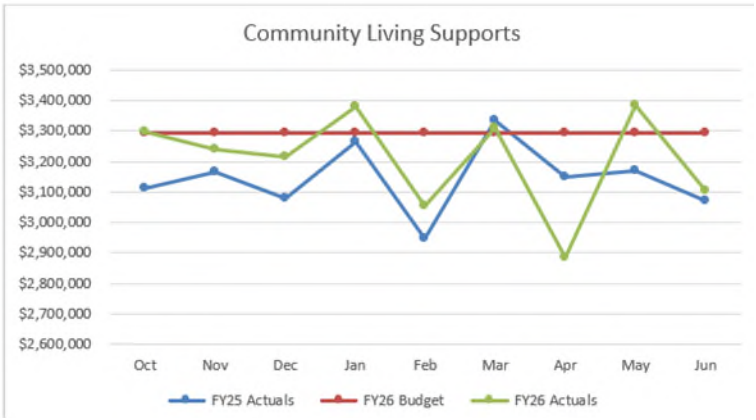


Healthy Michigan consumers served were 559 in June 2026. This is 49 more consumers served from the same time last year (510 served in June 2025). Autism consumers served in June 2026 was 320. This is 12 less consumers served from the same time last year (332 served in June 2025).

2. Financial Statement Highlights

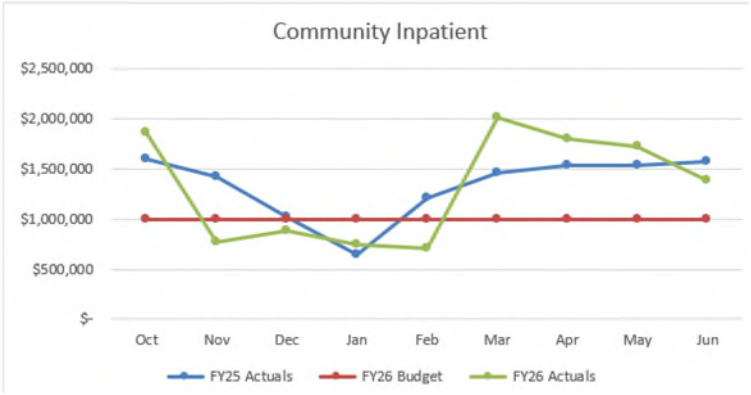
a. CLS service costs to date are estimated to be about $28.8 million and running just slightly under budget through June of FY 2026. The costs year to date are about 2.04% higher than last year at this time.

	FY25 Actuals	FY26 Budget	FY26 Actuals	YTD % Change
Oct	$ 3,110,404	$ 3,291,666	$ 3,298,711	6.05%
Nov	3,166,798	3,291,666	3,239,428	4.16%
Dec	3,077,601	3,291,666	3,213,745	4.24%
Jan	3,263,270	3,291,666	3,380,419	4.08%
Feb	2,946,981	3,291,666	3,052,654	3.98%
Mar	3,333,810	3,291,666	3,310,586	3.16%
Apr	3,150,443	3,291,666	2,884,030	1.50%
May	3,169,815	3,291,666	3,383,736	2.16%
Jun	3,070,142	3,291,666	3,103,036	2.04%
Jul	3,274,248	3,291,666		
Aug	3,121,309	3,291,666		
Sep	3,185,461	3,291,666		



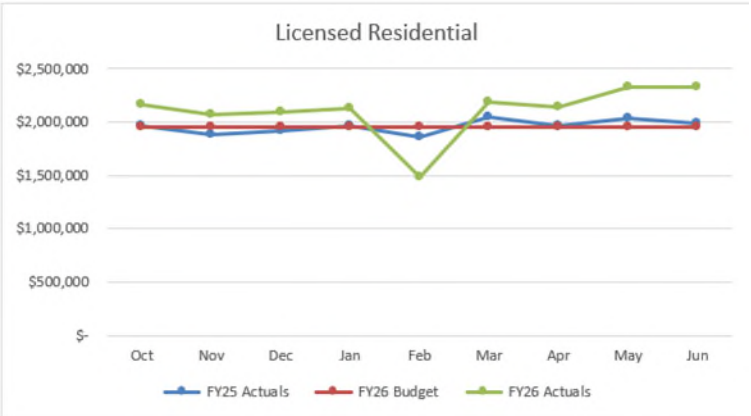
b. Community Inpatient costs to date are $11.9 Million. The costs year to date are lower than this time last year and are over budget by about 2 million YTD.

	FY25 Actuals	FY26 Budget	FY26 Actuals	YTD % Change
Oct	$ 1,605,037	$ 1,000,000	$ 1,861,507	15.98%
Nov	1,420,600	1,000,000	775,230	-12.85%
Dec	1,027,322	1,000,000	879,178	-13.25%
Jan	643,501	1,000,000	746,665	-9.24%
Feb	1,207,305	1,000,000	713,702	-15.71%
Mar	1,457,107	1,000,000	2,012,419	-5.06%
Apr	1,542,660	1,000,000	1,798,709	-1.30%
May	1,543,225	1,000,000	1,729,506	0.67%
Jun	1,572,138	1,000,000	1,388,611	-0.94%
Jul	1,459,593	1,000,000		
Aug	1,574,457	1,000,000		
Sep	1,652,209	1,000,000		



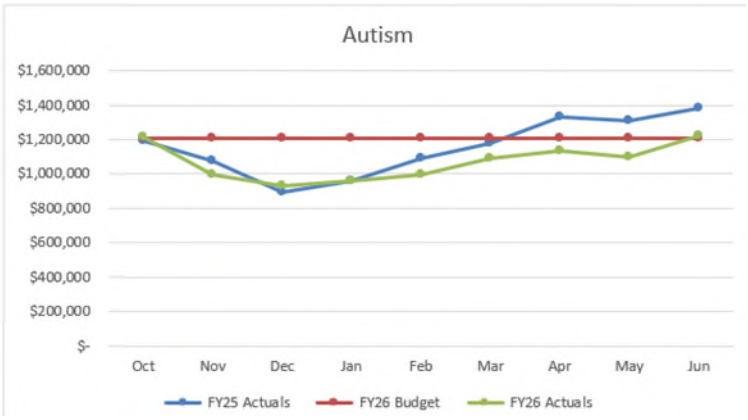
c. Licensed Residential costs to date are $18.9 Million and coming in slightly over budget. The costs year to date are about 7.3% more than this time last year.

	FY25 Actuals	FY26 Budget	FY26 Actuals	YTD % Change
Oct	$ 1,963,615	$ 1,958,333	$ 2,162,039	10.10%
Nov	1,887,271	1,958,333	2,067,657	9.84%
Dec	1,923,364	1,958,333	2,099,792	9.62%
Jan	1,961,078	1,958,333	2,132,709	9.40%
Feb	1,866,036	1,958,333	1,490,292	3.66%
Mar	2,051,542	1,958,333	2,184,189	4.15%
Apr	1,967,738	1,958,333	2,136,993	4.79%
May	2,040,781	1,958,333	2,327,965	6.00%
Jun	1,984,954	1,958,333	2,333,797	7.30%
Jul	2,063,159	1,958,333		
Aug	2,092,497	1,958,333		
Sep	2,082,652	1,958,333		



d. Applied Behavior Analysis/Autism service costs to date are $9.6 Million. The costs year to date are coming in under budget and trending about 7.4% lower than this time last year.

	FY25 Actuals	FY26 Budget	FY26 Actuals	YTD % Change
Oct	$ 1,190,528	$ 1,208,333	$ 1,211,534	1.76%
Nov	1,073,749	1,208,333	994,414	-2.58%
Dec	891,494	1,208,333	928,796	-0.67%
Jan	960,952	1,208,333	961,355	-0.50%
Feb	1,087,528	1,208,333	997,922	-2.12%
Mar	1,178,664	1,208,333	1,091,252	-3.10%
Apr	1,334,716	1,208,333	1,136,093	-5.13%
May	1,306,790	1,208,333	1,096,034	-6.73%
Jun	1,385,580	1,208,333	1,222,114	-7.40%
Jul	1,469,549	1,208,333		
Aug	1,268,414	1,208,333		
Sep	1,152,025	1,208,333		



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

3. PIHP Revenue Key Points

a. Medicaid capitation and Healthy Michigan Plan revenues are collected from the PIHP.
b. By funding source, Medicaid capitation is showing a surplus of $8.7 M through June.
c. By funding source, HMP is showing a deficit of $3 M through June.
d. Overall, the PIHP surplus is $5.6 M through June.

4. CCBHC Fee For Service (FFS) Key Points

a. CCBHC is billed to MDHHS on a fee-for-service basis.
b. CCBHC program is showing a deficit of $5.7 M through June.

5. State General Fund Key Points

a. General Fund programs and funding redirected to other Risk-Based programs is showing a surplus of approximately $2 M.

6. Local Key Points

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

b. Local Funds are currently showing a surplus of $500k through June.

c. Uses of Local Funding include:

   i. The 10% GF Match of non-residential services
   ii. Local contribution – required by MDHHS
   iii. Local share for State Facilities
   iv. Shelter expenses and other Local needs

7. Fund Balance

a. At the end of FY 2025, WCCMH has a fund balance of $6,342,913.

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
As of June 30, 2026

		Total
Medicaid **		
Revenue		
B & 1115i	$	46,787,976
HSW		26,525,854
Behavioral Health Home		-
Child Waiver/SED Waiver		766,510
Autism		9,315,530
Prior Year Adjustments		-
Care for Caid		87,180
Total Medicaid Revenue	$	83,483,050
Total Medicaid Expense	$	74,732,960
Medicaid Surplus/(Deficit)	$	8,750,090
Healthy Michigan **		
Revenue	$	5,275,677
Expense		8,361,703
Healthy MI Surplus/(Deficit)	$	(3,086,026)
CCBHC		
CCBHC FFS Revenue	$	17,296,399
Total CCBHC Revenue	$	17,296,399
CCBHC Non-Medicaid Expense		3,416,955
CCBHC HMP Expense		3,920,705
CCBHC Medicaid Expense		15,671,292
Total CCBHC Expense	$	23,008,951
CCBHC Surplus/(Deficit)	$	(5,712,552)
General Fund		
Revenue		
CMH Operations	$	3,278,295
CMH Operations Contra		-
GF Carryforward		-
Categorical		-
Redirect To Injectable Meds.		-
Redirect To CCBHC Non-Medicaid		-
Funding Fr. Other Local Sources		1,748,841
Total General Fund Revenue	$	5,027,136
Total General Fund Expense	$	2,989,966
General Fund Surplus/(Deficit)	$	2,037,170
HEALTH HOME SERVICES		
Revenue		
Behavioral Health Home	$	550,820
Other Revenue		-
Total BHH Revenue		550,820

Washtenaw County Community Mental Health
FINANCIAL PERFORMANCE BY FUND SOURCE
As of June 30, 2026

		Total
Expense		
Medicaid Health Home Services		447,019
Other Expenses		-
Total BHH Expenses		447,019
Behavioral Health Home Surplus/(Deficit)	$	103,801
Injectable Meds		
Revenue	$	51,269
Expense		58,599
Inj. Meds. Surplus/(Deficit)	$	(7,330)
Grants And Contracts		
Revenue	$	2,184,239
Expense		1,588,559
Grants & Cont. Surplus/(Deficit)	$	595,680
CMHSP To CMHSP		
Revenue	$	572,908
Redirect to GF		-
Expense		538,619
CMHSP to CMHSP Surplus/(Deficit)	$	34,289
Local		
Revenue	$	1,434,316
Expense		930,448
Local Surplus/(Deficit)	$	503,868
Private Grant & All NOR		
Revenue	$	188,816
Expense		175,038
Priv. Grant & NOR Surplus/(Deficit)	$	13,778
Grand Total		
Revenue	$	116,064,629
Expense		112,831,863
Grand Total Surplus/(Deficit)	$	3,232,766

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit)	$	5,664,064
WCCMH Surplus/(Deficit)		(2,431,298)
	$	3,232,766

Washtenaw County Community Mental Health
Budget to Actuals
For Four Months Ending June 30, 2026

	Current Fiscal Year				
	FY 2026 Amended Budget	FY 2026 Amended Budget YTD	FY 2026 YTD Actuals	YTD Actuals Over/(Under) YTD Budget	% O(U)
Operating Revenue					
PIHP Revenue					
Medicaid Capitation:					
Medicaid (b) & 1115i	$ 62,354,316	$ 46,765,737	$ 46,875,156	$ 109,419	0.23%
HSW	32,526,924	24,395,193	26,525,854	2,130,661	8.73%
Children & SED Waivers	1,100,446	825,335	766,510	(58,825)	-7.13%
Healthy Michigan Capitation	7,034,236	5,275,677	5,275,677	-	0.00%
Autism Capitation	12,347,733	9,260,800	9,315,530	54,730	0.59%
Behavioral Health Home	614,907	461,180	550,820	89,640	0.00%
TOTAL PIHP Revenue	$ 115,978,562	$ 86,983,922	$ 89,309,547	$ 2,325,626	2.67%
MDHHS Revenue					
CCBHC Fee-For-Service	29,000,000	21,750,000	17,296,399	(4,453,601)	-20.48%
State General Funds	4,461,704	3,346,278	3,278,295	(67,983)	-2.03%
Grants & Earned Contracts	2,392,867	1,794,650	1,577,967	(216,683)	-12.07%
All Other Revenue					
County Appropriation	$ 1,751,761	$ 1,313,821	$ 1,365,951	$ 52,130	3.97%
All Other	2,984,357	2,238,268	3,236,470	998,202	44.60%
TOTAL Operating Revenue	**$ 156,569,251**	**$ 117,426,938**	**$ 116,064,629**	**$ (1,362,309)**	-1.16%
Operating Expenses					
Administrative Expenses					
General Administration	$ 14,158,884	10,619,163	$ 9,830,521	$ (788,642)	-7.43%
Program Administration	4,750,000	3,562,500	3,474,229	(88,271)	-2.48%
Contracted Services					
Community Living Supports	$ 39,500,000	29,625,000	$ 28,764,235	$ (860,765)	-2.91%
Licensed Residential	23,500,000	17,625,000	17,836,800	211,800	1.20%
Applied Behavioral Analysis	14,500,000	10,875,000	9,619,943	(1,255,057)	-11.54%
Community Inpatient	12,000,000	9,000,000	11,002,386	2,002,386	22.25%
Vocational Services	3,100,000	2,325,000	2,370,683	45,683	1.96%
All Other Contracted	2,587,500	1,940,625	2,719,331	778,706	40.13%
Internal Services					
Case Management	$ 10,800,000	8,100,000	$ 7,311,186	$ (788,814)	-9.74%
Psychiatry	5,700,000	4,275,000	3,906,506	(368,494)	-8.62%
Vocational Services	3,900,000	2,925,000	1,579,353	(1,345,647)	-46.01%
Therapy Services	3,350,000	2,512,500	2,344,789	(167,711)	-6.68%
Nursing Services	3,100,000	2,325,000	2,044,783	(280,217)	-12.05%
ACT	2,600,000	1,950,000	1,381,541	(568,459)	-29.15%
All Other Internal	9,650,000	7,237,500	6,473,447	(764,053)	-10.56%
		-			
Other Expenses					
Local Matches & Shelter	980,000	735,000	594,163	$ (140,837)	-19.16%
Grants & Earned Contracts	2,392,867	1,794,650	1,577,967	(216,683)	-12.07%
TOTAL Operating Expenses	**$ 156,569,251**	**$ 117,426,938**	**$ 112,831,863**	**$ (4,595,075)**	-3.91%
Revenue Over/(Under) Expenses	-	-	3,232,766	3,232,766	

Washtenaw County Community Mental Health - Millage Advisory Committee
Millage Financial Update - For Six Months Ending June 30, 2026

Budget to Actuals

	Annual Budget	Budget YTD	Actuals YTD	Actuals YTD Over/(Under) Budget YTD
Community Wide Service Expansion				
CARES Team				
Access & Triage	$ 734,400	$ 367,200	$ 378,022	$ 10,822
Treatment & Stabilization Services	836,400	418,200	409,753	(8,447)
Crisis Response	877,200	438,600	439,008	408
Other CARES Team	459,000	229,500	205,875	(23,625)
Criminal Justice Diversion & Deflection				
Jail Medical Assisted Treatment	$ 400,000	$ 200,000	$ 135,000	$ (65,000)
Prosecutting Attorney Office	155,000	77,500	81,585	4,085
Supportive Housing				
Avalon - Permanent Supportive Housing	$ 438,362	$ 219,181	$ 219,181	$ -
Michigan Ability Partners	259,106	129,553	129,553	-
Ozone	246,551	123,276	123,276	-
Alpha House	96,700	48,350	48,350	
Shelter Association of MI	85,443	42,722	42,722	-
Ypsilanti Housing Commission	70,000	35,000	35,000	-
Emergency Housing	250,000	125,000	93,195	(31,805)
Youth Initiatives and Support				
Washtenaw Intermediate School District	$ 1,088,525	$ 544,263	$ 544,263	$ -
Student Advocacy Center	576,434	288,217	288,217	-
Packard Health - YBMen	230,677	115,339	115,339	-
Washtenaw Area Council for Children	87,542	43,771	43,771	-
All Other Youth Initaties and Support	250,000	125,000	87,320	(37,680)
Other Service Expansion				
Washtenaw Health Plan	$ 432,518	$ 216,259	$ 216,259	$ -
Jewish Family Services	385,642	192,821	192,821	-
Health Dept - Healthy Neighborhoods	268,027	134,014	134,014	-
Ypsilanti District Library	186,266	93,133	93,133	-
Women's Center of Southeastern MI	83,421	41,711	41,711	-
All Other Service Expansion	500,000	250,000	228,700	(21,300)
TOTAL Community Wide Service Expansion	$ 8,997,214	$ 4,498,607	$ 4,326,065	$ (172,542)

Budget to Actuals

	Annual Budget	Budget YTD	Actuals YTD	Actuals YTD Over/(Under) Budget YTD
Education & Prevention				
Health Dept - Anti Stigma Campaign	$ 278,199	$ 139,100	$ 139,100	$ -
NAMI Contract	189,223	94,612	94,612	-
Miles Jeffery Roberts Foundation	105,202	52,601	52,601	-
Issue Media Group	24,800	12,400	12,400	-
TOTAL Education & Prevention	$ 597,424	$ 298,712	$ 298,712	$ -
Evaluation & Communication				
CHRT Contract	$ 196,360	$ 98,180	$ 67,593	$ (30,587)
TOTAL Evaluation & Communication	$ 196,360	$ 98,180	$ 67,593	$ (30,587)
Administration of the Millage				
WCCMH	$ 780,000	$ 390,000	$ 391,702	$ 1,702
5 Healthy Towns (Planning)	60,742	30,371	30,371	-
National Assessment Center	20,660	10,330	10,330	-
TOTAL Administration of the Millge	$ 861,402	$ 430,701	$ 432,403	$ 1,702
Grand Totals	**$ 10,652,400**	**$ 5,326,200**	**$ 5,124,773**	**$ (201,427)**

Washtenaw County Community Mental Health
WCCMH

Fiscal Year 2027
Annual Operating Budget

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget

	FY 2027 Proposed Budget	FY 2026 Final Budget	FY 2027 Adjusted Budget Over / (Under) FY 2026 Budget	FY 2026 Projected YE	FY 2027 Adjusted Budget Over / (Under) FY 2026 Projections
Revenues					
Medicaid (b) & 1115i	$ 62,354,316	$ 62,354,316	$ -	$ 62,354,316	$ -
Habilitation Supports Waiver	32,526,924	32,526,924	-	34,726,924	(2,200,000)
Children's & SED Waivers	1,100,446	1,100,446	-	1,100,446	-
Autism Medicaid	12,347,733	12,347,733	-	12,347,733	-
Healthy Michigan Plan	7,034,236	7,034,236	-	7,034,236	-
Behavioral Health Home	614,907	614,907	-	714,907	(100,000)
CCBHC Fee-For-Service	29,000,000	29,000,000	-	24,000,000	5,000,000
State General Funds	4,461,704	4,461,704	-	4,461,704	-
Funding From Washtenaw County	1,751,761	1,751,761	-	1,751,761	-
Grants and Earned Contracts Incl. OBRA	2,392,867	2,392,867	-	2,392,867	-
CMHPSM/Affiliate & U of M Billings	950,000	950,000	-	950,000	-
All Other	2,034,357	2,034,357	-	3,284,357	(1,250,000)
Use of Prior Year Fund Balance	-	400,000	(400,000)	-	-
Total Revenues	**$ 156,569,251**	**$ 156,969,251**	**$ (400,000)**	**$ 155,119,251**	**$ 1,450,000**
Expenses					
Administrative Expenses					
WCCMH Administration	$ 14,158,884	$ 14,158,884	$ -	$ 13,507,000	$ 651,884
Total Administrative Expenses	$ 14,158,884	$ 14,158,884	$ -	$ 13,507,000	$ 651,884
Direct Services					
WCCMH Direct Services	$ 43,850,000	$ 43,850,000	$ -	$ 39,045,000	$ 4,805,000
Total Direct Services	$ 43,850,000	$ 43,850,000	$ -	$ 39,045,000	$ 4,805,000
Contracted Services					
WCCMH Contracted Services	$ 95,187,500	$ 95,187,500	$ -	$ 96,500,000	$ (1,312,500)
Total Contracted Services	$ 95,187,500	$ 95,187,500	$ -	$ 96,500,000	$ (1,312,500)
Other Non-Service Costs					
Special Item - Group Home Purchases	$ -	$ 400,000	$ (400,000)	$ 400,000	$ (400,000)
State Facilities Local Contribution	900,000	900,000	-	900,000	-
Shelter	80,000	80,000	-	80,000	-
Total Other Non-Service Costs	$ 980,000	$ 1,380,000	$ (400,000)	$ 1,380,000	$ (400,000)
Grants And Contracts	$ 2,392,867	$ 2,392,867	$ -	$ 2,392,867	$ -
Total Expenses	**$ 156,569,251**	**$ 156,969,251**	**$ (400,000)**	**$ 152,824,867**	**$ 3,744,384**
Revenue Over/(Under) Expenses	0	0	0	2,294,384	$ (2,294,384)

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget

WCCMH Administrative Expenses

		FY 2027 Proposed Budget	FY 2026 Final Budget	FY 2027 Budget Over / (Under) FY 2026 Budget	FY 2026 Projected YE	FY 2027 Budget Over / (Under) FY 2026 Projections
	Administration	$ 1,400,000	$ 1,450,000	$ (50,000)	$ 1,380,000	$ 20,000
(a)(b)	Compliance	190,000	190,000	-	175,000	15,000
(a)	Finance	1,500,000	1,650,000	(150,000)	1,500,000	-
	Human Resources	275,000	275,000	-	195,000	80,000
(a)	Information Management	275,000	275,000	-	270,000	5,000
(a)	Intake/Enrollment	775,000	775,000	-	775,000	-
(a)	Member Services	275,000	275,000	-	197,000	78,000
(a)	Network Management	675,000	675,000	-	650,000	25,000
(a)	Quality/Performance Imp.	410,000	500,000	(90,000)	396,000	14,000
(b)	Recipient Rights	1,550,000	1,650,000	(100,000)	1,480,000	70,000
(a)	Utilization Review	1,150,000	1,150,000	-	1,125,000	25,000
	County Cost Allocation Plan	5,680,884	5,290,884	390,000	5,364,000	316,884
	TOTAL	$ 14,155,884	$ 14,155,884	$ -	$ 13,507,000	$ 648,884

-

(a) All or a portion of this administrative category is a delegated function of the PIHP.

(b) Revenue contracts exist with Affiliate Partner CMH's for the purchase of these administrative functions.

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget

WCCMH Direct Service Expenses

	FY 2027 Proposed Budget	FY 2026 Final Budget	FY 2027 Budget Over / (Under) FY 2026 Budget	FY 2026 Projected YE	FY 2027 Budget Over / (Under) FY 2026 Projections
Program Support	$ 4,750,000	$ 4,750,000	-	$ 4,700,000	$ 50,000
ACT	2,600,000	2,600,000	-	2,100,000	500,000
Autism	420,000	420,000	-	145,000	275,000
Behavior Management	940,000	940,000	-	750,000	190,000
Case Management	10,800,000	10,800,000	-	9,750,000	1,050,000
Crisis Stabilization	3,000,000	3,000,000	-	2,750,000	250,000
Health Home	450,000	450,000	-	450,000	-
Home Based	1,725,000	1,725,000	-	1,650,000	75,000
Jail Services	680,000	680,000	-	675,000	5,000
Jail Diversion	185,000	185,000	-	275,000	(90,000)
Nursing	3,100,000	3,100,000	-	2,900,000	200,000
Nursing Home Services	190,000	190,000	-	160,000	30,000
Outpatient	3,350,000	3,350,000	-	3,200,000	150,000
Peer Supports	1,250,000	1,250,000	-	1,250,000	-
Psychiatric Services	5,700,000	5,700,000	-	5,300,000	400,000
Skill Building	2,200,000	2,200,000	-	1,400,000	800,000
Specialty Services	335,000	335,000	-	290,000	45,000
Supported Employment	1,700,000	1,700,000	-	900,000	800,000
Wraparound	475,000	475,000	-	400,000	75,000
TOTAL	$ 43,850,000	$ 43,850,000	$ -	$ 39,045,000	$ 4,805,000

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget

WCCMH Contracted Service Expenses

	FY 2027 Proposed Budget	FY 2026 Final Budget	FY 2027 Budget Over / (Under) FY 2026 Budget	FY 2026 Projected YE	FY 2027 Budget Over / (Under) FY 2026 Projections
Access/Assessments	$ 150,000	$ 150,000	$ -	$ 150,000	$ -
Autism Services	14,500,000	14,500,000	-	13,000,000	1,500,000
Community Inpatient	12,000,000	12,000,000	-	14,000,000	(2,000,000)
Community Living Supports	39,500,000	39,500,000	-	39,000,000	500,000
Licensed Facilities	23,500,000	23,500,000	-	23,800,000	(300,000)
Nursing	150,000	150,000	-	180,000	(30,000)
Outpatient	12,500	12,500	-	980,000	(967,500)
Peer Supports/Drop-In	400,000	400,000	-	300,000	100,000
PERS	150,000	150,000	-	150,000	-
PSR/Clubhouse	600,000	600,000	-	500,000	100,000
Respite	715,000	715,000	-	580,000	135,000
Skill Building	2,750,000	2,750,000	-	2,900,000	(150,000)
Specialty Services	150,000	150,000	-	150,000	-
Supported Employment	350,000	350,000	-	220,000	130,000
All Other Contracted Services	260,000	260,000	-	590,000	(330,000)
TOTAL	$ 95,187,500	$ 95,187,500	$ -	$ 96,500,000	$ (1,312,500)

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget by Fund Source

	Total
Medicaid **	
Revenue	
Medicaid (b), 1115i, Waivers & Autism	$ 108,329,419
Total Medicaid Revenue	$ 108,329,419
Expense	
Service Costs	$ 108,329,419
Total Medicaid Expense	$ 108,329,419
Medicaid Surplus/(Deficit)	$ -
Healthy Michigan Plan **	
Revenue	
Healthy Michigan Plan	$ 7,034,236
Total Healthy Michigan Revenue	$ 7,034,236
Expense	
Service Costs	$ 7,034,236
Total Healthy Michigan Expense	$ 7,034,236
	.
Total Healthy Michigan Surplus/(Deficit)	$ -
Behavioral Health Home **	
Revenue	$ 614,907
Expense	614,907
Behavioral Health Home Surplus/(Deficit)	$ -
** Denotes PIHP Medicaid Subcontracting Agreement Funds	
Certified Community Behavioral Health Clinic (CCBHC)	
Revenue	
CCBHC Fee for Service	$ 29,000,000
Total CCBHC Revenue	$ 29,000,000
Expense	
Service Costs	$ 29,000,000
Total CCBHC Expense	$ 29,000,000
	.
Total CCBHC Surplus/(Deficit)	$ -
General Fund	
Revenue	
CMH Operations	$ 4,461,704
Funding from Other Sources	-
Total General Fund Revenue	$ 4,461,704
Total General Fund Expense	$ 4,461,704
General Fund Surplus/(Deficit)	$ -
Grants and Contracts	
Revenue	$ 2,392,867
Expense	2,392,867
Grants & Cont. Surplus/(Deficit)	$ -
Local	
Revenue	$ 1,751,761
Expense	1,751,761
Local Surplus/(Deficit)	$ -
All Other	
Revenue	$ 2,984,357
Expense	2,984,357
All Other Surplus/(Deficit)	$ -
Grand Total	
Revenue	$ 156,569,251
Expense	156,569,251
Grand Total Surplus/(Deficit)	$ -

ATTACHMENT #5
AUGUST 2026

ANNUAL COMMUNITY NEEDS ASSESSMENT & BUDGET BOOK

FISCAL YEAR 2027

Table of Contents

MISSION, VISION AND VALUES

MISSION

To promote hope, recovery, resilience, and advance health equity in Washtenaw County by providing high quality, integrated behavioral health services to adults and youth with intellectual/developmental disabilities, mental health and/or substance use needs.

VISION

All residents can secure supports to improve their quality of life and reach their full potential.

VALUES

Excellence

We provide the highest level of service to promote recovery, quality of life and self-sufficiency through proven and innovative practices. We recognize that the foundation of excellent service is our relationships.

Growth

We believe in the capacity for change at every stage of development. We grow through shared learning, lived experiences and mentoring.

Well-being

We cultivate well-being through a commitment to physical and emotional safety, active listening, and a culture of appreciation.

Inclusion

Together we build a welcoming, respectful environment for all people. Through active engagement and shared decision-making, we build a stronger community.

Community

We develop strong, trusting partnerships with the people we serve, in our broader community, and within our own organization while advancing health equity.

Accountability

We are accountable to those we serve, to the larger community, and to each other for the equitable, effective, and efficient use of our resources.

Equity

Services will be delivered with a focus on eliminating health inequities by addressing and reducing the racial and economic disparities frequently impacting Black, Indigenous and People of Colors' health status, access, and outcomes

GUIDING DEFINITIONS

Wellness is not the absence of disease, illness, or stress but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness.

SAMSHA, Wellness Overview, 2016

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential**.**

SAMSHA, Recovery defined, August 2010

People with intellectual and/or developmental disabilities must be able to live the lives they choose and have a good quality of life.

The ARC, Quality of Life Position Statement, November 2009

NEEDS ASSESSMENT PROCESS

WCCMH uses a dynamic process to identify the needs and opportunities for behavioral health within the Washtenaw Community. This process looks at every facet of WCCMH, such as but not limited to programming, staffing, compliance, operations, and satisfaction to identify the needs of the community as it relates to behavioral health services. Each year the results are documented and used to adjust the WCCMH Strategic Plan and develop the budget for the following year as depicted on page 7 of this document. The result of this inclusive process is documented in the Environmental Drivers/Needs Assessment section.

Community Town Hall:

An annual Community Town Hall is conducted where all recipients of WCCMH services, their families, network providers, and the community at large are invited. This is an opportunity for individuals to provide feedback and input into the services that are delivered by WCCMH.

Community Assessments & Surveys:

WCCMH is fortunate to have major health systems and community partners that provide input into the service delivery models for behavioral health. These major health systems and partners often publish community behavioral health assessments. As the Community Mental Health Services Program (CMHSP) for Washtenaw County, we utilize these reports to provide input into our strategic plan which ultimately guides the budget development process.

Additionally, WCCMH conducts at least one annual consumer satisfaction survey. Beginning in FY 2025 we will be conducting an additional Mental Health Statistical Improvement Program (MHSIP) survey which will provide comparable data to assess for future planning.

Staff Input

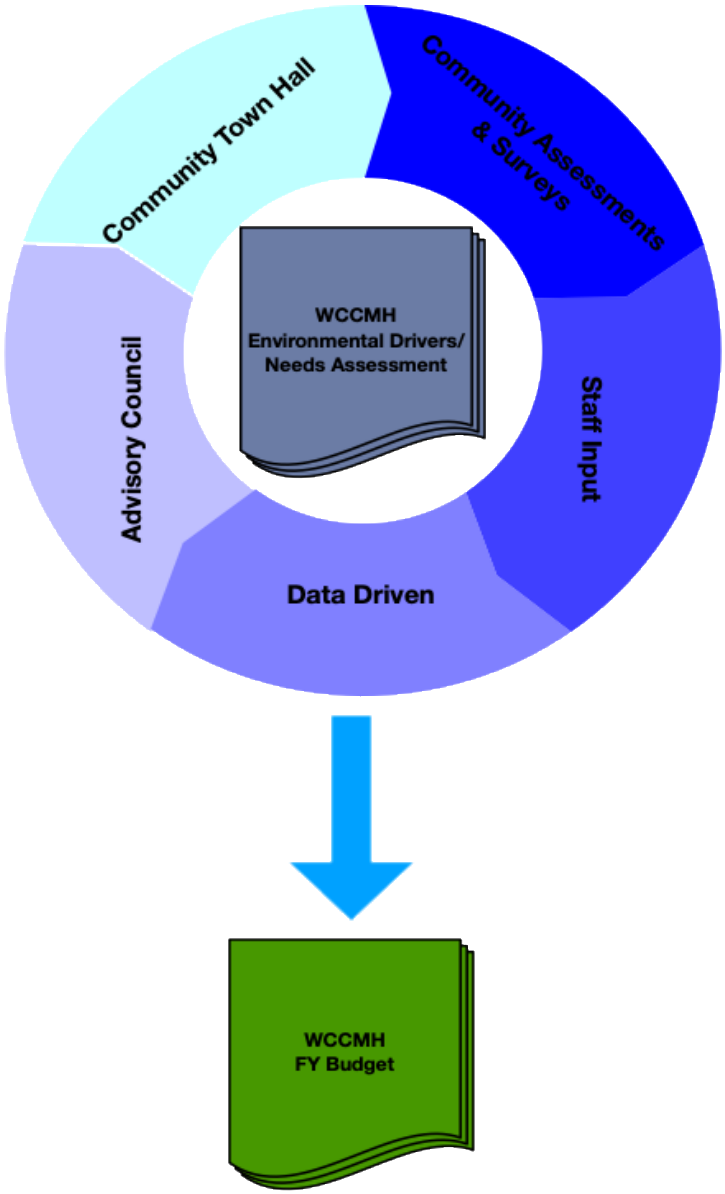
The WCCMH Executive Director provides a monthly all staff meeting (optional for staff to attend) to provide organizational updates and for staff to provide feedback. Additionally, WCCMH encourages its staff, supervisors and program administrators to solicit and provide feedback into various opportunities that may arise during clinical operations. This feedback is evaluated on a weekly basis by the WCCMH Executive Leadership Team and vetted with consideration for the needs of the organization as a whole.

Data Driven

WCCMH analyzes weekly, monthly and yearly financial and clinical reports to aid in the identification of organizational needs.

Advisory Council

The Advisory Council is made up of individuals receiving services from WCCMH. This committee provides input into all aspects of the organization. They meet monthly, provide feedback, and report out to the WCCMH Board on a quarterly basis.



STRATEGIC PLAN

Environmental Drivers/Needs Assessment

Access to Care

- There is a shortage of staff statewide with long waiting times, difficulty in accessing care or needs not getting met
- CMH system reform efforts are being driven by concerns about access and inconsistent statewide availability of services - encouraged to find ways to increase/improve access
- There is a lack of access to youth behavioral health services
- A severe statewide psychiatric hospital bed shortage with long waits for care
- A lack of a single point of access for all behavioral health services including substance use disorders

Performance/Quality

- Uneven metrics/performance by PHIPs and pressure from MCOs to shift payment from PIHPs to MCOs with competing bills in the legislature from Shirkey and Whiteford
- Current CMH system collects a lot of data but lacks a clear dashboard of metrics for accountability and performance
- State rate-setting efforts are expected to put emphasis on cost efficiency and effectiveness etc.

Expansion of Services

- Federal expansion of mental health funding through the designation of Michigan as a CCBHC state
- Passage of millage since the last strategic plan has shifted focus from exclusively mandated services for “eligible” individuals to comprehensive services for the general community
- Greater need for focus on prevention, early intervention, and community education

Other Drivers

- Inconsistency of support for behavioral health services by the State of Michigan
- Importance of telemedicine and the infrastructure to support it (i.e., broadband internet, county infrastructure and internet)
- Workforce recruitment and retention challenges
- The pandemic has forced isolation and created other stresses
- Racial and economic disparities in health status and in access to health care have become more obvious as people of color and lower income people bore disproportionate risks from COVID

- Excessive use of force and underutilization of behavioral science principles on the part of police officers, especially in interactions of white officers and citizens of color, have led to a growing public chorus for reform of how society deals with people in crisis

STRATEGIC GOALS

Ensure availability of behavioral health services through a single point of entry.

Tactic:

- Create a single point of entry for behavioral health services for individuals with substance use disorder, mental illness, or intellectual/developmental disabilities
  Completed by: January 2023
  Responsible Party: Melisa Tasker
  Measurement: TBD work with PIHP on evaluation criteria

- Establish and strengthen care coordination agreements to develop a behavioral health network of safety net providers in Washtenaw County
  Completed by: January 2025
  Responsible Party: Trish Cortes, Heather Linky, Dr. Florence
  Measurement: Care Coordination with key stakeholders. Examples may include Packard Health, Corner Health, Ozone, Catholic Social Services, Jewish Family Services, etc.

Promote wellness through the integration of physical and behavioral health.

Tactic:

- Achieve successful implementation of State of Michigan Behavioral Health Home
  Completed by: October 2023
  Responsible Party: Brandie Hagaman, Michael Harding
  Measurement: 200 Washtenaw County individuals enrolled through the State of Michigan, ongoing qualitative measure TBD in partnership with the State of Michigan

- Complete and successfully implement State of Michigan Certified Community Behavioral Health Clinic (CCBHC)
  Completed by: October 2023
  Responsible Party: Michael Harding
  Measurement:
  1. Successful State certification

2. 95% of individuals receiving qualified CCBHC services are enrolled in in the State Demonstration
3. Percent of the number of individuals requesting services that are assessed for medical necessity are provided services either through community partnerships or directly

Provide an array of crisis services that promotes care in the least restrictive setting.

Tactic:

- Partner in the development of a community plan to establish a youth assessment center
  Completed by: January 2024
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Presentation of the community plan to the WCCMH Board

- Implementation of Law Enforcement Assisted Diversion/Deflection (LEADD) in partnership with community stakeholders
  Completed by: January 2022
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: TBD CHRT Evaluation

- In partnership with Washtenaw County Sherriff's Office, develop protocols for metro dispatch to deploy a mobile mental health crisis team as an alternative to law enforcement response
  Completed by: January 2024
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: TBD Chicago Health Labs evaluation

Break down the barriers for all to reduce mental health disparities in access to care and improve health equity within Washtenaw County.

Tactic:

- Utilize existing studies and reports to identify health inequities within Washtenaw County. These studies will be utilized to develop a workplan that is specific to how WCCMH can impact health inequities within Washtenaw County
  Completed by: January 2024
  Responsible Party: Trish Cortes, Lisa Gentz, BLM Taskforce, Public Health
  Measurement: Work plan finalized and presented to key stakeholders

- Create interventions based on the workplan that target stigma, increase health education and training that aid in reducing health inequities
  Completed by: January 2025
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Measurements will be developed based on the workplan and will identify the impact of the interventions that WCCMH has implemented to reduce health inequities

Braid diversified revenue streams to support prevention, treatment, outreach, and equitable access to behavioral health services.

Tactic:

- Expand youth services through outreach and partnerships by leveraging all funding streams
  Completed by: January 2025
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Either directly or through agreements increases youths served by 25%

- Expand the adult service array through primary care agreements
  Completed by: January 2024
  Responsible Party: Trish Cortes, Dr. Florence
  Measurement: Agreements with primary care safety net clinics

- Implement 31N WISD School Mental Health Project to expand services within Washtenaw School districts
  Completed by: January 2023
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Number of schools receiving mental health resources

- Prioritize available resources to broaden outreach, education, and prevention efforts to address health inequities
  Completed by: January 2025
  Responsible Party: Trish Cortes, Lisa Gentz
  Measurement: Number of community events and training in geographic areas of need. No show rates for African Americans

Improve recruitment and retention of the behavioral health workforce.

Tactic:

- Advocate with MDHHS leadership and legislators to address behavioral health workforce shortages
  Completed by: January 2025
  Responsible Party: Trish Cortes
  Measurement: Additional funding allocated from the State for behavioral health staffing or decrease vacancies from 10% to 5%

- Collaborate with Washtenaw County administration and labor partners to strategize local efforts
  Completed by: January 2025
  Responsible Party: Trish Cortes, Nicole Phelps, Sally Amos O'Neal
  Measurement: County implementation of MAG Study

- Partner with provider network to address direct care workforce challenges
  Completed by: January 2022
  Responsible Party: Heather Linky
  Measurement: Implementation of direct care worker training reciprocity and/or increased funding for direct care workers

Thank you to the following groups that contributed to the WCCMH Strategic Plan:

Consumer Advisory Group
WCCMH All Staff
WCCMH Board
WCCMH Millage Advisory Group
WCCMH Black Lives Matter Taskforce
WCCMH Recipient Rights Committee
WCCMH Provider Network

The Following reports informed the WCCMH Strategic Plan:

CHRT Behavioral Health Environmental Analysis
Unite Report
WCCMH Staff Survey
Millage Advisory Committee Survey Results

WCCMH ENABLING LEGISLATION

Washtenaw County Community Mental Health (WCCMH)

The WCCMH has been designated by the State of Michigan as the Community Mental Health Services Program (CMHSP) as an agency model for Washtenaw County in accordance with Section 232a of the Michigan Mental Health Code.

Certified Community Behavioral Health Clinic (CCBHC)

The WCCMH is a Michigan Certified CCBHC Demonstration Site. A CCBHC is a new provider type in Medicaid and designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations.

State Innovation Model (SIM)

The WCCMH is an approved hublet site through the Washtenaw/Livingston Community Health Innovation Region (CHIR). CHIRs (pronounced “shires”) are intended to build community capacity to drive improvements in population health. The Care Delivery component includes the Patient-Centered Medical Home (PCMH) Initiative and the promotion of alternative payment models.

Behavioral Health Home (BHH)

The BHH provides comprehensive care management and coordination services to Medicaid beneficiaries with a select serious mental illness/serious emotional disturbance (SMI/SED) diagnosis. For enrolled beneficiaries, the BHH functions as the central point of contact for directing patient-centered care across the broader health care system.

Public Safety and Mental Health Preservation Millage

Washtenaw County's Public Safety and Mental Health Preservation Millage is a voter-approved homeowner tax that generates resources for mental health and substance use treatment programs that improve health and quality of life across the county. Millage-funded programs include a broad array of initiatives, but among the most important is access to mental health and substance use recovery services for all Washtenaw County residents who are having difficulty accessing private care, regardless of their insurance status or ability to pay for services.

FUNDING SOURCES

State General Funds

- The Michigan Department of Health and Human Services (MDHHS) authorizes the appropriation of State General Funds for community services. These authorizations may be adjusted throughout the year and may also include transfers pursuant to section 236 and section 307 of the Mental Health Code (MH Code). Appropriation is also contingent upon the funding contained in the current year state legislative Appropriations Act.

- The CMHSP is obligated to provide local matching funds as stipulated in the MH Code.
    - Revenue sources for this local obligation include
        - County Appropriations
        - Appropriations from other local governments such as cities and townships
        - Gifts and donations
        - Earned interest
        - First and third-party reimbursement reported under the Special Fund Account pursuant to section 226a of the Michigan Mental Health Code qualify as local matching funds
    - The local obligation is ten percent of service costs. The following exclusions apply:
        - Residential programs, including mental health services provided in the residency of the recipient and are part of a comprehensive individual plan of services (IPOS)
        - Services provided to people whose residency is transferred according to section 307 of the MH Code
        - Programs that are State responsibilities and that the State has transferred to the CMHSP
          Services provided to an individual under criminal sentence to a state prison

- At the conclusion of the fiscal year, the CMHSP may carry forward up to 5% of the State General Funds into the next fiscal year. The succeeding fiscal year budget will include planned expenditures of the full amount carried forward. Unexpended funds in that succeeding year must be returned to MDHHS.

- No Internal Service Fund (risk protection) may be maintained with State General Fund dollars.

Medicaid

- MDHHS administers the Medicaid Managed Specialty Supports and Services 1115 Medicaid Demonstration Waiver. Under this waiver, select state plan specialty services related to mental health and intellectual/developmental disability services as well as certain covered substance abuse services, have been carved out (removed) from Medicaid primary physical health care plans and arrangements. The 1115 Waiver includes Michigan's 1915(c) Habilitation Supports Waiver (HSW) for persons with intellectual/developmental disabilities, Children's Waiver Program (CWP), Children with Serious Emotional Disturbance Waiver (SED) and 1915(i) Waiver (previously identified as 1915(b)(3)). The concurrent 1915(i)/(c) programs are managed on a shared risk basis by Prepaid Inpatient Health Plans (PIHP) that have been selected through the Application for Participation (AFP) process.

- Medicaid funding is a shared risk arrangement whereby the PIHP may set aside a risk pool (Internal Service Fund - ISF) to cover potential future shortfalls of Medicaid funding and to cover unforeseen Medicaid expenses. The PIHP's shared risk is up to 7.5% of the total deficit: the first 5% is the PIHP's responsibility, the second 5% is shared equally with the state, and the remaining deficit is borne totally by the state.

- Capitated payments are set by the state and issued to the PIHP on a monthly basis. The rate of payment is based on numerous factors relating to Medicaid beneficiaries developed by the actuary agency, Milliman, Inc.

  Factors include but are not limited to:
  - Number of TANF (Temporary Assistance for Needy Families) beneficiaries
  - Number of DAB (Disabled, Aged & Blind) beneficiaries
  - Number of HMP (Healthy Michigan Plan) beneficiaries
  - Age
  - Gender
  - Entity Specific Factor
  - Autism
  - Enrollment in the Habilitation Supports Waiver
  - Enrollment in the Children's Waiver Program

Children's Waiver and SED Waivers

MDHHS determines if an individual meets the criteria to participate in these Waiver's. Up until 2019, the programs operated as a fee-for-service arrangement between the CMHSP and MDHHS. The Waiver programs have since been incorporated into the PIHP's Medicaid contract and are funded through the capitated funding model.

Certified Community Behavioral Health Clinic (CCBHC)

- MDHHS utilizes the CCBHC Prospective Payment System 1 (PPS-1) methodology in which CCBHC Demonstration Sites receive a daily clinic-specific rate for providing approved CCBHC services to eligible Medicaid individuals. Prior authorization for CCBHC services is not required under the CCBHC Demonstration, when services are eligible and determined medically necessary by a qualified provider.

- CCBHCs are not reconciled to actual costs. Per federal guidance, states are prohibited from making additional payments to CCBHCs at the end of the demonstration year if actual costs are higher than the amount received via PPS rate. CCBHCs are at risk for all services provided throughout the demonstration period.

- CCBHCs are also eligible to receive Quality Bonus Payments (QBPs) based on meeting or exceeding benchmarks on CMS defined quality metrics. These metrics are reviewed annually and are specific to Medicaid persons served.

Grants and Earned Contracts

- The WCCMH actively seeks additional funding through grants and earned contracts. In addition to Block Grants from the state, the WCCMH has been awarded several million dollars in other Federal and Private grants. These grants allow the WCCMH to be innovative and provide additional behavioral health services to individuals in Washtenaw County.

Appropriation from Washtenaw County

- An annual appropriation is provided to WCCMH by Washtenaw County to meet the local match requirements of the CMHSP.

Public Safety and Community Mental Health Preservation Millage

- The Community Mental Health portion of the funds generated from the millage are used to pay for four broad areas of mental health services: (1) crisis funding; (2) stabilization funding; (3) prevention funding; and (4) Jail Services for inmates with mental health issues.

WHO WE SERVE

Who We Serve

- Services are provided to individuals who have a mental illness, emotional disturbance, intellectual/developmental disability, or have a co-occurring disorder.
- An individual shall not be denied service because an individual is unable to pay for the service.
- Crisis and stabilization behavioral health services to any individual in the Washtenaw regardless of insurance status or ability to pay.

Medicaid Eligible

- Medicaid beneficiaries whose needs render them eligible for specialty services and supports are served through the PIHP/CMHSP, its Provider Network and/or its Lead Agency. Those who are experiencing or demonstrating mild or moderate psychiatric symptoms are not eligible for specialty services and are covered through the State's fee-for-service Medicaid Program.
- The number of Medicaid beneficiaries in Washtenaw County has averaged 33,000 plus or minus every month. The number of Healthy Michigan Plan beneficiaries averages 18,000 plus or minus each month.

Numbers Served

- 4652 Medicaid covered individuals were served in FY 2025.
- 1657 Healthy Michigan Plan (HMP) covered individuals were served in FY 2025.
- 994 individuals not covered by Medicaid/HMP were served in FY 2025.

PURPOSE AND SERVICES

State General Fund Supports and Services

- The purpose of the Community Mental Health Services Program (CMHSP) is to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area regardless of an individual's ability to pay.
- The array of services includes the following:
    - Crisis stabilization and emergency services for persons experiencing acute emotional, behavioral, or social dysfunctions, and the provision of inpatient or other protective environment for treatment
    - Assessment and diagnosis
    - Planning, linking, coordinating, follow-up, and monitoring
    - Specialized mental health services
        - Training, treatment, support
        - Therapeutic clinical interactions
        - Socialization and adaptive skills and coping skills training
        - Health and rehabilitative services
        - Pre-vocational and vocational services
    - Recipient Rights
    - Mental Health advocacy
    - Prevention action

Medicaid Supports and Services

- Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the Individual Plan of Services (IPOS) must meet medical necessity criteria, be appropriate to the individual's needs, and meet the standards set forth in the Medicaid Provider Manual.
- Services selected and included in the IPOS must be determined through the persons-centered planning process in accordance with the state guidelines.
- Medical Necessity is the determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology, and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with the clinical standards of care. Medical necessity shall be documented in the IPOS. **[APPENDIX A]**

1915 (i)

- Services are aimed at providing a wider, more flexible, and mutually negotiated set of supports and services that will enable individuals to exercise and experience greater choice and control over their individual plan of services.
- Services are intended to be more individualized, cost-effective, and in accordance with the beneficiary's needs and requests.
- Services are outlined in detail in the Michigan Provider Manual
    - Inpatient Psychiatric Services
    - Psychiatric Partial Hospitalization
    - Mental Health Clinic Services
    - Community Rehabilitation Services
    - Crisis Residential and Crisis Stabilization Services
    - Psychosocial Rehabilitation Program
    - Substance Abuse Rehabilitative Services
    - Targeted Case Management
    - Personal Care in Specialized Residential Settings
    - Specialty services to treat, correct or ameliorate an illness

1915 (c) Services

- Covered services in this waiver include:
    - Chore Service
    - Community Living Supports
    - Enhanced Dental
    - Enhanced Pharmacy
    - Enhanced Medical Equipment and Supplies
    - Environmental Modifications
    - Family Training
    - Out of home Non-Vocational Habilitation
    - Personal Emergency Response System
    - Pre-Vocational Habilitation
    - Private Duty Nursing
    - Respite Care
    - Supports Coordination
    - Supported Employment
    - Assertive Community Treatment Programs (ACT)
    - Clubhouse Psychosocial Rehabilitation Programs
    - Crisis Residential Programs
    - Day Program Sites
    - Crisis Observation Care
    - Home-Based Services

- Intensive Crisis Stabilization
- Wraparound

CCBHC Services

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization
- Screening, assessment, and diagnosis, including risk assessment
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning
- Outpatient mental health and substance use services
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk
- Targeted case management
- Psychiatric rehabilitation services
- Peer support and counselor services and family supports
- Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas

Community Mental Health Millage Investments

Plan and Integrate

Investment 1: CARES Team, Crisis Center and Stabilization Services, Planning and Integration of the System of Care
Investment 2: Youth Services
Investment 3: Substance Use Disorder Planning

Expand Services

Investment 4: Expand outreach services and maximize use of peer supports
Investment 5: Expand prevention services for youth
Investment 6: Implement CARES Team & Crisis Center & Stabilization Services
Investment 7: Expand access to MH/SUD services
Investment 7A: Expand injection clinic/services
Investment 7B: Expand in integrated care
Investment 7C: Expand SUD including opioid use treatment services
Investment 8: Increase in supportive housing services

Evaluate & Communicate

Investment 9: Implement robust communication initiative
Investment 10: Develop evaluation plan; track and communicate outcomes
Investment 11: Administer millage

SERVICE DELIVERY SYSTEM

Basic Organization Structure

- Administrative Functions are intended to support the Service Delivery System and to meet all the legal and regulatory requirements of a Managed Care and Clinical Delivery System.
    - Executive and Managing Levels of Operations
    - Budget and Finance
    - Provider Acquisition, Requirements, Compliance
    - Policy, Risk, Quality
    - Recipient Rights, Customer Services, Fair Hearings
    - Information Management
    - Service System Management
- Services are provided through WCCMH and the network of contracted providers.
- The Service Delivery System needs to meet the changing needs of the individuals served. Healthcare delivery and funding across the nation and state are ever changing and WCCMH must be flexible and able to adapt quickly to be sustainable.
- Utilization Management is a key component of a managed care system. It requires a systematic set of processes from prescreening and prior authorization for treatment as well as ongoing, retrospective service utilization review.

Crisis Services

This team provides mobile crisis intervention and stabilization services to individuals located in Washtenaw County for both youth and adults. Requests for services are received through the 24/7 Access Crisis Phone line. Requests for service come from individuals in crisis, family members, hospitals, external providers, law enforcement, schools, 988, and local merchants.
Masters prepared clinicians and Peer Support Specialists with lived experience make up the team.

Interventions provided during crisis intervention include:

- Suicide Risk assessment
- Substance abuse screening and referral
- Motivational interviewing
- Verbal de-escalation
- Brief solution focused on therapeutic techniques
- Dialectical Behavioral Therapy techniques

- Cognitive Behavioral Therapy techniques
- Safety planning
- Referral and authorization to outpatient treatment providers, partial hospitalization providers, Crisis Residential Services, and inpatient hospitalization

Individuals referred to the Crisis Team receive follow-up care that includes outreach, in office meetings, telehealth visits and phone calls until their crisis is resolved.

Access

The Access System is available and accessible to all individuals seeking assistance or service. The Access Triage team answers all phone calls that come through the 24/7 Crisis Line. The team documents and triages each call and determines an appropriate disposition.

Dispositions may include:

- Refer to Crisis (calls transferred to the mobile crisis team)
- Pre-admission screening (Hospitals call requesting authorization for inpatient admission)
- Access Screening (Individual or family is seeking outpatient care)
- Needs covered by community (the individual is provided with resources to meet their needs)
- SUD screening (caller is seeking SUD treatment authorization and referral)
- Transfer call to MiCal Peer Warmline for those who are not in crisis

The team is responsible for providing a welcoming environment for individuals who call. Assistance is person-centered, self-determined, and recovery oriented. All requests for services are held to state mandated timeliness standards, which are monitored and audited each quarter.

Person-Centered Planning

- The Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a person-centered planning process regardless of age, disability, or residential setting. In this process, the individual directs the planning with a focus on what he/she wants and needs, including the identification of possible services. This interactive strategy is intended to ensure individuals are provided with the most appropriate services necessary to achieve the desired outcomes.

- When an individual expresses a choice or preference for a support, service and/or treatment for which an appropriate alternative of lesser cost exists, and compromise fails, the individual may employ a process for dispute resolution and appeal.
- Self-determination incorporates a set of concepts and values that emphasize participation by the individual and achievement of personal control over their life. Person-centered planning is a central element of self-determination.
- The person-centered planning process is highly individualized and designed to respond to the expressed needs/desires of the individual.
- The process encourages strengthening and developing natural supports by inviting family and friends to participate in the planning. Developing natural supports is an equal responsibility of the CMHSP and the individual.

Individual Plan of Services (IPOS)

- Services must be delivered according to an individual plan of service based on an assessment of immediate need. The plan must be developed within 48 hours of admission and signed by the individual (if possible), the parent or guardian, the psychiatrist, and any other professionals involved in treatment planning as determined by the needs of the individual. The Case Manager must be involved in the treatment as soon as possible and must be involved in the follow-up services.
- The IPOS must clearly state goals and measurable objectives derived from the assessment of immediate need and stated in terms of specific observable changes in behavior, skills, attitudes, and circumstances.
- The array of covered services to meet the needs and desires of the individual are addressed in at the planning meeting and a copy of the plan is provided to the individual within 15 business days after the meeting.

Provider Agencies [APPENDIX B]

- To meet service obligations, WCCMH/CMHSP contracts with several provider agencies that provide a range of services.

Contract Services include:

  - Psychiatric Inpatient Hospitals
  - Partial Inpatient Hospitals
  - Licensed Residential
  - Community Living Supports
  - Clubhouse Psychosocial Rehabilitation
  - Peer-Operated Drop-In Center
  - Vocational Services
  - Applied Behavioral Analysis

- Miscellaneous Clinical Services

Assessments

- Health Assessments are provided by a registered nurse or nurse practitioner to determine the individual's need for medical services and to recommend a course of treatment within the scope of the practice of the nurse or dietician.
- Psychiatric Evaluations are comprehensive, face-to-face evaluations provided by a psychiatrist that include current clinical status, historical psychiatric, physical, and medication information, relevant personal and family history, personal strengths and assets, and a mental status examination.
- Psychological testing includes standardized tests and measures rendered by full, limited-licensed, or temporary-limited-licensed psychologists.
- Another assessment used is the Child and Adolescent Functional Assessment Scale (CAFAS)

Case Management/Supports Coordination

- This covered service is to assist beneficiaries in designing and implementing strategies for obtaining the services and supports that are goal-oriented and individualized. To assist in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports, the responsibilities of the case manager include:
  - Assessment
  - Planning
  - Linkage
  - Advocacy
  - Coordinating and Monitoring
- The case manager must review services at intervals defined in the IPOS and update the IPOS as needed.
- The case manager must determine, on an ongoing basis, if the services and supports have been delivered and if they are adequate to meet the needs/wants of the individual.
- Monitoring (frequency and scope of case management service) must reflect the intensity of the individual's health and welfare needs identified in the IPOS.

Assertive Community Treatment Program (ACT)

- ACT is a set of intensive clinical, medical, and psychosocial services provided by a mobile multi-disciplinary treatment team.
- ACT provides basic services and supports essential to maintain the individual's ability to function in community settings, including assistance with accessing basic needs

through available community resources, such as food, housing, medical care and supports to allow beneficiaries to function in social, educational, and vocational settings.
    - Services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the individual.

Individual/Group Therapy

- Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functions, reality oriented, re-motivation and emotional adjustment.
- Expected treatment outcome is improved functioning and more appropriate interpersonal and social relationships.

Medication Review/Administration

- Medication administration is the process of giving physician-prescribed oral medication, injection, intravenous or topical medication treatment to an individual.
- Medication review is the evaluation and monitoring of medications, their effects, and the need to continue or change the medication regimen.

Home-Based Services

- Mental health home-based services are designed to provide intensive services to children (birth through age 17) and their families with multiple service needs who require access to an array of mental health services.
- Primary goal of this program is to promote normal development, promotion healthy family functions, support and preserve families, reunite families who have been separated, reduce the use of, or shorten, the length of stay in psychiatric hospitals.

Health Services

- Health Services include assessment, treatment, and professional monitoring of health conditions that are related to or impacted by a person's mental health condition. A person's primary doctor will treat any other health conditions they may have.

Peer Delivered Services

- Peers offer help with food, clothing, socialization, housing, and support to begin or maintain mental health treatment. Peer Specialist services are activities designed to help persons with serious mental illness in their individual recovery journey and are

provided by individuals who are in recovery from serious mental illness. Peer Mentors help individuals with developmental disabilities.

Skill Building Assistance

- Skill Building assistance includes supports, services, and training to help an individual participate actively at school, work, volunteer, or community settings, or to learn social skills they may need to support themselves or to get around in the community.

Supported/Integrated Employment Services

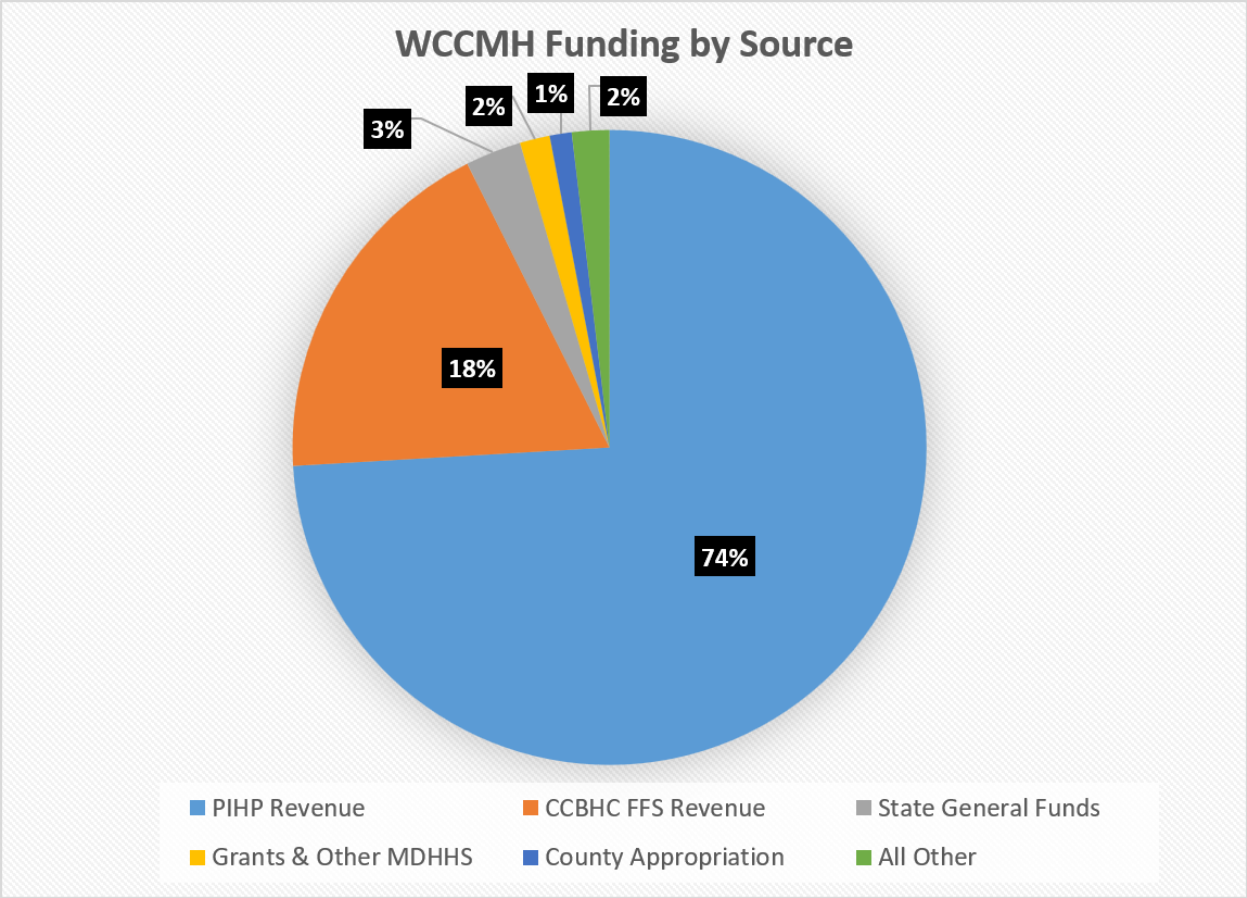
- Supported/Integrated employment services provide initial and ongoing supports, services, and training at the job site to help adults who are eligible for behavioral health services find and keep paid employment in the community.

Wraparound Services for Children and Adolescents

- Wraparound services are for individuals with serious emotional disturbance and their families that includes treatment and supports necessary to maintain the child in the family home.

BUDGET DEVELOPMENT

REVENUES:

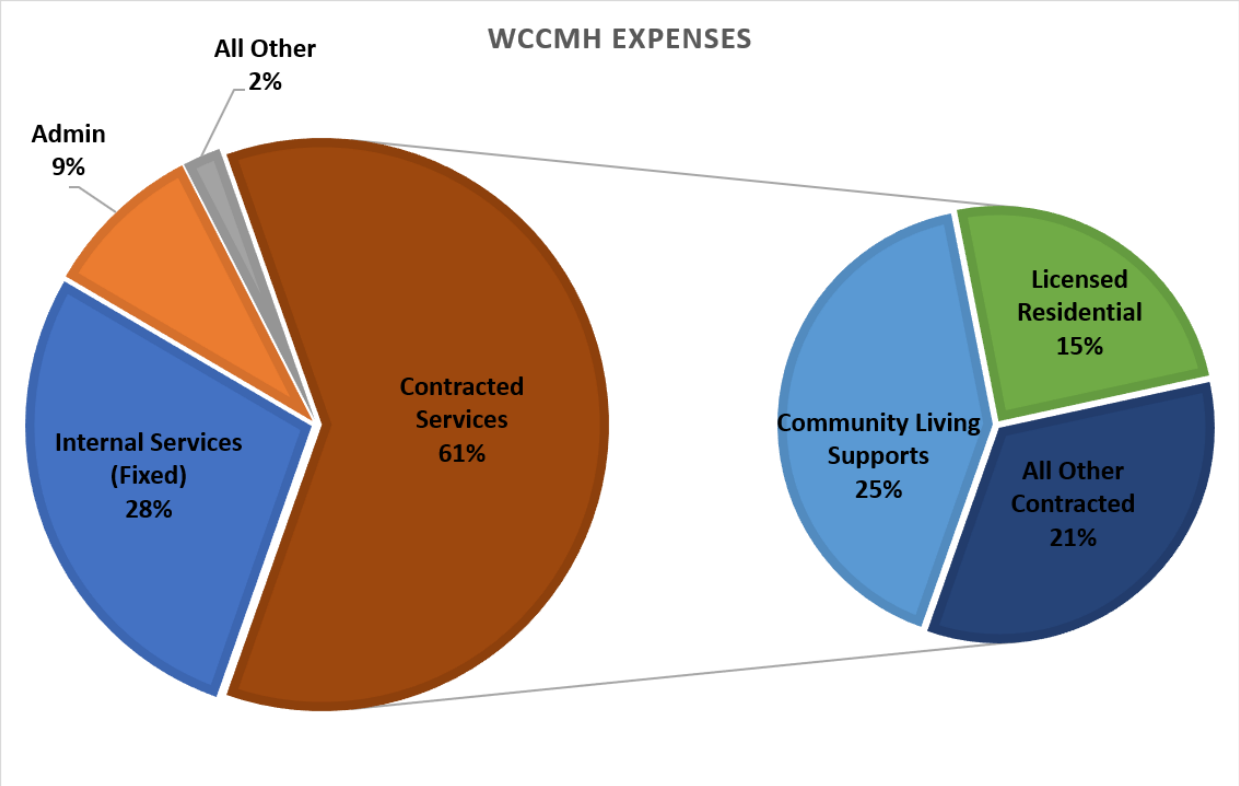


PIHP Revenue Assumptions:

- Community Mental Health Partnership of Southeast Michigan (CMHPSM/PIHP) prepared a FY 2027 Operating Budget assuming no increase or decrease to Medicaid revenues. At the regional level, the Internal Service Fund, which is the PIHPs Medicaid risk reserve is fully funded at the allowable level.

- The WCCMH FY 2027 Annual Operating Budget reflects a total of $115 million being distributed under the Medicaid Sub-Contracting Agreement from CMHPSM (PIHP) to WCCMH.

EXPENSES:



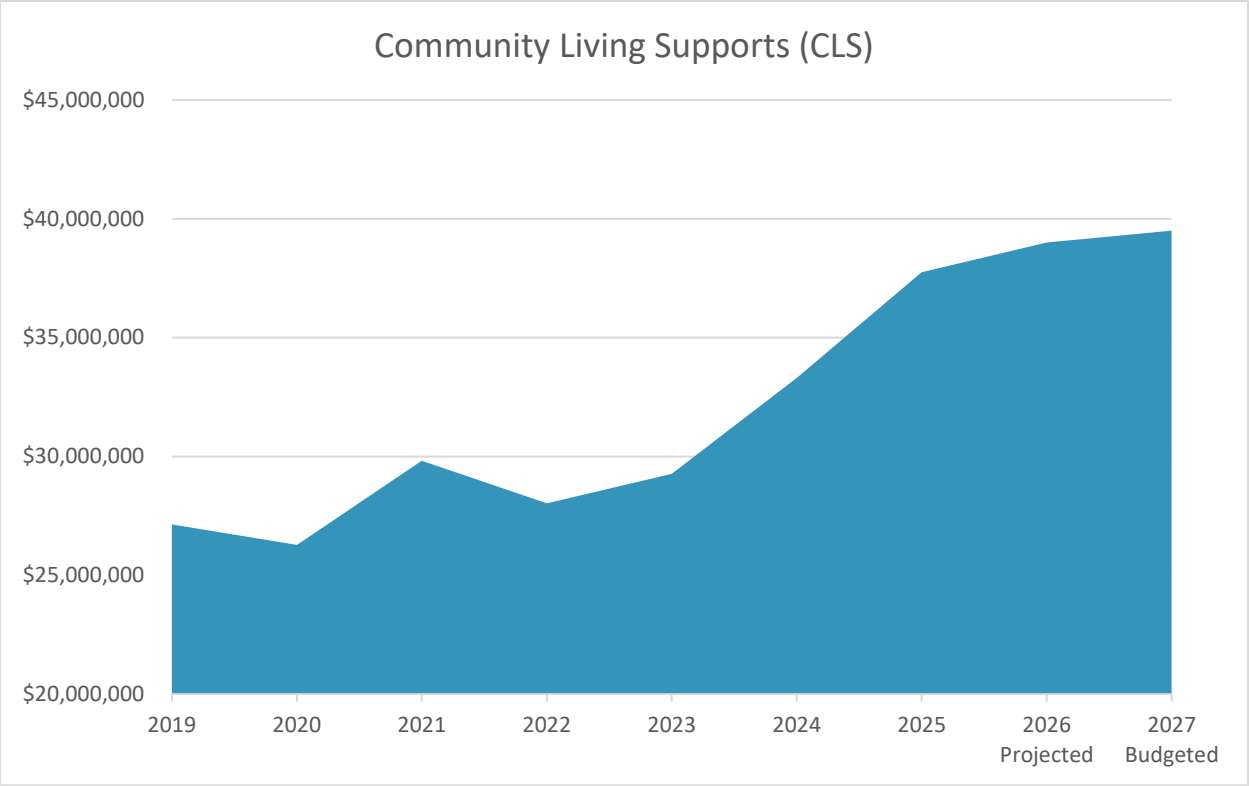
Internal Services and Administration Assumptions:

Internal services and administrative assumptions were built on current staffing levels and includes adequate resources to respond to growing service demands. There are also adequate resources accounted for in the budget to support negotiated increases and fringe benefits assumptions.

Contracted Services Assumptions:

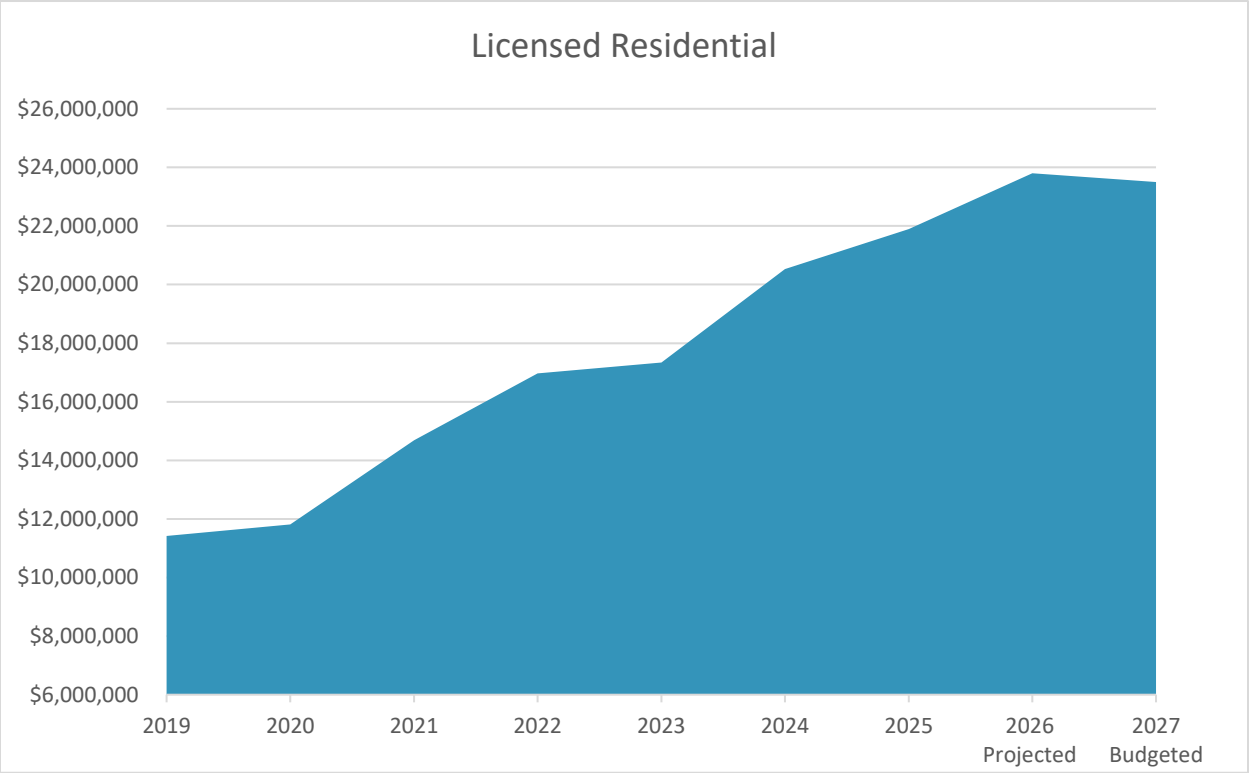
Contracted service costs are projected at prior-year utilization levels and known assumptions at the time of preparation. Residential and community support services include the continuation of the Direct Care Worker temporary wage increase.

Community Living Supports:



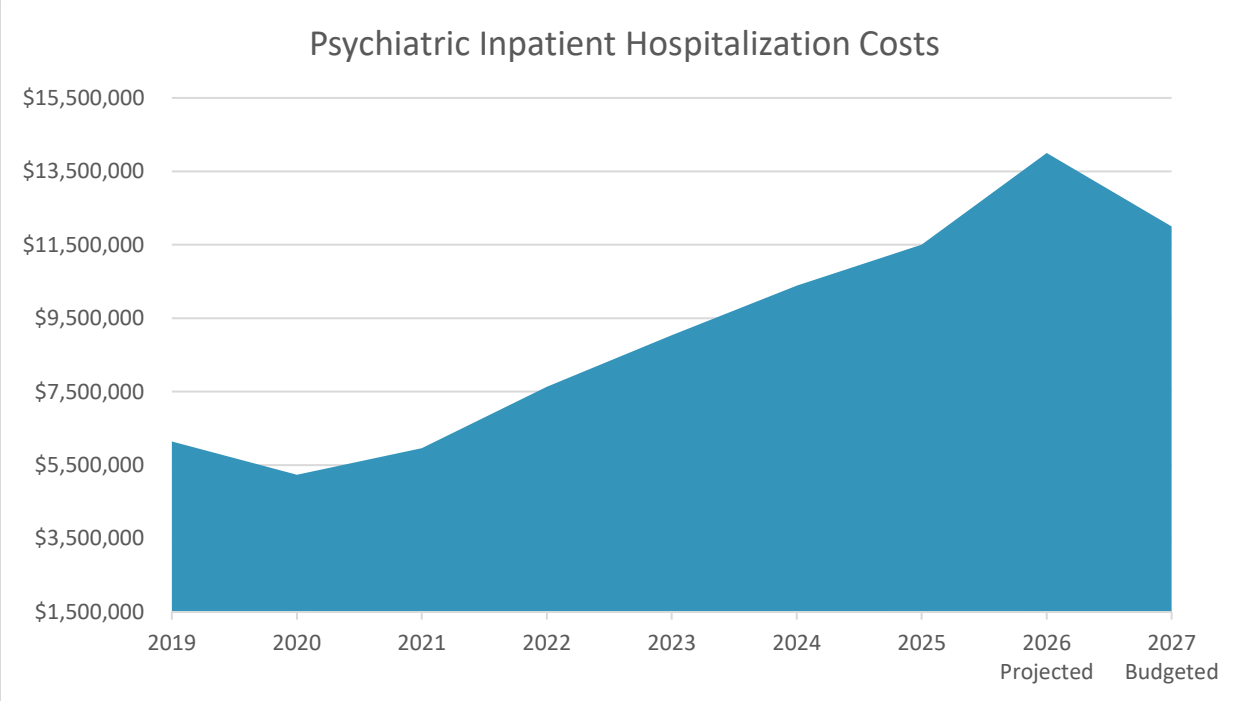
Community Living Supports (CLS) are residential and community-based supports provided to individuals in an unlicensed setting. A temporary direct care worker wage increase has been passed through to the CLS providers since the early onset of the COVID-19 pandemic. The continuation of this wage increase is assumed in the FY 2027 budget assumptions.

Specialized Residential:



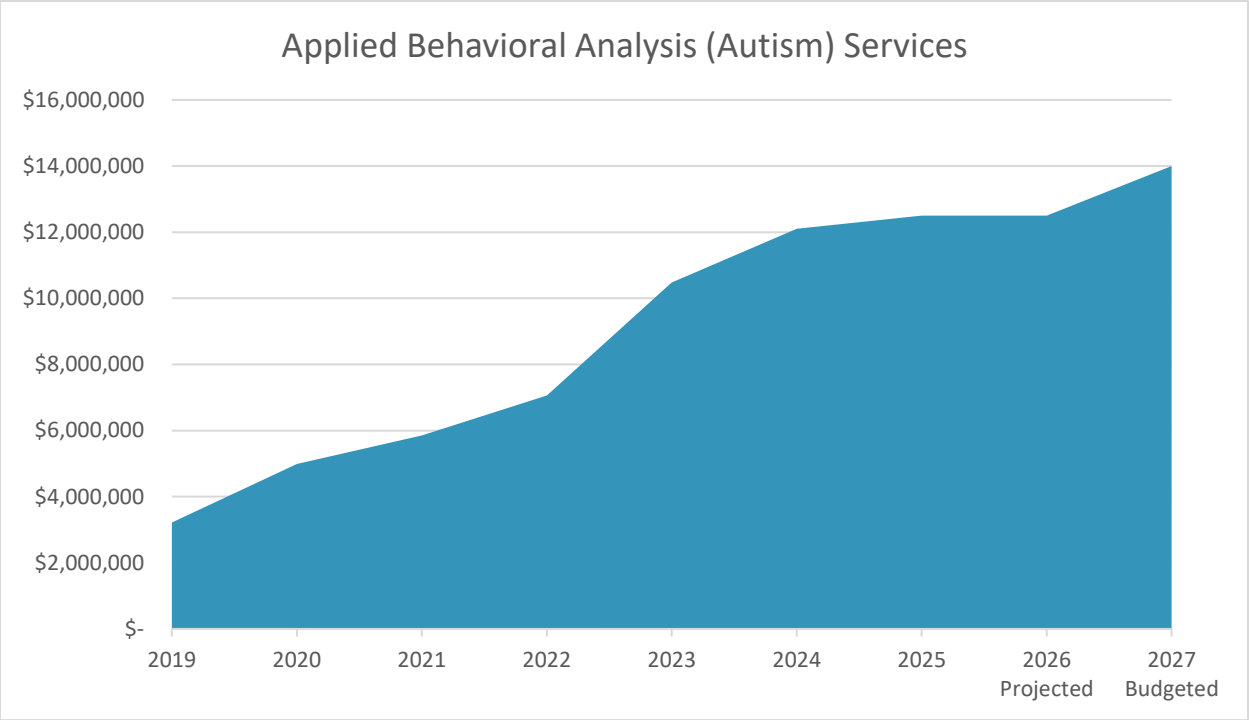
Specialized Residential services are residential and community-based supports provided to individuals in a licensed setting. A temporary direct care worker wage increase has been passed through to the residential providers since the early onset of the COVID-19 pandemic. The continuation of this wage increase is assumed in the FY 2027 budget assumptions.

Inpatient Hospitalizations:



Inpatient Hospitalization costs have been on a steady increase since emerging from the COVID-19 pandemic. The FY 2027 budget assumes a slight decrease in utilization of psychiatric hospitalizations.

Applied Behavioral Analysis (Autism) Services:



Autism services and the number of individuals served have been on a steady increase since the inclusion of applied behavioral analysis in the CMH eligible service array. The FY 2027 budget assumes a slight increase in utilization.

WCCMH Annual Operating Budget

October 1, 2026 – September 30, 2027

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget

	FY 2027 Proposed Budget	FY 2026 Final Budget	FY 2027 Adjusted Budget Over / (Under) FY 2026 Budget	FY 2026 Projected YE	FY 2027 Adjusted Budget Over / (Under) FY 2026 Projections
Revenues					
Medicaid (b) & 1115i	$ 62,354,316	$ 62,354,316	$ -	$ 62,354,316	$ -
Habilitation Supports Waiver	32,526,924	32,526,924	-	34,726,924	(2,200,000)
Children's & SED Waivers	1,100,446	1,100,446	-	1,100,446	-
Autism Medicaid	12,347,733	12,347,733	-	12,347,733	-
Healthy Michigan Plan	7,034,236	7,034,236	-	7,034,236	-
Behavioral Health Home	614,907	614,907	-	714,907	(100,000)
CCBHC Fee-For-Service	29,000,000	29,000,000	-	24,000,000	5,000,000
State General Funds	4,461,704	4,461,704	-	4,461,704	-
Funding From Washtenaw County	1,751,761	1,751,761	-	1,751,761	-
Grants and Earned Contracts Incl. OBRA	2,392,867	2,392,867	-	2,392,867	-
CMHPSM/Affiliate & U of M Billings	950,000	950,000	-	950,000	-
All Other	2,034,357	2,034,357	-	3,284,357	(1,250,000)
Use of Prior Year Fund Balance	-	400,000	(400,000)	-	-
Total Revenues	**$ 156,569,251**	**$ 156,969,251**	**$ (400,000)**	**$ 155,119,251**	**$ 1,450,000**
Expenses					
Administrative Expenses					
WCCMH Administration	$ 14,158,884	$ 14,158,884	$ -	$ 13,507,000	$ 651,884
Total Administrative Expenses	$ 14,158,884	$ 14,158,884	$ -	$ 13,507,000	$ 651,884
Direct Services					
WCCMH Direct Services	$ 43,850,000	$ 43,850,000	$ -	$ 39,045,000	$ 4,805,000
Total Direct Services	$ 43,850,000	$ 43,850,000	$ -	$ 39,045,000	$ 4,805,000
Contracted Services					
WCCMH Contracted Services	$ 95,187,500	$ 95,187,500	$ -	$ 96,500,000	$ (1,312,500)
Total Contracted Services	$ 95,187,500	$ 95,187,500	$ -	$ 96,500,000	$ (1,312,500)
Other Non-Service Costs					
Special Item - Group Home Purchases	$ -	$ 400,000	$ (400,000)	$ 400,000	$ (400,000)
State Facilities Local Contribution	900,000	900,000	-	900,000	-
Shelter	80,000	80,000	-	80,000	-
Total Other Non-Service Costs	$ 980,000	$ 1,380,000	$ (400,000)	$ 1,380,000	$ (400,000)
Grants And Contracts	$ 2,392,867	$ 2,392,867	$ -	$ 2,392,867	$ -
Total Expenses	**$ 156,569,251**	**$ 156,969,251**	**$ (400,000)**	**$ 152,824,867**	**$ 3,744,384**
Revenue Over/(Under) Expenses	0	0	0	2,294,384	$ (2,294,384)

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget

WCCMH Administrative Expenses

		FY 2027 Proposed Budget	FY 2026 Final Budget	FY 2027 Budget Over / (Under) FY 2026 Budget	FY 2026 Projected YE	FY 2027 Budget Over / (Under) FY 2026 Projections
	Administration	$ 1,400,000	$ 1,450,000	$ (50,000)	$ 1,380,000	$ 20,000
(a)(b)	Compliance	190,000	190,000	-	175,000	15,000
(a)	Finance	1,500,000	1,650,000	(150,000)	1,500,000	-
	Human Resources	275,000	275,000	-	195,000	80,000
(a)	Information Management	275,000	275,000	-	270,000	5,000
(a)	Intake/Enrollment	775,000	775,000	-	775,000	-
(a)	Member Services	275,000	275,000	-	197,000	78,000
(a)	Network Management	675,000	675,000	-	650,000	25,000
(a)	Quality/Performance Imp.	410,000	500,000	(90,000)	396,000	14,000
(b)	Recipient Rights	1,550,000	1,650,000	(100,000)	1,480,000	70,000
(a)	Utilization Review	1,150,000	1,150,000	-	1,125,000	25,000
	County Cost Allocation Plan	5,680,884	5,290,884	390,000	5,364,000	316,884
	TOTAL	$ 14,155,884	$ 14,155,884	$ -	$ 13,507,000	$ 648,884

-

(a) All or a portion of this administrative category is a delegated function of the PIHP.
(b) Revenue contracts exist with Affiliate Partner CMH's for the purchase of these administrative functions.

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget

WCCMH Direct Service Expenses

	FY 2027 Proposed Budget	FY 2026 Final Budget	FY 2027 Budget Over / (Under) FY 2026 Budget	FY 2026 Projected YE	FY 2027 Budget Over / (Under) FY 2026 Projections
Program Support	$ 4,750,000	$ 4,750,000	-	$ 4,700,000	$ 50,000
ACT	2,600,000	2,600,000	-	2,100,000	500,000
Autism	420,000	420,000	-	145,000	275,000
Behavior Management	940,000	940,000	-	750,000	190,000
Case Management	10,800,000	10,800,000	-	9,750,000	1,050,000
Crisis Stabilization	3,000,000	3,000,000	-	2,750,000	250,000
Health Home	450,000	450,000	-	450,000	-
Home Based	1,725,000	1,725,000	-	1,650,000	75,000
Jail Services	680,000	680,000	-	675,000	5,000
Jail Diversion	185,000	185,000	-	275,000	(90,000)
Nursing	3,100,000	3,100,000	-	2,900,000	200,000
Nursing Home Services	190,000	190,000	-	160,000	30,000
Outpatient	3,350,000	3,350,000	-	3,200,000	150,000
Peer Supports	1,250,000	1,250,000	-	1,250,000	-
Psychiatric Services	5,700,000	5,700,000	-	5,300,000	400,000
Skill Building	2,200,000	2,200,000	-	1,400,000	800,000
Specialty Services	335,000	335,000	-	290,000	45,000
Supported Employment	1,700,000	1,700,000	-	900,000	800,000
Wraparound	475,000	475,000	-	400,000	75,000
TOTAL	$ 43,850,000	$ 43,850,000	$ -	$ 39,045,000	$ 4,805,000

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget

WCCMH Contracted Service Expenses

	FY 2027 Proposed Budget	FY 2026 Final Budget	FY 2027 Budget Over / (Under) FY 2026 Budget	FY 2026 Projected YE	FY 2027 Budget Over / (Under) FY 2026 Projections
Access/Assessments	$ 150,000	$ 150,000	$ -	$ 150,000	$ -
Autism Services	14,500,000	14,500,000	-	13,000,000	1,500,000
Community Inpatient	12,000,000	12,000,000	-	14,000,000	(2,000,000)
Community Living Supports	39,500,000	39,500,000	-	39,000,000	500,000
Licensed Facilities	23,500,000	23,500,000	-	23,800,000	(300,000)
Nursing	150,000	150,000	-	180,000	(30,000)
Outpatient	12,500	12,500	-	980,000	(967,500)
Peer Supports/Drop-In	400,000	400,000	-	300,000	100,000
PERS	150,000	150,000	-	150,000	-
PSR/Clubhouse	600,000	600,000	-	500,000	100,000
Respite	715,000	715,000	-	580,000	135,000
Skill Building	2,750,000	2,750,000	-	2,900,000	(150,000)
Specialty Services	150,000	150,000	-	150,000	-
Supported Employment	350,000	350,000	-	220,000	130,000
All Other Contracted Services	260,000	260,000	-	590,000	(330,000)
TOTAL	$ 95,187,500	$ 95,187,500	$ -	$ 96,500,000	$ (1,312,500)

Washtenaw County Community Mental Health
Fiscal Year 2027 Budget by Fund Source

	Total
Medicaid **	
Revenue	
Medicaid (b), 1115I, Waivers & Autism	$ 108,329,419
Total Medicaid Revenue	$ 108,329,419
Expense	
Service Costs	$ 108,329,419
Total Medicaid Expense	$ 108,329,419
Medicaid Surplus/(Deficit)	$ -
Healthy Michigan Plan **	
Revenue	
Healthy Michigan Plan	$ 7,034,236
Total Healthy Michigan Revenue	$ 7,034,236
Expense	
Service Costs	$ 7,034,236
Total Healthy Michigan Expense	$ 7,034,236
Total Healthy Michigan Surplus/(Deficit)	$ -
Behavioral Health Home **	
Revenue	$ 614,907
Expense	614,907
Behavioral Health Home Surplus/(Deficit)	$ -

** Denotes PIHP Medicaid Subcontracting Agreement Funds

Certified Community Behavioral Health Clinic (CCBHC)	
Revenue	
CCBHC Fee for Service	$ 29,000,000
Total CCBHC Revenue	$ 29,000,000
Expense	
Service Costs	$ 29,000,000
Total CCBHC Expense	$ 29,000,000
Total CCBHC Surplus/(Deficit)	$ -
General Fund	
Revenue	
CMH Operations	$ 4,461,704
Funding from Other Sources	-
Total General Fund Revenue	$ 4,461,704
Total General Fund Expense	$ 4,461,704
General Fund Surplus/(Deficit)	$ -
Grants and Contracts	
Revenue	$ 2,392,867
Expense	2,392,867
Grants & Cont. Surplus/(Deficit)	$ -
Local	
Revenue	$ 1,751,761
Expense	1,751,761
Local Surplus/(Deficit)	$ -
All Other	
Revenue	$ 2,984,357
Expense	2,984,357
All Other Surplus/(Deficit)	$ -
Grand Total	
Revenue	$ 156,569,251
Expense	156,569,251
Grand Total Surplus/(Deficit)	$ -

WCCMH Proposed Millage Budget

January 1, 2027 – Decemeber 31, 2027

The WCCMH portion of the Public Safety and Mental Health Preservation Millage is effectively managed by the WCCMH Board's Millage Advisory Committee (MAC). The MAC makes recommendations to the WCCMH Board to meet the community priorities identified as millage investments.

A wealth of information on prior year investments, CMH millage impact reports and news can be found at www.washtenaw.org/millage

In 2024, WCCMH expended all the CMH millage funds levied and is projected to do the same in 2025. WCCMH utilized a Request for Proposal (RFP) to the local community to expand services utilizing the existing fund balance over the course of three years. For 2027, the mental health portion of the millage is expected to collect $9M.

The CMH millage budget also supports the continued investment in service expansion utilizing the WCCMH CARES Team, which is comprised of CMH staff providing supports for individuals in crisis as well as mental health services for those uninsured or underinsured. The CMH millage works in conjunction with other CMH fund sources to expand access and fill gaps in funding.

Washtenaw County Community Mental Health
FY 2027 Proposed Annual Millage Budget

	Fiscal Year 2027 Proposed Budget	Fiscal Year 2026 Projected Budget	FY27 Budget Over/(Under) FY26 Budget
Community Wide Service Expansion			
WCCMH CARES Team			
Access & Triage	$ 793,800	$ 756,000	$ 37,800
Treatment & Stabilization Services	904,050	861,000	43,050
Crisis Response	948,150	903,000	45,150
Other CARES Team	496,125	472,500	23,625
Criminal Justice Diversion & Deflection			
WCCMH Jail Services Team	$ 95,000	$ 90,000	$ 5,000
Prosecuting Attorney Office	162,750	155,000	7,750
Supportive Housing			
Avalon - Permanent Supportive Housing	$ 451,791	$ 438,632	$ 13,159
Michigan Ability Partners	271,992	259,106	12,886
Ozone	254,685	246,551	8,134
Ypsilanti Housing Commission	-	140,000	(140,000)
Alpha House	96,700	96,700	-
Shelter Association of MI	85,443	85,443	-
Homeless Outreach Team/ER Housing	550,000	550,000	-
Youth Initiatives and Support			
Washtenaw Intermediate School District	$ 803,879	$ 803,879	$ -
Student Advocacy Center	419,688	419,688	-
Packard Health - YBMen	237,600	230,677	6,923
Washtenaw Area Council for Children	89,730	87,542	2,188
Other Youth Initiatives and Support	250,000	250,000	-
Other Service Expansion			
Health Dept - Health Neighborhoods	$ 255,081	$ 268,027	$ (12,946)
Washtenaw Health Project	432,518	432,518	-
Jewish Family Services	385,642	385,642	
Ypsilanti District Library	191,760	186,266	-
Women's Center of Southeastern MI	83,421	83,421	-
All Other Service Expansion	500,000	500,000	-
TOTAL Community Wide Service Expansion	$ 8,759,805	$ 8,701,592	$ 52,719

	Fiscal Year 2027 Proposed Budget	Fiscal Year 2026 Projected Budget	FY27 Budget Over/(Under) FY26 Budget
Education & Prevention			
Education & Prevention			
Health Department - Anti Stigma Campaign	$ 170,000	$ 278,199	$ (108,199)
NAMI Contract	189,223	189,223	-
Miles Jeffery Roberts Foundation	45,000	45,000	-
Issue Media Group	12,000	12,000	-
TOTAL Education & Prevention	$ 416,223	$ 524,422	$ (108,199)
Evaluate & Communicate			
Evaluate & Communicate			
CHRT Contract	$ 230,000	$ 230,000	$ -
TOTAL Evaluation & Communication	$ 230,000	$ 230,000	-
Administration of the Millage			
WCCMH Administration	$ 682,500	$ 650,000	$ 32,500
5 Healthy Towns (Planning)	25,000	25,000	-
National Assessment Center	20,660	20,660	-
Grand Totals	**$ 10,134,188**	**$ 10,151,674**	**$ (22,980)**

Millage Advisory Committee (MAC)		
Committee Member	**Term Expiration**	**Member Position**
Annie Somerville (Chair)	3/31/2029	WCCMH Board Representative / Board of Commissioners Representative
Barb Higman	3/31/2029	WCCMH Board Representative
Amanda Carlisle	3/31/2028	Washtenaw Housing Alliance Representative
Anna Dusbiber	3/31/2027	Primary Consumer
Holly Heaviland	3/31/2029	Washtenaw Intermediate School District
Steve Petty	3/31/2027	Community Member
Marlene Radzik	3/31/2028	Law Enforcement Representative
Alfreda Rooks	3/31/2028	WCCMH Board Representative
Ray Rion	3/31/2028	Packard Health Representative
Marianne Udow-Phillips	3/31/2027	WCCMH Board Representative
George Waddles, Jr.	3/31/2028	Community Member

Appendices

APPENDIX A

Michigan Medicaid Medical Necessity Criteria:

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability, or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability, or substance use disorder; and/or
- Intended to treat, ameliorate, diminish, or stabilize the symptoms of mental illness, developmental disability, or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope, and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:
    - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
    - that are experimental or investigational in nature; or
    - for which there exists another appropriate, efficacious, less restrictive, and cost-effective service, setting or support that otherwise satisfies the standards for medically necessary services; and/or
- Employ various methods to determine amount, scope, and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

APPENDIX B

Master Contract List for FY2027
Service Contracts

Applied Behavioral Analysis Services	Start Date	End Date
ABA Insight, LLC	10/01/2026	09/30/2027
ABA Pathways, LLC	10/01/2026	09/30/2027
Acorn Health of Michigan, LLC	10/01/2026	09/30/2027
Anwar House of Therapy	10/01/2026	09/30/2027
Autism Spectrum Therapies, LLC DBA Total Spectrum	10/01/2026	09/30/2027
BlueMind Therapy, LLC	10/01/2026	09/30/2027
Centria Healthcare	10/01/2026	09/30/2027
Illuminate ABA Services, LLC	10/01/2026	09/30/2027
IvyRehab Michigan, LLC	10/01/2026	09/30/2027
Judson Center	10/01/2026	09/30/2027
Magnet ABA Therapy	10/01/2026	09/30/2027
Metropolitan Speech, Sensory & ABA Centers	10/01/2026	09/30/2027
Michigan Learning Community, LLC	10/01/2026	09/30/2027
RISE Center for Autism, LLC	10/01/2026	09/30/2027
Residential Options, LLC	10/01/2026	09/30/2027
Clubhouse/Drop-In Center		
Fresh Start Clubhouse	10/01/2026	09/30/2027
Full Circle Drop-In Center	10/01/2026	09/30/2027
Training & Treatment Innovations, Inc.	10/01/2026	09/30/2027
Community Inpatient Hospitals/Partial Hospitalizations		
BCA of Detroit, LLC DBA StoneCrest Center	10/01/2026	09/30/2027
Bronson-Acadia Joint Venture DBA Bronson Behavioral Health	10/01/2026	09/30/2027
Forest View Hospital	10/01/2026	09/30/2027
Havenwyck Hospital	10/01/2026	09/30/2027
Healthsource Saginaw, Inc	10/01/2026	09/30/2027
HFHS Acadia Joint Ventura DBA HF Behavioral Health Hospital	10/01/2026	09/30/2027
Hillsdale Community Health Center	10/01/2026	09/30/2027
Lansing Senior Partners LLC DBA Brightwell Behavioral Health	10/01/2026	09/30/2027
Madison Community Hospital DBA Samaritan Behavioral Center	10/01/2026	09/30/2027
Memorial Hospital DBA Memorial Healthcare	10/01/2026	09/30/2027
Mercy Memorial Hospital dba ProMedica Monroe Regional Hospital	10/01/2026	09/30/2027
Metropolitan Behavioral Health	10/01/2026	09/30/2027
New Oakland Family Center	10/01/2026	09/30/2027
Pine Rest	10/01/2026	09/30/2027
PHC of Michigan, LLC DBA Harbor Oaks Hospital	10/01/2026	09/30/2027
Straith Pediatric Behavioral Hospital	10/01/2026	09/30/2027
The Regents of The University of Michigan	10/01/2026	09/30/2027
Trinity Health-Michigan	10/01/2026	09/30/2027
Community Living Supports- Unlicensed		
A Heart That Cares, LLC	10/01/2026	09/30/2027
Agency with Choice Services, LLC	10/01/2026	09/30/2027
CHS Group, LLC	10/01/2026	09/30/2027
Community Residence Corporation DBA Community Alliance	10/01/2026	09/30/2027

Continuum Help Foundation	10/01/2026	09/30/2027
Exceptional Journeys Community Center	10/01/2026	09/30/2027
His Eye Is on the Sparrow	10/01/2026	09/30/2027
Home Sweet Home Care Services	10/01/2026	09/30/2027
Illuminate ABA Services	10/01/2026	09/30/2027
INI Group, Inc.	10/01/2026	09/30/2027
JOAK American Homes	10/01/2026	09/30/2027
JYB Homecare, LLC	10/01/2026	09/30/2027
Progressive Residential Services	10/01/2026	09/30/2027
Renaissance Community Homes DBA Pathlight Community Services	10/01/2026	09/30/2027
Skills and Ability Education, LLC	10/01/2026	09/30/2027
Specially Made Co. LLC	10/01/2026	09/30/2027
Spectrum Community Services	10/01/2026	09/30/2027
Toepfer Home		
Crisis Residential		
Renaissance Community Homes DBA Pathlight Community Services	10/01/2026	09/30/2027
Fiscal Intermediaries		
Community Living Network	10/01/2026	09/30/2027
Guardian Trac, LLC	10/01/2026	09/30/2027
Licensed Residential Services		
Adult Learning Systems- Lower Michigan	10/01/2026	09/30/2027
Beacon Specialized Living Services	10/01/2026	09/30/2027
Benjamin's Hope	10/01/2026	09/30/2027
Byerly Enterprises II, LLC	10/01/2026	09/30/2027
Christ Centered Homes, Inc.	10/01/2026	09/30/2027
Courtyard Manor of Wixom, Inc.	10/01/2026	09/30/2027
Elite AFC, LLC	10/01/2026	09/30/2027
Elite AFC II, LLC	10/01/2026	09/30/2027
Elite AFC III, LLC	10/01/2026	09/30/2027
Flatrock Manor	10/01/2026	09/30/2027
Forest Edge AFC	10/01/2026	09/30/2027
Harbor House Ministries, Inc.	10/01/2026	09/30/2027
Henlyn Care	10/01/2026	09/30/2027
Hope Network Behavioral Health Services	10/01/2026	09/30/2027
Hope Network West Michigan	10/01/2026	09/30/2027
JOAK American Homes	10/01/2026	09/30/2027
Moriah Inc. DBA Eisenhower Center	10/01/2026	09/30/2027
NRMI, LLC DBA NeuroRestorative	10/01/2026	09/30/2027
Pine Rest Christian Mental Health Services	10/01/2026	09/30/2027
Progressive Residential Services	10/01/2026	09/30/2027
Renaissance Community Homes DBA Pathlight Community Services	10/01/2026	09/30/2027
Renaissance House, Inc.	10/01/2026	09/30/2027
Saints, Inc.	10/01/2026	09/30/2027
Spectrum Community Services	10/01/2026	09/30/2027
St. Louis Center	10/01/2026	09/30/2027
Turning Leaf Behavioral Health Services	10/01/2026	09/30/2027
Umbrellex Behavioral Health Services	10/01/2026	09/30/2027

Pharmacy/Enhanced Pharmacy		
CareLinc Medical Equipment & Supply Co., LLC	10/01/2026	09/30/2027
County Pharmacy Services DBA Ann Arbor Professional Pharmacy	10/01/2026	09/30/2027
Genoa Healthcare, LLC	10/01/2026	09/30/2027
Private Duty Nursing		
A Quality Staffing, LLC DBA Elite Medical Staffing	10/01/2026	09/30/2027
Centria Healthcare	10/01/2026	09/30/2027
First Day Home Care, LLC	10/01/2026	09/30/2027
Mercy Plus Healthcare Services	10/01/2026	09/30/2027
Respite/Respite Camps		
A Heart That Cares, LLC	10/01/2026	09/30/2027
Agency with Choice Services, LLC	10/01/2026	09/30/2027
Camp Fish Tales	10/01/2026	09/30/2027
Camp SkyWild	10/01/2026	09/30/2027
Canton Township- Camp A.B.L.E.	10/01/2026	09/30/2027
CLD Gym, LLC DBA We Rock the Spectrum	10/01/2026	09/30/2027
Continuum Help Foundation	10/01/2026	09/30/2027
Indian Trails Camp DBA IKUS Life Enrichment Services	10/01/2026	09/30/2027
Just Us Club	10/01/2026	09/30/2027
Methodist Children's Home Society	10/01/2026	09/30/2027
Michigan League for Crippled Children DBA Camp Grace Bentley	10/01/2026	09/30/2027
St. Francis Camp on the Lake	10/01/2026	09/30/2027
Skill Building Services		
Blessed Hands Loving Hearts	10/01/2026	09/30/2027
Community Work Opportunities, LLC	10/01/2026	09/30/2027
Continuum Help Foundation	10/01/2026	09/30/2027
Exceptional Journeys Community Center	10/01/2026	09/30/2027
Lahser Prevocational Services	10/01/2026	09/30/2027
Life Enrichment Academy	10/01/2026	09/30/2027
Services to Enhance Potential (STEP)	10/01/2026	09/30/2027
St. Louis Center	10/01/2026	09/30/2027
The Ability Hub	10/01/2026	12/31/2026
Turning Leaf Behavioral Health Services	10/01/2026	09/30/2027
Work Skills Corporation	10/01/2026	09/30/2027
Specialty Services (OT/PT, Speech, Psychology, Treatment Planning, Housing Assistance, etc.)		
ABA Insight	10/01/2026	09/30/2027
ABA Pathways, LLC	10/01/2026	09/30/2027
Advanced Therapeutic Solutions	10/01/2026	09/30/2027
Anwar House of Therapy	10/01/2026	09/30/2027
Avalon Housing	10/01/2026	09/30/2027
Centria	10/01/2026	09/30/2027
Community Work Opportunities, LLC	10/01/2026	09/30/2027
HealthCall of Detroit	10/01/2026	09/30/2027
Illuminate ABA Services, LLC	10/01/2026	09/30/2027
Kelly Garland DBA Life Dynamic Music Therapy	10/01/2026	09/30/2027

Michigan Learning Community, LLC	10/01/2026	09/30/2027
Metropolitan Speech, Sensory & ABA Centers	10/01/2026	09/30/2027
Psych Resolutions	10/01/2026	09/30/2027
Renaissance Community Services DBA Pathlight Community Services	10/01/2026	09/30/2027
Residential Options, LLC	10/01/2026	09/30/2027
Sharon O'Bryan	10/01/2026	09/30/2027
Therapeutic Concepts, LLC	10/01/2026	09/30/2027

Supported Employment Services

Blessed Hands Loving Hearts	10/01/2026	09/30/2027
Continuum Help Foundation	10/01/2026	09/30/2027
Exceptional Journeys Community Center	10/01/2026	09/30/2027
Life Enrichment Academy	10/01/2026	09/30/2027
Services to Enhance Potential (STEP)	10/01/2026	09/30/2027
Skills and Abilities Education	10/01/2026	09/30/2027
Work Skills Corporation	10/01/2026	09/30/2027

County of Financial Responsibility (Revenue)

Macomb County CMH	10/01/2026	09/30/2027
Pathways CMH	10/01/2026	09/30/2027

County of Financial Responsibility (Expense)

Lapeer County CMH	10/01/2026	09/30/2027

*****The contracts listed above have no budget associated with them because the budget is contingent upon consumer utilization.**

WCCMH Vocational Contracts

Expense	Start Date	End Date	Budget
American Floor Care and Coatings, Inc	10/01/2026	09/30/2027	$8,000
Ann Arbor Rug & Carpet Cleaning	10/01/2026	09/30/2027	$9,200
Cintas	10/01/2026	09/30/2027	Per Actual Cost
Revenue			
Alpha House	10/01/2026	09/30/2027	***
Arbor Bridge Church	10/01/2026	09/30/2027	***
Chinmaya Mission	10/01/2026	09/30/2027	***
Shelter Association of Washtenaw County	10/01/2026	09/30/2027	***
The Thrift Shop of Ypsilanti	10/01/2026	09/30/2027	***
Washtenaw County Facilities Management	10/01/2026	09/30/2027	***
Washtenaw County Parks and Rec	10/01/2026	09/30/2027	***
Ypsilanti Senior Center	10/01/2026	09/30/2027	***

***** The revenue is contingent upon the frequency of services provided by consumer vocational groups.**

Administrative Contracts

Revenue Contracts	Start Date	End Date	Budget
15th District Court	10/01/2026	09/30/2027	Per Budget
Blue Care Network	10/01/2026	09/30/2027	Per Budget
CMHPSM Medicaid Revenue Contract	10/01/2026	09/30/2027	Per Budget
City of Ann Arbor	07/22/2026	07/22/2027	$135,000
Corner Health	10/01/2026	09/30/2027	Per Actual Cost
Hope Clinic	10/01/2026	09/30/2027	Per Actual Cost
Lenawee County CMH	10/01/2026	09/30/2027	Per Actual Cost
Livingston County CMH	10/01/2026	09/30/2027	Per Actual Cost
MDHHS (GF Contract)	10/01/2026	09/30/2027	Per Budget
Monroe County CMH	10/01/2026	09/30/2027	Per Actual Cost
Packard Health	10/01/2026	09/30/2027	Per Actual Cost
Regents of the University of Michigan (ORR)	10/01/2026	09/30/2027	Per Actual Cost
Washtenaw County Children's Services	10/01/2026	09/30/2027	Per Actual Cost
Washtenaw County Sheriff's Office	10/01/2026	09/30/2027	$302,217
Washtenaw County Trial Court	10/01/2026	09/30/2027	$8,000
Washtenaw County Trial Court	10/01/2026	09/30/2027	$85,000
Washtenaw County Trial Court	10/01/2026	09/30/2027	$15,000

Medicaid/General Fund Expense Contracts	Start Date	End Date	Budget
Bromberg & Associates, LLC	10/01/2026	09/30/2027	$1,500
Care Transport	10/01/2026	09/30/2027	$25,000
Crystal Jackson	10/01/2026	09/30/2027	$12,000
Culligan	10/01/2026	09/30/2027	$1,000
Deborah Kennard	10/01/2026	09/30/2027	$19,290
DLD Environmental Services, Inc.	10/01/2026	09/30/2027	$5,000
Dummies on the Run	10/01/2026	09/30/2027	$5,000
Eleos Health, Inc	10/01/2026	09/30/2027	$40,000
Human Resource Opportunities, Inc.	10/01/2026	09/30/2027	Per Actual Cost
Michigan Rehabilitative Services	10/01/2026	09/30/2027	$10,000
MDHHS Liaison	10/01/2026	09/30/2027	$76,400
NAMI of Washtenaw County	10/01/2026	09/30/2027	$23,250
NAPPI International USA, Inc. dba Welle	10/01/2026	09/30/2027	$5,000
Optum 360	10/01/2026	09/30/2027	$2,000
PCE Systems	10/01/2026	09/30/2027	$71,400
Rebecca Richardson	10/01/2026	09/30/2027	$2,000
Relias Learning	10/01/2026	09/30/2027	$72,191
RingCentral	10/01/2026	09/30/2027	$80,208
Roslund Prestage & Company	10/01/2026	09/30/2027	$15,680
Shelter Association of Washtenaw County	10/01/2026	09/30/2027	$90,000
Sheryl Goldberg	10/01/2026	09/30/2027	$1,200
The TM Group, Inc	10/01/2026	09/30/2027	Per Actual Cost
Thryve, LLC	10/01/2026	09/30/2027	$6,750
Toby's Instrument Shop	10/01/2026	09/30/2027	$2,000
UptoDate	10/01/2026	09/30/2027	$13,731
VelloHealth	10/01/2026	09/30/2027	$210,000
Verapose Yoga House	10/01/2026	09/30/2027	$5,000
Vertex Systems	10/01/2026	09/30/2027	$4,500

Zoom Video Communications, Inc.	10/01/2025	09/30/2026	$39,782

Group Home Leases	**Start Date**	**End Date**	**Budget**
4922 Munger LLC	10/01/2026	09/30/2027	$32,448
Catholic Social Services	10/01/2026	09/30/2027	$42,864
Catholic Social Services	10/01/2026	09/30/2027	$26,700
F.A. Kennedy Co.	10/01/2026	09/30/2027	$54,000
Legacy IV LDHA	10/01/2026	09/30/2027	$35,444
Legacy XII Limited Partnership	10/01/2026	09/30/2027	$38,653
Legacy X Limited Partnership	10/01/2026	09/30/2027	$38,653
Pathlight Community Services	10/01/2026	09/30/2027	$29,400
RDBZ II, LLC	10/01/2026	09/30/2027	$35,400
RDBZ II, LLC	10/01/2026	09/30/2027	$39,600
Renaissance House, Inc.	10/01/2026	09/30/2027	$25,704
Shafiq Kasham	10/01/2026	09/30/2027	$25,704
Spectrum Community Services	10/01/2026	09/30/2027	$11,259

Contracts in FY26 that we will no longer have in FY27:

A Touch of Grace 1596, Inc.
Allied Waste Systems, Inc. DBA Republic Waste Services of Southeast Michigan
Behavioral Outcomes Management DBA ExpertCare Management
Eagle Village
Early Autism Services
Full Life Independence
Havenwyck Hospital dba Cedar Creek Hospital
Imagine Center Farm
Integrated Home Care Agency
Jovie of Ann Arbor
Michigan Green Cabs Ann Arbor, LLC
Nutritional Healing of Ann Arbor
Oconomowoc Developmental Training Center dba Genesee Lake School

Board Members who need to abstain from approving the following contracts:

Alfreda Rooks: Regents of the University of Michigan
Anna Dusbiber: Community Living Network & Michigan Rehabilitative Services (MRS)
Barbara Higman: NAMI of Washtenaw County
Felicia Brabec: Regents of the University of Michigan
Judy Gardner: NAMI of Washtenaw County
Marianne Udow-Phillips: Regents of the University of Michigan
Melissa Tolstyka: Trinity- Health Michigan

Washtenaw County Community Mental Health
FY27 Service and Administrative Contracts and Leases

Master Contract List for FY2027
Service Contracts

Applied Behavioral Analysis Services	**Start Date**	**End Date**
ABA Insight, LLC	10/01/2026	09/30/2027
ABA Pathways, LLC	10/01/2026	09/30/2027
Acorn Health of Michigan, LLC	10/01/2026	09/30/2027
Anwar House of Therapy	10/01/2026	09/30/2027
Autism Spectrum Therapies, LLC DBA Total Spectrum	10/01/2026	09/30/2027
BlueMind Therapy, LLC	10/01/2026	09/30/2027
Centria Healthcare	10/01/2026	09/30/2027
Illuminate ABA Services, LLC	10/01/2026	09/30/2027
IvyRehab Michigan, LLC	10/01/2026	09/30/2027
Judson Center	10/01/2026	09/30/2027
Magnet ABA Therapy	10/01/2026	09/30/2027
Metropolitan Speech, Sensory & ABA Centers	10/01/2026	09/30/2027
Michigan Learning Community, LLC	10/01/2026	09/30/2027
RISE Center for Autism, LLC	10/01/2026	09/30/2027
Residential Options, LLC	10/01/2026	09/30/2027
Clubhouse/Drop-In Center		
Fresh Start Clubhouse	10/01/2026	09/30/2027
Full Circle Drop-In Center	10/01/2026	09/30/2027
Training & Treatment Innovations, Inc.	10/01/2026	09/30/2027
Community Inpatient Hospitals/Partial Hospitalizations		
BCA of Detroit, LLC DBA StoneCrest Center	10/01/2026	09/30/2027
Bronson-Acadia Joint Venture DBA Bronson Behavioral Health	10/01/2026	09/30/2027
Forest View Hospital	10/01/2026	09/30/2027
Havenwyck Hospital	10/01/2026	09/30/2027
Healthsource Saginaw, Inc	10/01/2026	09/30/2027
HFHS Acadia Joint Ventura DBA HF Behavioral Health Hospital	10/01/2026	09/30/2027
Hillsdale Community Health Center	10/01/2026	09/30/2027
Lansing Senior Partners LLC DBA Brightwell Behavioral Health	10/01/2026	09/30/2027
Madison Community Hospital DBA Samaritan Behavioral Center	10/01/2026	09/30/2027
Memorial Hospital DBA Memorial Healthcare	10/01/2026	09/30/2027
Mercy Memorial Hospital dba ProMedica Monroe Regional Hospital	10/01/2026	09/30/2027
Metropolitan Behavioral Health	10/01/2026	09/30/2027
New Oakland Family Center	10/01/2026	09/30/2027
Pine Rest	10/01/2026	09/30/2027
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Straith Pediatric Behavioral Hospital	10/01/2026	09/30/2027
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Trinity Health-Michigan	10/01/2026	09/30/2027
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Agency with Choice Services, LLC	10/01/2026	09/30/2027
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Washtenaw County Community Mental Health
FY27 Service and Administrative Contracts and Leases

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Exceptional Journeys Community Center	10/01/2026	09/30/2027
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INI Group, Inc.	10/01/2026	09/30/2027
JOAK American Homes	10/01/2026	09/30/2027
JYB Homecare, LLC	10/01/2026	09/30/2027
Progressive Residential Services	10/01/2026	09/30/2027
Renaissance Community Homes DBA Pathlight Community Services	10/01/2026	09/30/2027
Skills and Ability Education, LLC	10/01/2026	09/30/2027
Specially Made Co. LLC	10/01/2026	09/30/2027
Spectrum Community Services	10/01/2026	09/30/2027
Toepfer Home		

Crisis Residential

Renaissance Community Homes DBA Pathlight Community Services	10/01/2026	09/30/2027

Fiscal Intermediaries

Community Living Network	10/01/2026	09/30/2027
Guardian Trac, LLC	10/01/2026	09/30/2027

Licensed Residential Services

Adult Learning Systems- Lower Michigan	10/01/2026	09/30/2027
Beacon Specialized Living Services	10/01/2026	09/30/2027
Benjamin's Hope	10/01/2026	09/30/2027
Byerly Enterprises II, LLC	10/01/2026	09/30/2027
Christ Centered Homes, Inc.	10/01/2026	09/30/2027
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Elite AFC, LLC	10/01/2026	09/30/2027
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NRMI, LLC DBA NeuroRestorative	10/01/2026	09/30/2027
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Washtenaw County Community Mental Health
FY27 Service and Administrative Contracts and Leases

Pharmacy/Enhanced Pharmacy		
CareLinc Medical Equipment & Supply Co., LLC	10/01/2026	09/30/2027
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Genoa Healthcare, LLC	10/01/2026	09/30/2027
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Centria Healthcare	10/01/2026	09/30/2027
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Camp SkyWild	10/01/2026	09/30/2027
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St. Louis Center	10/01/2026	09/30/2027
The Ability Hub	10/01/2026	12/31/2026
Turning Leaf Behavioral Health Services	10/01/2026	09/30/2027
Work Skills Corporation	10/01/2026	09/30/2027
Specialty Services (OT/PT, Speech, Psychology, Treatment Planning, Housing Assistance, etc.)		
ABA Insight	10/01/2026	09/30/2027
ABA Pathways, LLC	10/01/2026	09/30/2027
Advanced Therapeutic Solutions	10/01/2026	09/30/2027
Anwar House of Therapy	10/01/2026	09/30/2027
Avalon Housing	10/01/2026	09/30/2027
Centria	10/01/2026	09/30/2027
Community Work Opportunities, LLC	10/01/2026	09/30/2027
HealthCall of Detroit	10/01/2026	09/30/2027
Illuminate ABA Services, LLC	10/01/2026	09/30/2027
Kelly Garland DBA Life Dynamic Music Therapy	10/01/2026	09/30/2027

Washtenaw County Community Mental Health
FY27 Service and Administrative Contracts and Leases

Michigan Learning Community, LLC	10/01/2026	09/30/2027
Metropolitan Speech, Sensory & ABA Centers	10/01/2026	09/30/2027
Psych Resolutions	10/01/2026	09/30/2027
Renaissance Community Services DBA Pathlight Community Services	10/01/2026	09/30/2027
Residential Options, LLC	10/01/2026	09/30/2027
Sharon O'Bryan	10/01/2026	09/30/2027
Therapeutic Concepts, LLC	10/01/2026	09/30/2027

Supported Employment Services

Blessed Hands Loving Hearts	10/01/2026	09/30/2027
Continuum Help Foundation	10/01/2026	09/30/2027
Exceptional Journeys Community Center	10/01/2026	09/30/2027
Life Enrichment Academy	10/01/2026	09/30/2027
Services to Enhance Potential (STEP)	10/01/2026	09/30/2027
Skills and Abilities Education	10/01/2026	09/30/2027
Work Skills Corporation	10/01/2026	09/30/2027

County of Financial Responsibility (Revenue)

Macomb County CMH	10/01/2026	09/30/2027
Pathways CMH	10/01/2026	09/30/2027

County of Financial Responsibility (Expense)

Lapeer County CMH	10/01/2026	09/30/2027

*****The contracts listed above have no budget associated with them because the budget is contingent upon consumer utilization.**

WCCMH Vocational Contracts

Expense	**Start Date**	**End Date**	**Budget**
American Floor Care and Coatings, Inc	10/01/2026	09/30/2027	$8,000
Ann Arbor Rug & Carpet Cleaning	10/01/2026	09/30/2027	$9,200
Cintas	10/01/2026	09/30/2027	Per Actual Cost
Revenue			
Alpha House	10/01/2026	09/30/2027	***
Arbor Bridge Church	10/01/2026	09/30/2027	***
Chinmaya Mission	10/01/2026	09/30/2027	***
Shelter Association of Washtenaw County	10/01/2026	09/30/2027	***
The Thrift Shop of Ypsilanti	10/01/2026	09/30/2027	***
Washtenaw County Facilities Management	10/01/2026	09/30/2027	***
Washtenaw County Parks and Rec	10/01/2026	09/30/2027	***
Ypsilanti Senior Center	10/01/2026	09/30/2027	***

***** The revenue is contingent upon the frequency of services provided by consumer vocational groups.**

Administrative Contracts

Washtenaw County Community Mental Health
FY27 Service and Administrative Contracts and Leases

Revenue Contracts	**Start Date**	**End Date**	**Budget**
15th District Court	10/01/2026	09/30/2027	Per Budget
Blue Care Network	10/01/2026	09/30/2027	Per Budget
CMHPSM Medicaid Revenue Contract	10/01/2026	09/30/2027	Per Budget
City of Ann Arbor	07/22/2026	07/22/2027	$135,000
Corner Health	10/01/2026	09/30/2027	Per Actual Cost
Hope Clinic	10/01/2026	09/30/2027	Per Actual Cost
Lenawee County CMH	10/01/2026	09/30/2027	Per Actual Cost
Livingston County CMH	10/01/2026	09/30/2027	Per Actual Cost
MDHHS (GF Contract)	10/01/2026	09/30/2027	Per Budget
Monroe County CMH	10/01/2026	09/30/2027	Per Actual Cost
Packard Health	10/01/2026	09/30/2027	Per Actual Cost
Regents of the University of Michigan (ORR)	10/01/2026	09/30/2027	Per Actual Cost
Washtenaw County Children's Services	10/01/2026	09/30/2027	Per Actual Cost
Washtenaw County Sheriff's Office	10/01/2026	09/30/2027	$302,217
Washtenaw County Trial Court	10/01/2026	09/30/2027	$8,000
Washtenaw County Trial Court	10/01/2026	09/30/2027	$85,000
Washtenaw County Trial Court	10/01/2026	09/30/2027	$15,000

Medicaid/General Fund Expense Contracts	**Start Date**	**End Date**	**Budget**
Bromberg & Associates, LLC	10/01/2026	09/30/2027	$1,500
Care Transport	10/01/2026	09/30/2027	$25,000
Crystal Jackson	10/01/2026	09/30/2027	$12,000
Culligan	10/01/2026	09/30/2027	$1,000
Deborah Kennard	10/01/2026	09/30/2027	$19,290
DLD Environmental Services, Inc.	10/01/2026	09/30/2027	$5,000
Dummies on the Run	10/01/2026	09/30/2027	$5,000
Eleos Health, Inc	10/01/2026	09/30/2027	$40,000
Human Resource Opportunities, Inc.	10/01/2026	09/30/2027	Per Actual Cost
Michigan Rehabilitative Services	10/01/2026	09/30/2027	$10,000
MDHHS Liaison	10/01/2026	09/30/2027	$76,400
NAMI of Washtenaw County	10/01/2026	09/30/2027	$23,250
NAPPI International USA, Inc. dba Welle	10/01/2026	09/30/2027	$5,000
Optum 360	10/01/2026	09/30/2027	$2,000
PCE Systems	10/01/2026	09/30/2027	$71,400
Rebecca Richardson	10/01/2026	09/30/2027	$2,000
Relias Learning	10/01/2026	09/30/2027	$72,191
RingCentral	10/01/2026	09/30/2027	$80,208
Roslund Prestage & Company	10/01/2026	09/30/2027	$15,680
Shelter Association of Washtenaw County	10/01/2026	09/30/2027	$90,000
Sheryl Goldberg	10/01/2026	09/30/2027	$1,200
The TM Group, Inc	10/01/2026	09/30/2027	Per Actual Cost
Thryve, LLC	10/01/2026	09/30/2027	$6,750
Toby's Instrument Shop	10/01/2026	09/30/2027	$2,000
UptoDate	10/01/2026	09/30/2027	$13,731
VelloHealth	10/01/2026	09/30/2027	$210,000
Verapose Yoga House	10/01/2026	09/30/2027	$5,000
Vertex Systems	10/01/2026	09/30/2027	$4,500
Zoom Video Communications, Inc.	10/01/2025	09/30/2026	$39,782

Washtenaw County Community Mental Health
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Group Home Leases	**Start Date**	**End Date**	**Budget**
4922 Munger LLC	10/01/2026	09/30/2027	$32,448
Catholic Social Services	10/01/2026	09/30/2027	$42,864
Catholic Social Services	10/01/2026	09/30/2027	$26,700
F.A. Kennedy Co.	10/01/2026	09/30/2027	$54,000
Legacy IV LDHA	10/01/2026	09/30/2027	$35,444
Legacy XII Limited Partnership	10/01/2026	09/30/2027	$38,653
Legacy X Limited Partnership	10/01/2026	09/30/2027	$38,653
Pathlight Community Services	10/01/2026	09/30/2027	$29,400
RDBZ II, LLC	10/01/2026	09/30/2027	$35,400
RDBZ II, LLC	10/01/2026	09/30/2027	$39,600
Renaissance House, Inc.	10/01/2026	09/30/2027	$25,704
Shafiq Kasham	10/01/2026	09/30/2027	$25,704
Spectrum Community Services	10/01/2026	09/30/2027	$11,259

Contracts in FY26 that we will no longer have in FY27:

A Touch of Grace 1596, Inc.
Allied Waste Systems, Inc. DBA Republic Waste Services of Southeast Michigan
Behavioral Outcomes Management DBA ExpertCare Management
Eagle Village
Early Autism Services
Full Life Independence
Havenwyck Hospital dba Cedar Creek Hospital
Imagine Center Farm
Integrated Home Care Agency
Jovie of Ann Arbor
Michigan Green Cabs Ann Arbor, LLC
Nutritional Healing of Ann Arbor
Oconomowoc Developmental Training Center dba Genesee Lake School

Board Members who need to abstain from approving the following contracts:

Alfreda Rooks: Regents of the University of Michigan
Anna Dusbiber: Community Living Network & Michigan Rehabilitative Services (MRS)
Barbara Higman: NAMI of Washtenaw County
Felicia Brabec: Regents of the University of Michigan
Judy Gardner: NAMI of Washtenaw County
Marianne Udow-Phillips: Regents of the University of Michigan
Melissa Tolstyka: Trinity- Health Michigan