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
4135 Washtenaw Ave, Ann Arbor, MI
Learning Resource Center-Michigan Room
May 17, 2019
9:30AM-11:30AM

I. Introductions

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 Board Meeting Minutes and Actions-4/19/19 (Attachment #1A)
   B. WCCMH Board Meeting Minutes and Actions-4/19/19 CLOSED SESSION (Attachment #1B) ****
   C. WCCMH Budget-Finance Committee Meeting Minutes and Actions-4/8/19 (Attachment #1C)
   D. WCCMH Program-Quality Committee Meeting Minutes and Actions-4/8/19 (Attachment #1D)
   E. WCCMH Contracts and Leases (Attachment #1E)
   F. WCCMH Executive Director Authorizations (Attachment #1F)
   G. WCCMH Consumer Advisory Council Meeting Minutes and Actions-4/10/19 (Attachment #1G)
   H. WCCMH Consumer Advisory Council Spring Newsletter (Attachment #1H)
   I. WCCMH Board and Board Committee Structure for the term of 4/1/19-3/31/20 (Attachment #1I)
   J. CMHPSM Service Verification Policy (Attachment #1J)
   K. CMHPSM Organizational Credentialing Recredentialing and Monitoring Policy (Attachment #1K)
   L. CMHPSM In-Region County of Financial Responsibility Policy (Attachment #1L)

V. Treasurer’s Report (5 minutes)
   • Financial Status Report (Attachment #2) ACTION
   • FY2019 Projections (Attachment #2A)

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

VII. CMHPSM Regional Update (10 minutes)
   • April 10, 2019 meeting minutes (Attachment #3)
   • May 8, 2019 meeting update

VIII. Old Business
   • Millage Update
   • 31n Legislation funding opportunity (Attachment #4)

IX. New Business
   • Diversion Council - M. Harding
   • Deconstructing the Direct Care Worker Crisis-Next Steps (Attachment #5)

X. Items for Future Discussions (5 minutes)
   • I/DD presentation-June
   • Youth Mapping
   • ABLE Change
   • Housing
   • Funding Crisis

XI. Adjournment of Public Meeting

***minutes will be distributed to WCCMH Board members only

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 OF DIRECTORS

MAY 17, 2019

CONSENT AGENDA

A. WCCMH Board Meeting Minutes and Actions-4/19/19
B. WCCMH Board Meeting Minutes and Actions-4/19/19-CLOSED SESSION ***
C. WCCMH Budget-Finance Committee Meeting Minutes and Actions-4/8/19
D. WCCMH Program-Quality Committee Meeting Minutes and Actions-4/8/19
E. WCCMH Contracts and Leases
F. WCCMH Executive Director Authorizations
G. WCCMH Consumer Advisory Council Meeting Minutes and Actions 4/10/19
H. WCCMH Consumer Advisory Council Spring Newsletter
I. WCCMH Board and Board Committee structure for the term of 4/1/19-3/31/20
J. CMHPSM Service Verification Policy
K. CMHPSM Organizational Credentialing Recredentialing and Monitoring Policy
L. CMHPSM In-Region County of Financial Responsibility Policy

***minutes will be distributed to WCCMH Board members only
J. Martin called the meeting to order at 9:35 am.

I. Introductions
   • WCCMH Board members introduced themselves.

II. Audience Participation
   • J. Barker stressed the importance of a way for CMH staff to intervene prior to anyone presenting themselves to the emergency room and the concern over after-hours medical treatment.
   • B. Pierce from Sylvan Township mentioned that he did apply to the WCCMH Board and even though he wasn’t chosen to serve on the board, he acknowledged that he is pleased with the new membership on the WCCMH Board.
   • G. Harris spoke about her concerns that if she couldn’t continue to support her son who would take care of him due to funding.
   • K. Van Den Berg, a WCCMH Peer Support staff, attended the Appropriations Committee in Lansing recently to share her recovery story and to address the importance of the continued funding for mental health. She stressed the importance of communication on what services we provide and how to communicate this to the public.

III. Board Response to Audience Participation
   • K. Walker stated that the Program Committee will work with WCCMH staff to investigate possible changes in the process that were raised by J. Barker.
   • J. Martin thanked everyone for their diligence in advocating for the mental health funding and continued services that we provide.
   • T. Cortes thanked K. Van Den Berg for sharing her story and for her continued advocacy efforts locally and in Lansing.

J. Martin presented a certificate of appreciation for M. Creekmore’s previous participation on the WCCMH Board and recognized him for his continued advocacy with the members that we serve.

J. Martin acknowledged M. Bloom for her previous WCCMH Board participation and for her continued advocacy for the members that we serve.
Notary, R. Dornbos conducted the swearing in of R. Jefferson for the term of April 1, 2019 through March 31, 2020. He is serving in the Washtenaw County Board of Commissioners spot that was previously vacated by K. Scott.

Notary, R. Dornbos conducted the swearing in of C. Richardson, K. Scott and B. King on Wednesday, April 10, 2019. The terms and WCCMH Board positions are as follows:

- C. Richardson, U of M Community Member with a term of April 1, 2019 through March 31, 2022
- K. Scott, Secondary Consumer with a term of April 1, 2019 through March 31, 2022
- B. King, Member at Large with a term of April 1, 2019 through March 31, 2022.

IV. Consent Agenda Actions

- WCCMH Board Meeting Minutes and Actions – 3/15/19 (Attachment #1A)
- WCCMH Budget-Finance Committee Meeting Minutes and Actions 1/14/19 (Attachment #1B)
- WCCMH Budget-Finance and Program-Quality Committee Meeting Minutes and Actions 3/11/19 (Attachment #1C)
- WCCMH Contracts and Leases (Attachment #1D)
- WCCMH Executive Director Authorizations (Attachment #1E)
- WCCMH Consumer Advisory Council Meeting Minutes and Actions- 1/19/19 (Attachment #1F)
- WCCMH Consumer Advisory Council Meeting Minutes and Actions- 3/13/19 (Attachment #1G)
- CMHPSM Claims Payment and Appeal Policy (Attachment #1H)
- CMHPSM Consumer Appeals Policy (Attachment #1I)
- DMHPSM Person Centered Planning Policy (Attachment #1J)

MOTION BY C. RICHARDSON SUPPORTED C. COLLINS TO APPROVE THE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH CONSENT AGENDA DATED APRIL 19, 2019 AS PRESENTED.

MOTION CARRIED

V. Financial Status Report

- N. Phelps reviewed the financial status report for the month ending February 28, 2019.
- Medicaid Enrollees were 33,884 in February 2019.
- Healthy Michigan Enrollees in February 2019 were 16,894.
- Medicaid consumers served through February 2019 are 3,216. This is 181 more consumers served than the same period last year.
- ABA Waiver consumers served through February 2019 were 151. This is 25 more consumers served than the same period last year.
- General Fund consumers served through February 2019 are 588. This is 35 more consumer served than the same period last year.
- Healthy Michigan consumers served through February 2019 are 737. This is 8 more consumers served than the same period last year.
- CLS costs to date are $10.7 Million. This is $285,000 under budget.
- Community Inpatient costs to date total $2.4 Million. This is $236,000 over budget.
- Licensed Residential costs to date are $4.5 Million. This is $202,000 under budget.
• Applied Behavior Analysis/Autism service costs to date are $1.3 Million. This is $205,000 over budget.

• Medicaid, Healthy Michigan and Autism funds are on budget.

• Financial performance by funding source:
  o Medicaid is showing a deficit of $3.0 Million.
  o Healthy Michigan is showing a deficit of $1.6 Million.
  o State General Funds is showing a deficit of $169,000.
  o Local Funds are showing a surplus of $299,000 through February 2019.

• The Fund Balance at the beginning of FY2018 was $2.7 Million. The Fund Balance is currently unknown at this time due to unexpected end of year transactions. An update will be provided when available.

• C. Collins suggested that it might be helpful for the WCCMH Board members to attend the WCCMH Budget-Finance Committee meetings to gather detailed information and to better understand the funding issues.


MOTION CARRIED

VI. Executive Director Report

• T. Cortes presented the Executive Director report to the WCCMH Board.
  o Appropriations Committee meeting in Lansing, MI on April 11, 2019
    ▪ T. Cortes thanked the members in attendance and the people that attended the 4/11/19 Appropriations Committee for their continued support for Community Mental Health. A link will be emailed to the board for them to view the video.
    ▪ T. Cortes also thanked S. Amos O'Neal for all of her hard work on coordinating the arrangements for people to attend the event.
  o Joint commission will be onsite on Monday, April 29th.
  o T. Cortes mentioned that there was a positive conversation with Kirk Profit and Ottawa County to come up with an advocacy plan.
  o T. Cortes will meet with B. King to see what ways he can help with the funding issues within the state.
  o Milliman will be working on rates for 2020. State is in the budget process and there is a slight increase in Autism and Medicaid.
  o Millage/CARES date to go live date is May 1st. The team has been doing a soft rollout with Packard Health and the emergency rooms already and they have served 55 people over the month without any communications to the public.

VII. CMHPSM Regional Update

• March 13, 2019 meeting minutes were reviewed.

• April 10, 2019 Regional update
  o C. Richardson provided the Regional update to the Board.
  o There was a lot of discussion about the deficit.
  o J. Terwilliger, the current Chief Executive Officer (CEO) of the PIHP submitted her resignation and it was accepted at the 4/10/19 PIHP meeting.
  o J. Colaianne, Chief Operations Officer(COO) of the PIHP is in the interim CEO.
There will be a new search for a new CEO of the PIHP.

VIII. Old Business

- WCCMH Board Officers
  - J. Martin distributed a revised spreadsheet to the board.
    - Election of Officers for the WCCMH Board for the term of 4/1/19 through 3/31/20:
      - J. Martin-WCCMH Board Chair and Executive Committee Chair
      - K. Walker-WCCMH Board Vice-Chair and Program-Quality Committee Chair
      - C. Collins-WCCMH Board Treasurer and Budget-Finance Committee Chair
      - N. Graebner-WCCMH Board Secretary

- WCCMH Committee Structure
  - WCCMH Executive Committee for the term of April 1, 2019 through March 31, 2020
    - J. Martin-Chair
    - F. Brabec
    - C. Collins
    - N. Graebner
    - B. King
    - K. Walker
  
  - WCCMH Budget-Finance Committee for the term of April 1, 2019 through March 31, 2020
    - C. Collins-Chair
    - A. Dusbiber
    - N. Graebner
    - R. Jefferson
    - B. King
    - K. Scott
    - D. Strong (Community Representative for Budget-Finance Committee only)

  - WCCMH Program-Quality Committee for the term of April 1, 2019 through March 31, 2020
    - K. Walker-Chair
    - S. Antonow
    - A. Dusbiber
    - N. Graebner
    - R. Jefferson
    - K. Scott
    - P. Spriggel

  - WCCMH CARES/Millage Advisory Committee for the term of April 1, 2019 through March 31, 2020
    - F. Brabec (WCCMH Board)
    - C. Collins (WCCMH Board)
    - A. Dusbiber (WCCMH Board)
    - N. Graebner (WCCMH Board)
    - B. King (WCCMH Board)
    - J. Martin (WCCMH Board)
    - K. Walker (WCCMH Board)
    - A. Carlisle (Washtenaw Housing Alliance)
o D. Jackson (Washtenaw County Sheriff’s Office)
o H. Haviland (Washtenaw Intermediate School District)
o R. Rion (Packard Health)
o G. Waddles (Community Member)

▪ CMHPSM Regional Committee for the term of April 1, 2019 through March 31, 2020
  o B. King
  o C. Richardson
  o K. Scott

• CARES/Millage Advisory Committee
  o T. Cortes stated that according to the WCCMH Bylaws the WCCMH Board can create the CARES/Millage Advisory Committee as a sub-committee of the WCCMH Board.
  o The CARES/Millage Advisory Committee will include some community members to overview the millage resources and how the funds are allocated.
  o The group would meet quarterly on the 2nd Monday of the month.
  o A suggestion by K. Scott to have members from the rural areas on this committee to ensure that we are reaching out the far boundaries of Washtenaw County. N. Graebner mentioned that she is in Chelsea and she is currently on quite several committees in Chelsea. K. Scott asked that maybe Nancy could be the contact person for the residents in Western Washtenaw.

MOTION BY K. SCOTT SUPPORTED BY K. WALKER TO APPROVE THE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY COMMITTEES AND OFFICERS WITH A TERM BEGINNING ON APRIL 1, 2019 AND ENDING ON MARCH 31, 2020.

MOTION CARRIED

IX. New Business

• Recipient Rights Training for the WCCMH Board
  o A. Bell conducted the Annual Recipient Rights Training for the WCCMH Board members present for this meeting.
  o The following WCCMH Board members received their Annual Recipient Rights Training for FY2019.
  o A. Bell stated that there was an assessment in November 2018 and the Rights Department received 193 out of 194 points.
  o Question was asked if there is an update on any recipient rights complaints and if this is communicated to the WCMCH Board. J. Martin stated that this conversation will continue at the Executive Committee and look at ways to address this.

• Consumer Advisory Council Quarterly Update
  o M. Hershberger gave the WCCMH Board the Consumer Advisory County Update
  o The Tobacco 21 Resolution is a proposal to have the age changed to 21 to legally purchase tobacco which was recently passed.
  o Public Health is discussing the possibility to bring the tobacco resolution to the BOC.
  o WCCMH board did approve moving forward with this resolution today.
o K. Holman, a member of the WCCMH Consumer Advisory Council shared her story with the WCCMH board.

• FY 19 Board Grant List
  o H. Linky presented the FY 2019 grant list to the Board

J. Martin welcomed the new members to the WCCMH Board and congratulated them on their appointments. He is looking forward to working with them. B. King mentioned that R. Jefferson, K. Scott and he are all active in the labor movement and will continue to include labor in this funding movement.

X. Items for future discussion
  • I/DD presentation-June
  • Youth mapping
  • ABLE Change
  • Housing
  • Funding crisis
  • Diversion council (data review)

MOTION BY K. SCOTT SUPPORTED BY C. RICHARDSON MOVE THE WCCMH BOARD INTO CLOSED SESSION TO DISCUSS PENDING LITIGATION AT 10:57 AM.

ROLL CALL VOTE: R. JEFFERSON, C. COLLINS, K. SCOTT, N. GRAEBNER, C. RICHARDSON, J. MARTIN, B. KING, P. SPRIGGEL (PHONE)

MOTION CARRIED

WCCMH BOARD MOVED INTO CLOSED SESSION AT 10:57AM.
WCCMH BOARD PUBLIC MEETING ADJOURNED AT 11:57AM
C. Collins called the meeting to order at 3:01 pm.

I. Introductions

- None

II. Audience Participation

- C. Collins introduced K. Scott who will be joining the Budget-Finance Committee. She will be officially appointed on this committee at the April 19, 2019 WCCMH Board meeting.
- J. Martin introduced B. King who will be joining the WCCMH Board and will fill the Member At Large position on the WCCMH Board. He has agreed to join the Budget-Finance Committee and will be officially appointed on this committee at the April 19, 2019 WCCMH Board meeting.
- C. Collins introduced R. Jefferson who will be joining the WCCMH Board as the Board of Commissioner Representative.
- G. Nelson (co-chair from the Citizens for Mental Health & Public Safety) distributed a copy of his email to the Ann Arbor City Council requesting they override Mayor Taylor's veto of Resolution 19-0581, Enactment No: R-19-37.

III. Budget-Finance Committee Minutes and Actions from 1/14/19

- Budget-Finance Committee Minutes and Actions of 1/14/19 were reviewed.

MOTION BY D. STRONG SUPPORTED BY A. DUSBIBER TO APPROVE THE MINUTES AND ACTIONS FROM THE JANUARY 14, 2019 BUDGET-FINANCE COMMITTEE MEETING.

MOTION CARRIED

- Budget-Finance and Program-Quality combined quarterly committee meeting minutes from 3/11/19 were reviewed.
MOTION BY D. STRONG SUPPORTED BY A. DUSBIBER TO APPROVE THE MINUTES AND ACTIONS FROM THE MARCH 11, 2019 BUDGET-FINANCE AND PROGRAM-QUALITY QUARTERLY COMMITTEE MEETING.

MOTION CARRIED

IV. Finance Status Reports

- N. Phelps reviewed the financial status report for the month ending February 28, 2019.
- Medicaid Enrollees were 33,884 in February 2019.
- Healthy Michigan Enrollees in February 2019 were 16,894.
- Medicaid consumers served through February 2019 are 3,216. This is 181 more consumers served than the same period last year.
- ABA Waiver consumers served through February 2019 were 151. This is 25 more consumers served than the same period last year.
- General Fund consumers served through February 2019 are 588. This is 35 more consumers served than the same period last year.
- Healthy Michigan consumers served through February 2019 are 737. This is 8 more consumers served than the same period last year.
- CLS costs to date are $10.7 Million. This is $285,000 under budget.
- Community Inpatient costs to date total $2.4 Million. This is $236,000 over budget.
- Licensed Residential costs to date are $4.5 Million. This is $202,000 under budget.
- Applied Behavior Analysis/Autism service costs to date are $1.3 Million. This is $205,000 over budget.
- Medicaid, Healthy Michigan and Autism funds are on budget.
- Financial performance by funding source:
  - Medicaid is showing a deficit of $3.0 Million.
  - Healthy Michigan is showing a deficit of $1.6 Million.
  - State General Funds is showing a deficit of $169,000.
  - Local Funds are showing a surplus of $299,000 through February 2019.
- The Fund Balance at the beginning of FY2018 was $2.7 Million. The Fund Balance is unknown at this time due to unexpected end of year transactions. An update will be provided when available.
- N. Phelps mentioned that the budget amendment that will be presented to the BOC will have to be firm by 9/30/19.
- BOC will also need to approve the CCBHC funding.
- Request to develop a new process for any future grants that need to be turned around quickly that will involve the County and the WCCMH.
- D. Strong mentioned that it would be a shame to not receive the CCBHC Grant funding.
• D. Strong requested a Task Force update would be appropriate to bring forward at a future meeting that would also include the revenue strings.

MOTION BY A. DUSBIBER SUPPORTED BY D. STRONG TO APPROVE THE FINANCIAL STATUS REPORT FOR THE MONTH ENDING FEBRUARY 28, 2019. MOTION CARRIED

V. Contracts and Leases

• CBI Rehabilitation Services
  o This contract is to provide licensed residential services for the period of April 1, 2019 – September 30, 2019.

• Washtenaw County Health Department
  o This contract is to provide a community wide anti-stigma marketing campaign for the period of May 1, 2019 – February 28, 2021.

MOTION BY D. STRONG SUPPORTED BY A. DUSBIBER TO APPROVE THE CONTRACTS AND LEASES AS PRESENTED. MOTION CARRIED

VI. Executive Director Contract Authorizations

• Washtenaw Alliance for Children & Youth (WACY)
  o This contract is to allow WCCMH to become a participating member of a leadership team that supports high school graduation rates.
  o This is for a period of July 1, 2018 – June 30, 2019.

MOTION BY D. STRONG SUPPORTED BY A. DUSBIBER TO APPROVE THE EXECUTIVE DIRECTOR CONTRACT AUTHORIZATIONS AS PRESENTED

MOTION CARRIED

VII. Regional Finance Update

• N. Phelps distributed the PIHP financial information to the committee.
• The direct care worker wage pass through of 25 cents per hour went into effect on April 1, 2019 and these amounts will affect the WCCMH budget.
• An amendment from the PIHP will be submitted once the additional revenue shows up from the State for the direct care wage increase.

VIII. Old Business

• None

IX. New Business

• C. Collins stated that the WCCMH Board will be assembling an advisory committee for the CCBHC/Millage/CARES that will meet quarterly to address funding sources.
• N. Phelps mentioned that the CCBHC and the Millage/CARES will be working on a calendar year, so their financial reports will reflect finances from January 1-December 31.

X. Items for Future Discussions
   • Budget Task Force Update
   • Solutions for on-going expense challenges

XI. Meeting adjourned at 3:00 pm.
WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH) PROGRAM-QUALITY COMMITTEE MEETING MINUTES DRAFT
4135 Washtenaw Ave, Ann Arbor, MI
Learning Resource Center, Huron Conference Room
April 8, 2019 3:00pm

MEMBERS ABSENT: P. Spriggel
OTHERS PRESENT: L. Lutomski, J. Martin, K. Scott, K. Homan, M. Adams, R. Jefferson, C. Honly

K. Walker called the meeting to order at 3:05pm.

I. Introductions
   • R. Jefferson introduced himself as a new WCCMH Board member that will be filling the vacant Washtenaw County Board of Commissioners (BOC) position on the WCCMH Board.

II. Audience Participation
   • M. Adams, a parent of a daughter with mental health issues asked if there was any data that is shared for children/adults regarding their established goals and their successes.
   • K. Walker stated that the WCCMH staff will connect with her on what measures/data WCCMH has available and what their process is to distribute this information.

III. WCCMH Budget-Finance and Program-Quality Committee Minutes and Actions
   • WCCMH Budget-Finance and Program-Quality Committee Minutes and Actions of 3/11/19 were reviewed.

   MOTION BY S. ANTONOW SUPPORTED BY N. GRABNER TO APPROVE THE MINUTES AND ACTIONS FROM THE MARCH 11, 2019 WASHTENAW COUNTY COMMUNITY MENTAL HEALTH BUDGET-FINANCE AMD PROGRAM-QUALITY COMBINED QUARTERLY COMMITTEE MEETING.

   MOTION CARRIED

IV. Discussion Items
   • None

V. Old Business
   • CARES/Millage Program Update
      o K. Bellus and M. Tasker provided an update on the CARES/Millage Program.
      o During the last 20 days the following updates are:
         ▪ Staffing and services have been in effect and staff have been trained as they are hired.
         ▪ Staff are assigned to the Annex and Towner.
         ▪ Treatment provided with this program is Psychiatry, Case Management, and Therapeutic Interventions.
         ▪ Groups are run by the peers out of the Annex and Towner locations.
- 31 clients have been served by peers.
- 12 clients are in their 20's
- 6 clients are in their 40's
- Most referrals are from people that have not received mental health services before
- 13 Medicaid referrals
- 17 Non-Medicaid referrals
- All Referrals are through the Crisis Team
- Psychiatric Emergency Services (PES) and Trinity Health have been sending referrals.
- 7 referrals from Bio-Psychosocial process
- 6 referrals from PES
- 6 hospital discharge appointments
  - The goal is to stabilize and connect with the community.
  - 3 of these referrals have already been stabilized and have been deployed back to the community.
  - Screening is still done through the regular Access phone 734-544-3050 and will continue to do so after May 1st.
  - The Anti-Stigma campaign will be wrapped together with the CARES/Millage team

VI. New Business
   - Data Dashboard
     - L. Higle presented the Data Dashboard to the committee.
     - There were no sentinel events from FY18 to date.
   - Youth and Family Presentation
     - E. Spring presented the Youth & Family Services Overview to the committee and distributed a handout detailing the Youth & Family Services Program

VII. Items for Future Discussions
   - CCBHC grant-May
   - Dashboard discussion-dashboard data indicators and different types of data measures
   - Annual communication plan with the public in terms of millage dollars

MOTION BY S. ANTONOW SUPPORTED BY N. GRAEBNER TO ADJOURN THE PROGRAM-QUALITY COMMITTEE MEETING AT 4:27PM.

MOTION CARRIED

VIII. Meeting adjourned at 4:27pm.
**ACTION REQUESTED:** To approve the following contract(s):

**BACKGROUND:**

1. PCE Systems – will provide an electronic health record and practice management system called the CARES system.
2. Genesee Lake School – out of state specialized licensed residential for one individual.

**Service Contracts**

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Funding</th>
<th>Estimated Budget</th>
<th>Contract Term</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PCE Systems</td>
<td>Millage</td>
<td>$93,800</td>
<td>April 1, 2019 - September 30, 2019</td>
<td>CARES System</td>
</tr>
<tr>
<td>2. Genesee Lake School</td>
<td>Medicaid</td>
<td>Per consumer authorizations</td>
<td>May 1, 2019 – September 30, 2019</td>
<td>Licensed Residential Services</td>
</tr>
</tbody>
</table>

**RECOMMENDATIONS:** To approve the contract(s) listed above.
Executive Director Contract Authorizations
May 2019 Finance Committee Meeting

ACTION REQUESTED: Acceptance of the Executive Director’s signature on contracts with a value of less that $25,000

## Contracts

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Amount</th>
<th>Term</th>
<th>Purpose</th>
<th>Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Interactive Services</td>
<td>$7,392</td>
<td>10/1/18 – 9/30/19</td>
<td>Reminder Communications</td>
<td>10/19/2018</td>
</tr>
<tr>
<td>Deborah Kennard</td>
<td>$2,000</td>
<td>10/1/18 – 9/30/19</td>
<td>Eye Movement Desensitization and Reprocessing Training</td>
<td>10/19/2018</td>
</tr>
<tr>
<td>Saline Area Schools</td>
<td>$20,000</td>
<td>10/1/18 – 9/30/19</td>
<td>Respite Services</td>
<td>10/19/2018</td>
</tr>
<tr>
<td>UpToDate</td>
<td>$5,850</td>
<td>10/1/18 – 9/30/19</td>
<td>Evidence-based physician-authored clinical decision support resource</td>
<td>10/19/2018</td>
</tr>
<tr>
<td>Policy Research Associates</td>
<td>$22,500</td>
<td>1/1/19 – 9/30/19</td>
<td>Youth System Intercept Mapping</td>
<td>1/18/2019</td>
</tr>
<tr>
<td>MEND</td>
<td>$22,116</td>
<td>3/1/19 – 9/30/19</td>
<td>Telemedicine system</td>
<td>3/15/2019</td>
</tr>
<tr>
<td>Washtenaw Alliance for Children &amp; Youth (WACY)</td>
<td>$4,000</td>
<td>7/1/18 – 6/30/19</td>
<td>Become a participating member of Leadership Team, supports increased high school graduation rates</td>
<td>4/19/2019</td>
</tr>
<tr>
<td>U.S. Transport Service</td>
<td>$4,000</td>
<td>5/1/19-9/30/19</td>
<td>Transportation Company</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendation:** Acceptance
WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)
WCCMH CONSUMER ADVISORY COUNCIL MEETING MINUTES
April 10, 2019

MEMBERS PRESENT: Barb Higman, Alayna Manzanares, Lisa Porzondek, Jason Zurawski, Laura Garcia, Ed Howlett, Pam Rathbun
STAFF PRESENT: Sally Amos O’Neal
MEMBERS ABSENT: Debbie Patterson, Denise Simpson, Kim Vandenburg

I. Called to order at 12:40 pm.
II. Audience Participation.
III. Consent Agenda Actions.
   • March minutes were approved as presented.

MOTION BY Alayna - SUPPORTED BY Ed TO APPROVE THE WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH) CONSUMER ADVISORY COUNCIL (CAC) MOTION CARRIED
IV. Chairpersons Report: Sally reported in Mert's absence. Discussed advocacy efforts at the State level.
V. CMHPSM Regional Consumer Advisory Council Update.
   • Discussion of a regional picnic, will look at parks in Washtenaw County
VI. Old Business
   • Articles suggested for the newsletter need to confirm deadline:
     o Ed is working on his story of recovery.
   • Speaker's Bureau, Lisa practiced her story for the group
   • Walk-A-Mile In My Shoes – Thursday, May 9, 2019. – Barb completed T-Shirt Design that will have Lady Liberty with a brain and footprints and the Motto: Carrying a Torch for Mental Illness. – Laura will read the message, “We are carrying a torch for mental illness. Let's make it brighter! Walk a mile in My shoes.”
VII. New Business.
   • Advocacy opportunity on April 11, 2019 at the House Appropriations Committee, many peers are attending and plan to speak
   • Coming Up for Air movie discussion on May 9, 2019 at 7:00pm at the Goodrich Theatres in Ann Arbor
   • Meeting adjourned at 1:24pm

Next meeting planned for May 9, 2019 at 12:30 pm. at 2140 E. Ellsworth, Ann Arbor.
RAISING THE MINIMUM SALES AGE OF TOBACCO PRODUCTS IN MICHIGAN TO AGE 21 RESOLUTION

“Raising the legal minimum age for cigarette purchaser to 21 could gut our key young adult market (17-20) where we sell about 25 billion cigarettes and enjoy a 70% market share.” Phillip Morris report, 1/21/86

WHEREAS: Each year over 16,200 Michiganders die from tobacco use and 5,200 Michigan children become new regular, daily smokers, of whom a third will die prematurely because of this addiction;

WHEREAS: 95% of adults began smoking before age 21, and 4 out of 5 become regular, daily smokers before age 21. Young people are sensitive to nicotine and can feel dependent earlier than adults, and the brain continues to develop until about age 25. The younger youth are when they start using tobacco, the more likely they will be addicted. Increasing the age at which young people first experiment with tobacco reduces the risk of nicotine addiction;

“If a man has never smoked by age 18, the odds are three-to-one he never will. By age 24, the odds are twenty-to-one.” RJ Reynolds researcher, 1982

WHEREAS: Adolescents are more likely to obtain cigarettes from social sources than through commercial transactions, and youth who reported receiving offers of cigarettes from friends were more likely to initiate smoking and progress to experimentation. Raising the legal age of access to 21 would reduce the likelihood that young people would have access to tobacco products through social sources;

WHEREAS: Over 330 local jurisdictions in 21 states have already raised the minimum age of legal access to tobacco products, and California, Hawaii, Oregon, Massachusetts, Maine, and New Jersey have passed statewide legislation;

WHEREAS: Smoking-caused health costs in Michigan total more than $4.5 billion per year, including more than $1.3 billion in state and federal Medicaid expenditures, and raising the age of legal access to tobacco products to age 21 will likely decrease overall tobacco use rates, which in turn will likely lead to reduced future tobacco-related health care costs;

WHEREAS: Tobacco companies spend an estimated $320 million to market their products in Michigan, and 90.7 percent of middle school students and 92.9 percent of high school students were exposed to pro-tobacco ads in stores, in magazines or on the internet. According to the U.S. Surgeon General, the more young people are exposed to cigarette advertising and promotional activities, the more likely they are to smoke. Nearly 9 out of 10 smokers start smoking by age 18, and more than 80% of underage smokers choose brands from among the top three most heavily advertised;

WHEREAS: The Institute of Medicine concluded that raising the age of legal access to tobacco products to 21 years of age will likely prevent or delay initiation of tobacco use by adolescents and young adults, immediately improve the health of adolescents and young adults, improve maternal, fetal, and infant health outcomes, and substantially reduce smoking prevalence and smoking-related mortality over time, and predicted that raising the age now to 21 nationwide would result in approximately 249,000 fewer premature deaths, 45,000 fewer deaths from lung cancer, and 4.2 million fewer years of life lost for those born between 2000 and 2019;

WHEREAS: Tobacco use is 50% more common among those with substance use, emotional, behavioral and mental health conditions compounding with other existing conditions to reduce longevity and increase morbidity of people with mental health conditions, and since those those with mental health conditions and substance use disorders smoke and vape more intensely; and tobacco related diseases account for 50% of all deaths among people with serious mental illnesses.
BE IT RESOLVED: That the undersigned endorses raising the minimum age of legal access to tobacco products to 21 years of age.

The ___________________________ (name of organization) of ___________________________ (location), confirms its support for each and all the above statements. The undersigned authorizes and encourages Tobacco-Free Michigan to use this signed Resolution to promote the above-stated objective.

Organization Name: ___________________________ Number of Members: ______
Title: (Mr./Mrs./Ms./Dr./Other) ______ Contact Person (Print): ___________________________
Address: ______________________________________________________________________
Phone, Fax, E-mail: ______________________________________________________________________
Authorized Signature: ___________________________ Date: __________

Please Print Name: ___________________________ Title: ___________________________
Please return to: Tobacco-Free Michigan P.O. Box 10231 Lansing, Michigan 48901

BE IT RESOLVED: That the undersigned endorses raising the minimum age of legal access to tobacco products to 21 years of age.

The _Community Mental Health – Consumer Advisory Council _ of _Washtenaw County_, confirms its support for each and all the above statements. The undersigned authorizes and encourages Tobacco-Free Michigan to use this signed Resolution to promote the above-stated objective.

Organization Name: Washtenaw County – Community Mental Health – Consumer Advisory Council
Number of Members: 11
Title: Bro. Contact Person (Print): Merton J. Hershberger
Address: 555 Towner Street, Ypsilanti, MI 48198
Phone, Fax, E-mail: C) 734-796-6944; F) 734-544-2906 E) hershergerm@washtenaw.org
Authorized Signature: ___________________________ Date: 3/13/2019

Please Print Name: Merton J. Hershberger
Title: Certified Peer Support Specialist / Tobacco Treatment Specialist – Council Liaison.
Please return to: Tobacco-Free Michigan P.O. Box 10231 Lansing, Michigan 48901
Consumer Advisory Council  
2019 — Spring Newsletter

**Washtenaw CARES**

A new branch of CMH has opened. It is a outreach arm impacting people in crisis throughout Washtenaw, regardless of insurance or lack thereof. Hopefully, you will see an impact from their work soon. Already more than 100 have been served. Thanks to all who voted for the millage, making this possible.

**New Oakland Family Center**  
Alayna Manzanares

There is a new clinic in Ann Arbor with services for those with mental illnesses. It is a branch of the New Oakland Family Centers. It has services for adults, families, and children. It is not a residential facility, but is a partial hospitalization program. It works with the emergency rooms of local hospitals and also Community Mental Health (CMH).

A person is referred by one of the local hospitals or CMH. The referral comes through the intake and assessment process at one of the hospitals or CMH, and then a recommendation is made to the New Oakland Family Center. The New Oakland Family Center takes all insurances except straight Medicaid but will work with CMH Case managers to ensure care is available to those who need it. They also take walk-ins and referrals from doctors within the community.

The New Oakland Family Center uses a face-to-face approach. The partial hospitalization program has two-week day program of intensive group therapy every day. Clients are also assigned a psychiatrist if needed. The client can have regular therapy or doctor visits as determined and assigned during intake assessment.

New Oakland Family Center also works with 24-hour crisis intervention, substance abuse, eating disorders, treating many mental illnesses, doing psychiatric evaluations, psychological testing and observation, in addition to the individual, family, and group therapies. There are currently 9 other locations throughout Southeast Michigan serving as a comprehensive mental health clinic and has been established since 1991.
My name is Lisa Porzondek, and I have a mental illness: depression, anxiety, and post-traumatic stress disorder (PTSD). I had symptoms of mental illness at a young age but didn’t have access to treatment. I was told later that if I had gotten help when I was younger, the outcome would have been quite different.

For years, I struggled to function when I didn’t have the resources to get therapy and medication. I had trouble with my relationships, holding a job, and frequent hospitalizations during depression, as well as during PTSD times. It wasn’t until 2001 when I found CMH that my life changed. They provided the help and support I needed and made sure that one way or another I got my medicine.

Symptoms of depression can include tiredness or exhaustion, loss of or increase in appetite, sleep disturbances, memory and concentration difficulties lasting two or more weeks.

Symptoms of anxiety include feeling fatigue easily, difficulty concentrating or recalling, muscle tension, racing heart, grinding teeth, and sleep difficulties. Emotional symptoms include being restless, irritable, or feeling on edge. Also, difficulty controlling worry or fear, and having dread or panic.

PTSD can cause disturbing thoughts, feelings or dreams related to the event. Also, trauma-related triggers, increase in the flight-or-fight response, anxiety, nightmares, and flashbacks.

I had not realized how important self-care is to my well-being. When I was not eating well enough, I used to tell my friend that I was tired and stressed. He would say to check my blood sugar, but I would tell him that it is just stress. We would go back and forth about it until finally I let him check my sugar. This happened 10 times, and every time it was low. So after that, I knew if I felt that way to just eat. So not eating properly made my symptoms worse.

I also found out how important it is to exercise. This was partly due to a study at the university in which I participated that involved regular walking groups in the community with new friends. Out developed friendships that lasted for years.

Years ago, I kept a check list of 10 self-care items: socializing, getting a good night’s sleep, eating well, exercising, etc. I wrote a sentence each day about how I was doing. I did this check list for a year and a half. When I looked back at my recording, I realized that...
when I exercised four or more times a week, I didn’t have any meltdowns. Exercise helped to keep me stable.

Getting a good night’s sleep also makes a difference. Lack of sleep can make you grumpy and foggy. It can impair attention, alertness, concentration, reasoning, and problem solving. Over time, without enough sleep, it can contribute to depression. People with insomnia are five times more likely to develop depression.

Social support plays a critical role in your well-being. Social support builds you up during times of stress and gives you strength to carry on and thrive. Poor social support has been shown to increase risk of depression and even suicide. Good social support, on the other hand, helps you cope better with stress. It can improve motivation and enhance self-esteem. It can also alleviate the effects of emotional distress, and promotes life-long good mental health.

I worked on the production of a DVD made to fight stigma in the community. Stigma is difficult. At my new cardiologist one time, I could hear the doctor in the back saying, “Lisa is mentally ill.”

Someone said, “Who, Lisa? Is she really?”

So after my EKG and echocardiogram, the doctor had me come into his office. Then he started yelling at me, “Have you been taking your heart medicine?”

I said, “You didn’t prescribe any.”

Then he said, “Have you been exercising like I told you?”

I said, “That is my complaint that I have been having (chest?) pain without activity.” But since I have mental illness, I must have done something wrong to cause this!!

I called my old family doctor back in tears, and they said, “DO NOT GO BACK TO HIM! Come here and we will refer you to a good cardiologist.” So that is my experience with stigma.

After receiving treatment, my whole life changed. I now work part-time. I have volunteered for Saline Area Social Services for 16 years. I have lived in my apartment for 17 years. I have been a member of Washtenaw County—Community Mental Health—Consumer Advisory Council for over 10 years. I have contributed articles for their newsletter since 2012. I have been part of a walking group that supports each other for 16 years.

After receiving the help I needed, including support groups, therapy, and medications, my life has improved greatly. I have a comfortable life and supportive friends now.
Update on the Mental Health and Public Safety Millage

On November 7, 2017, voters in Washtenaw County passed a millage to provide funds for mental health and public safety. This was a victory for the dedicated people who worked hard to educate citizens about the need for improved services for individuals living with mental health conditions. The ballot language stipulated that the revenue be divided as follows: 38% for mental health. 38% for public safety and 24% for jurisdictions with their own police force.

After the November 7th election, many people joined the discussion of exactly how the funds would be used. While, prior to the election, a majority of the members of the Ann Arbor City Council had announced their intention to appropriate 40% of the funds allocated to the City of Ann Arbor for climate change action, a poll of a random sample of registered voters in the city revealed 75% were unaware or only vaguely aware of this. Seventy seven percent believed the entirety of the millage funds would be used for mental health and public safety. The ensuing controversy led to the formation of the Ann Arbor Citizens for Mental Health & Public Health (CMHPS) which has developed a website with information about the issue. The AA City Council has disseminated a survey to determine what people want. It is vital that the survey be completed by as many potential respondents as possible.

CMHPS strongly encourages you to do the following:
- Visit the CMHPS website at: www.a2mentalhealthmillage.com where you will find the information needed to understand the issue and take action.
- Complete and submit the survey if you were randomly selected to receive it.
- Contact the mayor and city representatives from your ward prior to April 15, 2019, to express your concerns and recommendations; the representatives will be most receptive then as the City Administrator will present the budget to the Council on April 15th. You must do so before May 20, 2019 as the city budget will be adopted on that date. Personal stories and reasons for your opinion can be very powerful.

— Barb Higman

Q. What is the Consumer Advisory Council?

A. The Consumer Advisory Council members work as advocates to promote services, supports, communication, opportunities and legislation for all individuals recovering from mental illness and developmental and intellectual disabilities and emotional impairments, who are Community Mental Health (CMH) consumers. The Council also works to create an awareness of mental health issues for all people recovering from these issues. Through education & advocacy, the Council combats stigma.

B. To share your thoughts with the council, you may contact Mert Hershberger via email: HershbergerM@washtenaw.org or call: 734-796-6944.

Treat your neighbor well, and you will soon have plenty of friends.
Love your enemies, and you will soon have none.
### 2019 WCCMH Board, WCCMH Board Committees and WCCMH Board Officers (term of 4/1/19-3/31/20)

<table>
<thead>
<tr>
<th></th>
<th>Executive (meets quarterly)</th>
<th>Budget-Finance (meets monthly)</th>
<th>Program-Quality (meets monthly)</th>
<th>CMHPSM (meets monthly)</th>
<th>Officers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suzie Antonow</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Felicia Brabec</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carly Collins</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Treasurer/Budget-Finance Committee Chair</td>
</tr>
<tr>
<td>Anna Dusbiber</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nancy Graebner</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Secretary</td>
</tr>
<tr>
<td>Ricky Jefferson</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bob King</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>John Martin</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>Board Chair/Executive Committee Chair</td>
</tr>
<tr>
<td>Caroline Richardson</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Katie Scott</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patricia Spriggel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kari Walker</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>Vice-Chair/Program-Quality Committee Chair</td>
</tr>
</tbody>
</table>

**total current assigned to Committees**

<table>
<thead>
<tr>
<th>Executive</th>
<th>Budget-Finance</th>
<th>Program-Quality</th>
<th>CMHPSM</th>
<th>Officers</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**# board members required for committee-per Bylaws**

<table>
<thead>
<tr>
<th># board members required for committee-per Bylaws</th>
<th>Executive (7 officers, 2 additional board members and immediate past board chair)</th>
<th>Program-Quality (4 Treasurer and not less than 3 other Board members)</th>
<th>CMHPSM (4 Vice Chair and not less than 3 other board members)</th>
<th>Officers (3 per PIHP)</th>
</tr>
</thead>
</table>

**Quorum for committees**

<table>
<thead>
<tr>
<th>Executive</th>
<th>Budget-Finance</th>
<th>Program-Quality</th>
<th>CMHPSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/6</td>
<td>4/6</td>
<td>4/7</td>
<td></td>
</tr>
</tbody>
</table>

**Quorum for Board is 7/12**

<table>
<thead>
<tr>
<th>Community Representative for Budget-Finance Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doug Strong</td>
</tr>
</tbody>
</table>
CARES/Millage Advisory Committee  
(meets quarterly)

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felicia Brabec</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Carly Collins</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Anna Dusbiber</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Nancy Graebner</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Bob King</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>John Martin</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Kari Walker</td>
<td>WCCMH Board</td>
</tr>
<tr>
<td>Amanda Carlisle</td>
<td>Washtenaw Housing Alliance</td>
</tr>
<tr>
<td>Derrick Jackson</td>
<td>Washtenaw County Sheriff's Office</td>
</tr>
<tr>
<td>Holly Haviland</td>
<td>Washtenaw Intermediate School District</td>
</tr>
<tr>
<td>Ray Rion</td>
<td>Packard Health</td>
</tr>
<tr>
<td>George Waddles</td>
<td>Community Member</td>
</tr>
</tbody>
</table>

Quorum for CARES/Millage Advisory Committee: 7/12
I. PURPOSE
To establish guidelines as the Pre-Paid Inpatient Health Plan (PIHP) for the development and implementation of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) process for conducting the monitoring and oversight of the Medicaid and Healthy Michigan Plan claims/encounters submitted within the CMHPSM Provider Network. To assess for conflict of interest situations across the Provider Network and remove them. To ensure compliance with federal and state regulations and to establish a standardized process for the review of claims/encounters submitted for Medicaid and Healthy Michigan Plan beneficiaries in accordance with the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program Medicaid services Verification Technical Requirements.

II. APPLICATION
This policy applies to all staff, students, volunteers, individual contractors and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) that submit claims/encounters for services provided to Medicaid and Healthy Michigan Plan beneficiaries.

III. POLICY
The CMHPSM shall create, implement and maintain a published process to monitor and evaluate its Provider Network to ensure compliance with federal and state regulations. This includes protocol for monitoring and oversight of any claims/encounter provided to beneficiaries.
beneficiaries of Medicaid or Healthy Michigan services will be completed.

IV. DEFINITIONS

AUTHORIZATION: The documented formal approval of a service(s), with a designated CPT code(s) and specified amount scope and duration.

BENEFICIARY: An individual who has been determined eligible by the MDHHS according to state and federal rules and regulations for medical and behavioral healthcare coverage under Medicaid or Healthy Michigan Plan programs.

CLAIM: Invoice submitted for payment in accordance with the authorization issued to the particular contract provider.

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.

CORE PROVIDER: A local provider of substance abuse services utilizing the ROSC model that provides for and/or coordinates all levels of care for clients with substance use disorders.

CPT CODE: A standardized service code as listed in the Current Procedural Terminology manual issued by the American Medical Association. This manual is updated annually.

ENCOUNTER DATA: An electronic submission of services directly provided by a CMHSP in accordance with the related authorization.

HCPCS CODE: A standardized service code as listed in the Healthcare Common Procedure Coding System manual issued by the American Medical Association. This manual is updated annually.

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.

SERVICE VERIFICATION: Confirmation that services are medically necessary, provided by qualified staff, documented in accordance with the service definition (CPT code), connected to the consumer’s IPOS goals, and meet timeliness standards.
IV. STANDARDS

A. The CMHPSM shall conduct a full monitoring and verification process on a selected sample of claims/encounters. The reviews will be completed bi-annually. CMHPSM reserves the right to conduct further reviews of the Provider Network on an as needed basis.

B. Each CMHSP and ROSC Core Provider shall ensure services provided to consumers are documented in formats that provide sufficient support to assure accurate submissions of claims/encounters.

C. The Healthy Michigan claim/encounter review process may consist of the following components:
   1) Desk Audit: consists of a pre-review of select policies, protocols, and documents and other resource material submitted by the Provider Network to the CMHPSM for review prior to the on-site visit. In addition, a review of whether the provider meets state and federal standards for staff training requirements and for ongoing status as a provider with which the CMHSP/PIHP can maintain a contractual relationship
   2) On-Site Audit: consists of an on-site visit to the Provider Network to review and validate process requirements as needed.
   3) Claim/Encounter Review: the PIHP shall pull a random sample of Medicaid and Healthy Michigan Plan participants to complete verification of submitted claims/encounters
   4) Data Review and Analysis: includes analysis of the Provider Network

D. The overall responsibility for the verification of Medicaid and Healthy Michigan Plan claim/encounter verification and updating of the monitoring evaluation tool shall rest with the CMHPSM as the PIHP. The tool shall be reviewed on an annual basis to ensure functional utility and updated as necessary due to changing regulations, new contract terms and operational feedback received.

E. Each CMHSP and ROSC core providers shall submits encounters and/or claims within timeframe outlined in contracts (60 days from date of service; from date of discharge for hospitals). Submission of claims for consumers on the Habilitation Support service Waiver is within 30 days of service.

F. Each CMHSP and ROSC core providers shall have a service verification system in place to validate that services are provided to consumers according to their IPOS.

G. Each CMHSP and ROSC core providers shall adjudicate and pays claims timely; clean claims (i.e., error-free) are to be paid within 30 days of submission.

H. Any electronic claims payment system used by the CMHSPM shall have the following automatic integrity checks:
   • when a claim is submitted the system verifies that the claim information matches the authorization information
   • the claim submitted is within the allowed time period
   • the provider contract is active
• the system verifies that the code(s) submitted in the claim match the code(s) on the authorization and that there is a sufficient number of authorized units still available
• the system identifies the insurance type/funding source and verifies it was in effect at the time the service was provided
• the system provides information to retrospectively adjust for any retroactive changes to the fund source that were in effect at the time of the services
• a report is run monthly to retroactively adjust payments to the proper funding source. If the report indicates a correction to a fund source, journal entries are completed.

F.l. Each CMHSP shall conduct service verification activities of their contractual providers separately from the Medicaid Event Verification review by the CMHPSM.

G.l. Following the review, the CMHPSM shall develop a Medicaid Event Verification Report detailing the results of its verification review. Copies of this report shall be provided to the CMHSPs and all other Network Providers whose claims/encounters were included in the verification review. This report will include any corrective action plans (CAPS) that are required and the date the CAP is due back to the CMHPSM.

1) A summary detailing the PIHP’s overall review process and findings;
2) Detailed findings pertaining to each claim/encounter reviewed
3) “Recommendations” (if applicable) pertaining to any finding that will require corrective action for claims/encounters that are found not to be in substantial compliance with Medicaid verification scores
4) All claims/encounters found to be invalid will require correction either by resubmission or voiding.
5) Recoupment of funds for any fee for service provider for any claims/encounters that are found to be invalid.

H.k. Any suspected fraud or abuse discovered during the Medicaid Event Verification Process will be reported to MDHHS and a required to the Office of the Inspector General (OIG).

L. Summary findings of the Medicaid Event Verification audits shall be shared with the CMHPSM Regional Operations Committee and other regional committees as appropriate.

V. REFERENCES

A. Balanced Budget Act: 438.608; 447.46
B. The Deficit Reduction Act of 2005
C. Affordable Care Act of 2010
D. MDCH PIHP Contract
E. MDCH CMHSP Contract
C.F. Whistleblowers Protection Act of 1989
D.G. Title 42—Public Health; Part 455—Program Integrity; Subpart A—Medicaid
Fraud Detection and Investigation Program [cite: 42CFR455.17]

F.I. Healthcare Common Procedure Coding System (HCPCS) issued by the American Medical Association
G.J. Person Centered Plan Policy
H.K. Service Authorization Policy

VI. PROCEDURES

WHO DO WHAT

CSSN/CSSN-Look-Alike/Provider

1. Follows the Person-Centered Plan/Treatment Plan policy.
2. Issues Authorization in accordance with approved service entrance and exit criteria and appropriate CPT Code.
3. Monitors Authorizations and PCPs/Treatment Plans.
4. Documents services provided to individual consumers in a format that provides sufficient support to assure accurate claims submission.
5. Submits claims within timeframe outlined in contracts (60 days from date of service; from date of discharge for hospitals). Submission of claims for consumers on the Habilitation Service Waiver is within 30 days of service.

Local Finance Department

1. Adjudicates and Pays Claims timely. Clean Claims (i.e., error-free) are to be paid within 30 days of submission.
2. Runs monthly Reassignment Report to retroactively adjust payments to the proper Funding Source.
WHO

System Verification

4. The electronic claims payment system completed Automatic Integrity Checks. When Claim is submitted, the system verifies that the claim information matches the authorization information. The Authorization check verifies that the CPT Code was authorized, that there is a sufficient number of service units still available, submission of claim is within allowed time period, and that the Provider Contract is active.

5. System also identifies the Fund Source (insurance type) in effect at the time the service was provided.

6. The Reassignation Report provides information to retroactively adjust for retroactive changes to and Fund Source that should have been in effect at the time of the service.

PIHP Accountant

1. Completes Site Reviews of all contracted providers of the Community Mental Health Partnership of Southeastern Michigan (CMHPSM)—fifty percent the first year; the other fifty percent the second year.

2. Financial Site Review Process includes review of all Provider Documentation to determine whether or not that evidence supports that the claim paid was in accordance with the service authorization; i.e., proper CPT Code was used and units of service were actually provided.

3. Runs Claims Payment Detail Report including client-level detail of services paid.

4. Selects random sample of cases.

5. Conducts on-site review of Provider’s documentation.

6. If Financial Fraud is suspected, notifies PIHP Finance Director who then follows the Financial Fraud Investigation and Reporting Policy.

7. Monitors Financial Plan of Correction if one is required of the Provider.

PIHP Provider Relations Unit

1. Conducts review of Provider Documentation to determine if Provider properly implemented the Person Centered Plan (available to Provider through electronic system, Encompass) by review of Progress Notes, Community Outing Logs, Medication Charts, Safety of Environment, Current Consent Forms, Staffing Ratios, and/or Evident of State Trainings.

3. Completes Journal Entries in financial system if Reassignation Report indicates a correction to a fund-source.

DOES WHAT
<table>
<thead>
<tr>
<th>WHO</th>
<th>DOES WHAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PIHP Provider Relations Unit</td>
<td>2. May also include Consumer Interviews during Site Review.</td>
</tr>
<tr>
<td></td>
<td>3. Notifies Provider of Results of Clinical and Financial Site Reviews.</td>
</tr>
<tr>
<td></td>
<td>4. Notifies Office of Recipient Rights if a Rights Violation may have occurred.</td>
</tr>
<tr>
<td></td>
<td>5. Requires and Monitors of Service Provision Plan of Correction if necessary.</td>
</tr>
</tbody>
</table>
I. PURPOSE
To establish guidelines that ensure all organizational contractors who provide behavioral mental 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

<table>
<thead>
<tr>
<th>DATE</th>
<th>REV. NO.</th>
<th>MODIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/25/11</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11/30/11</td>
<td>2</td>
<td>Updated to reflect local practice, changes in delegated functions, and new policy format</td>
</tr>
<tr>
<td>8/20/2013</td>
<td>3</td>
<td>Updated to comply with requirements for OIG exclusions VII.C. Procedures removed. Procedures will be available in the Provider Manual.</td>
</tr>
<tr>
<td>6/11/2014</td>
<td>4</td>
<td>Revised to reflect the new regional entity.</td>
</tr>
<tr>
<td>8/24/2018</td>
<td>5</td>
<td>Rewrite</td>
</tr>
</tbody>
</table>

III. APPLICATION
This policy applies to all organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY
The CMHPSM will ensure that all organizations providing behavioral mental 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.

Regional Operations Committee (ROC): The ROC is comprised of the four CMHSP Executive Directors/CEO’s. The Managing Director participates in an ex-officio (non-voting) capacity. The ROC in collaboration with the CMHPSM Board and Managing Director creates the vision, mission and long term plans for the CMHPSM. The ROC and the Managing Director establishes and coordinates the priorities for CMHPSM Board consideration including matters of policy, personnel and fiscal considerations including the contractual development/agreements related to delegation and/or leasing arrangements between and among the CMHPSM and each CMHSP Partner.

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.

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

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.

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, re-credentialing, 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. CMHPSM Regional Provider Network Statuses:

   a) Credentialed In-Network Status: An organizational provider that has an approved current credentialed status as determined by the PIHP, CMHSP or SUD Core Provider. There is no requirement that a payer identified within this policy be mandated to enter into a contract with an organization that obtains credentialed or In-Network status. Organizations
may be credentialed for future capacity or backup capacity. Contract relationships will be determined by the appropriate applicable payer.

b) Contracted In-Network Status: A credentialed organizational provider that is currently contracted with one or more of the following payers: PIHP, CMHSPs or SUD Core Providers.

c) Out of Network Contracted Status: In certain situations, the PIHP, CMHSPs or SUD Core Providers may determine it is necessary to contract with an entity that is unwilling, or unable to join the CMHPSM Provider Network. Examples include but are not limited to:

   (1) Single Case Agreements:
      (a) Emergency Placements;
      (b) Limited Duration Placements;
      (c) Clinically determined placement for individual consumer with unique clinical need.

   (2) Out of Region and Network
      (a) Specialty service not delivered within CMHPSM region for a limited number of consumers; (Providers located outside of the CMHPSM region geographically are not required to be In-Network with the CMHPSM, however these providers are encouraged to participate as CMHPSM In-Network or obtain CMHPSM credentialing status through a reciprocity relationship with another PIHP/CMHSP region.

5. **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.

6. **Medicaid Service Verification Policy**

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

7. **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.

8. **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.

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

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

B. Variable Standards

1. **Payer / Provider Relationships Specific Standards**

   a. **PIHP Payer – CMHSP Relationship**

<table>
<thead>
<tr>
<th>1. Payer</th>
<th>CMHPSM as PIHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>CMHSP</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Payer</th>
<th>Regional CMHSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Organizational Provider Delivering Behavioral Health Services within CMHPSM region.</td>
</tr>
</tbody>
</table>

| 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 at minimum once every two years to the CMHSP. New organizational providers may be required by the CMHSP to submit additional credentialing application materials or information. Organizational providers may also be required to submit verification or supplemental documentation to support the credentialing application. Organizational providers are only required to submit credentialing documentation to one CMHSP to obtain regional CMHPSM network status. CMHSPs may require supplemental or additional credentialing information. |

<p>| 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. &amp; 4b. CMHSPs are not required to contract with every organizational provider that is regionally credentialed and considered In-Network within the CMHPSM Provider Network. |</p>
<table>
<thead>
<tr>
<th>5. Organizational Monitoring:</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Medicaid Service Verification:</td>
<td>The CMHSP and Organizational Provider will follow all requirements within the CMHPSM Medicaid Service Verification Policy.</td>
</tr>
<tr>
<td>7. Provider Network Significant Change Notification:</td>
<td>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.</td>
</tr>
<tr>
<td>8. Network Adequacy</td>
<td>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.</td>
</tr>
<tr>
<td>9. Reciprocity</td>
<td>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.</td>
</tr>
<tr>
<td>10. Debarment</td>
<td>All In-Network and Out-of-Network Organizational Providers delivering mental health services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.</td>
</tr>
</tbody>
</table>
### c. PIHP – SUD Core Provider Relationship

| 1. | Payer: | PIHP |
| 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 at minimum once every two years to the PIHP. |
| 4. Provider Network Status Participation: | SUD Core Providers are required to hold an In-Network CMHPSM Network Status. |
| 5. Organizational Monitoring: | SUD Core Providers will be monitored on an annual basis by the PIHP. |
| 6. Medicaid Service Verification: | The PIHP and SUD Core Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy. |
| 7. Provider Network Significant Change Notification: | The SUD Core Providers will notify the PIHP within three (3) business days of any incident or situation with a contracted provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a SUD Core Provider, and seven (7) business days of the original incident or situation. |
| 8. Network Adequacy | The PIHP and SUD Core Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM. |
| 9. Reciprocity | N/A, the PIHP will not accept reciprocity arrangements for SUD Core Providers. |
| 10. Debarment | The PIHP and SUD Core Providers must follow all applicable CMHPSM Debarment and Exclusion Policy requirements. |

### d. SUD Core Provider - SUD Organizational Provider Relationship

| 1. | Payer: | SUD Core Provider |
| 2. Provider Procurement: | Each SUD Core Provider will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Organizational Service Providers. |
| 3. Organizational Credentialing / Re-Credentialing Application Required: | All organizational providers delivering SUD services within the region will complete and submit an organizational credentialing application at minimum once every two years to the SUD Core Provider. New providers may be required by the SUD Core Provider to submit additional credentialing application materials or information. Providers may also be required to submit verification or supplemental documentation to support the credentialing application. |
| 4. Provider Network Status Participation: | SUD Core Providers must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region’s preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by SUD Core Providers to meet service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b. SUD Core Providers are not required to contract with every organizational provider that is regionally credentialed and considered In-Network within the CMHPSM SUD Provider Network. |
| 5. Organizational Monitoring: | SUD Organizational Service Providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the SUD Core Provider on a biennial basis (once every two years.) Organizations that are contracted to one or more SUD Core Providers typically will receive reciprocal status from one SUD Core Provider’s review. SUD Core Providers withhold the right to review each contracted provider organization individually if the SUD Core Provider determines. |
| 6. Medicaid Service Verification: | The SUD Core Provider and SUD Organizational Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy. |
| 7. Provider Network Significant Change Notification: | The SUD Core Provider will notify the PIHP within three (3) business days of any incident or situation with a contracted SUD provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a SUD Core Provider, and within seven (7) business days of the original incident or situation. |
| 8. Network Adequacy | The SUD Core Provider and SUD Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM. |
| 9. Reciprocity | Organizational providers will be credentialed, re-credentialed, and monitored on a reciprocal basis within the CMHPSM region. Providers typically will not be required to submit multiple applications when affiliated with multiple SUD Core Providers, a single credentialing determination can be made by one SUD Core Provider and provide in-network status for the entire region. SUD Core Providers reserve the right to conduct additional monitoring or require additional information from providers when the SUD Core Provider determines it necessary. SUD Core Providers will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. SUD Core Providers reserve the right to conduct additional monitoring or require additional information from providers when the SUD Core Provider determines it necessary. |
| 10. Debarment | The SUD Core Provider and all SUD Organizational Providers delivering SUD services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements. |
### e. PIHP - SUD Organizational Provider Relationship:

<table>
<thead>
<tr>
<th></th>
<th><strong>Payer:</strong></th>
<th><strong>PIHP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Provider:</strong></td>
<td>SUD Organizational Provider</td>
</tr>
<tr>
<td>2. <strong>Provider Procurement:</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Organizational Credentialing / Re-Credentialing Application Required:</strong></td>
<td>SUD Organizational Providers within the region will complete and submit an organizational credentialing application at minimum once every two years to the PIHP.</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Provider Network Status Participation:</strong></td>
<td>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. &amp; 4b.</td>
<td></td>
</tr>
<tr>
<td>5. <strong>Organizational Monitoring:</strong></td>
<td>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.)</td>
<td></td>
</tr>
<tr>
<td>6. <strong>Medicaid Service Verification:</strong></td>
<td>The PIHP and SUD Organizational Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.</td>
<td></td>
</tr>
<tr>
<td>7. <strong>Provider Network Significant Change Notification:</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>8. <strong>Network Sufficiency:</strong></td>
<td>The SUD Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.</td>
<td></td>
</tr>
<tr>
<td>9. <strong>Reciprocity:</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>10. <strong>Debarment:</strong></td>
<td>All In-Network and Out-of-Network Organizational Providers delivering SUD services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th><strong>Payer:</strong></th>
<th><strong>PIHP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Provider:</strong></td>
<td>Non-Federally Funded SUD Service Provider</td>
</tr>
<tr>
<td>2. <strong>Provider Procurement:</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>3. Organizational Credentialing / Re-Credentialing Application Required:</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>4. Provider Network Status Participation:</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>5. Organizational Monitoring:</td>
<td>The PIHP will determine all necessary organizational monitoring requirements for non-federally funded SUD service providers.</td>
<td></td>
</tr>
<tr>
<td>6. Medicaid Service Verification:</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>7. Provider Network Significant Change Notification:</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>8. Network Sufficiency</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>9. Reciprocity</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>10. Debarment</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

I. The entity that holds the contract with a provider (e.g. the contractor) will be responsible to credential, re-credential, and monitor that provider. For mental health services the CMHSP is the contractor delegated by the CMHPSM to credential, re-credential, and monitor their local provider panel.

For substance use disorder services, the contractor may be the CMHSP or the CMHPSM, depending on whether the CMHSP is the ROSC Core provider or there is a ROSC Core Provider separate from the local CMHSP. Where the CMHSP is also the ROSC Core Provider, the CMHSP is the contractor and the CMHPSM delegates credentialing, re-credentialing and monitoring responsibilities with SUD providers to the CMHSP.

Where the CMHSP is not the ROSC Core Provider, the CMHPSM is the contractor and is responsible for credentialing, re-credentialing and monitoring with SUD providers to the CMHSP.

The delineation of these responsibilities will be outlined in the CMHPSM contracts with CMHSPs and/or ROSC Core Providers.

II. Organizations that wish to provide mental health and substance use disorder services to consumers within the CMHP will successfully complete an initial application for membership on the CMHPSM network provider panel. Membership on the network panel is awarded by the local CMHSP Board/CMHPSM Board.

III. Providers will be informed that panel membership is not a guarantee that an organization will be awarded a contract, nor does it ensure that the organization will receive referrals if contracted to provide services. CMHPSM consumers may choose their providers from among the organizations on the network panel with contracts, and consumer choice is honored to every extent possible.
IV. Requests for Proposal (RFPs) for mental health services will be opened or closed by each CMHSP.

V. RFPs for substance use disorder services will be opened or closed by the CMHPSM.

For mental health services, each CMHSP shall issue contracts to organizations on the network provider panel on an as-needed basis, taking into account network capacity and consumer choice. In determining network capacity, consideration will be given at minimum to: anticipated Medicaid enrollment, expected utilization, numbers and types of providers required, number of network providers who are not accepting new beneficiaries, geographic location of providers and beneficiaries, distance, travel time, and transportation availability, including physical access for beneficiaries with disabilities.

VI. For substance use disorder services, either the CMHPSM or the CMHSP as a ROSC Core Provider shall issue contracts to organizations on the network provider panel on an as-needed basis, taking into account network capacity and consumer choice. In determining network capacity, consideration will be given at minimum to: anticipated Medicaid enrollment, expected utilization, numbers and types of providers required, number of network providers who are not accepting new beneficiaries, geographic location of providers and beneficiaries, distance, travel time, and transportation availability, including physical access for beneficiaries with disabilities.

VII. Once a contract is issued to an organization, the contractor will monitor to ensure that the organization maintains the contractual agreement in good standing and complies with relevant accreditation, local, state, and federal requirements.

VIII. Each CMHSP will conduct a local capacity and/or needs assessment annually, including a review of the adequacy of their local provider network.

IX. The CMHSPM Board will annually inventory the network panel/provider list. The Oversight Policy Board will review substance use disorder network panel/provider list prior to it being reviewed by the CMHPSM.

X. The CMHPSM will notify the Michigan Department of Community Health (MDCH) within seven (7) days of any significant changes to the CMHPSM provider network panel when notified of a change by a CMHSP.

XI. Any CMHSP that is contracting with the CMHPSM shall be annually reviewed by the CMHPSM to determine its capacity to provide delegated services, including its compliance with credentialing requirements. Any area of less than full compliance will be addressed in a plan of correction that will be monitored by the CMHPSM. Each CMHSP shall provide the CMHPSM with a copy of its current insurance certificate, the most recent accreditation report, and any additional information required by contract.

XII. Credentialing
Any hospital under contract with a CMHSPS will be credentialed by the contracting CMHSP prior to issuance of a contract. Credentialing shall include the verification of the hospital’s license, accreditation, as well as verification that the hospital is not excluded from Medicaid or Medicare participation.

Any organization seeking to contract with a CMHSP/CMHPSM will complete an RFP application which will be reviewed and, as applicable, scored by CMHSP/CMHPSM staff. Staff will conduct an on-site evaluation of the applicant’s administrative practices using a standard monitoring tool. If the applicant is already serving CMHSP consumers, an on-site evaluation of the applicant’s service delivery practices and verification of claims submitted will be conducted using a standard monitoring tool. If the applicant agency is not yet serving CMHSP consumers, the service delivery evaluation and verification of claims will be conducted after the organization has received referrals and is serving CMHSP consumers; within six months of being appointed to the provider panel, if possible.

The applicant organization must receive an acceptable score on its RFP application and initial site visit to be approved for appointment to the CMHPSM network panel. If necessary, approval will be probationary, pending the outcome of the service delivery site visit and claims verification. If the organization receives an acceptable score, it will receive notification from the relevant CMHSP/CMHPSM contract manager that its probationary period has ended and it has full approval to the CMHPSM network provider panel. If the score is not acceptable, the CMHSP/CMHPSM contract manager will bring this information to the CMHPSM Network Management Committee with a recommendation of either denial to the CMHPSM network panel, or provisional status.

Generally, a score of 80% or above shall be acceptable; however, an applicant may be denied membership on the network provider panel or granted provisional status if it receives a score of less than full compliance in a critical or high risk area.

If the organization is granted provisional approval, a plan of correction is required. The CMHSP/CMHPSM contract manager shall monitor the implementation of the plan of correction, and will provide consultation and technical assistance as needed. If the applicant can demonstrate that deficiencies were sufficiently addressed, the relevant section of the site visit tool will be re-scored taking the new information into account. When the applicant has achieved an acceptable score, the CMHSP/CMHPSM contract manager will recommend removing the provisional status. The contractor will determine if provisional status is removed and will ensure this information is provided to the CMHPSM Network Management Committee.

Any applicant organization that is debarred, sanctioned, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal or state department /agency will be denied membership to the CMHPSM provider network panel. The CMHPSM shall ensure that the CMHSPs, ROSC Core Providers, and their provider networks are monitored with regard to:

- Status of ownership and control interests
- Ensuring that all applicable entities and providers are not excluded from participation in federal health care programs (Medicare and Medicaid), in
accordance with the procedures and timeframes specified in MDCH contract language.

The CMHPSM and the CMHSPs shall ensure that credentialing and re-credentialing processes do not discriminate against:

- A health care professional solely on the basis of license, registration, or certification.
- A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

All contracts issued by the CMHPSM or CMHSPs shall require that the organizational provider must credential and re-credential their directly employed and subcontracted direct service providers in accordance with CMHPSM credentialing/re-credentialing policies and procedures and MDCH’s credentialing process.

XIII. Recredentialing

In order to ensure the continuous quality of specialty supports service providers in the CMHPSM provider network, the contractor will re-credential organizations that have an active contract during the course of ongoing monitoring, rather than on a periodic basis. Annual monitoring will include a check of the federal and state excluded/sanctioned Medicaid providers list.

Provider performance findings of the CMHPSM Quality Assessment and Performance Improvement Program (QAPIP) will be incorporated into the re-credentialing process.

XIV. Organizational Recredentialing

An organization that has been appointed to the CMHPSM network panel but has not been issued a contract or has not provided specialty support services to any CMHPSM consumer for two years (an “inactive” organization), will be contacted in writing to determine its interest in remaining on the network panel. If the organization indicates that it would like to remain on the panel, the contractor may or may not re-credential the organization depending on whether it continues to need the capacity. If this capacity continues to be needed, the organization will remain on the network panel if all required information is provided and a satisfactory re-credentialing score is achieved.

XV. Organizational Monitoring:

CMHSPs are delegated by the CMHPSM to conduct both organizational monitoring and at-risk monitoring for the providers with which they hold a contract. CMHPSM will monitor any SUD providers where the CMHSP is not the core provider. Any provider-related monitoring issues will be reported to the CMHPSM Network Manager and CMHPSM Network Management Committee.

Monitoring of providers shall occur on an annual basis. At minimum, monitoring entails an administrative review, a sample clinical record review of consumers.
served, and a sample of service sites reviewed. The CMHPSM expects that all contracted agencies providing specialty support services to consumers shall:

1. Not be presently debarred, sanctioned, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency (may be verified through the Michigan Department of Consumer and Industry Services and/or the federal “excluded parties” list);
2. Remain in good standing with all regulatory bodies and report to the contract administrator/manager any related issues as they arise;
3. Maintain current insurance and licensure as required by contract and provide evidence of same;
4. Respond promptly and effectively to any Recipient Rights findings, grievances or other complaints, or to any other service delivery concerns;
5. Participate as appropriate in administrative and service delivery monitoring and quality improvement efforts;
6. Maintain a minimum acceptable score of 80% for all annual audits conducted by the local CMHSP or the CMHPSM and/or full compliance in a critical or high risk area.
7. Address any deficiencies found during monitoring activities in a timely manner by submitting a plan of correction within the timeframe required; and
8. Maintain active accreditation by the Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or other nationally recognized accrediting body as approved by the CMHPSM. For SUD providers, Council on Accreditation (COA) and American Osteopathic Association (AOA) Accreditation are also acceptable. The CMHPSM Network Management Committee can make recommendations to the CMHPSM on other accrediting bodies that may be acceptable.
9. Ensure that criminal background checks are conducted as a condition of employment for the contracted agency’s own employees or potential employees.

For providers that have corrective action or for which at-risk monitoring is required, the CMHPSM will notify the CMHSP and/or the SUD provider if any further intervention needs to take place, and ensure that any applicable reporting to state or federal entities is completed.

Under limited circumstances, the accreditation requirement may be waived by the as the contractor when:

- No national accreditation standards exist for the type of service provided;
- The provider’s scale of business does not support the administrative burden of obtaining and maintaining accreditation;
- The provider has in place a plan to achieve accreditation which has been approved by the contractor and is being implemented; or
- Other reasons as deemed appropriate by the contractor

The reasons for waiving an accreditation requirement will be documented by the contractor and placed in the provider’s file. The CMHPSM Network Management Committee can make recommendations and provide their rationale to the contractor for waiving the accreditation requirement.
If the accreditation requirement has been waived, the contractor must remain in compliance with any applicable standards of the Joint Commission or other accrediting bodies, as they relate to the contractor and its subcontractors.

The accreditation requirement may not be waived for providers of substance use treatment or prevention services.

A report of monitoring findings for network providers will be made available to the public at least once every two years by the CMHPSM/CMHSP.

XVI. Risk Management Monitoring:

Potential issues related to quality of care with a provider that are discovered through or outside of normal monitoring activity are managed by the local contracting entity and brought to the attention of either the CMHPSM Director of Quality and Compliance. This information is compiled and maintained by the local contracting body for either immediate action where risk is clear or tagged for future/later review if more moderate issues accumulate to the point where risk becomes clear.

Areas for such review include but are not limited to:
- Health & Safety matters for consumers
- Substantiated Recipient Rights Investigations or interventions
- Grievances
- Medicaid Appeals
- Suspicion of Medicaid fraud or abuse (including claims/billing issues)
- Confidentiality breaches or risk thereof

Issues and information are collected from the following sources/departments for review:
- Office of Recipient Rights
- Customer Services (including Grievances and CS trends)
- Compliance/Monitoring
- Fair Hearings Officer
- Local Appeals Coordinator
- Regional Finance
- Local Compliance Officers
- Local Privacy Officers
- Local CMHSP staff/case managers
- Utilization Management

Providers generating such concerns are additionally reviewed/audited specifically in those areas of concern, as well as for any other potential risks; depending on the provider and extent of review required, this risk monitoring will be conducted by the CMHSP or the CMHPSM. From that review a specific compliance report and corrective action plan is written that includes timeframes and must-pass elements. Consequently, the provider is more closely monitored for at least the following fiscal year, at least on a quarterly basis.
Any non-compliance with must-pass elements or overall corrective action results in an immediate joint review by the applicable CMHSP Executive Administrative Team and the local CMHSP or CMHPSM Board (when indicated) for potential sanctions/contractual action in coordination with the contractor.

XVII. Out-of-Network Providers:

If the CMHPSM network provider panel is unable to accommodate a consumer’s needs, the affiliate county within the CMHPSM that serves the consumer shall contract with an out-of-network provider to provide services. All out-of-network providers will be assessed for their ability to provide quality services. If the provider is delivering services to another PIHP the CMHSPs may opt to rely on that PIHP’s credentialing decision. Generally, the contractor will attempt to add the out-of-network provider to the CMHPSM/ network provider panel by asking the provider to respond to an RFP and providing any assistance needed to facilitate the application process. However, the provider will remain an out-of-network provider if the provider’s distance or rates is such that it is not desirable for frequent usage, or if the use of the provider was intended to be temporary or limited.

XVIII. Delegation:

If the responsibility for credentialing/re-credentialing or selection of individual practitioners has been delegated to a subcontracted agency, the contractor retains the right to approve, suspend, or terminate its use of each staff person, contracted individual or organization who is credentialed under such delegation. The contractor may review the credentialing/re-credentialing process used by subcontracted organizations when monitoring those providers.

XIX. Reporting:

If provider misconduct results in the suspension or termination of the local contract, contractors shall ensure that it is reported to the appropriate authorities (e.g., CMHPSM Managing Director, CMHPSM Network Management Committee, MDCH, the provider’s regulatory board or agency, and/or the Attorney General, etc.) Reporting procedures will be consistent with current federal and state requirements, including those specified in the MDCH Medicaid Managed Specialty Supports and Services Contract.

XX. Termination:

When the Network Management Committee is notified of a local contract termination or suspension due to misconduct, it will review the appropriateness of the contractor remaining on the CMHPSM provider network. Any recommendation of removal by the Committee shall be submitted to the Regional Operations Committee for final determination.

XXI. Performance Improvement/Data Review:
The CMHPSM Network Management Committee will review provider performance data and make any relevant recommendations for performance improvements to the CMHPSM Clinical Performance Team as the PI entity of the CMHPSM.

VI. EXHIBITS
None

VII. REFERENCES

<table>
<thead>
<tr>
<th>Reference:</th>
<th>Check if applies:</th>
<th>Standard Numbers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR Parts 400 and 438 et al. (Balanced Budget Act)</td>
<td></td>
<td>438.230(b)</td>
</tr>
<tr>
<td>Public Law 109-171, Deficit Reduction Act of 2005,</td>
<td></td>
<td>Title VI</td>
</tr>
<tr>
<td>Public Law 111 – 148: Patient Protection &amp; Affordable Care Act of 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Public Law 111 – 152: Health Care &amp; Education Reconciliation Act of 2010</td>
<td></td>
<td>Title I, Subtitles C and D</td>
</tr>
<tr>
<td>45 CFR Parts 160 &amp; 164 (Health Information Portability and Accountability Act (HIPAA) and HITECH Act of 2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 CFR Part 2 (Substance Abuse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan Mental Health Code Act 258 of 1974</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Joint Commission - Behavioral Health Standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan Department of Community Health and Human Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Health and Human Services (MDHHSCH) Medicaid Contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan Department of Community Health and Human Services (MDHHS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Funds Contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDCH-MDHHS Substance Abuse Contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan Medicaid Provider Manual</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I. PURPOSE
To establish guidelines relating to the Community Mental Health Service Program CMHSP service and financial responsibility for consumers that the CMHPSM PIHP receives capitated payments for, whom live within the four-county region comprised of Lenawee, Livingston, Monroe and Washtenaw counties.

II. REVISION HISTORY

<table>
<thead>
<tr>
<th>DATE</th>
<th>REV. NO.</th>
<th>MODIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/1/2019</td>
<td></td>
<td>Reviewed and revised for clarity</td>
</tr>
</tbody>
</table>

III. APPLICATION
This policy only applies to consumers the CMHSPs serve that are covered by a capitated payment source received by the Community Mental Health Partnership of Southeast Michigan (CMHPSM), the Pre-Paid Health Plan (PIHP) for the four-county region comprised Lenawee, Livingston, Monroe and Washtenaw counties.

Individuals residing within the CMHPSM region receiving solely general fund supported services are not covered by this policy local funding is not managed by the CMHPSM.

Individuals residing within the CMHPSM region with an out of region County of Financial Responsibility (COFR) status are not covered by this policy; an out of region COFR is any individual where a county outside of the CMHPSM four county region is identified as COFR.

IV. POLICY
It is the policy of the CMHPSM that the four regional CMHSPs will not enter into a County of Financial Responsibility (COFR) arrangement with each other related to any individual whose services are covered by a CMHPSM PIHP capitated funding source. The CMHSP that provides services within the county where a consumer covered by this policy is currently residing is responsible for the delivery of all PIHP covered services regardless of the location of the consumer’s last residence in an independent arrangement. The CMHPSM will cost settle at the end of the fiscal year.
of each fiscal year with CMHSPs related to all PIHP covered services for consumers served within its PIHP region, including consumers covered by this policy.

V. DEFINITIONS

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

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.

County of Financial Responsibility (COFR): CMHSP who last served a consumer in the county where they last lived independently.

Electronic Health Record (EHR): The software platform used across the CMHPSM region in which consumer medical, behavioral health, demographic, utilization management, and claims payment data are entered and used in the management and provision of services.

Independent Living Arrangement: A living arrangement that,
   a. for an adult, is either an unlicensed setting or a setting in which the consumer required less than eight hours of specialized service/supports in the residence each day in order to maintain their health and safety in the least restrictive environment.
   b. for a child, is either the county in which the child/youth last resided with parents (birth or adoptive) prior to an out of home placement or if the child/youth is a temporary or permanent ward of the court, it is the county served by the “court of record”.

Individual Plan of Service (IPOS): The plan for the services and supports an individual will be provided that is developed using the principles of person centered/family centered planning as required by the Medicaid contract with the CMHPSM.

Originating CMHSP: Within the CMHPSM region, the CMHSP for the county in which a consumer last resided in an independent living arrangement.

Serving CMHSP: Within the CMHPSM region, the CMHSP for the county in which a consumer currently resides and is determined eligible to receive Medicaid services or is receiving Medicaid covered services.

VI. STANDARDS
A. Consumers must be provided appropriate services without delay resulting from issues of determining financial responsibility.

B. CMHSPs are responsible to ensure all medically necessary services are provided to a consumer residing within the CMHPSM four county region that is currently and continually eligible for Medicaid, Healthy Michigan or any other capitated funding source managed through the CMHPSM PIHP. The CMHSP delivering services to any individual covered by this policy will be recognized as the serving CMHSP, in relation to this policy.

C. The Serving CMHSP where a consumer is determined eligible to receive or is receiving services develops the Individual Plan of Service (IPOS), authorizes all medically necessary services, and enters all relevant service and claim documentation into the Electronic Health Record (EHR).

D. The Serving CMHSP is responsible to manage crisis and emergency services for inpatient hospitalization.

E. The CMHSP serving the County where an individual last resided in an independent living arrangement will still be tracked in relation to consumers covered by this policy. That CMHSP will be referred to as the originating CMHSP in relation to this policy.

F. If an individual consumer covered by this policy moves to a dependent setting in a County outside of the CMHPSM four County region, the originating CMHSP will be recognized as the COFR, where appropriate, related to any out of region COFR arrangement. The serving CMHSP will notify the Originating CMHSP when such an event occurs.

G. At the time a consumer moves outside the CMHPSM, the serving CMHSP will terminate services and the originating CMHSP becomes responsible for coordinating and funding services if an out of region COFR arrangement is required.

VII. EXHIBITS
None

VIII. REFERENCES

<table>
<thead>
<tr>
<th>Reference:</th>
<th>Check if applies:</th>
<th>Standard Numbers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDHHS/PIHP Managed Mental Health Supports and Services Contract</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>42 CFR Parts 400 et al. (Balanced Budget Act)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45 CFR Parts 160 &amp; 164 (HIPAA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 CFR Part 2 (Substance Abuse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan Mental Health Code Act 258 of 1974</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The Joint Commission - Behavioral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Michigan Department of Community Health (MDHHS) Medicaid Contract</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Michigan Medicaid Provider Manual</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
1. **Washtenaw County Enrollees**

A summary of FY 2019 Washtenaw County Medicaid and Healthy Michigan Enrollees is shown below:

![Graph showing enrollees over time](image)

Washtenaw County Medicaid Enrollees were 32,856 in March 2019. This is a 4.84% decrease from the same time last year (1,671 less enrollees than in March 2018). Healthy Michigan enrollment in March was 16,242. This is a 5.97% decrease from the same time last year (1,032 less enrollees than in March 2018).

2. **WCCMH Consumers Served to Date**

![Graph showing consumers served over time](image)
Medicaid consumers served through March 2019 are 3,357. This is 196 more consumers than the prior year (3,161 consumers were served through March 2018).

ABA Waiver consumers served through March 2019 are 164. This is 27 more consumers than the prior year (137 consumers were served through March 2018).

General fund consumers served through March 2019 are 640. This is 72 more consumers served than the same period last year.

Healthy Michigan consumers served through March 2019 were 817. This is 1 more consumer than the same period last year.
3. **Financial Statement Highlights**

   a. CLS service costs to date are $13.0 Million. The costs year to date are 4.21% more than last year as of March 2018. This is $152,000 under the budget.

   b. The graph below is presented with actual paid claims for CLS services and does not reflect the general ledger. Figures below have been updated retrospectively back to October in order to incorporate all paid claim amounts from prior periods. In doing so, the graph represents the most accurate and up to date information for this service at the time of report preparation.

   ![CLS Service Costs Graph]

   c. Community Inpatient costs to date are $3.3 Million. The costs year to date are 20.59% more than last year as of March 2018. This is $600,000 over the budget.

   ![Community Inpatient Costs Graph]
d. Licensed Residential costs to date are $5.5 Million. The costs year to date are 7.11% more than last year as of March 2018. This is $199,000 under the budget.

<table>
<thead>
<tr>
<th>Month</th>
<th>FY18 Actuals</th>
<th>FY19 Budget</th>
<th>FY19 Actuals</th>
<th>YTD % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct</td>
<td>$845,486</td>
<td>$958,333</td>
<td>$866,002</td>
<td>2.43%</td>
</tr>
<tr>
<td>Nov</td>
<td>$835,932</td>
<td>$958,333</td>
<td>$981,647</td>
<td>9.89%</td>
</tr>
<tr>
<td>Dec</td>
<td>$877,606</td>
<td>$958,333</td>
<td>$932,083</td>
<td>8.62%</td>
</tr>
<tr>
<td>Jan</td>
<td>$945,844</td>
<td>$958,333</td>
<td>$953,401</td>
<td>6.51%</td>
</tr>
<tr>
<td>Feb</td>
<td>$819,635</td>
<td>$958,333</td>
<td>$856,512</td>
<td>6.13%</td>
</tr>
<tr>
<td>Mar</td>
<td>$857,183</td>
<td>$958,333</td>
<td>$960,377</td>
<td>7.11%</td>
</tr>
<tr>
<td>Apr</td>
<td>$977,074</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>$897,294</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jun</td>
<td>$946,248</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jul</td>
<td>$973,928</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug</td>
<td>$950,501</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep</td>
<td>$907,217</td>
<td>$958,333</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

![Licensed Residential Costs Graph]


e. Applied Behavior Analysis/Autism service costs to date are $1.7 Million. The costs year to date are 37.95% more than last year as of March 2018. This is $288,000 over the budget.

<table>
<thead>
<tr>
<th>Month</th>
<th>FY18 Actuals</th>
<th>FY19 Budget</th>
<th>FY19 Actuals</th>
<th>YTD % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct</td>
<td>$232,440</td>
<td>$237,500</td>
<td>$274,122</td>
<td>17.93%</td>
</tr>
<tr>
<td>Nov</td>
<td>$191,560</td>
<td>$237,500</td>
<td>$241,620</td>
<td>21.64%</td>
</tr>
<tr>
<td>Dec</td>
<td>$211,309</td>
<td>$237,500</td>
<td>$342,030</td>
<td>35.02%</td>
</tr>
<tr>
<td>Jan</td>
<td>$206,977</td>
<td>$237,500</td>
<td>$220,299</td>
<td>27.99%</td>
</tr>
<tr>
<td>Feb</td>
<td>$147,684</td>
<td>$237,500</td>
<td>$314,818</td>
<td>40.20%</td>
</tr>
<tr>
<td>Mar</td>
<td>$252,156</td>
<td>$237,500</td>
<td>$320,839</td>
<td>37.95%</td>
</tr>
<tr>
<td>Apr</td>
<td>$197,173</td>
<td>$237,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>$257,596</td>
<td>$237,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jun</td>
<td>$284,231</td>
<td>$237,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jul</td>
<td>$170,328</td>
<td>$237,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug</td>
<td>$344,560</td>
<td>$237,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep</td>
<td>$223,270</td>
<td>$237,500</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

![Autism Costs Graph]
f. A significant amount of General Fund is used to supplement Medicaid deductibles for our consumers on a spend-down. The number of cases that did not meet their spend-down deductible through March 2019 were 133. The number of cases that met their spend-down deductible through March 2019 were 149. The amount spent through March 2019 is $483,000.

4. **PIHP Revenue Key Points**
   
a. Medicaid, Healthy Michigan Plan and Autism funds are coming in at budget.
b. By funding source, Medicaid is showing a deficit of $3.7 Million.
c. By funding source, HMP is showing a deficit of $2.0 Million

5. **State General Fund Key Points**
   
a. General Fund programs and funding redirected to other Risk-Based programs is showing a deficit of $211,000.
b. General Fund overages are primarily resulting in the CLS and Licensed Residential business units.
c. General Fund funding has been redirected by the WCCMH as detailed below:
   
   i. $22,000 to SED Waiver
   ii. $96,000 to Child Waiver

6. **Local Key Points**
   
a. The majority of Local Funding comes from Washtenaw County.
b. Local Funds are showing a surplus of $81,000 through March 2019.
c. Uses of Local Funding include:
   
   i. The 10% GF Match of non-residential services
   ii. Local contribution – required by MDHHS
   iii. Local share for State Facilities
   iv. Shelter expenses and other Local needs

7. **Fund Balance**
   
   WCCMH current has no fund balance available for fiscal year 2019.
### Medicaid **

<table>
<thead>
<tr>
<th><strong>Revenue</strong></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>B &amp; B3</td>
<td>$19,751,569.79</td>
</tr>
<tr>
<td>HSW</td>
<td>$11,519,283.05</td>
</tr>
<tr>
<td>Prior Year Adjustments</td>
<td>-</td>
</tr>
<tr>
<td>Care for Caid</td>
<td>89,468.02</td>
</tr>
<tr>
<td><strong>Total Medicaid Revenue</strong></td>
<td>$31,360,320.86</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Expense</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Costs</td>
<td>$31,121,107.38</td>
</tr>
<tr>
<td>Admin. Cost Allocation</td>
<td>3,954,413.86</td>
</tr>
<tr>
<td>Redirect To Cover COFR Exp.</td>
<td>-</td>
</tr>
<tr>
<td>Redirect To Cover MiChild Exp</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Medicaid Expense</strong></td>
<td>$35,075,521.24</td>
</tr>
</tbody>
</table>

Medicaid Surplus/(Deficit) $ (3,715,200.38)

### Autism Benefit **

<table>
<thead>
<tr>
<th><strong>Revenue</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Benefit</td>
<td>$1,260,698.44</td>
</tr>
<tr>
<td>MIChild Benefit</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Autism Benefit Revenue</strong></td>
<td>$1,260,698.44</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Expense</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Service Costs</td>
<td>$1,120,801.41</td>
</tr>
<tr>
<td>Admin. Cost Allocation</td>
<td>139,897.02</td>
</tr>
<tr>
<td>MIChild Service Costs</td>
<td>-</td>
</tr>
<tr>
<td>Admin. Cost Allocation</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Autism Benefit Expense</strong></td>
<td>$1,260,698.44</td>
</tr>
</tbody>
</table>

Autism Surplus/(Deficit) $ -

### Healthy Michigan **

<table>
<thead>
<tr>
<th><strong>Revenue</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,183,131.00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Expense</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,240,127.33</td>
<td></td>
</tr>
</tbody>
</table>

Healthy MI Surplus/(Deficit) $ (2,056,996.33)

### General Fund

<table>
<thead>
<tr>
<th><strong>Revenue</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CMH Operations</td>
<td>$1,577,338.17</td>
</tr>
<tr>
<td>CMH Operations Contra</td>
<td>-</td>
</tr>
<tr>
<td>Categorical</td>
<td>-</td>
</tr>
<tr>
<td>Redirect To SED Waiver</td>
<td>(22,799.70)</td>
</tr>
<tr>
<td>Redirect To Children's Waiver</td>
<td>(96,833.35)</td>
</tr>
<tr>
<td>Redirect To Injectable Meds.</td>
<td>(1,500.98)</td>
</tr>
<tr>
<td>Funding Fr. Other Local Sources</td>
<td>33,254.33</td>
</tr>
<tr>
<td><strong>Total General Fund Revenue</strong></td>
<td>$1,489,458.47</td>
</tr>
</tbody>
</table>

| **Total General Fund Expense** | $1,701,381.51 |

General Fund Surplus/(Deficit) $ (211,923.05)
<table>
<thead>
<tr>
<th>Fund Source</th>
<th>Total</th>
<th>Revenue</th>
<th>Expense</th>
<th>Surplus/(Deficit)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SED Waiver</strong></td>
<td></td>
<td>$ 59,998.19</td>
<td>$ 59,998.19</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>Children's Waiver</strong></td>
<td></td>
<td>$ 335,117.49</td>
<td>$ 335,117.49</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>Injectable Meds</strong></td>
<td></td>
<td>$ 1,500.98</td>
<td>$ 1,500.98</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>Grants And Contracts</strong></td>
<td></td>
<td>$ 711,014.71</td>
<td>$ 711,014.71</td>
<td>$ -</td>
</tr>
<tr>
<td><strong>CMHSP To CMHSP</strong></td>
<td></td>
<td>$ 337,389.52</td>
<td>$ (33,254.33)</td>
<td>$ 304,135.19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td><strong>Local</strong></td>
<td></td>
<td>$ 866,870.97</td>
<td>$ 785,060.85</td>
<td>$ 81,810.12</td>
</tr>
<tr>
<td><strong>Private Grant &amp; All NOR</strong></td>
<td></td>
<td>$ 108,909.16</td>
<td>$ 97,857.16</td>
<td>$ 11,052.00</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td>$ 38,377,020.27</td>
<td>$ 44,268,277.90</td>
<td>$(5,891,257.63)</td>
</tr>
</tbody>
</table>

** Denotes PIHP Medicaid Subcontracting Agreement Funds

PIHP Medicaid Surplus/(Deficit) $ (5,772,196.71)
WCCMH Surplus/(Deficit) $ (119,060.92)

$(5,891,257.63)
### Operating Revenue

**PHHP Revenue**

<table>
<thead>
<tr>
<th>FY 2019 Budget Amendment</th>
<th>FY 2019 Budget Amendment YTD</th>
<th>FY 2019 Current YTD Actuals</th>
<th>YTD Actuals Over/(Under) Amended Budget</th>
<th>% (U)</th>
<th>FY 2018 Prior YTD</th>
<th>YTD Actuals Over/(Under) Prior Year Actuals</th>
<th>% (U)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Capitation:</td>
<td>$37,898,761</td>
<td>$19,499,381</td>
<td>$460,026</td>
<td>2.43%</td>
<td>$19,409,406</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Plan/B3</td>
<td>37,898,761</td>
<td>$19,409,406</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSW</td>
<td>23,510,004</td>
<td>11,519,283</td>
<td>(235,719)</td>
<td>-2.01%</td>
<td>11,519,283</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Michigan Capitation</td>
<td>4,001,682</td>
<td>2,183,131</td>
<td>(920,551)</td>
<td>-43.5%</td>
<td>2,003,050</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism Capitation</td>
<td>2,951,725</td>
<td>1,602,862</td>
<td>127,000</td>
<td>8.61%</td>
<td>1,353,029</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticipated Medicaid Revenue</td>
<td>10,361,681</td>
<td>5,180,841</td>
<td>(100000)</td>
<td>-2.04%</td>
<td>2,185,277</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL PHHP Revenue</strong></td>
<td>$78,723,853</td>
<td>$39,361,927</td>
<td>$46,447,256</td>
<td>-11.81%</td>
<td>$35,369,464</td>
<td><strong>(654,782)</strong></td>
<td>-1.85%</td>
</tr>
</tbody>
</table>

**MDHHS Revenue**

<table>
<thead>
<tr>
<th>FY 2019 Budget Amendment</th>
<th>FY 2019 Budget Amendment YTD</th>
<th>FY 2019 Current YTD Actuals</th>
<th>YTD Actuals Over/(Under) Amended Budget</th>
<th>% (U)</th>
<th>FY 2018 Prior YTD</th>
<th>YTD Actuals Over/(Under) Prior Year Actuals</th>
<th>% (U)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State General Funds</td>
<td>$3,147,193</td>
<td>1,573,587</td>
<td>3,742</td>
<td>0.24%</td>
<td>1,392,288</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Fee for Service</td>
<td>820,235</td>
<td>275,483</td>
<td>(134,635)</td>
<td>-32.83%</td>
<td>229,326</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants &amp; Earned Contracts</td>
<td>3,509,117</td>
<td>1,754,559</td>
<td>780,382 (974,177)</td>
<td>-55.52%</td>
<td>719,827</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All Other Revenue</strong></td>
<td>$7,126,124</td>
<td>$3,251,891</td>
<td>$5,180,446</td>
<td>-100.00%</td>
<td>$46,766</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Appropriation</td>
<td>$2,185,277</td>
<td>1,092,639</td>
<td>515,831 (576,808)</td>
<td>-52.79%</td>
<td>466,766</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Revenue</td>
<td>751,000</td>
<td>369,626</td>
<td></td>
<td></td>
<td>350,996</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other</td>
<td>1,172,977</td>
<td>1,019,754</td>
<td>383,266</td>
<td>3.87%</td>
<td>1,156,967</td>
<td>(137,213)</td>
<td>-11.86%</td>
</tr>
<tr>
<td><strong>TOTAL Operating Revenue</strong></td>
<td><strong>$9,039,652</strong></td>
<td><strong>$45,154,826</strong></td>
<td><strong>$39,253,096</strong></td>
<td>-13.07%</td>
<td><strong>$39,685,634</strong></td>
<td><strong>(432,538)</strong></td>
<td>-1.09%</td>
</tr>
</tbody>
</table>

### Operating Expenses

**Administrative Expenses**

<table>
<thead>
<tr>
<th>FY 2019 Budget Amendment</th>
<th>FY 2019 Budget Amendment YTD</th>
<th>FY 2019 Current YTD Actuals</th>
<th>YTD Actuals Over/(Under) Amended Budget</th>
<th>% (U)</th>
<th>FY 2018 Prior YTD</th>
<th>YTD Actuals Over/(Under) Prior Year Actuals</th>
<th>% (U)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Administration</td>
<td>$6,503,782</td>
<td>3,251,891</td>
<td>3,439,776</td>
<td>5.78%</td>
<td>3,345,717</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Administration</td>
<td>3,408,000</td>
<td>1,704,000</td>
<td>1,743,314</td>
<td>2.31%</td>
<td>1,714,188</td>
<td>(30,874)</td>
<td>-1.74%</td>
</tr>
<tr>
<td>Residential Services</td>
<td>$26,400,000</td>
<td>13,200,000</td>
<td>13,048,980 (151,016)</td>
<td>-1.14%</td>
<td>12,039,181</td>
<td>1,009,803</td>
<td>8.39%</td>
</tr>
<tr>
<td>Licensed Residential</td>
<td>11,500,000</td>
<td>5,750,000</td>
<td>5,550,022 (199,978)</td>
<td>-3.48%</td>
<td>5,181,686</td>
<td>368,336</td>
<td>7.11%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>$2,850,000</td>
<td>1,425,000</td>
<td>1,735,280</td>
<td>20.25%</td>
<td>1,242,126</td>
<td>471,402</td>
<td>37.95%</td>
</tr>
<tr>
<td>Case Management</td>
<td>4,816,278</td>
<td>2,430,723</td>
<td>22,584</td>
<td>0.94%</td>
<td>2,270,381</td>
<td>160,342</td>
<td>7.06%</td>
</tr>
<tr>
<td>Supports Coordination</td>
<td>2,354,878</td>
<td>1,120,482</td>
<td>(56,997)</td>
<td>-4.84%</td>
<td>1,067,872</td>
<td>52,610</td>
<td>4.93%</td>
</tr>
<tr>
<td>Skill Building</td>
<td>5,979,556</td>
<td>3,170,291</td>
<td>180,513</td>
<td>6.04%</td>
<td>3,047,673</td>
<td>132,618</td>
<td>4.37%</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>1,747,546</td>
<td>991,522</td>
<td>117,749</td>
<td>13.48%</td>
<td>988,908</td>
<td>2,614</td>
<td>0.26%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2,747,242</td>
<td>1,403,047</td>
<td>29,426</td>
<td>2.14%</td>
<td>1,284,920</td>
<td>118,127</td>
<td>9.19%</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>2,282,899</td>
<td>1,111,561</td>
<td>(12,388)</td>
<td>-1.12%</td>
<td>952,140</td>
<td>159,425</td>
<td>16.74%</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>1,804,501</td>
<td>901,579</td>
<td>(672)</td>
<td>-0.07%</td>
<td>852,842</td>
<td>48,737</td>
<td>5.71%</td>
</tr>
<tr>
<td>Other Expenses</td>
<td>7,938,205</td>
<td>3,069,103</td>
<td>3,789,089 (189,014)</td>
<td>-4.76%</td>
<td>4,063,564</td>
<td>(283,475)</td>
<td>-6.88%</td>
</tr>
<tr>
<td>Community Inpatient</td>
<td>$5,400,000</td>
<td>2,700,000</td>
<td>3,300,454</td>
<td>22.24%</td>
<td>2,736,911</td>
<td>563,543</td>
<td>20.59%</td>
</tr>
<tr>
<td>Local Matches &amp; Shelter</td>
<td>1,282,838</td>
<td>658,596</td>
<td>17,177</td>
<td>0.26%</td>
<td>765,692</td>
<td>(107,096)</td>
<td>-13.99%</td>
</tr>
<tr>
<td>Grants &amp; Earned Contracts</td>
<td>3,259,917</td>
<td>866,382</td>
<td>(866,382)</td>
<td>-52.62%</td>
<td>719,827</td>
<td>60,555</td>
<td>8.41%</td>
</tr>
<tr>
<td><strong>TOTAL Operating Expenses</strong></td>
<td><strong>$9,039,652</strong></td>
<td><strong>$45,154,826</strong></td>
<td><strong>$45,144,354</strong></td>
<td>-0.02%</td>
<td><strong>$42,323,628</strong></td>
<td><strong>2,820,726</strong></td>
<td>6.66%</td>
</tr>
</tbody>
</table>

**Revenue Over/(Under) Expenses**

- - (5,893,258) (5,893,258) (2,637,994) (3,253,264)
Members Present: Judy Ackley, Greg Adams, Susan Fortney, Roxanne Garber, Bob King, Sandra Libstorff, Charles Londo, Gary McIntosh, Caroline Richardson, Katie Scott, Sharon Slaton

Members Absent: Charles Coleman, Ralph Tillotson

Staff Present: Kathryn Szewczuk, Trish Cortes, Connie Conklin, Stephannie Weary, Lisa Jennings, James Colaianne, Suzanne Stolz, Dana Darrow, Nicole Phelps, Marci Scalera

Others Present: Lori Lutomski

I. Call to Order
   Meeting called to order at 6:00 p.m. by Board Chair C. Londo.

II. Roll Call
   • A quorum of members present was confirmed.

III. Consideration to Adopt the Agenda as Presented

   Motion by S. Fortney, supported by K. Scott, to approve the agenda as amended
   Motion carried

   Additions:
   • Closed session to discuss personnel-related issue.
   • Resolution of appointment of an interim director for agency.

IV. Consideration to Approve the Minutes of the March 13, 2019 Regular Meeting and Waive the Reading Thereof

   Motion by S. Slaton, supported by G. McIntosh, to approve the minutes of March 13, 2019 Regular Meeting and waive the reading thereof
   Motion carried

V. Audience Participation
   None

VI. Old Business
   a. April Finance Report
      S. Stolz presented. Discussion followed.

   b. CEO Performance Evaluation Committee Report
Motion by R. Garber, supported by C. Richardson, to go into closed session  
Motion carried

- Regional Board meeting went into closed session at 6:25 p.m. All were excused from the meeting except for board members.

Motion by S. Fortney, supported by J. Ackley, for Board to go back into open session  
Motion carried

- Regional Board meeting went back into open session at 6:55 p.m.

Motion by C. Richardson, supported by R. Garber, to accept the voluntary resignation submitted orally by Jane Terwilliger at 4:10 p.m. on 4/10/2019, and further to authorize an offer of the balance of payment due under Ms. Terwilliger’s current employment contract in exchange for a waiver and release of all claims  
Motion carried

<table>
<thead>
<tr>
<th>Ackley</th>
<th>Yes</th>
<th>Londo</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>Yes</td>
<td>McIntosh</td>
<td>Yes</td>
</tr>
<tr>
<td>Coleman</td>
<td>Absent</td>
<td>Richardson</td>
<td>Yes</td>
</tr>
<tr>
<td>Fortney</td>
<td>Yes</td>
<td>Scott</td>
<td>Yes</td>
</tr>
<tr>
<td>Garber</td>
<td>Yes</td>
<td>Slaton</td>
<td>Yes</td>
</tr>
<tr>
<td>King</td>
<td>Yes</td>
<td>Tillotson</td>
<td>Absent</td>
</tr>
<tr>
<td>Libstorff</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Motion by C. Richardson, supported by R. Garber, to appoint James Colaianne as Interim Chief Executive Officer, and to begin a search process by appointing a search committee including county executive directors  
Motion carried

<table>
<thead>
<tr>
<th>Ackley</th>
<th>Yes</th>
<th>Londo</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>Yes</td>
<td>McIntosh</td>
<td>Yes</td>
</tr>
<tr>
<td>Coleman</td>
<td>Absent</td>
<td>Richardson</td>
<td>Yes</td>
</tr>
<tr>
<td>Fortney</td>
<td>Yes</td>
<td>Scott</td>
<td>Yes</td>
</tr>
<tr>
<td>Garber</td>
<td>Yes</td>
<td>Slaton</td>
<td>Yes</td>
</tr>
<tr>
<td>King</td>
<td>Yes</td>
<td>Tillotson</td>
<td>Absent</td>
</tr>
<tr>
<td>Libstorff</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VII. New Business
   a. FY19 Direct Care Wage Pass-Through
      • J. Colaianne presented. Discussion followed.
   b. Vendor Contracts
      • J. Colaianne presented. Discussion followed.

VIII. PIHP CEO Report to the Board
   • Oversight Policy Board (OPB) minutes were included with board packet.
   • M. Scalera provided an overview of OPB.

IX. Adjournment

   **Motion by S. Slaton, supported by C. Richardson, to adjourn the meeting**
   **Motion carried**

   Meeting adjourned at 7:25 p.m.

Judy Ackley, CMHPSM Board Secretary
This guidance is intended to provide instructions to intermediate school districts for developing their plan to implement services and processes under the 31n legislation.

Intent of the Legislation

- The overall intent of this 31n funding is to enhance and expand the availability of mental health services and supports to general education K-12 students in Michigan.
- Intermediate School Districts (ISDs) are encouraged to utilize resources and staff at the Michigan Department of Health and Human Services and Michigan Department of Education for technical assistance support.
- ISDs may choose to submit a plan for any 1 or up to all 3 subsections for which they initially applied.
- The ISD plan, including all relevant sections, shall be double spaced and no longer than 10 pages in length. Attachments can be included if needed.
- There is no required formula for ISDs to use to determine the distribution of funds in their districts. This is locally determined, although guidance in subsection 6 does provide some recommendations.
- The timeline for spending these funds for this fiscal year is September 30. This funding can span multiple years if necessary.

Subsection 6 Implementation Guidance

This guidance is intended to help stakeholders better understand the intent of the legislation to implement services
and processes to provide mental health supports to general education students.

Purpose of Funding

- The purpose of funding under 31n (6) is to expand the availability of mental health services and supports to K-12 students with mild to moderate mental health issues and provide appropriate referrals for students in need of more intensive services through the Community Mental Health system.

- Funding under subsection 6 is for services, not for training.
  - **Please note**: an ISD may provide mental health support services via the classroom teachers through training and sub stipends through the 31n (12) subsection.

- Funding shall be used for **expansion** of existing services or to start **new** mental health services in schools where there is a gap in available resources.

- Schools can contract with an external organization to provide onsite mental health services within the school or they can hire ISD or school district mental health service providers directly.

- Funding **must not supplant** any existing services or staff positions. Applications that do not clearly describe **expansion** or **new** services will be returned for revision by the Department.

- Funding shall be used to expand or hire any of the following professional mental health staff:
  - A psychiatrist;
  - A licensed master’s level psychologist;
  - A limited licensed master’s level psychologist, under the supervision of a licensed master’s level psychologist;
  - A MDE credentialed master’s level school psychologist;
  - A licensed master’s level marriage and family therapist;
  - A licensed master’s level professional counselor;
  - A limited licensed master’s level professional counselor, under the supervision of a licensed master’s level professional counselor;
  - A licensed master’s level social worker;
  - A licensed master’s level school social worker;
• A limited licensed master’s level social worker, under the supervision of a licensed master’s level social worker

• Funding under this subsection can be used to support the following services:
  • Administer a comprehensive behavioral health assessment including the use of validated screening tools, as indicated, to determine determining student’s needs for specific psychological, health or related services.
  • Development of a treatment service plan, with input from student and parents/caregivers as appropriate.
  • Behavior health interventions to enhance the psychological, behavioral, emotional, cognitive and social factors important for the prevention, treatment, or management of behavioral health concerns.
  • Behavioral Health (non-academic) Counseling services.
  • Psychotherapy to include client-centered student-guided services and families as appropriate.
  • Obtaining, integrating, and interpreting information regarding a student’s behavior and supports necessary for success in school and life, and the planning and managing of psychological services.
  • Assess the effectiveness of the delivered services toward achieving the student driven goals and objectives via treatment service plan review.
  • Assess needs for additional counseling services; making referrals when appropriate to Community Mental Health System.
  • Crisis intervention.
  • Psycho-education services provided to assist student and parents/caregivers in understanding student diagnosis, behavioral health needs and support services offered.

Medicaid Match

• There is a **minimum 20% local match requirement** under this section.
  • Any non-Federal funding stream such as State Aid, 31a, etc. can be used to meet the match requirement.
  • If ISDs choose to use the funding directly versus distributing it to partner districts, then the ISD shall provide the match.
Subsection 6: Staffing and Service Plan Requirements

- The staffing and service plan should reflect the needs of K-12 students within the targeted school building or district that is proposed to be served with this funding.

- **Please note:** funding under this subsection is **not intended** to be evenly distributed across all districts, but rather targeted to a few schools and/or districts based on need and the lack of existing services.

- Different school buildings and districts may have unique needs and those should be reflected in the ISD plan.

- Existing mental health services and supports should be taken into consideration when identifying which districts/schools to target with mental health service expansion.

- All mental health services funded through this subsection shall follow Michigan’s Mental Health Code, adhere to standards of care for the provision of mental health services, including timely client records documentation (assessment, screening tools as indicated, treatment plan and treatment plan review as warranted, consents, releases of information as necessary and referrals).

- Provisions must also be in place for appropriate supervision.
  - Confidentiality and privacy laws shall be communicated to clients, their families, school staff and shall be maintained.

- Out-of-county school of choice students whom are enrolled and attending a school within the jurisdiction of the ISD may receive services.

- The plan **cannot** put more requirements on local districts than what is in 31n without prior approval from MDE/MDHHS.

- If schools contract with an external organization or ISD mental health staff to provide onsite services within the school, there must be a Memo of Understanding (MOU) in place.

- The plan shall include:
  - A commitment to maintain mental health and support services delivered by licensed providers into future fiscal years.
  - A commitment to implement all federal Medicaid match methodologies and provide a local match of at least 20%.
  - Identify existing partnerships with community health care providers or the ability of the district to establish such partnerships.
• Documentation of need, including gaps in current mental health and support services for the general education population.

• A formal plan of action identifying the name of schools and number of students to be served.

• While preparing your formal communication plan consider:
  • Roles and responsibilities of these professionals (identified in the Memo of Understanding) to school building personnel.
  • How this work is connected with the Top 10 in 10 initiative and the Whole School, Whole Community, Whole Child (WSCC) Model.
  • Informing all relevant stakeholders.
  • How communication will take place (forms and process) to reduce confusion and disjointed services.

• Services to non-public pupils upon request.

• Written commitment from participating districts to:
  • Participate in ongoing trainings.
  • Submit an annual report to the state.
  • Work with the state to establish program and service delivery benchmarks.
  • Develop a school safety plan or begin a process of developing a school safety plan.

Staffing and Service Plan Recommendations

• The Departments recommend the work of the behavioral health therapist, placed in a school setting, should be structured around best clinical practices including a Student Assistance approach.

• Psychological, Counseling, Behavioral, and Social Work services may be provided in an individual or group setting by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440,50, through §440,60(a) and other applicable state and federal law or regulations.

• When identifying which districts or schools to target with this funding, the Departments recommend using some or all the following indicators:
  • Availability of existing mental health services either within the school or district, or nearby in the community.
• See attached maps with designated Mental Health Provider Shortage Areas.
• Click here to select map of Mental Health Professional Shortage Areas (HPSA).
• Click here to select map of Medically Underserved Areas/Populations (MUA/P).
• Other community resources within the building/district such as Child & Adolescent Health Centers, Pathway to Potential sites, Community Mental Health staff, etc.
• Suicide attempts or completions within the district or building.
• % students with Free or Reduced Lunch.
• % children in the county under 19 years of age with Medicaid or Medicaid eligible.
• Building or district level discipline, suspension, and expulsion data.
• Graduation rates (district and/or building level).
• Chronic absentee data
• MIPHY data or any other risk behavior data for the district or school building.
• District or building commitment to meet a minimum 20% local match commitment.
  • Please note: if the ISD hires mental health staff directly, they would be responsible for meeting the 20% match.
• Administrative support for expanding services within their school, dedicating private office space to allow for confidential mental health services, etc.
• District or school’s ability to comply with any administrative requirements such as participating in Medicaid match methodologies.
• Anecdotal data from teachers, parents, and other partners that demonstrates need for mental health services among the student population.
• Scoring local district applications higher based on those that can meet the 20% match requirements.
• The funds could be used to partner with other districts and/or ISDs to form a consortium of care.

ISDs are encouraged to use a rubric or other objective process to score and rank participating districts.

When submitting your Staffing and Service Plan, please clearly describe the process your ISD undertook and the criteria taken into consideration when selecting the district and/or schools that will be targeted with Subsection 6 funding. At a minimum, provide the Student Free and Reduced Lunch count for each building and/or district targeted, the mental health needs of
students within those buildings (see above criteria), and availability or lack of existing mental health services in the community.

Clearly explain how this plan leads to service **expansion** and is **not supplanting** services.

List the professional mental health staff that will be employed with this funding (see page 3) and a tentative coverage schedule (e.g. School A on Monday and Wednesday, School B on Tuesday and Thursday, School C on Fridays). If contracting with an outside agency, please provide a letter of commitment and/or contract detailing staff that will be employed along with their tentative coverage schedule.
DECONSTRUCTING THE DIRECT CARE SERVICE CRISIS

Deconstructing the Direct Care Service Crisis

Scott Brown

Renaissance Community Homes Inc.

Ted DeVantier

Macomb Residential Opportunities, Inc.

Anita Gibson

Work Skills Corporation

Sherri L. Turner

Adult Learning Systems-Lower Michigan

February 2019
DECONSTRUCTING THE DIRECT CARE SERVICE CRISIS

ACKNOWLEDGEMENTS

We would like to recognize the prior contributions made regarding the consideration of Michigan’s direct care workforce by the Workgroup on the Direct Support Workforce (aka the Workgroup). The Workgroup’s study, Section 1009 Report, published in 2016, determined that the frontline workforce delivering face-to-face supports and services to the state’s residents with intellectual and developmental disabilities, mental illness, or substance use disorders is not stable. The 1009 Report further concluded that employers, including individuals using self-determination as well as organizational employers, are not able to recruit and retain a qualified, competent workforce.1 These findings regarding hiring and retaining staff mirrored the experience of four providers of services to Medicaid recipients contracted by Community Mental Health Service Providers (CMHSP’s) within Region 6, the four-county region consisting of Lenawee, Livingston, Monroe and Washtenaw Counties. The four providers formed a workgroup at the request of Region 6 CMHSP Leadership, called the Action Workgroup, whose members consist of Sherri L. Turner, Adult Learning Systems-Lower Michigan; Ted DeVantier, Macomb Residential Opportunities, Inc.; Scott Brown, Renaissance Community Homes Inc; Anita Gibson, Work Skills Corporation; with support from Heather Linky, Director of Operations, Washtenaw County Community Mental Health; Sally Amos O’Neal, Director of Customer Service, Washtenaw County Community Mental Health; Megan Taylor, Network Management Supervisor, Washtenaw County Community Mental Health; Shane Ray, Director of Office of Recipient Rights, Washtenaw County Community Mental Health. The Action Workgroup was tasked with reviewing the 1009 Report recommendations, comparing findings with the current staffing landscape, provide insider knowledge of other opportunities to improve service delivery and begin to formulate a pilot program to positively impact the Community Living Support (CLS) staff in the four-county affiliation. Recommendations and strategies of the suggested pilot will be reviewed with CMHSP’s Region 6 Executive Leadership for approval. If approved, the pilot will then be shared with the State of Michigan to garner support for funding to begin implementing recommendations from both the 1009 Report and those of the Action Workgroup.

The Action Workgroup (AW) would like to acknowledge and thank the following Region 6 Community Mental Health (CMH) Executive Directors; Connie Conklin, Livingston County Community Mental Health Authority; Trish Cortes, Washtenaw County Community Mental Health Authority; Lisa Jennings, Monroe County Community Mental Health Authority; Kathryn Szewczuk, Lenawee County Community Mental Health Authority; Jane Terwilliger, Community Mental Health Partnership of Southeast Michigan; as without their proactive support this deeper dive into the direct care service crisis would not have occurred.
DECONSTRUCTING THE DIRECT CARE SERVICE CRISIS

EXECUTIVE SUMMARY

The service quality provided to Michigan’s Medicaid beneficiaries in Region 6 is reliant on direct care staff to provide daily, hands-on support to individuals with intellectual and developmental disabilities, mental illness, or substance use disorders. These frontline direct care staff function at the critical junction where the system connects with the individual consumer and vital caregiving rapport is formed. The role of a caregiver can be substantial in scope, intensity, and duration. Coupled with the necessity of establishing a professional and caring rapport, direct care work is characterized by unstable schedules, second jobs, salaries low enough to qualify for Medicaid, risk of physical injuries and emotional burnout.

The Community Mental Health Act of 1963, a major landmark in America’s history of mental health rights was signed into law by President John F. Kennedy on October 31, 1963. The Act was the first of several federal policy changes that helped spark a major transformation of the public mental health system by shifting resources away from large institutions towards community-based mental health treatment programs. Although this beginning of the larger deinstitutionalization movement led to great advances in the rights of and treatment options for children, youth, and adults living with mental illness, the full promise of community-based care has yet to be fully realized.

This rapid shift in population, commonly known as “deinstitutionalization,” was encouraged by federal legislation, policy changes, and litigation that incentivized and eventually mandated public mental health systems to shift the locus of care to the community. In 1965, Congress passed the Medicaid Act, which offered higher reimbursement rates for community-based care and excluded payments to mental health institutions. A few years later, the Supplemental Security Income (SSI) disability benefits program provided direct financial support for eligible individuals with mental illness living in the community. Over the next few decades, mental health advocates secured critical recognition by the judicial system of their client’s civil liberties, including requiring due process protections in involuntary commitment proceedings and mandating treatment in the least restrictive environment appropriate for meeting individuals’ needs.

Despite this progress, however, public mental health systems largely failed to develop sufficient resources and staffing adequate to treat and support individuals in home and community-based settings. Many public mental health systems were, and remain, critically underfunded and understaffed.

The Mental Health Code 330.1116 Powers and duties of department. Sec 116. states as follows: (1) Consistent with section 51 of article IV of the state constitution of 1963, which declares that the health of the people of the state is a matter of primary public concern, and as required by section 8 of article VIII of the state constitution of 1963, which declares that services for the care, treatment, education, or rehabilitation of those who are seriously mentally disabled shall always be fostered and supported, the department shall continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state.
Due to listed difficulties experienced by direct care staff, turnover and staff vacancy rates are high, continuity of care is compromised and the possibility of consumers being denied access to services likely. This climate is ripe for fostering increased reliance on same staff, which in turn necessitates increased workloads, potentially diminished quality and/or safety of care and unfunded excessive overtime. Providers must constantly recruit new workers and the employment pool to choose from is very low considering the state unemployment rate of 4.0%.\textsuperscript{4} In the four-county area in which our Action Workgroup operates in, the unemployment rate is even lower making staff recruitment that much tougher, with joblessness rates recorded in Washtenaw County at 2.8%, Livingston County at 2.9%, Lenawee County at 3.4% and Monroe County at 3.6%.\textsuperscript{5} Essential to comprehending this dilemma is understanding that a myriad of factors need to be considered not exclusive to direct care workers’ wages. To ensure high quality, on time service delivery, it is necessary to start from an outcome’s perspective. Hence the important question is: what do the direct care worker and the providers need to be able to deliver services in the manner which the consumer requires and desires?

**Section I: 1009 Report Executive Summary Overview**

- The following is taken specifically from the Section 1009 Report as it relates to immediate needed and long-range solutions to improve workforce stability:

**Immediate Actions Needed to Improve Wages and Benefits**

The Michigan Legislature and Governor need to make additional investments into all the named Medicaid covered supports and services to assure that:

- Direct support staff earn a starting wage of at least $2.00 per hour above the state’s minimum wage. These investments and the starting wage rate should increase as the state’s minimum wage increases and should include the mandatory employer costs (FICA, worker’s compensation, etc.) associated with employment.
- Direct support staff earn paid leave time at the rate of 1 hour for every 37 hours worked (i.e., 10 days a year for full-time employment).
- The Michigan Department of Health and Human Services (MDHHS) shall use its contractual authority to set Medicaid payment and reimbursement rates that provide sufficient funding to provide and maintain a starting wage rate of at least $2.00 per hour above the state’s minimum wage, associated employer costs, and paid time off to the direct support workforce.
- The Michigan Department of Health and Human Services and each Prepaid Inpatient Health Plan (PIHP) shall collect and publish data on the size, compensation, and stability (turnover rates and job vacancies) of the direct support staff providing the identified supports and services at least annually. The collected data shall be used to assess the impact of the funded wage increases on the wages paid, direct support staff turnover rates, job vacancies, service delivery, and the adequacy of the direct support workforce.
DECONSTRUCTING THE DIRECT CARE SERVICE CRISIS

Long Range Solutions to Improve Workforce Stability

- Develop and fund a promotional campaign to build public awareness and appreciation of people with disabilities and those who chose a career to support them. The campaign should build off the system’s mission of inclusion and stigma elimination. MDHHS, the PIHPs, employers, direct support staff, and people with disabilities should participate in the creation and execution of the campaign.
- Expand the existing MDHHS funded matching services registry for Home Help beneficiaries to include all Medicaid beneficiaries using the self-determination option to address the difficulties (conducting criminal background checks, advertising, recruiting, etc.) individuals using self-determination have in finding direct support staff.
- Change Michigan’s current laws and policies on criminal background checks to include a “rehabilitation review” similar to those authorized in 17 other states in order to increase the potential pool of applicants for direct support careers. Implementing a review process would allow people with a disqualifying criminal conviction to demonstrate that they no longer represent a threat to people needing supports and services or to their property.
- Provide publicly financed tuition reimbursement or incentives to direct support workers who are actively studying to become psychologists, behavior specialists, nurses, therapists and other health care occupations that serve people with intellectual and developmental disabilities, mental illness, and substance use disorders in order to increase the number of people interested in doing direct support work. This effort will also improve the frontline skills and broaden the experiences of other health care occupations serving these populations.
- Legislatively require the creation of a workgroup to identify the wide ranging initial competences, skills, and aptitudes needed by the direct support staff and to provide recommendations for a training and credentialing program to assure a competent direct support workforce.

Section II: Update on Implementation Recommendations

The findings in the 2016 1009 Report regarding the critical staffing shortage have not improved. Just as Direct Care Worker (DCW) wages are underfunded, so are the providers’ reimbursement rates to be able to ensure quality care is supplied utilizing a stable workforce. There has been only one of the 1009 Report recommendations that were partially implemented, and this was a .50 increase to DCW wages. The wage increase had unintended negative consequences on providers. Specifically, it is well known, as chronicled in the 1009 Report that overtime is excessive due to the staffing shortage epidemic. This raise made no allowances for increases that are necessary to payout for overtime, or any other benefit such as holiday pay, that requires wages to be elevated over straight time.
DECONSTRUCTING THE DIRECT CARE SERVICE CRISIS

Therefore, this shift added even more expense to providers paying out overtime as well as adding an administrative tracking burden. Further, the increase that the legislation passed for the increased wage was publicized so some providers began paying a higher salary prior to receiving the adjusted rate increase. Due to the way that providers were requested to track and verify the additional .50 wage, any increases prior to October 1st were not counted and providers were required to increase pay regardless of when the last wage increase was implemented. Additionally, this modest boost did not have the ability to attract new staff nor retain staff, although it likely did demonstrate that the direct care staff’s job is valued by the increased compensation. Upon review of the problems and proposed solutions, common ground can be found if all factions involved pick the strategy that addresses:

- Consumers: Access to continuous care and services, delivered by compassionate trained staff, in the least restrictive setting.
- Direct Care Staff: Access to training and continuing education, healthcare benefits for themselves and families, self-sufficient wages, opportunities for career advances, work environments that are safe and supported, and pride in being employed in a valued position.
- Providers: Reimbursement rates that permit recruitment, hiring, standardized training and retention of skilled, compassionate direct care staff.

Section III: Cost of Business

Providers need to stay abreast of best practices, which involve continued spending on talent recruitment, research, training, supervision, development and technology. Moreover, providers are locked into cyclic recruitment and costs, as low wages produce high turnover, creating overtime and necessitating hiring of unskilled workers. Each new hire requires unsupported upfront operational costs, in turn affecting margins and producing diminished levels of supervision, training and service quality. Reimbursement rates to providers have failed to keep pace with increased cost of benefits due to the Affordable Care Act (ACA) legislation, increased costs for advertising positions, increased costs associated with higher turnover and lower unemployment rates, frontline wages increasing across industries as well as state minimum wage upticks.

Home Help funding is a significant barrier for people who receive services through the PIHP/CMH system. The low and unchanged provider rates only amplifies the financial problem and adds to the crisis we are experiencing. The main focus of Home Help funding is to assist family members and community individual caregivers in providing services to people with disabilities in their own traditional family home. These services are not complicated in nature and do not take into account the needs of people that are part of the PIHP/CMH specialized residential system.

Today, when a person with a disability, that is eligible for residential (PC/CLS) services from a CMH provider, desires a setting different than a group home, often they cannot find a provider able to do the service due to the inadequate Home Help hourly funding rate. It should be noted,
DECONSTRUCTING THE DIRECT CARE SERVICE CRISIS

the greater the disability, the more home help hours are in place, the less the chance the person will find a provider.

Providers who choose to assist these consumers must accept all home help hours authorized as payment in full for service hours provided. The PIHP/CMH cannot add/supplement to this funding under Medicaid rules. Providers are also required to participate in a separate employee credentialing/billing system (CHAMPS) that is separate from, and redundant to, the employee credentialing/billing system used through the PIHP/CMH. Providers find themselves spending many extra hours of staffing time to comply with these separate set of rules and auditing just to find themselves underfunded for the critical services they provide. Therefore, consumers, whose assistance needs are partially funded through the home help program, as well as providers, are negatively impacted by what should be an additional benefit.

This disparity is evidenced by the following chart:

<table>
<thead>
<tr>
<th>Period Covered</th>
<th>Home Help Hourly Rate</th>
<th>CLS Hourly Rate</th>
<th>Michigan Minimum Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-5/31/16</td>
<td>$14.25 Len, $14.50 Mon&amp;Wash, $13.50 Liv</td>
<td>$15.40</td>
<td>$7.40</td>
</tr>
<tr>
<td>6/1/16- 9/30/16</td>
<td>$14.25 Len, $14.50 Mon&amp;Wash, $13.50 Liv</td>
<td>$16.32</td>
<td>$8.50</td>
</tr>
<tr>
<td>10/1/2016-9/30/17</td>
<td>$14.25 Len, $14.50 Mon&amp;Wash, $13.50 Liv</td>
<td>$16.64</td>
<td>$8.90</td>
</tr>
<tr>
<td>10/1/17-Present</td>
<td>$14.25 Len, $14.50 Mon&amp;Wash, $13.50 Liv</td>
<td>$17.20</td>
<td>$9.25</td>
</tr>
<tr>
<td>Late March 2019</td>
<td>$14.25 Len, $14.50 Mon&amp;Wash, $13.50 Liv</td>
<td>$17.20</td>
<td>$9.45</td>
</tr>
<tr>
<td>Total Change</td>
<td>0%</td>
<td>11.69%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Clearly the chart is only depicting the relationship between reimbursement rates and the state’s minimum wage. However, the 25.00% decrease in rates in relation to minimum wage plainly illustrates the widening of the reimbursement gap that providers are shouldering. Specifically, providers are paying out double in wages in relation to fee reimbursement. Please note this does not consider additional factors and overall operating costs providers have had to absorb, such as the Affordable Care Act (ACA) or higher staffing recruitment costs. In fact in terms of talent recruitment, job postings are costing up to 35% more just within the last year.

Consumers receiving services often qualify for both CLS and Home Help services. Home Help is currently reimbursed at the following rates in Region 6: Lenawee County is $14.25, Livingston County is $13.50, Monroe and Washtenaw Counties are $14.50 respectively. All of these reimbursement rates fall below the 2009 CLS rates. Providers typically do not accept new referrals with Home Help hours attached as the rate of return requires subsidizing services. Providers then need to make tough choices and may limit number of referrals accepted, or delay service starts due to staff shortages. Therefore, this limits consumers’ access to services and/or limits provider choices from which consumers can select. There have been at least 6 providers that withdrew from providing services in these four counties that jointly were reimbursed with Home Help and CLS rates. Equalizing rates for Home Help and CMH contracts need to occur.
We propose that the ill-fitting Home Help funding mechanism be removed from the PIHP/CMH system. The PIHP/CMH system needs to receive full Medicaid funding to replace those hours for service provision.

Section IV: Onboarding Expenses & Fees

To deliver direct care services, providers are expected to bear the costs of onboarding without reimbursement. Direct costs per hire are over $2,500 which include wages, mileage and direct costs for the following: TB Tests, Hepatitis Vaccinations, CPR/FA, Drug Testing, Health Appraisals/Physicals, Fingerprinting, Background Checks, Driver’s Checks, Insurance Proof, Credentialing Verifications, CMH Trainings-Bloodborne Infectious Disease Training, Cultural Competency Training, Due Process, Grievance and Appeals Training, Limited English Proficiency Training, Medicaid Integrity Training, Person Centered Planning Training, Recipient Rights 30 Day Temporary Training, Medications Administration Training and Recipient Rights Training. Training classes are limited in dates/hours and attendee numbers. Training is often not honored from county to county.

Section V: Talent Costs

Providers’ inability to recruit and retain direct care workers over the last several years has resulted in unparalleled rates of vacancy and 67% turnover among frontline staff. A 2015 snapshot of data suggested 4000 individuals were needed to fill the 2300 DCW positions. Excerpts from Stephen Campbell of the PHI projects there will be 7.8 million direct care job openings from 2016 to 2026: 3.6 million workers will leave the labor force, 2.8 million workers will leave the field for other occupations, and 1.4 million new positions will be created due to rising demand. The direct care workforce is expected to grow more than any single occupation in the country. Wages offered do not compete with other frontline positions. They are below the poverty line to support a family, and contribute to high turnover rates. The wages of a DCW is considered by many an indication that these low-wage workers possess skills that are undervalued in the labor market. Industry turnover is factored at an expense of $3,500 per employee which only contributes to the sting experienced due to high turnover. When the 1009 Report was written, the unemployment rate for September 2016 in Michigan was 5.1%. To contrast, it is now 1.1% lower (that’s 20%, which correlates with the increased difficulty providers are having of finding DCW’s due to the shrinking workforce. This in turn creates overtime (OT); an expense averaged at 9.46% for the proposed pilot providers. As previously mentioned, recent mandated wage increases did not factor in OT or Holiday Pay, and OT expenses were statistically increased following the .50 wage adjustment without a corresponding reimbursement rate for providers.

As stated in the 2016 1009 Report, the average starting wage for direct support staff was $8.69 per hour while experienced direct support staff in Michigan earned an average of $9.62 an hour. In the findings of our Action Workgroup, the average 2018 starting wage for a direct support staff is $10.00 an hour. This is a difference of a $1.31 although the increase in reimbursement rates were only .56, meaning providers made up the .55 variance in wages being paid out. Unfortunately, despite the wage increases, this still means a DCW with a family of four is below the poverty line and qualifies for governmental assistance as a member of the working poor. Until the wages can
be elevated, providers need to offer information on resources to assist with increasing the family’s financial stability.

Examples of resources implemented by providers in the Action Workgroup to support direct care workers are food programs where the direct care worker can pick up food at their employer or linkages to other food pantries. Other direct supports are needed as often times caregivers are not able to sit on hold for long periods of times connecting with agencies such as Michigan Department of Health and Human Services for affordable daycare or other services, so ancillary staff make the resource call on behalf of their caregiver.

Financial management and budgeting are another resource routinely provided to caregivers. For example, providers have arranged microloans of $1000 or less or payroll advances, as the caregivers frequently have to live paycheck to paycheck. These microloans eliminate the need for loans based on credit and can assist them with whatever financial hurdle is being encountered. Repayment of the loan is managed by direct withdrawals from their paycheck and includes another saving component so when the loan is paid back there are additional monies saved; which helps reinforce how to save and the importance of maintaining backup funds.

Other resources provided to caregivers include access to: legal services, affordable housing, affordable daycare, low cost car repairs, free income tax preparation, health and wellness classes, and credit repair and foreclosure prevention. All of these resources are necessary as any one of these could, and do; prevent the caregiver from working (i.e. no daycare, broken vehicles with no money to pay for repairs, housing stability issues, no food etc.) and contributes to the high DCW turnover rate. Caregiver’s financial circumstances are regularly teetering on the brink of derailment. DCW’s are the working poor that are providing much needed services and lifelines to the state’s most vulnerable citizens.

Section VI: Training Reciprocity Reform and Cost Efficiency

Currently staff may need to complete CMH training again, even if it is within a year of hire when becoming employed by another organization. However, if the training is CPR or First Aid this will transfer, as there is training reciprocity with these courses. This is because training is standardized in that it is from an approved curriculum delivered by qualified trainers. Thus, savings in terms of onboarding and staff’s time could be achieved if training standardization and reciprocity became the norm for DCW’s in Michigan. Specifically, Training Reciprocity (TR) is a suggested strategic reform involving the requirement of standardized transferrable training accepted by PIHP/CMHSP’s. TR would reduce access time to start new hires, provide cost savings in the form of redundant training elimination and improved quality as a result of standards vetted and established. If this became an approved process, all training records would need to be hosted in one repository for training confirmation.
Having available an online training venue is another suggested reform to reduce costs of mileage, improve choices for the time a training can occur, and improves flexibility for employees. Current trainings are limited in times offered/space available and often do not coincide with hours employees are available. For example, an employee hired for weekend work may not be available during the week due to other life/work commitments. Arizona has implemented a program wherein providers, after meeting eligibility requirements, are allowed to become Approved Training and Testing Program Sites. If this was adopted, providers would be able to arrange trainings that would coincide with shifts for which an employee has been hired. This may also serve to reduce mileage paid out to employee if it is the employer’s host site. The request is for dollars to review the Arizona model and begin to then implement the process within the State of Michigan for the Direct Care Workforce.

An additional strength would be the ability to centralize training records and give providers access to them. It is imperative to the success of reducing costs and gaining efficiencies across the state. The foundation for developing a centralized repository that can be viewed in real-time is already in place through the PCE Inc. Health Information Exchange (HIE) model. Over 95% of the Medicaid expenditures for behavioral health services are processed through a PCE developed system. These customers include PIHP’s, CMHSP, and behavioral health providers. This proposal is to enhance PCE systems HIE model to develop a training tracking database that pulls from all PCE systems training records so they can be accessible for all to view. However, the system will be system agnostic to the participating PIHP, CMHSP and provider that does not utilize a PCE System. The benefit of the system is that entities can track the necessary trainings in their own EMR/System without having to enter the information in a separate database. If entities do not have a training tracking system they can directly enter into the central PCE system. The central repository will include, but not be limited, to a history of training records, certifications, DCW employment history, etc. Contracts/Business Associate Agreements will be put in place between the contributing and viewing entities.

Additionally, cost containment measures could include allowing DCW’s who have related education and/or work experience an opportunity to perform a “challenge test” to test out of training. This cost saving strategy aligns with other standardized courses that offer challenge tests such as American Cross’ CPR/AED/First Aid. Due to high turnover, another possible consideration would be for a provider to have discretion whether or not to allow the DCW to provide care during the 90-day training period.

Section VII: Potential Cost Effectiveness/Efficiency

Suggestions to facilitate cost containment include promoting collaborative efforts and seeking provider volume discounts on contract requirements such as TB tests, Physicals and Hepatitis B Vaccinations. Other possible opportunities involve eliminating duplication by accepting one standard Incident Report form as current practices require submittal of two separate forms for same incident. (LARA and CMH) Another suggestion would be for the time frame for IR submittals to correspond with CMH’s business hours.
DECONSTRUCTING THE DIRECT CARE SERVICE CRISIS

Section VIII: Revaluing DCW’s

The intricacy and stressfulness of caregiving is a reality for most DCW’s. The 1009 Report has a job description outlining responsibilities. The job tasks are correct but the duties do not take into account the complexity of care a consumer requires. For instance, a consumer resisting getting dressed, getting up, eating or bathing is not captured in core job requirement of assisting with these Activities of Daily Living (ADL) functions. Likewise administering medication is different than the reality of following a cheking protocol, dealing with medication emesis, crushing medication, tracking and administration of prn’s or medication refusals, medication changes and the subsequent physician contacts for guidance as well as the requisite paperwork that needs to be completed.

Direct care staff lift consumers in and out of bed and bathtub transfer on and off toilets with or without proper equipment such as Hoyer lifts. They assist the individual with dressing, bathing (often not barrier-free bathtubs); exercising and feeding. They assist with mobility needs which may include supporting the consumer’s weight; all while the consumer may not be receptive, or is physically combative, while participating in their ADL’s. This resistance can become even more of a factor when supporting individuals on a one-to-one basis in their often non barrier free home as staff are essentially working in silos and do not have teammates on which to lean.

The role of a DCW is often times very physical and occupational injury rates for direct care workers are among the highest in the country. Direct care workers are most commonly injured when they overexert themselves through lifting and repositioning their clients. Injuries of staff also contribute to staff shortages and can create even more stress on existing staff and the strained system. Possible solutions to combat injuries and isolation would be to increase hands-on training and supervision/training shifts. A mentoring program may also help serve to reduce staff’s feelings of isolation and increased staff turnover.

To increase the likelihood of improving collective self-esteem of DCW’s, an elevation in status of the industry and job has been suggested. The Action Workgroup proposes to elevate hiring and job status of DCW’s by offering levels of training and CEU’s. Further, it is contended that an establishment of a career ladder for staff that includes upward mobility through empowerment and education to increase retention is paramount. In order to accomplish this, providers need to offer competitive compensation, healthcare and other incentive programs that are tuned to the market. Rates to providers would need to be adequate to allow for regular meetings for training and group cohesion to take place, regular opportunities for supervised training shifts to ensure continuous training and quality checks are in place. An additional suggestion would be to conduct focus groups with high performing DCW’s for suggestions on enhancing perceived status and improved working relationships. For without the input of direct care staff, what is important to these workers could qualify as conjecture.
DECONSTRUCTING THE DIRECT CARE SERVICE CRISIS

Section IX: Recommendations for Strategic Change

- Training Reciprocity:
  - Implement systems standardization for tests and training that transfer with the DCW who has not left the field for over two years.
  - Offer challenge tests to staff who have related education and/or work experience.
  - Make standardized training available online.
  - Allow provider discretion for staff to provide care during 90 day training period.
  - Allow providers to become Approved Training and Testing sites.
  - Create host repository site for training verifications.
  - Seek provider volume discounts for TB Tests, Physicals and Hepatitis B Vaccinations.
  - Eliminate duplicative efforts and streamline to one required IR.

- Re-Valuing DCW
  - Offer levels of training and CEU’s.
  - Provide publicly financed tuition reimbursement or incentives to direct support workers who are going into related field of study.
  - Create career ladders with opportunities for advancement of frontline staff.
  - Conduct focus groups of high performers for input.
  - Provide more one-on-one hands-on training.
  - Implement supervision shifts.
  - Employ mentoring programs.
  - Provide leadership training courses.
  - Develop promotional campaign to elevate appreciation of people with disabilities and DCW’s.
  - Provide resources to workers for income supports.
  - Host a repository site

Section X: Proposed Resources for Change

The strength of this proposal lies in the fact that consumers, providers and CMH have come together and are willing to look at opportunities of systemic change. As shown, the staffing crisis outlined by the 1009 Report has worsened. To be able to implement and affect a positive change it will be necessary to allocate monies that reflect current labor market realities and maximizes consumer preferences. There needs to be agreement for change in terms of who can provide training, regional training reciprocity and provider discretion with training. This will require cooperation and change at the CMH level. Additionally, parity of compensation regarding Home Help Services and CLS needs to occur so that consumers are afforded access to services. One suggestion is to have CMH responsible for the administration of Home Help funds and CLS to ensure equal fee reimbursement rates. Providers need to be compensated appropriately to be able to support innovative ideas, best practices and retain and recruit top talent. To effectively provide CLS services, quality assurance checks and supervision of direct care workers must be addressed and properly funded. Wages and benefits for workers should reflect the value society places on
this job and those that are served, as a full time job qualifying for food stamps does not coincide with the accepted idea of a good job. In turn, increased wages will help with staff vacancies, strain on over-utilized existing staff and provide cost containment relief to providers.

Section XI: Monetary requests associated with this proposal include the following:

Direct Care Worker Wage Increase – request of $2.00 an hour above the current and future State Minimum Wage.

Home Help Funding – shift already allocated funding to CMHSP for home help and review cost of living increases dating back to 2009, the last time home help rates were increased, to allow rate adjustments and to ensure equal fee reimbursement.

Monitoring and tracking of training – allocate one time funds to create a central repository for training records, within the already established electronic medical record, accessible to CMHSP’s and Providers alike.

Online Training Venue – funding to secure and support an online training venue to reduce costs of mileage, improve choices for the time training can occur, and improves flexibility for employees. Supporting an online training curriculum that also provides certification is yet another perk of training, supporting and valuing direct care workers.

Quality Assurance and Compliance (QA&C) model to educate, support and monitor the quality of care provided by DCW workers. Promoting and valuing QA&C would allow for providers to calculate a percentage based on the individuals served. The proposal is for a percentage calculated as follows: If an individual being served receives less than forty (40) hours per week, the amount of QA&C support would be 25% of the total in hours. If an individual being served received more than forty (40) hours per week, the amount of support would be 15% of the total in hours. The creation of QA&C would bring heightened awareness to the needs of both individuals being served and the staff providing the service, allowing real time review of training, staffing or other program changes to deliver quality services.

The final ask would be of funding to secure an evaluation team to review the implementation of the proposal and accomplishments gained by fully supporting, both philosophically and financially the goals of the original 1009 Report and the thoughtful action plan proposed by the members of the “Deconstructing the Direct Care Service Crisis” team.

REFERENCES


DECONSTRUCTING THE DIRECT CARE SERVICE CRISIS


6. Joel Cheesman, (December 13, 2017), As Google for Jobs Drinks Its Milkshake, Indeed Eyes LinkedIn’s InMail Model to Tap New Profits, [online], https://www.ere.net/indeed-price-increase/, November 13, 2018


Joel Cheesman, (December 13, 2017), As Google for Jobs Drinks Its Milkshake, Indeed Eyes LinkedIn’s InMail Model to Tap New Profits, [online], https://www.ere.net/indeed-price-increase/, November 13, 2018