CMHSP's A Cliff note Version.

1. The 1963 Michigan Constitution effective January 1, 1964 states in Article IV Section 51, "The public health and general welfare of the people of the state are here by declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health." and Article VIII Section 8 "Institutions, programs and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported."

2. In the 1963 Michigan Constitution Article IX Section 18 Note 6. Purchases in order to shield the State from financial risk and save its credit by sharing the risk with the local CMHSP and their supporting counties by stating the following, "Pledge of state's credit would not be involved if county mental health board expended public money to purchase services from a public or private agency under the Community Mental Health Services Act {M.C.L.A §§330.1201, 330.1208, and 330.1301 et seq.} but county mental health board would have to remain responsible for and in control of mental health program authorized by Act and could not surrender grant to another public or private agency and allow it to operate the program without violating this section forbidding pledging of state's credit. Op. Atty. Gen. 1965, No. 4470, p. 128.

   Community mental health board's purchase of mental health services through contract with other public or private agencies, as authorized by M.C.L.A. §§330.606 (repealed; see, note generally, M.C.L.A §330.1308) did not involve use of state's credit within this section, providing that state's credit is not to be granted to, nor in aid of any person, association, or corporation, public or private, except as authorized by the Constitution, id.

3. MH Code Sec. 330.1116 Powers and duties of department. Section 116 (1) consistent with section 51 of article IV of the state constitution of 1963,….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. To this end, the department shall have the general powers and duties described in this section."

4. MH Code Sec. 116(2)(ii)(b) Administer the provision of chapter 2 so as to promote and maintain an adequate and appropriate system of community mental health services programs throughout the state. In the administration of chapter 2, it shall be the objective of the department to shift primary responsibility for the direct delivery of public mental health services from the

state to a community mental health services program whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area.

5. Governmental Immunity. It is important to note that services provided by a CMHSP are mandated and not optional and with that comes great risk, so the CMHSPs are afforded Governmental immunity as the consumer base it is required to work with often involve judicial and law enforcement involvement. Immunity is in M.C.L. §330.1205(3)(b), "All the privileges and immunities from liability and exemption from laws, ordinances, and rules that are applicable to county community mental health agencies or community mental health organizations and their board members, officers, and administrators, and county elected officials and employees of county government are retained by the authority and the board members, officers, agents, and employees of an authority created under this section.

   The chain of governmental immunity is broken when the state or federal dollars leave a governmental entity to the private sector. This has been ruled on in the courts system and is noted in the state constitution that the states credit will be put on the line (Roberts v City Of Pontiac Doc. No. 103630 and 1963 Michigan Constitution Article IX Section 18 Note 6). Governmental Immunity has proven invaluable to protect the staff of the local behavioral health agency both in Michigan and around the Nation when faced with very difficult situations (A.G. Opinions 06431, 06813, 05390, and 06563, Court Case McClean et al. vs. Sam Harma, Hiawatha Behavioral Health, Robert McElhaney, M.D., and M.A.C.M.H.B Doc. No. 290781 and Peterson, Pryde et al. vs. the Commonwealth of Virginia, et al. Twenty-Second Judicial Circuit Court, Franklin County, Commonwealth of Virgina).

6. MH Code Sec. 114 (1) Subject to section 114a, as provided in section 9 of Act. No. 380 of the Public Acts of 1965, being section 16.109 of the Michigan Compiled Laws, the director may promulgate rules as necessary to carry out the functions vested in the department. Thus the Administrative rules R325.4151 to 330.10099.

7. From the Administrative Rules, "Rule 2701. (1) As a condition of state funding a single overall certification is required for each community mental health services program. (2) The certification process shall include a review of agencies or organizations that are under contract to provide mental health services on behalf of the mental health services program. (3) The governing body of a community mental health services program shall request certification by submitting a completed application to the department. If the department is already in receipt of information required for application, then submission of that information may be waived by the department. The application shall be submitted in the format specified by the department and

shall include all of the following information: (a) The legal name of the community mental health services program. (b) The address for legal notice and correspondence. (c) The governing structure of the community mental health services program. (d) The current annual budget, including all sources of revenue, of the community mental health services program…...(6) Failure of the community mental health services program to comply with the requirements of the certification process shall be grounds for the department to deny, suspend, revoke, or refuse to renew a program's certification."

8. Board Governance is described in Section 330.1226 Board; powers and duties; appointment of executive director. The Board Shall:
    a. Annually conduct a needs assessment
    b. Annually review and submit to the Department a needs assessment report, etc..
    c. A county community mental health agency, must obtain approval from the county commissioners for needs assessment, budget development, requests for new funds etc.. For organizations (urban cooperatives) copies must be provided to the counties per the terms of the inter-local agreement etc…. For authorities copies of plans, needs assessments etc….must be provided to each creating county.
    d. Submit needs assessment, annual plan, and request new funds.
    e. Provide and advertise a public hearing on the needs assessment, annual plan, and request funds.
    f. Submit to each board of commissioners for their approval funding requests.
    g. Annually approve the CMHSP operating budget for the year.
    h. Take actions necessary to secure funding.
    i. Approve and authorize all contracts.
    j. Review and evaluate the quality, effectiveness, and efficiency of services.
    k. Appoint an executive director.
    l. Establish general policy guidelines.
    m. Require the executive director to select a physician to advise.

    As 6(c) indicates there are three types of CMHSPs. County Boards, Organizations (Urban Cooperatives via Inter-local agreements), and Authorities.

9. Board Governance is also described in detail in the Administrative Rules starting with section R330.2802 and delineates the responsibilities of the "governing body" (AKA "Board") and the "Community Mental Health Services Program" (AKA "Program" or Operations) through section R330.2814.

10. Quick discussion about the Attorney General – The Attorney General is the Chief Law Officer of the State of Michigan. The following shall be considered when thinking about Attorney General Opinions:
    i. "Under Michigan laws, State Attorney General Opinions are binding upon State departments or agents which request them." M.C.L.A. § 14.32, Campbell v. Patterson, 724 F. 2d 41, Certiorari denied 104 s. ct. 1613, 465 U.S. 1107, 80 L. Ed 2 d 142.
    ii. "Office of Attorney General enjoys a wider range of powers, derived from both common law and statutory enactments" Michigan Beer & Wine Wholesalers Assn. V. Attorney General, 370 N.W. 2d 328, 142 Michigan Appeals 294, Appeal denied, Ceriorari denied 1075 CT 420, 479 U.S. 939, 93 L E.D. 2d. 371.
    iii. "The Attorney General has the statutory duty to give his opinion upon all questions of law submitted to him by the legislature, by either branch of the legislature, by the Governor, or by any other State Officer; While such opinions do not have the force of law, and are therefore not binding in courts, they have been held to be binding upon State Agencies and Officers." Michigan Beer & Wine Wholesalers Assn. V. Attorney General, 370 N.W. 2d 328, 142 Michigan Appeals 294
    iv. "The opinions of the Attorney Generals Office are binding on State Agencies for limited purposes only until the courts make a pronouncement on the issue." People v. Waterman (1984) 137 Mich. App. 429, 358, NW 2d 602.
    v. "Attorney General has the authority to bring actions involving matters of State interest and the courts should accord substantial deference to the Attorney Generals decisions that a matter constitutes a State interest." M.C.L.A. §§ 14.28, 14.101 Id.

11. Office of the Attorney General Opinion 5791, September 30, 1980 Addresses: Withholding of state funds from community mental health boards for its failure to comply with the rules of the Department. Conclusion – "It is my opinion, therefore, that the Department of Mental Health may withhold funds from a community mental health board for its failure to comply with rules of the Department, but the Department may not withhold funds from a community mental health board for violation of its policies."

12. Office of the Attorney General Opinion 5665, February 22, 1980: "Making inoperative the Wayne County Community Mental Health Board and provide community mental health services in the place and stead of Wayne County CMHB?" – Conclusion – "it is my opinion that while the Department may not terminate the Wayne County Community Mental Health Board nor assume the direct operation of the Wayne County Community Mental Health Program, the Department may withdraw funds previously allocated to the Wayne County Community Mental Health Program and use such funds to provide community mental health service in Wayne County."

13. Office of the Attorney General Opinion 6600, September 27, 1989: consolidation of county community mental health program with other county programs. Page 1, "Community mental health programs are governed by Chapter 2 of the Mental Health Code, MCL 330.1200 et seq.; MSA 14.800(200) et seq." Page 2, "Once established, the community mental health program becomes an official county agency…..As long as the program is established and administered in accordance with Chapter 2 of the Mental Health Code, the program is eligible for state financial support." Page 3, "If a county ordinance were to give some other county board the authority to exercise those powers or the authority to veto or alter the powers expressly given by the Legislature to the county community mental health board, that ordinance would be contrary to the Mental Health Code and, therefore, void." Conclusion: "It is my opinion, therefore, that the disbanding of a county community mental health board or the preempting of the board's power by another county body would cause the affected county community mental health program to be out of compliance with the provisions of the Mental Health Code."

14. In a May 15, 1997 letter from Mr. Peter Cohl to Mr. Richard Visingardi the Director of Ionia County Community Mental Health, Mr. Cohl states, "if a county ordinance were to give some other county board the authority to exercise those powers or the authority to veto or alter the powers expressly given by the Legislature to the county community mental health board, that ordinance would be contrary to the mental health code and, therefore, void." Id. at page 222. OAG opinions 5750 and 6563 prohibit CMHSPs from forming non-profits.

15. CMHSP's and assurance of continued Medicaid/Federal funding streams were addressed September 20, 2002 by the 19th Circuit Court in the case of Manistee-Benzie Community Mental Health vs. the Michigan Department of Community Health. This matter concerned the "Orphan Board" status of MBCMH in the 2002 Application for Proposal process wherein the Judge stated the following:

    "The Court considers such "orphan board" status where MBCMHP does not have the requisite 20,000 Medicaid lives to be able to "stand alone" to constitute irreparable harm in that it will leave MBCMH in the status of a precariously existing legal shell in danger of imminent collapse while undoing Michigan's statutorily based commitment to community based representation." Page 7

    "Thus, the Manistee and Benzie County Medicaid recipients are relegated to the status of being unrepresented and without DCH having assured itself of the best interests of the Medicaid recipients with seamless, integrated services and continuity of care for the approximately 90% of the recipients of MBCMHP

services. Thus the refusal of defendants to allow MBCMH to submit an AFP that includes affiliation with CEI…….constitutes irreparable harm to the Manistee-Benzie Medicaid recipients…" Page 7 & 8.

"This Court will enter its mandatory injunctive order which is operant against state executive branch officials only because the Court is convinced that irreparable harm will befall plaintiffs and the Medicaid eligible recipients of mental health services in Manistee and Benzie Counties and because in the circumstance of this case there is a clear duty for DCH officials to allow MBCMH's plan for affiliation to be evaluated…" Page 8 & 9

"…but Manistee and Benzie Medicaid funded mental health service recipients as well, who would have no representation for the assigned North Central provider and whose representation on the MBCMHSP would be an empty vessel" Page 9, "

16. Interlocal or Authority Agreement

17. How to Change a CMH's Name

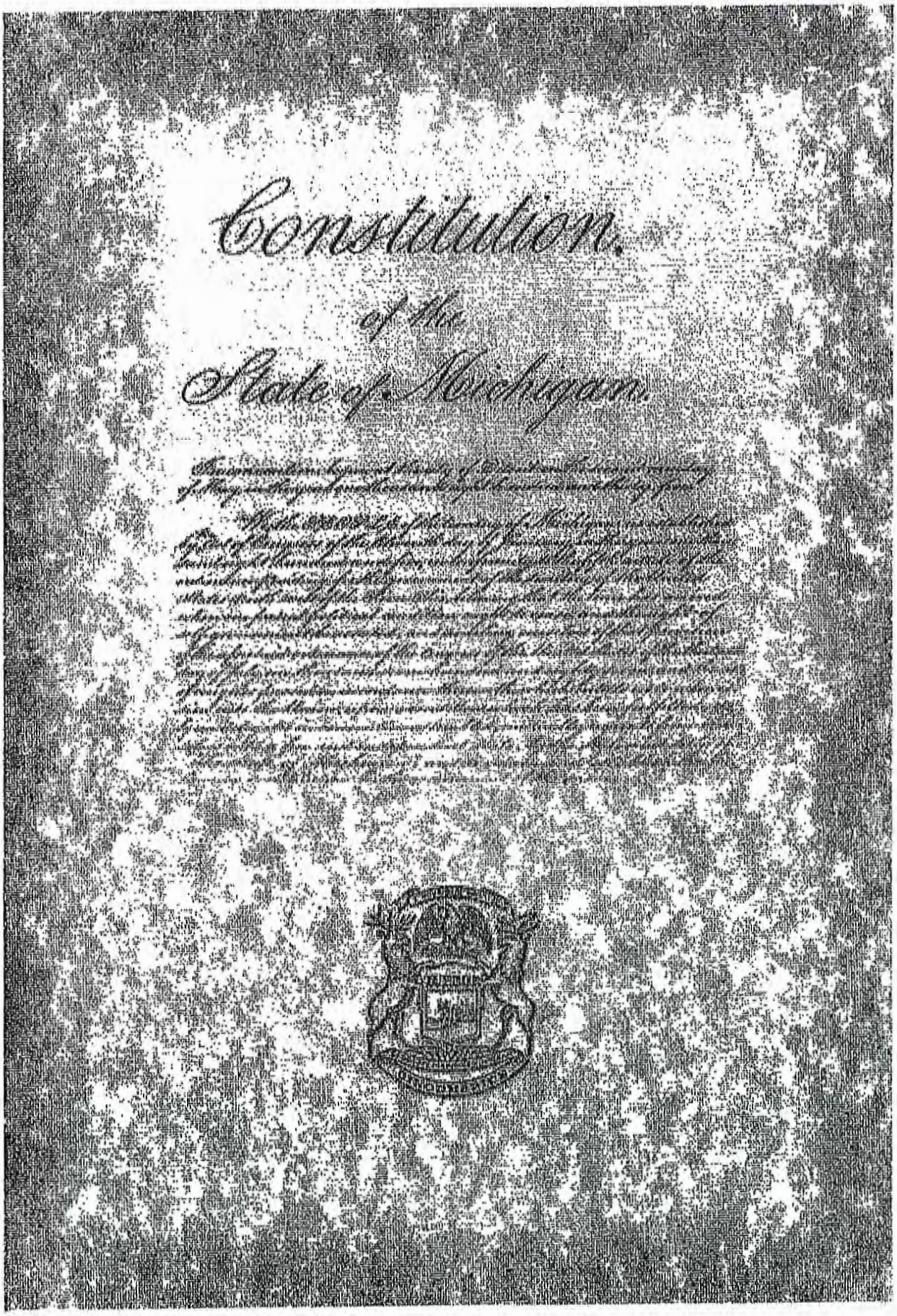
18. A Brief Modern History of Michigan's Public Mental Health System to 2004 by Patrick Berrie, Deputy Director Michigan Department of Community Health and CEO Washtenaw Community Mental Health

19. House Fiscal Agency History of the CMH system to 2014

20. Revised Plan for Procurement 2002. This document presents the revised plan of the Michigan Department of Community Health (MDCH) for procurement of Medicaid specialty Prepaid Health Plans (PHP)

21. The interplay between Medicare/Medicaid and Michigan's Wavier system. Enclosed is a 2009 CMS document "Brief Summaries of Medicare & Medicaid", a brief description of Title XIX Section 19 waivers, brief description of 1115 demonstrations, and Michigan's current Waivers and demonstrations.

Bullets 1 + 2



§ 50 Atomic and new forms of energy.

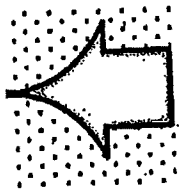
Sec. 50. The legislature may provide safety measures and regulate the use of atomic energy and forms of energy developed in the future, having in view the general welfare of the people of this state.

History: Const. 1963, Art. IV, §50, Eff. Jan. 1, 1964.

§ 51 Public health and general welfare.

Sec. 51. The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health.

History: Const. 1963, Art. IV, §51, Eff. Jan. 1, 1964.



§ 52 Natural resources; conservation, pollution, impairment, destruction.

Sec. 52. The conservation and development of the natural resources of the state are hereby declared to be of paramount public concern in the interest of the health, safety and general welfare of the people. The legislature shall provide for the protection of the air, water and other natural resources of the state from pollution, impairment and destruction.

History: Const. 1963, Art. IV, §52, Eff. Jan. 1, 1964.

§ 53 Auditor general; appointment, qualifications, term, removal, post audits.

Sec. 53. The legislature by a majority vote of the members elected to and serving in each house, shall appoint an auditor general, who shall be a certified public accountant licensed to practice in this state, to serve for a term of eight years. He shall be ineligible for appointment or election to any other public office in this state from which compensation is derived while serving as auditor general and for two years following the termination of his service. He may be removed for cause at any time by a two-thirds vote of the members elected to and serving in each house. The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

Independent investigations; reports.

The auditor general upon direction by the legislature may employ independent accounting firms or legal counsel and may make investigations pertinent to the conduct of audits. He shall report annually to the legislature and to the governor and at such other times as he deems necessary or as required by the legislature. He shall be assigned no duties other than those specified in this section.

Governing boards of institutions of higher education.

Nothing in this section shall be construed in any way to infringe the responsibility and constitutional authority of the governing boards of the institutions of higher education to be solely responsible for the control and direction of all expenditures from the institutions' funds.

Staff members, civil service.

The auditor general, his deputy and one other member of his staff shall be exempt from classified civil service. All other members of his staff shall have classified civil service status.

History: Const. 1963, Art. IV, §53, Eff. Jan. 1, 1964.

§ 54 Limitations on terms of office of state legislators.

Sec. 54. No person shall be elected to the office of state representative more than three times. No person shall be elected to the office of state senate more than two times. Any person appointed or elected to fill a vacancy in the house of representatives or the state senate for a period greater than one half of a term of such office, shall be considered to have been elected to

§ 6 Other institutions of higher education, controlling boards.

Sec. 6. Other institutions of higher education established by law having authority to grant baccalaureate degrees shall each be governed by a board of control which shall be a body corporate. The board shall have general supervision of the institution and the control and direction of all expenditures from the institution's funds. It shall, as often as necessary, elect a president of the institution under its supervision. He shall be the principal executive officer of the institution and be ex-officio a member of the board without the right to vote. The board may elect one of its members or may designate the president, to preside at board meetings. Each board of control shall consist of eight members who shall hold office for terms of eight years, not more than two of which shall expire in the same year, and who shall be appointed by the governor by and with the advice and consent of the senate. Vacancies shall be filled in like manner.

History: Const. 1963, Art. VIII, §6, Eff. Jan. 1, 1964.

§ 7 Community and junior colleges; state board, members, terms, vacancies.

Sec. 7. The legislature shall provide by law for the establishment and financial support of public community and junior colleges which shall be supervised and controlled by locally elected boards. The legislature shall provide by law for a state board for public community and junior colleges which shall advise the state board of education concerning general supervision and planning for such colleges and requests for annual appropriations for their support. The board shall consist of eight members who shall hold office for terms of eight years, not more than two of which shall expire in the same year, and who shall be appointed by the state board of education. Vacancies shall be filled in like manner. The superintendent of public instruction shall be ex-officio a member of this board without the right to vote.

History: Const. 1963, Art. VIII, §7, Eff. Jan. 1, 1964.

§ 8 Services for disabled persons.

Sec. 8. Institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported.

History: Const. 1963, Art. VIII, §8, Eff. Jan. 1, 1964;—Am. S.J.R. I, approved Nov. 3, 1998, Eff. Dec. 19, 1998.
Former Constitution: See Const. 1908, Art. XI, §15.

§ 9 Public libraries, fines.

Sec. 9. The legislature shall provide by law for the establishment and support of public libraries which shall be available to all residents of the state under regulations adopted by the governing bodies thereof. All fines assessed and collected in the several counties, townships and cities for any breach of the penal laws shall be exclusively applied to the support of such public libraries, and county law libraries as provided by law.

History: Const. 1963, Art. VIII, §9, Eff. Jan. 1, 1964.
Former Constitution: See Const. 1908, Art. XI, §14.

ARTICLE IX
Finance and Taxation

§ 1 Taxes for state expenses.

Sec. 1. The legislature shall impose taxes sufficient with other resources to pay the expenses of state government.

History: Const. 1963, Art. IX, §1, Eff. Jan. 1, 1964.
Former Constitution: See Const. 1908, Art. X, §2.

§ 2 Power of taxation, relinquishment.

Sec. 2. The power of taxation shall never be surrendered, suspended or contracted away.

History: Const. 1963, Art. IX, §2, Eff. Jan. 1, 1964.
Former Constitution: See Const. 1908, Art. X, §9.

Where legislature has recognized that limited access highways will benefit state as a whole and has provided for intergovernmental co-operation in construction of such facilities and for apportionment of costs between participating units, there is no lending of state's credit to participating units, even if payments are to be made by state out of general funds. Ziegler v. Witherspoon (1951) 49 N.W.2d 318, 331 Mich. 337.

Where intergovernmental contract for construction of limited access highways required state highway commissioner to pay $2,500,000, annually, to meet costs of bonds issued in finance project, but provided that such payments must be made solely from state highway fund rather than from general funds of state, there was no pledge of state's credit as security for bonds, and therefore no granting of credit of state to other governmental units involved. Id.

Enabling Act (M.C.L.A. § 123.951 et seq.) under which City of Detroit and County of Wayne incorporated and Authority to construct joint county and city building to be rented by Authority to city and county until bonds issued to pay for building were retired from revenues of building, did not violate constitutional provisions forbidding city and county to loan their credit. Walske v. Detroit-Wayne Joint Bldg. Authority (1949) 39 N.W.2d 73, 325 Mich. 562.

Money the City of Detroit and County of Wayne were advancing under interim contract entered into by city and county with an Authority incorporated by them pursuant to enabling act, to construct a joint city and county building to be rented by Authority to city and county until bonds issued to finance construction were retired from revenues of building, was for a lawful purpose and for full consideration, and was not an unconstitutional loan of credit of county and city, or the appropriation of tax money to be expanded by others than the taxing authority. Id.

A proposed sewage disposal project for a district in Oakland County, being a self-liquidating county revenue project, did not constitute a "loan of credit" by county in contravention of constitution. Drain Com'r of Oakland County v. City of Royal Oak (1938) 10 N.W.2d 435, 306 Mich. 124.

Oakland County, in establishing proposed sewage disposal system, would be performing an authorized county function in respect to public health, and the expending of money in actual establishment of such system would not constitute a "loan of credit" by county in contravention of constitution, even if project was not a self-liquidating one. Id.

P.A.1933, Nos. 81, 107, authorizing application of part of county's share of weight tax and gas tax to reduction of tax levied for township bonds issued for construction of roads taken over by state, were not unconstitutional as improper granting of state credit in aid of township. Township of Elba v. Gratiot County (1939) 283 N.W. 615, 287 Mich. 372.

P.A.1935, No. 147, creating state bridge commission and providing that commission may sue, plead, and contract, and have a common seal and issue bonds of state payable out of tolls of international bridge, was not unconstitutional on ground credit of state was lent to public corporation created by special act, since bonds issued by commission are not "debts" of state. Attorney General ex rel. Eaves v. State Bridge Commission (1936) 269 N.W. 388, 277 Mich. 373, affirmed and supplemented 270 N.W. 308, 277 Mich. 373.

Village had no authority to appropriate public funds for lighting a recreation field controlled by a veterans' organization even though the entertainment provided therein were free to the public. Op.Atty.Gen.1935-36, p. 5.

School funds may not be used to aid in construction of extension of electric line of private corporation. Op.Atty.Gen.1930-32, p. 174.

5. Fair exchange of value

Constitutional proscription against state or county grant of credit is not offended by fair exchange of value for value. Alan v. Wayne County (1972) 200 N.W.2d 628, 388 Mich. 210, 67 A.L.R.3d 1079, opinion adhered to, rehearing denied 202 N.W.2d 277, 388 Mich. 626.

Under normal circumstances, legislative or executive branch is judge of what is fair value in exchange, as respects constitutional proscription against state or county grant of credit, but judgment of officers is subject to judicial review for abuse. Id.

6. Purchases

Pledge of state's credit would not be involved if county mental health board expended public money to purchase services from a public or private agency under the

Note 8

Community Mental Health Services Act [M.C.L.A. § 330.601 et seq. (repealed; see, now, generally, M.C.L.A. §§ 330.1201, 330.1208 and 330.1301 et seq.)] but county mental health board would have to remain responsible for and in control of mental health program authorized by Act and could not surrender grant to another public or private agency and allow it to operate the program without violating this section forbidding pledging of state's credit. Op.Atty. Gen.1965, No. 4470, p. 128.

Community mental health board's purchase of mental health services through contract with other public or private agencies, as authorized by M.C.L.A. § 330.606 (repealed; see, now, generally, M.C.L.A. § 330.1308) did not involve use of state's credit within this section, providing that state's credit is not to be granted to, nor in aid of any person, association, or corporation, public or private, except as authorized by the Constitution. Id.

7. Sales

Const.1908, Art. 10, § 12 (see, now, this section), forbidding the grant of the credit of the state to or in aid of any person, association or corporation, public or private, did not forbid sale of city land for assertedly inadequate consideration, for reconveyance by grantee to federal government for use as site for training of men of city in reserve components of United States armed forces, since no credit was involved and since United States is not customarily regarded as a public corporation. Sommers v. City of Flint (1959) 96 N.W.2d 119, 355 Mich. 655.

8. Loans

Any guarantee of a loan by State Highway Commission pursuant to the State Transportation Preservation Act (M.C.L.A. § 474.51 et seq.) can avoid offending constitutional ban under this section on the state's granting or pledging its credit only if provisions for repayment are strictly limited to proceeds of constitutional restricted revenues placed in the general transportation fund and as long as no pledge of the state's full faith and credit is made. Advisory Opinion Re 1976 PA 295 and 1976 PA 297 (1977) 259 N.W.2d 129, 401 Mich. 686.

State Waterways Commission could not lawfully loan money to local governmental unit for construction of harbor facilities. Op.Atty.Gen.1958, No. 3264, p. 243.

9. Gifts

A gift or donation of money or property by city would constitute a violation of constitutional provisions forbidding the credit of State to be granted in aid of any person, association or corporation, and forbidding any city or village to loan its credit or to assess, levy, or collect any tax for other than a public purpose. Kaplan v. City of Huntington Woods (1959) 99 N.W.2d 514, 357 Mich. 612.

Proposed conveyance of city property without consideration therefor to United States government as site for a reserve armory school, though beneficial to the general public, would be void as amounting to an appropriation not for a city public purpose and an application thereof to public uses not under the control or care of the city in violation of constitutional provisions prohibiting assessment, levy or collection of any tax or assessment by city or village for other than a public purpose and providing that the credit of the state shall not be granted to or in aid of any person, association or corporation, public or private. Younglas v. City of Flint (1956) 77 N.W.2d 84, 345 Mich. 576.

Contracts involving use of public money to further private enterprise are void. Skutt v. City of Grand Rapids (1936) 266 N.W. 344, 275 Mich. 258.

Local Acts 1903, No. 489, § 66, following Local Acts 1899, No. 429, authorizing city of Detroit to aid an art museum incorporated as a private corporation under P.A.1885, No. 3, was violative of Const.1908, Art. 10, § 12 (see, now, this section), forbidding the granting of the credit of the state in aid of any public or private corporation. Detroit Museum of Art v. Engel (1915) 153 N.W. 700, 187 Mich. 432.

City funds may not be used for contribution to expenses of private voluntary groups operating recreation facilities for children. Op.Atty.Gen.1957, No. 3066, p. 476.

P.A.1939, No. 238, as amended, which authorized any township, upon a majority vote of the people to transfer the surplus moneys in the contingent fund "to the several school districts, on the basis of the last school census," would be constitutional when construed to mean that the transfer of surplus contingent funds would be made on the ratio of school census of each school district to combined school census of all

Bullet # 3

Sec. 113. A person employed by the department who is injured as a result of an assault by a recipient of mental health services shall receive his full wages by the department until workmen's compensation benefits begin and then shall receive in addition to workmen's compensation benefits a supplement from the department which together with the workmen's compensation benefits shall equal but not exceed the weekly net wage of the employee at the time of the injury. This supplement shall only apply while the person is on the department's payroll and is receiving workmen's compensation benefits and shall include an employee who is currently receiving workmen's compensation due to an injury covered by this section. Fringe benefits normally received by an employee shall be in effect during the time the employee receives the supplement provided by this section from the department.

History: Add. 1976, Act 414, Imd. Eff. Jan. 9, 1977.

330.1114 Rules.

Sec. 114. (1) Subject to section 114a, as provided in section 9 of Act No. 380 of the Public Acts of 1965, being section 16.109 of the Michigan Compiled Laws, the director may promulgate rules as necessary to carry out the functions vested in the department. — AKA: Admin Rules

(2) All modifications to rules that are needed to comply with the amendatory act that added this subsection shall be submitted to public hearing within 2 years after the effective date of that amendatory act.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

Administrative rules: R 330.1001 et seq. of the Michigan Administrative Code.

330.1114a Applicability of provisions requiring or permitting rule promulgation.

Sec. 114a. If the Michigan supreme court rules that sections 45 and 46 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.245 and 24.246 of the Michigan Compiled Laws, are unconstitutional, and a statute requiring legislative review of administrative rules is not enacted within 90 days after the Michigan supreme court ruling, any provision of this act that requires or permits the department to promulgate rules does not apply.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

Compiler's note: In separate opinions, the Michigan Supreme Court held that Section 45(8), (9), (10), and (12) and the second sentence of Section 46(1) ("An agency shall not file a rule ... until at least 10 days after the date of the certificate of approval by the committee or after the legislature adopts a concurrent resolution approving the rule.") of the Administrative Procedures Act of 1969, in providing for the Legislature's reservation of authority to approve or disapprove rules proposed by executive branch agencies, did not comply with the enactment and presentment requirements of Const 1963, Art 4, and violated the separation of powers provision of Const 1963, Art 3, and, therefore, were unconstitutional. These specified portions were declared to be severable with the remaining portions remaining effective. Blank v Department of Corrections, 462 Mich 103 (2000).

Administrative rules: R 330.1001 et seq. of the Michigan Administrative Code.

330.1116 Powers and duties of department.

Sec. 116. (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. To this end, the department shall have the general powers and duties described in this section.

(2) The department shall do all of the following:

(a) Direct services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance. The department shall give priority to the following services:

(*i*) Services for individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability.

(*ii*) Services for individuals with serious mental illness, serious emotional disturbance, or developmental disability who are in urgent or emergency situations.

(b) Administer the provisions of chapter 2 so as to promote and maintain an adequate and appropriate system of community mental health services programs throughout the state. In the administration of chapter 2, it shall be the objective of the department to shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area.

(c) Engage in planning for the purpose of identifying, assessing, and enunciating the mental health needs of the state.

Bullet #4

Sec. 113. A person employed by the department who is injured as a result of an assault by a recipient of mental health services shall receive his full wages by the department until workmen's compensation benefits begin and then shall receive in addition to workmen's compensation benefits a supplement from the department which together with the workmen's compensation benefits shall equal but not exceed the weekly net wage of the employee at the time of the injury. This supplement shall only apply while the person is on the department's payroll and is receiving workmen's compensation benefits and shall include an employee who is currently receiving workmen's compensation due to an injury covered by this section. Fringe benefits normally received by an employee shall be in effect during the time the employee receives the supplement provided by this section from the department.

History: Add. 1976, Act 414, Imd. Eff. Jan. 9, 1977.

330.1114 Rules.

Sec. 114. (1) Subject to section 114a, as provided in section 9 of Act No. 380 of the Public Acts of 1965, being section 16.109 of the Michigan Compiled Laws, the director may promulgate rules as necessary to carry out the functions vested in the department.

- AKA: Admin Rules

(2) All modifications to rules that are needed to comply with the amendatory act that added this subsection shall be submitted to public hearing within 2 years after the effective date of that amendatory act.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

Administrative rules: R 330.1001 et seq. of the Michigan Administrative Code.

330.1114a Applicability of provisions requiring or permitting rule promulgation.

Sec. 114a. If the Michigan supreme court rules that sections 45 and 46 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.245 and 24.246 of the Michigan Compiled Laws, are unconstitutional, and a statute requiring legislative review of administrative rules is not enacted within 90 days after the Michigan supreme court ruling, any provision of this act that requires or permits the department to promulgate rules does not apply.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

Compiler's note: In separate opinions, the Michigan Supreme Court held that Section 45(8), (9), (10), and (12) and the second sentence of Section 46(1) ("An agency shall not file a rule ... until at least 10 days after the date of the certificate of approval by the committee or after the legislature adopts a concurrent resolution approving the rule.") of the Administrative Procedures Act of 1969, in providing for the Legislature's reservation of authority to approve or disapprove rules proposed by executive branch agencies, did not comply with the enactment and presentment requirements of Const 1963, Art 4, and violated the separation of powers provision of Const 1963, Art 3, and, therefore, were unconstitutional. These specified portions were declared to be severable with the remaining portions remaining effective. Blank v Department of Corrections, 462 Mich 103 (2000).

Administrative rules: R 330.1001 et seq. of the Michigan Administrative Code.

330.1116 Powers and duties of department.

Sec. 116. (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. To this end, the department shall have the general powers and duties described in this section.

(2) The department shall do all of the following:

(a) Direct services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance. The department shall give priority to the following services:

(*i*) Services for individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability.

(*ii*) Services for individuals with serious mental illness, serious emotional disturbance, or developmental disability who are in urgent or emergency situations.

(b) Administer the provisions of chapter 2 so as to promote and maintain an adequate and appropriate system of community mental health services programs throughout the state. In the administration of chapter 2, it shall be the objective of the department to shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area.

(c) Engage in planning for the purpose of identifying, assessing, and enunciating the mental health needs of the state.

Bullet #5

ROBERTS v CITY OF PONTIAC

Docket No. 103630. Submitted January 4, 1989, at Detroit. Decided April 18, 1989.

Jeffrey Roberts sustained injuries in an automobile accident and died after receiving medical treatment in the emergency department of Pontiac General Hospital. At the time of treatment, the hospital's emergency department was operated under contract by Emergency Services-North Oakland, P.C., a private corporation operated for profit by Joseph F. Schirle, Jr., M.D. Medical treatment was provided to the decedent by Dr. Schirle, who was aided by Dr. Sang Choi, a surgical resident employed by the hospital, and Dr. Phan Thanh, a vascular surgeon with staff privileges at the hospital. Roger W. Roberts, as personal representative of the decedent's estate, brought a negligence action in Oakland Circuit Court against the City of Pontiac (the owner and operator of Pontiac General Hospital), Emergency Services-North Oakland, P.C., and Drs. Schirle, Choi and Thanh. The trial court, John N. O'Brien, J., denied motions brought by defendants for summary disposition on the basis of governmental immunity. Defendants sought leave to appeal to the Court of Appeals, which, in lieu of granting leave, peremptorily reversed the trial court with respect to the city and remanded for reconsideration of the remaining defendants' motions for summary disposition. On remand, the trial court granted summary disposition in favor of Drs. Choi and Thanh, but denied summary disposition as to the claims against Emergency Services and Dr. Schirle. Plaintiff appealed and Emergency Services and Dr. Schirle cross appealed.

The Court of Appeals *held:*

1. Emergency Services is a private entity which is not entitled to governmental immunity from tort liability. Dr. Schirle, as an employee of Emergency Services, is likewise not entitled to the protection of governmental immunity.

2. Drs. Choi and Thanh may properly claim governmental immunity as a defense only if they were acting as agents of the hospital at the time they treated the decedent. The facts, as developed so far, do not indicate whether these doctors were acting as agents of the hospital or as agents of Emergency Services. Thus, the grant of summary disposition in favor of these doctors must be reversed.

Affirmed in part, reversed in part, and remanded for further proceedings.

REFERENCES

Am Jur 2d, Agency §§ 1, 17-22; Hospitals and Asylums §§ 2, 22.

Immunity of state or governmental unit or agency from liability for damages in tort in operating hospital. 25 ALR2d 203.

1. GOVERNMENTAL IMMUNITY — MUNICIPAL HOSPITALS — PROFESSIONAL SERVICE CORPORATIONS.

A professional service corporation which is operated for profit by a physician and which, under a contract with a municipal hospital, operates the hospital's emergency department is not, by virtue of such contract, a governmental agency which may claim immunity from tort liability; employees of such corporation are likewise not entitled to the protection of governmental immunity.

2. WORDS AND PHRASES — AGENT.

An agent is a person having express or implied authority to represent or act on behalf of another person, who is called his principal.

3. AGENCY — AGENT.

An agent is one who acts for or in the place of another by authority from him; one who undertakes to transact some business or manage some affairs for another by authority and on account of the latter and to render an account of it; one who is a substitute or deputy, appointed by the principal, with power to do the things which the principal may or can do.

4. WORDS AND PHRASES — AGENT.

The term "agent" includes factors, brokers, and every other relation in which one person acts for or represents another by his authority.

5. AGENCY — CREATION OF RELATIONSHIP.

Whether an agency has been created is to be determined by the relations of the parties as they in fact exist under their agreements or acts.

Law Offices of Brochert & Ward (by *David S. Anderson*), for plaintiff.

Plunkett & Cooney, P.C. (by *Robert G. Kame-*

nec), for Emergency Services-North Oakland, P.C., and Joseph F. Schirle, Jr., M.D.

Martin, Bacon & Martin, P.C. (by *Michael R. Janes*), for Sang Choi, M.D.

Buesser, Buesser, Blank, Lynch, Fryhoff & Graham (by *Deborah F. Collins*), for Phan Thanh, M.D.

Before: GILLIS, P.J., and SHEPHERD and SAWYER, JJ.

PER CURIAM. Plaintiff appeals, and defendants Emergency Services and Schirle cross appeal, from an order of the circuit court granting summary disposition to defendants Choi and Thanh and denying summary disposition to defendants Emergency Services and Schirle. Summary disposition was granted on the basis of governmental immunity, MCR 2.116(C)(7). The order was certified as a final order with respect to Choi and Thanh pursuant to MCR 2.604(A).[1] We affirm in part and reverse in part.

[1] An interesting question concerning the jurisdiction of this Court is presented here, though the issue is not raised by the parties. Specifically, although the order appealed from denied summary disposition with respect to Emergency Services and Schirle, while granting summary disposition in favor of defendants Choi and Thanh, the trial court certified the order as a final order only with respect to Choi and Thanh. Thus, the question arises whether defendants Emergency Services and Schirle can invoke the jurisdiction of this Court by way of a cross appeal when plaintiff appeal from the certified final order. Clearly, had the trial court entered two separate orders, the first denying summary disposition with respect to defendants Emergency Services and Schirle and the second order granting summary disposition in favor of Choi and Thanh, with only the second order, of course, being certified as a final order under the rule, defendants Emergency Services and Schirle could not claim an immediate appeal from the order denying summary disposition since it would be an interlocutory order not certified as a final order, and any cross appeal filed in plaintiff's claim of appeal from the second order would be limited to the issues raised in that second order, specifically the propriety of granting summary disposition to defendants Choi and Thanh. Thus, under such a situation, defendants Emergency Services and Schirle could not claim an immediate appeal or cross appeal and challenge the denial of summary disposition with respect to them. Rather, they would have to wait until a final order was entered in the file from which they could appeal.

Similarly, had plaintiff not claimed an immediate appeal from the certified final order in this case, instead choosing to wait to appeal from the final order which disposed of the entire case, see *Comm'r of Ins v Advisory Bd of the Michigan State Accident Fund*, 173 Mich App 566; 434 NW2d 433 (1988), defendants Emergency Services and Schirle could not have claimed an appeal as against plaintiff from the certified final order since the order was not certified final by the trial court as to defendants Emergency Services and Schirle. To our knowledge, this Court has not previously had an opportunity to consider whether the jurisdiction of this Court could be invoked by the cross appeal under these circumstances. However, since the parties do not raise the issue themselves, and since considerations of judicial economy merit addressing the issue raised on cross appeal, we shall address that issue. If a detailed analysis would lead to the conclusion that defendants Emergency Services and Schirle cannot invoke the jurisdiction of this Court by claiming a cross appeal, then we consider their claim of cross appeal as an application for leave to appeal and grant that application.

Plaintiff's decedent, Jeffrey Roberts, was involved in an automobile accident and was taken to the emergency department of Pontiac General Hospital. Plaintiff's decedent was treated in the emergency department and later transferred to the hospital's intensive care unit. Plaintiff's decedent died the next day, allegedly as a result of negligent acts or omissions occurring while he was in the emergency room.

The emergency department of Pontiac General Hospital was operated under contract with defendant Emergency Services-North Oakland, P.C., which is a private corporation operated for profit by defendant Schirle. Schirle was, in fact, the emergency room physician on duty at the time plaintiff's decedent was admitted to the emergency department.

Defendant Choi was a fourth-year surgical resident employed by the hospital and was available to all hospital departments, including the emer-

gency room, while on duty. Defendant Thanh, on the other hand, is a vascular surgeon with staff privileges at Pontiac General Hospital. As a requirement of his staff privileges, he must make himself available during certain periods should his expertise be required by any physician rendering treatment at the hospital. During these "on-call" hours, Dr. Thanh is available to all hospital departments, including the emergency room. Allegedly, Dr. Schirle summoned both doctors to the emergency room to assist in treating plaintiff's decedent.

Defendants initially moved for summary disposition on the ground of governmental immunity and the trial court denied their motions. Defendants sought leave to appeal to this Court, which, in lieu of granting leave, peremptorily reversed the trial court with respect to defendant City of Pontiac, and ordered summary disposition granted in favor of the city. It also ordered the matter remanded to the trial court for reconsideration in light of various cases with respect to the remaining defendants. It is the trial court's disposition on remand which gives rise to the instant appeal.

For reasons which shall become clear as we proceed with this opinion, we choose to address the issue raised on the cross appeal first. On cross appeal, defendants Emergency Services and Schirle argue that the trial court erred in denying summary disposition with respect to them on the basis of governmental immunity. We disagree. There are two particularly relevant cases to be considered in addressing this issue. The first is *Jackson v New Center Community Mental Health Services,* 158 Mich App 25; 404 NW2d 688 (1987). In *Jackson,* the defendant was a nonprofit corporation which was under contract with the county to provide outpatient mental health services. The

defendant was sued by the plaintiffs after the plaintiffs were wounded by one of the defendant's patients. The defendant asserted a defense of governmental immunity arguing that, since it was performing a function for the county government, it was entitled to immunity as an agency of the government. This Court disagreed. The *Jackson* Court, *supra* at 35, explained its reasoning as follows:

> A private entity's performance of a governmental function does not confer governmental agency status on that entity. As noted in *Ross* [v *Consumers Power Co (On Rehearing),* 420 Mich 567; 363 NW2d 641 (1984)], p 616, mental health services, albeit required of a governmental agency, are commonly provided by private facilities. The Mental Health Code expressly contemplates the participation of both public and private mental health facilities in state and county community mental health programs.
>
> Notwithstanding its performance of a "governmental function" and its reliance on public funding, New Center retains its identity as a nongovernmental entity. Its employees are not county employees. It retains its separate corporate identity and is governed by its own board of directors. Except as it has voluntarily obligated itself by contract, New Center is not required to provide services or to remain in existence. While it may have been created in response to the recognition of mental health needs in Detroit, New Center's creation was not mandated by law.
>
> We are persuaded of no reason to treat a private entity as a governmental agency merely because that entity contracts with a governmental agency to provide services which the agency is authorized or mandated to provide.

Also to be considered is this Court's decision in *Hayes v Emerick,* 164 Mich App 138; 416 NW2d

350 (1987). In *Hayes,* the plaintiff sued a physician under contract with the county sheriff to provide medical care to inmates of the county jail. This Court concluded that the defendant was an agent of the county and, therefore, was entitled to the protection of governmental immunity.

To the extent that *Jackson* and *Hayes* represent conflicting views, we believe that *Jackson* presents the better rationale. Like the *Jackson* Court, we see no reason to extend the protection of governmental immunity to a private entity merely because it contracts with the government. *Jackson, supra* at 35.[2]

Accordingly, for the reasons stated above, we conclude that defendant Emergency Services, as a private entity, is not entitled to the protection of governmental immunity. It also follows that Dr. Schirle, as an employee of Emergency Services rather than of the hospital itself, is not entitled to raise as a defense the doctrine of governmental immunity.

Having disposed of the issue raised on cross appeal, we return to the issue raised on appeal, namely whether Drs. Choi and Thanh may raise the defense of governmental immunity. For reasons we will explain below, we believe that the applicability of the doctrine of governmental immunity to these defendants is dependent upon facts which have not yet been fully developed.

[2] We note a potential basis for distinguishing *Hayes* from *Jackson.* Specifically, while the defendant in *Jackson* was a corporation, it is not clear from the *Hayes* decision whether the defendant personally contracted with the county sheriff to provide medical services or whether the contract was between the sheriff and the defendant's professional corporation. Thus, a distinction might arise between cases where the contract with the government is by a private company as opposed to the government retaining the services of an individual. In any event, we follow the decision in *Jackson* in the case at bar, particularly since Pontiac General Hospital contracted with the Emergency Services-North Oakland Corporation and did not retain the services of Dr. Schirle personally.

The relevant inquiry as to the applicability of governmental immunity to Drs. Choi and Thanh is whether they were acting as agents of Emergency Services at the time of the alleged acts of malpractice or as agents of Pontiac General Hospital. If they were agents of Emergency Services, then, like Dr. Schirle, they are not entitled to governmental immunity since they were acting as agents of a private entity. However, if they were acting as agents of Pontiac General Hospital then, as governmental employees, they would be entitled to the protections of governmental immunity if their acts constituted discretionary decision-making conduct. *Hayes, supra* at 140. See also *Ross v Consumers Power Co (On Rehearing),* 420 Mich 567, 592; 363 NW2d 641 (1984).

This Court discussed the application of agency principles to the governmental immunity situation in *Hayes, supra* at 140-141:

> In *Ross, supra,* 420 Mich 624, n 38, the Supreme Court noted that "the individual tortfeasor's status as an employee, agent, independent contractor, etc., . . . will generally be determined with reference to common-law tort and agency principles." Therefore, general principles of agency law must be examined. In *Goldman v Cohen,* 123 Mich App 224, 228-230; 333 NW2d 228 (1983), lv den 422 Mich 865 (1985), this Court reiterated the definition of the term "agent" found in *Stephenson v Golden,* 279 Mich 710, 734-735; 276 NW 849 (1937):
>
> "'An agent is a person having express or implied authority to represent or act on behalf of another person, who is called his principal.' Bowstead on Agency (4th ed), 1.
>
> "'An agent is one who acts for or in the place of another by authority from him; one who undertakes to transact some business or manage some affairs for another by authority and on account of the latter, and to render an account of it. He is a

substitute, a deputy, appointed by the principal, with power to do the things which the principal may or can do.' 2 CJS 1025.

"The term 'agent' includes factors, brokers, etc. 2 CJS 1015.

"As said in *Saums* v *Parfet*, 270 Mich 165; 258 NW 235 (1935):

" ' "Agency" in its broadest sense includes every relation in which one person acts for or represents another by his authority.' 2 CJ 419.

" ' "Whether an agency has been created is to be determined by the relations of the parties as they in fact exist under their agreements or acts." 21 RCL 819.' "

Unlike the trial court, we do not believe it sufficient merely to rely upon the fact that Drs. Choi and Thanh were employees or agents of the hospital. Rather, we believe that facts must further be developed to determine their exact status at the time of the alleged acts of malpractice. That is, while it may be true that they were employees or agents of the hospital at the time, they may have been serving as agents of Emergency Services and, therefore, not entitled to the protection of governmental immunity. Relevant considerations include (1) whether Drs. Choi and Thanh were paid by Emergency Services, by Pontiac General Hospital, or by the patient directly for the time spent in the emergency room, (2) whether Emergency Services had to reimburse Pontiac General for the services rendered by Choi and Thanh, (3) whether the contractual relationship between Emergency Services and Pontiac General Hospital provided for Pontiac General supplying physicians to Emergency Services, and (4) what control and authority Emergency Services and its supervisory

personnel, i.e., Dr. Schirle, exercised over Drs. Choi and Thanh and any other physicians supplied by Pontiac General Hospital for work in the emergency room. While each of these considerations are relevant, the list is not necessarily exclusive nor is any given factor controlling. Rather, the totality of the circumstances must be considered in order to determine whether Choi and Thanh were acting as agents of Emergency Services or were acting as employees of Pontiac General Hospital.[3]

For the above reasons, we conclude that the determination of whether defendants Choi and Thanh are entitled to the protection of governmental immunity is dependent upon a further development of facts in order to determine whether they were acting as agents of Emergency Services or as agents of Pontiac General Hospital at the time of the alleged acts of malpractice. Therefore, we conclude that the trial court erred in granting summary disposition in favor of defendants Choi and Thanh merely because they were employees of Pontiac General Hospital.

Accordingly, we reverse the grant of summary disposition in favor of defendants Choi and Thanh and remand the matter to the circuit court for further proceedings consistent with this opinion. We do not retain jurisdiction. Plaintiff may tax costs.

Affirmed in part, reversed in part, and remanded.

[3] With respect to Dr. Thanh, we note, without deciding, that his status as a private physician with staff privileges makes his claim to governmental immunity more tenuous as, unlike Dr. Choi, he is not an employee of the governmental entity. Thus, the trial court will have to take special care in analyzing the status of Dr. Thanh. It would not necessarily be inconsistent for the trial court to conclude that one, but not both, is entitled to the protection of governmental immunity.

In the case at bar, the trial judge concluded that under the facts of this case there is a possibility that plaintiff could show actual malice at trial. While plaintiff's allegations with regard to actual malice are somewhat underwhelming at this point, we are not inclined to disturb the trial court's conclusion that plaintiff should have the opportunity to present the issue to a jury. Accordingly, the trial court's denial of summary judgment for defendant on this issue is also affirmed.

Affirmed. Costs to plaintiff.

JACKSON v NEW CENTER COMMUNITY MENTAL HEALTH SERVICES

Docket No. 85648. Submitted October 21, 1986, at Detroit. Decided February 18, 1987. Leave to appeal applied for.

Vinzell Jackson and Herman Bohler brought an action in the Wayne Circuit Court against New Center Community Health Services and Raghavendar R. Kilaru, M.D., a New Center employee, alleging negligence regarding defendants' care of their patient, Maurice Austin, who wounded Jackson and Bohler in a random shooting spree. Plaintiff Herman Bohler died while the action was pending and Herman A. Bohler, Jr., as personal representative of the estate of decedent, Herman Bohler, was substituted as a plaintiff. The trial court, John H. Gillis, Jr., J., granted defendants' motion for summary disposition, finding that New Center was a governmental agency and ruling that defendants were immune from tort liability under the governmental immunity act. The trial court subsequently denied plaintiffs' motion for a rehearing and plaintiffs appealed.

The Court of Appeals *held:*

1. New Center's contract with the Detroit-Wayne County Mental Health Board, a Wayne County agency, to provide outpatient mental health services in Detroit does not alter the fact that New Center is a private corporation which cannot claim immunity under the governmental immunity act. The trial court therefore erred in ruling that defendants were immune from liability.

2. However, defendants were entitled to summary disposition since they owed no actionable legal duty to plaintiff Jackson or plaintiff Bohler's decedent. Both men were hapless victims of

REFERENCES

Am Jur 2d, Municipal, School, and State Tort Liability § 92.

Am Jur 2d, Negligence § 63.5 (Supp).

Liability of one treating mentally afflicted patient for failure to warn or protect third persons threatened by patient. 83 ALR3d 1201.

Right of contractor with federal, state, or local public body to latter's immunity from tort liability. 9 ALR3d 382.

Austin's random shooting spree and, thus, were not readily identifiable potential victims of Austin's violent behavior whom defendants could have protected against Austin's conduct.

Affirmed.

1. GOVERNMENTAL IMMUNITY — MENTAL HEALTH — PRIVATE MENTAL HEALTH FACILITY.

A private corporation which is under contract with a county mental health board to provide outpatient mental health services is not, by virtue of such contract, a governmental agency which may claim immunity from tort liability under the governmental immunity act (MCL 691.1401; MSA 3.996[101]).

2. NEGLIGENCE — PSYCHIATRISTS — DUTY TO THIRD PERSONS.

A psychiatrist, when he determines or, pursuant to the standard of care of his profession, should determine that his patient poses a serious danger of violence to a readily identifiable person, has a duty to use reasonable care to protect that person against such danger.

Sachs, Nunn, Kates, Kadushin, O'Hare, Helveston & Waldman, P.C. (by *Sharon D. Blackmon*), for plaintiffs.

Barris, Sott, Denn & Driker (by *Sharon M. Woods* and *James S. Fontichiaro*), for New Center Community Mental Health Services.

Siemion, Huckabay, Bodary, Padilla & Morganti (by *Raymond W. Morganti*), for Raghavendar R. Kilaru, M.D.

Before: D. F. WALSH, P.J., and M. J. KELLY and C. W. SIMON,* JJ.

D. F. WALSH, P.J. Plaintiffs, Vinzell Jackson and Herman A. Bohler, Jr., personal representative of the estate of Herman Bohler, deceased, appeal from an order denying their motion for rehearing. The order reaffirmed the circuit court's entry of summary disposition in favor of defendants, New Center Community Mental Health Services and

* Circuit judge, sitting on the Court of Appeals by assignment.

Raghavendar R. Kilaru, M.D. The court had found that New Center was a governmental agency and that New Center and its employee, defendant Kilaru, were immune from liability to plaintiffs for negligence. We disagree with the lower court's analysis of governmental immunity. Because we are persuaded that defendants were entitled to summary disposition in their favor on another ground, however, we affirm.

I

On October 25, 1980, Herman Bohler and Vinzell Jackson were wounded by Maurice Austin, a former Northville Regional Psychiatric Hospital patient. Alleging negligence,[1] they sued defendant

[1] Plaintiffs alleged:

That the Defendants, by and through their agents and employees, were guilty of one or more of the following negligent acts or omissions:

(a) Failing to properly investigate the history of said Maurice Austin so as to accurately determine the degree of danger Mr. Austin presented to others;

(b) Failing to properly monitor the behavior of said Maurice Austin during the time he was under Defendants' care and treatment so as to accurately determine the degree of danger Mr. Austin presented to others:

(c) Failing to properly train and/or supervise those employees or agents who did investigate and/or monitor said Maurice Austin's history and behavior so as to accurately determine the degree of danger Mr. Austin presented to others;

(d) Failing to monitor the medication it did prescribe to said Maurice Austin, which the Defendants knew or should have known was necessary to minimize the violent and bizarre behavior Mr. Austin had demonstrated prior to April 7, 1980, and during the time he was under the care and treatment of the Defendants;

(e) Failing to take adequate and reasonable steps to insure that said Maurice Austin did take the medication it did prescribe for him;

(f) Failing to warn the public, in general, and Plaintiff's Decedent Herman Bohler and Plaintiff Vinzell Jackson, in particular, that said Maurice Austin was violent and a threat to their well being;

New Center, to which Austin had been referred for outpatient services upon discharge from Northville, and defendant Raghavendar R. Kilaru, M.D., Austin's treating physician at New Center.[2] Plaintiffs and Austin were strangers to each other prior to Austin's October 25, 1980, assaults.

The circuit court granted summary disposition to defendants. Finding that defendant New Center was "one hundred percent funded by government funds," the court ruled that New Center was a government agency and therefore immune from liability. The court ruled that defendant Kilaru, "an agent of the government," was also immune. Plaintiffs' motion for rehearing was denied, the court stating that defendant New Center was immune "because it's a mental health facility" and that defendant Kilaru was immune "because he's an employee of the mental health facility."[3]

II

GOVERNMENTAL IMMUNITY

A

Section 1 of the governmental immunity act defines "governmental agency" and related terms as follows:

(g) Failing to properly diagnose, and/or treat, and/or prescribe medication to said Maurice Austin so as to minimize Mr. Austin's demonstrated and foreseeable tendencies to commit violence toward others.

Plintiffs also alleged the creation of a nuisance. That theory appears to have been abandoned and, in any event, was merely a partial restatement of plaintiffs' negligence theory.

[2] Suit was commenced in 1982. Plaintiff Herman Bohler died on August 27, 1984. Herman A. Bohler, Jr., was appointed personal representative of his estate and was substituted as party plaintiff.

[3] Defendants filed a third-party complaint against Northville Regional Psychiatric Hospital and D. S. Yoon, M.D., who had treated Mr. Austin at Northville. Summary disposition was granted to the third-party defendants. That order is not challenged on appeal.

(a) "Municipal corporation" means any city, village, township or charter township, or any combination thereof, when acting jointly.

(b) "Political subdivision" means any municipal corporation, county, township, charter township, school district, port district, or metropolitan district, or any combination thereof, when acting jointly, and any district or authority formed by 1 or more political subdivisions.

(c) "State" means the state of Michigan and its agencies, departments, and commissions, and shall include every public university and college of the state, whether established as a constitutional corporation or otherwise.

(d) "Governmental agency" means the state, political subdivisions, and municipal corporations as herein defined. [MCL 691.1401; MSA 3.996(101). See *Hyde v University of Michigan Bd of Regents*, 426 Mich 223, 251-252; 393 NW2d 847 (1986).]

In *Ross v Consumers Power Co (On Rehearing)*, 420 Mich 567, 591; 363 NW2d 641 (1984), the Supreme Court held that all state and local governmental agencies are immune from tort liability for injuries arising out of the exercise or discharge of a nonproprietary, governmental function.[4]

Among the entities recognized as governmental agencies in *Ross* were the Department of Mental Health, Hawthorn Center (a state mental health facility for emotionally disturbed children), and Ypsilanti Regional Psychiatric Hospital (a state mental hospital). 420 Mich 641-647.

In support of the disparate treatment of public and private tortfeasors, the Supreme Court cited the conclusions of the California Law Commission's study of sovereign and governmental immunity:

[4] A "governmental function" is an activity which is expressly or impliedly mandated or authorized by constitution, statute or other law. 420 Mich 591, 620.

"The problems involved in drawing standards for governmental liability and governmental immunity are of immense difficulty. Government cannot merely be liable as private persons are for public entities are fundamentally different from private persons. Private persons do not make laws. Private persons do not issue and revoke licenses to engage in various professions and occupations. Private persons do not quarantine sick persons and do not commit mentally disturbed persons to involuntary confinement. Private persons do not prosecute and incarcerate violators of the law or administer prison systems. Only public entities are required to build and maintain thousands of miles of streets, sidewalks and highways. Unlike many private persons, a public entity often cannot reduce its risk of potential liability by refusing to engage in a particular activity, for government must continue to govern and is required to furnish services that cannot be adequately provided by any other agency. Moreover, in our system of government, decision-making has been allocated among three branches of government—legislative, executive and judicial—and in many cases decisions made by the legislative and executive branches should not be subject to review in tort suits for damages, for this would take the ultimate decision-making authority away from those who are responsible politically for making the decisions." 4 California Law Revision Comm Reports, Recommendations & Studies, p 810 (1963). [420 Mich 618-619.]

In its discussion of the inadequacies of the various definitions of "governmental function" which had been proposed, the Court observed:

Some activities which a governmental agency is required by law to undertake and provide to the public, and which have consistently been afforded immunity from tort liability, have common private sector counterparts, *e.g.*, public schools and state mental health facilities. [420 Mich 616.]

The Court recognized that particular public projects or activities for which a governmental agency is statutorily responsible may be performed by the private sector. 420 Mich 617.

B

Under the Michigan Mental Health Code, MCL 330.1001 *et seq.;* MSA 14.800(1) *et seq.*, the Department of Mental Health is directed to endeavor to ensure that adequate and appropriate mental health services are available to all Michigan citizens. MCL 330.1116; MSA 14.800(116). The department is authorized and directed to provide, directly or through contractual arrangement, services related to the treatment and care of the mentally ill; such services may be on a residential or nonresidential basis. MCL 330.1116(b), (d) and (j); MSA 14.800(116)(b), (d) and (j). See also *Hyde v University of Michigan Bd of Regents, supra,* pp 247-251.

County community mental health programs are governed by chapter 2 of the Mental Health Code. MCL 330.1200 *et seq.;* MSA 14.800(200) *et seq.* The Department of Mental Health is directed to "administer the provisions of chapter 2 so as to provide and maintain an adequate and appropriate system of county community mental health services throughout the state"; the department's objective in this regard is to shift from the state to a county the primary responsibility for the delivery of mental health services to the citizens of the county. MCL 330.1116(e); MSA 14.800(116)(e). Funding of county community mental health programs is shared by the county and state, with allowance for federal and private funds. MCL 300.1300 *et seq.;* MSA 14.800(300) *et seq.* The purpose of a county community mental health

program is to provide a range of mental health services for persons in the county; minimum services, which can include outpatient services for the mentally ill, are designated by the Department of Mental Health. MCL 330.1206, 330.1208(e); MSA 14.800(206), 14.800(208)(e).[5]

A county electing to establish a county community mental health program must establish a community mental health board. MCL 330.1212 *et seq.*; MSA 14.800(212) *et seq.* Board members may not include employees of the Department of Mental Health program, or employees or representatives of an agency having a contractual relationship with the county community mental health program. MCL 330.1222(3); MSA 14.800(222)(3). The board's powers and duties include the examination and evaluation of the county's mental health needs and the public and nonpublic services necessary to meet those needs, submission of the county community mental health program's annual budget to the Department of Mental Health, and approval and authorization of all contracts for the providing of services. MCL 300.1226; MSA 14.800(226). The board may enter into contracts for the purchase of mental health services with private or public agencies, including state facili-

[5] See 1984 AACS, R 330.2005:

> A community mental health board shall ensure that the following minimum types and scopes of mental health services are provided to all age groups, either directly by the board, by contract, or by formal agreement with public or private agencies or individuals:
> (a) Twenty-four-hour intervention services.
> (b) Prevention services.
> (c) Outpatient services.
> (d) Aftercare services.
> (e) Day program and activity services.
> (f) Public information services.
> (g) Inpatient services.

ties. MCL 330.1228; MSA 14.800(228). OAG 1981-1982, No 6022, p 514 (January 7, 1982).

A county community mental health program established under chapter 2 of the Mental Health Code is an official county agency. MCL 330.1204; MSA 14.800(204). Employees of the program are county employees. *Applebaum v Dep't of Public Health,* 123 Mich App 208, 211; 333 NW2d 226 (1983), OAG, 1977-1978, No 5269, p 362 (February 23, 1978).

C

New Center is a nonprofit Michigan corporation which provides outpatient mental health services. Its purpose, as described in its articles of incorporation, is

> [t]o deliver comprehensive community mental health services to the Central Detroit Catchment Area in accordance with standards set by appropriate county, state and federal agencies, and pursuant thereto, to receive funds, engage in research and training, to develop ancillary services and to serve as a vehicle of communications between interested parties, all pursuant to Act 54, PA 1963.[6]

The articles of incorporation describe New Center's general financing plan as "Grants from Detroit—Wayne County Mental Health Board and United States Department of Health, Education and Welfare."[7] The board of directors, as identified in the articles of incorporation, consists of thirty-seven members.

[6] See now 1974 PA 258, the Mental Health Code.

[7] Defendants' assertain that 99.5 percent of New Center's budget is publicly funded, the balance coming from insurers and financially able clients, is not disputed.

Wayne County has elected to establish a county community mental health program. The Detroit—Wayne County Mental Health Program is an official agency of Wayne County; employees of the program are Wayne County employees. MCL 330.1204, MSA 14.800(204). See OAG, 1977-1978, No 5269, *supra*, p 363, n 1. The Detroit—Wayne County Mental Health Board is vested with the authority to contract with private agencies to provide mental health services in the county. MCL 330.1226, 300.1228; MSA 14.800(226), 14.800(228). Pursuant to that authority, the board has contracted with New Center to provide outpatient mental health services in Detroit.

D

Public mental health facilities are immune from tort liability when engaged in a governmental function. *Ross, supra; Canon v Bernstein*, 144 Mich App 604; 375 NW2d 773 (1985), lv gtd 425 Mich 851 (1986).

New Center itself does not satisfy the definition of governmental agency set forth in the governmental immunity act. MCL 691.1401(d); MSA 3.996(101)(d). We find unpersuasive New Center's attempt to escape tort liability by virtue of its relationship with an official county agency.

In support of its claim to governmental agency status, New Center notes that it is a "publicly funded, non-profit, non-stock Michigan corporation, whose purpose is to perform a governmental function by providing outpatient mental health services" in Detroit. New Center further asserts that it was "created pursuant to and is part of the County Community Mental Health Services program, an official county agency."

New Center's argument confuses the issues of

governmental agency status and governmental function. A private entity's performance of a governmental function does not confer governmental agency status on that entity. As noted in *Ross, supra*, p 616, mental health services, albeit required of a governmental agency, are commonly provided by private facilities. The Mental Health Code expressly contemplates the participation of both public and private mental health facilities in state and county community mental health programs.

Notwithstanding its performance of a "governmental function" and its reliance on public funding, New Center retains its identity as a nongovernmental entity. Its employees are not county employees. It retains its separate corporate identity and is governed by its own board of directors. Except as it has voluntarily obligated itself by contract, New Center is not required to provide services or to remain in existence. While it may have been created in response to the recognition of mental health needs in Detroit, New Center's creation was not mandated by law.

We are persuaded of no reason to treat a private entity as a governmental agency merely because that entity contracts with a governmental agency to provide services which the agency is authorized or mandated to provide. We hold that New Center is not a governmental agency. Neither New Center nor its employee defendant Kilaru is immune from liability under *Ross, supra*.

III

DUTY

Defendants argue that, assuming they are not protected from liability by governmental immu-

nity, they owed no duty to Austin's victims under the circumstances of this case. We agree.[8]

In a negligence action, the court assesses competing policy considerations and determines as a matter of law whether the defendant owes an actionable legal duty to the plaintiff. *Friedman v Dozorc,* 412 Mich 1, 22; 312 NW2d 585 (1981); *Moning v Alfono,* 400 Mich 425, 436-439; 254 NW2d 759 (1977).

This Court has held that, when a psychiatrist determines or, pursuant to the standard of care of the profession of psychiatry, should determine that his or her patient poses a serious danger of violence to a readily identifiable person, the psychiatrist has a duty to use reasonable care to protect that person against such danger. *Davis v Lhim,* 124 Mich App 291, 298-305; 335 NW2d 481 (1983), remanded on other grounds 422 Mich 875 (1985), on remand 147 Mich App 8; 382 NW2d 195 (1985), lv gtd 425 Mich 851 (1986); *Bardoni v Kim,* 151 Mich App 169, 175-178; 390 NW2d 218 (1986).

In this case, there is no claim that Jackson or Bohler's decedent were readily identifiable potential victims of Austin's violence. The record conclusively establishes that they were the hapless victims of Austin's random shooting spree.[9]

Plaintiffs do not suggest that New Center's duty is greater than that of its employee, defendant Kilaru. On the authority of *Davis, supra,* therefore, we find that defendants were entitled to summary disposition pursuant to MCR 2.116(C)(10), *Bardoni, supra,* p 175.

[8] This issue was raised in the lower court but was never resolved by order of the court.

[9] The record includes the January 16, 1984, depositions of Vinzell Jackson and Herman Bohler, and the March 15, 1985, deposition of defendant Kilaru.

IV

CONCLUSION

Defendants were entitled to summary disposition because, as a matter of law, they owed no duty to plaintiff Jackson or to plaintiff Bohler's decedent. Because the court reached the right result, albeit for the wrong reason, we affirm. *Gilbert v Grand Trunk Western R Co,* 95 Mich App 308, 313; 290 NW2d 426 (1980), lv den 410 Mich 854 (1980).

Affirmed.

HAYES v EMERICK

Docket No. 90855. Submitted March 24, 1987, at Detroit. Decided September 14, 1987. Leave to appeal applied for.

Steven R. Hayes brought a medical malpractice action in Macomb Circuit Court against Myron R. Emerick, D.O., arising from treatment Hayes received from Emerick while Hayes was an inmate of the Macomb County Jail. Emerick provided medical services to Macomb County Jail inmates pursuant to an agreement with Macomb County and received compensation on an "individual fee for service" basis. The trial court, Lawrence P. Zatkoff, J., granted summary disposition in favor of defendant, ruling that defendant was an agent of Macomb County and that plaintiff's claim was barred by governmental immunity. Plaintiff appealed.

The Court of Appeals *held:*

1. Macomb County is obligated by law to provide medical services to inmates of its jail and defendant was acting on behalf of the county in treating plaintiff. The trial court properly ruled that defendant, as an agent of the county, was entitled to governmental immunity from tort liability.

2. Summary disposition was not granted prematurely and a remand for further discovery is not necessary since plaintiff failed to persuade the Court of Appeals that discovery was incomplete.

Affirmed.

1. GOVERNMENTAL IMMUNITY — LOWER-LEVEL OFFICIALS, EMPLOYEES AND AGENTS — TORT LIABILITY.

Lower-level governmental officials, employees and agents are immune from tort liability only when they are: (1) acting during the course of their employment and acting, or reasonably believe they are acting, within the scope of their authority; (2) acting in good faith; and (3) performing discretionary, as opposed to ministerial, acts.

REFERENCES

Am Jur 2d, States, Territories, and Dependencies §§ 99 *et seq.*; § 104.

State's immunity from tort liability as dependent on governmental or proprietary nature of function. 40 ALR2d 927.

2. GOVERNMENTAL IMMUNITY — TORT LIABILITY.

A physician who, under the terms of an agreement with a county, is obligated to provide medical services to inmates of the county's jail on an "individual fee for service" basis may properly claim governmental immunity from tort liability as an agent of the county in a medical malpractice action brought by a treated inmate.

Becker & Van Cleef, P.C. (by *Robert Van Cleef*), for plaintiff.

MacArthur, Cheatham, Acker & Smith, P.C. (by *James G. Gross*), for defendant.

Before: WAHLS, P.J., and R. M. MAHER and J. T. KALLMAN,* JJ.

PER CURIAM. On June 9, 1983, plaintiff, Steven Russell Hayes, filed a medical malpractice lawsuit against defendant, Myron R. Emerick, D.O. On January 8, 1986, defendant's motion for summary disposition based upon governmental immunity was granted by the trial court. Plaintiff appeals as of right.

Plaintiff claims two errors on appeal, alleging that (1) the trial court erred when it granted summary disposition in favor of defendant on the ground that defendant was an agent of Macomb County, and (2) either the trial court erred in granting summary disposition since discovery was incomplete or plaintiff should be allowed an opportunity on remand to conduct further discovery on the issue of defendant's status as an independent contractor.

Macomb County Jail employed defendant to provide medical care to the inmates. While plaintiff was an inmate of the jail, he was examined by defendant. Plaintiff's complaint set forth in a med-

* Circuit judge, sitting on the Court of Appeals by assignment.

ical malpractice action in which he asserted a claim of negligence against the defendant.

In discussing individual immunity in *Ross v Consumers Power Co (On Rehearing)*, 420 Mich 567, 592; 363 NW2d 641 (1984), the Supreme Court stated:

> Lower level officers, employees, and agents are immune from tort liability only when they are (a) acting during the course of their employment and are acting, or reasonably believe they are acting, within the scope of their authority; (b) acting in good faith; and (c) performing discretionary-decisional, as opposed to ministerial-operational, acts.

Plaintiff argues that defendant was not a "lower level officer, employee or agent," but rather was an independent contractor. The trial court found that the defendant was an agent entitled to governmental immunity. The defendant argues on appeal that he was either an agent or an employee.

In *Ross, supra,* 420 Mich 624, n 38, the Supreme Court noted that "the individual tortfeasor's status as an employee, agent, independent contractor, etc., . . . will generally be determined with reference to common-law tort and agency principles." Therefore, general principles of agency law must be examined. In *Goldman v Cohen,* 123 Mich App 224, 228-230; 333 NW2d 228 (1983), lv den 422 Mich 865 (1985), this Court reiterated the definition of the term "agent" found in *Stephenson v Golden,* 279 Mich 710, 734-735; 276 NW 849 (1937):

> "'An agent is a person having express or implied authority to represent or act on behalf of another person, who is called his principal.' Bowstead on Agency (4th ed), 1.
>
> "'An agent is one who acts for or in the place of another by authority from him; one who undertakes to transact some business or manage some affairs for another by authority and on account of the latter, and to render an account of it. He is a substitute, a deputy, appointed by the principal, with power to do the things which the principal may or can do.' 2 CJS 1025.
>
> "The term 'agent' includes factors, brokers, etc. 2 CJS 1025.
>
> "As said in *Saums v Parfet,* 270 Mich 165; 258 NW 235 (1935):
>
> "'"Agency" in its broadest sense includes every relation in which one person acts for or represents another by his authority.' 2 CJ 419.
>
> "'"Whether an agency has been created is to be determined by the relations of the parties as they in fact exist under their agreements or acts." 21 RCL 819.'"

This Court is satisfied that defendant was an agent of Macomb County. The county was obligated by law to provide medical services to the inmates of its jail pursuant to MCL 791.262(f)(3); MSA 28.2322(f)(3). In order to fulfill this obligation, Macomb County contracted with defendant to provide medical care to the jail residents on the county's behalf. If defendant did not provide such services, Macomb County would be forced to retain another physician in order to meet its legal obligations. Although the defendant provided the services on an "individual fee-for-service basis," he was employed on an ongoing basis. Defendant did not maintain a personal patient clientele at the county jail; rather, his work with the inmates was due solely to his contract with Macomb County to render such services. As in *Goldman,* defendant was acting on behalf of his principal, in this case, Macomb County, and therefore was its agent.

This Court is satisfied that summary disposition was not granted prematurely and that a remand

for further discovery is not necessary. Discovery was closed in this case in early November, 1984. The motion for summary disposition was not granted until January, 1986. Plaintiff did not argue at that time that further discovery was necessary. Plaintiff has failed to persuade this Court that discovery was incomplete.

Affirmed.

MITHRANDIR v DEPARTMENT OF CORRECTIONS

Docket No. 91685. Submitted February 5, 1987, at Detroit. Decided September 18, 1987. Leave to appeal applied for.

Jason K. Mithrandir and three other maximum security prisoners in administrative segregation at Marquette Branch Prison made written requests under the Freedom of Information Act seeking to inspect some five hundred files located at the prison but outside of the prison's security perimeter. George Pennell, an administrative assistant to the prison warden, responded to the requests by allowing Mithrandir and the other prisoners to select a representative to inspect the files for them or, alternatively, to obtain copies of the files upon payment of a fee. Not satisfied with the response to their request, Mithrandir and the other prisoners brought an action under the FOIA in Marquette Circuit Court against the Department of Corrections. Plaintiff Mithrandir moved for summary disposition seeking a right to personally inspect the files, contending that no material factual issues existed and that he was entitled to judgment as a matter of law. The trial court, Edward A. Quinnell, J., denied the motion and granted summary disposition in favor of defendant. Plaintiff Mithrandir appealed.

The Court of Appeals *held:*

The Department of Corrections has obligations with regard to prison security and the confinement of prisoners which are separate and distinct from its duty under the FOIA to provide a reasonable opportunity for persons and prisoners to inspect public records not exempt from disclosure under the FOIA. Considerations peculiar to the penal system justify the imposition of limitations on a prisoner's right to inspect a prison's public records. In this case, the alternatives offered to plaintiff Mithrandir in response to his request to personally inspect the files were reasonable and in compliance with FOIA disclosure requirements in view of the security risk and added burden on

REFERENCES

Am Jur 2d, Records and Recording Laws §§ 12 *et seq.*; 32 *et seq.*

Scope of judicial review under Freedom of Information Act (5 USC sec. 552(a)(3)), of administrative agency's withholding of records. 7 ALR Fed 876.

STATE OF MICHIGAN

COURT OF APPEALS

DONALD MCLEAN and CHRISTINE MCLEAN, Personal Representatives of the Estate of KAREN MCLEAN,

Plaintiffs-Appellees,

v

MAUREEN PHENIX,[1] SAMUEL W. HARMA and HIAWATHA BEHAVIORAL HEALTH,

Defendants-Appellants,

and

ROBERT B. MCELHANEY, M.D.,

Defendant,

and

MICHIGAN ASSOCIATION OF COMMUNITY MENTAL HEALTH BOARDS,

Amicus-Curiae.

FOR PUBLICATION
August 26, 2010
9:25 a.m.

No. 290781
Chippewa Circuit Court
LC No. 03-006994-NH

Before: WHITBECK, P.J., and SAWYER and BORRELLO, JJ.

BORRELLO, J.

This case requires this Court to construe the "medical care or treatment" exception to governmental immunity, MCL 691.1407(4). Defendants appeal as of right the trial court's denial of their motion for summary disposition. In denying defendants' motion, the trial court concluded that the "medical care or treatment" exception to governmental immunity applied and

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[1] Defendant Maureen Phenix died on May 22, 2007.

that plaintiffs' claims against defendants were therefore not barred by governmental immunity. For the reasons set forth in this opinion, we affirm, in part, and reverse and remand, in part.

I. FACTS AND PROCEDURAL HISTORY

Plaintiffs filed suit against defendants after the decedent, who was their daughter, died at age 30. Plaintiffs are the decedent's personal representatives. Defendants include defendant Hiawatha Behavioral Health (HBH), a community mental health services agency; defendant Maureen Phenix, a clinical social worker and employee of defendant HBH; and defendant Samuel W. Harma, the Chief Executive Officer of defendant HBH. For approximately 12 years, plaintiffs' decedent had suffered from a variety of mental and physical illnesses, including major depressive disorder, bipolar illness, borderline personality disorder, anorexia nervosa, bulimia, and hypoglycemia. She had also been an alcoholic for about five years and had an extensive psychiatric history that included several suicide attempts. Following her death, plaintiffs filed suit against defendants, asserting that the decedent died "from cardiopulmonary arrest secondary to seizures brought on by her withdrawal from alcohol" after she "unsuccessfully attempt[ed] detoxification without assistance or intervention by health care professionals." Plaintiffs' complaint alleged ordinary negligence, gross negligence, intentional misconduct, and civil conspiracy. The complaint also asserted that defendants provided medical care or treatment to patients under MCL 691.1407(4) and were therefore not immune from liability under the governmental immunity act.

Defendants HBH, Phenix, and Harma moved for summary disposition under MCR 2.116(C)(7) and (8).[2] In relevant part, defendants argued that defendants HBH and Phenix were entitled to governmental immunity because they did not provide plaintiffs' decedent with "medical care or treatment" under the "medical care or treatment" exception to governmental immunity, MCL 691.1407(4), and plaintiffs' decedent was not a patient at the time of her death; that defendants Phenix and Harma were not grossly negligent, MCL 691.1407(2)(c); and that defendant Harma was entitled to absolute immunity under MCL 691.1407(5) as the highest executive official of HBH. Defendants also argued that the decedent's own conduct, not their conduct, was the proximate cause of her death.

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[2] This was defendants' second motion for summary disposition. Defendants first moved for summary disposition in 2004, arguing that plaintiffs' claims were barred by the statute of limitations. The trial court granted defendants' motion, and this Court affirmed, *McLean v McElhaney*, 269 Mich App 196; 711 NW2d 775 (2005), rev'd 480 Mich 978 (2007). Our Supreme Court held the application for leave to appeal in abeyance pending its decision in *Mullins v St Joseph Mercy Hosp*, 480 Mich 948; 741 NW2d 300 (2007). After *Mullins* was decided, our Supreme Court reversed this Court's opinion and remanded the "case to the Chippewa Circuit Court for entry of an order denying the defendant's motion for summary disposition and for further proceedings not inconsistent with this order and the order in *Mullins*." *McLean*, 480 Mich 978.

Plaintiffs argued that defendants were not entitled to governmental immunity because the "medical care or treatment" exception to governmental immunity, MCL 691.1407(4), applied because "medical care or treatment" includes mental health care or treatment. Plaintiffs also argued that because the "medical care or treatment" exception applies to employees or agents of governmental agencies, defendant Harma was not entitled to absolute immunity as the highest executive official of HBH under MCL 691.1407(5). Plaintiffs further argued that even if, for some reason, the "medical care or treatment" exception did not apply, defendant Phenix was not immune from suit because her conduct was grossly negligent and her conduct was the proximate cause of the decedent's death.

The trial court denied defendants' motion for summary disposition, ruling that defendants were providing "medical care or treatment" to patients within the exception to governmental immunity, MCL 691.1407(4), and that the decedent was a patient under the exception. The trial court acknowledged that the Legislature "could have been more specific in what they said in this statute," but concluded that mental health care and treatment was included in the exception. Thus, the trial court ruled that defendants did not have governmental immunity. The trial court did not rule on whether defendant Harma was absolutely immune as the highest executive official of defendant HBH or whether defendants Harma and Phenix were grossly negligent. Following the trial court's denial of their motion, defendant Harma moved for reconsideration, and the trial court denied the motion.

II. STANDARDS OF REVIEW

This case involves the construction of MCL 691.1407(4). This Court reviews de novo the interpretation of a statute. *Manske v Dep't of Treasury*, 282 Mich App 464, 468; 766 NW2d 300 (2009). Similarly, the applicability of governmental immunity is a question of law that this Court reviews de novo. *Herman v Detroit*, 261 Mich App 141, 143; 680 NW2d 71 (2004). Furthermore, we also review de novo a trial court's grant or denial of a motion for summary disposition. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999).

Defendants moved for summary disposition under MCR 2.116(C)(7) and (8). Because the trial court's statements on the record and in its order denying summary disposition indicate that the basis for its ruling was its determination that the "medical care or treatment" exception to governmental immunity applied, we review the trial court's denial of defendants' motion under MCR 2.116(C)(7). The trial court may grant a motion for summary disposition under MCR 2.116(C)(7) on the ground that a claim is barred because of immunity granted by law. MCR 2.116(C)(7). To survive a motion raised under MCR 2.116(C)(7), the plaintiff must allege specific facts warranting the application of an exception to governmental immunity. *Renny v Dep't of Transportation*, 270 Mich App 318, 322; 716 NW2d 1 (2006), rev'd in part on other grounds 478 Mich 490 (2007). "The contents of the complaint are accepted as true unless contradicted by documentation submitted by the movant." *Maiden*, 461 Mich at 119. In deciding a motion brought pursuant to MCR 2.116(C)(7), a court may consider the affidavits, pleadings, depositions, admissions, and other documentary evidence submitted by the parties. MCR 2.116(G)(5); *Holmes v Michigan Capital Medical Ctr*, 242 Mich App 703, 706; 620 NW2d 319 (2000). If the pleadings or documentary evidence reveal no genuine issues of material fact, the court must decide as a matter of law whether the claim is statutorily barred. *Holmes*, 242 Mich App at 706.

III. ANALYSIS

A. MEDICAL CARE OR TREATMENT EXCEPTION TO GOVERNMENTAL IMMUNITY

The issue in this case is whether the "medical care or treatment" exception to governmental immunity, MCL 691.1407(4), encompasses mental health care or treatment or whether it is limited to care or treatment for physical illness or disease. Resolving this question requires this Court to construe MCL 691.1407(4). The primary objective in construing a statute is to ascertain and give effect to the Legislature's intent. *People v Williams*, 475 Mich 245, 250; 716 NW2d 208 (2006). If the language of the statute is clear and unambiguous, the Court must presume that the Legislature intended the meaning clearly expressed and enforce it as written; further judicial construction is neither permitted nor required. *Id.*

The governmental immunity act, MCL 691.1401 *et seq.*, provides, in relevant part: "Except as otherwise provided in this act, a governmental agency is immune from tort liability if the governmental agency is engaged in the exercise or discharge of a governmental function." MCL 691.1407(1). The immunity from tort liability provided in the governmental immunity act is expressed in the broadest possible language and extends to all governmental agencies and applies to all tort liability when the governmental agencies are engaged in the exercise or discharge of a governmental function. *Nawrocki v Macomb Co Rd Comm*, 463 Mich 143, 156; 615 NW2d 702 (2000). Further, the exceptions to governmental immunity are to be narrowly construed. *Maskery v U of M Bd of Regents*, 468 Mich 609, 614; 664 NW2d 165 (2003). Because the statutory exceptions to governmental immunity are to be narrowly construed, this Court must apply a narrow definition of the undefined phrase "medical care or treatment" in MCL 691.1407(4). See *Stanton v Battle Creek*, 466 Mich 611, 618; 647 NW2d 508 (2002).

The "medical care or treatment" exception to governmental immunity provides:

> This act does not grant immunity to a governmental agency or an employee or agent of a governmental agency with respect to providing medical care or treatment to a patient, except medical care or treatment provided to a patient in a hospital owned or operated by the department of community health or a hospital owned or operated by the department of corrections and except care or treatment provided by an uncompensated search and rescue operation medical assistant or tactical operation medical assistant. [MCL 691.1407(4).]

In *Briggs v Oakland Co*, 276 Mich App 369, 373-374; 742 NW2d 136 (2007), this Court concluded that the language in the "medical care or treatment" exception to governmental immunity was clear and unambiguous and therefore declined to examine the legislative history behind the current language of the statute, which was enacted in a 2000 amendment. We likewise conclude that the language in the "medical care or treatment" exception is plain and clear. Therefore, in resolving the issue in this case, we do not look to legislative history or references to medical care or treatment or similar phrases in other statutes for guidance in

interpreting the exception.[3] Rather, we simply look to the plain and clear language of the "medical care or treatment" exception itself.

The plain language of the exception uses the broad phrase "medical care or treatment" and does not contain any language restricting or limiting the exception to medical care or treatment for physical illness or disease alone. If the Legislature had intended to exclude care or treatment for mental illness or disease from the exception, it could have done so by specifically limiting medical care or treatment to care and treatment for physical disease or illness, by specifically excluding care and treatment for mental conditions or by defining medical care or treatment in such a manner as to exclude care or treatment of mental conditions. The Legislature did not do so. Our obligation to construe the "medical care or treatment" exception to governmental immunity narrowly does not require this Court to ignore the plain and broad language used by the Legislature or the fact that the Legislature chose not to exclude care or treatment for mental health infirmities. "We 'may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself.'" *Bay Co Prosecutor v Nugent*, 276 Mich App 183, 189; 740 NW2d 678 (2007), quoting *Roberts v Mecosta Co Gen Hosp*, 466 Mich 57, 63; 642 NW2d 663 (2002). The absence of any limiting language in the exception suggests a recognition of the interconnectedness of an individual's physical and mental health, and this Court must not read a limitation in the "medical care or treatment" exception that is not manifest from the plain language of the statute itself. To do so would be tantamount to the establishment of a judicially created exception or limitation to the "medical care or treatment" exception to governmental immunity that does not exist under the plain and clear language of the statute.

There is additional language in the "medical care or treatment" exception that also supports the conclusion that the Legislature did not intend to limit the exception to the care or treatment of physical illness or disease alone. MCL 691.1407(4) contains an exception to the exception, which provides for governmental immunity for "medical care or treatment provided to a patient in a hospital owned or operated by the department of community health . . . ." The website for the Department of Community Health (DCH) indicates that there are three state-operated psychiatric hospitals. This exception clearly does not apply in this case, as there is no dispute that plaintiff's decedent was not a patient in a hospital owned or operated by the DCH at the time of her death. However, based on the plain language of the exception, the fact that the Legislature specifically provided for immunity for medical care or treatment provided to a patient in such hospitals is telling. The Legislature would be aware that the primary medical care provided by a psychiatric hospital would be mental health care, although treatment related to the care and treatment of mental illness or disease would in some cases require treatment for physical conditions as well. The fact that the Legislature specifically provided for governmental immunity for patients in psychiatric hospitals owned or operated by the DCH supports the conclusion that the Legislature otherwise intended for the "medical care or treatment" exception to apply to the provision of medical care or treatment for mental disease or illness.

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[3] Only if "statutory language is ambiguous may we look outside the statute to ascertain the Legislature's intent." *People v Morey*, 461 Mich 325, 330; 603 NW2d 250 (1999).

In order for the "medical care or treatment" exception to apply, plaintiffs' decedent must have also been defendants' "patient." MCL 691.1407(4). Relying on *Saur v Probes*, 190 Mich App 636; 476 NW2d 496 (1991), defendants contend that plaintiffs' decedent was a "recipient," not a patient. In *Saur*, this Court held that the plaintiff did not fit into the statutory definition of the term "recipient" in the mental health code, MCL 330.1700.[4] Even if plaintiffs' decedent fit the definition of a "recipient" in the mental health code, this would not preclude plaintiffs' decedent from also being a "patient" under the "medical care or treatment" exception to governmental immunity. The two are not mutually exclusive. Therefore, we are not persuaded by defendants' reliance on *Saur*.

The term "patient" is not defined in the governmental immunity statute. *Stedman's Medical Dictionary* (26th ed) defines the word "patient" as "[o]ne who is suffering from any disease or behavioral disorder and is under treatment for it." This Court may consult dictionary definitions of terms that are not defined by statute. *Woodard v Custer*, 476 Mich 545, 561; 719 NW2d 842 (2006). The definition of the term "patient" in *Stedman's Medical Dictionary* includes a person who is under treatment for a behavioral disorder and supports our holding that the plain language of MCL 691.1407(4) ("medical care or treatment") is broad enough to include care or treatment for mental illness or disease.

In plaintiffs' complaint, plaintiffs assert that the decedent was under defendants' care "from on or about January 19, 1996 until December 13, 2000 when treatment services were effectively discontinued although not formally terminated until January 4, 2001." Plaintiffs' decedent died on February 14, 2001, which was after she was formally terminated from treatment with defendants. To survive defendants' motion for summary disposition under MCR 2.116(C)(7), plaintiffs must allege facts warranting the application of an exception to governmental immunity. *Renny*, 270 Mich App at 322. Plaintiffs' assertion that defendants' treatment of the decedent was formally terminated on January 4, 2001, which was approximately five weeks before she died, suggests that decedent was not a "patient" at the time of her death. However, elsewhere in their complaint, plaintiffs assert that after her treatment was formally terminated, plaintiffs' decedent made over 50 telephone calls to defendant HBH's crisis intervention workers "seeking emergency counseling for her deepening depression, feelings of hopelessness, eating disorder and alcoholism." During one of these telephone calls, plaintiffs' decedent advised the crisis worker that she was feeling suicidal. The complaint also asserts that employees of defendant HBH "completed or approved an 'Individual Plan of Service' which indicated that [the decedent] suffered from 'major depression and alcohol abuse.'" In addition, plaintiffs' complaint asserts that plaintiffs' decedent was scheduled to begin outpatient therapy for mental illness on February 15, 2001.[5] Under these circumstances, plaintiffs established an issue of fact regarding whether the decedent was a "patient" under MCL 691.1407(4) at the time

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[4] The term "recipient" is now defined in MCL 330.1100c(12).

[5] Elsewhere in the complaint, plaintiffs assert that outpatient therapy was scheduled to begin on April 15, 2001.

of her death, notwithstanding their acknowledgement in the complaint that the decedent was formally discharged from treatment on January 4, 2001.[6]

Although we hold that the trial court properly concluded that the "medical care or treatment" exception to governmental immunity includes care and treatment for mental illness or disease and that plaintiffs' decedent was a "patient" under the exception, we find that the trial court erred in concluding that this exception applied to defendant Harma. While plaintiffs' complaint contains factual allegations regarding defendants HBH and Phenix providing medical care to plaintiff's decedent, there are no factual allegations that defendant Harma provided medical care to the decedent. Therefore, while the trial court properly concluded that the "medical care or treatment" exception applied to defendants HBH and Phenix, it erroneously concluded that the exception also applied to defendant Harma.

B. INDIVIDUAL IMMUNITY

In ruling that the "medical care or treatment" exception applied and that defendants were therefore not immune from liability, the trial court did not rule on whether defendant Harma was individually immune under MCL 691.1407(5) as the chief executive officer of defendant HBH, or whether defendants Harma and Phenix were entitled to individual immunity under MCL 691.1407(2). In light of our holding that the trial court erred in concluding that the "medical care or treatment" exception applied to defendant Harma given the absence of any factual allegations in plaintiffs' complaint that defendant Harma provided medical care or treatment to plaintiffs' decedent, we remand for the trial court to address whether defendant Harma was entitled to absolute immunity under MCL 691.1407(5) or qualified immunity under MCL 691.1407(2).[7] *Odom v Wayne Co*, 482 Mich 459, 479-480; 760 NW2d 217 (2008). However, because the trial court properly concluded that the "medical care or treatment" exception applies to defendant Phenix, there is no need for the trial court to determine whether she was entitled to qualified immunity under MCL 691.1407(2).[8]

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[6] We observe that the definition of "patient" in *Stedman's Medical Dictionary* does not contain any requirement of a formal arrangement for a person to be considered to be "under treatment." Furthermore, because of the nature of mental illness and addictions, there is often no discrete event marking a person's recovery from such a condition. Often, recovery is a gradual and lifelong process, marked by progress and setbacks, that requires continuous care and treatment. Although not in the context of a mental illness or addiction, our Supreme Court has recognized that "[p]atients are often discharged from hospitals when their conditions still require active treatment under the daily direction or supervision of a physician." *Tryc v Michigan Veterans' Facility*, 451 Mich 129, 137 n 8; 545 NW2d 642 (1996).

[7] We note that if the trial court determines that defendant Harma is entitled to absolute immunity under MCL 691.1407(5), it need not also determine whether he is entitled to qualified immunity under MCL 691.1407(2). See *Nalepa v Plymouth-Canton Community Sch Dist*, 207 Mich App 580, 587-589; 525 NW2d 897 (1994), result only aff'd 450 Mich 934 (1995).

[8] MCL 691.1407(2) applies only in the absence of other applicable statutory provisions. *Grahovac v Munising Twp*, 263 Mich App 589, 597; 689 NW2d 498 (2004).

Affirmed, in part, and reversed and remanded, in part for proceedings consistent with this opinion. No taxable costs under MCR 7.219, neither party having prevailed in full. We do not retain jurisdiction.

/s/ Stephen L. Borrello
/s/ William C. Whitbeck
/s/ David H. Sawyer

STATE OF MICHIGAN

IN THE 20th CIRCUIT COURT FOR THE COUNTY OF OTTAWA

414 Washington Street
Grand Haven, MI 49417
616-846-8315

* * * * * * *

MARIANNE HUFF, Individually, and **PERSON-CENTERED ADVOCACY SERVICES, LLC**, a Michigan Limited Liability Company,

Plaintiffs,

v

LYNNE DOYLE, Individually, **STACY COLEMAN-AX**, Individually, **JEFFREY L. BROWN**, Individually,

Defendants.

OPINION AND ORDER ON MOTIONS FOR SUMMARY DISPOSITION AND MOTION FOR SANCTIONS

File No. 2018-5222-NZ
Hon. Jon H. Hulsing

This case can be succinctly summarized. First, plaintiffs mistakenly believe that the administrative rules governing Medicaid hearings provide plaintiffs with standing to privately interpret and enforce those administrative regulations. Second, plaintiffs claim they were wronged because defendants failed to renounce a letter received and distributed *to their own employees* which claimed that Huff was engaged in the unauthorized practice of law.

For the reasons stated below, all defendants are GRANTED summary disposition pursuant to MCR 2.116(C)(7) and MCR 2.116(C)(8). The Court also finds that plaintiffs' claims are frivolous. Plaintiffs' third attempt to cobble together a legally recognized cause of action fails. This latest iteration is an unjustified rehashing of prior allegations devoid of merit as was painstakingly pointed out in this Court's twenty-five page opinion from June, 2018 granting defendants' motions for summary disposition under MCR 2.116(C)(8). Defendants' respective motions for sanctions against plaintiffs AND their attorney are GRANTED.[1]

[1]. Pursuant to MCR 2.119(E)(3) the Court dispenses with oral arguments and renders this decision based on the written materials. This case with its various issues has been extensively briefed and was previously argued at a hearing Given the conclusion that plaintiff's claims are frivolous, plaintiffs' motion to begin discovery is denied.

Background Information

1. Plaintiffs' Second Amended Complaint

This opinion is properly understood as a continuation of this Court's June 19, 2018 opinion and order on motions for summary disposition. For this reason, the factual discussion and matters of law discussed in that opinion are incorporated by reference into this opinion.

On July 9, 2018, plaintiffs filed their second amended complaint.[2] While much of the second amended complaint is a reiteration of their original complaint, relevant amendments of the original complaint are summarized below.

The first and most important change is that plaintiffs are no longer suing former defendants Van Essen, Community Mental Health of Ottawa County (CMH), or the Lakeshore Regional Entity (LRE). Instead, plaintiffs now raise a tortious interference with business relations claim[3], and a civil conspiracy claim against defendants.[4]

The heart of plaintiffs' allegations is their claim that they are permitted to advocate as "authorized representatives" on behalf of consumers and providers, and that, as a result, they have a valid business expectancy regarding providing services to those consumers and providers.[5] Plaintiffs then allege that defendants knew of business relationships between plaintiffs and consumers and providers and interfered with those relationships.[6]

Defendants' "wrongs," according to plaintiffs originate from an August 29, 2017, letter from Van Essen to Huff "insisting" that Huff "no longer attempt to serve as an advocate not only in Ottawa County but in other Michigan counties" and threatening to report Huff to the Michigan State Bar Association for the unauthorized practice of law. The letter also indicated that Van Essen had "instructed Ottawa County CMH to refrain from further releasing any client information to you or to discussing [sic] any client matter with you, even if you have a release."[7]

Plaintiffs then complain that, Doyle "publish[ed]" Van Essen's "wrong" letter to Huff to "other CMH and LRE employees."[8] These "CMH and LRE employees" included Brown and

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[2] Second Amended Complaint, July 9, 2018.

[3] Second Amended Complaint, 24-37. Plaintiffs raise a "gross negligence" claim, but that is merely a continuation of their tortious interference claim with additional allegations designed to avoid governmental immunity. Accordingly, this Court treats the "gross negligence" claim as a part of the tortious interference claim. See *Adams v Adams (On Reconsideration)*, 276 Mich App 704, 710-711; 742 NW2d 399 (2007) (holding that "the gravamen of an action is determined by reading the complaint as a whole, and by looking beyond mere procedural labels to determine the exact nature of the claim.").

[4] Second Amended Complaint, 38-41.

[5] Second Amended Complaint, 25.

[6] Second Amended Complaint, 20 and 26.

[7] Second Amended Complaint, 20(a); August 29, 2017 Letter from Van Essen to Huff, attached as Exhibit 4 to Second Amended Complaint.

[8] Second Amended Complaint, 20(a).

Coleman-Ax.[9] Subsequently, according to plaintiffs, defendants conspired with each other to "discredit" plaintiffs by "refusing to confirm with and acknowledge to" the "other CMH and LRE employees" who received a copy of Van Essen's letter to Huff that plaintiffs "were statutorily authorized to act as the 'authorized representative' for consumers, their guardians and/or providers of services to consumers with regard to Medicaid Fair Hearings."[10]

The above actions, according to plaintiffs, caused the "CMH and LRE employees who received the 8/29/17 correspondence to believe the plaintiffs were engaged in" the unauthorized practice of law,[11] and "repeatedly left the providers, the consumers and the consumers' guardians with the belief, misunderstanding and/or opinion Ms. Huff was engaging in unethical, if not illegal, activities in providing such advocacy services at Medicaid Fair Hearings."[12] Plaintiffs further allege that this resulted in Huff "being told by multiple consumers, their guardians and providers of services to those consumers that they cannot and will not engage Ms. Huff or PCAS to provide advocacy services in the context of Medicaid Fair Hearings because they are afraid of retaliation, in the form of reduced services to be provided to them, or in some cases the complete termination of services by CMHOC, the LRE or other LRE members such as Network 180 or Allegan County Community Mental Health."[13] Plaintiffs allege that this resulted in plaintiffs losing "tens of thousands of dollars in current and future business."[14]

Turning to plaintiffs' newly restated civil conspiracy claim, plaintiffs' allege that, based on the factual allegations above,

> All of the individual Defendants acted in concert with each other for the purpose of accomplishing a criminal or unlawful purpose, or to accomplish a lawful purpose by criminal or unlawful means, including depriving Ms. Huff and/or PCAS of their ability to serve as the 'authorized representatives' for consumers, and for consumers, their families and providers to be advised and/or to have their respective and collective civil rights protected . . . .[15]

Plaintiffs allege that defendants' conspiracy resulted in "substantial economic injury, loss of goodwill, harm to their business reputation, loss of esteem and standing in the community, and loss of business opportunities, as well as their attorney fees and costs" to plaintiffs.[16] Plaintiffs

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[9] Second Amended Complaint, 31.

[10] Second Amended Complaint, 20(b).

[11] Second Amended Complaint, 29(a), 33(a).

[12] Second Amended Complaint, 29(b), 33(b).

[13] Second Amended Complaint, 29(c), 33(c).

[14] Second Amended Complaint, 29(c).

[15] Second Amended Complaint, 39.

[16] Second Amended Complaint, 40.

also reiterate in the context of their civil conspiracy claim their allegations regarding defendants' alleged gross negligence.[17]

As will be shown *infra*, many of plaintiff's allegations are simply cacophonous. That is, plaintiffs use much ink and paper in referring to regulations and statutes that are simply irrelevant to their tort claims.

2. *Parties' Present Motions*

a. *Doyle's Summary Disposition Motion*

On July 13, 2018, Doyle filed her present motion for summary disposition pursuant to MCR 2.116(C)(8).[18] Specifically, Doyle argues that plaintiffs' allegations are insufficient to establish her liability because the allegations do not indicate that Doyle performed actions sufficient to support plaintiffs' tortious interference and conspiracy claims against her.[19]

On August 31, 2018, plaintiffs responded to Doyle's motion. Plaintiffs argue that Doyle's action of "publishing" to "other CMH and LRE employees" Van Essen's August 29, 2017 letter to Huff is sufficient to support plaintiffs' claims against Doyle.[20]

b. *Brown's Summary Disposition Motion*

On July 23, 2018, Brown filed his present motion for summary disposition under MCR 2.116(C)(7) and (C)(8).[21] Brown argues that, pursuant to MCL 691.1407, he has absolute governmental immunity as the "highest appointive executive official" of a "level[] of government."[22] Alternatively, Brown argues that general governmental immunity applicable to him as a government employee bars any liability in this case.[23] Finally, Brown argues that plaintiffs fail to allege any specific act on his part that would support plaintiffs' tortious interference and conspiracy claims against him.[24]

On August 31, 2018, plaintiffs responded to Brown's motion. Plaintiffs argue that Brown is not entitled to absolute governmental immunity because LRE is not a level of government.[25]

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[17] Second Amended Complaint, 41.

[18] Doyle's Renewed Motion for Summary Disposition, July 13, 2018.

[19] Doyle's Brief in Support of Motion for Summary Disposition, July 13, 2018, 4-5.

[20] Plaintiffs' Response to Doyle's Motion for Summary Disposition, August 31, 2018, 3-7.

[21] Brown's Motion for Summary Disposition, July 23, 2018.

[22] Brown's Brief in Support of Motion for Summary Disposition, July 23, 2018, 6-7.

[23] Brown's Brief, 7-11.

[24] Brown's Brief, 12-14.

[25] Plaintiffs' Response to Brown's Motion for Summary Disposition, August 31, 2018, 7-10.

Plaintiffs also argue that their allegations demonstrate that Brown acted in a grossly negligent manner or in a manner lacking good faith, such that his general immunity as a government employee was negated in this case.[26] Finally, plaintiffs' argue that their allegations regarding Brown's failure to contradict Van Essen's conclusions in his August 29, 2017 letter to Huff are sufficient to support their claims against Brown.[27]

c. Coleman-Ax's Summary Disposition Motion

On July 23, 2018, Coleman-Ax filed her present motion for summary disposition under MCR 2.116(C)(7) and (C)(8).[28] Coleman-Ax argues that general immunity applicable to her as a government employee bars any liability in this case.[29] Coleman-Ax also argues that plaintiffs fail to allege any specific act on her part that would support tortious interference and conspiracy claims against her.[30]

On August 31, 2018, plaintiffs responded to Coleman-Ax's motion. Plaintiffs argue that their allegations demonstrate that Coleman-Ax acted in a grossly negligent manner or in a manner lacking good faith, such that her general immunity as a government employee was negated in this case.[31] Plaintiffs also argue that their allegations regarding Coleman-Ax's failure to contradict Van Essen's conclusions in his August 29, 2017 letter to Huff are sufficient to support their claims against Coleman-Ax.[32]

Standard of Review

Summary disposition may be granted under MCR 2.116(C)(7) when a claim is barred "because of . . . immunity granted by law . . . ." "When considering a motion brought under MCR 2.116(C)(7), it is proper for this Court to review all the material submitted in support of, and in opposition to, the plaintiff's claim."[33] Further, "[i]n determining whether a party is entitled to judgment as a matter of law pursuant to MCR 2.116(C)(7), a court must accept as true a plaintiff's well-pleaded factual allegations, affidavits, or other documentary evidence and construe them in the plaintiff's favor."[34] "If no facts are in dispute, or if reasonable minds could

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[26] Plaintiffs' Response to Brown's Motion for Summary Disposition, 10-14.

[27] Plaintiffs' Response to Brown's Motion for Summary Disposition, 14-17.

[28] Coleman-Ax's Motion for Summary Disposition, July 23, 2018.

[29] Coleman-Ax's Brief in Support of Motion for Summary Disposition, July 23, 2018, 6-9.

[30] Coleman-Ax's Brief, 10-12.

[31] Plaintiffs' Response to Coleman-Ax's Motion for Summary Disposition, August 31, 2018, 7-12.

[32] Plaintiffs' Response to Coleman-Ax's Motion for Summary Disposition, 12-15.

[33] *Bronson Methodist Hosp v Allstate Ins Co*, 286 Mich App 219, 222; 779 NW2d 304 (2009).

[34] *Id.* at 222-223.

not differ regarding the legal effect of the facts, the question whether the claim is barred by governmental immunity is an issue of law."[35]

Summary disposition may be granted under MCR 2.116(C)(8) if "[t]he opposing party has failed to state a claim on which relief can be granted." A motion under MCR 2.116(C)(8) tests the legal sufficiency of the complaint solely on the basis of the pleadings.[36] "When deciding a motion under (C)(8), this Court accepts all well-pleaded factual allegations as true and construes them in the light most favorable to the nonmoving party."[37] "Summary disposition under subrule (C)(8) is appropriate when a claim is so clearly unenforceable as a matter of law that no factual development could establish the claim and justify recovery."[38]

Finally, "only factual allegations, not legal conclusions, are to be taken as true under MCR 2.116(C)(7) and (8)."[39]

Legal Analysis

1. Preliminary Legal Discussion

In plaintiffs' second amended complaint, they attach/reference a series of authorities they claim support their legal opinion that defendants are in violation of a number of federal, state and local rules and regulations; and, claim that the violation of these rules, regulations and various statutes impedes their business expectations.[40] Perhaps CMH and LRE are in violation of those statues, rules, and regulations perhaps they are not. However, in *none* of these authorities cited, do plaintiffs have standing to use those authorities to support their claims.[41]

Plaintiffs note 42 CFR 431.200 *et seq*. which establishes Federal rules that states must follow regarding Medicare and Medicaid hearings. Ignored by plaintiffs but important to the analysis of this case is that these Federal requirements *only* address agency conduct of Medicare and Medicaid issues and the process involved. 42 CFR 431.200 *et seq* does not provide for any private enforcement or independent cause of action against local governmental units or individual governmental employees for perceived violation of these regulations.

Plaintiffs also reference Mich Admin Code R 792.11008, a Michigan Administrative Hearing System (MAHS) administrative code rule regarding the rights of parties at hearings

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[35] *Pierce v Lansing*, 265 Mich App 174, 177; 694 NW2d 65 (2005).

[36] *Corley v Detroit Bd of Ed*, 470 Mich 274, 277; 681 NW2d 342 (2004).

[37] *Dalley v Dykema Gossett*, 287 Mich App 296, 304-305; 788 NW2d 679 (2010).

[38] *AFSCME Local 25 v Wayne Co*, 297 Mich App 489, 494; 824 NW2d 271 (2012) (citation and quotation omitted).

[39] *Davis v Detroit*, 269 Mich App 376, 379 n 1; 711 NW2d 462 (2005).

[40] See generally, Second Amended Complaint, 35.

[41] Plaintiffs are free to contact the appropriate authority and/or bring public awareness to potential administrative rule violations.

concerning Michigan Department of Health and Human Services (DHHS) rulings. These rules are obviously based upon the aforementioned Federal regulations and provide in relevant part that:

> A claimant or his or her authorized representative has the right to all the following:
>
> * * *
>
> (b) To present a case with the aid of an authorized representative. A local agency office or county agency office or a state agency division involved in a hearing has the right to be represented by legal counsel and other representatives, including the county director or division head, and staff or former staff members directly involved in the issue presented. The regional office staff shall be available to assist the claimant or authorized representative.
>
> (c) To be represented by legal counsel, or other person of choice, at the claimant's expense.

An " '[a]uthorized representative' means a person, other than an attorney, representing a party in a proceeding."[42]

Similar to the Federal regulation, Mich Admin Code R 792.11008 *only* applies "to administrative hearings conducted by the hearing system for the department of human services and the department of community health, pursuant to the social welfare act."[43] Again, these administrative rules do *not* provide the basis for private enforcement or an independent cause of action against an entity or its employees for a perceived violation of these regulations. Rather, any aggrieved person may *appeal* any adverse administrative decision to the circuit court.[44]

In their briefs, plaintiffs refer to MCL 330.1776 which allows individuals to file complaints with the local office any alleged violation of act or rules promulgated under the

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[42] Mich Admin Code, R 792.10103. See also 42 CFR 435.923(A)(1) (providing in relevant part that "[t]he agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency.").

[43] Mich Admin Code R 792.11001. See also Mich Admin Code R 792.10101, the general scope of *all* administrative hearings which states:

> (1) These rules govern practice and procedure in administrative hearings conducted by the Michigan administrative hearing system under Executive Reorganization Order No. 2005-1, MCL 445.2021, Executive Reorganization Order No. 2011-4, MCL 445.2030, and Executive Reorganization Order No. 2011-6, MCL 445.2032.
> (2) The rules in part 1 apply to all administrative hearings conducted by the hearing system, except hearings specifically exempted under MCL 445.2021, MCL 445.2030, and MCL 445.2032, and subject to prevailing practices and procedures established by state and federal statutes and the rules for specific types of hearings contained in parts 2, 3, and 5 to 19 of the rules.

[44] Mich Admin Code R 792.11017.

Mental Health Code. Any appeal of the local decision is an administrative matter to the department. Again, no private enforcement is permitted.[45]

Plaintiffs also present as attachments to their complaint a series of policies and procedures from LRE and CMH which permit "authorized representatives" in the context of state administrative hearings regarding Medicaid benefits. These policies and procedures follow and repeat the aforementioned federal and state regulations.

The upshot is that plaintiffs fail to present *any* authority which governs defendants' conduct towards plaintiffs *outside* of the administrative arena. In other words, the authorities cited by plaintiffs do not establish any duty owed by defendants to plaintiffs outside of the administrative arena.

Even during the administrative process, an authorized representative is only entitled to assist a claimant with respect to communications to an agency. Any violation of these rules is subject to administrative action or federal action.[46] Astonishingly, plaintiffs have not named one claimant for whom hearing rights were allegedly violated.

Moreover, even though one may be an "authorized representative" pursuant to regulation, that does not settle the question of whether plaintiffs could still be liable for the unauthorized practice of law pursuant to Michigan statutes. An "authorized representative" must actually be representing a party during the hearing process. An "authorized representative" is *not* defined as one who seeks to be, or holds themselves out to be an authorized representative. In other words, hoping that one will be an "authorized representative," does not make one an "authorized representative." Further, using that label outside of the administrative hearing process by a non-attorney for hire may very well be the unauthorized practice of law.

As discussed in this Court's June 19, 2018 opinion, the Michigan Legislature has barred the unauthorized practice of law in MCL 600.916(1) and MCL 450.681. In *Dressel v Ameribank,* 468 Mich 557, 566; 664 NW2d 151 (2003), the Michigan Supreme Court held that "a person engages in the practice of law when he counsels or assists another in matters that require the use of legal discretion and profound legal knowledge." And, while the Michigan legislature can create statutory exceptions to MCL 600.916(1) and MCL 450.681, see *State Bar of Mich v Galloway*, 422 Mich 188; 369 NW2d 839 (1985), the parties have not raised any Michigan statute that would expressly exempt a person acting as an "authorized representative" from liability for engaging in the unauthorized practice of law. An administrative rule or regulation may not contravene state statute.

2. Governmental Immunity - MCR 2.116(C)(7)

Both Brown and Coleman-Ax argue that general immunity applicable to them as government employees bars any liability in this case.[47] The Court agrees. In *Odom v Wayne Co*, 482 Mich 459, 479-480; 760 NW2d 217 (2008), the Michigan Supreme Court articulated a series

[45] MCL 330.1786.

[47] Brown's Brief, 7-11; Coleman-Ax's Brief, 6-9.

of "steps to follow when a defendant raises the affirmative defense of individual governmental immunity":

> (1) Determine whether the individual is a judge, a legislator, or the highest-ranking appointed executive official at any level of government who is entitled to absolute immunity under MCL 691.1407(5).
>
> (2) If the individual is a lower-ranking governmental employee or official, determine whether the plaintiff pleaded an intentional or a negligent tort.
>
> (3) If the plaintiff pleaded a negligent tort, proceed under MCL 691.1407(2) and determine if the individual caused an injury or damage while acting in the course of employment or service or on behalf of his governmental employer and whether:
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> (a) the individual was acting or reasonably believed that he was acting within the scope of his authority,
>
> (b) the governmental agency was engaged in the exercise or discharge of a governmental function, and
>
> (c) the individual's conduct amounted to gross negligence that was the proximate cause of the injury or damage.
>
> (4) If the plaintiff pleaded an intentional tort, determine whether the defendant established that he is entitled to individual governmental immunity under the *Ross*[48] test by showing the following:
>
> (a) The acts were undertaken during the course of employment and the employee was acting, or reasonably believed that he was acting, within the scope of his authority,
>
> (b) the acts were undertaken in good faith, or were not undertaken with malice, and
>
> (c) the acts were discretionary, as opposed to ministerial.

Both Brown and Coleman-Ax seek governmental immunity regarding plaintiffs' tortious interference and civil conspiracy claims against them. Plaintiffs' tortious interference with business relationships claim is an intentional tort,[49] as is plaintiffs' civil conspiracy claim because it is based on their separate tortious interference claim.[50] Accordingly, this Court proceeds to address the test in *Odom* regarding employee governmental immunity for intentional torts. Plaintiffs' claims of wrongdoing can be boiled down to the following three items:

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[48] *Ross v Consumers Power Co*, 420 Mich 567; 363 NW2d 641 (1984).

[49] See *Dalley*, 287 Mich App at 304.

[50] See *Urbain v Beierling*, 301 Mich App 114, 132; 835 NW2d 455 (2013).

1. Doyle "publish[ed]" Van Essen's August 29, 2017 letter to Huff to "other CMH and LRE employees,"[51] including Brown and Coleman-Ax.[52]

2. Defendants then "discredit[ed]" plaintiffs by "refusing to confirm with and acknowledge to" the "other CMH and LRE employees" that plaintiffs "were statutorily authorized to act as the 'authorized representative' for consumers, their guardians and/or providers of services to consumers with regard to Medicaid Fair Hearings."[53]

3. As a result, "CMH and LRE employees who received the 8/29/17 correspondence . . . believe[d] the Plaintiffs were engaged in" the unauthorized practice of law[54]; "providers, the consumers and the consumers' guardians [were left] with the belief, misunderstanding and/or opinion Ms. Huff was engaging in unethical, if not illegal, activities in providing such advocacy services at Medicaid Fair Hearings"[55]; and plaintiffs lost "tens of thousands of dollars in current and future business."[56]

Based on the summary above and the parties' own positions, it appears that there is no dispute that Doyle's, Brown's, and Coleman-Ax's actions were undertaken during the course of their employment, and that their actions were discretionary.[57] Thus, the only element at issue is the second, good-faith element.

"The good-faith element of the *Ross* test is subjective in nature. It protects a defendant's honest belief and good-faith conduct with the cloak of immunity while exposing to liability a defendant who acts with malicious intent."[58]

> [A] governmental employee does not act in good faith if the employee acts maliciously or with a wanton or reckless disregard of the rights of another. And willful and wanton misconduct is made out only if the conduct alleged shows an

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[51] Second Amended Complaint, 20(a).

[52] Second Amended Complaint, 31.

[53] Second Amended Complaint, 20(b).

[54] Second Amended Complaint, 29(a), 33(a).

[55] Second Amended Complaint, 29(b), 33(b).

[56] Second Amended Complaint, 29(c).

[57] "'Discretionary-decisional' acts are those which involve significant decision-making that entails personal deliberation, decision, and judgment. 'Ministerial-operational' acts involve the execution or implementation of a decision and entail only minor decision-making." *Oliver v Smith*, 290 Mich App 678, 689-690; 810 NW2d 57 (2010) (citation and quotation omitted).

[58] *Odom*, 482 Mich at 481-482.

> intent to harm or, if not that, such indifference to whether harm will result as to be the equivalent of a willingness that it does.[59]

The crux of plaintiffs' claims against defendants is that (1) plaintiffs were legally entitled to act as "authorized representatives"; (2) that Van Essen was wrong when he concluded that plaintiffs were engaged in the unauthorized practice of law in his August 29, 2017 letter to Huff; and (3) that defendants *knew* Van Essen's letter to Huff was incorrect, but still disseminated the letter (Doyle) or refused to correct the letter (all defendants).

Plaintiffs make a legal conclusion that plaintiffs were legally entitled to act as "authorized representatives" without any possible liability under Michigan's unauthorized practice of law statutes. And, again, "only factual allegations, not legal conclusions, are to be taken as true under MCR 2.116(C)(7) and (8)."[60]

During oral arguments regarding the first round of summary disposition motions, the parties informed this Court that, as of that time, the State Bar of Michigan was struggling with resolving the question of whether plaintiffs' actions as an "authorized representative" constituted the unauthorized practice of law. Additionally, as discussed above, based on the *factual* allegations and legal authority presented to this Court, there was in August 2017 and there remains today unresolved legal questions regarding plaintiffs' ability to act as "authorized representatives" without also exposing themselves to liability for the unauthorized practice of law. Arguably, any "advocacy" outside of the administrative hearing process by a non-lawyer is the practice of law regardless of the label placed on that advocate.

For this reason, when Van Essen sent his August 29, 2017 letter to Huff, he was merely expressing the legal opinion of Ottawa County in the context of his role as the county's corporation counsel. As is the case with all legal opinions regarding complex legal issues of first impression, Van Essen's legal opinion may prove to be correct or incorrect.

Additionally, when Doyle, as Executive Director of CMH, forwarded Van Essen's August 29, 2017 letter to Huff to "other CMH and LRE employees," she merely forwarded the legal opinion of the corporation counsel of the branch of government of which Doyle was an employee. While this Court hypothesizes that in certain circumstances malice might be inferred where a person *knowingly* forwards their attorney's false statement of *fact*, plaintiffs allege here that Doyle should be held liable for forwarding Van Essen's mere *legal opinion*. And, contrary to plaintiffs' allegations, there was no way for Doyle to *factually know* that Van Essen's legal opinion was incorrect.

Finally, when defendants had received/disseminated a copy of Van Essen's legal opinion, and they allegedly chose not express a contradictory opinion to co-workers, they merely chose not to express a lay legal opinion in opposition to a legal opinion proffered by Ottawa County's corporation counsel. Once again, there was no way for defendants to *factually know* for certain that Van Essen's legal opinion was incorrect. Plaintiffs, in addition of seeking to privately

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[59] *Radu v Herndon & Herndon Investigations, Inc*, 302 Mich App 363, 386; 838 NW2d 720 (2013) (citations and quotations omitted).

[60] *Davis*, 269 Mich App at 379 n 1.

enforce federal and state rules for which they have no standing to enforce, now seek to dictate to a local governmental official *what* information to disseminate to his/her employees. If Ms. Huff wishes to administer a local unit of government, she is free to apply for that position.

Therefore, defendants' alleged conduct in the face of being presented with Van Essen's legal opinion falls short of the malicious or wanton or reckless disregard of plaintiffs' rights necessary to indicate that defendants did not act in good faith.[61] Defendants are entitled to governmental immunity applicable to intentional torts articulated in *Odom*, 482 Mich at 479-480.

In reaching this conclusion, this Court recognizes that Doyle has not explicitly moved for summary disposition pursuant to MCR 2.116(C)(7). Regardless, MCR 2.116(I)(1) provides that "[i]f the pleadings show that a party is entitled to judgment as a matter of law, or if the affidavits or other proofs show that there is no genuine issue of material fact, the court shall render judgment without delay." "Under [MCR 2.116(I)(1)], a trial court has authority to grant summary disposition sua sponte, as long as one of the two conditions in the rule is satisfied."[62] Thus, this Court grants Doyle summary disposition on governmental immunity grounds pursuant to MCR 2.116(I)(1).

Having determined that defendants are entitled to qualified governmental immunity, the Court need not address Brown's argument that he is cloaked with absolute immunity.

3. Failure to State a Claim - MCR 2.116(C)(8)

a. Plaintiffs' Tortious Interference Claim

> The elements of tortious interference with a business relationship or expectancy are (1) the existence of a valid business relationship or expectancy that is not necessarily predicated on an enforceable contract, (2) knowledge of the relationship or expectancy on the part of the defendant interferer, (3) an intentional interference by the defendant inducing or causing a breach or termination of the relationship or expectancy, and (4) resulting damage to the party whose relationship or expectancy was disrupted.[63]

Additionally, "[o]ne who alleges tortious interference with a contractual or business relationship must allege the intentional doing of a per se wrongful act or the doing of a lawful act with malice and unjustified in law for the purpose of invading the contractual rights or business relationship of another."[64] "If the defendant's conduct was not wrongful per se, the plaintiff must

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[61] *Odom*, 482 Mich at 481-482; *Radu*, 302 Mich App at 386. Additionally, the alleged facts demonstrate that defendants did not act with negligence, let alone gross negligence. As alluded to earlier, some or perhaps most, of plaintiffs advocacy may be the unauthorized practice of law. In contrast, for defendants to blindly allow plaintiffs' claimed advocacy to go unchallenged may result in complicity in the unauthorized practice of law to the detriment of the client.

[62] *Al-Maliki v LaGrant*, 286 Mich App 483, 485; 781 NW2d 853 (2009).

[63] *Health Call of Detroit v Atrium Home & Health Care Services, Inc*, 268 Mich App 83, 90; 706 NW2d 843 (2005).

[64] *CMI International, Inc v Intermet International Corp*, 251 Mich App 125, 131; 649 NW2d 808 (2002) (citation and quotation omitted).

demonstrate specific, affirmative acts that corroborate the unlawful purpose of the interference."[65] Further, "[i]n order to succeed under a claim of tortious interference with a business relationship, the plaintiffs must allege that the interferer did something illegal, unethical or fraudulent."[66]

It has not been established that plaintiffs had or have a valid and lawful business expectation. The Court previously noted that the term "authorized representative" has no legal meaning outside of the administrative hearing process. Further, within the administrative process, that term only applies to persons who have actually been designated as an "authorized representative." It is difficult at best to conclude that a non-lawyer who publicly holds themselves out for hire as an "authorized representative" to give assistance in the legal arena is engaged in a valid business expectation. Rather, it appears that this is an illegal business—the unauthorized practice of law.

Further, the lawful scope and authority of a self-described "authorized representative" is an open legal question. It was impossible for defendants to know of any valid legal relationship claimed by plaintiffs when the validity of their sought relationships is subject to legal debate.

The only "action" Brown and Coleman-Ax allegedly did in this case was passively receiving Doyle's forward of Van Essen's August 29, 2017 letter to Huff. This falls far short of a "wrongful per se" act, and there are no "specific, affirmative acts" that would corroborate some unlawful purpose on Brown's and Coleman-Ax's part.[67]

Turning to plaintiffs' allegations against Doyle, plaintiffs do allege one "specific, affirmative act" against her: forwarding Van Essen's August 29, 2017 letter to Huff to "other CMH and LRE employees." However, that "specific, affirmative act" must also corroborate an unlawful purpose. As discussed above, Doyle merely forwarded the legal opinion of the corporation counsel of the branch of government of which Doyle was an employee, and, there was no way for Doyle to *factually know* that Van Essen's legal opinion was incorrect. Therefore, Doyle's act of forwarding Van Essen's legal opinion was not "wrongful per se" and does not corroborate any unlawful purpose on her part.[68]

Once again, defendants were not under any duty to refute Van Essen's legal opinion as his opinion may, in fact, be correct. Plaintiffs have not established that defendants have a duty to: ensure that plaintiffs' business is successful; support plaintiffs' business venture; to speak favorably about plaintiffs; or to communicate with plaintiffs.

Further, general allegations that unnamed consumers and providers developed an unfavorable opinion of plaintiffs is not actionable.

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[65] *Id.*

[66] *Dalley*, 287 Mich App at 324 (citation and quotation omitted).

[67] *CMI International, Inc*, 251 Mich App at 131.

[68] *Id.*

For the reasons above, defendants are entitled to summary disposition pursuant to MCR 2.116(C)(8) because the tortious interference claim against them is clearly unenforceable as a matter of law.[69]

b. Plaintiffs' Civil Conspiracy Claim

"A civil conspiracy is a combination of two or more persons, by some concerted action, to accomplish a criminal or unlawful purpose, or to accomplish a lawful purpose by criminal or unlawful means."[70]

Here, plaintiffs' civil conspiracy claim is based on an allegation that:

> All of the individual Defendants acted in concert with each other for the purpose of accomplishing a criminal or unlawful purpose, or to accomplish a lawful purpose by criminal or unlawful means, including depriving Ms. Huff and/or PCAS of their ability to serve as the 'authorized representatives' for consumers, and for consumers, their families and providers to be advised and/or to have their respective and collective civil rights protected . . . .[71]

Therefore, plaintiffs' civil conspiracy claim is wholly based on their allegations in support of their tortious interference claims. As discussed *supra*, defendants are all entitled to summary disposition pursuant to MCR 2.116(C)(8) regarding the tortious interference claim. And, because a civil conspiracy claim must be based on a separate, actionable tort for liability for conspiracy to attach to a defendant,[72] defendants are also entitled to summary disposition pursuant to MCR 2.116(C)(8) because the civil conspiracy claim against them is clearly unenforceable as a matter of law.[73]

4. Motion for Sanctions

Brown and Coleman-Ax moved for sanctions against plaintiffs and plaintiffs' attorney pursuant to MCL 600.2591, MCR 2.114(D)-(F), and MCR 2.625[74] because plaintiffs' second amended complaint is "devoid of factual and legal merit with regard to the claims asserted

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[69] *AFSCME Local 25*, 297 Mich App at 494.

[70] *Advocacy Org for Patients & Providers v Auto Club Ins Ass'n*, 257 Mich App 365, 384; 670 NW2d 569 (2003), quoting *Admiral Ins Co v Columbia Cas Ins Co*, 194 Mich App 300, 313; 486 NW2d 351 (1992).

[71] Second Amended Complaint, 39.

[72] *Urbain*, 301 Mich App at 132.

[73] *AFSCME Local 25*, 297 Mich App at 494.

[74] Brown and Coleman-Ax's Motion for Sanctions, July 23, 2018.

against Brown and Coleman-Ax."[75] Doyle also requests sanctions pursuant to MCR 2.114(D) and MCL 600.2591 because plaintiffs' second amended complaint is frivolous.[76]

MCR 2.114(C)(1) requires that "[e]very document of a party represented by an attorney shall be signed by at least one attorney of record." MCR 2.114(D) provides that:

> The signature of an attorney or party, whether or not the party is represented by an attorney, constitutes a certification by the signer that
>
> (1) he or she has read the document;
>
> (2) to the best of his or her knowledge, information, and belief formed after reasonable inquiry, the document is well grounded in fact and is warranted by existing law or a good-faith argument for the extension, modification, or reversal of existing law; and
>
> (3) the document is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.

MCR 2.114(E) provides that:

> If a document is signed in violation of this rule, the court, on the motion of a party or on its own initiative, shall impose upon the person who signed it, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the document, including reasonable attorney fees. The court may not assess punitive damages.

Accordingly, pursuant to MCR 2.114(D), "[a]n attorney has an affirmative duty to conduct a reasonable inquiry into the factual and legal viability of a pleading before it is signed."[77] Regarding what constitutes a "reasonable inquiry," "[t]he reasonableness of the inquiry is determined by an objective standard and depends on the particular facts and circumstances of the case."[78]

Further, MCR 2.114(F) provides that "[i]n addition to sanctions under this rule, a party pleading a frivolous claim or defense is subject to costs as provided in MCR 2.625(A)(2). The court may not assess punitive damages." MCR 2.625(A)(2) provides that "if the court finds on motion of a party that an action or defense was frivolous, costs shall be awarded as provided by MCL 600.2591." MCL 600.2591 provides:

> (1) Upon motion of any party, if a court finds that a civil action or defense to a civil action was frivolous, the court that conducts the civil action shall award

[75] Brown and Coleman-Ax's Brief in Support of Motion for Sanctions, 5.

[76] Doyle's Brief, 5.

[77] *LaRose Mkt, Inc v Sylvan Ctr, Inc*, 209 Mich App 201, 210; 530 NW2d 505 (1995).

[78] *Id.*

> to the prevailing party the costs and fees incurred by that party in connection with the civil action by assessing the costs and fees against the nonprevailing party and their attorney.
>
> (2) The amount of costs and fees awarded under this section shall include all reasonable costs actually incurred by the prevailing party and any costs allowed by law or by court rule, including court costs and reasonable attorney fees.
>
> (3) As used in this section:
>
> (a) "Frivolous" means that at least 1 of the following conditions is met:
>
> (*i*) The party's primary purpose in initiating the action or asserting the defense was to harass, embarrass, or injure the prevailing party.
>
> (*ii*) The party had no reasonable basis to believe that the facts underlying that party's legal position were in fact true.
>
> (*iii*) The party's legal position was devoid of arguable legal merit.
>
> (b) "Prevailing party" means a party who wins on the entire record.

"The determination whether a claim or defense is frivolous must be based on the circumstances at the time it was asserted. That the alleged facts are later discovered to be untrue does not invalidate a prior reasonable inquiry."[79] Also, "[t]he mere fact that plaintiffs did not ultimately prevail does not render" the action frivolous.[80] Rather, "a claim is devoid of arguable legal merit if it is not sufficiently grounded in law or fact, such as when it violates basic, longstanding, and unmistakably evident precedent."[81]

As explained *supra*, plaintiffs have not stated a cause of action. It is painfully obvious that plaintiffs simply have an axe to grind with defendants because of perceived affronts to their business. The Court finds that this second amended complaint is simply vindictive and was filed to harass defendants. It is basic, longstanding, and unmistakably evident precedent that plaintiffs could not rely on an alleged legal conclusion in attempting to state a claim that would survive a MCR 2.116(C)(7) or (C)(8) motion.[82]

In sum, each of the claims against defendants are frivolous because they are devoid of arguable legal merit, and because defendants "win[] on the entire record" as discussed above. Defendants are entitled to costs and reasonable attorney fees pursuant to MCL 600.2591.

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[79] *Jerico Constr, Inc v Quadrants, Inc*, 257 Mich App 22, 36; 666 NW2d 310 (2003) (citations omitted).

[80] *Kitchen v Kitchen*, 465 Mich 654, 662; 641 NW2d 245 (2002).

[81] *Adamo Demolition Co v Dep't of Treasury*, 303 Mich App 356, 369; 844 NW2d 143 (2013) (citations and quotations omitted).

[82] *Davis*, 269 Mich App at 379 n 1; see also *Lucas v Awaad*, 299 Mich App 345, 365; 830 NW2d 141 (2013); *Lansing Sch Ed Ass'n v Lansing Bd of Ed (On Remand)*, 293 Mich App 506, 519; 810 NW2d 95 (2011).

Pursuant to MCL 600.2591(1), these costs and reasonable attorney fees shall be assessed against plaintiffs as the "nonprevailing part[ies]" and against plaintiffs' attorney.

Regarding whether defendants are also entitled to costs and reasonable fees under MCR 2.114(E), this Court finds that plaintiffs' counsel did not make a reasonable inquiry into the factual and legal viability of the second amended complaint. At the center of plaintiffs' claims is their allegation that defendants *knew for a fact* that Van Essen's legal opinion in his August 29, 2017 letter to Huff was incorrect. But, as explained above, it would have been impossible for any individual (attorney or lay person) to know with *factual certainty* that any one legal position regarding plaintiffs' ability to serve as "authorized representatives" without exposure to liability for the unauthorized practice of law was legally correct. Plaintiffs have one position on this issue and Van Essen has another, but this issue has not been resolved by the courts of the State of Michigan. And, again, plaintiffs cannot compensate for this gaping hole in the middle of their arguments by simply alleging a favorable legal conclusion as a part of their second amended complaint.[83] Thus, based on an objective standard and on the particular facts and circumstances of the case, this Court finds that plaintiffs' counsel's inquiry into plaintiffs' claims prior to the filing of the second amended complaint was unreasonable.[84] Defendants are also entitled to costs and attorney fees pursuant to MCR 2.114(D) and (E) regarding plaintiffs' second amended complaint. Pursuant to MCR 2.114(E), these costs and reasonable attorney fees shall be assessed against plaintiffs ("a represented party") and plaintiffs' attorney ("the person who signed" the second amended complaint).

Conclusion

For the reasons stated above, plaintiffs' tortious interference (coupled with plaintiffs' "gross negligence" claim) and civil conspiracy claims against Doyle, Brown, and Coleman-Ax are barred by defendants' governmental immunity, and, therefore, Brown and Coleman-Ax are GRANTED summary disposition regarding those claims pursuant to MCR 2.116(C)(7) and Doyle is GRANTED summary disposition regarding those claims pursuant to MCR 2.116(I)(1). Doyle, Brown, and Coleman-Ax are also GRANTED summary disposition pursuant to MCR 2.116(C)(8) regarding plaintiffs' claims against them.

Additionally, defendants' respective motions for sanctions against plaintiffs and plaintiffs' attorney are GRANTED regarding plaintiffs' second amended complaint pursuant to MCR 2.114(D) and (E), and MCL 600.2591(1). In its initial Opinion, the Court made it clear that the initial complaint was entirely meritless. Instead of letting reason reign, plaintiffs have now submitted a *third* iteration of a meritless claim. This is precisely the situation for which the aforementioned statutes and court rules were created.

Finally, two clarifying notes. First, defendants are instructed to set a time for a hearing regarding the amount of costs and attorney fees generated by plaintiffs' second amended complaint under *Pirgu v United Services Auto Ass'n*, 499 Mich 269; 884 NW2d 257 (2016).

[83] *Davis*, 269 Mich App at 379 n 1.

[84] *LaRose Mkt, Inc*, 209 Mich App at 210.

The scheduling of this hearing must occur within 60 days. Defendants shall submit their billings and other proposed exhibits to plaintiff for review at least 21 days before the hearing is held. Plaintiffs shall submit any proposed exhibits to defendants at least 10 days prior to the hearing.

Second, while plaintiffs are ineligible to file a third amended complaint pursuant to MCR 2.116(I)(5) because this Court grants summary disposition to defendants based on governmental immunity under MCR 2.116(C)(7),[85] this Court would also not permit a third amended complaint even if it merely granted summary disposition under MCR 2.116(C)(8). "A court should freely grant the nonprevailing party [regarding a motion pursuant to MCR 2.116(C)(8), (9), or (10)] leave to amend the pleadings unless the amendment would be futile or otherwise unjustified."[86] Here, based on the extensive and meritless litigation regarding the original complaint and the second amended complaint, this Court concludes that any further amendment of the complaint would be futile.

IT IS SO ORDERED.

Dated: 10-2-2018

Hon. Jon H. Hulsing, Circuit Judge

[85] MCR 2.116(5) provides that "[i]f the grounds [for summary disposition] asserted are based on subrule (C)(8), (9), or (10), the court shall give the parties an opportunity to amend their pleadings as provided by MCR 2.118, unless the evidence then before the court shows that amendment would not be justified."

[86] *Boylan v Fifty Eight LLC*, 289 Mich App 709, 728; 808 NW2d 277 (2010).

Bullet #6

Sec. 113. A person employed by the department who is injured as a result of an assault by a recipient of mental health services shall receive his full wages by the department until workmen's compensation benefits begin and then shall receive in addition to workmen's compensation benefits a supplement from the department which together with the workmen's compensation benefits shall equal but not exceed the weekly net wage of the employee at the time of the injury. This supplement shall only apply while the person is on the department's payroll and is receiving workmen's compensation benefits and shall include an employee who is currently receiving workmen's compensation due to an injury covered by this section. Fringe benefits normally received by an employee shall be in effect during the time the employee receives the supplement provided by this section from the department.

History: Add. 1976, Act 414, Imd. Eff. Jan. 9, 1977.

* **330.1114 Rules.**

Sec. 114. (1) Subject to section 114a, as provided in section 9 of Act No. 380 of the Public Acts of 1965, being section 16.109 of the Michigan Compiled Laws, the director may promulgate rules as necessary to carry out the functions vested in the department.

- AKA: Admin Rules

(2) All modifications to rules that are needed to comply with the amendatory act that added this subsection shall be submitted to public hearing within 2 years after the effective date of that amendatory act.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

Administrative rules: R 330.1001 et seq. of the Michigan Administrative Code.

330.1114a Applicability of provisions requiring or permitting rule promulgation.

Sec. 114a. If the Michigan supreme court rules that sections 45 and 46 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.245 and 24.246 of the Michigan Compiled Laws, are unconstitutional, and a statute requiring legislative review of administrative rules is not enacted within 90 days after the Michigan supreme court ruling, any provision of this act that requires or permits the department to promulgate rules does not apply.

History: Add. 1995, Act 290, Eff. Mar. 28, 1996.

Compiler's note: In separate opinions, the Michigan Supreme Court held that Section 45(8), (9), (10), and (12) and the second sentence of Section 46(1) ("An agency shall not file a rule ... until at least 10 days after the date of the certificate of approval by the committee or after the legislature adopts a concurrent resolution approving the rule.") of the Administrative Procedures Act of 1969, in providing for the Legislature's reservation of authority to approve or disapprove rules proposed by executive branch agencies, did not comply with the enactment and presentment requirements of Const 1963, Art 4, and violated the separation of powers provision of Const 1963, Art 3, and, therefore, were unconstitutional. These specified portions were declared to be severable with the remaining portions remaining effective. Blank v Department of Corrections, 462 Mich 103 (2000).

Administrative rules: R 330.1001 et seq. of the Michigan Administrative Code.

330.1116 Powers and duties of department.

Sec. 116. (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. To this end, the department shall have the general powers and duties described in this section.

(2) The department shall do all of the following:

(a) Direct services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance. The department shall give priority to the following services:

(*i*) Services for individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability.

(*ii*) Services for individuals with serious mental illness, serious emotional disturbance, or developmental disability who are in urgent or emergency situations.

(b) Administer the provisions of chapter 2 so as to promote and maintain an adequate and appropriate system of community mental health services programs throughout the state. In the administration of chapter 2, it shall be the objective of the department to shift primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program whenever the community mental health services program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area.

(c) Engage in planning for the purpose of identifying, assessing, and enunciating the mental health needs of the state.

Bullet #7

DEPARTMENT OF COMMUNITY HEALTH

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

GENERAL RULES

(By authority conferred on the department of mental health by sections 1 to 4 of Act No. 80 of the Public Acts of 1905, as amended, section 33 of Act No. 306 of the Public Acts of 1969, as amended, and sections 114, 130, 136, 157, 206, 244, 498n, 498r, 842, 844, 908, and 1002a of Act No. 258 of the Public Acts of 1974, as amended, being sections 19.141 to 19.144, 24.233, 330.1114, 330.1130, 330.1136, 330.1206, 330.1244, 330.1498n, 330.1498r, 330.1842, 330.1844, 330.1908, and 330.2002a of the Michigan Compiled Laws)

R 330.1001 General definitions.

Rule 1001. As used in these rules, except as otherwise defined in a particular part or a subpart:

(1) "Act" means Act No. 258 of the Public Acts of 1974, as amended, being §330.1001 et seq. of the Michigan Compiled Laws.

(2) Terms defined in the act have the same meanings when used in these rules.

History: 1979 AC; 1981 AACS; 1983 AACS; 1986 AACS; 1998-2000 AACS.

R 330.1005 Gifts, grants, bequests, and donations; approval.

Rule 1005. (1) Gifts, grants, bequests, and donations with a value of more than $1,500.00 shall not be accepted by a department facility without approval by the director of the department.

(2) Gifts, grants, bequests, and donations accounts shall be composed of subaccounts which detail the specific purpose for which the gifts, grants, bequests, and donations were made. One of the subaccounts shall be a patient benefit fund.

(3) The patient benefit fund may be expended to improve the general welfare of all patients or a specific group of patients and, in special cases, may provide aid to indigent patients.

(4) A gift, grant, bequest, or donation shall not be accepted or expended which commits the state to complete or continue a program or project without authorization.

(5) All funds received shall be deposited with the state.

(6) An annual report shall be submitted to the department by department facilities identifying all gifts, grants, bequests, and donations.

History: 1979 AC; 1981 AACS; 1983 AACS.

R 330.1015 Research.

Rule 1015. Research initiated, conducted, or supported by the department, or engaged in by staff of department facilities, licensed or certified agencies, or agencies

with whom it has contracts, shall be subject to administrative rules, department policies and procedures, and shall follow federal guidelines.

History: 1979 AC.

R 330.1017 Equality in employment.

Rule 1017. An otherwise qualified person shall not be subject to discrimination by the department, its hospitals, centers, or contractual parties in employment or training on the basis of race, color, nationality, religious or political belief, sex, handicap, or age, unless a requirement of sex or age is based on a bona fide occupational qualification.

History: 1981 AACS.

SUBPART 2. COMMUNITY MENTAL HEALTH CENTERS

R 330.1021 Definitions.

Rule 1021. As used in this subpart:

(a) "Community mental health center" or "center" means either of the following:

(i) An organization of service which consists of 1 or more affiliated service entities, certified by the department, for the purpose of assuring a comprehensive range of mental health services to persons in a geographical area containing a population which meets federal requirements and funded under the community mental health centers act of 1963, 42 U.S.C. 2661 et seq., and the federal regulations issued thereunder.

(ii) An organization of services which consists of 1 or more affiliated service entities, certified by the department, for the purpose of assuring a comprehensive range of mental health services to persons within a service area, and which is designated by the department as a community mental health center.

(b) "Service element" means 1 of the mental health services listed in the federal regulations issued under Public Law 88-164, as amended.

The 5 essential elements are:

(1) inpatient services;

(2) outpatient services;

(3) partial hospitalization services, such as day care, night care, and weekend care;

(4) emergency services, 24 hours per day; and

(5) consultation and educational services to community agencies and professional personnel.

Five additional elements are:

(1) diagnostic services;

(2) rehabilitative services, including vocational and educational programs;

(3) pre-care and aftercare services in the community, including foster home placement, home visiting, and halfway houses;

(4) training; and

(5) research and evaluation.

(c) "Service entity" means an organization supplying 1 or more elements of mental health service as a part of a community mental health center.

History: 1979 AC.

R 330.1025 Designation of center; certification of service entity.

Rule 1025. (1) Only an organization composed of 1 or more service entities that is certified by the department may be designated as a community mental health center. A service entity that supplies 1 or more service elements of a community mental health center shall be certified by the department pursuant to section 130 of the act. A service entity that is intended to function as a part of a community mental health center shall file an application with the department on forms prescribed and furnished by the department for a certificate of approval for the service elements the entity intends to supply.

(2) Certification as a service entity shall be based on the following requirements:

(a) A service entity shall insure that the service elements it provides are organized and related to insure continuity of care and to permit recipients to move easily from 1 type of service to another as recipient needs change.

(b) A service entity shall assure all of the following in its policies and procedures and in its delivery of service:

(i) That a person is not denied service on the basis of race, color, nationality, religious or political belief, sex, age, handicap, county of residence, or ability to pay. This assurance shall be specified in program statements of the service entity and in all contractual agreements.

(ii) That a person is not denied service on the basis that the person does not meet a requirement for a minimum period of residence in a service area.

(iii) That inpatient psychiatric services are licensed by the department pursuant to sections 134 to 150 of the act and administrative rules promulgated thereunder.

(iv) That recipients have the rights guaranteed by the act and the rules promulgated thereunder.

(v) That personnel policy and procedures do not discriminate against employees or applicants for employment with respect to hiring, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment because of race, color, nationality, religious or political belief, sex, age, or handicap, unless a requirement of sex or age is based on a bona fide occupational qualification.

History: 1979 AC; 1981 AACS.

R 330.1028 Service entity; records.

Rule 1028. (1) A service entity shall maintain administrative records, including all of the following:

(a) Recipient contacts and referrals.

(b) Personnel policies and practices.

(c) Job descriptions.

(d) Personnel procedures.

(2) A service entity shall maintain case records for each recipient, including, where appropriate:

(a) Identification data and consent forms.

(b) Personal history.

(c) Evaluations and examinations.

(d) Individualized treatment plans.

(e) Termination summaries.

History: 1979 AC.

R 330.1031 Service entity; provisional certificate of approval.

Rule 1031. If a service entity does not meet requirements for certification for a service element which it offers, the department may issue a provisional certificate of approval for a period not to exceed 6 months, based on a judgment that the service element in question will comply with these requirements before the end of the period of provisional certification.

History: 1979 AC.

R 330.1034 Service entity; biannual certificate of approval.

Rule 1034. An eligible service entity shall be issued a certificate of approval biannually. A service entity shall be subject to inspection and reevaluation by the department at any time. A certificate of approval is not transferable. A service entity shall notify the department of a change in sponsorship or operation of the service entity or of any service element. Existing approval shall be void on the date of change, and the service entity shall apply for a new certificate of approval.

History: 1979 AC.

R 330.1037 Contracts or agreements between service entities and service elements.

Rule 1037. If service elements of a center are provided by more than 1 service entity, the relationship between the service entities and the service elements shall be by contract or formal written agreement, which shall make specific provision for assuring compliance with these rules. Copies of contracts and formal written agreements shall be included with applications for certification.

History: 1979 AC.

R 330.1041 Evidence of fire safety approval.

Rule 1041. When applying for certification and during inspections, a service entity shall submit evidence that the facilities of service elements are approved for fire safety by the state fire marshal or a local fire safety authority, whichever has primary jurisdiction.

History: 1979 AC.

R 330.1045 Service element; staff; policies and procedures; space and facilities.

Rule 1045. (1) A service element shall be staffed with qualified professional, nonprofessional, and supporting personnel.

(2) A service element shall have written policies and procedures which facilitate delivery of service as part of a comprehensive range of services, established and agreed to by the service element and the sponsoring service entity.

(3) A service element shall have space and facilities which meet the standards of the department.

History: 1979 AC.

R 330.1051 Center; location and accessibility of services.

Rule 1051. (1) Services of a center shall be conveniently located for the population of the defined service area. Factors such as density of population, geographic and chronological distances, and availability of public transportation shall be considered in the determination.

(2) A center shall be free of physical obstacles to recipients whose mobility is impaired by physical handicaps.

(3) A center shall offer services at times which are compatible with the schedules of its service population to enable recipients to receive services with a minimum of disruption to other essential aspects of their lives.

History: 1979 AC.

R 330.1053 Center; requirements generally.

Rule 1053. (1) A center shall identify all of the following:

(a) Service agency which delivers services.

(b) Recipients.

(c) The amount of service given to each recipient.

(d) The type of service and rationale for services offered, including indirect services.

(2) A center shall insure:

(a) That policies and procedures governing protection of stored recipient information are developed, maintained, and followed.

(b) That copies of signed release-of-information forms are included in the case records of recipients.

(c) That there is periodic review of client case records to determine whether they contain the required service documentation and release-of-information records.

History: 1979 AC.

R 330.1055 Center; fiscal management.

Rule 1055. A center shall insure efficient distribution of funds according to procedures which include uniform accounting and purchasing policies, unit cost analyses, annual audits, contracts, and a preliminary plan of expenditures, and shall be based on the following:

(a) Clear, up-to-date records of expenditures.

(b) A unit cost analysis of services performed not less than annually.

(c) Purchasing policies which require systematic approval by responsible agency staff of expenditure for supplies, equipment, and contracted services.

(d) Spending reports made available annually to the department.

History: 1979 AC.

R 330.1057 Management information system; program evaluation; staff evaluation.

Rule 1057. (1) A center shall have a management information system consistent with that of the department, and consistent with that of the local community mental health board when the board contracts with the centers, which provides sufficient information about the functioning of the center to help determine to what degree programs are meeting their goals, including mechanisms for collecting pertinent, accurate data; provisions for interpreting data in a form that is useful for decision makers; a means for communicating information to program managers; mechanisms for making program changes as needed; and mechanisms for refining program evaluation systems to improve usefulness, economy of effort, and accuracy.

(2) A center shall provide opportunities for users of the evaluation system to influence initial planning and ongoing refinement of the system.

(3) Information for program evaluation shall be based on data which is sufficiently current to facilitate program decisions.

(4) A center staff evaluation program shall provide periodic assessments of the degree to which each staff person is adequately performing the functions of his position. Assessments shall be clearly communicated to the evaluated staff person and program managers involved in staff placement and training.

History: 1979 AC.

R 330.1059 Center; duties.

Rule 1059. (1) A center shall adopt purpose and service definitions that are in harmony with the needs of the population of the defined service area, contractual agreements with funding sources, limitations of resources, and legal and other constraints.

(2) A center shall coordinate its services with other mental health services and pertinent human services to assure that needs of the center's recipients are met in a comprehensive manner without fragmentation or duplication. To accomplish this, a center shall:

(a) Participate in community and regional planning, including health systems agency planning.

(b) Establish continuity of care agreements between appropriate service entities and with appropriate agencies providing services to the population of the center's service area, including department facilities.

(c) Whenever possible, provide the mental health component of health services established in the service area by health maintenance organizations and community health centers.

History: 1979 AC.

Bullet #7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION

COMMUNITY HEALTH PROGRAMS

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, 45a(6), or 48 of 1969 PA 306. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

SUBPART 1. COMMUNITY MENTAL HEALTH SERVICES

R 330.2005 Minimum services to be provided.

Rule 2005. A community mental health board shall ensure that the following minimum types and scopes of mental health services are provided to all age groups directly by the board, by contract, or by formal agreement with public or private agencies or individuals contingent on legislative appropriation of matching funds for provision of these services:

(a) Emergency intervention services.
(b) Prevention services.
(c) Outpatient services.
(d) Aftercare services.
(e) Day program and activity services.
(f) Public information services.
(g) Inpatient services.
(h) Community/caregiver services.

History: 1979 AC; 1984 AACS; 1986 AACS.

R 330.2006 Emergency intervention services.

Rule 2006. (1) "Emergency intervention services" means those outpatient services provided to a person suffering from an acute problem of disturbed thought, behavior, mood, or social relationship which requires immediate intervention as defined by the client or the client's family or social unit.

(2) Emergency intervention services include all the following:

(a) A telephone that is answered 24 hours a day for dealing with mental health emergencies. The number for this telephone shall be advertised through the telephone book, public information efforts, and by notifying the appropriate agencies of the telephone number and the services provided.

(b) Provision for face-to-face services to persons in the areas of crisis evaluation, intervention, and disposition.

(c) A manual on emergency care protocols for use by the emergency services unit staff.

(3) The community mental health services provider shall assign mental health professionals or trained mental health workers for telephone and walk-in services.

(4) Emergency care includes all the following:

(a) Evaluation, which means arrangements for determining the client's mental status, medical status and need for treatment, and, when indicated, medication status and family, job, or housing situations.

(b) Intervention, which means face-to-face counseling and initiation and monitoring of medication when indicated.

(c) Disposition, which means the ability to provide or make referral for all the following:

(i) Hospital emergency department services.

(ii) Psychiatric inpatient services.

(iii) Specific community-based services, such as the following examples:

(A) Respite care placement.

(B) Outpatient care.

(C) Home visits.

(D) Aftercare.

(E) Day treatment/care.

(F) Drug or alcohol programming.

(G) Problem pregnancy help.

(H) Spouse and child abuse help.

(I) Children's services.

(J) Adolescent services.

(K) Geriatric services.

(L) Services for persons with intellectual and developmental disabilities.

(M) Social services.

(5) For the disposition of emergency intervention matters, the community mental health services provider shall provide all the following:

(a) Written referral procedures, available to the staff, for emergency care and voluntary and involuntary psychiatric hospitalization.

(b) Documented efforts to arrange for the transportation of the client, when necessary.

(c) A list of available dispositions within the community mental health area of service with special notations for those dispositions having 24-hour accessibility.

(6) In the administration of the emergency services, the community mental health services provider shall provide evidence of all of the following:

(a) Periodic testing with regard to the accessibility, availability, and effectiveness, of those emergency intervention services.

(b) Regular meetings of staff involved in emergency services to discuss administrative, supervisory, training, programmatic, and client management issues.

(c) Confidential records of all mental health emergency contacts, whether the contacts are by telephone or walk-in contact.

(d) Training or experience of the emergency intervention staff using such factors as professional credentials, licensure, descriptions of training experiences, in-service orientation, in-service education, and continuing education.

History: 1979 AC; 1983 AACS; 2018 AACS.

R 330.2007 Prevention services.

Rule 2007. (1) Prevention services are those services of the county program directed to at-risk populations and designed to reduce the incidence of behavioral, emotional, or cognitive dysfunction and the need for individuals to become mental health recipients of treatment services.

(2) Prevention services may be provided through individualized services, time-limited recipient training, or community/caregiver services.

(3) Prevention services shall include both of the following:

(a) Provision for responding to the mental health dimensions of community catastrophes.

(b) Attention to the needs of children living with severely mentally impaired adult recipients.

(4) Prevention services shall also include 1 of the following:

(a) Infant mental health services.

(b) Services to increase life-coping skills of children and adolescents.

(c) Services to increase life-coping skills of adults.

(d) Services to reduce the stressful impact of life crises.

History: 1979 AC; 1986 AACS.

R 330.2008 Outpatient services.

Rule 2008. (1) Outpatient services include all the following:

(a) Diagnostic and evaluation service.

(b) Referral service.

(c) Counseling service by arrangement at scheduled intervals and in nonscheduled visits at times of increased stress.

(d) Service to families of individuals in mental hospitals or residential facilities, as appropriate and as requested.

(e) Life consultation and planning for the persons with intellectual disabilities, and persons with developmental disabilities as defined in section 100a of the act.

(f) Treatment service to individuals in mental hospitals or residential facilities when appropriate with the consent of the individual and the hospital or facility staff person in charge of the individual's plan of service.

(2) The community mental health services provider outpatient services shall be made available at times of the day and week appropriate to meet the needs of the population served.

(3) Outpatient services shall be accessible to the population served.

(4) Provision for adequate and appropriate space to deliver services, including provision for privacy and the special needs of children, adolescents, and physically

handicapped persons shall be provided by the community mental health services provider.

History: 1979 AC; 2018 AACS.

R 330.2009 Aftercare services.

Rule 2009. (1) Aftercare services shall only be provided with prior consent of an individual over the age of 18, a parent if the individual is under 18, or a legally empowered guardian.

(2) These aftercare services shall include both of the following:

(a) Follow-up services to assist individuals released from a hospital or facility or who have received other services from a community mental health program.

(b) Mental health services for individuals placed in foster care, family care, or community placement in the service area, unless otherwise provided. Collaborative programming and planning for provision of services shall take place before the time of placement.

(3) Aftercare services shall be available to individuals located within the service area regardless of whether or not the individual was a resident of the county or counties of the service area prior to admission to a hospital or facility.

(4) A county may be billed for services rendered to its residents pursuant to section 306 of the act.

(5) Aftercare services shall be offered by a community mental health agency without a request for service by a released individual, when authorized by the individual, and upon notification from a hospital or facility.

History: 1979 AC.

R 330.2010 Day program and activity services.

Rule 2010. Day program and activity services shall include providing habilitative and rehabilitative treatment and training activity for mentally ill children, mentally ill adults, children with intellectual disabilities, adults with intellectual disabilities, and persons with a developmental disability requiring services similar to those provided persons with intellectual disabilities.

History: 1979 AC; 2018 AACS.

R 330.2011 Public information services.

Rule 2011. Public information services shall include all of the following:

(a) Coordinating with community agencies and individuals involved with the mental health and general health of the community to provide a unified mental health information service with the cooperation of the department information office.

(b) A program of increasing the visibility of community mental health services.

(c) Distribution and dissemination of relevant mental health information, including mental health trends and priority of mental health needs of the population served.

History: 1979 AC.

R 330.2012 Emergency services unit.

Rule 2012. (1) An emergency service unit, if established, shall be a component of a community mental health board emergency intervention services program. A mental health professional who has experience or training, or both, in crisis intervention shall be designated to be the person in charge of the emergency service unit.

(2) For client contacts that are made in protective custody situations pursuant to section 427 of the act, an emergency service unit shall include on-call staff who are able to go to the unit location or, if necessary, any other site agreed upon by the unit and the peace officer.

(3) The on-call staff of the unit shall be specially trained to evaluate persons who are involved in mental health emergencies. The training shall include all of the following:

(a) Contacting referral services.

(b) Involving the police to control the situation.

(c) Arranging for the transportation of the person by the police to an inpatient or emergency diagnostic facility, if appropriate.

(4) An emergency service unit shall document the training of the crisis intervention personnel. Documentation shall include the facts concerning professional credentials, licensure, descriptions of training experiences, in-service orientation, in-service education, and continuing education.

(5) For client contacts that are made in protective custody situations pursuant to section 427 of the act, the unit shall provide or arrange for follow-up contact with the client beginning not more than 10 days after referral, excluding Sundays and holidays, to ensure that the service to which the client was referred was delivered and that it met the client's needs. If contact with the client cannot be made, attempts to contact the client shall be documented. Follow-up contact may also be made with the agency to which the referral was made, with appropriate client consent.

(6) For client contacts which are made in protective custody situations and which result in a client's transfer to a state hospital or center, a receiving hospital or center shall disclose the following information to the emergency service unit within 24 hours of the transfer and shall document that disclosure. Unless consented to, or authorized by subsequent law, the information shall include only the following:

(a) Whether the person was admitted.

(b) If admitted, the anticipated length of stay.

(c) If not admitted, the facts concerning disposition of the client contact, if known.

(7) The community mental health board shall explain the operation of the emergency service unit to all law enforcement agencies having jurisdiction within the county or counties served by the unit and to other relevant agencies and persons. The

board shall encourage law enforcement officers to cooperate with and use the service and shall promote knowledge of the service by others. All agreements with law enforcement agencies shall be in writing.

(8) The community mental health board shall provide documentation to the appropriate regional office of the department that the emergency service unit is in compliance with this rule and R 330.2006 before emergency intervention services are provided by the unit to persons in protective custody.

History: 1981 AACS.

R 330.2013 "Inpatient services" defined.

Rule 2013. "Inpatient services" means care, diagnosis, and therapeutic services for mentally ill persons in a psychiatric hospital or unit which is licensed or operated by the department and for developmentally disabled persons in a center for developmental disabilities.

History: 1984 AACS.

R 330.2014 Community/caregiver services.

Rule 2014. (1) Community/caregiver services are those services of the county program provided to agencies and community groups on behalf of client groups and at-risk populations by means of any of the following:

(a) Consultation relating to agency organization, program delivery, effectiveness of staff, or mental health needs of at-risk and treatment populations.

(b) Education and training of staff.

(c) Collaboration in planning and service development.

(2) The purposes of community/caregiver services shall be the facilitation of non-mental health services for developmentally disabled and chronically mentally ill clients and the reduction of service demands on the county program.

History: 1986 AACS.

R 330.2022 Waiver of minimum services.

Rule 2022. (1) If a community mental health board cannot ensure minimum services to all age groups, the board shall request a waiver of type or scope of services, or both, from the director of the department. Emergency intervention services to all age groups shall not be waived. The board shall initiate a waived type or scope of service within 24 months after the date application for a waiver is approved, contingent upon the availability of funds. This may be accomplished with the cooperation of another board or boards. To the extent fiscally possible, the board shall make arrangements for referral of those residents needing a waived service and for follow-up and continuity of care services in order that residents of the service area may obtain minimum direct services during the waived period.

(2) An application for waiver of specific types or scopes of minimum services shall be included in the proposed program and budget request.

(3) An application for waiver shall include all of the following:

(a) The types or scopes of services to be waived.

(b) The justification for a waiver, in detail.

(c) A description of the services to be waived.

(d) A description of the manner in which waived services may be provided by the end of the waiver period, including plans and dates for their initiation.

(e) A description and plan as to how the residents of the service area may receive waived minimum services during the waiver period. Plans shall include arrangements for referral, follow-up, and continuity of care.

History: 1979 AC; 1986 AACS.

SUBPART 2. COMMUNITY MENTAL HEALTH BOARD REPORTS

R 330.2035 Community assessment report.

Rule 2035. (1) One year from the establishment of a community mental health board pursuant to the act and on dates specified by the department, a community mental health board, with the assistance of the department, shall prepare a written assessment of community needs, including all of the following:

(a) A description of the population served, including demographic information, geographic descriptions, economic data, and estimates of the types and extent of significant social and health problems.

(b) A description of the human service systems serving the population.

(c) Estimates of the types and extent of mental health-related problems, including social indicator data, characteristics of case loads of mental health-related agencies, and observations by service agencies.

(d) An assessment of existing services dealing with the estimated mental health-related programs, including an evaluation of the degree to which the services match the estimated problems.

(e) A projection of the type and amount of mental health services required to adequately serve the comprehensive mental health needs of the client population, including a description of the methods and data used to project need.

(2) The community mental health board shall annually review and update as needed the community assessment report and submit this information as part of the proposed annual plan and budget to accurately reflect the current needs of the community.

History: 1979 AC.

R 330.2038 Annual program plan and proposed budget.

Rule 2038. (1) A community mental health board shall prepare a written program plan and projected budget for continuing programs and proposed new programs for

each fiscal year, which shall be submitted to the department on the date designated by the department and shall include all of the following:

(a) A service needs assessment by client groups and a description of how existing and proposed mental health programs fit service need projections, including the priority of new programs and estimated dates of implementation.

(b) A narrative description of the types and scopes of services.

(c) Projected service output described in quantitative terms.

(d) Breakdowns of the projected costs according to forms and procedures made available by the department.

(e) A statement of intent on the degree of the management of public mental health services the board wishes to assume.

(f) Other documents and data required in department policies, procedures, and guidelines.

(g) Certifications of endorsement or approval by both of the following:

(i) The county board of commissioners.

(ii) The community mental health services board.

(2) Copies of proposed operational contracts and contract revisions between the community mental health board and independent subagencies which supply services or operate mental health facilities shall be available for audit inspection. Such contracts and contract revisions shall be consistent with departmental criteria for state financing of community mental health services.

History: 1979 AC; 1983 AACS; 1986 AACS.

R 330.2039 Program plan review and approval.

Rule 2039. (1) A program plan and budget proposed by a county community mental health board shall be reviewed by the department based on the standards contained in section 234 of the act.

(2) The department shall respond to the board as to the results of the review of the submitted plan.

(3) After receipt of the results of the department's review, the board and the department shall negotiate a contract which is consistent with the availability of appropriated funds to the department. The contract shall contain all of the following:

(a) An approved service summary and spending plan which constitutes the board's allocation.

(b) A listing of policies and procedures required by statute or rule or agreed upon by the parties which shall govern the obligations and responsibilities of the department and the board.

(c) The process for amending or terminating the service summary and spending plan or the procedural obligations and responsibilities of the parties.

(d) Other authority and responsibility of the board and the department.

History: 1986 AACS.

R 330.2041 Filing of documents.

Rule 2041. The community mental health services provider shall keep the following documents current and on file with the department:

(a) Copies of the original resolution of the county board of commissioners, and revisions, which establish a community mental health program and community mental health board under the act and promulgated rules under the act.

(b) Copies of operational contracts, contract revisions, and agreements between the community mental health board and agencies which supply services or operate mental health or facilities for intellectual or developmental disabilities.

History: 1979 AC; 2018 AACS.

R 330.2044 Department information.

Rule 2044. The department shall provide written information annually to community mental health boards regarding all of the following:

(a) Program planning and development priorities based on community program data, findings, and evaluations.

(b) The availability of funds for programs and services.

(c) Funding priorities, policies and criteria to be used for allocating funds.

(d) Instructions and forms for submitting program proposals.

(e) Cost guidelines to indicate acceptable levels of budgeted costs.

(f) Guidelines which will be the basis for approval or rejection of proposed programs.

History: 1979 AC.

SUBPART 3. DEPARTMENT REVIEW AND EVALUATION

R 330.2051 Determination of compliance.

Rule 2051. The department shall review and evaluate community mental health boards, including operations, programs, services, and facilities operated directly by the board and those providing services by contract with the board, receiving or requesting state aid. Determination of compliance with the act, administrative rules, standards, and procedures shall be made. When there is a finding of noncompliance or demonstrable deficiency in a program or operating practice, the department shall list and describe deficiencies and make recommendations to the community mental health board.

History: 1979 AC.

R 330.2052 Withdrawal or reallocation of state funds.

Rule 2052. (1) The department may withdraw state funds from a board for a program not being administered in accordance with an approved plan and budget after written notice and opportunity for response. The department shall review budgets

and expenditures at least quarterly, and if funds are not needed or were not used for a program for which they were allocated for the period budgeted, it may withdraw the unused funds, with concurrence of the board.

(2) The department may reallocate unused state funds to other community mental health programs. Unused state funds on hand locally at the close of the fiscal year shall be returned to the state.

(3) A county director or a board may request a review by the director of the department of any department action proposing to make final disapproval, withdrawal, or allocation of funds to a county program.

History: 1979 AC.

R 330.2055 Visits, examinations, and inspections by department.

Rule 2055. (1) Authorized representatives of the department may visit, examine, and inspect at any time a service or facility operating directly or providing services by contract under the act for purposes of review and evaluation.

(2) Authorized representatives of the department may examine at any time the financial records and accounts of a community mental health board receiving or requesting state aid, or the financial records or accounts of a service or facility operated directly or providing services by contract with a community mental health board.

(3) Authorized representatives of the department may examine and review at any time clinical case records of a community mental health program or subagency receiving or requesting state aid, or the clinical case records of an agency providing services by contract with the board, if the examination and review is necessary in order for the department to discharge its responsibility to review and evaluate the relevancy, quality, effectiveness, and efficiency of the county program pursuant to section 244(b)(i) and section 748(4)(e) of the act. The department shall not collect information that would make it possible to identify by name an individual who receives a service from a county program.

(4) A contract between a community mental health board and an entity or program providing services shall contain provisions of this rule.

History: 1979 AC.

R 330.2058 Programs ineligible for state financial support.

Rule 2058. Programs ineligible for state financial support shall include all of the following:

(a) Programs other than those directed at mental illness, intellectual disabilities, or developmental disabilities or concerned with the prevention of mental illness, intellectual disabilities, or developmental disabilities, if programs for the appraised and perceived needs of the community's mentally ill, intellectual disabilities, or developmentally disabled do not exist.

(b) Programs and services that directly or indirectly violate the act and the rules promulgated under the act.

(c) Programs that do not meet the needs of the community.

(d) Programs determined by the department as unnecessary or inappropriate to ensure reasonable use of state funds and ensure a legitimate interest of the state.

History: 1979 AC; 2018 AACS.

SUBPART 4. COMMUNITY MENTAL HEALTH BOARD

R 330.2063 Roster of board membership.

Rule 2063. The membership of a community mental health services board shall be appointed and maintained as prescribed in chapter 2 of the act and the department shall be provided a current roster of membership.

History: 1979 AC.

R 330.2067 Community mental health board responsibilities.

Rule 2067. A community mental health board shall do all of the following:

(a) Ensure that a person is not denied service on the basis of race, color, nationality, religious or political belief, sex, age, handicap, county of residence, or ability to pay. This policy shall be stated in the program statements of the community mental health board and in contractual agreements.

(b) Operate under personnel practices that do not discriminate against an employee or an applicant for employment with respect to hiring, tenure, terms, conditions or privileges of employment, or any matter which is directly or indirectly related to employment because of race, color, religion, national origin, age, handicap, or sex, except if a requirement of age or sex is based on a bona fide occupational qualification.

(c) Report to the department on the types and scopes of services directly operated by the board, on services provided by contract with the board, and on expenditures and receipts on forms prescribed and furnished by the department.

(d) Require agencies which provide services by contract or agreement with the board and which receive state aid to furnish the board with an accounting of fee revenue received from patients or from persons paying on behalf of patients.

(e) Coordinate the board's services with other pertinent human services to ensure that the total needs of the population of the service area are met in a comprehensive manner without fragmentation or duplication of services. To accomplish this, a board shall do all of the following:

(i) Participate in community and regional planning, including health systems planning.

(ii) Establish, or cause to be established, continuity of care agreements between appropriate service entities and with appropriate agencies which provide services to the population served by the boards, including department facilities.

(iii) If possible, provide the mental health component of health services established in the service area by health maintenance organizations and community health centers.

(iv) If possible, collaborate with existing agencies rather than establishing competing services.

(f) Assure, on an annual basis, that none of its board members is in violation of the conflict of interest prohibition of section 222 of the act.

(g) Assure that each employee is made aware of the provisions concerning conflict of interest and attests to the absence of conflict of interest, and assure that each prospective employee is made aware of these provisions and is not offered employment if there is a conflict of interest as identified in Act No. 317 of the Public Acts of 1968, as amended, being S15.321 et seq. of the Michigan Compiled Laws.

(h) Require each of its contracts to contain mutual representations that, to the best of the respective parties knowledge, the entering into of the contract is free of conflict of interest as identified in Act No.317 of the Public Acts of 1968, as amended, being S15.321 et seq. of the Michigan Compiled Laws, and section 222 of the act.

History: 1979 AC; 1981 AACS; 1986 AACS.

R 330.2071 Full management board.

Rule 2071. (1) The department shall annually designate those boards which have full financial responsibility for, and financial authority over, the public mental health services for the following:

(a) All persons located in a county served by such a board who are not residents of state-operated facilities.

(b) All persons who are residents of state-operated or state-contracted facilities for whom such a board is financially liable under section 302 of the act.

(2) The department shall issue, under R 330.2044, the criteria for designation of boards which have full public mental health management responsibility and authority.

(3) Any disagreement regarding financial authority and responsibility pursuant to this rule, between a county community mental health board and a state-operated or state-contracted facility, shall be reviewed and decided by the department director after consultation with the affected facility administrator and county community mental health program director.

(4) The department shall notify, at least annually, the governor, the legislature, and probate judges of those county community mental health boards which have full public mental health services management responsibility and authority.

History: 1986 AACS.

SUBPART 5. COMMUNITY MENTAL HEALTH DIRECTOR

R 330.2081 Education and experience of a county director.

Rule 2081. (1) The county director of a county community mental health program shall meet the education and experience requirements specified in either of the following provisions:

(a) Be a physician, psychologist, social worker, registered nurse, or other human services professional who has at least a master's degree, 3 years of professional experience in his or her field of training, and 1 year of experience in the administrative supervision of mental health programs.

(b) Be a person who possesses at least a master's degree in a field of management relevant to the administration of a county community mental health program with 3 years of professional experience in management and 1 year of experience in the management of human services programs. The areas of community mental health administration, hospital administration, public administration, institution management, business administration, or public health are deemed to be relevant fields of management. (2) Notwithstanding the requirements specified in subrule (1) of this rule, if a person is a county director on the effective date of this rule, that person shall be deemed to meet the minimum education and experience requirements to be the county director of that or any other county program.

(3) If a candidate does not meet the minimum education and experience qualifications and the board requests review of this matter, the candidate may be deemed qualified by the department director to be a county director if the candidate is found to have substantially met the education and experience requirements of this rule.

History: 1990 AACS.

SUBPART 6. CHILDREN'S DIAGNOSTIC AND TREATMENT SERVICE

R 330.2105 Definitions.

Rule 2105. As used in this subpart:

(a) "Certified program" means a range of service, as required by this subpart, for which application for certification has been voluntarily made and which has been certified by the department as a children's diagnostic and treatment service.

(b) "Child mental health professional" means any of the following:

(i) A person who is trained and has 1 year of experience in the examination, evaluation, and treatment of minors and their families and who is one of the following:

(A) A physician.

(B) A psychologist.

(C) A certified social worker or social worker.

(D) A registered professional nurse.

(ii) A person with at least a bachelor's degree in a mental health-related field from an accredited school who is trained, and has 3 years of supervised experience, in the examination, evaluation, and treatment of minors and their families.

(iii) A person with at least a master's degree in a mental health-related field from an accredited school who is trained, and has 1 year of experience, in the examination, evaluation, and treatment of minors and their families.

(c) "Emergency evaluation" means an immediate assessment by a child mental health professional who is available for a face-to-face contact for the purpose of

determining if a minor is emotionally disturbed, as defined in section 498b of the act, and requires immediate intervention because of any of the following situations:

(i) The minor is dangerous to himself or herself or others.

(ii) The minor will not allow for the provision of care to meet his or her basic needs.

(iii) The minor has experienced a severe emotional trauma which is identified by his or her parent or, when the parent or guardian cannot be immediately contacted, by a person having physical custody of the minor.

(d) "Emergency referral" means a referral for the purpose of having services provided immediately to a minor or the minor's family pursuant to R 330.2006.

(e) "Initial screening" means providing for either a face-to-face or telephone interaction concerning a minor in which a preliminary judgment is made regarding the need for mental health services for the minor and whether the minor's situation is one requiring nonemergency mental health services or emergency evaluation.

(f) "Intake evaluation" means social and psychological assessments which are appropriate in identifying the problems of the minor, together with a mental history and other assessments as necessary to ascertain the mental health needs of the minor.

(g) "Plan of service" means the written plan of service developed pursuant to R 330.7045 by a child mental health professional with participation of the minor's family, where applicable, and is based upon the assessment, recommendations, and, where necessary, consultations with other professionals.

(h) "Primary therapist" means a child mental health professional who is responsible for the direct treatment of a minor for the agency providing direct treatment services.

(i) "Referral" means facilitating access for the minor and the minor's family to the services of the certified program or to the services of another agency for the purpose of meeting the minor's needs.

History: 1990 AACS.

R 330.2110 Evaluation and screening.

Rule 2110. (1) A certified program shall have the capacity to provide an initial screening, emergency evaluation, and intake evaluation to ascertain the mental health needs of a minor.

(2) A mental health professional shall be available, by telephone consultation, to emergency service staff on a 24-hour basis to respond to potentially life-threatening or physically or emotionally damaging situations identified in an initial screening. An emergency evaluation shall be completed by a child mental health professional on the next regular working day from the day of an emergency referral.

(3) Intake evaluations may occur during multiple contacts with the minor and his or her family and shall be conducted by a child mental health professional. These evaluations shall form the basis for the plan of service.

(4) Intake evaluations for a nonemergency situation should be completed not more than 4 weeks from the date of the initial screening. If this time period cannot be met, the staff of a certified program shall document any reasons for further delay.

Nothing in this rule shall prevent a certified program from ranking requests for nonemergency services based on need for the service.

History: 1990 AACS.

R 330.2115 Referrals.

Rule 2115. (1) The community mental health board from which emergency or short-term mental health services are requested from a minor shall be responsible for providing appropriate mental health services. However, if the minor is located in the county, but is a resident of a county served by another community mental health board, then the certified program may refer the minor to the appropriate community mental health board once the minor's immediate needs for protection or security are met.

(2) Each certified program shall maintain a written list of resources it utilizes which indicates the types of services provided, eligibility criteria, and names and locations of the referral sources.

(3) A certified program shall have written arrangements with public and private human service agencies which provide educational, judicial, child welfare, and other health services. These arrangements shall clarify the respective responsibilities for the coordination and provision of services.

(4) A waiver by the department of the requirement of subrule (3) of this rule shall be granted when it is documented that the community mental health board does not have a contractual relationship with the child's human services agency due to that agency's failure to execute a proposed contract.

History: 1990 AACS.

R 330.2120 Range of services.

Rule 2120. (1) A certified program shall develop mechanisms for coordinating the delivery of a necessary range of services specifically oriented to meet the needs of minors and their families. The available range of services shall, at a minimum, include all of the following:

(a) Diagnostic services sufficient to develop a plan of service.

(b) Client case management by a child mental health professional who shall be responsible for the development, coordination, implementation, and monitoring of the plan of service. Client case management services shall assure that services are timely, appropriate, and updated in accordance with the minor's needs. Both the on-site review of the minor's progress and record documentation shall be conducted at least quarterly. The child mental health professional providing client case management shall attend interagency case conferences relating to the minor.

(c) Crisis stabilization and responses that reduce acute emotional disabilities and their physical and social manifestation in order to ensure the safety of the minor, his or her family, and others.

(d) Specialized mental health training and treatment, which shall include both of the following:

(i) A range of clinical therapies which can be provided to individuals, groups, and families.

(ii) Opportunities to learn, improve, and demonstrate specific skills that are appropriate to the child's needs, which may include problem-solving skills, communication skills, and acceptable social interaction.

(e) Out-of-home treatment, which includes both inpatient and community residential treatment.

(2) Mental health service locations shall be accessible through publicly available transportation, if any. A family that indicates an inability to transport a minor to the service locations shall be evaluated for other assistance in transportation as a part of the plan of service.

(3) In addition to traditional clinic locations, certified programs shall provide mental health services in the minor's home or other community settings, if appropriate.

(4) Services of a certified program shall be available in a barrier-free environment.

(5) The certified program shall provide mental health services to emotionally disturbed minors located within its service area who are any of the following:

(a) Hearing impaired.

(b) Visually impaired.

(c) Developmentally disabled.

(d) Chronically ill.

(e) Physically handicapped.

History: 1990 AACS.

R 330.2125 Staffing and training.

Rule 2125. (1) The certified program shall provide for the establishment of a formalized staff development program to assure professional development and training in identifying and treating the needs of minors and their families.

(2) Each full-time staff member in the certified program shall complete not less than 24 clock hours annually of formalized professional development and training.

(3) Staff shall receive training before performing initial screenings.

(4) For persons who are hired after the effective date of this rule, the certified program shall be clinically supervised by a child mental health professional who has at least a master's degree in a mental health-related field and 3 years of clinical experience working with minors and their families.

History: 1990 AACS.

R 330.2130 Administration.

Rule 2130. (1) The community mental health board shall have contracts with all individuals and agencies which provide services for each component of the certified program outside of the community mental health board. The contracts shall provide for coordinated program planning and continuity of service delivery and shall clearly identify the responsibilities of both parties.

(2) A certified program shall designate a child mental health professional to act as liaison with all out-of-home treatment facilities to which minors are referred for care.

(3) The community mental health board plan and budget shall delineate a separate and distinct part designated for the certified program.

(4) The community mental health board shall implement a public information program to facilitate community awareness of the certified program. The public information program shall provide all of the following information:

(a) The services that are available.

(b) Hours of operation.

(c) Location.

(d) Access to public transportation, if any.

(e) Telephone numbers. Services provided shall be pursuant to the provisions of R 330.2011 and R 330.2005(f).

(5) The board shall establish procedures for evaluating its certified program, on an annual basis, which shall include client and agency consumer evaluations of services of the certified program. The opportunity for client and consumer agency input shall be a part of this evaluation. The method and results of the evaluation shall be available for departmental review at the time of certification renewal.

(6) The agencies under contract to the community mental health board which comprise the certified program shall have the capacity to share confidential client information in order to provide for the coordination of services for a minor or for the transition of the minor from one agency to another.

(7) Information to be shared with agencies having cooperative agreements with the certified program shall be provided through appropriate releases of information.

History: 1990 AACS.

R 330.2135 Certification process.

Rule 2135. (1) A request for certification for a children's diagnostic and treatment services program may be made to the department at any time by 1 or more county programs. If county programs propose a combined children's diagnostic and treatment services program, the county programs shall specify the administrative structure in the request and indicate who speaks for the proposed combined program before certification.

(2) The department shall provide technical assistance to boards seeking certification.

(3) The community mental health board shall designate all agencies and services included in the certified program.

(4) A determination on initial or renewal certification by the department shall be completed within 6 months of a request for certification and submission of all necessary documentation or a program shall be considered certified. Certification shall occur when a determination of substantial compliance with the requirements of the act and this part has been made. If a program is certified despite instances of noncompliance with the requirements of the act and this part, the certification shall identify the items of noncompliance and the items shall be

corrected. The department shall require the county program to submit a plan to correct items of noncompliance before recertification or sooner if required by the department. If the correction of items of noncompliance is dependent on additional state or federal financial resources, recertification of a county program shall not be denied solely on that basis.

(5) Certification shall expire after 3 years. Renewal requests shall be submitted to the department 6 months before the certification expiration date.

(6) Certification is not transferable to another program or agency.

(7) The director of the department shall designate a person who is responsible for the process of certifying children's programs.

(8) An application for initial or renewal certification shall be on a form designated by the department. Before an on-site inspection or review is scheduled, all required information shall be completed and in the possession of the department. The department shall determine when an application is complete and shall notify the community mental health board of any additional information required to complete the application.

(9) By applying for or accepting certification, the community mental health board authorizes the department to conduct the reviews it deems necessary to determine compliance with these rules.

(10) The community mental health board shall promptly notify the department of any changes in the certified program.

(11) Reviews shall include at least both of the following:

(a) Inspections of the program to be certified and its operation.

(b) Inspection of program records, recipient clinical records, and other documents maintained by the program which may otherwise be privileged or confidential information.

(12) Certification may be denied, suspended, or revoked for 1 or more of the following reasons:

(a) Substantial violation by the certified program, its director, or staff of any rule relating to certification promulgated by the department.

(b) Conduct or practices found to be harmful to the welfare of a minor in the program or other family members.

(c) Substantial deviation by the program from the plan of operation originally certified by the department.

(d) Failure of an applicant to cooperate with the department in connection with a certification review.

(13) When it has been determined that a certified program or an applicant for a certified program has committed an act or engaged in conduct or practices which justify the denial, suspension, or revocation of certification, the departmental certifying person shall notify the community mental health board, by certified mail, of the department's intent to suspend, deny, or revoke the certification.

(14) The notice required by subrule (13) of this rule shall set forth the particular reasons for the proposed action and offer a hearing, if so requested by the county program, before the director of the department or his or her designee. The date of the hearing shall be not less than 30 days from the date of receipt of the request for a hearing.

(15) The decision of the director of the department shall be based on the hearing or on the default of the board. A copy of the decision shall be sent, by certified mail, to the community mental health board not less than 45 days after the close of the hearing.

(16) The revocation or suspension of a certificate shall become final when the determination of the director of the department is mailed, unless the community mental health board, within 60 days of the mailing or service of the decision, appeals the decision to a court and obtains a stay.

(17) A reapplication for certification subsequent to a revocation or suspension of a certificate may be made. The application shall be accompanied by a description for certification and will be followed by an interview with the certifying staff of the department before commencement of the formal certification review process.

(18) The certification shall expire on the date shown on its face, unless application has been made for renewal and application has not been denied or unless certification is terminated in accordance with these rules.

(19) Instead of denying reapplication for certification, the department may issue provisional certification to a community mental health board for up to 6 months when the community mental health board has submitted a plan of correction and it has been accepted by the department. A provisional certificate shall expire on the date set forth on its face. The holder of a provisional certificate shall be reinspected for compliance with these rules not less than 60 days before the expiration date of the provisional certificate. The department may extend a provisional certificate for a period of not more than 6 months. A provisional certificate which has not been extended or which has been extended 1 time shall expire automatically on its expiration date without notice or hearings.

History: 1990 AACS.

SUBPART 7. CERTIFICATION PROCESS

R 330.2701 Application process.

Rule 2701. (1) As a condition of state funding, a single overall certification is required for each community mental health services program.

(2) The certification process shall include a review of agencies or organizations that are under contract to provide mental health services on behalf of the mental health services program.

(3) The governing body of a community mental health services program shall request certification by submitting a completed application to the department. If the department is already in receipt of information required for application, then submission of that information may be waived by the department. The application shall be submitted in the format specified by the department and shall include all of the following information:

(a) The legal name of the community mental health services program.

(b) The address for legal notice and correspondence.

(c) The governing structure of the community mental health services program.

(d) The current annual budget, including all sources of revenue, of the community mental health services program.

(e) The organizational chart of the community mental health services program.

(f) The name of the executive director of the community mental health services program.

(g) A list of all contracts with other agencies or organizations that provide mental health services under the auspices of the community mental health services program.

(h) A description of the services provided by the community mental health services program, including any services provided by contract with another agency or organization.

(i) If applicable, documentation of the community mental health services program's accreditation, including accreditation of any contract agency or organization, by an accrediting body deemed acceptable by the department as specified in R 330.2702(2).

(4) Upon receipt of an application, the department shall determine if the application is complete. The department shall acknowledge receipt of an application. If an application is incomplete, the department shall notify the applicant within 30 days from date of receipt of any corrections or additions needed, may return the materials to the applicant, or both. An incomplete application shall not be regarded as an application for certification. Return of the application materials or failure to take further action to issue a certificate shall not constitute denial of an application for certification.

(5) After the department's acceptance of a complete application, the department shall determine whether the applicant meets certification standards. The certification process may include conducting an on-site review.

(6) Failure of the community mental health services program to comply with the requirements of the certification process shall be grounds for the department to deny, suspend, revoke, or refuse to renew a program's certification.

History: 1997 AACS.

R 330.2702 Deemed status.

Rule 2702. (1) The department will accept, in whole or in part, the accreditation of a national accrediting organization deemed acceptable by the department as documentation of the community mental health services program's equivalent compliance with certification standards.

(2) The department shall not grant deemed status for matters related to the safeguarding and protection of recipient rights.

(3) The community mental health services program shall request deemed status in writing and shall include all of the following documents:

(a) A copy of the official document indicating accreditation.

(b) A copy of the written survey report from the accrediting body.

(c) A copy of the program's response, if any, to the report from the accrediting body.

(4) The department may deem the community mental health services program to be in compliance with certification standards, in whole or in part, after reviewing the submitted documents.

History: 1997 AACS.

R 330.2703 Acceptance of licensure, certification, or other approval by governmental regulatory authority.

Rule 2703. The department may accept licensure, certification, or other regulatory approval by a government agency with regulatory jurisdiction in place of compliance with certification standards, or portions thereof, for any component of a community mental health services program.

History: 1997 AACS.

SUBPART 8. CERTIFICATION STANDARDS

R 330.2801 Compliance with certification standards.

Rule 2801. The department shall assess compliance with the following certification standards by determining the degree to which all of the following provisions apply:

(a) The organization has established processes, policies, and procedures necessary to achieve the required result.

(b) The established processes, policies, and procedures are properly implemented.

(c) The expected result of the processes, policies, and procedures is being achieved.

History: 1997 AACS.

R 330.2802 Governance.

Rule 2802. (1) The governing body of the community mental health services program shall ensure the development of program policy, ensure that quality services are delivered, and ensure accountability to the community.

(2) The governing body of the program shall appoint an executive director to be responsible for program performance.

(3) The community mental health board, as the overall governing body, shall be composed as described in the act.

(4) The governing body of the program shall delineate its structure, responsibilities, and operational practices.

(5) The governing body of the program shall orient new members to their duties and to program operations and services.

(6) The governing body of the program shall keep minutes of all its public meetings. The minutes shall provide a record of attendance, the issues covered, and the decisions made.

(7) The governing body of the program shall ensure that the concerns of the consumers and interested parties are considered in the program's decision-making process.

(8) A program shall assess community needs as outlined in section 226 of the act.

History: 1997 AACS.

R 330.2803 Mission statement.

Rule 2803. The governing body of the community mental health services program shall adopt a mission statement that shall be reviewed at least annually and revised when appropriate.

History: 1997 AACS.

R 330.2804 Community education.

Rule 2804. (1) A community mental health services program shall undertake activities to educate the general community regarding all of the following:

(a) Mental illness.

(b) Serious emotional disturbance.

(c) Developmental disabilities.

(d) Mental health.

(2) A program shall publicize the array of available mental health services and service eligibility criteria to the community.

History: 1997 AACS.

R 330.2805 Improvement of program quality.

Rule 2805. (1) A community mental health services program shall continuously evaluate and improve organizational processes and performance.

(2) A program shall continually solicit customer feedback on the quality of services and utilize this information to improve service delivery.

(3) A program shall compile, analyze, and use data on service outcomes to improve performance.

(4) A program shall promote consumer and family member participation in the design of programs and services.

(5) A program shall promote consumer and family member participation in the evaluation of programs and services.

History: 1997 AACS.

R 330.2806 Personnel and resource management.

Rule 2806. (1) A community mental health services program shall maintain job descriptions for all employees.

(2) Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all of the following:

(a) Educational background.

(b) Relevant work experience.

(c) Cultural competence.

(d) Certification, registration, and licensure as required by law.

(3) A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.

(4) A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

(5) A program shall have personnel policies which address all of the following areas:

(a) Working conditions.

(b) Wages and benefits.

(c) Hiring and promotion practices.

(d) Performance evaluation.

(e) Disciplinary and termination guidelines.

(f) Grievance procedures.

(g) Conflicts of interest.

(h) The use of volunteers and students.

(6) A program shall make its personnel policies available to staff in a handbook or other easily accessible medium.

(7) A program shall maintain personnel records for all staff. The personnel records shall contain all of the following documents:

(a) An employment application.

(b) An employee's current license, registration, and certification, as applicable.

(c) An employee's performance evaluations.

(8) A program shall maintain a volunteer file for all volunteers. The volunteer file shall contain the volunteer's current certification, registration, or license, if applicable.

History: 1997 AACS.

R 330.2807 Physical/therapeutic environment.

Rule 2807. (1) A community mental health services program's facilities and equipment shall be in compliance with all applicable zoning, safety, health, and building codes.

(2) A program shall establish preventive maintenance, sanitation, and safety systems.

(3) A program's services shall be physically accessible to all individuals.

(4) A program shall establish written emergency plans, which address all of the following areas:

(a) Natural disasters.

(b) Fires.

(c) Medical emergencies.

(d) Bomb threats.

(5) A program shall conduct, and document, training to familiarize personnel with evacuation plans on a regular basis.

(6) A program shall post safety and emergency rules and practices in conspicuous places.

(7) A program shall implement additional health and safety precautions as necessary to address individual needs.

(8) A program shall be in compliance with all MIOSHA requirements.

(9) A program shall establish policies that address the monitoring, identification, prevention, and control of infectious diseases.

(10) A program shall provide infection control training to staff.

History: 1997 AACS.

R 330.2808 Fiscal management.

Rule 2808. (1) The governing body of a community mental health services program shall plan and approve an annual operating budget for a program based on anticipated revenues and projected expenditures.

(2) The governing body of the community mental health services program shall establish procedures for interim modification of the annual operating budget.

(3) When applicable, a community mental health services program shall develop a capital expenditure plan, including detailed amortization schedules.

(4) An independent certified public accountant shall conduct an annual audit of the program's financial records and audit exceptions shall be corrected.

(5) A program shall establish policies and procedures for purchasing and competitive bidding.

(6) A program shall analyze per unit costs of services and establish appropriate service fees at least annually.

(7) A program shall comply with the ability to pay process as outlined in the act.

(8) When applicable, a program shall establish policies regarding the investment of funds.

(9) A program shall utilize generally accepted accounting principles and maintain detailed records of all revenues and expenses.

(10) A program shall restrict access to community mental health services program funds to appropriate personnel.

(11) A program shall control the disbursement of funds, the receipt of funds, and the use of credit.

(12) A program shall manage risk and reduce potential liability by purchasing insurance, pooling risk, or utilizing other appropriate mechanisms, or a combination of these methods.

(13) A program's contracts shall specify, in measurable terms, the obligations of the parties.

(14) A program shall monitor a contract agency's compliance with the provisions of the contractual agreement.

(15) A program shall maintain and control inventory.

History: 1997 AACS.

R 330.2809 Consumer information, education, and rights.

Rule 2809. (1) A program shall establish a system of rights protection as required by chapters 7 and 7A of the act.

(2) A program shall inform consumers about all of the following information at the time consumers apply for services:

(a) The type and nature of available services.

(b) The organization's procedures for the development of an individualized plan of service.

(c) Service rates, financial liability, financing arrangements, and related appeal procedures.

(d) The consumer's rights as specified in chapters 7 and 7A of the act.

(e) The consumer's right to request second opinions on hospitalization as specified in chapter 4 of the act.

History: 1997 AACS.

R 330.2810 Eligibility and initial screening.

Rule 2810. (1) A community mental health services program shall establish and utilize an initial screening process to determine all of the following:

(a) An individual's eligibility for services.

(b) An individual's need for services.

(c) An individual's need for additional assessment.

(2) Service priority and eligibility criteria shall be consistent with the act.

(3) A program shall establish one or more preadmission screening units in accordance with section 409 of the act.

History: 1997 AACS.

R 330.2811 Waiting lists; alternative services.

Rule 2811. (1) A community mental health services program shall establish and manage waiting lists in accordance with section 124 of the act.

(2) A program shall review waiting lists periodically to ensure consistency with the community mental health services program's established priorities and the priorities specified in the act.

(3) A program shall take action to reduce or eliminate waiting lists for services.

(4) A program shall recommend and refer individuals to alternative services when necessary to meet individual needs.

History: 1997 AACS.

R 330.2812 Array of services.

Rule 2812. A community mental health services program shall offer a full array of services as specified in chapter 2 of the act.

History: 1997 AACS.

R 330.2813 Medication; control.

Rule 2813. A community mental health services program shall control the storage, preparation, dispensation, and administration of medications.

History: 1997 AACS.

R 330.2814 Individual plan of service.

Rule 2814. A community mental health services program shall develop individual plans of service using a person-centered process in accordance with section 712 of the act and R 330.7199.

History: 1997 AACS.

Bullet #8

(7) In order to meet the requirement under subsection (1) related to the appointment of primary consumers and family members without terminating the appointment of a board member serving on March 28, 1996, the size of a board may exceed the size prescribed in section 212. A board that is different in size than that prescribed in section 212 shall be brought into compliance within 3 years after the appointment of the additional board members.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 2002, Act 596, Imd. Eff. Dec. 3, 2002;—Am. 2003, Act 278, Imd. Eff. Jan. 8, 2004.

330.1224 Board; terms of members; vacancy; removal from office; compensation; expenses.

Sec. 224. The term of office of a board member shall be 3 years from April 1 of the year of appointment, except that of the members first appointed, 4 shall be appointed for a term of 1 year, 4 for 2 years, and 4 for 3 years. A vacancy shall be filled for an unexpired term in the same manner as an original appointment. A board member may be removed from office by the appointing board of commissioners or, if the board member was appointed by the chief executive officer of a county or a city under section 216, by the chief executive officer who appointed the member for neglect of official duty or misconduct in office after being given a written statement of reasons and an opportunity to be heard on the removal. A board member shall be paid a per diem no larger than the highest per diem for members of other county advisory boards set by the county board of commissioners and be reimbursed for necessary travel expenses for each meeting attended. The mileage expense fixed by the county board of commissioners shall not exceed the mileage reimbursement as determined by the state officers compensation commission. A board member shall not receive more than 1 per diem payment per day regardless of the number of meetings scheduled by the board for that day.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1976, Act 348, Imd. Eff. Dec. 21, 1976;—Am. 1977, Act 88, Imd. Eff. Aug. 2, 1977;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1226 Board; powers and duties; appointment of executive director; reimbursement to program providing assisted outpatient treatment services.

Sec. 226. (1) The board of a community mental health services program shall do all of the following:

(a) Annually conduct a needs assessment to determine the mental health needs of the residents of the county or counties it represents and identify public and nonpublic services necessary to meet those needs. Information and data concerning the mental health needs of individuals with developmental disability, serious mental illness, and serious emotional disturbance shall be reported to the department in accordance with procedures and at a time established by the department, along with plans to meet identified needs. It is the responsibility of the community mental health services program to involve the public and private providers of mental health services located in the county or counties served by the community mental health program in this assessment and service identification process. The needs assessment shall include information gathered from all appropriate sources, including community mental health waiting list data and school districts providing special education services.

(b) Annually review and submit to the department a needs assessment report, annual plan, and request for new funds for the community mental health services program. The standard format and documentation of the needs assessment, annual plan, and request for new funds shall be specified by the department.

(c) In the case of a county community mental health agency, obtain approval of its needs assessment, annual plan and budget, and request for new funds from the board of commissioners of each participating county before submission of the plan to the department. In the case of a community mental health organization, provide a copy of its needs assessment, annual plan, request for new funds, and any other document specified in accordance with the terms and conditions of the organization's inter-local agreement to the board of commissioners of each county creating the organization. In the case of a community mental health authority, provide a copy of its needs assessment, annual plan, and request for new funds to the board of commissioners of each county creating the authority.

(d) Submit the needs assessment, annual plan, and request for new funds to the department by the date specified by the department. The submission constitutes the community mental health services program's official application for new state funds.

(e) Provide and advertise a public hearing on the needs assessment, annual plan, and request for new funds before providing them to the county board of commissioners.

(f) Submit to each board of commissioners for their approval an annual request for county funds to support the program. The request shall be in the form and at the time determined by the board or boards of commissioners.

(g) Annually approve the community mental health services program's operating budget for the year.

(h) Take those actions it considers necessary and appropriate to secure private, federal, and other public

funds to help support the community mental health services program.

(i) Approve and authorize all contracts for the provision of services.

(j) Review and evaluate the quality, effectiveness, and efficiency of services being provided by the community mental health services program. The board shall identify specific performance criteria and standards to be used in the review and evaluation. These shall be in writing and available for public inspection upon request.

(k) Subject to subsection (3), appoint an executive director of the community mental health services program who meets the standards of training and experience established by the department.

(*l*) Establish general policy guidelines within which the executive director shall execute the community mental health services program.

(m) Require the executive director to select a physician, a registered professional nurse with a specialty certification issued under section 17210 of the public health code, 1978 PA 368, MCL 333.17210, or a licensed psychologist to advise the executive director on treatment issues.

(2) A community mental health services program may do all of the following:

(a) Establish demonstration projects allowing the executive director to do 1 or both of the following:

(*i*) Issue a voucher to a recipient in accordance with the recipient's plan of services developed by the community mental health services program.

(*ii*) Provide funding for the purpose of establishing revolving loans to assist recipients of public mental health services to acquire or maintain affordable housing. Funding under this subparagraph shall only be provided through an agreement with a nonprofit fiduciary.

(b) Carry forward any surplus of revenue over expenditures under a capitated managed care system. Capitated payments under a managed care system are not subject to cost settlement provisions of section 236.

(c) Carry forward the operating margin up to 5% of the community mental health services program's state share of the operating budget for the fiscal years ending September 30, 2005, 2006, 2007, and 2008. As used in this subdivision, "operating margin" means the excess of state revenue over state expenditures for a single fiscal year exclusive of capitated payments under a managed care system. In the case of a community mental health authority, this carryforward is in addition to the reserve accounts described in section 205(4)(h).

(d) Pursue, develop, and establish partnerships with private individuals or organizations to provide mental health services.

(e) Share the costs or risks, or both, of managing and providing publicly funded mental health services with other community mental health services programs through participation in risk pooling arrangements, reinsurance agreements, and other joint or cooperative arrangements as permitted by law.

(3) In the case of a county community mental health agency, the initial appointment by the board of an individual as executive director is effective unless rejected by a 2/3 vote of the county board of commissioners within 15 calendar days.

(4) A community mental health services program that has provided assisted outpatient treatment services during a fiscal year may be eligible for reimbursement if an appropriation is made for assisted outpatient treatment services for that fiscal year. The reimbursement described in this subsection is in addition to any funds that the community mental health services program is otherwise eligible to receive for providing assisted outpatient treatment services.

History: 1974, Act 258, Eff. Aug. 6, 1975;—Am. 1986, Act 149, Imd. Eff. July 2, 1986;—Am. 1995, Act 290, Eff. Mar. 28, 1996;—Am. 1996, Act 588, Imd. Eff. Jan. 21, 1997;—Am. 1998, Act 417, Imd. Eff. Dec. 22, 1998;—Am. 2000, Act 273, Imd. Eff. July 7, 2000;—Am. 2002, Act 595, Imd. Eff. Oct. 17, 2002;—Am. 2004, Act 497, Eff. Mar. 30, 2005.

330.1226a Board; special fund account.

Sec. 226a. A community mental health services program board may create a special fund account to receive recipient fees and third-party reimbursements for services rendered. In the case of a county community mental health agency, approval of the board of commissioners of each participating county is necessary before creation of the special fund account. Receipts into the fund shall be recorded by source of payment and by type of service rendered, and a report regarding this information shall be submitted on a quarterly basis to the department. Money in the special fund account shall be used only for matching state funds or for the provision of community mental health services.

History: Add. 1980, Act 423, Eff. Mar. 31, 1981;—Am. 1984, Act 107, Imd. Eff. May 24, 1984;—Am. 1995, Act 290, Eff. Mar. 28, 1996.

330.1227 School-to-community transition services.

Sec. 227. Each community mental health services program shall participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional

department to deny, suspend, revoke, or refuse to renew a program's certification.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2702 Deemed status.

Rule 2702. (1) The department will accept, in whole or in part, the accreditation of a national accrediting organization deemed acceptable by the department as documentation of the community mental health services program's equivalent compliance with certification standards.

(2) The department shall not grant deemed status for matters related to the safeguarding and protection of recipient rights.

(3) The community mental health services program shall request deemed status in writing and shall include all of the following documents:

(a) A copy of the official document indicating accreditation.

(b) A copy of the written survey report from the accrediting body.

(c) A copy of the program's response, if any, to the report from the accrediting body.

(4) The department may deem the community mental health services program to be in compliance with certification standards, in whole or in part, after reviewing the submitted documents.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2703 Acceptance of licensure, certification, or other approval by governmental regulatory authority.

Rule 2703. The department may accept licensure, certification, or other regulatory approval by a government agency with regulatory jurisdiction in place of compliance with certification standards, or portions thereof, for any component of a community mental health services program.

History: 1997 MR 7, Eff. Aug. 12, 1997.

SUBPART 8. CERTIFICATION STANDARDS

R 330.2801 Compliance with certification standards.

Rule 2801. The department shall assess compliance with the following certification standards by determining the degree to which all of the following provisions apply:

(a) The organization has established processes, policies, and procedures necessary to achieve the required result.

(b) The established processes, policies, and procedures are properly implemented.

(c) The expected result of the processes, policies, and procedures is being achieved.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2802 Governance.

Rule 2802. (1) The governing body of the community mental health services program shall ensure the development of program policy, ensure that quality services are delivered, and ensure accountability to the community.

(2) The governing body of the program shall appoint an executive director to be responsible for program performance.

(3) The community mental health board, as the overall governing body, shall be composed as described in the act.

(4) The governing body of the program shall delineate its structure, responsibilities, and operational practices.

(5) The governing body of the program shall orient new members to their duties and to program operations and services.

(6) The governing body of the program shall keep minutes of all its public meetings. The minutes shall provide a record of attendance, the issues covered, and the decisions made.

(7) The governing body of the program shall ensure that the concerns of the consumers and interested parties are considered in the program's decision-making process.

(8) A program shall assess community needs as outlined in section 226 of the act.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2803 Mission statement.

Rule 2803. The governing body of the community mental health services program shall adopt a mission statement that shall be reviewed at least annually and revised when appropriate.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2804 Community education.

Rule 2804. (1) A community mental health services program shall undertake activities to educate the general community regarding all of the following:

(a) Mental illness.
(b) Serious emotional disturbance.
(c) Developmental disabilities.
(d) Mental health.

(2) A program shall publicize the array of available mental health services and service eligibility criteria to the community.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2805 Improvement of program quality.

Rule 2805. (1) A community mental health services program shall continuously evaluate and improve organizational processes and performance.

(2) A program shall continually solicit customer feedback on the quality of services and utilize this information to improve service delivery.

(3) A program shall compile, analyze, and use data on service outcomes to improve performance.

(4) A program shall promote consumer and family member participation in the design of programs and services.

(5) A program shall promote consumer and family member participation in the evaluation of programs and services.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2806 Personnel and resource management.

Rule 2806. (1) A community mental health services program shall maintain job descriptions for all employees.

(2) Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all of the following:

(a) Educational background.
(b) Relevant work experience.
(c) Cultural competence.
(d) Certification, registration, and licensure as required by law.

(3) A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.

(4) A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

(5) A program shall have personnel policies which address all of the following areas:

(a) Working conditions.
(b) Wages and benefits.
(c) Hiring and promotion practices.
(d) Performance evaluation.
(e) Disciplinary and termination guidelines.
(f) Grievance procedures.
(g) Conflicts of interest.
(h) The use of volunteers and students.

(6) A program shall make its personnel policies available to staff in a handbook or other easily accessible medium.

(7) A program shall maintain personnel records for all staff. The personnel records shall contain all of the following documents:

(a) An employment application.
(b) An employee's current license, registration, and certification, as applicable.

(c) An employee's performance evaluations.

(8) A program shall maintain a volunteer file for all volunteers. The volunteer file shall contain the volunteer's current certification, registration, or license, if applicable.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2807 Physical/therapeutic environment.

Rule 2807. (1) A community mental health services program's facilities and equipment shall be in compliance with all applicable zoning, safety, health, and building codes.

(2) A program shall establish preventive maintenance, sanitation, and safety systems.

(3) A program's services shall be physically accessible to all individuals.

(4) A program shall establish written emergency plans, which address all of the following areas:

(a) Natural disasters.

(b) Fires.

(c) Medical emergencies.

(d) Bomb threats.

(5) A program shall conduct, and document, training to familiarize personnel with evacuation plans on a regular basis.

(6) A program shall post safety and emergency rules and practices in conspicuous places.

(7) A program shall implement additional health and safety precautions as necessary to address individual needs.

(8) A program shall be in compliance with all MIOSHA requirements.

(9) A program shall establish policies that address the monitoring, identification, prevention, and control of infectious diseases.

(10) A program shall provide infection control training to staff.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2808 Fiscal management.

Rule 2808. (1) The governing body of a community mental health services program shall plan and approve an annual operating budget for a program based on anticipated revenues and projected expenditures.

(2) The governing body of the community mental health services program shall establish procedures for interim modification of the annual operating budget.

(3) When applicable, a community mental health services program shall develop a capital expenditure plan, including detailed amortization schedules.

(4) An independent certified public accountant shall conduct an annual audit of the program's financial records and audit exceptions shall be corrected.

(5) A program shall establish policies and procedures for purchasing and competitive bidding.

(6) A program shall analyze per unit costs of services and establish appropriate service fees at least annually.

(7) A program shall comply with the ability to pay process as outlined in the act.

(8) When applicable, a program shall establish policies regarding the investment of funds.

(9) A program shall utilize generally accepted accounting principles and maintain detailed records of all revenues and expenses.

(10) A program shall restrict access to community mental health services program funds to appropriate personnel.

(11) A program shall control the disbursement of funds, the receipt of funds, and the use of credit.

(12) A program shall manage risk and reduce potential liability by purchasing insurance, pooling risk, or utilizing other appropriate mechanisms, or a combination of these methods.

(13) A program's contracts shall specify, in measurable terms, the obligations of the parties.

(14) A program shall monitor a contract agency's compliance with the provisions of the contractual agreement.

(15) A program shall maintain and control inventory.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2809 Consumer information, education, and rights.
Rule 2809. (1) A program shall establish a system of rights protection as required by chapters 7 and 7A of the act.
(2) A program shall inform consumers about all of the following information at the time consumers apply for services:
(a) The type and nature of available services.
(b) The organization's procedures for the development of an individualized plan of service.
(c) Service rates, financial liability, financing arrangements, and related appeal procedures.
(d) The consumer's rights as specified in chapters 7 and 7A of the act.
(e) The consumer's right to request second opinions on hospitalization as specified in chapter 4 of the act.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2810 Eligibility and initial screening.
Rule 2810. (1) A community mental health services program shall establish and utilize an initial screening process to determine all of the following:
(a) An individual's eligibility for services.
(b) An individual's need for services.
(c) An individual's need for additional assessment.
(2) Service priority and eligibility criteria shall be consistent with the act.
(3) A program shall establish one or more preadmission screening units in accordance with section 409 of the act.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2811 Waiting lists; alternative services.
Rule 2811. (1) A community mental health services program shall establish and manage waiting lists in accordance with section 124 of the act.
(2) A program shall review waiting lists periodically to ensure consistency with the community mental health services program's established priorities and the priorities specified in the act.
(3) A program shall take action to reduce or eliminate waiting lists for services.
(4) A program shall recommend and refer individuals to alternative services when necessary to meet individual needs.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2812 Array of services.
Rule 2812. A community mental health services program shall offer a full array of services as specified in chapter 2 of the act.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2813 Medication; control.
Rule 2813. A community mental health services program shall control the storage, preparation, dispensation, and administration of medications.

History: 1997 MR 7, Eff. Aug. 12, 1997.

R 330.2814 Individual plan of service.
Rule 2814. A community mental health services program shall develop individual plans of service using a person-centered process in accordance with section 712 of the act and R 330.7199.

History: 1997 MR 7, Eff. Aug. 12, 1997.

Bullet # 10

(/)

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December 29, 1983

United States Court of Appeals for the Sixth Circuit

Campbell v. Patterson

Cite as: Campbell v. Patterson, 724 F.2d 41 (6th Cir. 1983) hide (#)

(AltLaw cannot guarantee this citation is correct — double check!)

724 F.2d 41

This case cites:

1982
- Wolfel v. Sanborn (/v1/cases/499001)

1981
- Johnson v. Granholm (/v1/cases/497728)

1980
- Gomez v. Toledo (/v1/cases/381029)

1978
- STUMP v. SPARKMAN (/v1/cases/393586)

1976
- Imbler v. Pachtman (/v1/cases/394415)

1967
- Ray v. United States (/v1/cases/393336)

(Only cases currently available in AltLaw are listed.)

Vito C. Peraino, argued, Cincinnati, Ohio, for plaintiff-appellant.

John F. Allen, argued, Troy, Mich., for defendants-appellees in No. 81-1116.

Frank J. Kelley, Atty. Gen. of Mich., Thomas L. Casey, Asst. Atty. Gen., argued, Lansing, Mich., for defendants-appellees in No. 81-1421.

Before JONES and KRUPANSKY, Circuit Judges, and PECK, Senior Circuit Judge.

PER CURIAM.

1

This is a consolidated appeal by Chester Wheeler Campbell (Campbell) from two separate decisions below which found that no violation of Campbell's civil rights were committed by the Michigan Attorney General, state prison officials and county prosecutors who cancelled Campbell's scheduled parole release for reasons later shown to be erroneous. The trial court in No. 81-1116 (hereinafter Patterson) granted summary judgment in favor of the Oakland County Prosecutor and two assistants concluding that they correctly applied Michigan law as to Campbell's eligibility for parole and so deprived Campbell of no rights. In No. 81-1421 (hereinafter Kelley), the court dismissed an action against the Attorney General and prison officials for reasons of immunity.

2

The salient facts of the matter are not disputed. Campbell was informed on January 22, 1980 that he was eligible for parole from the Southern Michigan Prison on February 1, 1980 as the result of "good time" and "special good time" credits. Campbell was then serving concurrent sentences for firearms and drug violations which sentences had been enhanced under Michigan's Habitual Offender Statute because Campbell had a previous felony conviction. M.C.L.A. Sec. 769.12.

3

In January of 1980, news of Campbell's impending parole was unofficially communicated to an assistant Oakland County prosecutor. The assistant, together with another assistant, discussed the parole as it related to M.C.L.A. Sec. 769.12(3) which states, in part, that habitual offenders may not be paroled "before the minimum term fixed by the sentencing judge," which term in Campbell's case, absent good time credits, would not expire until January 23, 1982. At the time of the assistant prosecutors' discussions, Michigan appellate authority existed which held that good time credits could not reduce the minimum term of habitual offenders. People ex rel. Oakland County Prosecuting Attorney v. Bureau of Pardons and Paroles, and Trudeau v. Oakland Circuit Judge, 78 Mich.App. 111, 259 N.W.2d 385 (1977).

4

Accordingly, the assistant prosecutors contacted both the prison officials and the Michigan Attorney General seeking information as to Campbell's status in light of the aforementioned precedent. The prison officials thereupon formally requested an opinion from the Attorney General, who responded in an opinion unfavorable to Campbell on the day before this scheduled release. This parole was cancelled and, in May, 1980, Campbell filed the actions presently at bar asserting that the various state officials here involved had conspired to deprive him of his right to a parole.

5

Initially, the suit against the prosecutor and his assistants was terminated by a grant of summary judgment in favor of the officials. As noted, the district court, in accepting a magistrate's report, found that Campbell was not entitled to credits in reduction of his minimum sentence as a matter of Michigan law and therefore the

prosecutors deprived Campbell of no right. However, subsequent to this decision, but prior to consideration of the suit against the Attorney General and the prison authorities, the Michigan Court of Appeals ruled that the prohibition of sentence reduction in cases of habitual offenders applied only to those offenders whose crime was committed subsequent to the date of the original appellate pronouncement in Trudeau, supra. Lamb v. Bureau of Pardons and Paroles, 106 Mich.App. 175, 307 N.W.2d 754 (1981). Thus, Campbell had been entitled to parole in February, 1981.

6

Subsequent to Lamb, the action against the Attorney General and the prison administrators came before the district court. In that proceeding, the trial judge acknowledged that the construction of Michigan law applied by the state officers to Campbell had been incorrect, but dismissed the suit because the Attorney General, and the prison authorities required to follow his official opinions of state law, were entitled to absolute immunity. The present appeals ensued.

7

Initially, it is settled that judicial immunity, which has historically protected judges acting in their official capacity, Pierson v. Ray, 386 U.S. 547, 87 S.Ct. 1213, 18 L.Ed.2d 288 (1967), also attaches to public officials who perform quasi-judicial duties. Johnson v. Granholm, 662 F.2d 449 (6th Cir.1981), cert. denied, 457 U.S. 1120, 102 S.Ct. 2933, 73 L.Ed.2d 1332 (1982). Moreover, this immunity is not forfeit if the action taken was erroneous, malicious or exceeded authority. Stump v. Sparkman, 435 U.S. 349, 98 S.Ct. 1099, 55 L.Ed.2d 331 (1978).

8

In Michigan, the Attorney General is obligated by statute to render opinions interpreting law at the request of state agencies or officials. M.C.L.A. Sec. 14.32. Moreover, such opinions are binding upon the state department or agent which requested them. See People v. Penn, 102 Mich.App. 731, 302 N.W.2d 298 (1981). Thus, the district judge correctly ascribed absolute immunity to the Attorney General and the prison officials in this case.

9

The immunity analysis, however, is not dispositive of the case involving the prosecutor and his assistants. While it is settled that prosecutors are entitled to absolute immunity when initiating and pursuing a criminal prosecution, Imbler v. Pachtman, 424 U.S. 409, 96 S.Ct. 984, 47 L.Ed.2d 128 (1976), it is also clear that prosecutorial functions not "intimately associated with the judicial phase of the criminal process," 424 U.S. at 430, 96 S.Ct. at 995, obviate the supporting rationale for absolute immunity in favor of qualified good-faith immunity. Id. at 431, n. 33, 96 S.Ct. at 995, n. 33. Inasmuch as qualified good-faith immunity is an affirmative defense which must be asserted below, Gomez v. Toledo, 446 U.S. 635, 640, 100 S.Ct. 1920, 1923, 64 L.Ed.2d 572 (1980), and inasmuch as the matter involving the prosecutors was summarily resolved upon grounds, later shown to be erroneous, which made unnecessary a defense of immunity, it is appropriate to remand Patterson to the district court for reconsideration of the motion for summary judgment. See Wolfel v. Sanborn, 691 F.2d 270 (6th Cir.1982), cert. denied, --- U.S. ----, 103 S.Ct. 751, 74 L.Ed.2d 969 (1983).

10

Accordingly, the decision of the district court in No. 81-1421 is hereby AFFIRMED, and No. 81-1116 is REMANDED to the district court for further proceedings consistent with this opinion.

This case is cited by:

1987

- **Sparks v. Character and Fitness Comm. of Kentucky (/v1/cases/499556)**

1986

- **Unpublished Disposition NOTICE: Sixth Circuit Rule ... (/v1/cases/992239)**
- **Joseph v. Patterson (/v1/cases/501403)**

1985

- **Mills v. Killebrew (/v1/cases/499682)**

(Only cases currently available in AltLaw are listed.)

Plain English

Plain English in the Department of Attorney General

by Assistant Attorneys General

As the state's largest public law firm, the Michigan Department of Attorney General provides its governmental clients a full range of legal services. Assistant attorneys general serve as prosecutors in criminal cases, as trial counsel in complex civil litigation, as appellate advocates in state and federal appellate tribunals, and as general counsel to the state's departments and agencies. Each of these responsibilities requires clear and concise legal writing. Plain English is especially important to the Department of Attorney General because so much of its work involves the public interest. The Department's legal writing is read as often by interested lay persons as it is by judges and lawyers.

Attorney General Jennifer M. Granholm is committed to quality legal writing. In November 1999, Ms. Granholm underscored her commitment by sponsoring an all-day, advanced legal writing seminar patterned after programs presented to state and federal judges for assistant attorneys general. This renewed emphasis on quality writing is supported by well-established departmental procedures intended to assure that legal papers prepared by assistant attorneys general are well-written and worthy of the important issues they address. This article offers an overview of these procedures, focusing on plain English in the opinion process, in civil and criminal litigation, and in appellate writing.

PLAIN ENGLISH IN THE OPINION PROCESS

The extensive opinion-writing process, by its nature, promotes plain English. By statute,[1] the Attorney General is required to give her opinion on questions of law submitted by the Legislature, Governor, Auditor General, Treasurer, or any other state officer.[2] Michigan's Supreme Court has recognized that one of the "primary missions" of the Attorney General is to give legal advice to members of the Legislature and to departments and agencies of state government. Opinions of the Attorney General are binding on state agencies and state officers.[3] While not precedentially binding on the judiciary, opinions of the Attorney General constitute "persuasive authority" on legal issues.[4]

Upon receipt, all opinion requests are referred to the Assistant Attorney General for Law, Theodore E. Hughes. Opinion requests are initially evaluated to determine whether to grant the request. Typical reasons for declining a request are that the requester lacks standing (e.g., is not a person named in the statute cited at n 1), or that the question:

- seeks an interpretation of proposed legislation that may never become law
- is currently pending before a tribunal
- involves the operation of the judicial branch of government or a local unit of government
- seeks legal advice for or involves disputes between private persons or entities

If the request is granted, it is then determined whether the response should be classified as a formal opinion, letter opinion, or informational letter. Formal opinions address questions significant to the state's jurisprudence that warrant publication. Letter opinions involve questions that should be addressed by the Attorney General, but that are of limited impact and do not warrant publication. Informational letters address questions that have relatively clear, well-established answers. Copies of all pending requests are provided to the Governor's Legal Counsel, thereby affording the opportunity for input.

If an opinion request is granted, it is assigned to an assistant attorney general having a recognized expertise in the relevant area of the law. This attorney is expected to prepare a thoroughly researched and well-written draft. Mr. Hughes edits the draft to assure it is both legally sound and well-written. The draft may be circulated to other Department lawyers for

substantive review.

All informational letters, and most letter opinions, are submitted directly to the Deputy Attorney General, William J. Richards, for review and approval. If the draft does not require further editing, it is submitted to Attorney General Granholm or, in the case of informational letters, the draft is signed and issued by Deputy Attorney General Richards. Drafts of all formal opinions and some letter opinions are first submitted for consideration and approval by the Attorney General's Opinion Review Board (ORB).

The ORB, which meets weekly to review draft opinions, consists of seven senior attorneys general. The ORB assures that draft opinions are both legally accurate and well-written. In considering a draft, the ORB has several options, including receiving input from the drafter as well as from persons outside the Department, revising the draft, directing that revisions be made by others, and requesting that a counter draft be submitted by either the original drafter or by another person.

Upon final ORB approval, draft opinions are submitted to Deputy Attorney General Richards for review and, if approved, to Attorney General Granholm for her approval and signature. As part of their review, the Deputy Attorney General and the Attorney General approve the draft opinion as is, make editing changes or, in rare instances, make significant revisions.

Upon issuance, formal opinions are published and indexed in the Biennial Report of the Attorney General. Formal opinions issued since January 1, 1997, are available on the Attorney General's website: www.ag.state.mi.us Formal opinions issues since 1977 can be found on both Westlaw and Lexis. Formal and letter opinions are available on request from the Department's opinions librarian. The Department is currently in the process of placing on its website all formal and letter opinions issued since 1962.

PLAIN ENGLISH IN LITIGATION PAPERS

Under Michigan law, the office of Attorney General is recognized as having plenary authority to prosecute and defend all actions in which the state may have an interest and to "intervene in and appear for the people of the state...in any...court or tribunal, in any cause or matter, civil or criminal, in which the people of the state may be a party or interested."[5] This sweeping authority includes the right to intervene "at any stage of the proceeding."[6]

Besides the broad grant of authority to intervene in any litigation of interest to the people of the state in any court, the Attorney General has a multitude of specific statutory duties outside the scope of this article. These duties include not only the obvious, such as the representation of state officers[7] and state agencies,[8] but the esoteric, such as a civil action to recover illegally expended public moneys[9] or to seek an accounting of the assets of any charitable trust.[10] The comprehensive authority of the Attorney General makes writing in plain English a lofty but necessary goal.

Commensurate with its statutory and common law duties, the office handles a vast array of litigation. At any given time, the Attorney General staff represents state agencies and employees in approximately 12,000 lawsuits. Of these, approximately 5,000 are requests for restoration of driver's licenses[11] and approximately 2,300 are prisoner complaints against the Michigan Department of Corrections.[12]

While the Department is defending these cases, it is also representing the state and its departments in approximately 17,000 additional cases filed by the Attorney General. Of these cases, more than half are petitions filed in the Family Division of Wayne County Circuit Court seeking termination of parental rights or other action to protect the interests of Wayne County children. The Attorney General brings approximately 2,000 collection actions[13] and approximately 2,000 unemployment claims per year.[14] The remaining 4,000 civil actions cover every subject from agriculture to worker's compensation. Altogether, the Attorney General carries a litigation caseload of about 29,000 cases, in addition to 4,000 administrative matters.

In most instances, the lower court pleadings in departmental litigation (*e.g.*, answers, motions, discovery papers, *etc.*) are handled by division-level assistant attorneys general, who are expected to file clear and concise legal papers. Some dispositive motions in major cases, and all potential civil and criminal complaints, are submitted to the Attorney General's Litigation Coordinator, Michael C. McDaniel, for review and approval before filing.[15] The review and approval process assures that legal documents filed on behalf of the state are well-written, straightforward, and clearly express the state's legal position. The Litigation Coordinator also reviews the document to assure that all allegations are stated without rancor, and that the legal position is supportable and consistent with the policies of the Attorney General and with past

positions taken on similar issues.

PLAIN ENGLISH IN STATE APPEALS AND OTHER MISCELLANEOUS DOCUMENTS

The Attorney General represents the state in state and federal appellate courts, including the Michigan Supreme Court and the U.S. Supreme Court. The Department's Appellate Division, headed by Solicitor General Thomas L. Casey, coordinates the Department's appellate activities.[16] In most appeals, briefs are initially prepared by the assistant attorney general who handled the matter in the trial court or before the state agency.

Before filing, briefs are reviewed by the assistant in charge of the division involved in the appeal and then by an experienced lawyer in the Appellate Division. In cases of major significance, draft appellate briefs are also reviewed by the Deputy Attorney General or the Attorney General. Each level of review assures that the Department's appeal papers are thoroughly researched and well-written in plain English. Like other litigation papers, appellate briefs are reviewed to assure that they clearly express the state's legal position and that the arguments are consistent with departmental policy and with past briefs filed on similar issues.

In addition to opinions, litigation papers, and appellate briefs, assistant attorneys general perform a wide variety of daily assignments requiring an application of plain English principles. Each day, the Department's lawyers prepare memoranda of advice, complex transactional documents such as contracts, leases, or bond documents, and correspondence to lawyers, governmental officials, and members of the public. The Department encourages its attorneys to use plain English in these and all legal papers. Further, communication skills, including clear, concise legal writing, are an important element in the Department's annual performance review of each assistant attorney general.

Individual employees of the Department have likewise embraced the Attorney General's emphasis on plain English. Two assistant attorneys general serve on the Plain English Committee. Recently, Assistant Attorney General Matthew H. Rick, of the Department's State Affairs Division, developed a new plain English "proof of mailing" form for use by the Department. The new form eliminates arcane legalistic phrases such as "being first duly sworn," "deposes and says," and "plainly addressed" in favor of plain English, stating the date the notice was sent, how it was sent, and to whom it was sent. The form has been added to the Department's file server and is now available, through a simple mouse click, to all Department personnel.

Attorney General Granholm's commitment to quality legal writing has not gone unnoticed by the Plain English Committee. In 1999, the committee presented the Department with clarity awards citing a formal opinion; a motion for summary disposition; administrative rules adopted by a state agency; and a proof of mailing legal form.

The Attorney General believes that good writing, in plain English, is an essential part of good lawyering. Good lawyers write well and allow their writing to be understood by lawyers and laypersons alike. We happily join our colleagues in the private bar who believe that good lawyers serve the public and uplift our profession by communicating in plain English.

Footnotes

1. MCL 14.32; MSA 3.185.

2. *LaFountain v Attorney General*, 200 Mich App 262, 264; 503 NW2d 739 (1993).

3. *Traverse City School Dist v Attorney General*, 384 Mich 390, 410, n 2; 185 NW2d 9 (1971); *Queen Airmotive, Inc v Dep't of Treasury*, 105 Mich App 231, 236; 306 NW2d 461 (1981); People v Penn, 102 Mich App 731; 302 NW2d 298 (1981).

4. *Macomb Co Prosecutor v Murphy*, 233 Mich App 372, 382; 592 NW2d 745 (1999); *Indenbaum v Mich Bd of Medicine*, 213 Mich App 263, 274; 539 NW2d 574 (1995).

5. MCL 14.28; MSA 3.181.

6. MCL 14.101; MSA 3.211; Butcher v Twp of Grosse Ile, 387 Mich 42; 194 NW2d 845 (1972).

[7] MCL 14.29; MSA 3.182.

[8] MCL 600.6419; MSA 27A.6419(1).

[9] MCL 14.143; MSA 3.243.

[10] MCL 14.261; MSA 26.1200(11).

[11] MCL 257.323; MSA 9.2023.

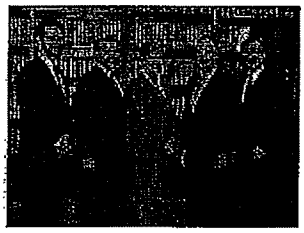
[12] This figure includes appeals to circuit court of the denial of requests for parole, pursuant to MCL 791.234(7); MSA 28.2304.

[13] MCL 14.131, 134; MSA 3.231, 234 provide that the Attorney General may bring a civil action "for the purpose of collecting all past due moneys and accounts which are owing to the State of Michigan or any department, commission or institution thereof."

[14] MCL 421.11; MSA 17.511.

[15] The Litigation Coordinator oversees the department's litigation and makes recommendations to the Attorney General and the Deputy Attorney General on civil settlements and consent judgments, as well as criminal plea agreements.

[16] The Solicitor General is a statutory position appointed by the Attorney General to represent the state in the Supreme Court. MCL 14.28; MSA 3.181.



Pictured from left to right: Matthew H. Rick, Michael C. McDaniel, Attorney General Jennifer M. Granholm, Theodore E. Hughes, Eric J. Eggan. Matthew Rick has been an Assistant Attorney General, assigned to the State Affairs Division, since 1997. A 1990 graduate of the Detroit College of Law, he is the chair of the State Bar Law Day Committee. Michael C. McDaniel serves as the Attorney General's Litigation Coordinator. He has been with the Attorney General's Office since 1984 and is a 1981 graduate of Case Western Reserve University Law School.

Jennifer M. Granholm was elected Michigan's 51st Attorney General in November 1998. A graduate of Harvard Law School, she currently serves as a Michigan State Bar Commissioner. Theodore E. Hughes serves as the Assistant Attorney General for Law and

as a chairperson of the Attorney General's Opinion Review Board. A 1969 graduate of the Detroit College of Law, he has been an Assistant Attorney General since 1983. Eric J. Eggan is the Assistant in Charge of the Attorney General's Casino Control Division. A 1980 graduate of the Thomas M. Cooley Law School, he has been an Assistant Attorney General since 1981.

Journal Home

[Previous Page] [Home Page]

STATE OF MICHIGAN

FRANK J. KELLEY, ATTORNEY GENERAL

Opinion No. 5791

September 30, 1980

MENTAL HEALTH:

Withholding of state funds from community mental health boards

Department rules and policies

The Department of Mental Health may withhold funds from a community mental health board for its failure to comply with the rules of the Department, but it may not withhold State funds for failure of the board to comply with policies of the Department.

Dr. Frank M. Ochberg

Director

Michigan Department of Mental Health

Lewis Cass Building

Lansing, Michigan

Your predecessor asked for my opinion as to the following question:

> Does the Department of Mental Health have authority to withhold state financing from community mental health boards on the ground that their community mental health programs lack compliance with departmental rules or established policy?

The answer to your question is controlled by two opinions of the Attorney General. In OAG 1979-1980, No 5685, p 703 (April 9, 1980), it is stated:

> 'Your last three questions, relate to the circumstances under which state financial support may be withheld from the county mental health program. 1974 PA 258, supra, Secs. 202 and 242 (1) are applicable to those questions. They provide as follows:
>
> "Sec. 202. The state shall financially support, in accordance with chapter 3, county community mental health programs that have been established and that are administered pursuant to the provisions of this chapter.

"Sec. 242. The following expenditures by a county program are not eligible for state financial support:

"(a) The construction, purchase, remodeling, or any similar capital cost of a building or facility, except that such cost shall be eligible for state financial support or an annual expense basis in an amount equal to a fair rental value of the space or building being utilized.

"(b) The capital cost of equipment or similar items in an amount greater than that established by the department.

"(c) Any cost item that does not represent or constitute a real or actual expenditure by the county program.

"(d) That part of any expenditure that is obviously and manifestly extravagant in relation to its specific objective and context.

"(e) Any category of expenditure or any portion of any category of expenditure whose ineligibility the department shall determine is necessary and appropriate to assure the reasonable use of state funds or to assure a legitimate interest of the state and which determination is in accord with the intent and provisions of this chapter. This subdivision shall be effectuated by officially adopted rules of the department.' [Emphasis supplied]

'It is evident that the State has an obligation to provide financial support for county community mental health programs. Section 242 enumerates those expenditures by a county program which are not eligible for State financial support. The Department has effectuated the statutory provision by promulgating an administrative rule which states in part:

"Programs ineligible for state financial support.

"A program ineligible for state financial support shall include:

"(b) Programs and services which directly or indirectly violate the act and the rules promulgated thereunder.' 1979 AACS, R 330.2058

'The contractual arrangement in question falls within the prohibition of 1974 PA 258, Sec. 222(3), supra. Thus, the Department may determine that the expenditure of monies to pay the lease rentals is not a reasonable use of state funds and is contrary to a legitimate interest of the state in accordance with 1974 PA 258, Sec. 242, supra, and Rule 2058.

Under such circumstances, 1974 PA 258, supra, Sec. 236 is applicable. It provides in pertinent part as follows:

'. . . The department may withdraw funds that have been allocated to a county program when such funds are being expended in a manner not provided for in the approved plan and budget.'

Although the above-quoted opinion dealt with a specific violation of the Mental Health Code, 1974 PA 258, MCLA 330.1001 et seq; MSA 14.800(1) et seq, the same conclusion would follow in any instance where a community mental health program was not being operated in conformance with the Mental Health Code, 1974 PA 258, supra, or rules promulgated by the Department of Mental Health. See also OAG, 1979-1980, No 5665, p 636 (February 22, 1980).

Your question as phrased inquires into the ability to withhold funds for failure to comply with rules or 'established policy.' It should be noted that 1974 PA 258, supra, Sec. 242 and 1979 AACS, R 330.2058, discussed in the above-quoted portion of 1979-1980, No 5685, p 703 (April 9, 1980), both make the Department's authority to withhold funds contingent on the provisions of the statute or the existence of rules. Those rules must be properly promulgated pursuant to the Administrative Procedures Act of 1969, 1969 PA

306; MCLA 24.201 et seq; MSA 3.560(101) et seq.

It is my opinion, therefore, that the Department of Mental Health may withhold funds from a community mental health board for its failure to comply with rules of the Department, but the Department may not withhold funds from a community mental health board for violation of its policies.

Frank J. Kelley

Attorney General

(1) MCLA 330.2202; MSA 14.800(242); MCLA 330.2242; MSA 14.800(202).

[Previous Page] [Home Page]

http://opinion/datafiles/1980s/op05791.htm
State of Michigan, Department of Attorney General
Last Updated 03/23/2001 12:20:26

Bullet #12

[Previous Page] [Home Page]

STATE OF MICHIGAN

FRANK J. KELLEY, ATTORNEY GENERAL

Opinion No. 5665

February 22, 1980

MENTAL HEALTH:

Authority of Director of Department of Mental Health

Community mental health boards

APPROPRIATIONS:

Expenditure of monies appropriated for community mental health programs

The Director of the Department of Mental Health is without authority to terminate a county community mental health board or to assume the direction of its operation.

The Department of Mental Health may provide mental health services in a county where the county community mental health board is expending allocated mental health funds in a manner not provided for in the approved plan and budget, and the Director of the Department of Mental Health may use funds appropriated by 1979 PA 105 to provide community mental health services to such county.

Frank M. Ochberg, M.D.

Director

Michigan Department of Mental Health

Lewis Cass Building

Lansing, MI 49826

You have asked for my opinion with regard to the following question: 'May the Department of Mental Health make inoperative the Wayne County Community Mental Health Board and provide community mental health services in the place and stead of the Wayne County Community Mental Health Board?'

The powers and duties of the Department of Mental Health (hereinafter referred to as the 'Department') are set forth, in general, in the Mental Health Code, 1974 PA 258, as amended, MCLA 330.1001 et seq; MSA 14.800(1) et seq. Included in these powers and duties are the following set forth in the Mental Health Code, supra, Sec. 116:

'. . . [It] shall continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state. . . .

(b) It may provide, on a residential or nonresidential basis, any type of patient or client service including but not limited to prevention, diagnosis, treatment, care, education, training, and rehabilitation.

'(d) It may operate directly or through contractual arrangement such facilities as are necessary or appropriate.

'(e) (i) It shall administer the provisions of chapter 2 so as to promote and maintain an adequate and appropriate system of county community mental health services throughout the state.

'(ii) In the administration of chapter 2, it shall be the objective of the department to shift from the state to a county the primary responsibility for the direct delivery of public mental health services whenever such county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of such county.

(j) It may enter into any agreement, contract, or arrangement with any public or nonpublic entity that is necessary or appropriate to fulfill those duties or exercise those powers that have by statute been given to the department.

(l) It shall have such powers as are necessary or appropriate to fulfill those duties and exercise those powers that have by statute been given to the department and which are not otherwise prohibited by law.'

Chapter 2 of the Mental Health Code, supra, provides for the establishment and operation of county community mental health programs. In substance, a county community mental health program is established by a majority vote of the board of commissioners of the county. Mental Health Code, supra, Sec. 210. Upon the establishment of the county program, the board of commissioners also establishes a 12-member county community health board, the members of which are appointed by the board of commissioners, except in the case of Wayne County where the mayor of the City of Detroit appoints six of the twelve members. Mental Health Code, supra, Secs. 212 and 216. A county community mental health program operates pursuant to an annual plan and budget approved by the county community mental health board. The annual plan and budget are approved by the county board of commissioners and submitted to the Department. The plan and budget, as submitted, are the county program's official application for State funds. Mental Health Code, supra, Sec. 226.

The Department reviews each county's annual plan and budget and may approve or disapprove the annual plan and budget in whole or in part. Departmental approval is necessary for State financial support. The Department of Mental Health allocates State appropriated funds in accordance with approved plans and budgets. Mental Health Code, supra, Sec. 232. The criteria for the approval or disapproval of a county plan and budget are set forth in the Mental Health Code, supra, Sec. 234.

The Mental Health Code, supra, Sec. 236, provides for the Department, at intervals during the year, to review the expenditures of a county community mental health program and to withdraw funds that have been allocated, with the concurrence of the county community mental health board, if allocated funds are not needed by the county program. This section also authorizes the Department to withdraw funds that have been allocated to a county program when such funds are being expended in a manner not provided for in the approved plan and budget. In the Mental Health Code, supra, Sec. 238, the legislature has provided that if a county director or board 'specifically so requests,' any action by the Department involving, inter alia, a withdrawal of funds 'shall be reviewed in consultation with the affected county director or board before such action shall be considered final,' and that at the consultation 'the representative of the county program shall be afforded full opportunity to present his position.'

The only method provided in the Mental Health Code, supra, for the termination of a county program is found

in Sec. 220:

> 'Termination of a county's participation in a county program, whether such participation is singular or joint, may be accomplished by an official notification from the county's board of commissioners to the department and the other concerned county boards of commissioners. The date of termination shall be 2 years following the receipt of such notification by the department, unless the director of the department consents to an earlier termination. In the interim between notification and official termination, the county's participation in the county program shall be maintained in good faith.'

From the foregoing recital of the provisions of the Mental Health Code, supra, it is apparent that it contains no provision authorizing the Department of Mental Health to unilaterally terminate nor to operate a county community mental health program. This is not the end of the inquiry, however. The Department has the duty under the Mental Health Code, Sec. 116, supra, quoted above, to ensure that mental health services are available to all citizens of the State. Pursuant to that same section, the Department has authority to provide any type of mental health service, either directly or through contract. The Department is directed in subpart (e)(i) of that section to 'administer the provisions of chapter 2 so as to promote and maintain an adequate and appropriate system of county community mental health services throughout the state.' And, subsection (e)(ii), while it makes it the objective of the Department to shift from the State to a county the primary responsibility for the direct delivery of public mental health services, contains the conditional language 'whenever such county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of such county.'

The Mental Health Code, supra, Sec. 314, provides that the county's annual appropriation for the cost of services provided by the State and for the county's cost of supporting the county community mental health program shall be made as a single appropriation to the board of the county program. (1)

You advise that Wayne County, apparently in disregard of this section, had budgeted funds for its community mental health program for only four months beginning December, 1979.

The Wayne County Community Mental Health Board has submitted the county's annual plan and budget to the Department. This plan and budget has been approved pursuant to the provisions of the Mental Health Code, Sec. 232, supra. The plan and budget, as approved, include in the total amount of the budget, the 10% required to be provided by Wayne County for the State fiscal year beginning October 1, 1979, and the Department's allocation of State funds was predicated upon Wayne County in fact appropriating its full 10% and not some fraction thereof.

In my opinion, under these circumstances (the failure of Wayne County to appropriate its full 10% of the budget), the provisions of the last sentence of the Mental Health Code, Sec. 236, supra, come into play. That sentence reads, 'The department may withdraw funds that have been allocated to a county program when such funds are being expended in a manner not provided for in the approved plan and budget.' Thus, because Wayne County has not appropriated its full 10% to the approved plan and budget of the Wayne County Community Mental Health program, the Department may withdraw funds that have been allocated to the Wayne County program at least in proportion to the amount of the budget not appropriated by Wayne County. In short, assuming that Wayne County has appropriated only 5% rather than the required 10% of the community mental health program's approved plan and budget, the Department at least may reduce its allocation from 90% of the approved plan and budget to 45%.

It should be reiterated, however, that the provisions of the Mental Health Code, Sec. 238, supra, provide that any action by the Department for the withdrawal of funds from a county program must be reviewed, if requested, in consultation with the affected county director or board before such action shall be considered final.

The next part of your question is whether the Department may use the funds withdrawn from allocation to the Wayne County Community Mental program to implement under the Department's direction community mental health services within Wayne County. In my opinion, under the provisions of the Mental Health Code, Sec.

116, supra, set forth above, the Department has ample authority to provide community mental health services in Wayne County, particularly in view of the fact that Wayne County has not demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of the county. 1979 PA 105, the appropriations act for the Department, appropriates money for community mental health services and contains no provision which would preclude the Department from using the money appropriated for that purpose to provide mental health services in a county which is expending allocated mental health funds in a manner not provided for in the plan and budget approved by the Department.

In summary, under the facts herein recited, it is my opinion that while the Department may not terminate the Wayne County Community Mental Health Board nor assume the direct operation of the Wayne County Community Mental Health Program, the Department may withdraw funds previously allocated to the Wayne County Community Mental Health Program and use such funds to provide community mental health services in Wayne County. An action to withdraw funds would not be final until it was reviewed in consultation with the Wayne County Community Mental Health Board or its director, if a review were specifically requested.

Frank J. Kelley

Attorney General

(1) In general, the Mental Health Code, supra, Secs. 302 and 308, mandates that the county pay 10% and the state 90% of the cost of an approved county community mental health program.

[Previous Page] [Home Page]

http://opinion/datafiles/1980s/op05665.htm
State of Michigan, Department of Attorney General
Last Updated 03/23/2001 12:20:26

Bullet #13

[Previous Page] [Home Page]

STATE OF MICHIGAN

FRANK J. KELLEY, ATTORNEY GENERAL

Opinion No. 6600

September 27, 1989

COUNTIES:

Consolidation of county community mental health program with other county programs

MENTALLY DEFICIENT AND MENTALLY ILL PERSONS:

County community mental health program--governance by county community mental health board

The disbanding of a county community mental health board or the preempting of the board's powers by another county body would cause the affected county community mental health program to be out of compliance with the provisions of the Mental Health Code.

Honorable David M. Gubow

State Representative

Capitol Building

Lansing, MI 48913

You have asked for my opinion on the following question:

> "Does the disbanding of a county community mental health board appointed pursuant to Chapter 2 of the Mental Health Code or the pre-empting of powers given to such a board by the Mental Health Code by another body render the county community mental health program out of compliance with the current provisions of the Mental Health Code?"

You state that it is your understanding that several counties have consolidated within one department the responsibility for delivering mental health services, public health services, and various other human services. The reorganized department has its own advisory board. In some instances that board has replaced the previously existing county community mental health board. The Department of Mental Health advises that in other instances, the community mental health board serves only in an advisory capacity to the new board and the new board has authority to alter or amend recommendations from the community mental health board.

Community mental health programs are governed by Chapter 2 of the Mental Health Code, MCL 330.1200 et seq; MSA 14.800(200) et seq. A county or a group of adjoining counties can establish a county community mental health program by a majority vote of each county board of commissioners. MCL 330.1210; MSA

14.800(210). Once estblished, the community mental health program becomes an official county agency. MCL 330.1204; MSA 14.800(204). As long as the program is established and administered in accordance with Chapter 2 of the Mental Health Code, the program is eligible for state financial support. MCL 330.1202; MSA 14.800(202).

MCL 330.1212; MSA 14.800(212), provides in pertinent part as follows:

> "Upon electing to establish a county program, the county or combination of counties shall establish a 12-member county community mental health board,...." (Emphasis added.)

When the wording of a statute is unambiguous, the provisions of the statute must be applied as written. City of Grand Rapids v. Crocker, 219 Mich 178, 182; 189 NW 221 (1922). Furthermore, the use of the word "shall" in a statute generally means that the statutory requirement in question is mandatory. King v. Director of the Midland County Dep't of Social Services, 73 MichApp 253; 251 NW2d 270 (1977). MCL 330.1212; MSA 14.800(212), quoted above, is clear and unambiguous in its mandate that a county or counties electing to establish a community mental health program shall have a community mental health board.

Therefore, the answer to the first part of your question is that a county or counties which desire to continue to have a county community mental health program may not disband the county community mental health board.

It should be noted that nothing in Chapter 2 of the Mental Health Code gives any particular name to the county community mental health board. If the county or counties wish to refer to that board as a human services board or some similar title, the statute would not prohibit the use of such a name. However named, the board must meet the remaining requirements of Chapter 2 of the Mental Health Code. For example, MCL 330.1222; MSA 14.800(222), sets forth detailed requirements for membership on a community mental health board. Any board functioning as the county community mental health board must adhere to those membership requirements.

By whatever name, the board functioning as the county community mental health board can have only those functions and powers set forth in Chapter 2 of the Mental Health Code. It cannot perform any other functions. At least two principles of statutory construction lead to such a conclusion. The first principle is that the express mention in a statute of one thing implies the exclusion of other similar things. In the present context, that principle means that when an entity is created by statute and is given certain powers, the enumeration of those powers is deemed to exclude all others. Sebewaing Industries, Inc v. Village of Sebewaing, 337 Mich 530, 545; 60 NW2d 444 (1953). The powers of a community mental health board are set forth in MCL 330.1226 and 330.1228; MSA 14.800(226) and 14.800(228). All of the powers enumerated relate to the operation of a community mental health program. Nothing in the statute empowers the board to operate a public health or other human resources program.

The second principle of statutory construction which is applicable is that in construing a statute, it is important to ascertain and give effect to the legislative intent. In re Certified Questions, 416 Mich 558; 331 NW2d 456 (1982). There are a number of provisions in Chapter 2 of the Mental Health Code from which it can be inferred that the legislative intent was that a community mental health board function solely in the area of community mental health. For example, MCL 330.1222(1); MSA 14.800(222)(1), provides for the composition of a county mental health board to include representation from providers of mental health services, recipients of mental health services, and people having a working involvement with mental health services.

MCL 330.1226; MSA 14.800(226), requires a community mental health board to survey mental health needs in the county or counties it represents and submit a budget request to the county board(s) of commissioners, thus clearly envisioning that the board would take an advocacy stance on behalf of those in need of mental health services. If that same board were also responsible for advocating for other programs and services, there would necessarily be a dilution of its advocate role in the mental health area. These and other provisions of Chapter 2 of the Mental Health Code give rise to a strong inference that the intent of the Legislature, in adopting the provisions of Chapter 2, was to have a community mental health board that performed only mental health related functions.

The second part of your question relates to the possibility that some counties have set up systems where other advisory boards have preempted the powers of the community mental health board or have the power to alter, amend, or veto recommendations of the community mental health board before those recommendations are presented to the board of commissioners. A county has only those powers that have been conferred upon it by the Constitution or state statutes. Brownstown Twp v. Wayne County, 68 MichApp 244; 242 NW2d 538 (1976), lv den 399 Mich 831 (1977). A county ordinance which contravenes a state statute is void. Gray v. Wayne County, 148 MichApp 247, 259; 384 NW2d 141, lv den 426 Mich 872 (1986).

As noted, in Chapter 2 of the Mental Health Code, the Legislature has given to county community mental health boards certain powers. For example, in MCL 330.1226; MSA 14.1800(226), each county community mental health board is given the power to review and approve an annual plan and budget for the county program, to submit a budget request to the county board of commissioners, to authorize and approve all contracts, and to take any other actions it considers necessary and appropriate to obtain funds to support the program. If a county ordinance were to give some other county board the authority to exercise those powers or the authority to veto or alter the powers expressly given by the Legislature to the county community mental health board, that ordinance would be contrary to the Mental Health Code and, therefore, void.

It is my opinion, therefore, that the disbanding of a county community mental health board or the preempting of the board's powers by another county body would cause the affected county community mental health program to be out of compliance with the provisions of the Mental Health Code.

Frank J. Kelley

Attorney General

[Previous Page] [Home Page]

http://opinion/datafiles/1980s/op06600.htm
State of Michigan, Department of Attorney General
Last Updated 03/23/2001 12:41:00

Bullet #14

97-26

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May 15, 1997

ATTORNEY-CLIENT PRIVILEGE

Mr. Rich Visingardi
Executive Director
Community Mental Health Systems of Ionia County
P.O. Box 155
Orleans, Michigan 48865

Dear Mr. Visingardi:

This is in response to your request for our office to review the proposed Mid-Michigan Community Mental Health Partnership Agreement. In your correspondence, you indicated that this proposed "Partnership" was not intended to be a legal entity, but rather various Community Mental Health Boards working in cooperation with each other.

Contractual Undertakings by the Group

Initially, it should be noted that a partnership is a legal entity, capable of entering into contracts and conducting business in its own name. Because your group is not a legal "partnership," we recommend that a different designation be used by your group to avoid possible legal problems.

Because the group is not a separate legal entity, it cannot legally obligate individual Community Mental Health Program members. Therefore, each of the participants must individually enter into contracts. The legal structure of each participant will determine the extent to which that Community Mental Health Board can enter into a contract.

Delegation of CMH Board Powers

The Mental Health Code provides the powers of CMH Boards in part at MCL § 330.1226. These powers include approving and authorizing all contracts for the provisions of services, the establishment of general policy guidelines within which the executive director executes a CMH program, and the appointment of the executive

director. The statutory powers ensure that the CMH boards have the power to carry out the duties imposed by the Mental Health Code. However, as noted in O.A.G. 1989, No. 660, p 220, the statutorily proscribed powers of a CMH board may not be delegated to another entity. In addressing this issue, the Attorney General noted that "if a county ordinance were to give some other county board the authority to exercise those powers or the authority to veto or alter the powers expressly given by the Legislature to the county community mental health board, that ordinance would be contrary to the mental health code and, therefore, void." Id. at page 222. Therefore, certain statutorily proscribed powers of the CMH Board such as to oversee the operations of the community health program and to approve contracts may not be delegated, in whole or in part, to another entity.

While certain statutory powers of a CMH Board may not be delegated, certain functions may be performed by another entity under a contract. As suggested on page six (6) of the proposed "Partnership Agreement," personnel services may be performed by one CMH Board for other CMH Boards, pursuant to a contractual arrangement. Other similar services that comprise the ministerial functions of CMH Programs may also be contracted.

Creation of a Holding Company to Govern all Partnership Participants

On page six of the proposed "Partnership Agreement," it has been suggested that a holding company or other entity be created to manage the group's Community Mental Health operations. The Michigan Attorney General has repeatedly opined that, counties lack the ability to form corporations. OAG 1980, No 5750, pg 897; OAG 1989, No 6563, pg 27. The rationale for these opinions also applies to Community Mental Health Programs. Therefore, unlike private health care providers, Community Mental Health Programs, as government entities, do not have the power to create nonprofit corporations to act as holding companies for the group's participants.

Although CMH Programs may not create nonprofit corporations, there are several statutes that give them the power to perform joint governmental operations. See Intergovernmental Contracts Between Municipalities Act, MCL 124.1 et seq, and Intergovernmental Transfers of Functions and Responsibilities Act, MCL 124.531. These Acts are in addition to the section in the Mental Health Code that permit counties to join together pursuant to MCL 330.1219 to jointly perform mental health services, or to form an authority pursuant to MCL 330.1205. Also see the Urban Cooperation Act, MCL 125.501 et seq.

The above-noted Acts have different definitions of governmental entities. The Intergovernmental Contracts Act ("Contracts Act") has the most expansive definition of the kinds of governmental entities eligible to enter into joint agreements. That Act includes within its definition of municipal entities[1] empowered to make intergovernmental contracts any "local agency with the power to enter into contractual undertakings."[2]

The Urban Cooperation Act and the Intergovernmental Transfer of Functions Act, both limit their definitions of public agencies to the traditional political subdivisions, such as counties, cities, villages, and townships.[3] Therefore, the Community Mental

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[1] MCL 124.1(a), which states: "Municipal corporation" means any county, charter county, county road commission, township, charter township, city, village, school district, intermediate school district, community college district, metropolitan district, court district, public authority, or drainage district as defined by Act No. 40 of the Public Acts of 1956, as amended, being sections 280.1 to 280.630 of the Michigan Compiled Laws, or any other local governmental authority or local agency with power to enter into contractual undertakings. For purposes of sections 5 to 12b, "municipal corporation" includes a public transportation corporation.

[2] MCL 330.1228 provides: "subject to the provisions of this chapter, a board is authorized to enter into contracts for the purchase of mental health services and property lease arrangements with private or public agencies or individuals. A board may enter into a contract with any facility or entity of the department with the approval of the director of the department.

[3] *See* The Urban Cooperation Act, at MCL 124.502(e), which defines governmental agencies empowered by the Act as:

> "Public agency" means a political subdivision of this state or of any state of the United States or the Dominion of Canada, including, but not limited to, state government; a county, city, village, township, charter township, school district, single and multipurpose special district, or single and multipurpose public authority; provincial government, metropolitan government, borough, or any other political subdivision of the Dominion of Canada; any agency of the United States government; or any similar entity of any other states of the United States and of the Dominion of Canada.

Also See the Intergovernmental Transfers of Functions Act, at MCL § 124.531(b), which defines governmental agencies empowered by the Act as:

> "Political subdivision" means a city, village, other incorporated political

Health Boards likely fall outside the definition of entities capable of using these acts. However, contracts between CMH entities are the most expedient method of sharing services.

Any proposed agreement sharing or transferring services should be reviewed by legal counsel, to ensure that the transfer is legally permissible.

If you have any questions, please do not hesitate to contact us.

Very truly yours,

COHL, STOKER & TOSKEY, P.C.

Peter A. Cohl

Jeffrey M. Kaelin

PAC/JMK/lm
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subdivision, county, school district, community college, intermediate school district, township, charter township, special district or authority.

Bullet #15

TRUE COPY
MARILYN KLIBER
Manistee County Clerk

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF MANISTEE

MANISTEE-BENZIE COMMUNITY MENTAL HEALTH SERVICES,
Plaintiff,

v

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, and JAMES K. HAVEMAN, JR., DIRECTOR, MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, in his official capacity,
Defendants.

CASE NO. 02-10814-CZ

HON. JAMES M. BATZER

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OPINION OF THE COURT

At a session of said Court, held in the Circuit Courtroom, Manistee County Courthouse, Manistee, Michigan, on the 20th day of September, 2002.

The Court consolidated hearings on preliminary and permanent injunctions on this matter.

Historically, the individual states' Medicaid programs were similar across the country. Prior to the imposition of federal competitive procurement regulations, Medicaid services were first provided in Michigan by Community Mental Health Boards, and later by Community Mental Health Programs (CMHSPs). Both the establishment of a CMHSP, by a county or counties, and the subsequent assumption of responsibility by the CMHSP for providing mental health services was discretionary with the counties.

Between 1974 and 1991, all counties in Michigan elected to establish CMHSPs, often as multi-county ventures, and to accept the transfer of responsibility for mental health and developmental disability services from the state. The Michigan Department of Community Health (DCH) and the CMHSPs negotiated contractual provisions and funding mechanisms that accomplished the transfer of authority and resources from the state to the local CMHSPs under an arrangement referred to as "full management."

By the early 1980s, the Michigan Medicaid program already had established some services and benefits that were rendered by various health care professionals or that were enrolled as providers by the state Medicaid program. In an effort to meet the special needs of beneficiaries with serious mental illnesses and developmental disabilities, the state began to expand the scope of Medicaid services in 1983. As the state Medicaid agency gradually added these optional services to Michigan's Medicaid Plan, CMHSPs became interested in becoming enrolled Medicaid providers so that they could offer these services.

By the mid-1990s, the Mental Health Administration within DCH was interested in trying to more closely link and coordinate certain services available through the state Medicaid program with other services required under the Mental Health Code. This "systems integration" project

proved to be a difficult undertaking. To overcome or resolve impediments to service integration, DCH turned its attention to the possibility of using a federal Medicaid managed-care waiver under the authority of Section 1915(b) of Title XIX of the Social Security Act. Congress and the Centers for Medicaid/Medicare Services (CMS) encouraged states to develop more individualized programs by using such waivers to cover services in ways that are not necessarily consistent with the published federal statutory or regulatory requirements. CMS allowed Michigan to use the waiver authorized under Section 1915(b) of Title XIX of the Social Security Act.

In 1997, the Mental Health Administration at the Michigan Department of Community Health (DCH) began work on federal waivers to move certain Medicaid covered services into a managed-care arrangement, and to give preferential consideration to Community Mental Health Service Providers (CMHSPs) for the administration of the proposed managed-care waiver programs. DCH submitted two federal Medicaid waiver applications to CMS which were rejected by CMS. On June 26, 1998, DCH received formal approval from CMS to implement the proposed Medicaid managed-care program to place specialty services related to mental health and developmental disability services to the management of Prepaid Health Plans (PHPs).

CMS granted Michigan a time-limited exemption from the federal competitive procurement rules so that DCH could contract on a sole-source basis with Michigan's 49 county-sponsored CMHSPs to serve as specialty PHPs and manage Medicaid services on a prepaid, shared-risk basis. CMS stipulated that within two years[1] DCH had to submit a detailed plan to shift from sole-source procurement for its PHP contracts to full and open competitive procurement to comply with the

[1]This coincides with the end of the initial waiver period and the date of the waiver renewal application.

federal procurement rules at 45 CFR Part 74.

In September 1999, DCH published a preliminary plan for competition. After the preliminary plan was released, DCH held ten public hearings and received over 750 written comments. On September 28, 2000, Michigan formally submitted the Revised Plan for Procurement of Medicaid Specialty Prepaid Health Plans - Final Version as part of the state's official renewal application for the § 1915(b) waiver. In February 2001, CMS approved the waiver.

DCH moved forward with instructions to CMHSPs regarding the application process. On October 26, 2001, Statement of Status documents were sent to all CMHSPs with a memorandum indicating that the Applications for Participation (AFP) would be issued in January 2002. Between November 2001 and January 2002, six question and answer documents were published by DCH. Also, the questions and answers regarding the deadline and requirements, including the process and time line for the AFP release, DCH staff review, state advisory panel review, selection and PHP applicant notification, were all published on the DCH website.

To apply for PHP status, CMHSPs or affiliations of CMHSPs were required to have 20,000 Medicaid covered lives in their "catchment" area. If a CMHSP did not have the requisite lives, then it could not submit a "stand alone" application, but rather it was required to affiliate with other CMHSPs to reach the 20,000 threshold. A thorough review of the record reveals that the business of affiliation was not as easy as originally envisioned. It is apparent to the Court that MBCMH faced problems in the affiliation process that were not unique to MBCMH.[2] In 1997, MBCMH attempted to affiliate with the Northern Michigan affiliation, which included, *inter alia*, North Central CMH.

[2]It is readily apparent from the record that other service providers, such as North Central and Newaygo, did not affiliate with groups with which they initially negotiated, indicating that the affiliation process was not an easy undertaking.

MBCMH withdrew from attempting to affiliate with Northern Michigan after DCH opined that the affiliation would be too large and unworkable.

In late 2000 and early 2001, MBCMH attempted to form an affiliation with West Michigan CMH and Newaygo CMH. However, West Michigan CMH withdrew from the affiliation, and MBCMH was forced to seek another affiliation because the 20,000 lives threshold was not satisfied.

During April or May 2001, MBCMH pursued the possibility of entering into an affiliation with North Central CMH. However, such affiliation proved impossible because North Central attempted to enter into an illegal contract with MBCMH in which local CMH boards would be divested of their statutory "local control" authority. Subsequently, in November 2001, MBCMH undertook to enter into an affiliation with Newaygo CMH, Clinton-Eaton-Ingham (CEI) CMH, Gratiot CMH, and Ionia CMH. However, MBCMH was unable to finalize an affiliation with this group prior to February 22, 2002 because DCH failed to provide CEI with written assurances that the geographical location of MBCMH would not jeopardize CEI's AFP.[3]

The crux of the instant case is whether MBCMH was led to believe by former DCH Deputy Director Geiger that February 22, 2002 was not the absolute deadline for submitting an AFP.[4] On December 27, 2001, Mr. Michael Moran, the Director of Manistee-Benzie CMH, had a meeting with Mr. Geiger in which it was represented to Mr. Moran that MBCMH would be able to join the

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[3]2002 P.A. 56, § 417(1) provides: "It is the intent of the legislature that the department support projects by community mental health boards to establish regional partnerships. Community mental health boards located in counties within a 45-mile radius of each other shall be allowed to collaborate for the purpose of forming regional partnerships."

[4]In an October 9, 2001 memorandum from DCH Director Haveman to "Community Mental Health Service Provider Directors and Staff," Haveman announced, "He [Geiger] will be sherpherding the Application for Participation process from now until inception."

Clinton-Eaton-Ingham (CEI) affiliation after the February 22 deadline. In a December 29, 2002 letter, MBCMH referenced the December 27 meeting on the topic of CEI and the inclusion of MBCMH. On February 21, 2002, the CEI board of directors passed a resolution to extend an invitation to MBCMH to affiliate with CEI, under the apparent belief that there was a possibility of affiliation notwithstanding the February 22 deadline.

Even after the February 22 deadline had passed, MBCMH and CEI continued to inform DCH that they were continuing efforts to undertake an affiliation. Moreover, DCH did not dissuade the parties from pursuing such affiliation. In a letter dated March 1, 2002, DCH acknowledged MBCMH's intent to affiliate with CEI. In a telephone conversation with Deputy Director Geiger on March 11, 2002, Moran inquired as to what the process would be for affiliation with CEI. Moran understood that Geiger would get back with Moran regarding the procedure for MBCMH to continue to pursue affiliation with CEI. Importantly, on March 13, 2002, Moran was assured by Geiger that information submitted by MBCMH would be forwarded to the Specialty Services Board with a recommendation by DCH, and that MBCMH would be amended into the CEI plan after CEI's AFP had been reviewed. DCH did not assert to MBCMH or CEI that affiliation would be prohibited until June 6, 2002.[5]

Based on the statements and assurances of former Deputy Director Geiger and his subsequent conversations with MBCMH on and after December 27, 2001, the Court is satisfied that Mr. Moran relied to the detriment of MBCMH on Geiger's assurances and re-assurances of a method to affiliate subsequent to the February 22, 2002 deadline. It is worth noting that MBCMHP filed its Statement of Status with DCH indicating CEI as its preferred affiliation on November 29, 2001. Without

[5]Interestingly, former Deputy Director Geiger left DCH on June 5, 2002.

Geiger's assurances, Moran and MBCMH would have pursued affiliation with North Central, contractual problems with the statutory autonomy notwithstanding, because to do otherwise would have left MBCMH where it is today, an "orphan board" in danger of losing the approximately 90% of its clientele who are Medicaid recipients. Such a status is a virtual death sentence to MBCMH's ability to provide services in its present configuration. The Court considers such "orphan board" status where MBCMHP does not have the requisite 20,000 Medicaid lives to be able to "stand alone" to constitute irreparable harm in that it will leave MBCMH in the status of a precariously existing legal shell in danger of imminent collapse while undoing Michigan's statutorily based commitment to community based representation.

Beyond even the consideration of MBCMHP's detrimental reliance, the greatest concern to the Court is that it appears that the entire *raison de existence* for the § 1915(b) waiver was for the seamless, integrated services and continuity of care for the recipients of Medicaid. Yet DCH Deputy Director Patrick Barrie's testimony was that MBCMH's recipients would be integrated to the sphere of North Central without local representation and without DCH having gone through an evaluation of the best interest of the Manistee and Benzie County Medicaid recipients as DCH has done in approving affiliations. Thus, the Manistee and Benzie County Medicaid recipients are relegated to the status of being unrepresented[6] and without DCH having assured itself of the best interests of the Medicaid recipients with seamless, integrated services and continuity of care for the approximately

[6]Mich Comp Laws Ann § 330.1222 provides: "The composition of a community mental health services board shall be representative of providers of mental health services, recipients or primary consumers of mental health services, agencies and occupations having a working involvement with mental health services, and the general public. At least 1/3 of the membership shall be primary consumers or family members, and of that 1/3 at least 2 members shall be primary consumers. All board members shall be 18 years of age or older."

90% of the recipients of MBCMHP services. Thus the refusal of defendants to allow MBCMH to submit an AFP that includes affiliation with CEI (so long as CEI is willing to affiliate) with the subsequent scoring, site visits and evaluation by the Specialty Services Board constitutes irreparable harm to the Manistee-Benzie Medicaid recipients whose interests the Court believes may be represented by Plaintiff in the limited circumstances of this case.

Although the record reveals the pursuit of affiliation by Manistee-Benzie and the problems therein, there is at least the lurking possibility that MBCMH lacked sufficient urgency and dawdled in its pursuit of such affiliation and defendants seem to argue such at times.. Notwithstanding any such dawdling, the record is clear that MBCMH was led down a somewhat confusing primrose path by the assurances and re-assurances of former Deputy Director Geiger. The record is clear in that Mr. Moran could not submit a stand-alone AFP by the February 22 deadline, because MBCMH did not have the requisite 20,000 Medicaid lives. Consequently, Moran relied on Geiger's assurances and re-assurances.

It would be wholly inappropriate for this Court to re-constitute itself into some sort of super administrative authority over the state executive department having responsibility for the administration of mental health laws and this Court, it should go without saying, has not the slightest interest in doing so. Nor can the Court fault defendants for having a reasonable time line for participation in the affiliation process for those CMH agencies having less than 20,000 Medicaid covered lives. This Court will enter its mandatory injunctive order which is operant against state executive branch officials only because the Court is convinced that irreparable harm will befall plaintiffs and the Medicaid eligible recipients of mental health services in Manistee and Benzie Counties and because in the circumstances of this case there is a clear duty for DCH officials to

allow MBCMH's plan for affiliation to be evaluated by the Specialty Service Panel[7] which shall exercise its discretion on such plan after any requisite scoring and site visits. There exists no discernible impediment in federal law (including the Revised Plan) that has been cited to the Court in submitting an application for MBCMH affiliation with CEI to the Specialty Services Panel at this time. At the same time there exists in Michigan law an imperative for submitting such application to the Specialty Services Panel, to wit MCL 400.109g, 2001 P.A. 60, and 2002 P.A. 56.[8]

It would be a bitter irony for Medicaid eligible recipients of mental health services in Manistee and Benzie Counties to be finessed out of the benefits of seamless, integrated services, with continuity of care which is the very *raison de existence* for Michigan's § 1915(b) federal waiver without the statutorily created Specialty Services Panel ever having passed on the ability of the proposed MBCMH affiliation with CEI to provide such, because Mr. Moran relied on the past assurances and re-assurances of the former Deputy Director affiliation "shepherd," and because a different administrator now has a different view, thus engendering and ensuring "orphan" status for not only MBCMHP, but Manistee and Benzie Medicaid funded mental health service recipients as well, who would have no representatives for the assigned North Central provider and whose representation on the MBCMHSP would be an empty vessel.[9]

In short, this Court sees the present barring of an AFP from MBCMHP to the Specialty

[7]Mich Comp Laws Ann § 400.109g.

[8]2002 P.A. 56, § 428(5) provides, "The enactment of this section shall not result in any increase in the local match or county match obligation above the level of funding provided for mental health services in fiscal year 2001-2002. This section shall further confirm that the Medicaid program for specialty services and supports is part of the county-based community mental health services program system."

[9]Mich Comp Laws Ann § 330.1222.

Services Panel in the circumstances of the assurances and re-assurances of former Deputy Director Geiger as much less a matter of the requisites of federal law and much more as a bureaucratic pique designed to punish Mr. Moran's presumed (and perhaps very real) transgressions of bureaucratic etiquette. This Court finds such action by DCH unworthy of the high purpose of the best interests of the Medicaid recipients of mental health services in Manistee and Benzie Counties,[10] the very real practical problems to Defendant of an AFP from MBCMHP at this late date notwithstanding.[11]

It appears to the Court that the best interests of the Medicaid recipients of Manistee and Benzie Counties have not been considered by DCH.[12] Moreover, it appears that irreparable harm will befall the Medicaid recipients if local board participation were to be negated because the recipients would lose their local representation.

Certainly, DCH through its highest officials is eminently entitled to pursue the very high, proper and legitimate interest of not jeopardizing Michigan's federal waiver. However, the Court can discern nothing in federal or state law that prohibits MBCMH from affiliating now, nor does the Court discern any authority preventing DCH or the Specialty Services Panel from taking action now, and such action does not appear to violate the Revised Plan. The Court cannot divine into the mind of federal authorities having oversight over Medicaid waiver plans and this Court has no jurisdiction

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[10]2001 P.A. 60, § 417(2) provides, "The purpose of the regional partnerships should be to expand customer choice, promote service integration, and produce system efficiencies through the coordination of efforts, or other outcomes, as may be determined by participating community mental health boards." See 2001 Appropriations Act.

[11]It should be borne in mind that many of these practical problems are due to Defendant's resistance in acknowledging the assurances and re-assurances of its affiliation shepherd, former Deputy Director Geiger.

[12]See Deputy Director Patrick Barrie's August 14, 2002 testimony.

over any such federal authorities and least of all can it speak for them, but the Court finds no prohibition in federal law or in the Revised Plan of the remedy the Court will impose.

Plaintiff is entitled to injunctive relief allowing it up to two weeks from the effective date of the injunctive order that will enter to submit a plan or plans for affiliation to DCH. DCH will conduct the requisite site visits and do the requisite scoring forthwith and submit it for a decision by the Specialty Services Panel. DCH cannot retaliate against any entities or already approved affiliations that are willing to accept MBCMH into their affiliations. If the Specialty Services Panel is of the opinion that affiliation with MBCMH would diminish the level of services and quality of services of any already affiliated programs to the extent that they would not have had their affiliation approved had such new affiliation with MBCMH been a part of their original AFP reviewed by the Specialty Services Panel, then MBCMH shall not be allowed to affiliate.

Plaintiff shall forthwith submit an order in accordance with this opinion. Any such order that is objected to as to form by defendants shall come on before the Court for hearing for settlement on Monday, September 30, 2002, at 3:00 p.m.

9/20/02
Date

James M. Batker, Circuit Judge

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF MANISTEE

MANISTEE-BENZIE COMMUNITY
MENTAL HEALTH,

Plaintiff,

v File No. 02-10814 CZ

MICHIGAN DEPARTMENT OF COMMUNITY
HEALTH and JAMES K HAVEMAN, JR,
in his official capacity,

Defendants

Richard McNulty (P41668)	R Philip Brown (P25141)
Attorney for Plaintiff	Attorney for Defendants
601 N Capitol Ave	PO Box 30217
Lansing MI 48933	Lansing, MI 48909

ORDER

At a session of said Court held in the Circuit Courtroom, Manistee County Courthouse, 415 Third St., Manistee, Michigan, on the 20th day of September, 2002.

PRESENT: HONORABLE JAMES M. BATZER, CIRCUIT JUDGE

An opinion having been entered in the above captioned matter on September 20, 2002 and the said opinion having been forwarded to counsel in this matter; Now therefore,

IT IS ORDERED that any objection to any proposed order submitted to the Court by a party pursuant to said opinion shall be heard on September 30, 2002 at 3:00 p.m. or as soon thereafter as counsel may be heard in the Circuit Courtroom, Manistee County Courthouse, 415 Third Street, Manistee, Michigan. If there are no objections to the form of any proposed order, no hearing shall take place.

JAMES M. BATZER

Hon. James M. Batzer, Circuit Judge

AGREEMENT FOR THE COMMUNITY MENTAL HEALTH BOARD
OF MANISTEE AND BENZIE COUNTIES

THIS AGREEMENT made and entered into this 15th day of December, A.D., 1992, by and between the Boards of Commissioners of Manistee County and Benzie County (hereinafter collectively referred to as "Counties").

WITNESSETH:

WHEREAS, Act 258 of Public Acts of 1974, as amended, of the State of Michigan provides that any combination of counties may elect to establish a County Community Mental Health Program (hereinafter referred to as "CMH program") by a majority vote of each County Board of Commissioners; and

WHEREAS, Section 204 of Act 258 of Public Acts of 1974, as amended, requires an agreement to establish and determine procedures and regulations for a county CMH program; and

WHEREAS, Article 7, Section 28 of the Michigan Constitution of 1963 and Act 7 of the Public Acts of 1967, as amended, MCL 124.501 et seq., permit counties to, by agreement, perform functions that could be performed by individual counties; and

WHEREAS, the Counties desire to enter into an agreement to establish and create a board known as the Community Mental Health Board of Manistee and Benzie Counties (hereinafter sometimes referred to as CMHB), and to specify the powers and duties under which it will operate pursuant to the above cited authority;

THEREFORE, for and in consideration of the mutual covenants hereinafter contained, IT IS HEREBY AGREED as follows:

I.

Establishment

Pursuant to the Mental Health Code, 1974 PA 258, MCL 330.1200, et seq., as amended, and pursuant to the Michigan Constitution of 1963, Article 7, Section 28, and 1967 PA 7, as amended, MCL 124.501, et seq., the duly elected Commissioners of the Counties of Manistee and Benzie, State of Michigan hereby establish a board to be known as the Community Mental Health Board of Manistee and Benzie Counties.

II.

Definitions

The following terms for this Agreement shall have the meanings attached to them:

"Board" means the Community Mental Health Board for Manistee and Benzie Counties.

"Executive Director" means the director of the CMHB of Manistee and Benzie Counties.

"Service" means a mental health service.

"Department" means the Department of Mental Health of the State of Michigan.

"Director" means the director of the Department of Mental Health of the State of Michigan.

III.

Purpose of the Board

The purpose of the Community Mental Health Board of Manistee and Benzie Counties is to provide a range of mental health services for persons located within the two counties as required by and permitted under 1974 PA 258, as amended. The Board shall carry out the applicable provisions of the Mental Health Code and shall, subject to the rules designated by the Michigan Department of Mental Health, provide services in at least one of the following mental health areas:

mental illness, developmental disabilities, organic brain and other neurological impairment or disease, alcoholism and/or substance abuse.

A service provided pursuant to this Agreement is any of the following:

a) Prevention, consultation, collaboration, education or information service;

b) Diagnostic service;

c) Emergency service;

d) In-patient service;

e) Out-patient service;

f) Partial hospitalization service;

g) Residential, sheltered or protective care service;

h) Habilitation or rehabilitation service;

i) Any other service approved by the State Department of Mental Health.

IV.

Area Served

The Board shall provide the services set forth herein to persons who are located within Manistee and Benzie Counties.

V.

Establishment of the Board

The Counties hereby establish a Community Mental Health Board consisting of twelve (12) members to serve for the term and upon the conditions set forth in Article VI. Each Board of Commissioners shall by a majority vote appoint the Board members from its County. Recommended new appointments to the Board shall be made annually following the organizational meeting of the Boards of Commissioners. The membership of the Board for each of the Counties shall be divided between the Counties in proportion to each County's population, except that each County shall be entitled to at least one Board membership:

County	Population*	%	Member(s)
Manistee	21,265	63.5	8
Benzie	12,200	36.5	4
TOTAL:	33,465	100.0	12

(*1990 Census). The allocation of Board members shall be re-established, if necessary, subsequent to each decennial census.

VI.

Term of Board Membership,
Vacancies, Removal From Office

The term of office of a Board member shall be three (3) years from January 1 of the year of appointment, except that of the members first appointed, four shall be appointed for a term of one year, four for two years and four for three years. Vacancies shall be filled for unexpired terms in the same manner as original appointments. A Board member may be removed from office by the appointing Board of Commissioners for either neglect of official duty or misconduct in office after being given a written statement of reasons and an opportunity to be heard thereon.

VII.

Qualifications for Board Members

1. The composition of the Community Mental Health Board shall be representative of providers of mental health services, recipients or consumers of mental health services, agencies and occupations having a working involvement with mental health services, and the general public, although such representation need not be in any fixed proportion.

2. Not more than four (4) members of the Board may be county commissioners. No more than half of the total Board members may be state, county or local public officials. For purposes of this section, public officials are

defined as persons serving in an elected or appointed public office or employed more than twenty (20) hours per week by an agency of federal, state, city or local government.

3. A Board member shall have his/her place of residence in the county he/she represents. An employee of the Department, an employee of the CMHB, or an employee or representative of an agency having a contractual relationship with the CMHB may not be appointed to serve on the Board.

VIII.

Compensation and Expenses For Board Members

A Board member shall be paid per diems for meetings attended in an amount authorized pursuant to 1974 PA 258, as amended, Section 224. Board members shall receive a mileage reimbursement at a rate not in excess of the rate determined by the State Officers' Compensation Commission. A Board member shall not receive more than one per diem payment per day, regardless of the number of meetings attended related to CMHB business.

The Board members shall be eligible for necessary other expenses and reimbursements as are permitted by the Manistee or Benzie County Boards of Commissioners with respect to conferences, seminars and other CMHB related activities. The CMHB shall seek reimbursement from the Department subject to its rules and regulations for per diem payments made to the CMHB under Section 224 of Act 258 of Public Acts of 1974, as amended.

IX.

Board Duties

The Board shall:

a) Annually examine and evaluate the mental health needs of the Counties and the public and non-public services necessary to meet those needs.

b) Review and approve an annual plan and budget. The format and

documentation of the annual plan and budget shall be specified by the Department.

c) Submit the annual plan and budget to the Department by such date as is specified by the Department after review by each Board of Commissioners. Such submission to the Department shall constitute the program's official application for state funds.

d) Provide and advertise a public hearing on the annual plan and budget prior to submitting it to the County Board of Commissioners.

e) Submit to each Board of Commissioners an annual request for County funds to support the program. Such request shall be in the form and at the time determined by the Board of Commissioners.

f) Take action to secure private, federal and other public funds to help support its program.

g) Approve and authorize all contracts for the providing of services.

h) Review and evaluate the quality, effectiveness, and efficiency of services being provided by its program.

i) Appoint an executive director who shall meet standards of training and experience established by the Department.

j) Establish general policy guidelines within which the executive director shall execute the CMHB program.

~~k)~~ State and local contributions and all other funds received shall be handled and banked directly by the CMHB, which has the duty to insure that the funds are banked and accounted for consistent with requirements of law for local governmental units.

X.

Powers of the Board

The Board shall have all the rights, powers, duties and obligations set forth in the Mental Health Code, 1974 PA 258, as amended, and shall have the following powers and duties in addition to the other powers and duties stated under this agreement:

1. To enter into contracts, including contracts for the purchase of mental health services with private persons and/or entities or public agencies. The contracts may be entered into with any facility or entity of the State Department of Mental Health.

2. To acquire ownership, custody, operation, maintenance, lease or sale of real or personal property, subject to any limitation on the payment or funding therefor now or subsequently imposed by the Mental Health Code, 1974 PA 258, as amended.

3. To dispose of, divide, and distribute property.

4. To accept gifts, grants, assistance, funds or bequests.

5. To make claims for federal or state aid payable to the participants in the programs of the Board.

6. To incur debts, liabilities or obligations which do not constitute the debts, liabilities or obligations of any of the parties to this agreement, subject to any limitations thereon which are now or hereafter imposed by the Mental Health Code, 1974 PA 258, as amended.

7. To, in its own name, employ employees and agents, which employees or agents shall be considered employees or agents of the Board. The Board shall have the powers, duties and responsibility for establishing policies, guidelines and procedures for employees and shall have the power, duty and responsibility to establish wages and fringe benefits such as, but not limited to, sick leave,

vacation, health insurance, pension and life insurance; to provide for worker's compensation and for any and all other terms and conditions of employment of an employee of the Board. However, any County employee initially transferred to the Community Mental Health Board by either of the contracting Counties shall continue to have all benefits, obligations and status with respect to pay, seniority credits, and sick leave, vacation, insurance and pension credits that the individual held as a County employee. The above-stated conditions and limitations upon the transfer of County employees shall not serve to limit the right of the Board to hire County employees voluntarily seeking a job change upon such terms and conditions as the Board and the individual may agree upon.

8. To fix and collect charges, rates, rents or fees where appropriate and to promulgate rules and regulations related thereto.

XI.

Director

The executive director shall function as the chief executive and administrative officer of the Community Mental Health program and shall execute and administer the Community Mental Health program in accordance with the approved plan and budget, the general policy guidelines established by the Board, the applicable procedures and regulations, and the provisions of state statute. The terms and conditions of the executive director's employment, including tenure of service, shall be as mutually agreed to by the Board and the executive director and shall be specified in writing.

XII.

Funding

Cost sharing for Manistee and Benzie Counties shall be based upon population distribution as displayed in the most recent decennial census at the rate of local match required under Public Act 258. Nothing contained herein shall

prevent any County from allocating available local funds in excess of the minimum obligation pursuant to this contract and the Mental Health Code upon such terms as the Board of Commissioners determines.

XIII.

Information

The Board shall provide to Manistee and Benzie Counties, separately and/or jointly, as requested, any and all information related to the operations of the Board on a timely basis.

XIV.

Duration of This Agreement
and Rights Upon Termination

a) The duration of this agreement shall be perpetual. However, either of the Counties participating pursuant to this agreement may accomplish a termination by official notice from the County's Board of Commissioners to the State Department of Mental Health and the other County's Board of Commissioners. The date of termination shall be two (2) years following the receipt of such notification by the State Department of Mental Health, unless the Director of that Department consents to an earlier termination. In the interim between notification and official termination, the County participation in the program pursuant to this agreement shall be maintained. Upon the termination of participation by either County, the CMHB shall be dissolved on the effective date of termination.

b) Upon the termination of the CMHB, each County shall receive from the Board, in proportion to its total economic contribution for the existence of the Board, such real and personal property as is then held by the Board after the payment by the Board of all outstanding debts and obligations, including the return to the State or other entity such real and/or personal property as that

entity has a legitimate legal claim to receive.

Nothing contained herein shall preclude the two Counties from otherwise jointly agreeing in writing to any distribution of the real and personal property among themselves as they deem proper.

XV.

Status of the Board

The Board established pursuant to this agreement shall be a separate legal entity with the power to sue and be sued.

XVI.

Amendment Procedures

This agreement may be amended only by the mutual agreement of the contracting Counties pursuant to resolution authorized by both of the County Boards of Commissioners and entered into in writing.

XVII.

Conflict of Provisions

If there is any conflict between this agreement and the Mental Health Code, as existing or as subsequently amended, the Mental Health Code shall prevail, and those provisions of this agreement inconsistent therewith shall be deemed of no effect.

XVIII.

Effectuation of Agreement

This agreement shall not take effect until at least three (3) public hearings on this agreement have been held and until this agreement is approved by the Governor of the State of Michigan and the State Department of Mental Health as provided for in 1967 PA 7. Subsequent to the three (3) hearings and upon receipt of the approval of the Governor and the State Department of Mental Health, this agreement shall take immediate effect.

The business address of the Community Mental Health Board of Manistee-Benzie Counties is Manistee-Benzie Community Mental Health Services, 310 N. Gloucheski Drive, P.O. Box 335, Manistee, Michigan 49660-0335. Any subsequent change thereof by the Board shall be reported in writing to the forming Counties, the State Department of Mental Health and the Governor of Michigan.

The persons signing this agreement hereby verify by their signatures that they are authorized to execute this agreement pursuant to appropriate County Board of Commissioner resolution.

IN THE PRESENCE OF:

MANISTEE COUNTY

12/15/92
Date

By: Carl Rutske
Chairperson
Manistee County Board of Commissioners

12-15-92
Date

By:
Manistee County Clerk

IN THE PRESENCE OF:

BENZIE COUNTY

12-15-92
Date

By:
Chairperson
Benzie County Board of Commissioners

12-15-92
Date

By:
Benzie County Clerk

PREPARED BY:
COHL, STOKER & TOSKEY, P.C.
601 North Capitol Avenue
Lansing, Michigan 48933
517/372-9000
December 1992

By:
Peter A. Cohl

ID:C:\WP\MANISTEE\CMHB.AGT

Ingemar Johansson - PRIV ATT CLIENT COMM.

Mic

Mic

From: "Richard McNulty" <rmcnulty@cstmlaw.com>
To: <ijohansson@centrawellness.org>
Date: 05/09/2011 4:59 PM
Subject: PRIV ATT CLIENT COMM.
CC: "Peter Cohl" <pcohl@cstmlaw.com>

Mr. Johansson:

Per our conversation, here is an outline for Community Mental Health Board of Manistee and Benzie Counties undertaking to use a d/b/a or "assumed name" of Centra Wellness Network (CWN).

FIRST, I cannot locate any procedure or statutory basis for a municipal corporation to utilize a d/b/a or "assumed name". Other types of Michigan corporations have specific authority by statute to use an assumed name. See, Act 284, Public Acts of 1972 (profit corporations), Act 162, Public Acts of 1982(nonprofit corporations), Act 213, Public Acts of 1982 (limited partnerships), or Act 23, Public Acts of 1993 (limited liability companies). Further, corporations are excluded from the statutory procedure whereby an individua (or partnership) can use an assumed name. [MCL 445.1]. Thus, I cannot guarantee that a d/b/a or "assumed name" is even permitted for a municipal corporation-- there is nothing authorizing this in any statute I could locate. This may lead you to conclude that, if the Department of Energy, Labor and Economic Growth (DELG) does not permit you to make this change, you might want to consider a name change. Here is the form utilized by DELG for assumed names: http://www.dleg.state.mi.us/bcsc/forms/corp/llc/541.pdf

SECOND, in reading the resolutions of the Counties, it is unclear whether the Counties were authorizing an assumed name or a change in name. The difference is that if it is a "name change", then Community Mental Health Board of Manistee and Benzie Counties no longer exists as an entity and rather the entity is CWN. If it is an assumed name, then Community Mental Health Board of Manistee and Benzie Counties continues to exist but it is authorized to also be doing business under the name CWN. More specically, "doing business as", is a formal declaration that an individual, company or organization is conducting business **under a different name but also maintaining it's current corporate name.** DBA's are also commonly referred to as fictitious business names, assumed business names and trade names. All these terms mean the same thing. In other words, a DBA **is used when a company is doing business under a name other than its legal business name.**

If DELG allows an assumed name for a municipal corporation (a BIG IF, because I can locate no statutory authority or procedure for this) the advantages to using the assumed name procedure is that Community Mental Health Board of Manistee and Benzie Counties continues to exist as an entity and you don't have to change bank accounts, signs etc -- in that CWN is just an additional name for the same entity. If DELG does not permit a municipal corporation to have an assumed name, then a formal name change is the only vehicle. Thus, Step 1-- check with DELG whether Community Mental Health Board of Manistee and Benzie Counties can file for an assumed name. If the answer is yes, I believe that the Counties will need to clarify their previous resolutions to make clear that they were authorizing an assumed name and not a name change.

The Motion would look something like this:

A Motion to revoke the County's Motion dated December 21, 2010 (Benzie) (I don't have the date for Manistee) and substitute it with a Motion to authorize Community Mental Health Board of Manistee and Benzie Counties to register for an assumed name and, in the future, also do business as Centra Wellness Network.

THIRD, If you decide to just go with a change in name, then all that needs be done is the authorizing document (for example the agreement between the Counties establishing a mental health authority and the Articles of Incorporation) need be amended to contain the new name. I could not locate the procedure (or whether there is a different procedure under Michigan law) for filing with the State a certification of such new name FOR A MUNICIPAL ENTITY. However, the procedure for changing the business name for a corporation in Michigan is generally:

File a certificate of amendment to the articles of incorporation to change the name of a corporation. Include the old and new business name in the amendment paperwork. Submit the amendment and a $25 filing fee to the Michigan Department of Energy, Labor and Economic Growth.

Michigan Department of Energy, Labor and Economic Growth
Bureau of Commercial Services, Corporate Division
P.O. Box 30054
Lansing, MI 48909-7554

The form can be found at: http://www.dleg.state.mi.us/bcsc/forms/corp/corp/515.pdf

If you have any other questions, please contact me.

Richard D McNulty
Cohl, Stoker & Toskey, P.C.
517-372-9000
rmcnulty@cstmlaw.com

STEVEN E BURNHAM
ATTORNEY AT LAW
10286 N RIVERVIEW
PLAINWELL, MICHIGAN 49080-9688

December 02, 2010

Chip Johnston
Chief Executive Officer
Manistee-Benzie Community Mental Health
310 N Gloucheski Drive
Manistee, Michigan 49660-0335

RE: Urban Cooperation Act and Doing Business As (D/B/A) interaction

Dear Mr. Johnston: Chip

You have requested that I provide a brief legal opinion as to the implications of, and utility of, having an Urban Cooperation Act Board also register as a D/B/A.

First of all it is important to note that the real issue here is one of how your organization is legally organized. At one level utilizing the Urban Cooperation Act (UCA) is in the same vein as organizing as a D/B/A. The significant difference is found in the protection, rights, powers and liabilities that you assume under the different structures.

Your Board formed as a UCA board back in 1992. The statute allows certain governmental entities to come together for mutual purposes to conduct its business. It provides for certain rights and obligations and for protections to the individual governmental entities that create the agreement.

Filing an Assumed Name or Doing Business As (D/B/A) is not so much a legal structure as it is notice to the general public that you are conducting business in a name other than your own legal name, or that of your partners. In this case instead of Manistee Community Mental Health and Benzie Community Mental Health, separately, it is that you are conducting business as (D/B/A) Manistee- Benzie Community Mental Health.

Where you typically see a d/b/a is John Smith as a sole proprietor starting a small business such as a snow removal service- "Smitty's Snow B Gone". He could go through the expense of forming a corporation, a LCC or some other legal entity or he can file his fictitious name and off he goes to move snow.

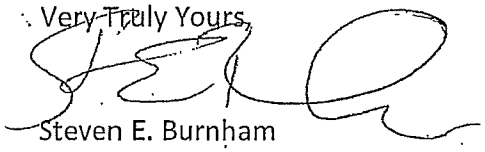
As a LCC or corporation the company would typically be sued or is responsible for legal filings and there are tax differences. A d/b/a is really just giving notice to the world that John Smith is also Smitty's Snow B Gone. It does not provide any immunity to John personally.

I have always recommended to my clients that if they are going to use any name other than the basic legal name that they file notice of the assumed name. I am attaching the form that Kalamazoo County Clerk's office uses for folks to register their D/B/A. It is cheap, easy and puts the world on notice that you are who you are! It does not create any additional liability, cost or effort. It is simply notice.

I hope this short discussion of filing a D/B/A is useful and answers the question you have posed. If it does not please do not hesitate to contact me.

Thank you for the opportunity to be of assistance to you and your agency.

Very Truly Yours,



Steven E. Burnham
Attorney At Law

Enc.

BCS/CD-540 (Rev. 05/10)

MICHIGAN DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
BUREAU OF COMMERCIAL SERVICES

Date Received	Extended To:	This document is effective on the date filed, unless a subsequent effective date within 90 days after received date is stated in the document.
Date Received	Extended To:	

(FOR BUREAU USE ONLY)

FILED

NOV 09 2010

Administrator
BUREAU OF COMMERCIAL SERVICES

Tran Info:1 16305951-1 11/08/10
Chk#: 05642 Amt: $10.00
ID: MANISTEE BENZIE COMMUNITY

EXPIRATION DATE: 03/31/2011

Name		
MBCMH c/o Ingemar Johansson		
Address		
310 N. Glocheski Dr.		
City	State	ZIP Code
Manistee	MI	49660

Document will be returned to the name and address you enter above.

597145

APPLICATION FOR RESERVATION OF NAME
For use by Corporations, Limited Partnerships, and Limited Liability Companies
(Please read information and instructions on reverse side)

Pursuant to the provisions of Act 284, Public Acts of 1972 (profit corporations), Act 162, Public Acts of 1982 (nonprofit corporations), Act 213, Public Acts of 1982 (limited partnerships), or Act 23, Public Acts of 1993 (limited liability companies), the undersigned applicant executes the following Application:

1. The name to be reserved is:

   Centra Wellness Network

2. This name is reserved for use as the name of a (check appropriate box):

   - ☐ Profit Corporation (for six months following the month of filing) - $10.00
   - ☑ Nonprofit Corporation (for four months following the month of filing) - $10.00
   - ☐ Limited Partnership (for four months following the month of filing) - $10.00
   - ☐ Limited Liability Company (for six months following the month of filing) - $25.00

Signed this 2nd day of November, 2010

Ingemar Johansson
(Type or Print Name of Applicant)

(Signature of Applicant)

Chief Operating Officer
(Type or Print Title)

310 N. Glocheski Drive
(Street Address)

Manistee, MI 49660
(City, State, ZIP Code)

Centra Wellness
NETWORK

February 15, 2017

To Whom it May Concern:

In review of documents related to Centra Wellness Network's (CWN) name change from Manistee-Benzie CMH (MBCMH), it was discovered the effective date was incorrect. Please accept the attached correspondence with corrected effective date of MBCMH's change in name to CWN.

Thank you.

Sincerely,

N. Warlin

Nicole Warlin
Executive Assistant
Centra Wellness Network

Centra Wellness
NETWORK

May 6, 2011

Kendra Brinkley
Contract Manager
Bureau of Community Mental Health Services
Michigan Department of Community Health

Dear Kendra;

As I indicated to you in an email of April 15, 2011, Manistee-Benzie Community Mental Health is doing business as "Centra Wellness Network" beginning on May 3, 2011.

In that light, we are not changing our tax identification number, but keeping it the same. We will also keep "Manistee-Benzie Community Mental Health Services" in MAIN. For your information, we completed our vendor profile change in DTMB.

Please notify all necessary entities within MDCH and I hope this completes our name change notice to you. If you have any further questions, please do not hesitate to contact me at any time.

Sincerely,

Ingemar Johansson, Chief Operating Officer
Centra Wellness Network

Centra Wellness
NETWORK

May 6, 2011

Kendra Binkley
Contract Manager
Bureau of Community Mental Health Services
Michigan Department of Community Health

Dear Kendra;

As I indicated to you in an email of April 15, 2011, Manistee-Benzie Community Mental Health is doing business as "Centra Wellness Network" beginning on May 3, 2001.

In that light, we are not changing our tax identification number but keeping it the same. We will also keep "Manistee-Benzie Community Mental Health Services" in MAIN. For your information, we completed our vendor profile change in DTMB.

Please notify all necessary entities within MDCH and I hope this completes our name change notice to you. If you have any further questions, please do not hesitate to contact me at any time.

Sincerely,

Ingemar Johansson, Chief Operating Officer
Centra Wellness Network

MENTAL HEALTH BOARD/NAME CHANGE

Moved by Kowalski, supported by Hilliard to approve that the Manistee County Board of Commissioners acknowledge that effective May 2, 2011, the Community Mental Health Board of Manistee and Benzie counties shall be known as Centra Wellness Network.

YEAS: 7 Schmidt, Anderson, Hilliard, Kowalski, Krolczyk, Lottie, Rutske

NAYS: 0

Motion Carried

++++++++++++++++++++

SHERIFF'S DEPARTMENT/TRANSFER FUNDS

Moved by Rutske, supported by Schmidt to approve transferring $6,500.00 from the Sheriff's Contingency Surplus Line Item #216 000 390.013 to General Fund Line Item #101 301 730.000 "Equipment" and authorize the County Controller to make the proper budget amendments, to be used toward the purchase of the following items from the following vendors:

Allen Supply

Schlage combo lock & installation in the women's locker room/shower area=$863.40,

Date-Link Associates, Inc.

Storage supplies for armory=$1,503.76

J. A. Scott, Inc.

60" stainless steel shower curtain rod with flanges and 72" shower curtain with hooks for the Women's locker room=$107.00.

70" Emco R1 Satin aluminum coat rack/shelf for the Men's locker room=$328.00.

Jackpine Business Center

AARCO Heavy duty cork board=$535.00
Signage for doors=$350.00
Tripod easel 1"=$110.00
Easel pad=$60.00

BENZIE COUNTY
BOARD OF COMMISSIONERS

448 COURT PLACE – BEULAH, MI 49617 – (231) 882-9671
www.benzieco.net

SPECIAL MEETING
BENZIE COUNTY BOARD OF COMMISSIONERS
AGENDA
February 9, 2010

Commissioners Room, 448 Court Place, Beulah, Michigan

9:00 a.m. Call to Order

Roll call

Invocation & Pledge of Allegiance

Approval of Agenda

Discussions with General Fund Dept Heads regarding Budget Cuts

Any further business to come before the board.

Public Input

Adjournment

THE COUNTY OF BENZIE WILL PROVIDE NECESSARY REASONABLE AUXILIARY AIDS AND SERVICES, SUCH AS SIGNERS FOR THE HEARING IMPAIRED AND AUDIO TAPES OF PRINTED MATERIALS BEING CONSIDERED AT THE MEETING, TO INDIVIDUALS WITH DISABILITIES AT THE MEETING OR HEARING UPON THIRTY (30) DAYS NOTICE TO THE COUNTY OF BENZIE. INDIVIDUALS WITH DISABILITIES REQUIRING AUXILIARY AIDS OR SERVICES SHOULD CONTACT THE COUNTY BY WRITING OR CALLING THE FOLLOWING:

BENZIE COUNTY CLERK
448 COURT PLACE
BEULAH MI 49617
(231) 882-9671

This notice was posted by Dawn Olney, Benzie County Clerk, on the bulletin board in the main entrance of the Benzie County Governmental Center, Beulah, Michigan, at least 18 hours prior to the start of the meeting. This notice is to comply with Sections 4 and 5 of the Michigan Open Meetings Act (PA 267 of 1976).

PUBLIC INPUT

Purpose: The Benzie County Board of Commissioners is a public policy setting body and subject to the Open Meetings Act (PA 267 of 1976). The Board also operates under a set of "Benzie County Board Rules (section 7.3)" which provides for public input during their meetings. It continually strives to receive input from the residents of the county and reserves two opportunities during the monthly scheduled meeting for you the public to voice opinions, concerns and sharing of any other items of common interest. There are however, in concert with meeting conduct certain rules to follow.

Speaking Time: Agenda items may be added or removed by the board but initially at least two times are devoted to Public Input. Generally, however, attendees wishing to speak will be informed how long they may speak by the chairman. All speakers are asked to give their name, residence and topic they wish to address. This and the statements/comments will be entered into the public record (minutes of the meeting). Should there be a number of speakers wishing to voice similar opinions, an option for a longer presentation may be more appropriate for the group and one or more speakers may talk within that time frame.

Group Presentations – 15 minutes
Individual Presentations – 3 minutes

Board Response: Generally, as this is an "Input" option, the board will not comment or respond to presenters. Silence or non-response from the board should not be interpreted as disinterest or disagreement by the board. However, should the board individually or collectively wish to address the comments of the speaker(s) at the approval of the Chair and within a time frame previously established, responses may be made by the board. Additionally, the presenter may be in need of a more lengthy understanding of an issue or topic and may be referred to a committee appropriate to address those issues.

Public Input is very important in public policy settings and is only one means for an interchange of information or dialogue. Each commissioner represents a district within the county and he/she may be individually contacted should greater depth or understanding of an issue be sought. Personal contact is encouraged and helpful to both residents and the board.

Commissioner Contacts:

District I - Mark Roper (Almira).....275-6270
District II - Mary Pitcher (Platte, Crystal Lake, and Lake).....882-4592
District III - Kristin Hollenbeck (Gilmore, Frankfort)..... 352-9094
District IV - Anne Damm (Benzonia).....882-9081
District V - Frank Walterhouse (Homestead).....325-2964
District VI - Tom Kelley (Colfax, Inland).....378-4474
District VII – Don Tanner (Blaine, Joyfield, Weldon).....882-7266

General Fund Cuts:

Year	Taxable Value	Millage	Revenue
2009 actual	1,112,924,614	3.5144	3,911,262.26
2010 estimate	1,068,407,629	3.5144	3,754,811.77

Budget	3,911,169.00
Projected	3,754,811.77
Difference	156,357.23
State Cuts	20,677.31
Total cuts	177,034.54

Department	Original Budget	Balance as of 1/31/2010	Percent of change 7.1558610%
101 Commissioners	98,350	72,764.70	5,206.94
131 Circuit Court	306,228	219,675.45	15,719.67
136 District Court	187,932	138,511.45	9,911.69
141 Friend of the Court	118,300	104,203.46	7,456.65
142 Friend of the Court - JV Division	80,979	80,996.80	5,796.02
145 Law Library	1,500	750.00	-
148 Probate Court	217,070	149,437.73	10,693.56
172 Administrator/Controller	92,016	53,853.15	3,853.66
215 County Clerk	164,427	126,347.56	9,041.26
253 County Treasurer	151,937	110,346.91	7,896.27
257 Equalization	136,346	88,682.06	6,345.96
261 Cooperative Extension	67,838	47,297.72	3,384.56
262 Elections	41,000	34,162.06	2,444.59
265 Building & Grounds	255,355	177,869.15	12,728.07
266 Legal & Contracted Services	106,250	74,496.18	5,330.84
267 Prosecuting Attorney	191,486	125,230.93	8,961.35
268 Register of Deeds	139,611	97,513.82	6,977.95
275 Drain Commission	8,285	4,406.68	315.34
278 Surveyor	771	771.00	-
282 Plat Board	250	250.00	17.89
285 Central Services	58,000	42,192.49	-
286 Technology Support	43,254	26,166.22	-
301 Sheriff	798,846	485,436.86	34,737.19
333 Secondary Road Patrol	75,441	52,583.41	3,762.80
334 Zero Tolerance, Bailiff	45,201	30,288.80	2,167.42
426 Emergency Management	23,311	17,270.16	1,235.83
601 Health Department	196,928	98,813.26	7,070.94
648 Medical Examiner	15,950	12,394.10	886.90
649 Mental Health	159,536	62,697.22	4,486.53
670 Human Services Board	10,000	-	-
721 Planning Department	18,303	952.37	-
722 Zoning Department	8,215	3,297.23	-
723 Soil Erosion Control	12,000	8,218.40	-
728 Economic Development	63,601	60,476.00	-
751 Parks & Recreation	8,450	8,450.00	604.67
851 Insurance & Bonds	120,301	117,182.82	-
852 Medical Insurance	615,224	417,799.94	-
861 Retirement	277,840	179,729.31	-
862 Social Security	155,153	99,234.30	-
870 Unemployment Insurance	20,000	20,000.00	-
871 Workers Compensation Insurance	25,092	25,092.00	-
899 Tax tribunal/BOR Refunds Ordered	1,000	216.71	-
966 Transfer Out	654,008	588,183.00	-
	5,771,585	4,064,241.41	177,034.54

ACCOUNT	DESCRIPTION	2009-10 ORIG BUDGET	2009-10 AMENDED BUDGET	YEAR-TO-DATE THRU 01/31/10	ACTIVITY FOR MONTH ENDED 01/31/2010	AVAILABLE BALANCE	% OF BUDGET USED
Expenditures							
Dept 649: MENTAL HEALTH							
101-649-800.00	CONTRACTED SERVICES	25,614.00	25,614.00	25,613.78	0.00	0.22	100.00
101-649-836.00	APPROPRIATIONS	133,922.00	133,922.00	71,225.00	0.00	62,697.00	53.18
Total - Dept 649		159,536.00	159,536.00	96,838.78	0.00	62,697.22	60.70
Total Expenditures		159,536.00	159,536.00	96,838.78	0.00	62,697.22	60.70
NET OF REVENUES AND EXPENDITURES		(159,536.00)	(159,536.00)	(96,838.78)	0.00	(62,697.22)	

Present:			
x	Risser, Chair	x	Edmondson
	Stapleton, Vice Chair	x	Smeltzer
	Hooghart, Secretary	x	Tanner
x	Haik	x	Wilson
	Hilliard	x	Wisniski
x	Kelley	x	Worden
	B. Sage, Recording Secretary		

Guests:

Staff: Chip Johnston, Cheryl Kobernik, Donna Nieman, Ingemar Johansson, Amy Taylor

Manistee Benzie Community Mental Health Services Board Minutes

9:00 a.m.
10/14/10

Benzie Resource Center

Schedule of Significant Events
Board of Directors-10/14/10, 9:00 a.m. BCRC
Legislative 10/14/10 12:30 p.m. BCRC
Board Conference 10/18 & 10/19/2010
Personnel 10/25/10 2:00 p.m. ADM
Planning & Finance Cmte-10/28/10,1:00 p.m. ADM
Policy Cmte-10/28/10, 9:00 a.m. BRC
Executive Cmte- 11/09/10, 1:00 p.m. ADM
Community Srvs & Relations-11/09/10 12:00 p.m. ADM
Board of Directors-11/18/10, 9:00 a.m. ADM
Recipient Rights-12/15/10, 2:30 p.m. BRC & ADM

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
9:00	**Opening**			
	Pledge			
	Roll Call	**DR, KS, AH, EH, TK, LE, DS, DT, LW, JW JOW, Absent KH**		
	Introductions	None		
	Public Comment	None		
	Board Member Comment	Wisniski informed the Board of Johnston's activities in Manistee, including meeting with township officials and 911. Wisniski encouraged Johnston to do the same with Benzie County.		
	Staff Comment	None		
9:05	**Minutes/Agenda Actions**			
	Modify or approve agenda	Adding CSR's to the Rights Committee Changing the date of the November Board meeting. Changing the date of the Finance meeting.	Wisniski **Motioned** and Smeltzer **Second** to approve the agenda with the noted changes.	
	Modify or approve minutes from 9/9/10		Wisniski **Motioned** Worden **Second** to approve the minutes from 9/9/10 as written.	
	Eliminate recordings	**9/9/10 Full Board** **8/25/10 Planning & Finance Cmte** **8/27/10 Personnel Cmte** **8/26/10 Policy Cmte** **8/31/10 Community Services and Relations** **9/1/10 Executive Cmte** **8/12/10 Legislative Cmte** **6/16/10 Recipient Rights**	Smetlzer **Motioned** and Wilson **Second** to eliminate the mentioned recordings.	

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
9:10	**Operations Report and Over-site**			
9:15	Employee of the Month	Debra Krieger		
9:25	Health Care Reform	Johnston reviewed the timelines of the Health Care Reform Bill. For FY 2014 it is expected that Medicaid guidelines will be expanded to 133% poverty, which will include General Funds. Also, there will be an Exchange, which covers those who are above the 133% poverty level. This would be like an additional insurance. Discussed the (ACO) Accountable Care Organizations, which seek to provide financial incentives for cost containment and quality improvement. The ACO are expected to coordinate care for their shared patients. Discussed the Health Reform Summary, which includes integration and payment structures. Potentially there would be 4 types of payment methods; it just depends on what the State decides on. Johnston will be working with the Federally Qualified Heath Care.		
9:10	Directors Report	Because of the possible Health Care Reform we will be focusing on Customer Service Trainings. We received a letter from DCH, which stated that they are giving us a one time payment of $75,000 to cover our over spending of General Funds. We have made a plan to manage our general fund consumers in the future. Discussed changing the date for the next Board meeting in November.	The group decided to have Bonnie Sage get 3 dates together and get a consensus on what date is desired.	We will continue with November 18, 2010
	Board Committee Reports			
	Executive Committee			
9:55	Actions Needed	Risser reviewed the Report from 10/5/10. Discussed whether to pay the invoice for our Association membership.	Haik **Motioned** and Kelley **Second** to pay the Association membership invoice. *All in Favor.*	Yes: TK, DS, LE, LW, AH, JW, EH, JOW, KS, DR No: DT Absent: KH

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
		Discussed Customer Service Training for staff.		
		Approval of the 10/5/10 report	Wilson **Motioned** and Worden **Second** to approve the report from 10/5/10. *All in Favor*	
10:10	*Planning and Finance*			
	Actions Needed	Wisniski gave the report from September 22, 2010		
	Financial Statements for August 2010	Nieman reviewed the August 2010 Financial Statements	Wisniski made a recommendation to place the Financial Statements on file.	
	Credit Card Statement		Kelley **Motioned** and Worden **Second** to approve the Credit Card Statement as presented. *All in Favor.*	
	2010 Budget Revision #2	The Final Budget still is not complete do to the consumer's ineligibility for Medicaid. Adjustments have been made due to CEI giving us a certain amount of funding and then tacking it back.	Edmondson **Motioned** and Worden **Second** to approve the Budget Revision as presented. *All in Favor.*	Yes: JOW, JW, DS, DR, LW, TK, AH, KS, LE, DT, EH No: None Absent: KH
	Residential Bid Review Update	Discussed concerns in changing residential providers. Taylor and Kidder will be interviewing guardians and consumers in regard to the residential issue. Discussed Job Fairs for our consumers.		
	Financial & Compliance Auditor	CEI, our affiliation has allowed us to choose Rosland and Prestage for our Financial and Compliance Auditor.	Hooghart **Motioned** and Kelley **Second** To have Rosland and Prestage for our Financial & Compliance Auditor *All in Favor.*	
	Contract: Managed Health General Fund Contract	Discussed the stipulation of Section 7.73 Abatement of GF Internal Service Funds (ISF).	Smeltzer **Motioned** and Edmondson **Second** to allow the Executive Director sign the Contract with the stipulation of Section 7.73 abatement of GF ISF. *All in Favor*	Yes: DT, KS, JW, JOW, LW, EH, AH, DS, DR, TK, LE No: None Absent: KH

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
	COLA 3%	There was a recommendation to take off the 3% COLA in the budget FY 11, due to unknown funding.	Smeltzer **Motioned** and Hooghart **Second** to remove the 3% COLA from the proposed budget. *All in Favor.*	Yes: DS, EH, TK, AH, KS, LE, JW, DR, LW, DT, JOW No: None Absent: KH
10:35	*Recipient Rights*			
	Action Needed?	Wisniski reviewed the report from September 15, 2010		
	Adding CSR's to Committee	There was a recommendation for the Customer Service Reps. (CSR) to join the Recipient Rights Committee	Kelley **Motioned** and Worden **Second** to have the CSR's join the Rights Committee. *All in Favor.*	
	Report from Worden	Worden gave a report about the different activities that are going on at the Drop-In-Center.		
11:10	Legislative Ad-hoc			
	Actions Needed?	Smeltzer gave the report from September 9, 2010.		
11:20	*Community Services and Relations*			
	Actions Needed?	Stapleton gave the report from October 5, 2010. The Needs Assessment for 2011 is complete. Discussed screenings at West Shore Hospital.		
	Name Change	Johansson updated the group why we want to change our Name, Logo, and Web-Site. The name "Centra Wellness Network" has been recommended.	Haik **Motioned** and Worden **Second** to go forward with the new name. *All in Favor.*	Yes: DS, KS, EH, JOW, DT, LE, No: TK, JW, AH, DR, LW Absent: KH
11:45	*Personnel Committee*			
	Action Needed?	Hooghart gave the report from September 27, 2010. There was a discussion whether to have the Staff Rep. give their committee report to the Personnel Committee. The committee is no longer mandating a Staff Report but Staff Reps. are invited at anytime.	Tanner **Motioned** and Smeltzer **Second,** to no longer mandate a Staff Report. *All in Favor*	
	Bargaining unit	There was a recommendation to have Hooghart involved in the bargaining unit. If Hooghart cannot attend Wisniski will be the designee.	Haik **Motioned** and Kelley **Second** to have Hooghart involved with the bargaining unit.	

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
			All in Favor.	
	Severance pay	For anyone that is in the Union, there is a recommendation that if one of them would like to retire, they would be allowed a severance pay of 1 month salary and 1 month of insurance coverage for those 5 –10 years of service, those with 10-15 years of service would receive 2 months salary and 2 months of insurance coverage, and those over 15 years would receive 3 months of salary and 3 months of insurance coverage.	Haik **Motioned** and Kelley **Second** to allow a response of 30 days to accept the severance pay. *All in Favor.*	Yes: DR, AH, LE, JOW, LW, DT, DS, TK, JW, EH, KS No: None Absent: KH
	Employee Benefit Statement	Barton did a study on the total cost of employees. A breakdown was prepared called Employee Benefit Statement. This was compared with the other CMH's that we used for the Salary study.		
		Approval of report from September 27, 2010	Haik **Motioned** and Tanner **Second** to accept the 9/27/10 report. *All in Favor.*	
12:10	*Policy and Process*			
	Action Needed?	Smeltzer gave the report from September 22, 2010.	Hooghart **Motioned** and Kelley **Second** to accept the report from 9/22/10. *All in Favor.*	
	09.05 Employment Practices	Vote for Adoption	Smeltzer **Motioned** and Hooghart **Second** for the Adoption of 09.05 Employment Practices. *All in Favor.*	
	09.04.09 Open Door	Vote for Implementation	Smeltzer **Motioned** and Risser **Second** to implement the following mentioned procedures into public hearings. *All in Favor.*	
	09.05.01 Recruitment & Selection	Vote for Implementation		
	09.05.08 Performance Evaluation & Monitoring	Vote for Implementation		
	09.06.01 Compensatory	Vote for Implementation		

	Time, Overtime, Flexible Time			
	09.07 Time Off/Leave	Vote for Implementation		
	09.07.02 Family & Medical Leave	Vote for Implementation		
	09.07.03 Military Leave	Vote for Implementation		
	09.08.02 Tuition Reimbursement	Vote for Implementation		
Time	**Agenda Items (Action items are in bold type)**	**Action/Responsible Party**	**Decision**	**Roll Call Vote**
	09.15 Transportation Guidelines	Vote for Implementation		
	Clinical Policies and Procedures	There was a recommendation for the Policy Committee to review the Clinical Policies and Procedures.	Smeltzer **Motioned** and Edmondson **Second** for the Policy Cmte. Review the Clinical Policies and Procedures for public input. *All in Favor.*	
12:30	**Unfinished Business**			
	None			
12:30	**New Business**			
	New Board member Orientation Information Economic Impact Study	Stapleton discussed having a basic overview of Board Members responsibilities.	Stapleton **Motioned** and Tanner **Second** to pay the $1,000 for the Economic Impact Study. *All in Favor.*	Yes: AH, DR, DS, EH, LW, KS, JOW, LE, DT No: JW, TK Absent: KH
	Public Input			
	(3 minute limit per individual)	None		
	Adjournment	Haik **Motioned** and Kelley **Second** to adjourn at 12:40 p.m.		

Goals for 2010:

1. Familiarize the Board on operations and regulatory oversight.
2. Each committee will need to set goals and objectives with a community structure.
3. Develop and implement compensation plan.
4. Revise employee evaluation system that is tailored to each employee.
5. Formalize cooperation relations between CMHP's and other organizations.

Annie Hooghart, Board Secretary — Date
Bonnie Sage, Recording Secretary

Present:			
x	Risser, Chair	x	Edmondson
	Stapleton, Vice Chair	x	Smeltzer
	Hooghart, Secretary	x	Tanner
	Schmidt	x	Wilson
x	Hilliard	x	Wisniski
x	Kelley	x	Worden
x	B. Sage, Recording Secretary		

Guests: Chris Cooke

Staff: Amy Taylor, Chip Johnston, Donna Nieman, Cheryl Kobernik, Ingemar Johansson, Tammy Reimer

Manistee Benzie Community Mental Health Services Board Minutes

9:00 a.m.
1/13/11

Manistee Administration Office

Schedule of Significant Events
Board of Directors-1/13/11, 9:00 a.m. ADM
Personnel 1/24/11 2:00 p.m. ADM
Planning & Finance Cmte-1/26/11,1:00 p.m. ADM
Policy Cmte-1/27/11, 9:00 a.m. BRC
Executive Cmte- 2/01/11, 2:00 p.m. ADM
Community Srvs & Relations-2/01/11 12:00 p.m. ADM
Board of Directors-2/10/11, 9:00 a.m. BRC
Recipient Rights-3/16/11, 2:30 p.m. BRC & ADM

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
9:00	**Opening**			
	Pledge			
	Roll Call	Present: DT, DR, LW, LE, JOW, RS, KH, TK, JW Absent: DS, AH, KS		
	Introductions	Richard Schmidt who is our new Board Member was introduced.		
	Public Comment	None		
	Board Member Comment	Tanner commented on the Mental Health systems in other states. Wisniski responded regarding the speech that Obama gave last night, addressing the responsibility of the Mental Health Systems.		
	Staff Comment	None		
9:05	**Minutes/Agenda Actions**			
	Modify or approve agenda for 1/13/11	Chris Cooke will be attending about 10:30 instead of 9:30 as scheduled.	Tanner **Motioned** and Hilliard **Second** to approve the 1/13/11 agenda as amended. *All in Favor*	
	Modify or approve minutes from 12/08/10		Wisniski **Motioned** and Risser **Second** to approve the minutes from 12/08/10 as written. *All in Favor*	
	Eliminate recordings?	12/09/10 Full Board 09/15/10 Recipient Rights 11/09/10 Community Services and Relations 11/24/10 Planning and Finance 11/22/10 Personnel Committee 11/23/10 Policy Committee 12/01/10 Executive Committee	Hilliard **Motioned** and Kelley **Second** to eliminate the recordings as listed. *All in Favor*	

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
9:10	**Operations Report and Over-site**			
9:10	Employee of the Month	Tammy Reimer Employee of the Month for December 2010.		
9:30	Directors Report	Johnston handed out a summary of the 1/7/11 meeting with Olga Dazzo, newly appointed Department of Community Health Director and Mike Head. They reviewed what their direction is in the future, including innovative programs across the State, budget proposals, children services, general funds and the sub-capitation management. The Snyder administration is looking at sharing administrative support and the potential of integrating CA's (Coordinating Agencies) and PIHP's (Pre-paid Inpatient Healthcare Provider). Johnston stated that there could be more interested parties in Medicaid funding. We are working actively with staff to impress on them the Customer Service model including outcomes and cost effectiveness. Our PIHP is projecting to delegate functions within our Contract. Johnston is looking into this proposal. Johnston has met with Judy Williams who is the director of the local FQHC (Federally Qualified Health Care) provider for possible integration of services. Johnston also met with the local Superintendents regarding our Safenet program and the funding there of. Kobernik updated the Board what responsibilities the Safenet program has.		

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
	Board Committee Reports			
9:40	*Executive Committee*			
	Actions Needed Board Retreat Name Change	Risser gave the report from 1/4/11. Date confirmed for January 21, 2011 at 9:00 a.m. at the Best Western in Beulah. The Benzie County Commissioners have Motioned approving our name change to Centra Wellness Network. Manistee Commissioners would like a letter from the Board about our name change.	Wisniski **Motioned** and Worden **Second** approving the report from 1/4/11.	
9:50	*Planning and Finance*			
	Actions Needed	Wisniski gave the report from December 22, 2010	Hooghart **Motioned** and Edmondson **Second** to approve the report from 12/22/10.	
	Financial Statements for November 2010	Our final notification from our affiliation on Medicaid funding will not be settled until the end of the fiscal year.	Hilliard **Motioned** and Kelley **Second** to approve the November 2010 Financial Statements and place on file. *All in Favor*	
	Aging Accounts Receivables ending November 2010.		Kelley **Motioned** and Worden **Second** to approve the aging account receivables and place on file. *All in Favor*	
	Credit Card Statement		Hilliard **Motioned** and Kelley **Second** to approve the credit card statement and place on file. *All in Favor*	
	Check register as of 1/04/2011		The Full Board voted *All in favor* to place the check register on file.	
	Contracts		Hilliard **Motioned** and Kelley **Second** to have the Executive Director sign the addressed contracts as presented.	
	Handicap Van	We received funding from the local Revenue Sharing Board to purchase a lift van. The van proposals were then discussed. The Board has requested Nieman to write a letter to Watson's regarding their bid proposal.		

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
10:30	Legal Consultation	Wisniski **Motioned** and Worden **Second** to agree with the resolution on the terms discussed in closed session.	Hilliard **Motioned** and Worden **Second** to go into a closed session. *All in Favor* Wisniski **Motioned** and Worden **Second** to open the meeting to the public at 10:55 *All in Favor*	
11:05	**Phone System**	Nieman noted that the upgrade of the phone system would not be going through as an expense because it is considered depreciation. Fred Feiger explained the process that it will take to change the phone system. We will be using our hardware so the cost of the installation will be less. Call Accounting software will also be installed. This will help in requested reports to the State. Contracting with other counties for the use of this system was also discussed.	Wisniski **Motioned** and Edmondson **Second** to approve the new phone system with the presented bids. *All in Favor*	
11:15	*Recipient Rights*			
	Action Needed?	Wisniski reviewed the report from December 15, 2010. Jan Morningstar presented the summary of the recipient rights annual report for FY 2010. Incident reports are going to be aggregated for monitoring.	The Full Board will have core recipient rights training after the next board meeting in February. Smeltzer **Motioned** and Kelley **Second** to approve the 12/15/10 report.	
11:25	Legislative Ad-hoc			
	Actions Needed?	Did not meet in December		
11:25	*Community Services and Relations*			
	Actions Needed? **Annual Needs Assessment Report**	Risser gave the report from 1/4/11. Discussed the reports that were presented at the Committee meeting. Each month the committee will review a section at a time of mandated reports. Once approved by the Board, the Annual Needs Assessment packet needs to be submitted to the department by 1/31/11.	Hooghart **Motioned** and Worden **Second** to approve the 1/4/11 report. Wilson **Motioned** and Edmondson **Second** to approve the needs assessment report. *All in Favor*	

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
11:45	*Personnel Committee*			
	Action Needed?	Hooghart reviewed the report from 12/20/2010. We have not had very many applications for the newly opened positions. We are looking to change the descriptions slightly so more may apply. Discussed paid time off (PTO) for employees regarding a carry over at the end of the fiscal year.	Smeltzer **Motioned** and Worden **Second** to approve the 12/20/10 report. Hooghart **Motioned** and Worden **Second** to allow a 5 day carry over in PTO at the end of each fiscal year. *All in Favor*	
11:55	*Policy and Process*			
	Action Needed?	Report from December 22, 2010.	Smelter **Motioned** and Kelley **Second** to approve the 12/22/10 report.	
	09.04.02 Workplace Violence	Vote for Adoption	Hilliard **Motioned** and Smeltzer **Second** to adopt the said procedures. *All in Favor*	
	09.05.12 Diversity and Inclusion	Vote for Adoption		
	09.06.04 Temporary Assignment	Vote for Adoption		
	03.10 Abuse and Neglect	Vote for Adoption		
	03.11 Access to Media-Resident Rights in Specialized Residential Setting	Vote for Adoption		
	03.12 Change in Type of Treatment	Vote for Adoption		
	03.13 Comprehensive Examinations-Resident Rights in Specialized Residential Setting	Vote for Adoption		
	03.14 Confidentiality and Disclosure	Vote for Adoption		
	03.15 Consent to Treatment	Vote for Adoption		
	03.16 Dignity and Respect	Vote for Adoption		
	03.17 Family Planning	Vote for Adoption		
	03.18 Fingerprinting, Photographs, Audiotape, or Use of 1-way glass	Vote for Adoption		

Time	Agenda Items (Action items are in bold type)	Action/Responsible Party	Decision	Roll Call Vote
	03.19 Freedom of Movement- Resident Rights in Specialized Residential Setting	Vote for Adoption		
	03.20 Labor- Resident Rights in Specialized Residential Setting	Vote for Adoption		
	03.21 Mail, Telephone and Visitation- Resident Rights in Specialized Residential Setting	Vote for Adoption		
	03.22 Medicaid Beneficiary Appeals/Grievances	Vote for Adoption		
	03.23 Personal Property and Funds- Resident Rights in Specialized Residential Setting	Vote for Adoption		
	03.25 Recipient Rights Complaints	Vote for Adoption		
	03.26 Recipient Rights Office and Staff	Vote for Adoption		
	03.27 Services Suited to Conditions	Vote for Adoption		
	03.28 Treatment by Spiritual Means- Resident Rights in Specialized Residential Setting	Vote for Adoption		
	New Policies/Procedures			
	03.05 Out of Network Services	Vote to send into public hearing	Hilliard **Motioned** and Wisniski **Second** to send these procedures into public hearing. *All in Favor*	
	03.24 Recipient Rights Advisory Committee	Vote to send into public hearing		
	03.29 Least Restrictive Setting	Vote to send into public hearing		
	03.30 Restraint and Seclusion	Vote to send into public hearing		
	05.02 Credentialing and Recredentialing	Vote to send into public hearing		
12:00	**Unfinished Business**			
		None		
12:00	**New Business**			
		None		
12:00	**Public Input**			
	(3 minute limit per individual)	None		
12:00	**Adjournment**	Risser Adjourned the meeting at 12:00 p.m.		

Goals for 2010:

1. Familiarize the Board on operations and regulatory oversight.
2. Each committee will need to set goals and objectives with a community structure.
3. Develop and implement compensation plan.
4. Revise employee evaluation system that is tailored to each employee.
5. Formalize cooperation relations between CMHP's and other organizations.

Annie Hooghart, Board Secretary
Bonnie Sage, Recording Secretary

Date

MICHIGAN MENTAL HEALTH COMMISSION

A BRIEF MODERN HISTORY OF MICHIGAN'S PUBLIC MENTAL HEALTH SYSTEM

THE INSTITUTIONAL ERA

Every society has grappled with the plight of individuals who manifest certain patterns of thinking, feeling and/or behavior that are considered signs of a serious mental disorder or condition. Michigan has long recognized a fundamental state obligation to assist those with serious mental disorders. Specific provisions in the state constitutions of 1850, 1908 and 1963 established the legal foundation for state involvement in the care and treatment of those with serious mental illness. The provisions in the 1850 and 1908 constitutions affirmed state support for institutions to serve those with mental illness (and other disabilities). In the 1963 constitution (Article VIII, § 8), state support was extended to include institutions, programs and services for the care, treatment, education or rehabilitation of the mentally disabled.

Initially, the state fulfilled its constitutional commitment through the establishment of state psychiatric asylums. In the mid-19th century, the development of mental asylums was considered enlightened and progressive public policy and a humane response to the plight of those with mental disorders. Michigan's first state institution for the mentally ill, the Kalamazoo Asylum for the Insane, began accepting patients in 1859, and over the next forty years, similar facilities were established in Pontiac, Traverse City and Newberry.

For much of the 19th century, public asylums in America generally housed a relatively modest proportion of long-term or chronically incapacitated patients, and these facilities had not yet assumed the role of custodial care institutions. Many patients entering public asylums during this period did not have prolonged lengths of stay at the facility, and they were eventually discharged back into the community. The circumstances that produced this diverse patient mix were complex, and involved legal issues, divided responsibilities among levels of government and certain financial liabilities and incentives.

By the end of the 19th century, however, these circumstances had changed, precipitating a steady increase in the proportion of chronically disabled, elderly, and disordered individuals with underlying somatic conditions among the population of state and county-operated psychiatric hospitals. This trend continued into the 20th century, and the average length of stay at public hospitals increased dramatically, with a concomitant decrease in discharge rates. The changing utilization patterns swelled the resident census at state facilities, necessitating the expansion of existing facilities, the establishment of additional state psychiatric hospitals, and a gradual shift in the role of the facilities from supportive and restorative treatment to custodial care.

The changing characteristics of the resident population (greater chronicity, more age-related psychiatric impairments, refractory symptomatology related to underlying physical causes) and the changing role of the public psychiatric hospital (provision of long-term custodial care) fostered an overly pessimistic perception of serious mental illness among the general public. Mental illness came to be regarded as a lifelong, gravely disabling, malady with little prospect for recovery or remediation of the illness. This gloomy perspective, in turn, diminished public support and legislative concern for state psychiatric facilities, and the hospitals steadily became more overcrowded, understaffed, regimented, bureaucratic, drab and impoverished. By the mid-1950s, there were over 559,000 individuals in publicly operated psychiatric hospitals across the United States. In that same period, over 20,000 Michiganians with mental illness were residing in state or county-operated psychiatric facilities.

SEEDS OF CHANGE

Despite prevailing negative stereotypes regarding mental illness and the seemingly pervasive indifference to the conditions in public institutions, there were other developments that were harbingers of new perspectives and treatment approaches for serious mental disorders. The National Mental Health Act of 1946 established the National Institute of Mental Health (NIMH) and authorized grants to states to support existing outpatient clinics that served the mentally ill, or to establish new clinics or programs for this purpose. In 1953, the American Medical Association and the American Psychiatric Association recommended a national study regarding the treatment of persons with mental illness. Congress adopted this recommendation and passed the Mental Health Study Act in 1955.

At the same time, scientific developments and psychosocial treatment modifications were changing institutional care for the seriously mentally ill. In 1952, the antipsychotic property of the drug chlorpromazine (Thorazine) was discovered, and the introduction of this medication (and other drugs of similar efficacy) into the treatment regimen at state facilities produced significant symptomatic improvement in many patients. Innovations in hospital milieu therapy were also being developed, reemphasizing the therapeutic (rather than custodial) orientation of state facilities.

With the widespread use of antipsychotic agents, improvements in the hospital milieu, and a growing professional recognition of the adverse effects of prolonged institutional care, the patient census at public institutions began to gradually recede, not just in Michigan but also across the United States. In Michigan, initially there was only modest flow of patients out of state facilities (the year-to-year census in Michigan's state-operated hospitals declined 16% from 1955 to 1965). Over time, however, this slow trickle became a mass exodus. While the advance in pharmacological treatment was not the sole factor responsible for the incremental census reduction, the new antipsychotic medications had clearly engendered a sense of hope regarding serious mental disorders and had altered public sentiments about these conditions.

As these changes were unfolding, the Joint Commission on Mental Illness and Health (operating under the auspices of the Mental Health Study Act of 1955) completed the study authorized by Congress and published its findings. The report, ***Action for Mental Health***, (1961), recommended changes in archaic state hospital systems (smaller facilities, better staffing) and suggested development of local centers to address the needs of the mentally ill returning to the community. The report stated that:

> *"The objective of modern treatment of persons with major mental illness is to enable the person to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. Therefore, aftercare and rehabilitation are essential parts of all services to mental patients, and the various methods of achieving rehabilitation should be integrated into all forms of service."*

In 1963, in response to this report, President Kennedy formed an interagency task force on mental illness to determine priorities for action and proposals for implementation. In 1963, reflecting the Joint Commission report and interagency task force recommendations, Congress passed, and President Kennedy signed, the Community Mental Health Centers (CMHC) Act. President Kennedy had previously (in a February 1963 address to Congress) called for 50% reduction in state hospital census over the next ten years, and the CMHC Act provided funds for the development of community-based care centers to help achieve this objective. The Act had some controversial aspects, however, since federal funding to establish CMHCs would bypass state government and go directly to grantees selected by the federal government. This created a split in authority and responsibility between the state hospital system and the new federally funded CMHCs.

The federal government went on to establish a number of ancillary social programs in the 1960s and early 1970s - medical assistance, income support, housing subsidies, and vocational rehabilitation services - that became instrumental in the successful transition of seriously mentally ill individuals from institutional care to community settings.

While Michigan had expanded institutional capacity during the first half of the 20th century, the state had also established a limited number of community-based programs to meet the needs of persons with mental illnesses. Community aftercare clinics had been established in various parts of the state under the auspices of nearby state psychiatric hospitals. Several child guidance centers had been founded by private organizations, and some of these later received state and/or local operating subsidies or contributions. In 1944, legislation was enacted to allow local county boards to appropriate funds for operation of child guidance centers and adult clinics.

In April 1963, (six months before the enactment of the federal CMHC Act), the Michigan Legislature passed **Public Act 54**. The intent of the legislation was to stimulate development of community mental health services throughout the state. Act 54 permitted counties – either singly or in combination – to form Community Mental Health Boards and to receive state matching funds for the operation of these agencies. In its original form, Act 54 allowed state match funds of 40% to 60% of the cost of an approved county program. The law was later amended to set the rate of state match for an approved program at 75%. By 1969, there were thirty-three (33) Act 54 boards, covering forty-nine (49) counties. State policy at that time promoted the gradual inclusion of other local publicly supported mental health services and clinics under the ambit of the Act 54 boards.

The federal CMHC grants and state support for community mental health boards spurred development of community programs and service capacity, consistent with the emerging perspective that serious mental illness was an enduring disorder with periodic exacerbation,

reoccurrence, and residual impairments (like other chronic disease states), but the condition was amenable to ameliorative, restorative and rehabilitative treatments and supports. Some individuals with serious mental illness might require episodic state hospital care during acute phases of the illness, but these individuals could (and should) be released back to their community and local "aftercare" programs, as soon as their condition stabilized and acute symptoms had receded.

Practice patterns in Michigan began to reflect this revised conception of mental illness, with the emphasis on more limited utilization of state facilities and greater reliance on community clinics and services. Between 1965 and 1975, the patient census at state psychiatric hospitals fell from 17,000 to roughly 5,000 patients. The national policy of deinstitutionalization had taken firm hold in Michigan.

In the early 1970s, changing societal views and perceptions regarding mental illness triggered numerous legal and advocacy challenges to existing civil commitment standards, inadequate hospital conditions, certain treatment methods, violations of constitutional rights and overly restrictive care arrangements. Complaints regarding inadequate community care emerged at the same time, with critics citing frequent readmissions (the "revolving door" phenomenon) among discharged patients, faulty coordination between the state and community agencies, insufficient community service capacity, and diffuse accountability for recipient care.

THE SHIFT TO COMMUNITY-BASED CARE

To address these issues and to provide a new framework for the organization and operation of Michigan's public mental health system, the Legislature passed **Public Act 258** in 1974. This statute - popularly known as the **Mental Health Code** - was a "tipping point" in the conversion from an institutional care system to a community-based treatment and supports model. The statute modernized civil commitment standards and due process procedures, clarified the roles and responsibilities of the state department and county-sponsored community mental health services programs (CMHSPs), designated priority populations for service and core program requirements, established the principle of "least restrictive setting" for care and treatment decisions, specified the rights of service recipients, and devised a monitoring and protection system. The legislation increased state match for approved county community mental health programs to 90% and stipulated that:

> *" it shall be the objective of the department to shift from the state to a county the primary responsibility for the direct delivery of public mental health services from the state to a community mental health services program whenever the county shall have demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of the county." (Section 116e)*

Despite passage of this landmark legislation and its sweeping prescription for change, implementation of many Code provisions lagged in the years following enactment of the statute. Coordination between hospital and community agencies continued to be problematic; discharge plans and community placement arrangements were often incomplete and haphazard; and local service capacity remained inadequate. To ensure more rapid transformation of the system, Governor Milliken established the "Governor's Committee on Unification of the Public Mental Health System" in 1979. In its final report, ***Into the 80s***, the Committee recommended:

> *" establishing a single point of responsibility for voluntary and involuntary entry into Michigan's public mental health system, for determination and oversight of the services it provides, for system exit, and for the resources that support service delivery. That single point of responsibility is to be located in the community. It is designated as a local mental health authority encompassing one or more counties."*

Following publication of the report, the state assumed a more aggressive posture toward system restructuring and the pace of change accelerated. The Department of Mental Health (DMH) devised a new arrangement – referred to as "**full management**" - to affect the shift of responsibility, authority and fiscal resources for public mental health services from the department to the county-sponsored community mental health services programs. Under full management, the CMHSPs became the single entry/single exit point for the entire public mental health system. Funding related to utilization of state psychiatric hospitals and developmental centers (as well as funding for community-based services) were allocated to the CMHSPs, which in turn "purchased" inpatient services from state institutions as needed. If a CMHSP could reduce its utilization of the state hospital, it retained the savings (referred to as "**trade-off**" dollars) for expansion of community programs and capacity.

Beyond the structural, fiscal and contractual changes, DMH promoted the adoption of innovative community treatment and support programs for adults and children with serious mental illness and emotional disorders. The department provided expansion funding to CMHSPs to develop, implement or replicate service models such as the Fairweather Lodge Program, Assertive Community Treatment (ACT), Psychosocial Rehabilitation (PSR) Programs (Clubhouses), Home-Based Services for Children, Wraparound, Supportive Independent Housing and Supported Employment.

At the national level, federal policy on mental health shifted in the 1980s. In 1977, President Carter had established a Presidential Commission on Mental Health to review mental health care in America and make recommendations for improvement. The Commission's findings generated ambitious and far-reaching strategies for change and called for significant federal involvement in addressing the problem of serious mental illness. However, this approach was not pursued by the new administration, and federal involvement in mental health policy and funding gradually receded. Despite the more limited participation of the federal government in mental health policy, the National Institute of Mental Health continued its efforts to promote improved programs for adults with serious mental illness and children with serious emotional disturbances through the Community Support Program (CSP) and the Child and Adolescent Service System Program (CASSP).

By the end of the decade of the 1980s, the direction of Michigan's public mental health system (progressive deinstitutionalization, admission diversions, gradual facility downsizing, development of community-based alternatives and investment in programmatic innovations) was broadly accepted and generally enjoyed bipartisan legislative support. DMH policy emphasized continued reduction in state facility utilization and the establishment of a "continuum of care" (comprehensive service array) within each CMHSP. The "dollar follows the patient" concept ("trade-off") encouraged community placement and reductions in facility utilization, and the funds retained by the CMHSPs were used to expand local service capacity and options.

However, during the 1980s, Michigan (similar to other states) began to increasingly rely on Medicaid coverages and federal reimbursement to support its community-based treatment services and rehabilitative programs. The establishment and gradual expansion of optional Medicaid services targeted to the needs of persons with serious mental illnesses provided additional revenue for the public system and increased the fiscal stability of community programs. However, the introduction and growth of Medicaid reimbursement also increased the complexity of funding arrangements, and encouraged certain budgetary adjustments that slowly compromised state-county collaboration on mental health care.

PUBLIC MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

Establishing a coherent public policy for children's mental health services posed persistent challenges for Michigan's mental health system throughout the 1970s and 1980s. Public institutional care had not been as frequently or extensively used for children as it had been for adults with serious mental illness, and hence the ability to finance increased community service capacity for children through the "trade-off" mechanism was much more limited. Most state psychiatric hospitals for children had been established adjacent to existing state adult facilities, and total bed capacity of these facilities was limited. In addition, Michigan had been an early pioneer and proponent of community-based child guidance clinics, which were supported by private donations, state funds, and/or local government allocations.

A number of national evaluations regarding the need for and the availability of mental health care for children and adolescents had estimated significant prevalence of mental disorders among this population, documented limited service capacity and availability, and revealed low rates of treatment and service utilization. The first of these reports emerged from the work of the Joint Commission on the Mental Health of Children, which published its report, ***Crisis in Child Mental Health***, in 1969. In 1978, the **Task Panel on Infants, Children and Adolescents**, a sub-committee of President Carter's Commission on Mental Health, found that children continued to receive inadequate mental health care, and noted that recommendations contained in the Joint Commission report of 1969 had never been implemented. In 1982, the Children's Defense Fund (CDF) published an extensive and highly unfavorable study of the provision of mental health care to children and adolescents in state mental health systems. The report, ***Unclaimed Children***, concluded that the vast majority of severely emotionally disturbed children and adolescents were not receiving adequate mental health care, and many received no treatment at all.

In Michigan, the ***Report of the Child Mental Health Study Group*** (1982) came to many of the same conclusions. Responding to these and other findings, Department of Mental Health policy and funding strategies in the 1980s emphasized the development and expansion of community mental health services for children and adolescents. Legislation passed in 1984 required the establishment of a "Children's Diagnostic and Treatment Services Program" within each CMHSP, to provide comprehensive evaluation, diagnosis and disposition arrangements for children in urgent or emergent need of mental health care. The Legislature also provided additional categorical funds to CMHSPs for expansion of intensive home-based services, therapeutic foster care, respite care programs and prevention initiatives. Finally, the state began to promote the development of local "systems of care" for children and adolescents, an approach first articulated through the federal CAASP initiative.

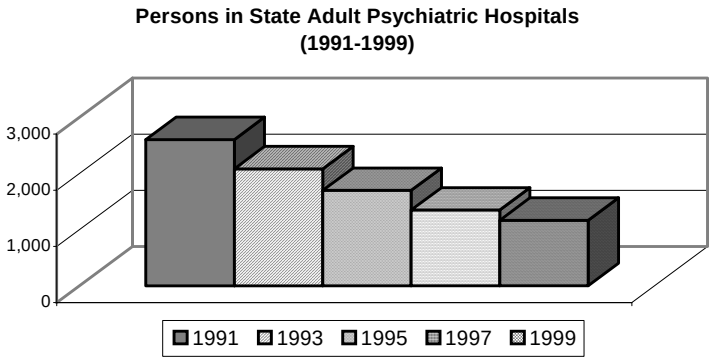
An enduring issue affecting the provision of mental health services to children and adolescents during the 1980s was the problem of coordinating service efforts and care responsibilities

among different child-serving agencies and systems. Many children in non-mental health systems (e.g., education, child welfare, juvenile justice, primary care settings, Head Start, etc.) exhibited signs of emotional disturbances and mental disorders. Determining service responsibilities, reconciling statutory mandates, and coordinating complicated funding arrangements often strained relations between agencies and drained energy and resources from service provision. Dissatisfaction with this state of affairs led to proposals for a state "superagency" for children's services, which would house and reconcile multiple programs directed toward the well being of children and families. However, these proposals were controversial and were never acted upon by the Legislature.

ACCELERATING CHANGE AND NEW DIRECTIONS: 1991 TO 1996

At the beginning of the decade of the 1990s, the transition of the public mental health system from institutional care to community-based service arrangements was significantly accelerated. Although the tension between institutional care and community-based services is not an either/or contest, resource limitations and funding constraints often press states to make choices regarding where to spend the bulk of their mental health budget. In Michigan, the recession of the early 1990s and ensuing shortfalls in state revenues precipitated an Executive Branch decision to close a number of state facilities, triggering a decisive shift in resources away from state hospitals and toward the community-based system.

The extent and pace of facility closures was controversial and strained the general consensus regarding state mental health policy that had characterized the 1970s and 1980s. Between 1991 and 1997, the state closed six (6) state psychiatric hospitals for adults with serious mental illnesses, and five (5) state psychiatric facilities for children with serious emotional disturbances. As the state withdrew from the provision of mental health care, county-sponsored CMHSPs assumed the lion's share of treatment and support obligations for persons with serious mental illnesses and children with serious emotional disturbances. While the county-sponsored CMHSPs received some additional funding during these years, much of this growth was attributable to facility closures ("trade-off"), the shift of responsibility from the state to the counties, and the assumption of new service obligations, rather than true economic increases or cost-related adjustments.



For CMHSPs located in less populated areas of the state, these changes generally did not produce any dramatic consequences. The number and needs of individuals with serious mental disorders within the catchment area of these CMHSPs was manageable, and many of these agencies had already significantly reduced their utilization of state institutions. However, certain CMHSPs in more populous areas of the state faced significant problems adapting to the closure of the institutions.

Beyond the closure of multiple state facilities and the transfer of care responsibilities to the CMHSPs, the public mental health system encountered other changes and challenges during the 1990s. The Department of Mental Health, which operated state facilities and directed, funded and monitored the CMHSP system, was abolished by Executive Order and subsumed within the Department of Community Health (DCH). Some feared that this development would eventually reduce visibility, interest and financial support for mental health services.

The creation of the Department of Community Health reflected a changing state posture and presence in the public mental health system. The system was becoming increasingly decentralized as more authority and responsibility devolved to county-sponsored community mental health services programs. In a decentralized system, community programs were now executing many of the functions and activities previously performed within the state bureaucracy.

Responding to these changing circumstances, the Legislature enacted major revisions to the state's Mental Health Code. Key provisions of the legislation (P.A. 290 of the Public Acts of 1995) included:

(a) The establishment of a new type of CMHSP entity - the "Authority" - which had greater administrative independence and operational control than previous CMHSP organizational options;
(b) A requirement that CMHSPs be "certified" by the Department, or achieve accreditation through a nationally recognized accreditation organization;
(c) The inclusion of primary consumers and family members on CMHSP governing boards;
(d) A new obligation for the CMHSPs to provide jail diversion services; and
(e) The requirement that the individual plan of service for all recipients of the public mental health system be developed through a "person-centered" planning process.

The Legislature also pressed the Department (through boilerplate provisions in the Appropriations Act) to improve CMHSP data reporting and to establish a performance indicator system to assess CMHSP activity on key dimensions. The Department implemented its Mission Based Performance Indicator System in 1997.

In regard to mental health services for children, the Department promoted the expansion of multi-purpose collaborative bodies (MPCBs) throughout the state to encourage greater interagency collaboration, to promote a "systems of care" approach for seriously emotionally disturbed (SED) children, and to facilitate pooled funding arrangements for children and families involved with multiple public systems. Pilot projects (Michigan Interagency Family Preservation Initiative or MIFPI) were carried out in several communities within the state. However, funding for prevention and early intervention services declined, and many CMHSPs scaled back local initiatives.

IMPLEMENTATION OF MANAGED PUBLIC MENTAL HEALTH CARE IN MICHIGAN

Shortly after its creation, the new Department of Community Health announced major changes in the operation of Medicaid, the state-federal entitlement program that covers a wide array of specialty services for beneficiaries with serious mental illnesses. Medicaid reimbursement, introduced into the funding framework of the public mental health system during the 1980s,

played a major role in underwriting the cost of community services and programs. DCH indicated that it would move most Medicaid recipients and Medicaid benefits into capitated, risk-based "managed care" arrangements, and that it was proceeding with the submission of federal waivers to affect these changes. The state elected to "carve-out" Medicaid specialty mental health benefits and proposed that CMHSPs administer and deliver these benefits under a capitated, shared-risk, managed care program. DCH submitted a 1915(b) Medicaid managed specialty services waiver to the federal government in 1998, along with a request for an exemption from federal procurement requirements. The waiver and exemption were granted and the program was launched in October 1998.

Managing Medicaid specialty benefits under a federal waiver and on a shared-risk basis introduced additional complexities into the public mental health system. The CMHSPs had evolved and historically operated under the "community model" of organization and service provision. This model was predicated on geographic catchment areas, grant funding, priority populations for service provision, relational contracting between governmental units, and a stable non-competitive network of providers, responsive to governmental policies and priorities. Under Medicaid managed care, however, CMHSPs were forced to operate more like an insurance entity or health plan, with entitled beneficiaries, defined benefits and service obligations, medical necessity standards, stringent due process requirements, and increased administrative responsibilities.

These challenges were compounded by federal stipulations that the state develop a plan for moving to "open and full competition" for management of Medicaid specialty services. After tumultuous debate within the state, DCH submitted a revised plan to the federal government that successfully argued the "impracticality" of competition for management of these Medicaid services. The federal government accepted this argument and the state was allowed to continue sole-source contracting, albeit with some significant changes. CMHSPs in less densely populated areas of the state, with small numbers of Medicaid beneficiaries within the catchment areas, were required to affiliate as a condition of participation in the Medicaid managed specialty services program.

Additional Developments in the Late 1990s

In July 1990, President Bush proclaimed the 1990s as the "decade of the brain". Neuroscientific research over the course of the decade expanded our understanding of the etiology of mental disorders and pharmacological research produced a number of new medications to treat major mental illness. By the later part of the decade, these new therapeutic agents (atypical antipsychotics) were being widely used within the public mental health system and were rapidly replacing older medication regimens used to treat serious mental illness.

In 1996, Congress passed the Mental Health Parity Act, which prohibited (with certain exceptions) insurers and group health plans from placing annual or lifetime dollar limits on mental health benefits that are lower than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.

Promotion of mental health issues and concerns were further bolstered in the late 1990s by the publication of ***Mental Health: A Report of the Surgeon General*** (1999). This landmark examination and study of mental illness established that mental disorders were pervasive, disabling, amenable to a range of effective treatments, and deserving of greater attention and consideration in national health policy.

Finally, during the late 1990s, the **recovery** concept of mental illness emerged as the guiding theme for mental health policy and practice. While defined in different ways by different parties, the recovery model emphasizes that persons with serious mental illnesses can regain control over significant aspects of their lives and develop a sense of identity and purpose, despite experiencing exacerbations and/or the persistence of symptoms and impairments. The recovery vision emphasizes both positive individual expectations (hope, empowerment, and self-directedness) and organized interventions (treatment, rehabilitation, and environmental supports). The concept looks beyond symptom alleviation to the kind of life experiences and situations - including social, vocational, educational, relational, and residential - needed and desired by a person with a serious mental illness.

PUBLIC MENTAL HEALTH CARE IN THE NEW CENTURY

The Surgeon General's 1999 Report indicated that roughly 20% of the U.S. adult population is affected by mental disorders during a given year. A sub-population of 5.4% of adults is identified as having a serious mental illness (SMI), applying a definition of SMI established in federal regulation. Roughly half (2.6%) of those with SMI are considered even more seriously impaired, and are described as having "severe and persistent" mental illness.

There are high rates of comorbity (individuals with co-occurring mental illness and a substance abuse condition) among those with a mental illness. Individuals with co-occurring disorders typically utilize more services than those with a single disorder, and they are more likely to experience a chronic course in their illness.

Annual prevalence rates of mental disorders for children and adolescents have not been as well established or documented as those for adults. Current estimates are that 20% of children and adolescents experience a mental disorder in a given year, and approximately 5% to 9% of children and adolescents between the ages of 9 and 17 have a "serious emotional disturbance" (SED), again applying a definition of SED established in federal regulation.

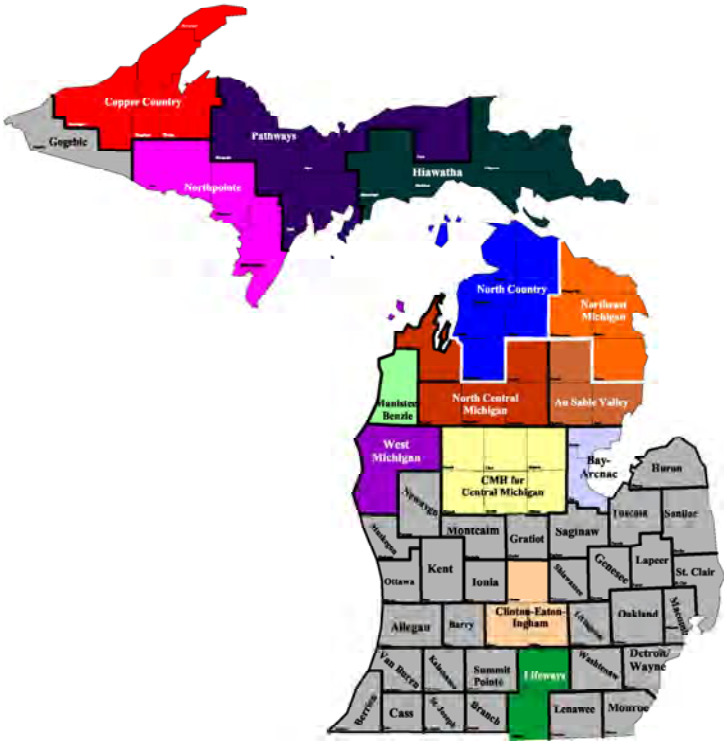
The Michigan Mental Health Code has a more circumscribed definition of serious mental illness (SMI) and serious emotional disturbance (SED) than those found in federal regulations. However, using the more liberal federal definition, the National Mental Health Information Center estimated that there were 403,930 adults with serious mental illness and 67,586 children and adolescents (ages 9-17) with serious emotional disturbance in Michigan in 2002.

Michigan has a relatively evolved public service system to address the needs of individuals with mental illness. However, by statutory intent and design, Michigan's public mental health system is configured to serve individuals with the most serious forms of mental illness and emotional disturbance, and those experiencing an acute psychiatric crisis. The Mental Health Code explicitly directs that priority for service be given to individuals with the most severe conditions and those in crisis.

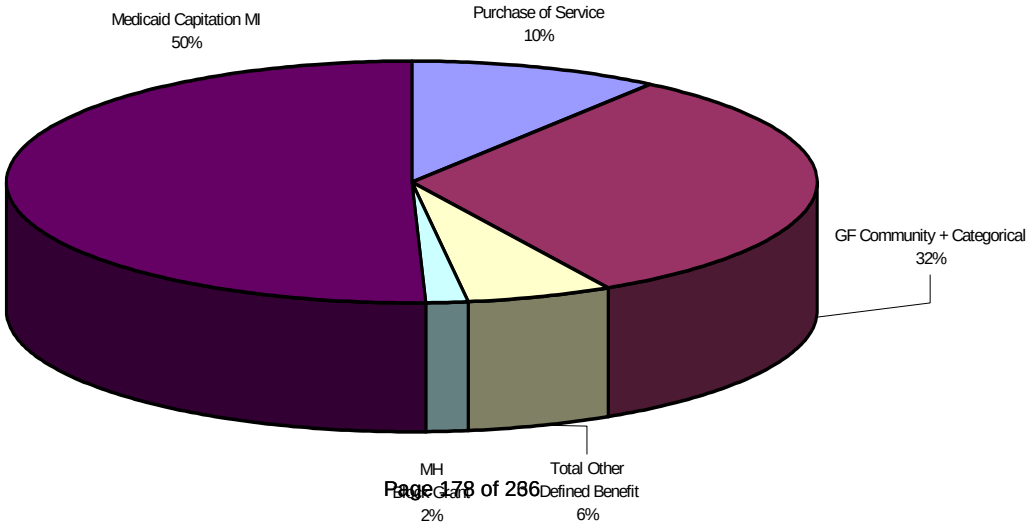
The state maintains three regional state psychiatric hospitals for adults (in Westland, Caro and Kalamazoo) and one state psychiatric facility for children and adolescents (Hawthorn Center in Northville). On any given day, there are roughly 600 adults in state regional hospitals and 80 children and adolescents at the Hawthorn Center. The state also operates the Center for Forensic Psychiatry in Ann Arbor, a 210-bed facility that provides both diagnostic services to the

criminal justice system and psychiatric treatment for criminal defendants adjudicated incompetent to stand trial and/or acquitted by reason of insanity.

Community-based mental health services are organized, administered, provided and arranged through 46 Community Mental Health Services Programs, which cover all 83 counties in the state. Forty CMHSPs have adopted the Authority form of CMHSP structure, five remain agencies of county government and one is formed under the Urban Cooperation Act as a CMHSP organization. CMHSPs are required by the Mental Health Code and through their participation in the Medicaid program to provide a comprehensive array of mental health services and supports, and they fulfill these requirements by providing these services directly, contracting with non-profit providers, or through a combination of these two approaches. Each CMHSP is required to have a pre-screening unit to assess individuals being considered for psychiatric hospitalization, and to provide alternatives to hospitalization whenever appropriate.



Community mental health services are funded through a complex mix of general fund allocations, purchase of service dollars (to pay for any utilization of state facilities), and capitated payments for the Medicaid Managed Mental Health Care Program, the Adult Benefit Waiver Program, and the MiChild program. According to the Senate Fiscal Agency, funding for community mental health has been tightly constrained over the past six years, with very limited adjustments. In fiscal year 2003-2004, roughly $870,000,000 of state appropriations for community mental health was available to fund services to adults and children with serious mental illness.



The table below displays the number of children and adults with mental illness served by the CMHSPs over a four-year period (1999-2002).

Number of Children and Adults with Mental Illness Served by Michigan's Public Mental Health System

Fiscal Year	Individuals with Mental Illness						Total
	Children		Adults		Age Not Reported		
	N	%	N	%	N	%	
1999	40,998	23.7%	125,814	72.9%	5,885	3.4%	172,697
2000	35,994	23.8%	110,826	73.4%	4,264	2.8%	151,084
2001	29,356	21.6%	101,799	74.9%	4,809	3.5%	135,964
2002	36,732	23.7%	117,174	75.5%	1,394	0.9%	155,300

Source: Community Mental Health Service Programs Demographic and Cost Data, FY1999 - FY2002, November 2003.

Mental Illness: An individual is determined to have mental illness if he/she has a DSM-IV diagnosis of mental illness, excluding mental retardation, developmental disability or substance abuse disorder.

Children are those consumers who are 18 years of age or younger during the fiscal year of reporting.

Note: Individuals who were dual eligible during FY '01 or FY '02 are not included in this table.

CURRENT CHALLENGES

Public mental health systems across the nation are in distress. The title of a recent report by the Bazelon Center, ***Disintegrating Systems: The State of Public Mental Health Systems***, aptly captures the mood of dissatisfaction and the sense of urgency. The President's New Freedom Commission on Mental Health has declared that " the mental health delivery system is fragmented and in disarray".

Multiple funding streams now support public mental health care, each with varying eligibility standards, differential access policies, different service obligations and benefits, and sundry appeal processes. This has introduced tremendous complexity into the administration of mental health programs. In addition, mental health related activities are increasingly performed through many other agencies of state and local government, funded by sources outside the control of the formal public mental health system. This produces fragmentation in the state's efforts to address the mental health needs of its citizens. Finally, a significant number of individuals lack health insurance, and those with private coverage often discover that their mental health benefits do not adequately cover services needed by persons with serious mental illnesses.

Increasingly, individuals with significant mental health problems are showing up among the clientele served by other public systems (child welfare, juvenile justice, law enforcement, courts, corrections, education). These other agencies and entities are frequently ill-equipped to deal with such mental health needs, and these settings do not represent adequate or appropriate treatment venues for such conditions.

A recent analysis concluded that access to care for persons with serious mental illnesses has generally been maintained, but access and services for individuals with less severe conditions (which constitute a relatively large group) have declined considerably[1]. Prevention and early intervention services have also been greatly diminished. A key challenge over the next several years will be to devise financing strategies that can enhance access for individuals with less severe disorders and promote prevention and early intervention efforts.

[1] "Treatment of People with Mental Illness: A Decade-Long Perspective"; David Mechanic and Scott Bilder, *Health Affairs*, July/August 2004

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Community Mental Health Services in Michigan

Margaret Alston, Senior Fiscal Analyst

Introduction

Major changes have occurred within Michigan's public mental health system during the past two decades. The Mental Health Code has been significantly rewritten. The Department of Community Health (DCH) was established by an Executive Order merging the former Departments of Mental Health and Public Health with Medical Services. The DCH implemented the Managed Specialty Services and Supports Program for the delivery of specialty mental health, developmental disability, and substance abuse services.

This publication, *Community Mental Health Services in Michigan*, will discuss the constitutional, statutory, and federal authorization for the delivery of community mental health services, organizational structure of community mental health services programs (CMHSPs) and prepaid inpatient health plans (PIHPs), mental health services provided by CMHSPs and PIHPs, powers and duties of CMHSPs boards, permissive activities of CMHSPs, financial liability of the county and state for CMHSPs, and funding methodology for PIHPs.

This publication also discusses appropriations for Medicaid and non-Medicaid services provided by CMHSPs and PIHPs for the past ten years, highlighting the major components of the appropriation line item changes from previous fiscal years.

Constitutional, Statutory, and Federal Authorization for the Delivery of Community Mental Health Services

Article IV, Section 51 of the **Michigan Constitution of 1963** states that the public health and welfare of the people are matters of primary public concern and requires the Legislature to pass suitable laws for the protection and promotion of public health.

Article VIII, Section 8 of the **Michigan Constitution of 1963**, as amended on December 19, 1998, requires that institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled always be fostered and supported. The 1998 amendment changed the term "handicapped" to "disabled".

In conjunction with provisions of the **Michigan Constitution**, the **Mental Health Code of 1974** as amended (**MCL 330.1001 - 330.2106**), requires the following of the DCH:

- Continually and diligently endeavor to ensure that adequate and appropriate mental health services are available to all citizens throughout the state;
- Direct services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance;
- Give priority to services for individuals with the most severe forms of serious mental illness, serious emotional disturbance, or developmental disability;
- Promote and maintain an adequate and appropriate system of community mental health services programs (CMHSPs) throughout the state;
- Shift primary responsibility for the direct delivery of public mental health services from the state to a CMHSP whenever a CMHSP has demonstrated a willingness and capacity to assume those responsibilities; and
- Financially support CMHSPs.

The **Mental Health Code** also requires the following of CMHSPs:

- Provide a comprehensive array of mental health services, appropriate for individuals, regardless of their ability to pay, and
- Provide services to individuals who have a serious mental illness, serious emotional disturbance, or developmental disability.

The **Social Welfare Act of 1939** as amended (**MCL 400.109f - 400.109g**) requires:

- The DCH to support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance, or substance abuse disorder;
- Medicaid-covered specialty services and supports to be managed and delivered by specialty prepaid health plans (oftentimes referred to as prepaid inpatient health plans – PIHPs) chosen by the DCH, in consultation with a Specialty Services Panel created in Section 109g (a panel that was abolished in 2007 with its power and duties transferred to DCH);
- Specialty and support services be "carved out" from basic Medicaid health care benefits; and
- Specialty prepaid health plans to be considered managed care organizations as described in Title XIX of the Social Security Act.

Congruent with provisions of the **Social Welfare Act**, Section 232b of the **Mental Health Code** (**MCL 330.1232b**) requires the DCH to establish standards for CMHSPs designated as specialty prepaid health plans (hereafter referred to as PIHPs) which reference applicable federal regulations and specify state requirements. In essence, PIHPs are either CMHSPs or affiliations of CMHSPs that receive capitated payments for Medicaid mental health and substance abuse covered services.

The Centers for Medicare and Medicaid Services (CMS) approval of Sections 1915(b) and 1915(c) waivers provides federal authorization for PIHPs to manage the Medicaid Specialty Services and Supports Program. The CMS approval of Section 1115 demonstration waiver provides federal authorization for PIHPs to manage the Medicaid Adult Benefits Waiver Program (ABW), a program for non-pregnant and childless adults with limited Medicaid benefits. Approved state plan amendments to the waiver requires existing ABW program participants to transition to Medicaid and the program to sunset on April 1, 2014.[1]

[1] December 30, 2013 letter to Mr. Stephen Fitton, Director of Michigan Medicaid Services Administration, from the Department of Health and Human Services' Centers for Medicare and Medicaid Services

Organizational Structure of CMHSPs and PIHPs

Community mental health services programs are established under the Mental Health Code and organized in one of the following three ways:

- **County community mental health (CMH) agency** in which the procedures and policies for the organization are set by the county Board of Commissioners or counties Board of Commissioners;
- **CMH organization** in which two or more counties are organized under the Urban Cooperation Act **(MCL 124.501 - 124.512)**; the public governmental entity is separate from the counties that established it; procedures and policies are set by the Board of the CMHSP; and
- **CMH authority** in which the separate legal public governmental entity is created under Section 205 of the Code **(MCL 330.1205)**; the county CMH agency or CMH organization is certified by the DCH under Section 232a of the Code **(MCL 330.1232a)**; and procedures and policies are set by the Board of the CMHSP.

There are currently 39 CMH authorities (including Detroit-Wayne County CMHSP which converted to an authority on October 1, 2013), 5 CMH agencies (Allegan County CMH Services, Lapeer County CMH Services, Macomb County CMH Services, CMH Services of Muskegon County, and CMH of Ottawa County), and 2 CMH organizations (Manistee-Benzie CMH d.b.a. Centra Wellness Network and Washtenaw Community Health Organization).

Prepaid inpatient health plans (PIHPs) are established through a procurement process completed by the DCH in which qualified CMHSPs were given initial consideration to operate as PIHPs for designated service areas. The approved plan submitted by the DCH to CMS indicated that a CMHSP must have at least 20,000 Medicaid beneficiaries ("covered lives") within their respective catchment area to be eligible to apply for designation as a PIHP. If CMHSPs did not meet the threshold of 20,000 Medicaid beneficiaries, they were able to combine with other CMHSPs and make a consolidated application for designation as a PIHP. The qualification for designation as a PIHP included certain administrative capabilities, cost parameters, service capacity, eligibility and access assurance, and enhancement of consumer opportunities.[2]

There were 18 PIHPs established throughout the state. Effective January 1, 2014, however, there are 10 PIHPs based on realignment of the PIHP system.

Mental Health Services Provided by CMHSPs and PIHPs

Pursuant to the Mental Health Code, mental health services offered and/or provided directly or under contract by CMHSPs are, at the minimum, to include the following:

- Crisis stabilization and response including a 24-hour, 7-day per week crisis emergency service;
- Identification, assessment, and diagnosis to determine the specific needs of the individual and development of an individual plan of services;
- Planning, coordination, and monitoring to assist the individual in gaining access to services;
- Specialized mental health treatment which includes therapeutic clinical interactions;
- Recipient rights services;
- Mental health advocacy;
- Prevention activities; and
- Other services approved by the DCH.

[2] MDCH FY 2010 Base Program Descriptions

Prepaid inpatient health plans, either directly or under contract, are required to offer the array of services identified above for CMHSPs to Medicaid beneficiaries of mental health services, and the following Medicaid specialty services and supports as outlined in the Department of Community Health's Medicaid Provider Manual[3]:

- Applied behavior analysis;
- Assertive community treatment;
- Behavior treatment review;
- Child therapy;
- Clubhouse psychosocial rehabilitation programs;
- Crisis interventions and residential services;
- Family therapy;
- Health and home-based services;
- Individual and group therapy;
- Inpatient psychiatric hospital admissions;
- Intensive crisis stabilization services;
- Intermediate care facility for individuals with mental retardation (ICF/MR) services;
- Medication administration and review;
- Nursing facility mental health monitoring;
- Occupational therapy;
- Outpatient partial hospitalization services;
- Personal care in licensed specialized residential setting;
- Physical therapy;
- Speech, hearing, and language;
- Targeted case management;
- Telemedicine;
- Transportation; and
- Treatment planning.

In broad terms, services provided to and/or received by individuals who meet the priority mental health needs identified in the Mental Health Code may be different for Medicaid beneficiaries and individuals who do not qualify for Medicaid. The Medicaid program is a joint federal-state funded program that pays for mental health services and entitles eligible individuals to certain services. Conversely, CMHSPs are contractually required to provide services to individuals not eligible for Medicaid to the extent general fund/general purpose (GF/GP) resources are available.

The most recent report from the DCH indicates that CMHSPs and PIHPs provided services to 242,884 individuals in FY 2011-12.[4] Of this total, 176,196 individuals were eligible for Medicaid (a number in which an individual eligibility for programs can be counted more than once for also the following program eligibility categories or groups: Adoption Subsidy, Medicare, Supplemental Security Income (SSI), or Commercial Health Insurance). The CMHSPs and PIHPs provided services to 200,424 individuals in FY 2004-05.[5] Of this total, 122,235 individuals were eligible for Medicaid. The growth in the number of individuals served has been driven by increased Medicaid eligibility.

[3] MDCH, Medicaid Provider Manual, Mental Health/Substance Abuse, October 2013

[4] Report for Section 404, Community Mental Health Services Programs Demographic and Cost Data, FY 2012

[5] Report for Section 404, Community Mental Health Services Programs Demographic and Cost Data, FY 2005

Powers and Duties of CMHSPs Boards

The powers and duties of the boards of CMHSPs are specified in the Mental Health Code. They include:

- Conduct an annual needs assessment to determine the mental health needs of the county residents and identify public and nonpublic services necessary to meet those needs;
- Annually review and submit a needs assessment report, annual plan, and request for new funds for the CMHSPs to DCH;
- In the case of a county CMH agency, obtain approval of its needs assessment, annual plan and budget, and request for new funds from the county Board of Commissioners; and in the case of a CMH organization or CMH authority, provide a copy of its need assessment, annual plan, and request for new funds to the county Board of Commissioners creating the organization or authority;
- Annually approve the CMHSP operating budget;
- Take necessary and appropriate action to secure private, federal, and other public funds to support the CMHSP;
- Approve and authorize all contracts for the provision of services; and
- Review and evaluate the quality, effectiveness, and efficiency of services provided by CMHSPs.

Permissive Activities of CMHSPs

In accordance with provisions of the Mental Health Code, CMHSPs are permitted to do the following:

- Carry forward any surplus of revenue over expenditures under a capitated managed care system;
- Carry forward the operating margin (excess of state revenue over state expenditures for a fiscal year exclusive of capitated payments) up to 5% of the CMHSP's state share of the operating budget for the fiscal years ending September 30, 2009, 2010, and 2011 (an expired provision in law that is currently included in CMHSPs' contracts[6]); in the case of CMH authorities, the carry forward authorization is in addition to reserve accounts to cover vested employee benefits, depreciation of capital assets, and expected future expenditures for an organization retirement plan;
- Pursue, develop, and establish partnerships with private individuals or organizations to provide mental health services; and
- Share the costs or risks, or both, of managing and providing publicly funded mental health services with other CMHSPs.

Financial Liability of County and State for CMHSPs

The county is financially liable for 10% of the "net cost" of any service that is provided by DCH, directly or by contract, to a resident of that county. "Net cost" is defined as the operating cost of providing the service minus that part paid for with federal and private funds and the amount received by the state as reimbursement from those individuals and insurers who are financially liable for the cost of services. This provision in law does not apply to family support subsidies (monthly payments to income-eligible families with a child under age 18 living at home who is severely mentally impaired, severely multiply impaired, or autistic). Nor does this provision apply to services provided to an individual under a criminal sentence to a state prison, a criminal defendant determined incompetent to stand trial, or individuals acquitted of a criminal charge by reason of insanity.

[6] 7.7.1.1 of MDCH/CMHSP Managed Mental Health Supports and Services Contracts: FY 14

The state is required to pay 90% of the annual "net cost" of a CMHSP, a requirement subject to the availability of funds appropriated by the Legislature for this purpose. "Net cost" means CMHSPs expenditures eligible for state financial support and approved by DCH that are not paid for by federal and state funds, or reimbursements from individuals and insurers who are financially liable for the cost of services. This statutory requirement does not apply to a CMHSP in the fiscal year after it becomes a CMH authority as the 10% local county match requirement changes subject to the availability of local and state funds. Nor does this provision apply to family support subsidies in which the state is required to pay for the subsidies.

Funding Methodology for PIHPs

The Prepaid Inpatient Health Plans (PIHPs) receive a capitation payment (fixed per person monthly rate payable) for Medicaid covered specialty mental health, developmental disability, and substance abuse services provided to individuals in a managed care environment. Medicaid managed care capitation payments are used by PIHPs and other managed care organizations such as health maintenance organizations (HMOs) to control the growth of mental health and physical health care costs rather than create savings.[7] The capitation payment rates for PIHPs are required by the federal CMS to be actuarially sound – rates developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.

Milliman, Inc. was retained by the DCH to develop capitation rates for the Managed Specialty Services and Support Waiver for FY 2013-14. A letter from Milliman documented the rate methodology, illustrated an actuarially sound rate range, and provided the required certification regarding actuarial soundness.[8]

Factors used in determining FY 2013-14 monthly capitation payment rates for PIHPs were: health insurance claim assessment, age, gender, and geographic region for the Temporary Assistance for Needy Families (TANF) and Disabled, Aged, and Blind (DAB) populations. The capitation base rate/range for certain populations may differ between PIHPs based on historical revenue requirements to serve the enrolled Medicaid beneficiaries and estimated morbidity (frequency with which a disease appears in a population) variation outside of age and gender.

According to the DCH, DCH then determined the rate/point within that range that each PIHP will receive. In the past, some PIHPs received rates on the lower end of their individual ranges while others received rates on the higher end and, accordingly, there was no assurance of consistency in picking the point within the range for each individual PIHP. For the first two quarters of FY 2013-14, DCH identified a payment rate for each PIHP at the highest consistent percentile of the respective payment ranges in an effort to achieve greater equity within the amount appropriated for PIHPs capitation payments. The change has resulted in an increase or decrease in Medicaid revenue for PIHPs per member per monthly capitation payment rates (increase for 9 PIHPs and decrease for 9 PIHPs).[9]

The base capitation payment rates and methodology for PIHPs are being evaluated by actuaries. As noted in the 2013 Application for Participation for Specialty Prepaid Inpatient Health Plans[10], it is DCH's intent to re-develop rate structure, methodologies, and adjustors in order to increase the percentage of the ratio reflecting morbidity and decrease the percentage that is based on historic revenue and geographic regions. Public Act 59 of 2013, Section 504 of Article IV, establishes a Workgroup comprised of representatives of DCH, PIHPs, and CMHSPs to make recommendations on achieving more uniformity in capitation payments made to the PIHPs. The recommendations are to be provided to the House and Senate Appropriations Subcommittees on Community Health, House and Senate Fiscal Agencies, and State Budget Director by March 1, 2014.

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[7] 7.4.1.1. of MDCH/PIHP Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program FY 14

[8] September 24, 2013 letter to the Department of Community Health from Milliman, Inc.

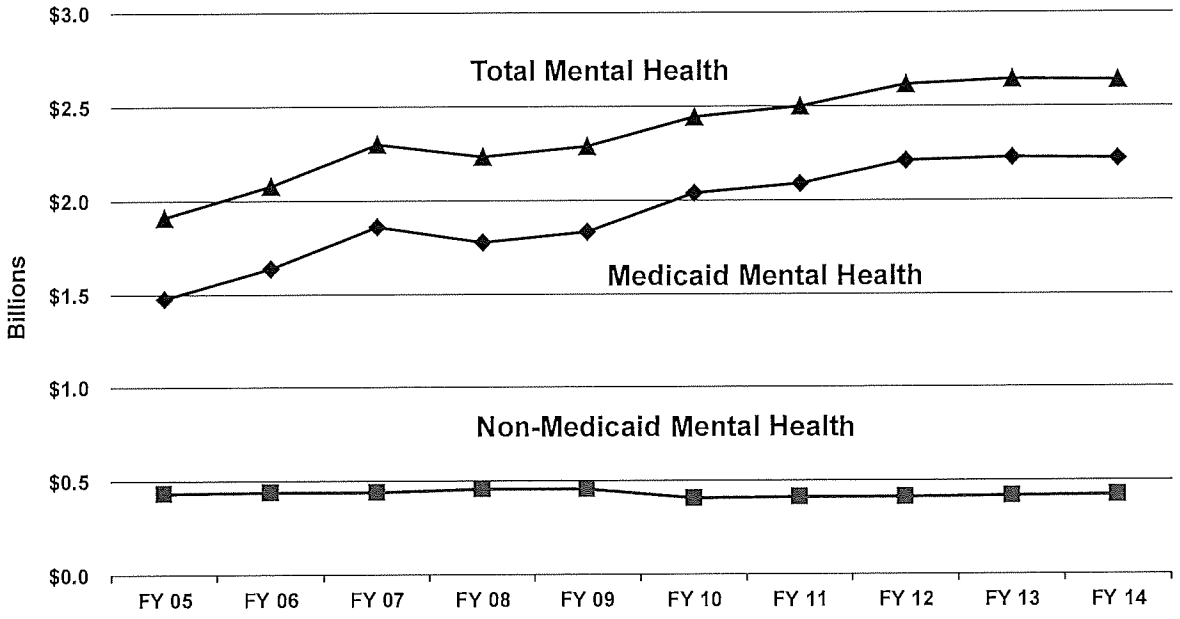
[9] October 31, 2013, MDCH, Prepaid Inpatient Health Plans 1st Quarter Payments – Specialty Service and Supports Capitation Rates Fiscal Years 2013 and 2014

[10] 2013 Application for Participation for Specialty Prepaid Inpatient Health Plans, Michigan Department of Community Health Behavioral Health and Developmental Disabilities Administration, 2/6/2013

Appropriations for Medicaid and Non-Medicaid Services Provided by CMHSPs and PIHPs FY 2004-05 Through FY 2013-14

Since FY 2004-05, Medicaid mental health gross appropriations have increased by $744.6 million (50.5%), non-Medicaid mental health gross appropriations have decreased by $12.6 million (2.9%), and total mental health gross appropriations have increased by $731.8 million (38.4%).[11] *The appropriations do not include enacted supplemental appropriations or appropriations included in the Medicaid Reform/Healthy Michigan Plan Legislation - Public Act 107 of 2013.*

Figure 1



Medicaid mental health appropriations in this publication represent funding for the following four appropriation line items:

- **Medicaid mental health services** - Medicaid managed care capitated funds for CMHSPs or PIHPs serving state residents in which mental health services are provided by CMHSPs or PIHPs, or contract with public or private agencies;
- **Medicaid adult benefits waiver** - funds provided to CMHSPs to provide limited mental health and substance abuse services to childless eligible adult; beneficiaries are paid under a prepaid capitation basis with CMHSPs and department-designated community mental health entities for substance abuse services;
- **Children's waiver home care program** - funds for home- and community-based services for eligible children with developmental disabilities that enables them to reside at home with their birth and adoptive families, and who would otherwise require institutional care; and
- **Children with serious emotional disturbance waiver** - funding that allows counties and CMHSPs to provide home- and community-based mental health services to eligible children with serious emotional disturbance, including a program with the Department of Human Services that provides services for abused and neglected children.

[11] House Fiscal Agency FY 2004-05 through FY 2013-14 Final Decision Documents for Department of Community Health

Non-Medicaid mental health appropriations in this publication represent funding for the following two appropriation line items:

- **Community mental health non-Medicaid services** - non-Medicaid funds provided to CMHSPs serving residents of the state who are not covered by Medicaid or who require services that are not benefits under the state Medicaid plan in which the mental health services are provided directly by CMHSPs, or by contract with public or private agencies; and
- **CMHSP, purchase of state services contracts** - funding that is used by CMHSPs to purchase state services for clients in their catchment areas or develop their own community alternatives to utilization of state-operated psychiatric hospitals. *(Funding is categorized and/or treated as local revenue when supporting the appropriations for state-operated psychiatric hospitals.)*

Table 1
Major Components of Medicaid and Non-Medicaid Mental Health Cumulative Gross and GF/GP Appropriation Line Item Changes from Previous Fiscal Years FY 2004-05 Through FY 2013-14

Description	Gross Funding Amount	GF/GP Funding Amount	Gross Percentage of Major Components	GF/GP Percentage of Major Components
Federal Medical Assistance Percentage Changes	($4,632,800)	($162,292,400)	(0.6)	(166.7)
Medicaid Eligibles Caseload Adjustments	$368,675,100	$134,730,800	51.1	138.4
Actuarially Sound Capitation Payment Rates For PIHPs	$363,083,100	$125,148,300	50.3	128.6
Changes in the Utilization of Days of Care at State Facilities by CMHSPs	$1,343,300	($6,234,300)	0.2	(6.4)
Provider Tax, Use Tax, and Health Insurance Claim Assessment Revenue for PIHPs	($99,316,300)	($5,947,200)	(13.8)	(6.1)
New Medicaid Programs and Services for PIHPs and CMHSPs	$74,228,900	($5,572,200)	10.3	(5.7)
Funding Changes for CMHSPs Non-Medicaid Programs and Services	$88,477,700	$75,609,500	12.3	78.7
Programs and Services Reductions for PIHPs and CMHSPs	($71,306,800)	($60,540,900)	(9.9)	(62.2)
Medicaid Mental Health-Related Program Endeavors Not Approved by the Federal Government	$805,200	$2,448,800	0.1	2.5
TOTAL	**$721,357,400**	**$97,350,400**		

Federal Medical Assistance Percentage Changes

As stated earlier in the section on mental health services provided by CMHSPs and PIHPs, the Medicaid program is a joint federal-state funded program that pays for mental health services and entitles eligible individuals to certain services. The federal government's share of a state's expenditures is called the federal medical assistance percentage (FMAP) rate. The remainder is referred to as the nonfederal share or state share.[12] Changes in the regular and enhanced FMAPs for Medicaid, State Children's Health Insurance Program (SCHIP) and American Recovery and Reinvestment Act of 2009 (ARRA) has an impact on Medicaid mental health-related funding. The regular FMAP increased from 55.89% to 66.39% from FY 2004-05 through FY 2012-13 and decreased to 66.32% in FY 2013-14. The enhanced FMAP for SCHIP which supported the Medicaid Adults Benefit Waiver Program from FY 2004-05 through FY 2009-10 increased from 69.12% to 74.23%. And, the enhanced FMAP for ARRA which supported the Medicaid mental health programs in FY 2009-10 and FY 2010-11 increased the regular FMAP rate from 63.19% to an average annualized rate of 71.24%.

All of the noted changes in the FMAP for Medicaid mental health appropriations have resulted in the following: a decrease of $4.6 million in gross appropriations; an increase of $159.0 million in federal revenue; an decrease of $1.4 million in state restricted revenue; an increase of $72,100 in local revenue; and a decrease of $162.3 million in general fund/general purpose appropriations.

Caseload Adjustments for Medicaid Eligibles

Caseload adjustments for those individuals eligible for Medicaid is a major component of Medicaid mental health related funding changes. From FY 2004-05 through FY 2013-14, $368.7 million Gross ($134.7 million GF/GP) has been appropriated for changes in the number of eligible Medicaid beneficiaries. The average monthly caseload for those individuals eligible for Medicaid mental health services during FY 2004-05 and FY 2012-13 were respectively 1,280,110 and 1,617,899 – an increase of 26.4% in the average monthly Medicaid caseload. This information is based on reports prepared by the DCH which notes PIHPs monthly capitation payments and eligibles.[13]

When Public Act 107 of 2013 (Enrolled House Bill 4714) becomes effective April 1, 2014, it is anticipated that more individuals with mental illness will qualify for Medicaid and be 100% federally covered until 2017 given the change to 133% of the federal poverty level as a determinant of Medicaid eligibility.

Actuarially Sound Capitation Payment Rate for PIHPs

As discussed earlier in the detail on the funding methodology for PIHPs, PIHP capitation payment rates are required by the federal CMS to be actuarially sound. From FY 2004-05 through FY 2013-14, $363.1 million Gross ($125.1 million GF/GP) has been appropriated for PIHPs to ensure that capitation payment rates are actuarially sound. The rate increase was 2.5% in FY 2004-05 and 1.25% in the current fiscal year. The average yearly rate increase over this ten year period is $33.0 million Gross ($11.4 million GF/GP).

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[12] Congressional Research Service, Medicaid's Federal Medical Assistance Percentage (FMAP), FY 2014, January 30, 2013

[13] Appropriation 02965 – Medicaid Mental Health Services, FY 2005 Projected Managed Care Payments
Appropriation 02965 – Medicaid Mental Health Services, FY 2013 Projected Managed Care Payments

Changes in the Utilization of Days of Care at State Facilities by CMHSPs

The days of care utilized by CMHSPs for their clients at state-operated facilities impacts the amount of funding received by this entity as well as PIHPs. Slightly more than $1.3 million has been included in the budget for these purposes, except for FY 2007-08, FY 2010-11, FY 2011-12, and FY 2012-13 (fiscal years in which the DCH was examining and evaluating funding options for recognizing prior fiscal year changes in the utilization of days of care at state hospitals by CMHSPs or managing this type of adjustment through spending authorizations for state hospitals).

On the surface, the funding allocation and/or component may appear to be insignificant and not noteworthy; however, this type of adjustment has been primarily financed through the redirection of funds from other line items. In total, $40.8 million GF/GP has been redirected from the CMHSP, Purchase of State Services Contracts and Community Mental Health Non-Medicaid Services appropriations. In addition, in FY 2009-10, the state realized GF/GP savings of $6.2 million by "federalizing" earned days of care provided to clients at the former Mt. Pleasant Center for Individuals with Developmental Disabilities and establishing a specialized rate increase for the placement of those clients in the community. In the current fiscal year, almost $9.0 million GF/GP has been redirected from the CMHSP, Purchase of State Services Contracts appropriation to the Community Mental Health Non-Medicaid Services appropriation. This budgetary change from the previous fiscal year recognizes the utilization of days of care at state facilities by CMHSPs from FY 2005-06 through FY 2010-11 and enables CMHSPs to provide services to individuals with mental illness who are not covered by Medicaid.

Provider Tax, Use Tax, and Health Insurance Claim Assessment Revenue for PIHPs

There have been a variety of assessments or revenue mechanisms developed for PIHPs (as well as other managed care organizations) to generate additional federal revenue for PIHPs and offset State GF/GP support that would otherwise be required to support Medicaid mental health programs. The assessments or mechanisms for PIHPs are and have been:

- 6.0% and 5.5% quality assurance assessment program fee on PIHPs, oftentimes referred to as either QAAP or the provider tax;
- 6.0% Use Tax on PIHPs, revenue which went to the State's General Fund; and
- 1.0% health insurance claim assessment (HICA) on claims paid by health insurance providers, a revenue replacement for the Use Tax which also goes to the State's General Fund.

The PIHP provider tax was terminated during 2009 because the Federal Deficit Reduction Act of 2005 changed provider class definition to include Medicaid and non-Medicaid managed care organizations. The Use Tax on PIHPs was repealed in 2011 as the tax was deemed at risk with the federal government and not considered a broad based tax. The health insurance claim assessment was instituted in 2011 to cover the loss of revenue from the 6.0% Use Tax.

The budgetary adjustments related to these assessments and revenue mechanisms for the noted Medicaid mental health appropriations resulted in a gross net decrease of $99.3 million ($5.9 million GF/GP). The adjustments include: an additional $94.7 million Gross, in conjunction with corresponding reduction of $38.7 million GF/GP, given the 6.0% provider tax on PIHPs; elimination of $133.2 million Gross ($45.1 million GF/GP) in use tax revenue anticipating a 1.0% HICA on PIHPs; and a reduction of $69.4 million Gross ($23.5 million GF/GP) due to the reversal of use tax revenue adjustments included in Public Act 278 of 2012 supplemental.

Funding for New Medicaid Initiated Programs and Services for PIHPs and CMHSPs

Very few Medicaid mental health-related programs and services have been initiated in the past ten fiscal years, with limited budget impact. Following is a description of these programs and services:

- In FY 2006-07, federal Medicaid funding was authorized for the Children with Serious Emotionally Disturbance Waiver Program that expanded coverage to 43 children with serious emotional disturbances and/or children who were chronically mentally ill. Services are provided to children less than 21 years old in the community rather than institutional settings and the GF/GP match for the federal funds are provided by CMHSPs. The waiver program was modified in FY 2009-10. Currently, this program has been implemented in 37 counties and 25 CMHSPs in which home- and community-based services are provided to 804 eligible children with serious emotional disturbance, including a program with the Department of Human Services that provides services for abused and neglected children – as referenced earlier in the description of this line item.

- The hospital reimbursement adjustor (HRA) payments to PIHPs were authorized for the Medicaid Mental Health Services line item in FY 2009-10. Similar to the case of regular hospital reimbursement adjustor payments made to Medicaid Health Plan Services, estimated payments from private inpatient psychiatric hospitals for mental health services are incorporated into the monthly capitation payments to PIHPs. These adjustor payments result in an increase in the amount of funding provided to PIHPs.

- A Department of Human Services (DHS) funded increase for an enhanced rate and incentive payment through PIHPs to serve abused and neglected children was implemented in FY 2012-13 given the approval of a state plan waiver amendment. The children must have a serious emotional disturbance, be eligible for Medicaid, be between the ages of 0 to 18, served in the DHS Foster Care System or Child Protective Services, and meet one of the following service criteria in the eligible month: wraparound services, home-based services, or 2 or more state plan mental health services covered under the Specialty Services and Supports Waiver, excluding one-time assessments.

- Three behavioral health homes demonstration projects have been authorized funding in the current fiscal year. The projects have been implemented for the purposes of ensuring better coordination of physical and behavioral health care for Medicaid beneficiaries with chronic conditions such as asthma, heart disease, obesity, mental condition, or substance abuse disorder.

Funding for the noted Medicaid programs and services has resulted in a gross increase of $74.2 million and a reduction of $5.6 million GF/GP. Most of the funding increase is attributable to the hospital reimbursement adjustor payments for PIHPs. Also, included in the total funding change is $4.1 million Gross ($0 GF/GP) that was allocated for the Children's Waiver Home Care Program in recognition of CMHSPs administrative costs and adjustor payments (additional federal Medicaid dollars partially covering the cost of waiver services that were previously funded with CMHSPs non-Medicaid resources).

Funding Changes for CMHSPs Non-Medicaid Programs and Services

Most of the funding changes for CMHSPs Non-Medicaid programs and services, excluding changes in the utilization of days of care by CMHSPs for clients at state-operated facilities and program reductions, is attributable to the following items:

- Transfer of funding to CMHSPs for expired state-administered residential leases;
- Financing economic adjustments related to state-operated facilities;
- Financing the inflationary adjustments for pharmacy costs at state facilities;
- Employee-related savings and consolidation of operations at state facilities;
- Wage increases for direct care workers in community residential settings (which also impacted the Medicaid Mental Health Services appropriation); and
- Replacement of lease/rental revenue, base cost adjustments for state facilities, and Mt. Pleasant Center certification costs.

The Community Residential and Support Services appropriation finances the costs of community residential leases for individuals under the Department of Community Health's responsibility. Once the lease arrangements have expired for the state, the financial responsibility for them is transferred to CMHSPs. From FY 2003-04 through the current fiscal year, $2.8 million GF/GP has been transferred to CMHSPs for an estimated 95 expired state-administered residential leases.

Only GF/GP revenue supports the CMHSP, Purchase of State Services Contracts line item which finances economic adjustments related to state-operated facilities such as: wage and salary adjustments for nonexclusively represented and unionized employees; adjustments for employees defined benefit and contribution retirement costs as well as insurance costs; other post-employment benefit costs for employees; patients food costs; and gas, fuel, and utility costs. Since FY 2003-04, $62.0 million GF/GP has been allocated from the CMHSP, Purchase of State Services Contracts line item for state facilities economic adjustments.

The CMHSP, Purchase of State Services Contracts line item also finances inflationary adjustments for pharmacy costs at state-operated facilities. The inflationary adjustment has ranged from 22.8% to 3.0% and totals $2.4 million GF/GP. Furthermore, employee-related savings of $12.0 million GF/GP have been achieved through early retirement incentives for employees, elimination of funded and vacant FTE positions, and the consolidation of operations at state facilities.

Wage increases for direct care workers in community residential settings were financed in the FY 2005-06, FY 2007-08, and FY 2009-10 budgets. As noted in Section 404 of Article IV, Public Act 59 of 2013, direct care workers are considered employees in local residential settings and other settings where skill building, community living supports and training, and personal care services are provided by CMHSPs or PIHPs directly or through contracts with provider organizations. During this time period, $26.7 million Gross ($12.3 million GF/GP) was specifically allocated for wage increases for direct care workers.

Miscellaneous funding adjustments for CMHSP Non-Medicaid Programs and Services include the replacement of state restricted revenue that was no longer available with GF/GP, funds to support base costs at state-operated facilities, funding to ensure Medicaid certification of Mt. Pleasant Center for Persons with Development Disabilities. The adjustments for these purposes total $6.5 million Gross ($8.1 million GF/GP).

Program and Service Reductions for PIHPs and CMHSPs

From FY 2009-10 through FY 2013-14, there have been measures included in the budgets to reduce funding for Medicaid and Non-Medicaid programs and services provided by PIHPs and CMHSPs and/or redirect funding for new program initiatives. Those measures undertaken include:

- Annualization of the Executive Order 2009-22 reduction of $10.0 million for non-Medicaid services provided by CMHSPs and other administrative and service capacity reductions;
- Elimination of the Transitional Medical Assistance (TMA) Plus program which provided health care coverage including mental health and substance abuse services to families with incomes up to 185% of the federal poverty level who are transitioning off of Medicaid and are no longer eligible for regular TMA;
- A reduction and/or freeze in the enrollment of individuals in the federal Home and Community-Based Services Habilitation and Supports Waiver program which provides community-based services to individuals with developmental disabilities who would otherwise require the level of services provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);
- Reduction in funding for the Children's Waiver Home Care program; and
- Redirection of funds to the Behavioral Health Program Administration appropriation (formerly the Mental Health/Substance Abuse Program Administration appropriation) to finance a jail diversion programs initiative and project that provides a safety net for individuals with developmental disabilities who are at risk of placement in licensed adult foster care facilities or being admitted to hospital inpatient units.

The programs and services reductions for PIHPs and CMHSPs total $71.3 million Gross ($60.5 million GF/GP).

Medicaid Mental Health-Related Funding Endeavors Not Approved by the Federal Government

As a means of capturing additional federal and state restricted revenue, reducing GF/GP support for mental health funded program, and increasing payment rates for PIHPs, some endeavors were undertaken by the DCH in FY 2004-05 through FY 2008-09 that were not successful due to lack of approval by the federal government. The endeavors include:

- Replacing $3.5 million in GF/GP with state restricted revenue by taxing group home beds for individuals with developmental disabilities;
- Capturing $14.8 million in additional QAAP and Medicaid revenue and saving $5.3 million in GF/GP by transferring anti-psychotic pharmaceutical costs of PIHP capitation payments; and
- Transferring $149.1 million Gross ($65.1 million GF/GP) for pharmaceutical costs to PIHP capitation payments.

The unsuccessful endeavors resulted in a net increase of $805,200 Gross ($2.4 million GF/GP) due to changes in the federal medical assistance percentages and QAAP.

Conclusion

As discussed in previous sections, highlighted major components of Medicaid and non-Medicaid mental health cumulative line item changes during the past ten years have resulted in an increase of $721.4 million Gross ($97.4 million GF/GP). The increase in Gross appropriations has been driven mainly by increases in Medicaid-eligibles caseload, actuarially sound capitation payment rate adjustments, new Medicaid initiated programs and services for PIHPs and CMHSPs, and funding changes for CMHSPs non-Medicaid programs and services. General fund increases for those factors have been partially offset by increases in the Federal Medical Assistance Percentage match rate, and program and service reductions for PIHPs and CMHSPs.

The state of Michigan is transitioning into a system in which PIHPs are realigned and funds are distributed to departmentally-designated community mental health entities responsible for a continuum of substance abuse prevention, education, and treatment. Michigan is also in the process of implementing an integrated care for individuals eligible for Medicare and Medicaid demonstration project in four regions of the state in which PIHPs will be expected to cover behavioral health and habilitative services for individuals with mental illness, developmental disabilities, or substance use issues. Implementation of the Medicaid reform legislation, Public Act 107 of 2013, will also result in more individuals with mental illness qualifying for Medicaid and being 100% federally covered until 2017. These systematic changes will have a profound impact on Medicaid and non-Medicaid funding allocations for PIHPs and CMHSPs.

* * *

NOTE: This report was written by Margaret Alston, Senior Fiscal Analyst. Kathryn Bateson, Administrative Assistant, prepared the report for publication. We appreciate the assistance provided by the Department of Community Health in providing information utilized in this report. The House Fiscal Agency is solely responsible for the content of the report.

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MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

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REVISED PLAN FOR PROCUREMENT OF MEDICAID SPECIALTY PREPAID HEALTH PLANS

FINAL VERSION

September 2000

PREFACE

This document presents the revised plan of the Michigan Department of Community Health (MDCH) for procurement of Medicaid specialty Prepaid Health Plans (PHP). The state has been working on a plan for procurement for the last eighteen months and previously issued (in September 1999) a preliminarily proposal regarding competition for management of publicly-funded specialty services.

During this period, MDCH has had extensive discussions with beneficiaries, family members of disabled individuals, advocacy organizations, public officials, providers and CMHSPs regarding procurement of specialty PHPs. We have learned much from these discussions and from the public dialogue that has emerged around this topic. MDCH has thoroughly examined the application of competitive procurement to specialty services, with particular attention to the basic objectives of the specialty services system, certain economic characteristics of specialty care, and the outcomes of competitive managed specialty arrangements in other states.

The analysis presented, arguments made and conclusions arrived at in this paper are admittedly technical, arcane and - for the general reader - somewhat cumbersome. A degree of complexity is unavoidable, given the nature of the topic and the important considerations involved. To compensate for this, the department previously issued a summary version of this paper, which condensed the basic reasoning and concisely described the revised plan for procurement.

It is important to emphasize that the line of reasoning pursued in the paper and the conclusions drawn *apply specifically to specialty services for persons with serious mental illness, developmental disabilities and addictive disorders*. These populations were historically confined in segregated state-operated hospitals and centers. The long journey from confinement in state-operated facilities to community-care settings has required enormous cooperation and collaboration between the state and local governments. In short, the considerations regarding competition for specialty services *are not directly applicable or comparable* to other circumstances and situations, such as competitive procurement for Medicaid *physical health services or long-term care services for other groups of disabled beneficiaries.*

In examining possibilities for competitive procurement, MDCH has maintained its focus on enhancing the capability to function, freedom to choose and the opportunity to achieve for persons with mental illness, developmental disabilities and addictive disorders. The touchstone for evaluating various procurement options has been how well each alternative comports with the basic principles and objectives of a publicly-funded specialty service system. In earlier papers on specialty-managed care, the state has outlined these core principles and aspirations and it is appropriate that we reiterate these values in the preface to the state's revised plan for procurement. The state has previously noted that in a modern specialty service system, disabled individuals should be:

- Empowered to exercise choice and control over their lives, including the purchase of services or supports and the choice of providers;
- Involved in meaningful relationships with family and friends;
- Supported to live with family while children and interdependently as adults;
- Engaged in daily activities that are meaningful, such as school, work, social, recreational and volunteering;
- Fully included in community life and activities;
- Afforded all rights guaranteed in law, including confidentiality of service information;
- Afforded access to effective services and supports intended to reduce the personal, social, and economic consequences of their disabilities;
- Committed to the ordinary obligations of citizenship and the responsibilities of community membership.

We believe the solution that the state has devised for procurement of specialty services honors and preserves these basic principles and aspirations.

REVISED PLAN FOR PROCUREMENT OF SPECIALTY PREPAID HEALTH PLANS

TABLE OF CONTENTS

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
REVISED PLAN FOR PROCUREMENT OF SPECIALTY SERVICE PREPAID HEALTH PLANS

PART ONE: THE CURRENT MDCH PERSPECTIVE ON COMPETITION

1. BACKGROUND

On June 26, 1998, the Michigan Department of Community Health (MDCH) received approval from the Health Care Financing Administration (HCFA) to implement a Medicaid managed care program for specialty mental health, substance abuse and developmental disability services. Under the approved plan, nearly all Medicaid state plan specialty services related to mental health and developmental disability services, as well as outpatient substance abuse services, were “carved out” (removed) from Medicaid primary physical health care plans and arrangements and placed under the management of specialty care Prepaid Health Plans (PHPs). A specialty Prepaid Health Plan (PHP) is a managed care entity that provides Medicaid covered specialty services - under a contract with the state and on the basis of prepaid capitation fees - to beneficiaries who need such care.

In approving the waiver, HCFA granted the state a time-limited exemption from federal procurement rules so that MDCH could contract - on a sole source basis - with Michigan's 49 county-sponsored Community Mental Health Services Programs (CMHSPs) to serve as the specialty PHPs and manage Medicaid specialty mental health, substance abuse and developmental disabilities services on a prepaid, shared-risk basis.

2. THE BENEFITS OF THE WAIVER AND MEDICAID MANAGED SPECIALTY CARE

The implementation of managed care for Medicaid specialty service was consistent with long-held system reform objectives in Michigan. For over thirty years, the state has pursued the development of community-based specialty care systems to facilitate integration and inclusion for persons with serious mental illness, developmental disabilities and addictive disorders. A persistent obstacle to comprehensive community care systems has been the various and disparate policies, service arrangements and funding streams that support community integration and inclusion efforts. With the managed care program and the designation of CMHSPs as the specialty Prepaid Health Plans, the state had achieved unified system management for specialty services at a local level, under a single contract that brought together multiple policies, programs, and payment sources. This arrangement permitted the county-sponsored entities to reconcile different eligibility requirements and to provide comprehensive and flexible rehabilitation and support services for persons with mental illness, developmental disabilities and addictive disorders, using appropriate resource streams.

3. THE MEDICAID WAIVER AND UNIFIED SYSTEM MANAGEMENT AS A MEANS TO A LARGER END

Achieving consolidated management of all publicly-funded specialty services - Medicaid benefits as well as other services and supports paid for through alternative funding arrangements – was not merely an exercise in administrative simplification. Rather, the goal of unified system management was a *means* to a much larger *end* – that of enhancing the freedom and capability of persons with behavioral or developmental disabilities to make choices among service and support arrangements.

Instead of being regarded as a passive recipient of dispensed benefits, the person's direct involvement in considering and choosing among different service and support alternatives affirms one of the most cherished aspects of everyday life: the ability to pursue individual life objectives and to participate in activities that one regards as having value. Visualizing possibilities and considering alternatives are much easier when all resources relevant to the person's choices are in the same "basket" (i.e., under unified or consolidated management).

The freedom to achieve – the ability to make decisions and to utilize services to support the life one desires and values – has become a core principle within Michigan's specialty service system. In 1996, Michigan law was amended to require "Person-Centered Planning" (PCP) within the specialty service system. PCP is the vehicle through which the freedom to achieve, to participate and to choose is realized.

4. Federal Requirements and the Rationale for Competitive Procurement

In approving Michigan's waiver, HCFA stipulated that within two years the state must submit "… a detailed plan to shift from sole source procurements for its Prepaid Health Plan (PHP) contracts to full and open competitive procurement which comply with the Federal procurement rules at 45 CFR Part 74". MDCH accepted this condition.

The federal position on competitive procurement, as stated in 45 CFR Section 74.43, is that "… all procurement transactions shall be conducted in a manner to provide, *to the maximum extent practical*, open and free competition" (emphasis added). The rationale for requiring competition is that it provides an equitable opportunity for qualified bidders to contend for governmental contracts. Beyond basic fairness, competitive contracting presumably puts economic incentives into place that assure that the purchaser will obtain the best possible product at the lowest possible price (best value). HCFA's stipulation that Michigan competitively procure specialty care PHP contracts was consistent with federal regulations and with the general premise that market arrangements ensure equity and efficiency.

5. Development of a Plan for Competition

For the past eighteen months, MDCH has diligently worked to develop a plan for competition that would conform to federal requirements. In approaching competition, Michigan did not want to compromise certain system design features and legal safeguards which have greatly facilitated freedom, participation, integration and inclusion for persons with serious mental illness, developmental disabilities and addictive disorders.

Specifically, MDCH was concerned that competitive selection of Medicaid specialty Prepaid Health Plans posed the risk that one of the ingredients of a comprehensive community care system - Medicaid specialty service benefits - might be split off and placed under separate governance. Such a separation would reintroduce the inefficiencies, service fragmentation and coordination problems that have historically hindered effective care for beneficiaries with serious mental illness, developmental disabilities and addictive disorders.

In addition, in contemplating possible new managers for specialty services, MDCH was also intent upon preserving the principles of freedom, participation, choice and inclusion described above, and on maintaining highly valued statutory achievements (e.g., person-centered planning, participation of consumers on governing boards, etc.) that promote and facilitate the application of those principles to individuals with mental illness, developmental disabilities and addictive disorders.

5.1. The Initial MDCH Plan for Competition

In September 1999, MDCH published a preliminary plan for competition that attempted to address these legal and public policy dilemmas while sustaining some form of market-driven selection process (competitive procurement) for specialty PHPs, consistent with federal requirements. In the preliminary plan, MDCH proposed:

> "… to extend competitive procurement to include all service populations (state priorities, eligible beneficiaries, federally mandated groups), all management responsibilities, all service options and settings, and all available funding for specialty services.
>
> Under this proposition, the department would bid out management of both the Medicaid funds for specialty services and other funds currently assigned by state statute or practice exclusively to county-sponsored entities. In a competitively "neutral" process (level playing field), the department would award management contracts for each designated service area to a single public, private, or public-private partnership organization in that locality or region which submitted a proposal most responsive to the purchasing specifications outlined in the bid packet.
>
> A competitively neutral process means designing the procurement so that all qualified bidders - public, not-for-profit and private for-profit - are treated in an equal fashion in the bidding process. To the extent possible, all barriers to the public entity flexibility are removed, as are some special privileges or protections currently afforded these entities. Similarly, private entities are required - if they are successful bidders - to take on legal responsibilities and procedural obligations currently borne only by public sector entities." ("Competition for Management of Publicly-Funded Specialty Services", page 25).

5.2. Public Reaction to the Preliminary Plan

Following the release of the paper, MDCH held ten public hearings to solicit input on the preliminary plan and the department received over 750 written comments from stakeholders regarding the document.

An analysis of stakeholder comments revealed considerable concern among all respondent groups that competition would diminish *local control and oversight* of community-based service systems. Remarks received indicated that stakeholders valued certain characteristics and processes of the current system that promote freedom, equity, and community participation for persons with behavioral or developmental disabilities. Respondents feared that these characteristics and processes (e.g., open meetings, consumer participation on governing boards, efforts to reduce stigma, self-determination, person-centered planning, etc.) would be lost under market arrangements that stress efficiency over freedom and equity considerations.

Stakeholders also expressed great reservations about the *high-powered incentives* characteristic of competitive environments. There was apprehension that profit considerations would compromise access and quality, encouraging managing entities to expropriate (in a revenue/profit stream) funds that should go to enhance services or to promote independence for disabled beneficiaries.

Other concerns expressed by all respondent groups were that there would be *disruptions in care continuity* if new managers were selected, and that competition – especially if it were narrowly focused upon price considerations - would result in the

elimination or reduction of certain highly valued services that promote the freedom to achieve, choose and participate in society. Finally, a number of respondents questioned the premise that competition should be applied to management of these services at all.

Stakeholders responded positively to some parts of the preliminary plan. In particular, they endorsed the guiding principles and service paradigms (recovery, strength-based ecological approach, self-determination) set forth in the plan and they applauded efforts to ensure accountability of managing entities (including replacing poorly performing organizations). Most stakeholders also agreed that the resource streams supporting local systems of specialty care *should not* be split apart (bifurcated).

5.3. LESSONS LEARNED

In working on the preliminary plan for competition, MDCH had come to recognize that competitive procurement for Medicaid specialty PHPs would be problematic for a number of reasons. Medicaid beneficiaries receiving services from the specialty PHP also needed seamless access to a range of other services supported through different funding streams. Some beneficiaries with special needs move in and out of Medicaid eligibility, and these status changes complicate the situation even further. If Medicaid specialty services were administered separately from these other services, care coordination and cost-shifting problems could intensify. In addition, while contractual provisions could be employed to compel compliance, non-governmental entities selected as the Medicaid specialty PHP would not be under statutory obligation to implement certain activities that facilitate participation, integration and inclusion of persons with mental illness, developmental disabilities and addictive disorders.

As indicated above, the state's proposed solution to these problems – an open competitive bid for Medicaid specialty PHPs and all other service funds and responsibilities – was cautiously received by system stakeholders. Feedback from stakeholders suggested that important aspects of local governance - processes that facilitate equity and inclusion - had been neglected in the MDCH analysis and subsequent plan. Comments received also indicated strong reservations about the incentive intensity of market arrangements, and worry that competition would cause disruptions in care or reductions in services. Stakeholders were, however, positively inclined toward certain service paradigms (e.g., self-determination) and measures to hold managing entities accountable.

For the last ten months, the state has pondered how to best address concerns raised by stakeholders, while maintaining elements of the preliminary plan that were widely endorsed. During this time, MDCH continued to engage in dialogue with interested parties, and the state initiated discussions with HCFA about possible alternative arrangements. In the course of these deliberations, MDCH considered various alternatives (e.g., two-plan option) to safeguard beneficiaries and to mitigate certain incentive problems associated with market selection. While these options appeared to satisfy federal requirements, none of these alternatives seemed to make economic sense, nor did they represent a better solution than current arrangements. In short, while sole-source contracts for Medicaid specialty PHP contracts are problematic, the state was not able to identify a superior alternative arrangement that could be implemented with net gain to the beneficiary.

In struggling to define a workable approach for competitive procurement of PHPs, MDCH began to suspect that adopting a *rigid* interpretation of federal requirements for competitive procurement could be forcing specialty care into an unnatural scheme or

pattern. Perhaps specialty services have certain characteristics that cannot be easily fitted into the simple competitive market model.

6. RETHINKING COMPETITIVE PROCUREMENT

Rather than develop increasingly more intricate models to make competitive procurement work, MDCH gradually began to question whether classic competitive selection of specialty PHPs was actually feasible or desirable. Determining the feasibility of competition required a rather detailed consideration of economic issues. Establishing whether competition was desirable required an assessment of which arrangements best facilitate freedom, equity, opportunities for achievement, community integration and inclusion for beneficiaries with serious mental illness, developmental disabilities and addictive disorders.

6.1. UNDERSTANDING COMPETITION

As noted previously, federal regulations requiring competition presume that market mechanisms promote equity and best value. It is fair to inquire, however, whether this is true under all conditions and circumstances.

In rethinking competition, MDCH applied a particular analytic framework - transaction-cost economics - to the problem of competitive procurement for specialty services. Transaction-cost economics is an innovative perspective that examines the institutional context and economic reasons why certain activities are organized or conducted under different forms or arrangements. It seeks to identify the conditions or circumstances that produce market solutions, hierarchies (internal organization of activities) or hybrid arrangements.

From the transaction-cost perspective, all economic activities occur within the context of certain formal rules (laws) and informal constraints (customs, tradition, codes of conduct). These rules and constraints are collectively referred to as the institutional environment. The institutional environment reduces uncertainty and provides a stable structure for certain activities to be carried out. The formal institutional framework (the law) may purposely and deliberately limit the types of organizations that can carry out certain activities.

While the institutional environment significantly shapes economic activity, it is not the only factor influencing whether economic transactions are conducted through classical markets, hierarchies or hybrid contracting arrangements. The differing characteristics of certain economic activities or transactions favor different "governance" structures. Transactions of a specific kind readily lend themselves to "market" governance (classic competitive model). For other kinds of transactions, however, market arrangements may not be the most efficient means of organizing the production and transfer of a particular good or service.

6.1.1. The Simple Competitive Market Model

As indicated, federal regulations requiring competitive procurement presume that market arrangements are the best means to assure fairness and efficiency. However, to reap the benefits of competition (equity and best value), certain conditions must prevail in the marketplace. Competition tends to work best when there is a large number of equally informed parties engaged in the exchange, all the relevant characteristics of the goods or services to be acquired are readily discernible, and the transaction is a discrete event (i.e., after the transaction each party - buyer and seller - can go its own way at negligible cost to the other). In situations where the conditions of the simple competitive market model

(complete contracting) do not prevail, the presumed benefits of competitive procurement may not materialize.

6.1.2. More Complex Situations: Adjustments and Modifications

It is more difficult to competitively structure an exchange when there is a limited number of sellers, information is inadequate or unequally distributed, the activity or service being procured is rather involved and difficult to fully specify at the outset, and the transaction entails an ongoing relationship between the parties. Even under these circumstances, however, competition may still be feasible, *if the activity or service sought by the purchaser and provided by the seller has general-purpose use and the exchange does not require significant relation-specific investment.* In these circumstances, a sufficient number of sellers can be attracted for the exchange, and if the transaction deteriorates after the exchange, each party (buyer and seller) can redeploy their respective resources (albeit at some cost) for other uses.

These types of exchange situations are challenging, and often entail complex contracts (to define the conditions of exchange) and significant monitoring arrangements (to ensure compliance).

6.1.3. Circumstances not Conducive to Competitive or Market Arrangements

Transaction-cost analysis suggests that classic competition or market approaches may not work well under the following circumstances:

a) the purchaser needs the seller to make significant *asset-specific* investments (e.g., specialized facilities, dedicated programs, distinctive workforce, etc.) to organize, produce and/or deliver certain unique goods or services;
b) frequent interaction and close collaboration between the parties is required to achieve certain common objectives; and
c) continuous adaptations or adjustments to the arrangement must be made in response to changing circumstances or unanticipated contingencies.

Under these circumstances - when the purchaser and supplier have made durable specialized investments (that are not easily redeployable) in support of one another and to facilitate certain activities and common objectives - the parties are said to be in a condition of *bilateral dependency*.

Under this set of circumstances, classic competitive (market) arrangements are generally not practical or sustainable. In some situations, there is not a market for the particular activity or service: no supplier will make the necessary specialized investments without some assurances from the outset that there will be a continuing relationship with the purchaser. In other situations, there may be competition at the outset, but the purchaser and successful bidder - after making the durable specialized investments and acquiring particular technical abilities - eventually develop an ongoing dependency that undermines the practicality or utility of future competition.

When conditions of bilateral dependency obtain - either from the outset or over time - this dependency poses certain contractual hazards for both parties. Each party has incomplete information about future contingencies and the appropriate adjustments that may need to be made to the agreement down the road. In addition, either of the parties may exhibit opportunism, and attempt to mislead or

deceive the other party regarding necessary adjustments in order to extract unwarranted concessions or to expropriate unjustified economic increases.

To mitigate these hazards, contractual safeguards are commonly devised. In many situations, these contractual safeguards become elaborate and convoluted, with strenuous ex ante (before execution of the agreement) efforts to intricately define in the contract all possible scenarios, and laborious ex post (after execution) mechanisms to monitor the agreement and deter opportunism.

The high transaction costs involved in devising and implementing these types of safeguards often result in bilateral dependent parties eschewing the traditional arm-length adversarial contracting process and costly haggling in favor of *relational contracting*. In this type of hybrid arrangement, the parties recognize that to reach a common objective they must work cooperatively, and it is, therefore, in each party's interest to adjust flexibly to one another's concerns. The formal contract describes the basic parameters of the exchange, but it is the entire context of the relationship over time and the incentives that each party has to sustain *valued transaction-specific efficiencies* that accrue from the relationship, which facilitate equitable dispute resolution and discourages opportunism.

It is important to note that the relational contract is not necessarily an inferior or inefficient method of organizing certain economic activities. Indeed, under conditions of bilateral dependency, the relational contract *may well be the most efficient means* to acquire services and to minimize transaction costs.

6.1.4. Summary of MDCH Considerations Regarding Competition

Below, in table form, is a brief summary of the types of exchange that are conducive either to classic market competition, complex competitive contracting or relational contracting (bilateral dependency).

Attributes of the Particular Good/Service and Investment Characteristics to Support the Exchange

Exchange Frequency	Standard Good/Service Non-Specific Investment to Support Transaction	Complex Good/Service General Purpose Use Some Specific Investment	Highly Specific Good or Service Significant Specialized or Relation-Specific Investment
Occasional	Market	Market	Complex Competitive Contracting
Recurrent or Ongoing	Market	Complex Competitive Contracting	Bilateral Dependency **Relational Contracting**

6.2. Applying the Analysis to Competition for Specialty Prepaid Health Plans

MDCH has concluded that the characteristics of specialty Prepaid Health Plans are such that neither the simple market model, nor more complex forms of competitively organized exchange are applicable to these contracts. In contracting with specialty PHPs, the state must obtain an agent that is committed to the objectives of integration and inclusion for beneficiaries with serious mental illness, developmental disabilities, and addictive disorders. The PHP must make certain relation-specific highly specialized investments to support this objective, including specialized management

strategies and possible direct operation of certain unique or highly individualized programs if necessary suppliers cannot be found. A specialty PHP must frequently interact with the state regarding beneficiaries that are placed in state facilities, and must collaborate with the state in returning individuals from segregated settings to community placements - without costly haggling that might delay reintegration. The PHP must establish and sustain close and cooperative long-term ties with other community agencies that fund or provide certain ancillary services and supports needed by beneficiaries.

In short, contracting conditions for specialty Prepaid Health Plans constitute a situation of bilateral dependency. Even if a competitive environment could be established for an initial bid, the nature of the ongoing relationship – necessary to facilitate the objective of integration and inclusion – quickly erodes the initial competitive environment.

Since most CMHSPs already have many of the characteristics that the state would be seeking in a competitive bid for a specialty PHP, there seems little utility in conducting a procurement in which CMHSPs would almost certainly be the successful bidders. Nor can one easily argue that there is a vigorously competitive private market for specialty PHP services and that limiting procurement is therefore unfair. Due to consolidation in the for-profit managed behavioral health care sector, competitive procurement in other states has degenerated from the standard market model into an oligopolistic market situation, in which a few large organizations dominate the bid process.

6.3. Competition for Physical Health, Long-Term Care and Specialty Services

Medicaid has been described as a program that essentially has three component parts: a health insurance program for low-income individuals (physical health care); a long-term care program for elderly and physically disabled persons; and a specialized service program for persons with developmental disabilities and mental illness/addictive disorders.

The state has utilized competitive contracting in managed care arrangements for Medicaid physical health care services and has proposed a competitive framework to implement managed care for long-term care services. Why does the state believe that competitive contracting is feasible for managed physical health care services and for long-term care but is impractical for specialty services for persons with developmental disabilities, mental illness and addictive disorders?

6.3.1. Competition for Management of Physical Health Care Services

Procurement of Health Maintenance Organizations (HMOs) to manage physical health services for Medicaid beneficiaries is a situation of complex competitive contracting. There are a limited number of sellers, the activity or service being procured is somewhat involved and difficult to fully specify at the outset, and the transaction entails an ongoing relationship between the parties (contracts are let for multi-year periods).

It is important to note, however, that in regard to Medicaid physical health care services, HMOs represent a *general-purpose application or technology*. The care management strategies and provider network components that an HMO uses to manage physical health care for Medicaid beneficiaries can also be utilized to manage physical health care for other insured populations sponsored by other payers. While some "transaction-specific" investments are required if the HMO contracts with the state to manage physical health care for Medicaid beneficiaries, these investments can be redeployed to alternative uses (i.e., to

manage physical health care for other insured populations) should the HMO or the state elect to terminate the arrangement.

Categorizing HMOs as a general-purpose managed care technology does not mean that there are no differences in managed physical health care for Medicaid beneficiaries and for commercial populations. Medicaid does have some distinctive features as a program that differs from insurance principles used in commercial plans. These distinctive features introduce additional complexities into the competitive procurement process and contract execution activities.[1] The designation of HMOs as general-purpose technology does point to the fact that management of physical health care for Medicaid beneficiaries is not an *asset-specific* endeavor. This lack of asset-specificity (the HMO can redeploy its managed care activities and investments to serve other insured populations) is the principal reason that a variety of sellers can be induced to compete for contracts, and why a competitive market place can be sustained over repeated contracting cycles.

6.3.2. Competition for Management of Long-Term Care Services

Long-term care consists of many different services aimed at helping elderly individuals and persons with chronic physical conditions secure appropriate medical services and compensate for limitations in their ability to function independently. As indicated in the recent report from the Michigan Long-Term Care Work Group, existing long-term care services in Michigan for these populations "…are not integrated into a coordinated system of care. There are no incentives for planning and use of private resources, and dual public funding streams (Medicaid and Medicare) create confusion and impede efficiency".[2]

Various managed care models for long-term care in Michigan have been identified and efforts to pilot these approaches are underway. All of the models - to a greater or lesser degree - seek to consolidate and decentralize administrative responsibilities for care, allow greater flexibility and individualization in care arrangements, and integrate various service components (e.g., acute care, general aging and advocacy services, long-term supports, etc.).

Because existing long-term care services are not highly organized and since numerous demonstration models are proposed, the state is using competitive solicitation as a means to induce new forms of coordination and integration among existing service components. Competition and capitation are regarded as catalysts for creation of organized systems of long-term care.

Competition to demonstrate and implement various forms of managed long-term care for the elderly and physically disabled is possible at the outset since the state (as purchaser) is attempting to persuade suppliers to organize and offer a new "product" (i.e., integrated, risk-based, long-term care services). It is difficult to determine at this point whether competitive contracting for long-term care will transform over time from the initial (ex ante) large number supply situation (many bidders) to an eventual (ex post) small number situation (bilateral dependency).

[1] See "Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts", by the Center for Health Policy Research, George Washington University.
[2] "Long-Term Care Innovations: Challenges and Solutions", page 2.

6.3.3. Differences Between Physical Health, Long-Term Care and Specialty Services

In contrast to managed care for physical health care, managed specialty services for persons with serious mental illness, developmental disabilities and addictive disorders requires a *special-use managed care application or technology* with significant, transaction-specific investment in specialized techniques, facilities, programs and workforce. Unlike emerging managed models for long-term care, specialty services are already highly organized and previously experienced a *fundamental transformation* to a condition of bilateral dependency.

6.3.3.1. Special Use Characteristics and Asset-Specificity

Beneficiaries with serious mental illness, developmental disabilities and addictive disorders need special assistance, distinctive care management strategies, specialized interventions, and highly individualized support arrangements that are not typically available from or covered by other payers and managed care systems. Also, as the Institute of Medicine noted in a recent report on behavioral health:

> "…a significant portion of the public care system for individuals with the most disabling conditions extends beyond health care services to rehabilitation and support services, including housing, job counseling, literacy, and other programs. The coordination of these services requires collaboration and cooperative relationships among many agencies, including public health, social services, housing, education, criminal justice, and others. Most of these services are not covered by private insurance and have not been developed by most private behavioral health care companies."[3]

Management of specialty services for behaviorally or developmentally disabled beneficiaries is an activity characterized by a high degree of asset-specificity - the managing entity must invest in singular care management strategies, dedicated programs, transaction-specific facilities and a specialized workforce. These special-use characteristics mean that these investments cannot be shifted to alternative uses or redeployed for alternative payers. Accordingly, such investments would never be made at all without credible commitments regarding a sustained relationship between the purchaser and the supplier.

The special-use characteristics of managed specialty service activities and the high degree of transaction-specific investment required constrains the use of market mechanisms and distinguishes specialty PHPs from general-use managed care technology applied to physical health care services. In addition, the critical need for close and persistent collaboration between the managing entity and other human service agencies further limits the applicability of competitive contracting in these situations.

[3] Managing Managed Care: Quality Improvement in Behavioral Health, Institute of Health, 1997, Page 3.

6.3.3.2. Fundamental Transformation and Specialty Services

Michigan's specialty care system for persons with serious mental illness, developmental disabilities and addictive disorders is a highly organized and integrated managed delivery system. The high degree of organization and integration is the result of focused and persistent state policy over the last two decades.

Michigan, like many states, had a long history of placing persons with mental illness, developmental disabilities and addictive disorders in segregated state-operated facilities. Even into the early 1970s, there were very few community services available for these special populations.

To reduce the use of segregated state facilities, the state needed to develop community-based service and support arrangements. However, developing such alternatives required highly specific investments in dedicated programs, local facilities, distinctive service management strategies and a specialized workforce.

The state legislature recognized that - due to the condition of asset specificity - investments for community alternatives to state facilities *would never be made* unless there were credible commitments regarding the future. To provide such assurances, the legislature passed statutory changes that transferred primary responsibility for management and delivery of specialty services from the state to county-sponsored public entities. These changes greatly accelerated Michigan's transition from a facility-based segregated care system to a community-based service and support model. The law provided assurances and incentives for counties to invest in dedicated, population-specific programs and care settings, and to attract the necessary specialized managerial and professional workforce.

In the 1980s, the state elected to expand the scope of Medicaid coverage to include several optional benefits specifically tailored to the needs of beneficiaries with serious mental illness, developmental disabilities or addictive disorders. The state tightly coordinated the provision of these Medicaid services with the programs and service activities of the existing county-based systems of care, to ensure that these benefits would contribute to community integration and inclusion for disabled beneficiaries.

Thus, the specialty services system in Michigan has already experienced what has been referred to as a *fundamental transformation* (Williamson, 1985[4]). Fundamental transformation refers to circumstances in which a possible market situation (large number of potential bidders) has been transformed into an exchange situation of bilateral dependency between purchaser and dedicated suppliers. This transformation occurs *when an exchange situation requires significant, specialized, durable investments in transaction-specific human or physical assets.* When this happens, future parity (for bidding purposes) is upset and what might have been potentially or initially a

[4] The Economic Institutions of Capitalism, by Oliver Williamson, Free Press, 1985

situation of large number bidding is transformed into a situation of bilateral supply.

As noted previously, the state is planning to implement several models to manage long-term care for elderly and disabled individuals. Because existing long-term care services are not "…integrated into coordinated systems of care", competition to implement these models is still possible. A large number of bidders may vie - at the outset - for the right to implement these models*. Long-term care - in contrast to specialty services for persons with serious mental illness, developmental disabilities, and addictive disorders - has not yet gone through a fundamental transformation to the condition of bilateral dependency*. Whether competitive parity can be maintained in future contracting periods is, however, still to be determined.

6.4. WHY CLASSIC COMPETITIVE PROCUREMENT FOR SPECIALTY PHPS IS NOT DESIRABLE

Even if the economic obstacles to classic competitive procurement could be surmounted, it is also important to consider whether market selection of specialty PHPs would be desirable. Specialty PHPs must assume an important role in the protection of vulnerable populations and in securing full participation, integration and inclusion for these individuals. In short, specialty PHPs have responsibilities for ensuring freedom, opportunities for achievement, equity and participation that go far beyond the usual and customary obligations of a managed care entity.

Transaction-cost economics draw attention to the institutional (legal) framework in which economic activities take place. In relation to specialty services, the institutional framework encompasses all aspects of public law that impose a duty upon government to both protect vulnerable populations and to ensure the full participation of disabled individuals in society. These legal considerations have impelled state and local government to become heavily involved in the organization, management, production and delivery of specialty services and supports. Under the Americans with Disabilities Act and the subsequent Olmstead decision, the state also has an affirmative obligation to utilize Medicaid to promote community integration for disabled beneficiaries.

There is a plausible argument that competitive selection of specialty PHPs might undermine, rather than strengthen, the state's legal obligation to pursue community integration for beneficiaries with mental illness, developmental disabilities and addictive disorders. Unlike HMOs responsible for physical health, specialty PHPs serve beneficiaries that still struggle to realize the basic rights of citizenship. Competitive procurement introduces some significant new principal-agent problems and incentives that might lead PHPs to overemphasize efficiency objectives in relation to other considerations.

7. THE CURRENT MDCH PERSPECTIVE: CLASSIC COMPETITIVE PROCUREMENT IS NOT PRACTICAL

After eighteen months of analysis, an exhaustive examination of different options, and extensive discussion with stakeholders, MDCH now believes that classic "open and full" competition for specialty PHP contracts - required by HCFA and previously agreed to by the state - is not practical, for the reasons outlined above. The state also contends that, beyond the issue of the impracticality of competitive procurement, a deviation from the procurement requirements would "facilitate comprehensive or integrated service delivery" as stipulated in 45 CFR 74.4 ("Deviations"). Specifically, permitting non-competitive procurement would

allow the state to maintain an integrated community-based service delivery system for beneficiaries with serious mental illness, developmental disabilities and addictive disorders.

The state believes that organizing the production of necessary services and supports and managing the smooth transfer of these goods to vulnerable beneficiaries is a difficult undertaking, fraught with significant issues of social equity and involving important "externalities" of consumption that affect the community as a whole. We now believe that the traditional non-market method for designating the managing entity - with some refinements - may in fact represent the *least costly* institutional arrangement for managing specialty service transactions.

In short, MDCH contends that both the formal institutional (legal) framework and the specific circumstances of specialty service management and care delivery (bilateral dependency) make the standard market model of "open and full" competition for Medicaid specialty PHPs impractical and possibly detrimental to the goal of full community inclusion for behaviorally or developmentally disabled beneficiaries.

In arguing against the feasibility of classic competitive procurement, the state has carefully analyzed the structure of the relevant market and has compared this analysis to previously issued guidance by HCFA on sole-source contracting.[5] The state has also considered its argument for a non-competitive procurement process in relation to provisions of the Balanced Budget Act of 1997.

While MDCH maintains that classic competitive procurement for specialty PHP contracts is impractical, it is not suggesting that all competitive aspects be eliminated from the PHP selection process, nor does it claim that all current specialty PHPs should be retained in the future. Rather, the MDCH plan, outlined next in this document, calls for a different kind of competition, a reduction in the number of specialty PHPs, and a rigorous qualification process to select PHPs from a restricted pool of initial applicants. While ensuring that specialty PHPs meet high standards and represent the least-costly feasible structure for managing specialty care, the revised MDCH plan also introduces mechanisms to assure "best value" in the selection of providers and to afford beneficiaries adequate choice in service and support arrangements.

[5] Letter from Rodney Armstead to State Medicaid Directors dated August 11, 1995, and a subsequent letter from Bruce Merlin Fried to State Medicaid Directors, dated December 7, 1995.

PART TWO: THE MDCH PROCUREMENT FRAMEWORK

1. INTRODUCTION: RESTATING THE CASE FOR NON-COMPETITIVE PROCUREMENT

In the previous section, MDCH argued that trying to fit specialty PHPs into the standard "open and full" competitive market model is a procrustean bed situation - the rigid imposition of a standard that ignores important characteristics of specialty PHPs.

The discussion in Part One called attention to the basic purpose of the state's managed care waiver – to achieve unified local system management for both Medicaid benefits and the specialty services/supports paid for through other funding arrangements. We indicated that this objective – unified system management at a local level – was essentially a *means* to a larger *end:* facilitating the freedom to participate, choose and achieve for beneficiaries with serious mental illness, developmental disabilities and addictive disorders. We noted that specialty PHPs operate within a unique institutional (legal) framework, employ particular processes and practices that promote freedom, equity, empowerment and participation, and pursue distinctive (support, accommodation, community inclusion) kinds of outcomes for beneficiaries. Finally, we pointed out that specialty PHPs also have singular economic characteristics – the condition of *bilateral dependency* between purchaser and supplier - that make classic market competition for these contracts unfeasible or of little utility.

We also described in Part One the extensive public process that the state engaged in as it sought to devise a workable market solution for specialty PHP procurement. We noted that despite all of these efforts, the state was not able to arrive at any plan which seemed to represent a superior or more efficient alternative than the current form of procurement and the relational contracting arrangement, and we indicated that our market selection options were not generally supported by system stakeholders.

2. PROPOSED FRAMEWORK: RETAIN BUT REFINE THE CURRENT SELECTION PROCESS

Elaborate attempts to make management and delivery of these services conform to the standard market model have not been successful. Rather than continue down this road, MDCH believes that *refining the state's current selection method* is a more promising vehicle for attaining the outcomes (efficiency, choice and community inclusion) sought by the state, HCFA and system stakeholders. If we set aside a procrustean interpretation of federal regulations, we can readily discern opportunities for pragmatic system reform that lie just outside the classic competitive paradigm.

MDCH is very much aware of the strong legislative preference - expressed in federal statute and regulations - for competitive procurement. In regard to Medicaid managed care, provisions of the Balanced Budget Act of 1997 have reinforced this preference for competition and for beneficiary choice.

However, federal regulations give the Secretary of Health and Human Services discretion to approve non-standard forms of procurement. We believe that the exercise of this discretion in regard to Michigan's managed care program for Medicaid specialty services would be in the best interest of beneficiaries with serious mental illness, developmental disabilities and addictive disorders.

While the intent of federal regulations regarding competition is to achieve fairness for qualified bidders, and efficiency (best value in terms of price and quality) and choice for beneficiaries, the state believes that the particular circumstances of specialty care expose the limitations of the classic competitive model as a vehicle to attain these aims.

Specifically, the state contends that the basic objective of Michigan's Medicaid managed specialty care program is to facilitate the beneficiary's freedom and ability to fashion services and support arrangements consistent with personal choices and individual life objectives. This objective can best be accomplished through a managed system in which the beneficiary has access – through a single local entity – to all resource streams (Medicaid and non-Medicaid) that finance services and supports required for accommodation and community inclusion. The state also believes that beneficiary freedom, participation and integration can best be promoted through a local managing entity (the specialty PHP) that has specific *statutorily proscribed equity and justice functions*.

The state acknowledges that limiting the applicant pool for specialty PHPs to CMHSPs does restrict other entities that might wish to participate. However, we believe that this restriction must be viewed against the essential purposes of the waiver: to facilitate beneficiary freedom, participation, choice, achievement, integration and community inclusion. The state contends that fairness must ultimately be judged in relation to what is most equitable for the beneficiary and not merely by what seems an equitable situation for specific interested entities.

The state has also made the case that the economic characteristics of specialty PHPs do not easily lend themselves to the classic market approach and, hence, we cannot presume that competitive procurement will produce the most economically efficient (best value) outcome. Certain economic activities are organized outside of markets precisely because these non-standard arrangements are a more efficient (economize on transaction costs) mode of organization for the particular activity, good or service.

For these reasons, the state proposes to retain the central dimensions of the waiver program (eligibility model for specialty services, designation of a single-specialty-PHP per area) and the basic framework for specialty PHP selection (restrict initial consideration to CMHSPs). We will describe the revised procurement plan in detail later in the document. But first, the state will identify problematic aspects of the proposed approach to procurement and indicate safeguards that might be applied to compensate for these limitations.

3. LIMITATIONS AND COMPENSATIONS

The state's proposal to use a non-standard procurement process, with a restricted pool of initial applicants (CMHSPs) and the selection of a single PHP for each designated area, carries with it hazards that must be recognized and remedied. In the sections below, the state examines some of the weaknesses and liabilities of the proposed procurement framework and identifies methods to compensate for these vulnerabilities.

3.1. OPPORTUNISM AND POTENTIAL FOR COLLUSION

In previous discussions, HCFA has raised the general caution that sole-source procurement and relational contracting between the state and county-sponsored entities may gradually tilt toward opportunism and unintended collusion, to the detriment of the federal government. If incentives, risk arrangements and contractual provisions are poorly structured, county-sponsored entities could accumulate significant savings from Medicaid specialty PHPs activities, and these savings could be used to supplant or reduce state general fund obligations and local contributions for services to non-Medicaid, state-defined priority populations.

The state has already taken necessary steps to eliminate these risks (opportunism and collusion) to our federal partners. Capitation rates for specialty services were based upon fee-for-service or claims data for beneficiaries that have fairly predictable

expenditure histories for specialty care. Capitation payments to the specialty PHPs under the waiver must be used to provide Medicaid covered state plan specialty services (or approved alternatives) to eligible Medicaid beneficiaries. Savings achieved by the specialty PHP within the approved risk corridor *must* be reinvested back into services for Medicaid beneficiaries and may not be diverted to purchase services for non-Medicaid recipients. Finally, the state agreed that no capitation payments to specialty PHPs would be returned to the state as an intergovernmental transfer.

3.2. THE NUMBER OF SPECIALTY PHPS: ADMINISTRATIVE CAPABILITIES AND EFFICIENCIES

Under the current arrangement, MDCH contracts with each of the 49 Community Mental Health Service Programs to serve as the specialty PHP within their designated service area. The number of Medicaid beneficiaries covered by a specialty PHP ranges from over 300,000 in the largest CMHSP-PHP, to less than 3,000 in the smallest CMHSP-PHP.

There are certain efficiencies or returns to scale in PHP administrative activities as the number of covered lives increases. Beyond efficiency considerations, larger size confers other advantages, including greater adaptive capabilities (i.e., the ability to meet enhanced PHP administrative requirements, particularly those related to data management and quality monitoring systems) and better ability to absorb risk (including chance variations in utilization).

In short, efficiency characteristics, administrative capacity requirements and risk management considerations all imply that the state should *reduce the number of specialty PHPs* in future procurements. The state's revised plan for PHP selection directly addresses the need for reduction by imposing a *minimum number of covered lives criteria* as a pre-qualification standard for specialty PHPs.

3.3. CONFLICT OF INTEREST SAFEGUARDS

MDCH has argued that, in general, CMHSPs with certain characteristics are the entities best qualified to serve as the specialty PHPs. This implies, however, that the administrative or management role of the CMHSP is primary, and that this function be distinguished from the CMHSPs activities as a direct provider of services.

Conflict of interest issues related to CMHSPs as specialty PHPs can develop at both the administrative (managerial) and the direct-service levels. Since CMHSPs (if selected as the specialty PHP) will manage both Medicaid and non-Medicaid resources, they may be tempted to *disproportionately* apply Medicaid funds (imprecise cost allocation) to support their overall administrative burden. At a direct provider level, the CMHSPs may prefer to maintain existing direct operations, even when outside suppliers may be more efficient or offer higher quality.

The state believes that it can promote administrative efficiencies within specialty PHPs (beyond those efficiencies garnered through a reduction in the number of specialty PHPs) and reduce conflict-of-interest temptations by imposing a limit on administrative payments to PHPs. To this end, the state intends to make Medicaid capitation payments that are comprised of "administrative" and "service" components. The specialty PHP may only use the administrative component of the capitation payments to underwrite the cost of contractually defined PHP administrative activities.

To assure the primacy of the CMHSP managerial role and to reduce potential conflict-of-interest regarding direct program operation, MDCH will require that the provider network of the specialty PHP be assembled either through competitive contracting, or

through a comparative cost method that demonstrates network selection processes were equitable to all interested entities and that the providers selected represent “best-value” from a price and quality perspective.

3.4. Principal-Agent Problems in an Eligibility-Based, Single Plan Model

Michigan has employed an eligibility model rather than an enrollment model for Medicaid specialty services. Any Medicaid beneficiary in a given area that needs specialty services may obtain such care from the designated specialty PHP that serves that area. MDCH designates a single entity within each area to operate as the specialty PHP.

The state believes that the eligibility model and the single-PHP-per-area approach have important benefits in a specialty service system of care. Enrollment models for specialty care present substantial administrative complexities and entail significant transaction costs. Similarly, several specialty PHPs in an area multiples administrative costs and presents adverse selection problems that are difficult to anticipate and counteract.

Beyond the costs and complexities, the state contends that enrollment models and multiple plans do not provide beneficiaries with the kinds of choices they value the most. The economic characteristics of specialty service provision impose some natural limits on the number and types of supplier organizations. In multiple plan situations, competing managing entities frequently contract with the same, relatively stable, network of community providers. The ability to choose between managing organizations that have very similar or identical provider arrangements does not materially increase the beneficiary’s true freedom to choose and the opportunity to achieve.

While the state believes that there is a compelling case for an eligibility approach and a single-PHP-per-area model, it does acknowledge that this arrangement presents some nettlesome *principal-agent problems* for beneficiaries. Under the MDCH model, a CMHSP (if selected as the specialty PHP) is the "agent" charged with acting on behalf of the "principal" - the beneficiary with a serious mental illness, developmental disability and/or addictive disorder. Principal-agent problems arise when the agent acts primarily for its own benefit or interest, rather than in the interest of the beneficiary whom it is supposed to serve.

Within the MDCH framework for specialty PHPs, three problematic principal-agent situations can be anticipated:

- Access and Eligibility Decisions
- Application of Person-Centered Planning
- Plan Implementation (including disclosure of options and resource allocation)

In Part Three of this document, MDCH will suggest specific remedies for each of these potential principal-agent problems. In general, state solutions involve reducing information asymmetries (providing beneficiaries better information about access, eligibility and service alternatives), tighter monitoring, and introduction of an external facilitation option (for person-centered-planning).

3.5. Dealing with the Possibility of Non-Market Failure

Since MDCH has proposed that county-sponsored governmental entities be afforded initial consideration as specialty PHPs, it is fair to ask what the state will do if a CMHSP

does not meet qualification standards for selection, or if a selected CMHSP does not fulfill performance requirements.

There is a legitimate concern that granting initial consideration to CMHSPs for specialty PHP designation could degenerate - under political pressures - into a perfunctory process that virtually guarantees approval for incumbent entities even if they have serious deficiencies.

To preclude this possibility, MDCH will employ rigorous and objective qualification criteria and utilize a special procurement committee (with beneficiaries, family and advocacy representation on the committee) to select specialty PHPs. If a CMHSP does not meet the qualifications set by MDCH and as adjudged by the committee, the area will be declared vacant in regard to a specialty PHP and open for competitive solicitation. Both public entities and private organizations will be permitted to bid in these open regions.

If the procurement committee does certify that a CMHSP meets the qualifications for specialty PHP designation, the state will retain the option to sanction, temporarily operate or replace a poorly performing CMHSP-PHP. Replacement of the CMHSP-PHP, if necessary, would be accomplished through competitive solicitation.

In the event that a CMHSP-PHP must be replaced, the state will insist upon recovery of reserve funds and assets related to the Medicaid managed specialty service program, to satisfy residual obligations of the old PHP and to assist with start-up costs for the replacement entity.

4. A Final Perspective on these Limitations and Remedies

These imperfections in the proposed procurement framework may seem daunting at first glance. It is important to reiterate, however, an important consideration previously noted in this document. *All methods* for selecting specialty PHPs - both competitive models and other arrangements - have problems and imperfections. In the comparative analysis of procurement options, MDCH concluded that competitive or market selection of PHPs posed more serious and irremediable problems - *in relation to the primary objectives of the state's managed specialty services program* - than did non-competitive procurement and sole-source contracting. In short, the state could not identify any superior feasible alternative arrangement (to the current procurement method) that could be devised and implemented with a net gain for disabled beneficiaries. The state believes that its refined or adjusted procurement model is the best *feasible* method to ensure that selected specialty PHPs are committed *to the larger end or greater goal* of the managed care program: that is, enhancing the beneficiary's freedom and opportunity to select services and support arrangements that are consistent with personal preferences, identified needs and individual life objectives.

PART THREE: REVISED MDCH PLAN FOR PROCUREMENT OF SPECIALTY PHPS

1. INTRODUCTION

As previously indicated, MDCH plans to *retain the fundamental structure* of the current waiver program and procurement model while simultaneously *introducing certain significant alterations* to address particular areas of concern. The basic strategy for compensatory modifications has been briefly described in Part Two of this document. In this section, the basic strategy is directly applied and described with greater specificity.

2. BASIC STRUCTURAL CONFIGURATION AND PLAN DIMENSIONS

The state's revised plan for procurement retains the basic structural configuration of the state approved managed specialty services waiver, but limits CMHSP prerogatives within this structure.

2.1. PRESERVATION OF THE CARVE OUT, RETENTION OF ELIGIBILITY & SINGLE PHP MODEL

The state will maintain the carve out for Medicaid specialty mental health, developmental disability and substance abuse services. Any Medicaid beneficiary in a given area that needs specialty services may obtain such care from the designated specialty PHP that serves that area. MDCH will designate a single entity within each area to operate as the specialty PHP.

2.2. ROLE OF COMMUNITY MENTAL HEALTH SERVICES PROGRAMS (CMHSPS)

As noted previously, the institutional (legal) environment, experience considerations, equity functions, economic features and particular output (community inclusive outcomes) characteristics make competition for specialty PHPs impractical.

Therefore, the state will afford *qualified* CMHSPs an *initial consideration* to operate as the specialty PHP for a designated service area. However, the state *will not offer this initial consideration to all existing CMHSPs* as individual, stand-alone organizations.

The state will not be precluded from obtaining specialty PHP services from private organizations if a CMHSP cannot meet state specifications.

2.3. SAFEGUARDS REGARDING MEDICAID FUNDS

Capitation payments to the specialty PHPs are for Medicaid covered state plan specialty services (or approved alternative) for eligible Medicaid beneficiaries. Capitation payments to specialty PHPs will not be returned to the state as an intergovernmental transfer.

The specialty PHP will manage Medicaid specialty services for eligible beneficiaries on a prepaid, shared-risk basis. Savings achieved by the specialty PHP within the approved risk corridor, must be reinvested back into services for Medicaid beneficiaries and may not be diverted to purchase services for non-Medicaid recipients.

3. ALTERATIONS AND ADJUSTMENTS

While the basic dimensions of the specialty service plan remain intact, MDCH is introducing a significant new capacity requirement, with options for CMHSPs that are unable – as individual stand-alone organizations - to meet the standard.

3.1. MINIMUM COVERED LIVES CRITERIA

Single CMHSPs that have at least 20,000 Medicaid beneficiaries (covered lives) within their respective catchment area boundaries will be eligible (as individual stand-alone

organizations) to apply for designation as a specialty Prepaid Health Plan for their catchment area. CMHSPs that do not meet the covered lives criteria will be afforded a range of options for program participation, including an opportunity for *multiple contiguous CMHSPs to make a consolidated application* for PHP designation.

The state has determined that an eligibility base of roughly 20,000 is the point at which scale economies for PHP administrative activities begin to develop. Since specialty PHPs will have enhanced administrative responsibilities in the future (as promulgated regulations related to several federal statutes take effect), achieving some measure of scale economies becomes more important than in previous contracting periods.

3.1.1. Options for CMHSPs with Less Than 20,000 Medicaid Beneficiaries

Single CMHSPs with less than 20,000 Medicaid covered lives may choose among several options for participation in the Medicaid managed specialty services program.

3.1.1.1. Affiliation & Consolidated Application for PHP Designation

Multiple CMHSPs - with contiguous boundaries - that collectively have at least 20,000 Medicaid beneficiaries in their combined catchment areas may submit a consolidated application for PHP designation. The consolidated application must describe the relationship that exists among the affiliated entities, including any legal agreements that define or circumscribe these relationships.

MDCH will accept consolidated applications that conform to one of the following structural arrangements:

- The affiliated CMHSPs submitting a consolidated application identify one CMHSP in the affiliation to serve as the "hub" for regional efforts*. This CMHSP would serve as the Prepaid Health Plan for the region*. The affiliated CMHSPs may designate the hub CMHSP formally (through the Intergovernmental Transfer of Functions and Responsibilities Act) or simply by informal agreement. In any case, *only the hub-CMHSP will be considered for designation as the specialty PHP for the region*, *and it must meet all other qualifications established by MDCH to be awarded this status*. The other CMHSPs in the affiliation would be eligible for a special provider designation – that of “Comprehensive Specialty Service Network” (CSSN) – that affords them special consideration in the provider network and qualifies them to receive a sub-capitation from the PHP or hub-CMHSP.
- The affiliated CMHSPs may submit a consolidated application along with a declaration - supported by legal documentation - that they have, or are in the process of creating, a new organizational entity (under the Urban Cooperation Act) which they are nominating for consideration as the specialty PHP for the region. The new entity would have to meet all qualifications established by MDCH before it could be designated as the specialty PHP for the region.

3.1.1.2. Inability of CMHSPs to Form Affiliations or Select an Option

In the event that various contiguous CMHSPs cannot form affiliations or PHP regions that meet the minimum covered lives standard, or if a

CMHSP does not indicate its preferred participation option for the Medicaid managed specialty services program, the department may open the region for competitive procurement or designate an adjacent qualifying CMHSP to serve as the specialty PHP for the region.

3.2. Qualification Requirements for PHP Designation: Application for Participation

An individual, stand-alone CMHSP - or an affiliated group of CMHSPs - that meets the minimum covered lives criteria, may complete an "Application for Participation" (AFP), developed by MDCH in conjunction with consumers, family members and advocacy organizations. The AFP contains all pertinent technical requirements and conditions of participation that CMHSPs must meet in order to be designated as the specialty PHP for a particular area. The AFP will require the CMHSP to describe its administrative and managerial capabilities related to managing care and its processes and accomplishments in areas related to community inclusive practices and outcomes.

3.2.1. Administrative Capabilities

The CMHSP must describe its capacity to carry out standard managed care administrative functions and its ability to perform certain enhanced functions for managed care organizations stipulated under proposed rules to the Balanced Budget Act and other federal legislation.

If the CMHSP does not have sufficient administrative capabilities to perform necessary managed care functions or to meet the enhanced criteria, the CMHSP must acquire these capabilities by contracting with another organization (e.g., a private sector managed care organization) in advance of DCH entering into a contract with them. If the CMHSP fails to develop or acquire the necessary capabilities to function as the PHP, it will not qualify for designation as the specialty PHP for the area.

Administrative capabilities include, but are not limited to:

- Governance inclusive of consumer members
- Access and authorization systems responsive to beneficiary demand
- Care management and monitoring responsive to beneficiary choice
- Utilization management systems which assure medically necessary services and due process notifications
- Internal quality improvement program consistent with federal rule and/or state requirements
- Grievance and appeal procedures consistent with federal regulations
- Member services
- Provider network management
- Information systems
- Claims processing capabilities, including electronic data exchange
- Financial management, solvency and stability

3.2.2. Administrative Costs

In addition to describing administrative capabilities against the standard and enhanced requirements, the CMHSP will be required to identify the portion or amount of their current premium payment (PEPM payments) that is used to underwrite or support existing managed care administrative capabilities and functions.

As noted previously, MDCH intends to change the way capitation payments are made in the future. It will split PEPM payments into an administrative-capitation portion and a service-capitation allotment. This adjustment will allow MDCH to limit administrative costs to a particular level, and to impose any monetary sanctions that might be necessary against the administrative portion of the CMHSP's payments.

Information on current administrative costs acquired through the AFP will be the first step in the state's process for setting administrative cap rates.

The CMHSP will also be required to certify the amount of Medicaid funds currently allocated to the organization's risk reserve account. As a condition of participation, the organization must agree that in the event of contractual default, these reserve funds will be returned to the state to pay accumulated obligations and to assist with start-up costs of the successor PHP.

3.2.3. Equity Functions and Community Inclusive Practices and Outcomes

MDCH has argued that one rationale for sole-source arrangements with CMHSPs for specialty PHP services is that CMHSPs have certain legal obligations and engage in particular processes and activities which affirmatively assist persons with mental illness, developmental disabilities and addictive disorders in community participation, integration and inclusion. If a CMHSP is not adequately fulfilling these functions, this undermines the case that the organization should receive preferential consideration for PHP designation.

The AFP will require the CMHSP seeking designation as the specialty PHP to thoroughly describe all aspects of their organization, operation and practice which facilitate integration, inclusion and participation for beneficiaries with behavioral or developmental disabilities. CMHSPs must provide relevant information regarding governing board and advisory committee composition, the number of consumers employed by the organization or sub-contractor agencies, percentage of funds spent on consumer operated or directed services and on self-determination arrangements, the organization's use of segregated living arrangements and programs, state facility utilization and placement history, language and communication accommodation capabilities, efforts to ensure cultural competency, and similar items.

In assessing CMHSP performance of equity-related functions and achievement of community inclusive outcomes, MDCH will - whenever possible - utilize available current and historical performance data on the CMHSP.

3.2.4. Service Array

The CMHSP must assure that all currently defined Medicaid state plan specialty services and approved alternatives are available to beneficiaries.

In addition, the CMHSP must assure that certain state designated covered services meet "structural integrity" criteria. These services would include Assertive Community Treatment, Psychosocial Clubhouses, Home-Based Service Programs for children and adolescents, Consumer-Run Drop-In Centers, Methadone Maintenance Clinics, and Intensive Outpatient Programs (IOP).

3.2.5. Service Eligibility

The CMHSP must describe all processes utilized to determine beneficiary eligibility for specialty services. It must provide copies of any written information or promotional materials that describe the Medicaid specialty services program and eligibility considerations. Finally, the CMHSP must indicate how it routinely "tests" its internal systems and processes (including sub-contractors) to ensure that beneficiaries are properly evaluated for service eligibility.

MDCH will require, as a condition of participation, that the CMHSP - through its customer or member service program - monitors access and eligibility determination processes to assess the prevalence of both informal and formal denials of service eligibility. The CMHSP will be required to utilize a variety of monitoring and testing techniques - including "mystery shopper" programs - and to document corrective actions taken when problems are detected. These local requirements do not preclude additional monitoring at the state level.

MDCH will also require CMHSPs that wish to be designated as PHPs to regularly communicate - using a variety of media - information to the community regarding eligibility for specialty services. MDCH will establish a specialty service eligibility hotline for beneficiaries to provide an additional available source of accurate information on specialty service eligibility and PHP responsibilities.

3.2.6. Provider Network Selection, Composition and Configuration

Earlier in this document, the state indicated that while it planned to use a non-competitive procurement process to select specialty PHPs, it intended to inject mechanisms into that process to achieve the basic objectives of federal requirements (best value and beneficiary choice).

One of these mechanisms is a new MDCH requirement that the PHP provider network be assembled either through competitive contracting, or through a comparative cost method that demonstrates network selection processes were equitable to all interested entities and that the providers selected represent “best-value” from a price and quality perspective.

3.2.6.1. Single CMHSPs with over 100,000 Medicaid Covered Lives

CMHSPs with over 100,000 Medicaid beneficiaries in the service area must assemble the provider network through a competitive selection process. Bids or proposals received in response to the procurement must be reviewed *by a joint evaluation panel composed of CMHSP officials, MDCH representatives and beneficiaries and/or their family members*.

The purpose of the procurement process for CMHSPs with over 100,000 covered Medicaid lives is not to select large numbers of unaffiliated individual practitioners, agencies and programs. Rather, the CMHSP should design the procurement process to attract competing proposals from vertically integrated, comprehensive, Provider Sponsored Specialty Networks (PSSN). PSSNs are organized and operated by affiliated groups of providers and offer relatively complete "systems of care" for beneficiaries with particular conditions.

A CMHSP with more than 100,000 covered Medicaid lives must select at least two PSSNs for each special population (i.e., adults with mental

illness and/or addictive disorders; children with emotional disturbances and/or addictive disorders, and persons with developmental disabilities). Beneficiaries would have a choice regarding which PSSN they elected to use for specialty care, and could move between these networks if dissatisfied. The CMHSP-PHP may use prospective and risk-based payment arrangements with the PSSNs, as long as it is recognized that PSSNs are not "plans" (no beneficiary enrollment) and appropriate adjustments are made to reflect beneficiary movement and service use variation.

The CMHSP selection process may exempt certain highly specialized or cultural specific agencies from inclusion in the PSSN organizations, to maintain unimpeded beneficiary access to these unique providers.

3.2.6.2. CMHSPs with 20,000 to 100,000 Medicaid Covered Lives

Single CMHSPs (or affiliated group of CMHSPs) with 20,000 to 100,000 Medicaid covered lives within the catchment area would be required to develop a plan for the selection of network providers that defined and assured “best value” for the Medicaid program and for beneficiaries.

- If the CMHSP (or affiliated group of CMHSPs) does not directly operate any services or programs, this selection plan will typically be some form of competitive solicitation, with consumers and advocates serving on the selection panel.
- If the CMHSP (or affiliated group of CMHSPs) is a direct provider of services, the situation becomes more complex and the conflict-of-interest potential becomes more pronounced. In these circumstances, the state will *directly* assist the CMHSP in the selection methodology and process, to ensure that: a) non-CMHSP providers are afforded an equitable opportunity to participate in the network; b) the CMHSP applies a “best-value” analysis to any direct-run or in-house program considered for inclusion in the network; and c) safeguards are devised to prevent the CMHSP from steering consumers to direct-run operations.

  In circumstances where the CMHSP has established that a directly operated service or program represents "best-value" it must still assure that a consumer has an option - for certain state designated services - to use either the CMHSP service or an alternative outside supplier of that service.

3.2.7. Facilitating Consumer Choice and the Opportunity to Achieve

Specialty PHPs are responsible for promoting community inclusive outcomes for beneficiaries with serious behavioral or developmental disabilities. In Michigan, person-centered planning (PCP) is considered the key “tool” for fostering community inclusive practices and outcomes. Beneficiaries, family members and advocates have indicated that this vital process is not always implemented in accordance with statute and MDCH practice guidelines.

3.2.7.1. Service Plan Development

The CMHSP must offer beneficiaries - as a covered benefit - the option to choose a person-centered planning (PCP) facilitator who is external to the CMHSP-PHP and/or its service provider organizations.

Requirements for or certification of PCP facilitators will be established by MDCH. The facilitator will be responsible for maintaining the fidelity and integrity of the PCP process and for assuring that the needs and desires of the beneficiary are fully identified in a process directed by the beneficiary.

The CMHSP-PHP remains responsible for the identification and description of available resources and service/support options, as well as the actual development of the written plan and the dissemination of due process information.

3.2.7.2. Service Array and Provider Choice Accommodations

The CMHSP-PHP must assure the availability of choice among provider agencies or individual practitioners for selected services identified by MDCH. This includes, but is not limited to, case management, supports coordination, physician-psychiatry services, and personal care assistance.

The CMHSP-PHP must allow the beneficiary to utilize out-of-network providers under special circumstances:

- The PHP has only one choice of a provider organization or practitioner for a department designated service.
- The beneficiary has a special need for which the PHP does not have a qualified provider.
- The beneficiary has specific cultural needs or requires accommodations due to special communication circumstances.
- The beneficiary desires to retain a valued, long-standing relationship with a practitioner (psychiatrist) or personal care attendant, and these providers meet network participation qualifications (these should be flexibly adapted to meet particular circumstances or types of services).

3.2.7.3. Consumer Operated Services and Consumer Directed Support Models

MDCH, consumers, family members and advocacy organizations have promoted consumer involvement in all aspects of the specialty service system, including governance, needs assessment, service planning, provider recruitment and selection, and quality oversight. The department strongly endorses the principle that consumers should be involved in all decisions that affect their lives, and MDCH supports program models that increase beneficiary participation in service delivery, and which afford individuals greater choice and control over service and support arrangements.

In keeping with this principle and emerging service paradigms, CMHSPs must develop and promote the use of consumer operated service models and consumer-directed support options that are

consistent with the desires, preferences, health and welfare needs of beneficiaries and compatible with existing regulations.

4. SELECTION PROCESS FOR SPECIALTY PREPAID HEALTH PLANS

CMHSPs (or an affiliated group of CMHSPs) that wish to be considered for designation as the specialty PHP in their respective areas must submit the completed Application for Participation (AFP) to a *special state-level selection panel* comprised of state personnel *and consumer, family and advocacy representatives*.

The panel will establish evaluation criteria for the AFP and due process principles that will be applied to applicants. If a CMHSP applicant for specialty PHP designation is not certified as meeting basic requirements, and necessary corrective action is deemed too extensive for timely remediation of deficiencies, the panel will reject the application and designate the service area as "unfilled" in regard to a specialty PHP and hence available for an immediate competitive selection process.

5. CONTRACT MANAGEMENT, QUALITY MANAGEMENT AND ENFORCEMENT ACTION

MDCH will enter into a prepaid risk contract for management of Medicaid special services with those entities designated by the selection panel as the specialty PHP for a given service area.

The quality management system for monitoring PHP performance will be enhanced to comply with officially promulgated final federal rules related to the Balanced Budget Act of 1997, including the requirement for PHPs to have internal quality improvement programs consistent with HCFA's Quality Improvement System in Managed Care (QISMC) guidelines. It will also incorporate the finding and recommendations that emerged from HCFA monitoring visits conducted during June and July of 2000.

Specialty PHPs that fail to meet contractual and performance obligations will be subject to remedial actions and sanctions, up to and including monetary penalties applied to the administrative capitation payments to the PHP, temporary MDCH management of the PHP's operations, and/or cancellation of the contract and replacement by a different or newly selected PHP.

CONCLUDING REMARKS

This document summarizes the state's efforts to meet federal requirements for competitive procurement of specialty PHP contracts. In the course of its explorations, the state concluded that certain important considerations and characteristics made market selection of specialty PHPs impractical and undesirable. The state provided a detailed rationale for this conclusion and described the benefits of a different type of procurement process. The state also took note of the problematic aspects of this alternative procurement method and suggested different remedies and compensations for these problems. Finally, in the last section of the paper, the state explained the basic structure for procurement, the proposed criteria for PHP designation, and provided details regarding the selection process and panel.

BRIEF SUMMARIES

of

MEDICARE & page 6

MEDICAID page 18

Title XVIII and Title XIX of

The Social Security Act

as of November 1, 2009

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NOTE: The following are brief summaries of complex subjects. They should be used only as overviews and general guides to the Medicare and Medicaid programs. The views expressed herein do not necessarily reflect the policies or legal positions of the Centers for Medicare & Medicaid Services (CMS) or the Department of Health and Human Services (DHHS). These summaries do not render any legal, accounting, or other professional advice, nor are they intended to explain fully all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs. Original sources of authority should be researched and utilized.

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Introduction

Since early in the 20th century, health insurance coverage has been an important issue in the United States. The first coordinated efforts to establish government health insurance were initiated at the State level between 1915 and 1920. However, these efforts came to naught. Renewed interest in government health insurance surfaced at the Federal level during the 1930s, but nothing concrete resulted beyond the limited provisions in the Social Security Act that supported State activities relating to public health and health care services for mothers and children.

From the late 1930s on, most people desired some form of health insurance to provide protection against unpredictable and potentially catastrophic medical costs. The main issue was whether health insurance should be privately or publicly financed. Private health insurance, mostly group insurance financed through the employment relationship, ultimately prevailed for the great majority of the population.

Private health insurance coverage grew rapidly during World War II, as employee fringe benefits were expanded because the government limited direct wage increases. This trend continued after the war. Concurrently, numerous bills incorporating proposals for national health insurance, financed by payroll taxes, were introduced in Congress during the 1940s; however, none was ever brought to a vote.

Instead, Congress acted in 1950 to improve access to medical care for needy persons who were receiving public assistance. This action permitted, for the first time, Federal participation in the financing of State payments made directly to the providers of medical care for costs incurred by public assistance recipients.

Congress also perceived that aged individuals, like the needy, required improved access to medical care. Views differed, however, regarding the best method for achieving this goal. Pertinent legislative proposals in the 1950s and early 1960s reflected widely different approaches. When consensus proved elusive, Congress passed limited legislation in 1960, including legislation titled "Medical Assistance to the Aged," which provided medical assistance for aged persons who were less poor, yet still needed assistance with medical expenses.

After lengthy national debate, Congress passed legislation in 1965 establishing the Medicare and Medicaid programs as Title XVIII and Title XIX, respectively, of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly, with coverage added in 1973 for certain disabled persons and certain persons with kidney disease. Medicaid was established in response to the widely perceived inadequacy of welfare medical care under public assistance.

Responsibility for administering the Medicare and Medicaid programs was entrusted to the Department of Health, Education, and Welfare—the forerunner of the current Department of Health and Human Services (DHHS). Until 1977, the Social Security Administration (SSA) managed the Medicare program, and the Social and Rehabilitation Service (SRS) managed the Medicaid program. The duties were then transferred from SSA and SRS to the newly formed Health Care Financing Administration (HCFA), renamed in 2001 to the Centers for Medicare & Medicaid Services (CMS).

National Health Care Expenditures

Historical Overview

Health spending in the United States has grown rapidly over the past few decades. From $27.5 billion in 1960, it grew to $912.5 billion in 1993, increasing at an average rate of 11.2 percent annually. This strong growth boosted health care's role in the overall economy, with health expenditures rising from 5.2 percent to 13.7 percent of the Gross Domestic Product (GDP) between 1960 and 1993.

Between 1993 and 1999, however, strong growth trends in health care spending subsided. Over this period health spending rose at a 5.6-percent average annual rate to reach nearly $1.3 trillion in 1999, and the share of GDP going to health care stabilized, with the 1999 share measured at 13.7 percent. This stabilization reflected the nexus of several factors: the movement of most workers insured for health care through employer-sponsored plans to lower-cost managed care; low general and medical-specific inflation; excess capacity among some health service providers, which boosted competition and drove down prices; and GDP growth that matched slow health spending growth.

Between 1999 and 2002, growth picked up, averaging 8.2 percent annually. During this period, the share of GDP devoted to health care increased from 13.7 to 15.3 percent. Health spending grew more slowly after 2002, averaging 6.6 percent annually from 2003 to 2007, and its share of GDP remained more stable over this time period, increasing from 15.8 to 16.2 percent. In 2007, health spending reached $2.2 trillion, or $7,421 per person.

Health care is funded through a variety of private payers and public programs. Privately funded health care includes individuals' out-of-pocket expenditures, private health insurance, philanthropy, and non-patient revenues (such as revenue from gift shops and parking lots), as well as health services that are provided at employers' establishments. For the years 1974-1991, these private funds paid for 59.3 to 58.4 percent of all health care costs. By 1995, however, the private share of health costs had declined further to 54.3 percent of the country's total health care expenditures, due primarily to the falling share of out-of-pocket spending, and then remained relatively stable at 55-56 percent between 1997 and 2005. The share of health care provided by public spending increased correspondingly during the 1992-1996 period and stabilized during the period 1997-2005. After 2006, there was a slight increase in the share of health care spending paid for by public programs as the implementation of Medicare Part D caused shifts in the sources of funds that pay for prescription drugs.

Public spending represents expenditures by Federal, State, and local governments. A significant portion of public health spending can be attributed to the programs administered by the Centers for Medicare & Medicaid Services (CMS)—Medicare, Medicaid, and the Children's Health Insurance Program (CHIP, known from its inception until March 2009 as the State Children's Health Insurance Program, or SCHIP). Together, Medicare, Medicaid, and CHIP financed $769.6 billion in health care services in 2007—slightly more than one-third of the country's total health care expenditures and almost three-fourths of all public spending on health care. Since their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes designed to make improvements in the provision of health care services to our nation's aged, disabled, and disadvantaged. A significant example is the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173), which created the Medicare Advantage program and provided Part D prescription drug coverage for Medicare beneficiaries beginning in 2006.

The remaining portion of publicly funded health care spending in the United States amounted to $266.1 billion in 2007 and includes expenditures for the following: the Department of Defense health care

program for military personnel, the Department of Veterans' Affairs health program, non-commercial medical research, payments for health care under Workers' Compensation programs, health programs under State-only general assistance programs, the construction of public medical facilities and the purchase of equipment, maternal and child health services, school health programs, subsidies for public hospitals and clinics, Indian health care services, substance abuse and mental health activities, and medically related vocational rehabilitation services.

Projected Expenditures

The latest update of the annual projections of national health spending consists of estimates from 2008 through 2018. These projections are based on National Health Expenditure (NHE) historical data through 2007, which were released by CMS in January 2009. The Medicare and Medicaid projections, as well as the economic and demographic assumptions, are based on the 2008 Medicare Trustees Report and the 2008 Old-Age and Survivors Insurance and Disability Insurance Trustees Report, updated to reflect available information through January 2009. This update includes the expected effects associated with the recession that began in December 2007.

National health expenditures are projected to reach $4.4 trillion in 2018, up from $2.2 trillion in 2007. After increasing 6.1 percent in 2007, NHE growth is projected to remain steady at 6.1 percent in 2008 and to decelerate to 5.5 percent in 2009, largely as a result of the recession. GDP growth is expected to slow, from 4.8 percent in 2007 to 3.5 percent in 2008. In 2009, nominal GDP growth is projected to decline for the first time since 1949, to –0.2 percent. This expected difference between the 2009 NHE and GDP growth rates would result in the largest 1-year increase in the health share of GDP in history (from 16.6 percent in 2008 to 17.6 percent in 2009). Such an outcome is consistent with historical experience, which indicates that the health share of GDP tends to increase most rapidly during periods of recession, since health spending growth typically does not decelerate as quickly as overall economic growth.

From 2007 through 2018, health care spending is projected to grow at an average annual rate of 6.2 percent, 2.1 percentage points faster than the expected rate of GDP growth. As a percentage of GDP, national health spending is expected to reach 20.3 percent by 2018, up from 16.2 percent in 2007.

Largely as a result of the recession, private and public personal health care spending growth rates are expected to exhibit divergent trends through 2009. Private health spending growth is projected to decelerate from 5.8 percent in 2007 to a 15-year low of 3.9 percent by 2009, driven by expected slower income growth and declines in the number of persons covered by private health insurance. Public health spending growth, on the other hand, is projected to accelerate from 6.4 percent in 2007 to 7.4 percent by 2009 due to projected faster growth in Medicaid enrollment and expenditures. In addition, Medicare spending growth is projected to be relatively rapid in 2008 and 2009 at approximately 8.0 percent per year.

The recession is also expected to affect spending growth trends in the major health sectors, such as hospital care and prescription drugs, in 2008 and 2009. Total hospital spending growth is expected to edge downward slightly from 7.3 percent in 2007 to 7.2 percent in 2008 and then to decrease further in 2009 to 5.7 percent. Driving this deceleration is a weakening demand for hospital services resulting from projected slowing income growth associated with the recession. Moreover, hospital price growth is expected to decelerate to 2.9 percent in 2008 and 2.6 percent in 2009, the slowest rates since 2000 (when price growth was 2.6 percent).

The demand for prescription drugs has been influenced by the recession, as well. Prescription drug spending growth is projected to slow from 4.9 percent in 2007 to 3.5 percent in 2008, as many consumers fill fewer prescriptions or become increasingly willing to switch to lower-cost generic drugs. Growth is

expected to rebound to 4.0 percent in 2009 as projected double-digit increases in Medicare and Medicaid expenditures more than offset the continuing recession-related deceleration in the growth in prescription drug spending by private payers.

In 2010, NHE growth is projected to decelerate to 4.6 percent, down from 5.5 percent in 2009, largely due to a projected 5.5-percentage-point decline in Medicare spending growth (from 8.0 percent in 2009 to 2.5 percent in 2010). This projected decline is principally attributable to a 21-percent cut to Medicare physician payment rates required under the Sustainable Growth Rate (SGR) formula in current law. In practice, Congress is virtually certain to override this formula to prevent a reduction in physician fees, as it has for each year from 2003 through 2009.

NHE growth is anticipated to begin accelerating in 2011 under current law and to eventually reach 7.2 percent by 2018. Private health spending growth is expected to rebound through the remainder of the projection period (from 4.2 percent in 2010 to 6.1 percent by 2018) based on a projected economic recovery. Public spending growth is projected to increase from 5.0 percent in 2010 to 8.1 percent in 2018, in large part as a result of the oldest baby boomers becoming eligible for Medicare. Growth in Medicare expenditures is projected to accelerate from 6.2 percent in 2011 to 8.6 percent by 2018. Although Medicaid spending growth is expected to slow from 9.6 percent in 2009 to 7.8 percent in 2012 because of projected improving economic conditions, it is expected to accelerate through 2018 to 8.9 percent as the relatively expensive aged and disabled eligibility groups constitute a larger share of total Medicaid enrollment.

Medicare: A Brief Summary

Overview of Medicare

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled," is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 or over. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with end-stage renal disease (ESRD), and certain otherwise non-covered aged persons who elect to pay a premium for Medicare coverage. Beginning in July 2001, persons with Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) are allowed to waive the 24-month waiting period. (This very broad description of Medicare eligibility is expanded in the next section.)

Medicare originally consisted of two parts: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), which in the past was also known simply as Part B. Part A helps pay for inpatient hospital, home health, skilled nursing facility, and hospice care. Part A is provided free of premiums to most eligible people; certain otherwise ineligible people may voluntarily pay a monthly premium for coverage. Part B helps pay for physician, outpatient hospital, home health, and other services. To be covered by Part B, all eligible people must pay a monthly premium.

A third part of Medicare, sometimes known as Part C, is the Medicare Advantage program, which was established as the Medicare+Choice program by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33) and subsequently renamed and modified by the Medicare Prescription Drug, Improvement,

and Modernization Act (MMA) of 2003 (Public Law 108-173). The Medicare Advantage program expands beneficiaries' options for participation in private-sector health care plans.

The MMA also established a fourth part of Medicare, known as Part D, to help pay for prescription drugs not otherwise covered by Part A or Part B. Part D initially provided access to prescription drug discount cards, on a voluntary basis and at limited cost, to all enrollees (except those entitled to Medicaid drug coverage) and, for low-income beneficiaries, transitional limited financial assistance for purchasing prescription drugs and a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and phased out during 2006. In 2006 and later, Part D provides subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of premium, for all beneficiaries, with premium and cost-sharing subsidies for low-income enrollees.

Part D activities are handled within the SMI trust fund, but in an account separate from Part B. It should thus be noted that the traditional treatment of "SMI" and "Part B" as synonymous is no longer accurate, since SMI now consists of both Parts B and D. The purpose of the two separate accounts within the SMI trust fund is to ensure that funds from one part are not used to finance the other.

When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2009, almost 46 million people are enrolled in one or both of Parts A and B of the Medicare program, and almost 11 million of them have chosen to participate in a Medicare Advantage plan.

Entitlement and Coverage

Part A is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed these monthly cash benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in Federal, State, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months, are entitled to Part A benefits. (As noted previously, the waiting period is waived for persons with Lou Gehrig's Disease. It should also be noted that, over the years, there have been certain liberalizations made to both the waiting period requirement and the limit on earnings allowed for entitlement to Medicare coverage based on disability.) Part A coverage is also provided to insured workers with ESRD (and to insured workers' spouses and children with ESRD), as well as to some otherwise ineligible aged and disabled beneficiaries who voluntarily pay a monthly premium for their coverage. In 2008, Part A provided protection against the costs of hospital and specific other medical care to about 45 million people (37.5 million aged and 7.4 million disabled enrollees). Part A benefit payments totaled $232.3 billion in 2008.

The following health care services are covered under Part A:

- *Inpatient hospital* care coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required of beneficiaries who are admitted to a hospital, plus copayments for all hospital days following day 60 within a benefit period (described later).

- *Skilled nursing facility* (SNF) care is covered by Part A only if it follows within 30 days (generally) of a hospitalization of 3 days or more and is certified as medically necessary. Covered

services are similar to those for inpatient hospital but also include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period (described later), with a copayment required for days 21-100. Part A does not cover nursing facility care if the patient does not require skilled nursing or skilled rehabilitation services.

- *Home health agency* (HHA) care is covered by both Parts A and B. The BBA transferred from Part A to Part B those home health services furnished on or after January 1, 1998 that are unassociated with a hospital or SNF stay. Part A will continue to cover the first 100 visits following a 3-day hospital stay or a SNF stay; Part B covers any visits thereafter. Home health care under Part A and Part B has no copayment and no deductible.

  HHA care, including care provided by a home health aide, may be furnished part-time by a HHA in the residence of a home-bound beneficiary if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and durable medical equipment (DME) may also be provided, though beneficiaries must pay a 20-percent coinsurance for DME, as required under Part B of Medicare. There must be a plan of treatment and periodical review by a physician. Full-time nursing care, food, blood, and drugs are not provided as HHA services.

- *Hospice* care is a service provided to terminally ill persons with life expectancies of 6 months or less who elect to forgo the standard Medicare benefits for treatment of their illness and to receive only hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and symptom management. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. The Medicare beneficiary pays no deductible for the hospice program, but does pay small coinsurance amounts for drugs and inpatient respite care.

An important Part A component is the benefit period, which starts when the beneficiary first enters a hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by Part A during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and copayment requirements (detailed later) apply for days 61-90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, he or she can elect to use days of Medicare coverage from a non-renewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care. Copayments are also required for such additional days.

All citizens (and certain legal aliens) age 65 or over, and all disabled persons entitled to coverage under Part A, are eligible to enroll in Part B on a voluntary basis by payment of a monthly premium. Almost all persons entitled to Part A choose to enroll in Part B. In 2008, Part B provided protection against the costs of physician and other medical services to about 42 million people (35 million aged and 7 million disabled enrollees). Part B benefits totaled $180.3 billion in 2008.

Part B covers certain medical services and supplies, including the following:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists. Also covered are the services provided by these Medicare-approved practitioners who are not physicians: certified registered nurse anesthetists, clinical psychologists, clinical social workers (other than in a hospital or SNF), physician assistants, and nurse practitioners and clinical nurse specialists in collaboration with a physician.

- Services in an emergency room, outpatient clinic, or ambulatory surgical center, including same-day surgery.
- Home health care not covered under Part A.
- Laboratory tests, X-rays, and other diagnostic radiology services.
- Certain preventive care services and screening tests.
- Most physical and occupational therapy and speech pathology services.
- Comprehensive outpatient rehabilitation facility services, and mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it.
- Radiation therapy, renal (kidney) dialysis and transplants, heart, lung, heart-lung, liver, pancreas, and bone marrow transplants, and, as of April 2001, intestinal transplants.
- Approved DME for home use, such as oxygen equipment and wheelchairs, prosthetic devices, and surgical dressings, splints, casts, and braces.
- Drugs and biologicals that are not usually self-administered, such as hepatitis B vaccines and immunosuppressive drugs. (Certain self-administered anticancer drugs are covered.)
- Certain services specific to people with diabetes.
- Ambulance services, when other methods of transportation are contraindicated.
- Rural health clinic and Federally qualified health center services, including some telemedicine services.

To be covered, all services must be either medically necessary or one of several prescribed preventive benefits. Part B services are generally subject to a deductible and coinsurance (see next section). Certain medical services and related care are subject to special payment rules, including deductibles (for blood), maximum approved amounts (for Medicare-approved physical, speech, or occupational therapy services performed in settings other than hospitals), and higher cost-sharing requirements (such as those for certain outpatient hospital services). The preceding description of Part B-covered services should be used only as a general guide, due to the wide range of services covered under Part B and the quite specific rules and regulations that apply.

Medicare Parts A and B, as described above, constitute the original fee-for-service Medicare program. Medicare Part C, also known as Medicare Advantage, is an alternative to traditional Medicare. While all Medicare beneficiaries can receive their benefits through the traditional fee-for-service program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare Advantage plan instead. Medicare Advantage plans are offered by private companies and organizations and are required to provide at least those services covered by Parts A and B, except hospice services. These plans may (and in certain situations must) provide extra benefits (such as vision or hearing) or reduce cost sharing or premiums. Following are the primary Medicare Advantage plans:

- Local coordinated care plans, including health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), local preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet standards set forth in the law. Generally, each plan has a network of participating providers. Enrollees may be required to use these

providers or, alternatively, may be allowed to go outside the network but pay higher cost-sharing fees for doing so.

- Regional PPO (RPPO) plans, which began in 2006 and offer coverage to one of 26 defined regions. Like local PPOs, RPPOs have networks of participating providers, and enrollees must use these providers or pay higher cost-sharing fees. However, RPPOs are required to provide beneficiary financial protection in the form of limits on out-of-pocket cost sharing, and there are specific provisions to encourage RPPO plans to participate in Medicare.

- Private fee-for-service plans, which for the most part do not have provider networks. Rather, members of a plan may go to any Medicare provider willing to accept the plan's payment.

- Special Needs Plans (SNPs), which are restricted to beneficiaries who are dually eligible for Medicare and Medicaid, live in long-term care institutions, or have certain severe and disabling conditions.

For individuals entitled to Part A or enrolled in Part B (except those entitled to Medicaid drug coverage), the new Part D initially provided access to prescription drug discount cards, at a cost of no more than $30 annually, on a voluntary basis. For low-income beneficiaries, Part D initially provided transitional financial assistance (of up to $600 per year) for purchasing prescription drugs, plus a subsidized enrollment fee for the discount cards. This temporary plan began in mid-2004 and phased out in 2006.

Beginning in 2006, Part D provides subsidized access to prescription drug insurance coverage on a voluntary basis, upon payment of a premium, to individuals entitled to Part A or enrolled in Part B, with premium and cost-sharing subsidies for low-income enrollees. Beneficiaries may enroll in either a stand-alone prescription drug plan (PDP) or an integrated Medicare Advantage plan that offers Part D coverage. Enrollment began in late 2005. In 2008, Part D provided protection against the costs of prescription drugs to about 32 million people. Part D benefits totaled $49.0 billion in 2008.

Part D coverage includes most FDA-approved prescription drugs and biologicals. (The specific drugs currently covered in Parts A and B remain covered there.) However, plans may set up formularies for their prescription drug coverage, subject to certain statutory standards. Part D coverage can consist of either standard coverage (defined later) or an alternative design that provides the same actuarial value. For an additional premium, plans may also offer supplemental coverage exceeding the value of basic coverage.

It should be noted that some health care services are not covered by any portion of Medicare. Non-covered services include long-term nursing care, custodial care, and certain other health care needs, such as dentures and dental care, eyeglasses, and hearing aids. These services are not a part of the Medicare program unless they are a part of a private health plan under the Medicare Advantage program.

Program Financing, Beneficiary Liabilities, and Payments to Providers

All financial operations for Medicare are handled through two trust funds, one for HI (Part A) and one for SMI (Parts B and D). These trust funds, which are special accounts in the U.S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administrative costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

Program Financing

The HI trust fund is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the United States work in employment covered by Part A and pay taxes to support the cost of benefits for aged and disabled beneficiaries. The Part A tax rate is 1.45 percent of earnings, to be paid by each employee and a matching amount by the employer for each employee, and 2.90 percent for self-employed persons. Beginning in 1994, this tax is paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) The Part A tax rate is specified in the Social Security Act and cannot be changed without legislation.

Part A also receives income from the following sources: (1) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries; (2) premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily; (3) reimbursements from the general fund of the U.S. Treasury for the cost of providing Part A coverage to certain aged persons who retired when Part A began and thus were unable to earn sufficient quarters of coverage (and those Federal retirees similarly unable to earn sufficient quarters of Medicare-qualified Federal employment); (4) interest earnings on its invested assets; and (5) other small miscellaneous income sources. The taxes paid each year are used mainly to pay benefits for current beneficiaries.

The SMI trust fund differs fundamentally from the HI trust fund with regard to the nature of its financing. As previously noted, SMI is now composed of two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The nature of the financing for both parts of SMI is similar, in that both parts are primarily financed by contributions from the general fund of the U.S. Treasury and (to a much lesser degree) by beneficiary premiums.

For Part B, the contributions from the general fund of the U.S. Treasury are the largest source of income, since beneficiary premiums are generally set at a level that covers 25 percent of the average expenditures for aged beneficiaries. The standard Part B premium rate will be $110.50 per beneficiary per month in 2010. There are, however, three provisions that can alter the premium rate for certain enrollees (and the third will reduce the premium for most enrollees in 2010). First, penalties for late enrollment (that is, enrollment after an individual's initial enrollment period) may apply, subject to certain statutory criteria. Second, beginning in 2007, beneficiaries whose income is above certain thresholds are required to pay an income-related monthly adjustment amount, in addition to their standard monthly premium. Following are the 2010 Part B income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries who file either individual tax returns (and are single individuals, heads of households, qualifying widows or widowers with dependent children, or married individuals filing separately who lived apart from their spouses for the entire taxable year) or joint tax returns:

Beneficiaries who file individual tax returns with income:	Beneficiaries who file joint tax returns with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $85,000	Less than or equal to $170,000	$0.00	$110.50
Greater than $85,000 and less than or equal to $107,000	Greater than $170,000 and less than or equal to $214,000	$44.20	$154.70
Greater than $107,000 and less than or equal to $160,000	Greater than $214,000 and less than or equal to $320,000	$110.50	$221.00
Greater than $160,000 and less than or equal to $214,000	Greater than $320,000 and less than or equal to $428,000	$176.80	$287.30
Greater than $214,000	Greater than $428,000	$243.10	$353.60

The income-related monthly adjustment amounts and total monthly premium amounts to be paid by beneficiaries who are married and lived with their spouses at any time during the taxable year, but who file separate tax returns from their spouses, are as follows:

Beneficiaries who are married and lived with their spouses at any time during the year, but who file separate tax returns from their spouses:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $85,000	$0.00	$110.50
Greater than $85,000 and less than or equal to $129,000	$176.80	$287.30
Greater than $129,000	$243.10	$353.60

Finally, a "hold-harmless" provision, which prohibits increases in the standard Part B premium from exceeding the dollar amount of an individual's Social Security cost-of-living adjustment, lowers the premium rate for most individuals who have their premiums deducted from their Social Security checks. Under this provision, the Part B premium for 2010 will remain at the 2009 amount of $96.40 for about 73 percent of Part B enrollees because the Social Security cost-of-living adjustment is 0 percent for 2010. Higher premium amounts ($110.50 or more, as shown in the tables above by income level) will be in effect for about 27 percent of Part B enrollees, all of whom are not eligible for protection under the "hold-harmless" provision. (Those not protected include most new enrollees during the year; enrollees with high incomes who are subject to the income-related monthly adjustment amount; and enrollees—such as certain Federal, State, and local government retirees—who do not have their Part B premium withheld from a Social Security check. Also not protected are premiums paid on behalf of dual Medicare-Medicaid beneficiaries by State Medicaid programs.) The increase in the standard Part B premium rate, from $96.40 to $110.50, is higher than it otherwise would have been because the cost of adequately funding Part B is spread across a minority of enrollees, rather than across all of them. It must be noted that the above description of Part B premium amounts for 2010 is accurate as of November 1, 2009. It is possible that Congress will override the increase in the standard Part B premium to $110.50 and instead set it at the 2009 amount of $96.40. As of November 1, the House of Representatives had passed such legislation, and the bill is under consideration in the Senate.

For Part D, as with Part B, general fund contributions account for the largest source of income, since Part D beneficiary premiums are to represent, on average, 25.5 percent of the cost of standard coverage. The Part D base beneficiary premium for 2010 will be $31.94. The actual Part D premiums paid by individual beneficiaries equal the base beneficiary premiums adjusted by a number of factors. In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium. As of this writing, it is estimated that the average monthly premium for basic Part D coverage, which reflects the specific plan-by-plan premiums and the estimated number of beneficiaries in each plan, will be about $30 in 2010. Penalties for late enrollment may apply. (Late enrollment penalties do not apply to enrollees who have maintained creditable prescription drug coverage.) Beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced premiums or no premiums at all (and are not subject to late enrollment penalties).

In addition to contributions from the general fund of the U.S. Treasury and beneficiary premiums, Part D also receives payments from the States. With the availability of prescription drug coverage and low-income subsidies under Part D, Medicaid is no longer the primary payer for prescription drugs for Medicaid beneficiaries who also have Medicare, and States are required to defray a portion of Part D expenditures for those beneficiaries.

During the Part D transitional period that began in mid-2004 and phased out during 2006, the general fund of the U.S. Treasury financed the transitional assistance benefit for low-income beneficiaries. Funds were transferred to, and paid from, a Transitional Assistance account within the SMI trust fund.

The SMI trust fund also receives income from interest earnings on its invested assets, as well as a small amount of miscellaneous income. It is important to note that beneficiary premiums and general fund payments for Parts B and D are redetermined annually and separately.

Payments to Medicare Advantage plans are financed from both the HI trust fund and the Part B account within the SMI trust fund in proportion to the relative weights of Part A and Part B benefits to the total benefits paid by the Medicare program.

Beneficiary Payment Liabilities

Fee-for-service beneficiaries are responsible for charges not covered by the Medicare program and for various cost-sharing aspects of both Part A and Part B. These liabilities may be paid (1) by the Medicare beneficiary; (2) by a third party, such as an employer-sponsored retiree health plan or private "Medigap" insurance; or (3) by Medicaid, if the person is eligible. The term "Medigap" is used to mean private health insurance that pays, within limits, most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet Federally imposed standards, are offered by Blue Cross and Blue Shield and various commercial health insurance companies.

For beneficiaries enrolled in Medicare Advantage plans, the beneficiary's payment share is based on the cost-sharing structure of the specific plan selected by the beneficiary, since each plan has its own requirements. Most plans have lower deductibles and coinsurance than are required of fee-for-service beneficiaries. Such beneficiaries, in general, pay the monthly Part B premium. However, some Medicare Advantage plans may pay part or all of the Part B premium for their enrollees as an added benefit. Depending on the plan, enrollees may also pay an additional plan premium for certain extra benefits provided (or, in a small number of cases, for certain Medicare-covered services).

For hospital care covered under Part A, a fee-for-service beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period ($1,100 in 2010). This deductible covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments ($275 per day in 2010) are required through the 90th day of a benefit period. Each Part A beneficiary also has a "lifetime reserve" of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once, and coinsurance payments ($550 per day in 2010) are required.

For skilled nursing care covered under Part A, Medicare fully covers the first 20 days in a benefit period. But for days 21-100, a copayment ($137.50 per day in 2010) is required from the beneficiary. After 100 days per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or coinsurance payment by the beneficiary. In any Part A service, the beneficiary is responsible for fees to cover the first 3 pints or units of non-replaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for most people covered by Part A. Eligibility is generally earned through the work experience of the beneficiary or of his or her spouse. However, most aged people who are otherwise ineligible for premium-free Part A coverage can enroll voluntarily by paying a monthly premium, if they also enroll in Part B. For people with fewer than 30 quarters of coverage as defined by the Social Security Administration (SSA), the 2010 Part A monthly premium rate will be $461; for those with 30 to 39 quarters of coverage, the rate will be reduced to $254. Penalties for late enrollment may apply. Voluntary coverage upon payment of the Part A premium, with or without enrolling in Part B, is also available to disabled individuals for whom coverage has ceased due to earnings in excess of those allowed.

For Part B, the beneficiary's payment share includes the following: one annual deductible ($155 in 2010); the monthly premiums; the coinsurance payments for Part B services (usually 20 percent of the remaining allowed charges, with certain exceptions noted below); a deductible for blood; certain charges above the Medicare-allowed charge (for claims not on assignment); and payment for any services that are not covered by Medicare. For outpatient mental health services, the beneficiary is currently liable for 50 percent of the approved charges, but this percentage is to phase down to 20 percent over the 5-year period of 2010 through 2014. For services reimbursed under the outpatient hospital prospective payment system, coinsurance percentages vary by service and currently fall in the range of 20-50 percent. For certain services, such as clinical lab tests, home health agency services, and some preventive care services, there are no deductibles or coinsurance.

For the standard Part D benefit design, there is an initial deductible ($310 in 2010). After meeting the deductible, the beneficiary pays 25 percent of the remaining costs, up to an initial coverage limit ($2,830 in 2010). The beneficiary is then responsible for all costs until an out-of-pocket threshold is reached. (The 2010 out-of-pocket threshold will be $4,550, which is equivalent to total covered drug costs of $6,440.) For costs thereafter, there is catastrophic coverage, which requires enrollees to pay the greater of 5 percent coinsurance or a small defined copayment amount ($2.50 in 2010 for generic or preferred multi-source drugs and $6.30 in 2010 for other drugs). The benefit parameters are indexed annually to the growth in average per capita Part D costs. Beneficiaries meeting certain low-income and limited-resources requirements pay substantially reduced cost-sharing amounts. In determining out-of-pocket costs, only those amounts actually paid by the enrollee or another individual (and not reimbursed through insurance) are counted; the exception to this "true out-of-pocket" provision is cost-sharing assistance from the low-income subsidies provided under Part D and from State Pharmacy Assistance programs. Many Part D plans offer alternative coverage that differs from the standard coverage described above. In fact, the majority of beneficiaries are not enrolled in the standard benefit design but rather in plans with low or no deductibles, flat payments for covered drugs, and, in some cases, partial coverage in the coverage gap. The monthly premiums required for Part D coverage are described in the previous section.

Payments to Providers

For Part A, before 1983, payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now made under a reimbursement mechanism known as the prospective payment system (PPS). Under the PPS for acute inpatient hospitals, each stay is categorized into a diagnosis-related group (DRG). Each DRG has a specific predetermined amount associated with it, which serves as the basis for payment. A number of adjustments are applied to the DRG's specific predetermined amount to calculate the payment for each stay. In some cases the payment the hospital receives is less than the hospital's actual cost for providing the Part A-covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient hospital stays and other situations. Payments for skilled nursing care, home health care, inpatient rehabilitation hospital care, long-term care hospitals, inpatient psychiatric hospitals, and hospice are made under separate prospective payment systems.

For Part B, before 1992, physicians were paid on the basis of reasonable charge. This amount was initially defined as the lowest of (1) the physician's actual charge; (2) the physician's customary charge; or (3) the prevailing charge for similar services in that locality. Beginning January 1992, allowed charges are defined as the lesser of (1) the submitted charges, or (2) the amount determined by a fee schedule based on a relative value scale (RVS). (In practice, most allowed charges are based on the fee schedule.) Payments for DME and clinical laboratory services are also based on a fee schedule. Most hospital outpatient services are reimbursed on a prospective payment system, and home health care is reimbursed under the same prospective payment system as Part A.

If a doctor or supplier agrees to accept the Medicare-approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full for that service. The provider may not request any added payments (beyond the initial annual deductible and coinsurance) from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess (which may be paid by Medigap insurance). Limits now exist on the excess that doctors or suppliers can charge. Physicians are "participating physicians" if they agree before the beginning of the year to accept assignment for all Medicare services they furnish during the year. Since beneficiaries in the original Medicare fee-for-service program may select their doctors, they have the option to choose those who participate.

Medicare Advantage plans and their precursors have generally been paid on a capitation basis, meaning that a fixed, predetermined amount per month per member is paid to the plan, without regard to the actual number and nature of services used by the members. The specific mechanisms to determine the payment amounts have changed over the years. In 2006, Medicare began paying plans capitated payment rates based on a competitive bidding process.

For Part D, each month for each plan member, Medicare pays Part D drug plans (stand-alone PDPs and the prescription drug portions of Medicare Advantage plans) their risk-adjusted bid (net of estimated reinsurance), minus the enrollee premium. Plans also receive payments representing premiums and cost-sharing amounts for certain low-income beneficiaries for whom these items are reduced or waived. Under the reinsurance provision, plans receive payments for 80 percent of costs in the catastrophic coverage category.

To help them gain experience with the Medicare population, Part D plans are protected by a system of "risk corridors," which allow Medicare to assist plans with unexpected costs and to share in unexpected savings. The risk corridors became less protective after 2007.

Under Part D, Medicare provides certain subsidies to employer and union prescription drug plans that continue to offer coverage to Medicare retirees and meet specific criteria in doing so.

Medicare Claims Processing

Medicare's Part A and Part B fee-for-service claims are processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the Federal government. These claims processors are known as intermediaries and carriers. They apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare intermediaries process Part A claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. They also process outpatient hospital claims for Part B. Examples of intermediaries are Blue Cross and Blue Shield (which utilize their plans in various States) and other commercial insurance companies. Intermediaries' responsibilities include the following:

- Determining costs and reimbursement amounts.
- Maintaining records.
- Establishing controls.
- Safeguarding against fraud and abuse or excess use.
- Conducting reviews and audits.

- Making the payments to providers for services.
- Assisting both providers and beneficiaries as needed.

Medicare carriers handle Part B claims for services by physicians and medical suppliers. Examples of carriers are the Blue Shield plans in a State, and various commercial insurance companies. Carriers' responsibilities include the following:

- Determining charges allowed by Medicare.
- Maintaining quality-of-performance records.
- Assisting in fraud and abuse investigations.
- Assisting both suppliers and beneficiaries as needed.
- Making payments to physicians and suppliers for services that are covered under Part B.

Claims for services provided by Medicare Advantage plans (that is, claims under Part C) are processed by the plans themselves.

Part D plans are responsible for processing their claims, akin to Part C. However, because of the "true out-of-pocket" provision discussed previously, the Centers for Medicare & Medicaid Services (CMS) has contracted the services of a facilitator, who works with CMS, Part D drug plans (stand-alone PDPs and the prescription drug portions of Medicare Advantage plans), and carriers of supplemental drug coverage, to coordinate benefit payments and track the sources of cost-sharing payments. Claims under Part D also have to be submitted by the plans to CMS, so that certain payments based on actual experience (such as payments for low-income cost-sharing and premium subsidies, reinsurance, and risk corridors) can be determined.

Because of its size and complexity, Medicare is vulnerable to improper payments, ranging from inadvertent errors to outright fraud and abuse. While providers are responsible for submitting accurate claims, and intermediaries and carriers are responsible for ensuring that only such claims are paid, there are additional groups whose duties include the prevention, reduction, and recovery of improper payments.

Quality improvement organizations (QIOs; formerly called peer review organizations, or PROs) are groups of practicing health care professionals who are paid by the Federal government to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. One function of QIOs is to ensure that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting.

The ongoing effort to address improper payments was intensified after enactment of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), which created the Medicare Integrity Program (MIP). The MIP provides CMS with dedicated funds to identify and combat improper payments, including those caused by fraud and abuse, and, for the first time, allows CMS to competitively contract with entities other than carriers and intermediaries to conduct these activities. MIP funds are used for (1) audits of cost reports, which are financial documents that hospitals and other institutions are required to submit annually to CMS; (2) medical reviews of claims to determine whether services provided are medically reasonable and necessary; (3) determinations of whether Medicare or other insurance sources have primary responsibility for payment; (4) identification and investigation of potential fraud cases; and (5) education to inform providers about appropriate billing procedures. In addition to creating the MIP, HIPAA established a fund to provide resources for the Department of

Justice—including the Federal Bureau of Investigation—and the Office of Inspector General (OIG) within the Department of Health and Human Services (DHHS) to investigate and prosecute health care fraud and abuse.

The Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) established and funded an additional activity called the Medicare-Medicaid Data Match Program, which is designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information. As is the case under the MIP, CMS can contract with third parties. The funds also can be used (1) to coordinate actions by CMS, the States, the Attorney General, and the DHHS OIG to protect Medicaid and Medicare expenditures and (2) to increase the effectiveness and efficiency of both Medicare and Medicaid through cost avoidance, savings, and the recoupment of fraudulent, wasteful, or abusive expenditures.

Administration

DHHS has the overall responsibility for administration of the Medicare program. Within DHHS, responsibility for administering Medicare rests with CMS. SSA assists, however, by initially determining an individual's Medicare entitlement, by withholding Part B premiums from the Social Security benefit checks of most beneficiaries, and by maintaining Medicare data on the master beneficiary record, which is SSA's primary record of beneficiaries. The MMA requires SSA to undertake a number of additional Medicare-related responsibilities, including making low-income subsidy determinations under Part D, notifying individuals of the availability of Part D subsidies, withholding Part D premiums from monthly Social Security cash benefits for those beneficiaries who request such an arrangement, and, for 2007 and later, making determinations as to the amount of the individual's Part B premium if the income-related monthly adjustment applies. The Internal Revenue Service (IRS) in the Department of the Treasury collects the Part A payroll taxes from workers and their employers. IRS data, in the form of income tax returns, play a role in determining which Part D enrollees are eligible for low-income subsidies (and to what degree) and, for 2007 and later, which Part B enrollees are subject to the income-related monthly adjustment amount in their premiums (and to what degree).

A Board of Trustees, composed of two appointed members of the public and four members who serve by virtue of their positions in the Federal government, oversees the financial operations of the HI and SMI trust funds. The Secretary of the Treasury is the managing trustee. The Board of Trustees reports to Congress on the financial and actuarial status of the Medicare trust funds on or about the first day of April each year.

State agencies (usually State Health Departments under agreements with CMS) identify, survey, and inspect provider and supplier facilities and institutions wishing to participate in the Medicare program. In consultation with CMS, these agencies then certify the facilities that are qualified.

Data Summary

The Medicare program covers 95 percent of our nation's aged population, as well as many people who are on Social Security because of disability. In 2008, Part A covered almost 45 million enrollees with benefit payments of $232.3 billion, Part B covered almost 42 million enrollees with benefit payments of $180.3 billion, and Part D covered over 32 million enrollees with benefit payments of $49.0 billion. Administrative costs in 2008 were under 1.4 percent, 1.6 percent, and 0.6 percent of expenditures for Part A, Part B, and Part D, respectively. Total expenditures for Medicare in 2008 were $468.1 billion.

Medicaid: A Brief Summary

Overview of Medicaid

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, State legislatures may change Medicaid eligibility, services, and/or reimbursement at any time.

Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP, known from its inception until March 2009 as the State Children's Health Insurance Program, or SCHIP), is a program initiated by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33). The BBA provided $40 billion in Federal funding through fiscal year (FY) 2007 to be used to provide health care coverage for low-income children—generally those below 200 percent of the Federal poverty level (FPL)—who do not qualify for Medicaid and would otherwise be uninsured. Subsequent legislation, including the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Public Law 111-3), extended CHIP funding through FY 2013. Under CHIP, States may elect to provide coverage to qualifying children by expanding their Medicaid programs or through a State program separate from Medicaid. A number of States have also been granted waivers to cover parents of children enrolled in CHIP.

Medicaid Eligibility

Medicaid does not provide medical assistance for all poor persons. Under the broadest provisions of the Federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the groups designated below. Low income is only one test for Medicaid eligibility for those within these groups; their financial resources also are tested against threshold levels (as determined by each State within Federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, States are required to provide Medicaid coverage for certain individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for State-only programs. The following enumerates the mandatory Medicaid "categorically needy" eligibility groups for which Federal matching funds are provided:

- Limited-income families with children, as described in section 1931 of the Social Security Act, are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996.
- Children under age 6 whose family income is at or below 133 percent of the FPL. (As of January 2009, the FPL has been set at $22,050 for a family of four in the continental U.S.; Alaska and Hawaii's FPLs are substantially higher.)
- Pregnant women whose family income is below 133 percent of the FPL. (Services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care.)
- Infants born to Medicaid-eligible women, for the first year of life with certain restrictions.
- Supplemental Security Income (SSI) recipients in most States (or aged, blind, and disabled individuals in States using more restrictive Medicaid eligibility requirements that pre-date SSI).
- Recipients of adoption or foster care assistance under Title IV-E of the Social Security Act.
- Special protected groups (typically individuals who lose their cash assistance under Title IV-A or SSI due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).
- All children under age 19, in families with incomes at or below the FPL.
- Certain Medicare beneficiaries (described later).

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which States can receive Federal matching funds for coverage under the Medicaid program include the following:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL. (The percentage amount is set by each State.)
- Children under age 21 who meet criteria more liberal than the AFDC income and resources requirements that were in effect in their State on July 16, 1996.
- Institutionalized individuals, and individuals in home and community-based waiver programs, who are eligible under a "special income level." (The amount is set by each State—up to 300 percent of the SSI Federal benefit rate.)
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services (HCBS) waivers.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.
- Aged, blind, or disabled recipients of State supplementary income payments.
- Certain working-and-disabled persons with family income less than 250 percent of the FPL who would qualify for SSI if they did not work.

- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were in a Medicaid-covered category. (Coverage is limited to TB-related ambulatory services and TB drugs.)

- Certain uninsured or low-income women who are screened for breast or cervical cancer through a program administered by the Centers for Disease Control and Prevention. The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) provides these women with medical assistance and follow-up diagnostic services through Medicaid.

- "Optional targeted low-income children" included in the CHIP (formerly SCHIP) program established by the BBA.

- "Medically needy" persons (described below).

The medically needy (MN) option allows States to extend Medicaid eligibility to additional persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State. Persons may qualify immediately or may "spend down" by incurring medical expenses that reduce their income to or below their State's MN income level.

Medicaid eligibility and benefit provisions for the medically needy do not have to be as extensive as for the categorically needy, and may be quite restrictive. Federal matching funds are available for MN programs. However, if a State elects to have a MN program, there are Federal requirements that certain groups and certain services must be included; that is, children under age 19 and pregnant women who are medically needy must be covered, and prenatal and delivery care for pregnant women, as well as ambulatory care for children, must be provided. A State may elect to provide MN eligibility to certain additional groups and may elect to provide certain additional services as part of its MN program. As of 2007, thirty-four States plus the District of Columbia have elected to have a MN program and are providing services to at least some MN beneficiaries. All remaining States utilize the "special income level" option to extend Medicaid to the "near poor" in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193)—known as the "welfare reform" bill—made restrictive changes regarding eligibility for SSI coverage that impacted the Medicaid program. For example, legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996 are ineligible for Medicaid for 5 years. Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban are State options; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of these restrictions regarding SSI coverage, Medicaid can continue only if these persons can be covered for Medicaid under some other eligibility status (again with the exception of emergency services, which are mandatory). Public Law 104-193 also affected a number of disabled children, who lost SSI as a result of the restrictive changes; however, their eligibility for Medicaid was reinstituted by Public Law 105-33, the BBA.

In addition, welfare reform repealed the open-ended Federal entitlement program known as Aid to Families with Dependent Children (AFDC) and replaced it with Temporary Assistance for Needy Families (TANF), which provides States with grants to be spent on time-limited cash assistance. TANF generally limits a family's lifetime cash welfare benefits to a maximum of 5 years and permits States to impose a wide range of other requirements as well—in particular, those related to employment. However, the impact on Medicaid eligibility has not been significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996 are generally still eligible for Medicaid. Although most persons covered by TANF receive Medicaid, it is not required by law.

Medicaid coverage may begin as early as the third month prior to application—if the person would have been eligible for Medicaid had he or she applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows States to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106-170) provides or continues Medicaid coverage to certain disabled beneficiaries who work despite their disability. Those with higher incomes may pay a sliding scale premium based on income.

The Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) refined eligibility requirements for Medicaid beneficiaries by tightening standards for citizenship and immigration documentation and by changing the rules concerning long-term care eligibility—specifically, the look-back period for determining community spouse income and assets was lengthened from 36 months to 60 months, individuals whose homes exceed $500,000 in value are disqualified, and the States are required to impose partial months of ineligibility.

Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans. However, some Federal requirements are mandatory if Federal matching funds are to be received. A State's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Pregnancy-related services, including prenatal care and 60 days postpartum pregnancy-related services.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.

- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive Federal matching funds to provide certain optional services. Following are some of the most common, currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.
- Intermediate care facilities for the mentally retarded (ICFs/MR).
- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Transportation services.
- Rehabilitation and physical therapy services.
- Hospice care.
- Home and community-based care to certain persons with chronic impairments.
- Targeted case management services.

The BBA included a State option known as Programs of All-inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons aged 55 or older who require a nursing facility level of care. The PACE team offers and manages all health, medical, and social services and mobilizes other services as needed to provide preventive, rehabilitative, curative, and supportive care. This care, provided in day health centers, homes, hospitals, and nursing homes, helps the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both Titles XVIII and XIX, without amount, duration, or scope limitations and without application of any deductibles, copayments, or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

Amount and Duration of Medicaid Services

Within broad Federal guidelines and certain limitations, States determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, States are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) Medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under Federal law, must be covered even if those services are not included as part of the covered services in that State's Plan; and

(2) States may request waivers to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, States have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, States may not provide room and board for the beneficiaries). With certain exceptions, a State's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within Federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. During 1988-1991, excessive and inappropriate use of the DSH adjustment resulted in rapidly increasing Federal expenditures for Medicaid. Legislation that was passed in 1991 and 1993, and again in the BBA of 1997, capped the Federal share of payments to DSH hospitals. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106-554) increased DSH allotments for 2001 and 2002 and made other changes to DSH provisions that resulted in increased costs to the Medicaid program.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid beneficiaries for certain services. The following Medicaid beneficiaries, however, must be excluded from cost sharing: pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid beneficiaries must be exempt from copayments for emergency services and family planning services. Under the DRA, new cost-sharing and benefit rules provide States the option of imposing new premiums and increased cost sharing on all Medicaid beneficiaries except for those mentioned above and for terminally ill patients in hospice care. The DRA also established special rules for cost sharing for prescription drugs and for non-emergency services furnished in emergency rooms.

The Federal government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. In FY 2009, the FMAPs varied from 50 percent in thirteen States and the Territories to 75.84 percent in Mississippi, and averaged 59.08 percent overall. The BBA permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent. For children covered through the CHIP program, the Federal government pays States a higher share, or "enhanced" FMAP, which averaged 71.36 percent in FY 2009. The American Recovery and Reinvestment Act (ARRA) of 2009 (Public Law 111-5) provided States with an increase in their Medicaid FMAPs for the nine-quarter period beginning with the first quarter of FY 2009. For FY 2009 these increases ranged from 6.2 to nearly 14 percentage points, depending on State unemployment rates.

The Federal government also reimburses States for 100 percent of the cost of services provided through facilities of the Indian Health Service, for 100 percent of the cost of the Qualifying Individuals (QI) program (described later), and for 90 percent of the cost of family planning services, and shares in each State's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions, such as development of mechanized claims processing systems.

Except for the CHIP program, the QI program, DSH payments, and payments to Territories, Federal payments to States for medical assistance have no set limit (cap). Rather, the Federal government matches (at FMAP rates) State expenditures for the mandatory services, as well as for the optional services that the individual State decides to cover for eligible beneficiaries, and matches (at the appropriate administrative rate) all necessary and proper administrative costs.

Medicaid Summary and Trends

Medicaid was initially formulated as a medical care extension of Federally funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s extended Medicaid coverage to a larger number of low-income pregnant women and poor children and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

In most years since its inception, Medicaid has had very rapid growth in expenditures. This rapid growth has been due primarily to the following factors:

- The increase in size of the Medicaid-covered populations as a result of Federal mandates, population growth, and economic recessions.
- The expanded coverage and utilization of services.
- The DSH payment program, coupled with its inappropriate use to increase Federal payments to States.
- The increase in the number of very old and disabled persons requiring extensive acute and/or long-term health care and various related services.
- The results of technological advances to keep a greater number of very-low-birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very costly care.
- The increase in drug costs and the availability of new expensive drugs.
- The increase in payment rates to providers of health care services, when compared to general inflation.

As with all health insurance programs, most Medicaid beneficiaries incur relatively small average expenditures per person each year, and a relatively small proportion incurs very large costs. Moreover, the average cost varies substantially by type of beneficiary. National data for 2006, for example, indicate that Medicaid payments for services for 30.2 million children, who constituted 52 percent of all Medicaid beneficiaries, averaged $1,752 per child. Similarly, for 13.8 million adults, who represented 24 percent of

beneficiaries, payments averaged $2,527 per person. However, other groups had much larger per-person expenditures. Medicaid payments for services for 4.8 million aged, who constituted 8 percent of all Medicaid beneficiaries, averaged $12,712 per person; for 9.1 million disabled, who represented 16 percent of beneficiaries, payments averaged $13,409 per person. When expenditures for these high- and lower-cost beneficiaries are combined, the 2006 payments to health care vendors for 57.8 million Medicaid beneficiaries averaged $4,672 per person.

Long-term care is an important provision of Medicaid that will be increasingly utilized as our nation's population ages. The Medicaid program paid for nearly 42 percent of the total cost of nursing facility care in 2007. National data for 2006 show that Medicaid payments for nursing facility services (excluding ICFs/MR) totaled $45.8 billion for more than 1.7 million beneficiaries of these services—an average expenditure of $26,617 per nursing home beneficiary. The national data also show that Medicaid payments for home health services totaled $5.9 billion for 1.2 million beneficiaries—an average expenditure of $4,985 per home health care beneficiary. With the percentage of our population who are elderly or disabled increasing faster than that of the younger groups, the need for long-term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, HMOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the States with greater flexibility in the design and implementation of their Medicaid managed care programs. Waiver authority under sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow States to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow Statewide health care reform experimental demonstrations to cover uninsured populations and to test new delivery systems without increasing costs. Finally, the BBA provided States a new option to use managed care without a waiver. The number of Medicaid beneficiaries enrolled in some form of managed care program is growing rapidly, from 48 percent of enrollees in 1997 to 70.9 percent in 2008.

In FY 2008, total expenditures for the Medicaid program (Federal and State) were $356.3 billion, including direct payment to providers of $234.5 billion, payments for various premiums (for HMOs, Medicare, etc.) of $84.1 billion, payments to disproportionate share hospitals of $15.6 billion, administrative costs of $19.4 billion, and $2.7 billion for the Vaccines for Children Program. Expenditures under the CHIP (formerly SCHIP) program in FY 2008 were $10 billion. With no changes to the program, spending under Medicaid is projected to reach $577.6 billion by FY 2014. (CHIP is currently funded only through FY 2013.)

The Medicaid-Medicare Relationship

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For such persons who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their State's Medicaid program, according to eligibility category. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always the "payer of last resort."

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-

Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those Medicare beneficiaries who have financial resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. For QMBs, Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI) Part B premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid program pays only the Part B premiums. A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Part B coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their Part A premiums as Qualified Disabled and Working Individuals (QDWIs).

For Medicare beneficiaries with incomes above 120 percent and less than 135 percent of the FPL, States receive a capped allotment of Federal funds for payment of Medicare Part B premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike the QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a State plan. The QI benefit is 100 percent Federally funded, up to the State's allotment. The QI program was established by the BBA for FY 1998 through FY 2002 and has been extended several times. The most recent extension continues the program through December 2010.

The Centers for Medicare & Medicaid Services (CMS) estimates that, in 2008, Medicaid provided some level of supplemental health coverage for 8.1 million Medicare beneficiaries.

In January 2006, a new Medicare prescription drug benefit began that provides drug coverage for Medicare beneficiaries, including those who also receive coverage from Medicaid. In addition, under this benefit, individuals eligible for both Medicare and Medicaid receive a low-income subsidy for the Medicare drug plan premium and assistance with cost sharing for prescriptions. Medicaid no longer provides drug benefits for Medicare beneficiaries.

Since the Medicare drug benefit and low-income subsidy replace a portion of State Medicaid expenditures for drugs, States will see a reduction in Medicaid expenditures. To offset this reduction, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) requires each State to make a monthly payment to Medicare representing a percentage of the projected reduction. For 2006 this payment was 90 percent of the projected 2006 reduction in State spending. After 2006 the percentage will decrease by 1⅔ percent per year to 75 percent for 2015 and later.

NOTES:

National Health Expenditure (NHE) historical estimates and projections are from the National Health Statistics Group in the Office of the Actuary (OACT), the Centers for Medicare & Medicaid Services (CMS). Refer also to:

Articles	Also available on the Internet at
"National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth since 1998," by M. Hartman *et al.*, Health Affairs, January/February 2009, Volume 28, Number 1, pages 246-261.	http://content.healthaffairs.org/cgi/content/abstract/28/1/246/
"Health Spending Projections through 2018: Recession Effects Add Uncertainty to the Outlook," by Andrea Sisko *et al.*, Health Affairs, Web Exclusive, February 24, 2009, pages w346–w357.	http://content.healthaffairs.org/cgi/content/abstract/28/2/w346/
"National Health Expenditure Data"	http://www.cms.hhs.gov/NationalHealthExpendData/

Medicare enrollment data are based on estimates prepared for the 2009 annual report of the Medicare Board of Trustees to Congress (available on the Internet at http://www.cms.hhs.gov/ReportsTrustFunds/). Medicare benefit payments, administrative costs, and total expenditures for 2008 are actual amounts for the calendar year, as determined from financial statements provided by the Department of the Treasury and CMS, except that premiums from enrollees, total income, benefit payments, and total expenditures for Medicare Part D—and thus for SMI and for total Medicare—include premium amounts paid by beneficiaries directly to Part D plans. These premium amounts are available only on an estimated basis.

Medicaid data are based on the projections of the Mid-Session Review of the President's Fiscal Year 2009 Budget and are consistent with data received from the States through MSIS and Forms CMS-37 and CMS-64.

CMS.gov

Feedback

State Medicaid Plans and Waivers

State Medicaid plans or state plan amendments often indicate what types of services Medicaid covers in your state. You can find more information about state Medicaid plans on Medicaid.gov.

You can also contact your state Medicaid office to determine which services are covered. Under a Medicaid waiver, a state can waive certain Medicaid eligibility requirements, covering care for people

who might not otherwise be eligible for Medicaid.

HCBS 1915 waiver programs

Through certain waivers, states can target services to people who need LTSS. These waivers are called home- and community-based services (HCBS) 1915 waivers.

All of the HCBS 1915 waiver programs:

- Are fee-for-service programs, meaning that the provider is paid for each service the patient receives (such as a test or procedure)
- Require individuals to meet criteria set by the state and based on level of need

1915 (c) HCBS waivers

Through the 1915(c) waiver program, a state can help people who need LTSS and are Medicaid-eligible by designing its HCBS services based on their needs. Waivers vary from state to state, and many states offer more than one type of 1915(c) waiver.

These waivers cannot be limited to a certain ethnic or racial group but can be limited in other ways:

- May be statewide or geographically limited in coverage
- May be limited to a certain medical diagnosis (e.g., mental health, developmental disability)

Learn more about 1915(c) waivers at Medicaid.gov.

1915 (i) HCBS waivers

This waiver, which may be provided under a state's Medicaid plan, allows the state to provide certain HCBS to people who have incomes lower than 150% of the Federal Poverty Level and do not need to live in a facility to receive care.

States can set additional requirements for the waiver to target services to groups of people with specific needs.

See Medicaid.gov's overview of 1915(i) waivers.

1915(j) self-directed personal assistance services

This program provides individuals with active roles in the services they receive. Through self-directed personal assistance services, participants can:

- Direct types of care that they receive that they understand but cannot do (e.g., a person with a physical disability may wish to direct his or her own exercise program)
- Choose who will be involved in providing their care
- Include their own preferences, choices, and abilities in the service plan

States can target this program to people who already receive services under 1915(c) waivers and may want to direct their own care. States can limit the number of people who self-direct their care and decide whether this program will be statewide or limited to certain areas.

Read Medicaid.gov's overview of 1915(j) self-directed personal assistance services.

1915 (k) Community First Choice

This option expands Medicaid opportunities for the provision of home and community-based LTSS, facilitates community integration, and provides an

enhanced federal match of six additional percentage points.

Read Medicaid.gov's overview of 1915(k) Community First Choice.

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Nondiscrimination & Accessibility

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No Fear Act

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About Section 1115 Demonstrations

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

CMS performs a case-by-case review of each proposal to determine whether its stated objectives are aligned with those of Medicaid. CMS also considers whether proposed waiver and/or expenditures authorities are appropriate and consistent with federal policies, including the degree to which they supplant state-only costs for existing programs or services and can and should be supported through other federal and non-Federal funding sources.

Demonstrations must also be "budget neutral" to the Federal government, which means that, during the course of the project, Federal Medicaid expenditures will not be more than Federal spending without the demonstration. CMS policy (PDF, 453.97 KB) requires the demonstration's budget ceiling to be rebased using recent cost data and growth trends at every extension, and will also limit carry-forward of accumulated savings from one approval period to the next.

Generally, section 1115 demonstrations are approved for an initial five-year period and can be extended for up to an additional three to five years, depending on the populations served. States commonly request and receive additional 5-year extension approvals. Certain demonstrations that have had at least one full extension cycle without substantial program changes will be eligible for CMS' "fast track (PDF, 111.36 KB)" review process for demonstration extensions. For more information on the fast track federal review process for section 1115 Medicaid and CHIP demonstration extensions, visit the How States Apply page.

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State Waivers List

Section 1115 demonstrations and waiver authorities in section 1915 of the Social Security Act are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). All current and concluded state programs authorized under these authorities may be accessed using the below dynamic list. Learn more about the section 1915(b), section 1915(c), and section 1115 authorities.

Search State Waiver List

Showing 1 to 10 of 12 results SHARE RESULTS ›

Flint Michigan Section 1115 Demonstration – Lead

State: **Michigan**

Waiver Authority: **1115**

Status: **Approved**

Healthy Kids Dental Waiver (MI-15)

State: **Michigan**

Waiver Authority: **1915 (b1), 1915 (b4)**

Status: **Approved**

Healthy Michigan

State: **Michigan**

Waiver Authority: **1115**

Status: **Approved**

MI Children's Waiver Program (4119.R06.00) IDD 0-17

State: **Michigan**

Waiver Authority: **1915 (c)** ✓

Status: **Approved**

✓**MI Choice (0233.R05.00)** Adult Day Health 65+ And physically disabled 18-64

State: **Michigan**

Waiver Authority: **1915 (c)** ✓

Status: **Approved**

MI Choice (MI-18) 0018.R01.00 ~~Com~~ 65+ physically disabled community v. nursing Home.

State: **Michigan**

Waiver Authority: **1915 (b1), 1915 (b4)**

Status: **Approved**

MI Habilitation Supports Waiver (0167.R06.00) IDD

State: **Michigan**

Waiver Authority: **1915 (c)**

Status: **Approved**

MI Health Link HCBS (1126.R01.00) 65+ + Physically disabled

State: **Michigan**

Waiver Authority: **1915 (c)**

Status: **Approved**

MI HealthLink (MI-19) – Duals 65+ + disabilities 21+ on medicaid/~~and~~ medicare

State: **Michigan**

Waiver Authority: **1915 (b1), 1915 (b2), 1915 (b4)**

Status: **Approved**

MI Waiver for Children with Serious Emotional Disturbances (0438.R03.00) SMI 0-21

State: **Michigan**

Waiver Authority: **1915 (c)**

Status: **Approved**

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1 | 2 | Next › | Last »

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State Waivers List

Section 1115 demonstrations and waiver authorities in section 1915 of the Social Security Act are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). All current and concluded state programs authorized under these authorities may be accessed using the below dynamic list. Learn more about the section 1915(b), section 1915(c), and section 1115 authorities.

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Showing 11 to 12 of 12 results

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Michigan 1115 Behavioral Health Demonstration (formerly Pathways to Integration)

SUD full continuum + 1915(b)(3) services
Transition to 1915(i)

State: **Michigan**

Waiver Authority: **1115**

Status: **Approved**

Michigan Comprehensive Health Care Program 1915(b) (MI-11) – Health Plans

State: **Michigan**

Waiver Authority: **1915 (b1), 1915 (b2), 1915 (b4)**

Status: **Approved**

« First | ‹ Previous | 1 | **2** **Show**

10

entries

Table of Contents

State/Territory Name: MI 1915i for Behavioral Health
State Plan Amendment (SPA) #: 19-0006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

September 27, 2019

Kate Massey, Medicaid Director
Medical Services Administration
Michigan Department of Health and Human Services
400 South Pine Street, P.O. Box 30479
Lansing, Michigan 48909-7979

ATTN: Erin Black

Dear Ms. Massey:

This letter serves as the Centers for Medicare and Medicaid Services (CMS) approval letter for Michigan TN 19-0006: 1915(i) Behavioral Health: This State Plan Amendment will authorize the provision of Community Supports Services to Medicaid beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability.

- Effective Date: October 1, 2022
- Approval Date: September 27, 2019

Since the state has elected to target the population who can receive these §1915(i) state plan home and community based services, **CMS approves this SPA for a five-year period** in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

The Code of Federal Regulations ("CFR"), 42 CFR §441.745(a)(i), requires the state to annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) state plan HCBS in the previous year. Additionally, at least 18 months prior to the end of the five-year approval period, the state must submit evidence of its quality monitoring in accordance with the Quality Improvement Strategy included in their approved SPA. The evidence must contain data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

If you have any questions, please contact Keri Toback at (312) 353-1754 or keri.toback@cms.hhs.gov.

Sincerely,

/s/
Ruth A. Hughes
Deputy Director
Center for Medicaid and CHIP Services
Regional Operations Group

Enclosure

cc: Erin Black, MDHHS