Manager and Location Building
John P. Duvendeck - Lewis Cass Building, 320 S. Walnut
Contract Number #_____

Agreement Between
Michigan Department of Health and Human Services
And
PIHP_____
For
The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs

Period of Agreement:
This contract shall commence on October 1, 2016 and continue through September 30, 2017. This agreement is in full force and effect for the period specified.

Program Budget and Agreement Amount:
Total funding available for specialty supports and services is identified in the annual Legislative Appropriation for community mental health services programs. Payment to the PIHP will be paid based on the funding amount specified in Part II (A), Section 8.0 of this contract. The estimated value of this contract is contingent upon and subject to enactment of legislative appropriations and availability of funds.

The terms and conditions of this contract are those included in: (a) Part I: General Provisions, (b) Part II (A): General Statement of Work, Part II (B) SUD Statement of Work and (c) Part III: MDHHS Responsibilities, (d) all Attachments as specified in Parts I, II (A), II (B), III of the contract.

Special Certification:
The individuals signing this agreement certify by their signatures that they are authorized to sign this agreement on behalf of the organization specified.

Signature Section:

For the Michigan Department of Health and Human Services

_____ _____
Kim Stephen, Director Date
Bureau of Purchasing

For the CONTRACTOR:

_____ _____
Name (print) Title (print)

_____ _____
Signature Date

CONTRACT ATTACHMENTS 9

DEFINITIONS/EXPLANATION OF TERMS 10

PART I: CONTRACTUAL SERVICES TERMS AND CONDITIONS 14

GENERAL PROVISIONS 14

1.0 PURPOSE 14

2.0 ISSUING OFFICE 14

3.0 CONTRACT ADMINISTRATOR 15

4.0 TERM OF CONTRACT 15

5.0 PAYMENT METHODOLOGY 15

6.0 LIABILITY 15

6.1 Liability: Cost 15
6.2 Liability: Contract 15
7.0 PIHP RESPONSIBILITIES 16

7.1 PIHP Governance and Board Requirements 16
7.2 PIHP Substance Use Disorder Oversight Policy Board 16
8.0 PUBLICATION RIGHTS 17

9.0 DISCLOSURE 17

10.0 CONTRACT INVOICING AND PAYMENT 17

11.0 MODIFICATIONS, CONSENTS AND APPROVALS 17

12.0 SUCCESSOR 17

13.0 ENTIRE AGREEMENT 18

14.0 LITIGATION 18

15.0 CANCELLATION 19

16.0 CLOSEOUT 19

17.0 CONFIDENTIALITY 20

18.0 ASSURANCES 20

18.1 Compliance with Applicable Laws 20
18.1.1 Anti-Lobbying Act 21
18.1.2 Non-Discrimination 21
18.1.3 Debarment and Suspension 22
18.1.4 Pro-Children Act 22
18.1.5 Hatch Political Activity Act and Intergovernmental Personnel Act 23
18.1.6 Limited English Proficiency 23
18.1.7 Health Insurance Portability and Accountability Act and 42 CFR PART 2 23
18.1.8 Byrd Anti-Lobbying Amendment 24
18.1.9 Davis-Bacon Act 24
18.1.10 Contract Work Hours and Safety Standards 24

18.1.11 Rights to Inventions Made Under a Contract or Agreement *25*
18.1.12 Clean Air Act and Federal Water Pollution Control Act *25*
18.2 Special Waiver Provisions for MSSSP *25*
19.0 DISPUTE RESOLUTION *25*
20.0 NO WAIVER OF DEFAULT *26*
21.0 SEVERABILITY *26*
22.0 DISCLAIMER *26*
23.0 RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR) *26*
24.0 NOTICES *26*
25.0 UNFAIR LABOR PRACTICES *27*
26.0 SURVIVOR *27*
27.0 GOVERNING LAW *27*
28.0 MEDIA CAMPAIGNS *27*
29.0 ETHICAL CONDUCT *27*
30.0 CONFLICT OF INTEREST *27*
31.0 HUMAN SUBJECT RESEARCH *27*
32.0 FISCAL SOUNDNESS OF THE RISK-BASED PIHP *28*
33.0 PROGRAM INTEGRITY *28*
34.0 PIHP OWNERSHIP AND CONTROL INTERESTS *28*
34.1 PIHP Responsibilities for Monitoring Ownership and Control Interests Within Their Provider Networks *28*
34.2 PIHP Responsibility for Disclosing Criminal Convictions *29*
34.3 PIHP Responsibility for Notifying MDHHS of Administrative Actions That Could Lead to Formal Exclusion *29*
35.0 PUBLIC HEALTH REPORTING *30*
36.0 MEDICAID POLICY *30*
37.0 PROVIDER PROCUREMENT *30*
38.0 SUBCONTRACTING *30*
39.0 FISCAL AUDITS AND COMPLIANCE EXAMINATIONS *32*
39.1 Reviews and Audits *33*
39.2 MDHHS Reviews *33*
39.3 MDHHS Audits *34*
PART II (A) 35
GENERAL STATEMENT OF WORK 35
1.0 SPECIFICATIONS *35*
1.1 Targeted Geographical Area for Implementation *35*
1.2 Target Population *35*

1.3 Responsibility for Payment of Authorized Services *35*
1.4 Behavior Treatment Plan Review Committee *36*
2.0 1915(b)/(c) AND HEALTHY MICHIGAN PROGRAMS *36*
2.1 1915(b) Services *36*
2.2 1915(b)(3) Services *36*
2.3 1915(c) Services *37*
2.4 Autism Services *37*
2.5 Healthy Michigan Plan *37*
2.6 SUD Community Grant Services *37*
3.0 SERVICE REQUIREMENTS *37*
3.1 Program Operation *38*
3.2 Notification of Modifications *38*
3.3 Software Compliance *38*
4.0 ACCESS ASSURANCE *38*
4.1 Access Standards *38*
4.2 Medical Necessity *38*
4.3 Service Selection Guidelines *38*
4.4 Person Centered Planning *38*
4.5 Cultural Competence *38*
4.6 Early Periodic Screening, Diagnosis and Treatment (EPSDT) *39*
4.7. Self-Determination *39*
4.8 Choice 39
4.9 Second Opinion *39*
4.10 Out of Network Responsibility *39*
4.11 Denials by a Qualified Professional *40*
4.12 Utilization Management Incentives *40*
4.13 Recovery Policy *40*
5.0 SPECIAL COVERAGE PROVISIONS *40*
5.1 Nursing Home Placements *40*
5.2 Nursing Home Mental Health Services *40*
5.3 Capitated Payments and Other Pooled Funding Arrangements *40*
5.4 Payments to FQHCs and RHCs *40*
5.5 Special Health Care Needs *41*
6.0 PIHP ORGANIZATIONAL STRUCTURE *41*
6.1 Critical Incidents *41*
6.2 Administrative Personnel *41*
6.3 Customer Services: General *42*
6.3.1 Recipient Rights/Grievance and Appeals *42*
6.3.2 Information Requirements *43*
7.0 PROVIDER NETWORK SERVICES *44*
7.1 Provider Credentialing *45*
7.2 Collaboration with Community Agencies *45*
7.3 Medicaid Health Plan (MHP) Agreements *45*
7.4 Integrated Physical and Mental Health Care *46*
7.5 Health Care Practitioner Discretions *46*
7.6 Home and Community Character *46*
7.7 Management Information Systems *47*

7.7.1 Uniform Data and Information *48*
7.7.2 Encounter Data Reporting *48*
7.7.3 Supports Intensity Scale *49*
7.7.4. National Core Indicators *50*
7.8 Financial Management System: General *51*
7.8.1 Rental Costs *51*
7.8.2 Claims Management System *51*
7.9 Quality Assessment/Performance Improvement Program and Standards *53*
7.9.1 External Quality Review *53*
7.9.2 Annual Effectiveness Review *53*
7.9.3 MDHHS Standard Consent Form *53*
7.10 Service and Utilization Management *54*
7.10.1 Beneficiary Service Records *54*
7.10.2 Other Service Requirements *54*
7.10.3 Jail Diversion *54*
7.10.4 School-to Community Transition *54*
7.10.5 Advance Directives *55*
7.11 Regulatory Management *55*
7.12 P.A. 500 and 2013 Application for Participation Requirements *55*
7.12.1 PIHP Boards *55*
7.12.2 PIHP Substance Use Disorder Oversight Policy Boards *55*
7.12.3 Procedures for Approving Budgets and Contracts *56*
7.12.4 Maintaining Provider Base *56*
7.12.5 Reports and Annual Budget Boilerplate Requirements *56*
8.0 CONTRACT FINANCING *56*
8.1 Local Obligation *56*
8.2 Revenue Sources for Local Obligation *57*
8.3 Local Obligations - Requirement Exceptions *57*
8.4 MDHHS Funding *58*
8.4.1. Medicaid *58*
8.4.2 Contract Withholds *63*
8.5 Operating Practices *66*
8.6 Financial Planning *66*
8.6.1 Risk Corridor *66*
8.6.2 Savings and Reinvestment *67*
8.6.3 Risk Management Strategy *68*
8.6.4 PIHP Assurance of Financial Risk Protection *68*
8.7 Finance Planning, Reporting and Settlement *69*
8.8 Legal Expenses *69*
8.9 Performance Objectives *69*
9.0 CONTRACT REMEDIES AND SANCTIONS *69*

PART II (B) 71

SUBSTANCE USE DISORDER (SUD) SERVICES 71

1.0 STATEMENT OF WORK *71*
1.1 Agreement Amount *72*
1.2 Purpose 72

1.3 Financial Requirements *72*
1.4 Performance/Progress Report Requirements *72*
1.5 General Provisions *72*
1.6 Action Plan *72*
2.0 SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT REQUIREMENTS AND APPLICABILITY TO STATE FUNDS *72*
2.1 Selected Specific Requirements Applicable to PIHPs *73*
2.2 Program Operation *73*
2.3 Notification of Modifications *73*
2.4 Software Compliance *73*
2.5 Licensure of Subcontractors *74*
2.6 Accreditation of Subcontractors *74*
3.0 SAMHSA/DHHS LICENSE *74*
4.0 MONITORING OF DESIGNATED WOMEN'S SUBCONTRACTORS *74*
5.0 ADMINISTRATIVE AND FINANCIAL MATCH RULES *75*
5.1 Unobligated Funds *75*
5.2 Fees 75
5.3 Reporting Fees and Collections Revenues *75*
5.4 Management of Department-Administered Funds *75*
5.5 Sliding Fee Scale *75*
5.6 Inability to Pay *76*
5.7 Subcontracts with Hospitals *76*
6.0 RESIDENCY IN PIHP REGION *76*
7.0 REIMBURSEMENT RATES FOR COMMUNITY GRANT, MEDICAID AND OTHER SERVICES 76
8.0 MINIMUM CRITERIA FOR REIMBURSING FOR SERVICES TO PERSONS WITH CO-OCCURRING DISORDERS *76*
9.0 MEDIA CAMPAIGNS *77*
10.0 NOTICE OF EXCESS OR INSUFFICIENT FUNDS (NEIF) *77*
11.0 SUBCONTRACTOR INFORMATION TO BE RETAINED AT THE PIHP *77*
12.0 LEGISLATIVE REPORTS (LRS) AND FINANCIAL REPORTS *78*
13.0 NATIONAL OUTCOME MEASURES (NOMS) *79*
14.0 MICHIGAN PREVENTION DATA SYSTEM (MPDS) *79*
15.0 CLAIMS MANAGEMENT SYSTEM *79*
16.0 CARE MANAGEMENT *79*
17.0 PURCHASING DRUG SCREENS *79*
18.0 PURCHASING HIV EARLY INTERVENTION SERVICES *80*
19.0 SERVICES *80*
19.1 12-Month Availability of Services *80*
19.2 Persons Associated with the Corrections System *80*

19.3 State Disability Assistance (SDA) (Applies Only to Agencies Who Have Allocations for this Program) ... 81
19.4 Persons Involved with the Michigan Department of Health and Human Services (MDHHS) 82
19.5 Primary Care Coordination ... 82
19.6 Charitable Choice ... 82
19.7 Treatment ... 83
20.0 CLINICAL ELIGIBILITY: DSM - -DIAGNOSIS ... 84
21.0 SATISFACTION SURVEYS ... 85
22.0 MI CHILD ... 85
22.1 Eligibility ... 86
22.2 Per Enrolled Child Per Month ... 86
23.0 ACCESS TIMELINESS STANDARDS ... 86
24.0 INTENSIVE OUTPATIENT TREATMENT – WEEKLY FORMAT ... 86
25.0 SERVICES FOR PREGNANT WOMEN, PRIMARY CAREGIVER WITH DEPENDENT CHILDREN, CAREGIVER ATTEMPTING TO REGAIN CUSTODY OF THEIR CHILDREN ... 86
25.1 Federal Requirements ... 86
25.2 Requirements Regarding Providers ... 87
25.3 Financial Requirements on Quarterly FSRs ... 87
25.4 Treatment Episode Data Set SUD (TEDS) and Encounter Reporting Requirements .. 87
26.0 ADMISSION PREFERENCE AND INTERIM SERVICES ... 87
27.0 ACCESS TIMELINESS STANDARDS ... 88
28.0 EARMARK-FUNDED SPECIAL PROJECTS: REPORTING REQUIREMENTS ... 88
29.0 PARTNERSHIP FOR SUCCESS II (PFS II) ... 89
29.1 Required Annual Deliverables: ... 89
29.2 Project Requirements ... 89
29.3 Role of the PIHP ... 90
30.0 PREVENTION SERVICES ... 90
31.0 SYNAR COVERAGE STUDY: PROTOCOL ... 91
32.0 OPIOID TREATMENT SERVICES ... 94
32.1 Standards for the Provision of Medication Assisted Treatment ... 95
33.0 FETAL ALCOHOL SPECTRUM DISORDERS ... 95
33.1 FASD Prevention Activities ... 96
33.2 FASD Screening ... 96
34.0 SUB-ACUTE DETOXIFICATION ... 97
Outpatient Setting ... 97
Residential Setting ... 98
35.0 RESIDENTIAL TREATMENT ... 98
36.0 DISCRETIONARY AND CATEGORICAL GRANTS FROM OROSC ... 98
36.1 Addressing a Strategic Prevention Planning Framework ... 98
36.2 Addressing Prevention and Mental Health Promotion Programming ... 99

PART III 99

RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES .. 99

1.0 RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ... 99

1.1 General Provisions 100
1.2 Contract Financing 100
2.0 FRAUD AND ABUSE REPORTING RESPONSIBILITIES 101

CONTRACT ATTACHMENTS

P.1.4.1 Technical Requirement for Behavior Treatment Plans
P.4.1.1 Access Standards
P.4.4.1.1 Person-Centered Planning Practice Guideline
P.4.7.1 Self Determination Practice & Fiscal Intermediary Guideline
P.4.7.4 Technical Requirement for SED Children
P.4.13.1 Recovery Policy & Practice Advisory
P.6.3.1. Customer Services Standards
P.6.3.1.1 Appeal and Grievance Resolution Processes Technical Requirement
P.6.3.2.1.B.i Technical Advisory for Estimated Cost of Services
P.6.3.2.1.B.ii Technical Requirement for Explanation of Benefits
P.6.4.1 Medicaid Verification Process
P.7.1.1 Credentialing and Re-Credentialing Processes
P.7.3.1 PIHP-MHP Model Agreement
P.7.3.1.1 Reciprocity Standards
P.7.7.1.1 PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries
P.7.9.1 Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans
P.7.10.2.1 Inclusion Practice Guideline
P.7.10.2.2 Housing Practice Guideline
P.7.10.2.3 Consumerism Practice Guideline
P.7.10.2.4 Personal Care in Non-Specialized
P.7.10.2.5 Family-Driven and Youth-Guided Policy & Practice Guideline
P.7.10.2.6 Employment Works! Policy
P.7.10.3.1 Jail Diversion Practice Guidelines
P.7.10.4.1 School to Community Transition Planning
P.8.0.1 Contract Financing
P.8.6.4.1 Internal Service Fund Technical Requirement
P.8.9.1 PIHP Performance Objectives
P.13.0.B Application for Participation
P.37.0.1 Procurement Technical Requirement
P.39.0.1 Compliance Examination Guidelines
P.39.0.1.1 Appeal Process for Compliance Examination Decisions
P.39.3.1. MDHHS Audit Report and Appeal Process
P.II.B.A. Substance Use Disorder Policy Manual

DEFINITIONS/EXPLANATION OF TERMS

The terms used in this contract shall be construed and interpreted as defined below unless the contract otherwise expressly requires a different construction and interpretation.

Appropriations Act: The annual appropriations act adopted by the State Legislature that governs MDHHS funding.

Capitated Payments: Monthly payments based on the Capitation Rate that are payable to the PIHP by the MDHHS for the provision of Medicaid services and supports pursuant to Part II (A) Section 8.0 of this contract.

Capitation Rate: The fixed per person monthly rate payable to the PIHP by the MDHHS for each Medicaid eligible person covered by the Concurrent 1915(b)/1915(c) Waiver Program, regardless of whether or not the individual who is eligible for Medicaid receives covered specialty services and supports during the month. There is a separate, fixed per person monthly rate payable for each eligible person covered by the Healthy Michigan Program. The capitated rate does not include funding for beneficiaries enrolled in the Medicaid 1915(c) Children's Waiver, children enrolled in Michigan's separate health insurance program (MiChild) under Title XXI of the Social Security Act.

Clean Claim: A clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended.

Contractor: See PIHP.

Cultural Competency: is an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of minority populations.

Customer: In this contract, customer includes all Medicaid eligible individuals located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, individuals, persons served, Medicaid Eligible.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): EPSDT is Medicaid's comprehensive and preventive child health program for beneficiaries under age 21.

Health Care Professional: A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), registered/certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Public Law 104-191, 1996 to improve the Medicare program under Title XVIII of the Social Security Act, the Medicaid program under Title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper. HIPAA was amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), as set forth in Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009. The United States Department of Health and Human Services (DHHS) promulgated administrative rules to implement HIPAA and HITECH, which are found at 45 C.F.R. Part 160 and Subpart E of Part 164 (the "Privacy Rule"), 45 C.F.R. Part 162 (the "Transaction Rule"), 45 C.F.R. Part 160 and Subpart C of Part 164 (the "Security Rule"), 45 C.F.R. Part 160 and Subpart D of Part 164 (the "Breach Notification Rule") and 45 C.F.R. Part 160, subpart C (the "enforcement Rule"). DHHS also issued guidance pursuant to HITECH and intends to issue additional guidance on various aspects of HIPAA and HITECH compliance. Throughout this contract, the term "HIPAA" includes HITECH and all DHHS implementing regulations and guidance.

Healthy Michigan Plan: The Healthy Michigan Plan is a new category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that began April 1, 2014.

Healthy Michigan Plan Beneficiary: An individual who has met the eligibility requirements for enrollment in the Healthy Michigan Plan and has been issued a Medicaid card.

Intellectual/Developmental Disability: As described in Section 330.1100a of the Michigan Mental Health Code.

Medicaid Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care. 42 CFR 455.2

Medicaid Fraud: The intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or another person. 42 CFR 455.2.

Michigan Medicaid Provider Manual-Mental Health/Substance Abuse Chapter: The Michigan Department of Health and Human Services periodically issues notices of proposed policy for the Medicaid program. Once a policy is final, MDHHS issues policy bulletins that explain the new policy and give its effective date. These documents represent official Medicaid policy and are included in the Michigan Medicaid Provider Manual: Mental Health Substance Abuse section.

Per Eligible Per Month (PEPM): A fixed monthly rate per Medicaid eligible person payable to the PIHP by the MDHHS for provision of Medicaid services defined within this contract.

Persons with Limited English Proficiency (LEP): Individuals who cannot speak, write, read or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies.

Post-stabilization Services: Covered specialty services specified in Section 2.0 that are related to an emergency medical condition and that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the beneficiary's condition.

Practice Guideline: MDHHS-developed guidelines for PIHPs and CMHSPs for specific service, support or systems models of practice that are derived from empirical research and sound theoretical construction and are applied to the implementation of public policy.

Prepaid Inpatient Health Plan (PIHP): In Michigan and for the purposes of this contract, a PIHP is defined as an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. (In Medicaid regulations Part 438., Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" The PIHP also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program also manages the Autism iSPA, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds. "

Regional Entity: An entity established by a combination of community mental health services programs under section 204b of the Michigan Mental Health Code- Act 258 of 1974 as amended.

Sentinel Events: Is an “unexpected occurrence” involving death (not due to the natural course of a health condition) or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase “or risk thereof” includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome. (JCAHO, 1998) Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Serious Emotional Disturbance: As described in Section 330.1100c of the Michigan Mental Health Code, a serious emotional disturbance is a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

1) A substance use disorder
2) A developmental disorder
3) A "V" code in the diagnostic and statistical manual of mental disorders

Serious Mental Illness: As described in Section 330.1100c of the Michigan Mental Health Code, a serious mental illness is a diagnosable mental, behavioral, or emotional disorder

affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.

Sub-Contractor: A person, business or organization which has a contract with the PIHP to provide some portion of the work or services which the PIHP has agreed to perform within this contract.

Substance Use Disorder (SUD): The taking of alcohol or other drugs as dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

SUD Community Grant: A combination of the federal grant received by the State from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the general fund dollars appropriated by the legislature for the prevention and treatment of SUD.

Technical Advisory: MDHHS-developed document with recommended parameters for PIHPs regarding administrative practice and derived from public policy and legal requirements.

Technical Requirement: MDHHS/PIHP contractual requirements providing parameters for PIHPs regarding administrative practice related to specific administrative functions, and that are derived from public policy and legal requirements.

PART I: CONTRACTUAL SERVICES TERMS AND CONDITIONS
GENERAL PROVISIONS

1.0 PURPOSE

The Michigan Department of Health and Human Services (MDHHS) hereby enters into a contract with the specialty Prepaid Inpatient Health Plan (PIHP) identified on the signature page of this contract.

Under approval granted by the Centers for Medicare and Medicaid Services (CMS), MDHHS operates a Section 1915(b) Medicaid Managed Specialty Services and Support Program Waiver. Under this waiver, selected Medicaid state plan specialty services related to mental health and developmental disability services, as well as certain covered substance abuse services, have been "carved out" (removed) from Medicaid primary physical health care plans and arrangements. The 1915(b) Specialty Services Waiver Program operates in conjunction with Michigan's existing 1915(c) Habilitation Supports Waiver for persons with developmental disabilities. From the Healthy Michigan Amendment: In addition, CMS has approved an 1115 Demonstration project titled the Healthy Michigan Plan which provides health care coverage for adults who become eligible for Medicaid under section 1902(2) (10)(A)(i)(VIII) of the Social Security Act. Such arrangements have been designated as "Concurrent 1915(b)/(c)" Programs by CMS. In Michigan, the Concurrent 1915(b)/(c) Programs and the Healthy Michigan Plan are managed on a shared risk basis by specialty Prepaid Inpatient Health Plans (PIHPs), selected through the Application for Participation (AFP) process. Further, under the approval of SAMHSA, MDHHS operates a SUD prevention and treatment program under the SUD Community Grant.

The purpose of this contract is to obtain the services of the selected PIHP to manage the Concurrent 1915(b)/(c) Programs, the Healthy Michigan Plan and SUD Community Grant Programs, and relevant I Waivers in a designated services area and to provide a comprehensive array of specialty mental health and substance abuse services and supports as indicated in this contract. The PIHP shall manage its responsibilities in a manner that promotes maximum value, efficiency and effectiveness consistent with state and federal statute and applicable waiver standards. These values include limiting managed care administrative duplication thereby reducing avoidable costs while maximizing the medical loss ratio. The PIHP shall actively manage behavioral health services throughout its service area using standardized methods and measures for determination of need and appropriate delivery of service. The PIHP shall ensure that cost variances in services are supported by quantifiable measures of need to ensure accountability, value and efficiency. The PIHP shall minimize duplication of contracts and reviews for providers contracting with multiple CMHSPs in a region.

This contract is a cost reimbursement contract under OMB Circular A-2 CFR 200 Subpart E Cost Principles. It is therefore subject to compliance with the principles and standards of OMB Circular 2 CFR 200 Subpart E for determining costs for Federal awards carried out through cost reimbursement contracts, and other agreements with State and local governments and federally recognized Indian tribal governments (governmental units).

2.0 ISSUING OFFICE

This contract is issued by the Michigan Department of Health and Human Services (MDHHS). The MDHHS is the sole point of contact regarding all procurement and contractual matters relating to the services described herein. MDHHS is the only entity authorized to change,

modify, amend, clarify, or otherwise alter the specifications, terms, and conditions of this contract. Inquiries and requests concerning the terms and conditions of this contract, including requests for amendment, shall be directed by the PIHP to the attention of the Director of MDHHS's Bureau of State Hospitals and Behavioral Health Administrative Operations Mental Health and Substance Abuse Services and by the MDHHS to the contracting organization's Executive Director.

3.0 CONTRACT ADMINISTRATOR

The person named below is authorized to administer the contract on a day-to-day basis during the term of the contract. However, administration of this contract implies no authority to modify, amend, or otherwise alter the payment methodology, terms, conditions, and specifications of the contract. That authority is retained by the Department of Health and Human Services, subject to applicable provisions of this agreement regarding modifications, amendments, extensions or augmentations of the contract (Section 16.0). The Contract Administrator for this project is:

Thomas R. Renwick, Director
Bureau of Community Based Services
Department of Health and Human Services
5th Floor – Lewis Cass Building
320 South Walnut Street
Lansing, Michigan 48913

4.0 TERM OF CONTRACT

The term of this contract shall be from October 1, 2016 through September 30, 2017. The contract may be extended in increments no longer than 12 months, contingent upon mutual agreement to an amendment to the financial obligations reflected in Attachment P 8.4.1, and other changes required by the department. No more than three (3) one-year extensions after September 30, 2017 shall occur. Fiscal year payments are contingent upon and subject to enactment of legislative appropriations.

5.0 PAYMENT METHODOLOGY

The financing specifications are provided in Part II, Section 8.0 "Contract Financing" and estimated payments are described in Attachment P 8.4.1 to this contract. The Contractor is required by PA 533 of 2004 to receive payments by electronic funds transfer. The payment methodology for SUD Community Grant services is addressed in Part II (B), SUD Services.

6.0 LIABILITY

6.1 Liability: Cost

The MDHHS assumes no responsibility or liability for costs under this contract incurred by the PIHP prior to October 1, 2016. Total liability of the MDHHS is limited to the terms and conditions of this contract.

6.2 Liability: Contract

A. All liability, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out pursuant to the obligation of the PIHP under this contract shall be the responsibility of the PIHP, and not the responsibility of the MDHHS, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the part of the PIHP, its employees, officers or agent. Nothing herein shall be

construed as a waiver of any governmental immunity for the county(ies), the PIHP, its agencies or employees as provided by statute or modified by court decisions.

B. All liability, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out pursuant to the obligations of the MDHHS under this contract shall be the responsibility of the MDHHS and not the responsibility of the PIHP if the liability, loss, or damage is caused by, or arises out of, the action or failure to act on the part of MDHHS, its employees, or officers. Nothing herein shall be construed as a waiver of any governmental immunity for the State, the MDHHS, its agencies or employees or as provided by statute or modified by court decisions.

C. The PIHP and MDHHS agree that written notification shall take place immediately of pending legal action that may result in an action naming the other or that may result in a judgment that would limit the PIHP's ability to continue service delivery at the current level. This includes actions filed in courts or by governmental regulatory agencies.

7.0 PIHP RESPONSIBILITIES

The PIHP shall be responsible for the operation of the Concurrent 1915(b)/(c), SUD Community Grant, the Healthy Michigan Plan, Autism Benefit under iSPA, and other public funding within its designated service area. Operation of the Concurrent 1915(b)/(c) Program must conform to regulations applicable to the concurrent program and to each (i.e., 1915(b) and 1915 (c) and 1115) Waiver. The PIHP shall also be responsible for development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract. If the PIHP elects to subcontract, the PIHP shall comply with applicable provisions of federal procurement requirements, as specified in Attachment P 37.0.1, except as waived for CMHSPs in the 1915(b) Waiver. The PIHP is responsible for complying with all reporting requirements as specified in Part II, Section 7.7.1 of the contract and the finance reporting requirements specified in Part II, Section 8.7. Additional requirements are identified in Attachment P 8.9.1 (Performance Objectives).

7.1 PIHP Governance and Board Requirements

For the purposes of this contract, the designation as a PIHP applies to single county Community Mental Health Service Programs or regional entities (organized under Section 1204b of the Mental Health Code or Urban Cooperation Act) serving the PIHP regions as defined by MDHHS. The PIHP must either be a single county CMHSP, or a regional entity jointly and representatively governed by all CMHSPs in the region pursuant to Section 204 or 205 of Act 258 of the Public Acts of 1974, as amended in the Mental Health Code.

7.2 PIHP Substance Use Disorder Oversight Policy Board

The PIHP shall establish a SUD Oversight Policy Board by October 1, 2014, through a contractual arrangement with the PIHP and each of the counties served under appropriate state law. The SUD Oversight Policy Boards shall include the members called for in the establishing agreement, but shall have at least one board member appointed by the County Board of Commissioners for each county served by the PIHP.

7.3 PIHP Reciprocity Standards

The PIHP shall be responsible for the Reciprocity Standards policy. See attachment P7.3.1.1.

8.0 PUBLICATION RIGHTS

When applicable, all of the following standards apply regarding the Publication Rights of MDHHS and the PIHP;

1. Where the Contractor exclusively develops books, films, or other such copyrightable materials through activities supported by this agreement, the Contractor may copyright those materials. The materials that the Contractor copyrights cannot include service recipient information or personal identification data. Contractor grants the Department a royalty-free, non-exclusive and irrevocable license to reproduce, publish and use such materials and authorizes others to reproduce and use such materials.
2. Any materials copyrighted by the Contractor or modifications bearing acknowledgment of the Department's name must be approved by the Department before reproduction and use of such materials. The State of Michigan may modify the material copyrighted by the Contractor and may combine it with other copyrightable intellectual property to form a derivative work. The State of Michigan will own and hold all copyright and other intellectual property rights in any such derivative work, excluding any rights or interest granted in this agreement to the Contractor. If the Contractor ceases to conduct business for any reason, or ceases to support the copyrightable materials developed under this agreement, the State of Michigan has the right to convert its licenses into transferable licenses to the extent consistent with any applicable obligations the Contractor has to the federal government.
3. The Contractor shall give recognition to the Department in any and all publications papers and presentations arising from the program and service contract herein: the Department will do likewise.
4. The Contractor must notify the Department’s Grants and Purchasing Division 30 days before applying to register a copyright with the U.S. Copyright Of The Contractor must submit an annual report for all copyrighted materials developed by the Contractor through activities supported by this agreement and must submit a final invention statement and certification within 90 days of the end of the agreement period.

9.0 DISCLOSURE

All information in this contract is subject to the provisions of the Freedom of Information Act, 1976 PA 442, as amended, MCL 15.231, et seq.

10.0 CONTRACT INVOICING AND PAYMENT

MDHHS funding obligated through this contract is Medicaid capitation payments. Detail regarding the MDHHS financing obligation is specified in Part II, Section 8.0 of this contract and in Attachment P 8.0.1 to this contract.

11.0 MODIFICATIONS, CONSENTS AND APPROVALS

This contract cannot be modified, amended, extended, or augmented, except in writing and only when negotiated and executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

12.0 SUCCESSOR

Any successor to the PIHP must be prior approved by the MDHHS. Such approval or disapproval shall be the sole discretion of the MDHHS.

13.0 ENTIRE AGREEMENT

The following documents constitute the complete and exhaustive statement of the agreement between the parties as it relates to this transaction.

A. This contract including attachments and appendices
B. The standards as contained in the 2013 Application for Participation as they pertain to the provision of specialty services to Medicaid beneficiaries and the implementation plans submitted and approved by MDHHS and any stated conditions, as reflected in the MDHHS approval of the application unless prohibited by federal or state law
C. SUD Administrative Rules:
    a. Program Match Requirements, R 325.4151 - 325.4156
    b. Substance Use Disorders Service Program, R 325.14101 - 325.14125
    c. Licensing of Substance Use Disorder Programs, R 325.14201 - 325.14214
    d. Recipient Rights, R 325.14301 - 325.14306
    e. Methadone Treatment and Other Chemotherapy, R 325.14401 - 325.14423
    f. Prevention, R 325.14501 - 325.14530
    g. Case-finding, R 325.14601 - 325.14623
    h. Outpatient Programs, R 325.14701 - 325.14712
    i. Inpatient Programs, R 325.14801 - 325.14807
    j. Residential Program, R 325.14901 - 325.14928
D. Michigan Mental Health Code and Administrative Rules
E. Michigan Public Health Code and Administrative Rules
F. Approved Medicaid Waivers and corresponding CMS conditions, including 1915(b), (c) and 1115 Demonstration Waivers
G. MDHHS Appropriations Acts in effect during the contract period
H. Balanced Budget Act of 1997 (BBA) final rule effective 42 CFR Part 438 effective June 14, 2002All other applicable pertinent Federal, State and local Statutes, Rules and Regulations
I. All final MDHHS guidelines, and final technical requirements, as referenced in the contract. Additional guidelines and technical requirements must be added as provided for in Part 1, Section 11.0 of this contract
J. Michigan Medicaid Provider Manual
K. MSA Policy Bulletin Number: MSA 13-09

In the event of any conflict over the interpretation of the specifications, terms, and conditions indicated by the MDHHS and those indicated by the PIHP, the dispute resolution process in included in section 19.0 of this contract shall be utilized.

This contract supersedes all proposals or prior agreements, oral or written, and all other communications pertaining to the purchase of Medicaid specialty supports and services between the parties.

14.0 LITIGATION

The State, its departments, and its agents shall not be responsible for representing or defending the PIHP, PIHP's personnel, or any other employee, agent or subcontractor of the PIHP, named as a defendant in any lawsuit or in connection with any tort claim. The MDHHS and the PIHP

agree to make all reasonable efforts to cooperate with each other in the defense of any litigation brought by any person or people not a party to the contract.

The PIHP shall submit annual litigation reports providing the following detail for all civil litigation, relevant to this contract that the PIHP is party to. Reports must include the following details:

1. Case name and docket number
2. Name of plaintiff(s) and defendant(s)
3. Names and addresses of all counsel appearing
4. Nature of the claim
5. Status of the case

The provisions of this section shall survive the expiration or termination of the contract.

15.0 CANCELLATION

The MDHHS may cancel this contract for material default of the PIHP. Material default is defined as the substantial failure of the PIHP to fulfill the obligations of this contract, or the standards promulgated by the department pursuant to P.A. 597 of the Public Acts of 2002 (MCL 330.1232b). In case of material default by the PIHP, the MDHHS may cancel this contract without further liability to the State, its departments, agencies, and employees, and procure services from other PIHPs.

In canceling this contract for material default, the MDHHS shall provide written notification at least thirty (30) days prior to the cancellation date of the MDHHS intent to cancel this contract to the PIHP and the relevant Governing Board. The PIHP may correct the problem during the thirty (30) day interval, in which case cancellation shall not occur. In the event that this contract is canceled, the PIHP shall cooperate with the MDHHS to implement a transition plan for recipients. The MDHHS shall have the sole authority for approving the adequacy of the transition plan, including providing for the financing of said plan, with the PIHP responsible for providing the required local match funding. The transition plan shall set forth the process and time frame for the transition. The PIHP will assure continuity of care for all people being served under this contract until all service recipients are being served under the jurisdiction of another contractor selected by MDHHS. The PIHP will cooperate with MDHHS in developing a transition plan for the provision of services during the transition period following the end of this contract, including the systematic transfer of each recipient and clinical records from the PIHP's responsibility to the new contractor.

If the Department takes action to cancel the contract under the provisions of MCL 330.1232b, it shall follow the applicable notice and hearing requirement described in MCL 330.1232b(6).

16.0 CLOSEOUT

If this contract is canceled or expires and is not renewed, the following shall take effect:

1. Within 45 days (interim), and 90 days (final), following the end date imposed under Section 12.0, the PIHP shall provide to MDHHS, all financial, performance, and other reports required by this contract.
2. Payment for any and all valid claims for services rendered to covered recipients prior to the effective end date shall be the PIHP's responsibility, and not the responsibility of the MDHHS.

3. The portion of all reserve accounts accumulated by the PIHP that were funded with MDHHS funds and related interest are owed to MDHHS within 90 days, less amounts needed to cover outstanding claims or liabilities, unless otherwise directed in writing by MDHHS.
4. Reconciliation of equipment with a value exceeding $5,000, purchased by the PIHP or its provider network with funds provided under this contract, since January 1, 2015 will occur as part of settlement of this contract. The PIHP will submit to the MDHHS an inventory of equipment meeting the above specifications within 45 days of the end date. The inventory listing must identify the current value and proportion of Medicaid funds used to purchase each item, and also whether or not the equipment is required by the PIHP as part of continued service provision to the continuing service population. MDHHS will provide written notice within 90 days or less of any needed settlements concerning the portion of funds ending. If the PIHP disposes of the equipment, the appropriate portion of the value must be returned to MDHHS (or used to offset costs in the final financial report). See Attachment P7.7.1.1 PIHP Reporting.
5. All earned carry-forward funds and savings from prior fiscal years that remain unspent as of the end date, must be returned to MDHHS within 90 days. No carry-forward funds or savings as provided in section 8.6.2, can be earned during the year this contract ends, unless specifically authorized in writing by the MDHHS.
6. All financial, administrative, and clinical records under the PIHP's responsibility must be retained according to the retention schedules in place by the Department of Management and Budget's (DTMB) General Schedule #20 at: http://michigan.gov/dmb/0,4568,7-150-9141_21738_31548-56101--,00.html unless these records are transferred to a successor organization or the PIHP is directed otherwise in writing by MDHHS.

The transition plan will include financing arrangements with the PIHP, which may utilize remaining Medicaid savings and reserves held by the PIHP and owed to MDHHS.

Should additional statistical or management information be required by the MDHHS after this contract has ended, at least 45 days' notice shall be provided to the PIHP.

17.0 CONFIDENTIALITY

MDHHS and the PIHP shall maintain the confidentiality, security and integrity of beneficiary information that is used in connection with the performance of this contract to the extent and under the conditions specified in HIPAA, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 C.F.R. Part 2.

18.0 ASSURANCES

The following assurances are hereby given to the MDHHS:

18.1 Compliance with Applicable Laws

The PIHP shall comply with all federal, state and local laws, and require that all PIHPs will comply with all applicable Federal and State laws and regulations including MCL 15.342 Public officer or employee; prohibited conduct, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1973, and the Rehabilitation Act of 1973, and the Americans with Disabilities Act. Statutory and regulatory provisions related to Title XXI (The Children's Health Insurance Program) are applicable to

services rendered under the MIChild program. The PIHP will also comply with all applicable general administrative requirements such as OMB Circulars covering cost principles, grant/agreement principles, and audits in carrying out the terms of this agreement. For purposes of this Agreement, OMB Circular 2 CFR 200 Subpart E is applicable to PIHPs that are local government entities, and OMB Circular 2 CFR 200 Subpart E is applicable to PIHPs that are non-profit entities.

In addition, the PIHP's Substance Use Disorder service delivery system shall comply with:

1. The Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse;
2. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616) as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism;
3. §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee 3), as amended, relating to confidentiality of alcohol and drug abuse patient records
4. Any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and,
5. The requirements of any other nondiscrimination statute(s) which may apply to the application.

18.1.1 Anti-Lobbying Act

The PIHP will comply with the Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq, and Section 503 of the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act (Public Law 104-209). Further, the PIHP shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

18.1.2 Non-Discrimination

In the performance of any contract or purchase order resulting herefrom, the PIHP agrees not to discriminate against any employee or applicant for employment or service delivery and access, with respect to their hire, tenure, terms, conditions or privileges of employment, programs and services provided or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. The PIHP further agrees that every subcontract entered into for the performance of any contract or purchase order resulting here from will contain a provision requiring non-discrimination in employment, service delivery and access, as herein specified binding upon each subcontractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.2201 et seq, and the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended, MCL 37.1101 et seq, and Section 504 of the Federal Rehabilitation Act 1973, PL 93-112, 87 Stat. 394, and any breach thereof may be regarded as a material breach of the contract or purchase order.

Additionally, assurance is given to the MDHHS that pro-active efforts will be made to identify and encourage the participation of minority-owned, women-owned, and handicapper-owned businesses in contract solicitations. The PIHP shall incorporate language in all contracts

awarded: (1) prohibiting discrimination against minority-owned, women-owned, and handicapper-owned businesses in subcontracting; and (2) making discrimination a material breach of contract.

18.1.3 Debarment and Suspension

Assurance is hereby given to the MDHHS that the PIHP will comply with Federal Regulation 45 CFR Part 76 and certifies to the best of its knowledge and belief that it, including its employees and subcontractors:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or PIHP;
2. Have not within a three-year period preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
3. Are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in section 2, and;
4. Have not within a three-year period preceding this agreement had one or more public transactions (federal, state or local) terminated for cause or default.

18.1.4 Pro-Children Act

Assurance is hereby given to the MDHHS that the PIHP will comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The PIHP also assures that this language will be included in any sub-awards that contain provisions for children's services.

The PIHP also assures, in addition to compliance with Public Law 103-227, any service or activity funded in whole or in part through this agreement will be delivered in a smoke-free facility or environment. Smoking shall not permitted anywhere in the facility, or those parts of the facility under the control of the PIHP. If activities or services are delivered in residential facilities or in facilities or areas that are not under the control of the PIHP (e.g., a mall, residential facilities or private residence, restaurant or private work site), the activities or services shall be smoke free.

18.1.5 Hatch Political Activity Act and Intergovernmental Personnel Act
The PIHP will comply with the Hatch Political Activity Act, 5 USC 1501-1509, and 7324-7328, and the Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, Public Law 95-454, 42 USC 4728 - 4763. Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally assisted programs.

18.1.6 Limited English Proficiency
The PIHP shall comply with the Office of Civil Rights Policy Guidance on the Title VI Prohibition Against Discrimination as it affects persons with Limited English Proficiency. This guidance clarifies responsibilities for providing language assistance under Title VI of the Civil Rights Act of 1964.

18.1.7 Health Insurance Portability and Accountability Act and 42 CFR PART 2
To the extent that MDHHS and PIHP are HIPAA Covered Entities and/or Programs under 42 CFR Part 2, each agrees that it will comply with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule and 42 CFR Part 2 (as now existing and as may be later amended) with respect to all Protected Health Information and substance use disorder treatment information that it generates, receives, maintains, uses, discloses or transmits in the performance of its functions pursuant to this Agreement. To the extent that PIHP determines that it is a HIPAA Business Associate of MDHHS and/or a Qualified Service Organization of MDHHS, then MDHHS and PIHP shall enter into a HIPAA Business Associate Agreement and a Qualified Service Organization Agreement that complies with applicable laws and is in a form acceptable to both MDHHS and PIHP.

1. The PIHP must not share any protected health data and information provided by the Department that falls within HIPAA requirements except as permitted or required by applicable law; or to a subcontractor as appropriate under this agreement.

2. The PIHP will ensure that any subcontractor will have the same obligations as the Contractor not to share any protected health data and information from the Department that falls under HIPAA requirements in the terms and conditions of the subcontract.

3. The PIHP must only use the protected health data and information for the purposes of this agreement.

4. The PIHP must have written policies and procedures addressing the use of protected health data and information that falls under the HIPAA requirements. The policies and procedures must meet all applicable federal and state requirements including the HIPAA regulations. These policies and procedures must include restricting access to the protected health data and information by the Contractor's employees.

5. The PIHP must have a policy and procedure to immediately report to the Department any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements of which the Contractor becomes aware. The Contractor will work with the Department to mitigate the breach, and will provide assurances to the Department of corrective actions to prevent further unauthorized uses or disclosures.

6. Failure to comply with any of these contractual requirements may result in the termination of this agreement in accordance with Part I, Section 15.0 Cancellation. In accordance with HIPAA

requirements, the Contractor is liable for any claim, loss or damage relating to unauthorized use or disclosure of protected health data and information by the Contractor received from the Department or any other source.

7. The PIHP will enter into a business associate agreement should the Department determine such an agreement is required under HIPAA.

8. All recipient information, medical records, data and data elements collected, maintained, or used in the administration of this contract shall be protected by the PIHP from unauthorized disclosure as required by state and federal regulations. The PIHP must provide safeguards that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the contract.

9. The PIHP must have written policies and procedures for maintaining the confidentiality of all protected information.

In accordance with 45 CFR § 74, the Contractor shall comply with all of the following Federal regulations:

18.1.8 Byrd Anti-Lobbying Amendment
The PIHP shall comply with all applicable standards, orders, or requirements issued under 31 U.S.C. 1352 and 45 CFR Part 93. No appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

18.1.9 Davis-Bacon Act
(All contracts in excess of $2,000). (40 U.S.C. 276a to a-7) -- When required by Federal program legislation, all construction contracts awarded by the recipients and sub-recipients of more than $2,000 shall include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) and as supplemented by Department of Labor regulations (29 CFR part 5), "Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction"). Under this act, contractors shall be required to pay wages to laborers and mechanics at a rate not less than the minimum wages specified in a wage determination made by the Secretary of Labor. In addition, contractors shall be required to pay wages not less than once a week. The recipient shall place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation and the award of a contract shall be conditioned upon the acceptance of the wage determination. The recipient shall report all suspected or reported violations to the federal awarding agency.

18.1.10 Contract Work Hours and Safety Standards
(All contracts in excess of $2,000 for construction and $2,500 employing mechanics or laborers). (40 U.S.C. 327 - 333) -- Where applicable, all contracts awarded by recipients in excess of $2,000 for construction contracts and in excess of $2,500 for other contracts that involve the employment of mechanics or laborers shall include a provision for compliance with Section 102 and 107 of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327 - 333), as

supplemented by Department of Labor regulations (29 CFR part 5). Under Section 102 of the Act, each contractor shall be required to compute the wages of every mechanic and laborer on the basis of a standard workweek of 40 hours. Work in excess of the standard workweek is permissible provided that the worker is compensated at a rate of not less than 1 and 1/2 times the basic rate of pay for all hours worked in excess of 40 hours in the workweek. Section 107 of the Act is applicable to construction work and provides that no laborer or mechanic shall be required to work in surroundings or under working conditions that are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

18.1.11 Rights to Inventions Made Under a Contract or Agreement
(All contracts containing experimental, developmental, or research work). Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention in accordance with 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

18.1.12 Clean Air Act and Federal Water Pollution Control Act
(Contracts in excess of $100,000). Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended -- Contracts and sub-grants of amounts in excess of $100,000 shall contain a provision that requires the recipient to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.). Violations shall be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

18.1.13 HCBS Transition Implementation
The PIHPs will work with MDHHS to establish policy guidance and monitoring standards which will include what functions may be delegated, oversight standards and expectations, remediation strategies for both initial and ongoing compliance, to assure full compliance with the Home and Community Based Setting requirements and the state's approved transition plan no later than March 2019 as required by the rule.

18.2 Special Waiver Provisions for MSSSP
Michigan’s Specialty Services and Supports Waiver Program authorized under 1915(b)(1), (3) and (4) of the Social Security Act is currently approved until September 30, 2016.

The 1915(b) Waiver is concurrent with a five-year 1915(c) waiver, referred to as the Home and Community-Based Habilitation Supports Waiver, serving people with a developmental disability, is currently approved until September 30, 2016. Under these waivers, beneficiaries are entitled to specified medically necessary specialty supports and services from the PIHP.

19.0 DISPUTE RESOLUTION

Disputes by the PIHP may be pursued through the dispute resolution process.

In the event of the unsatisfactory resolution of a non-emergent contractual dispute or compliance/performance dispute, and if the PIHP desires to pursue the dispute, the PIHP shall request that the dispute be resolved through the dispute resolution process. This process shall

involve a meeting between agents of the PIHP and the MDHHS. The MDHHS Deputy Director for Behavioral Health and Developmental Disabilities will identify the appropriate Deputy Director(s) or other department representatives to participate in the process for resolution, unless the MDHHS Director has delegated these duties to the Administrative Tribunal.

The PIHP shall provide written notification requesting the engagement of the dispute resolution process. In this written request, the PIHP shall identify the nature of the dispute, submit any documentation regarding the dispute, and state a proposed resolution to the dispute. The MDHHS shall convene a dispute resolution meeting within twenty (20) calendar days of receipt of the PIHP request. The Deputy Director shall provide the PIHP and MDHHS representative(s) with a written decision regarding the dispute within fourteen (14) calendar days following the dispute resolution meeting. The decision of the Deputy Director shall be the final MDHHS position regarding the dispute.

Any corrective action plan issued by the MDHHS to the PIHP regarding the action being disputed by the PIHP shall be on hold pending the final MDHHS decision regarding the dispute.

In the event of an emergent compliance dispute, the dispute resolution process shall be initiated and completed within five (5) working days.

20.0 NO WAIVER OF DEFAULT

The failure of the MDHHS to insist upon strict adherence to any term of this contract shall not be considered a waiver or deprive the MDHHS of the right thereafter to insist upon strict adherence to that term, or any other term, of the contract.

21.0 SEVERABILITY

Each provision of this contract shall be deemed to be severable from all other provisions of the contract and, if one or more of the provisions shall be declared invalid, the remaining provisions of the contract shall remain in full force and effect.

22.0 DISCLAIMER

All statistical and fiscal information contained within the contract and its attachments, and any amendments and modifications thereto, reflect the best and most accurate information available to MDHHS at the time of drafting. No inaccuracies in such data shall constitute a basis for legal recovery of damages, either real or punitive. MDHHS will make corrections for identified inaccuracies to the extent feasible. Captions and headings used in this contract are for information and organization purposes.

23.0 RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR)

The relationship between the MDHHS and the PIHP is that of client and independent contractor. No agent, employee, or servant of the PIHP or any of its subcontractors shall be deemed to be an employee, agent or servant of the State for any reason. The PIHP will be solely and entirely responsible for its acts and the acts of its agents, employees, servants, and subcontractors during the performance of a contract resulting from this contract.

24.0 NOTICES

Any notice given to a party under this contract must be written and shall be deemed effective, if addressed to such party at the address indicated on the signature page and Section 3.0 of this contract upon (a) delivery, if hand delivered; (b) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (c) the third (3rd)

business day after being sent by U.S. mail, postage prepaid, return receipt requested; or (d) the next business day after being sent by a nationally recognized overnight express courier with a reliable tracking system. Either party may change its address where notices are to be sent by giving written notice in accordance with this section.

25.0 UNFAIR LABOR PRACTICES

Pursuant to 1980 PA 278, as amended, MCL 423.321 et seq., the State shall not award a contract or subcontract to an employer or any subcontractor, manufacturer or supplier of the employer, whose name appears in the current register compiled by the Michigan Department of Licensing and Regulatory Affairs. The State may void any contract if, subsequent to award of the contract, the name of the PIHP as an employer, or the name of the subcontractor, manufacturer or supplier of the PIHP appears in the register.

26.0 SURVIVOR

Any provisions of the contract that impose continuing obligations on the parties including, but not limited to, the PIHP's indemnity and other obligations, shall survive the expiration or cancellation of this contract for any reason.

27.0 GOVERNING LAW

This contract shall in all respects be governed by, and construed in accordance with, the laws of the State of Michigan.

28.0 MEDIA CAMPAIGNS

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media. Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. Any media campaigns funded through Substance Use Disorder Community Grant funds must be compatible with MDHHS values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. The PIHP shall not finance any media campaign using Department-administered funding without prior written approval by the Department.

29.0 ETHICAL CONDUCT

MDHHS administration of this contract is subject to the State of Michigan State Ethics Act: Act 196 of 1973, “Standards of Conduct for Public Officers and Employees. Act 196 of 1973 prescribes standards of conduct for public officers and employees.

MDHHS administration of this contract is subject to the State of Michigan Governor’s Executive Order No: 2001-03, “Procurement of Goods and Services from Vendors.”

30.0 CONFLICT OF INTEREST

The PIHP and MDHHS are subject to the federal and state conflict of interest statutes and regulations that apply to the PIHP under this contract, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. §423): 18 U.S.C. §207)): 18 U.S.C. §208: 42 CFR §438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222.

31.0 HUMAN SUBJECT RESEARCH

The PIHP will comply with Protection of Human Subjects Act, 45 CFR, Part 46, subpart A, sections 46.101-124 and HIPAA. The PIHP agrees that prior to the initiation of the research, the PIHP will submit institutional Review Board (IRB) application material for all research

involving human subjects, which is conducted in programs sponsored by the Department or in programs which receive funding from or through the State of Michigan, to the Department's IRB for review and approval, or the IRB application and approval materials for acceptance of the review of another IRB. All such research must be approved by a federally assured IRB, but the Department's IRB can only accept the review and approval of another institution's IRB under a formally-approved interdepartmental agreement. The manner of the review will be agreed upon between the Department's IRB Chairperson and the Contractor's IRB Chairperson or Executive Officer(s).

32.0 FISCAL SOUNDNESS OF THE RISK-BASED PIHP

Federal regulations require that the risk-based PIHPs maintain a fiscally solvent operation and MDHHS has the right to evaluate the ability of the PIHP to bear the risk of potential financial losses, or to perform services based on determinations of payable amounts under the contract.

33.0 PROGRAM INTEGRITY

The PIHP must have administrative and management arrangements or procedures for compliance with 42 CFR 438.608. Such arrangements or procedures must identify any activities that will be delegated and how the PIHP will monitor those activities.

34.0 PIHP OWNERSHIP AND CONTROL INTERESTS

In order to comply with 42 CFR 438.610, the PIHP may not have any of the following relationships with an individual who is excluded from participating in Federal health care programs:

a. Excluded individuals cannot be a director, officer, or partner of the PIHP:
b. Excluded individuals cannot have a beneficial ownership of five percent or more of the PIHP's equity: and
c. Excluded individuals cannot have an employment, consulting, or other arrangement with the PIHP for the provision of items or services that are significant and material to the PIHP's obligations under its contract with the State.

"Excluded" individuals or entities are individuals or entities that have been excluded from participating, but not reinstated, in the Medicare, Medicaid, or any other Federal health care programs. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance loans.

Federal regulations require PIHPs to disclose information about individuals with ownership or control interests in the PIHP. These regulations also require the PIHP to identify and report any additional ownership or control interests for those individuals in other entities, as well as identifying when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other.

The PIHP shall comply with the federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 C.F.R. §455.104-106. In addition, the PIHP shall ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment or services provided under the Medicaid agreement require compliance with 42 C.F.R. §455.104-106.

34.1 PIHP Responsibilities for Monitoring Ownership and Control Interests Within Their

Provider Networks
At the time of provider enrollment or re-enrollment in the PIHP's provider network, the PIHP must search the Office of Inspector General's (OIG) exclusions database to ensure that the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent or more or a managing employee), have not been excluded from participating in federal health care programs. Because these search activities must include determining whether any individuals with ownership or control interests in the provider entity appear on the OIG's exclusions database, the PIHP must mandate provider entity disclosure of ownership and control information at the time of provider enrollment, re-enrollment, or whenever a change in provider entity ownership or control takes place.

The PIHP must search the OIG exclusions database monthly to capture exclusions and reinstatements that have occurred since the last search, or at any time providers submit new disclosure information. The PIHP must notify the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS immediately if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in a provider entity are on the OIG exclusions database.

34.2 PIHP Responsibility for Disclosing Criminal Convictions
PIHPs are required to promptly notify the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS if:

- **a.** Any disclosures are made by providers with regard to the ownership or control by a person that has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. (See42 CFR 1001.1001(a)(1): or
- **b.** Any staff member, director, or manager of the PIHP, individual with beneficial ownership of five percent or more, or an individual with an employment, consulting, or other arrangement with the PIHP has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. (See 42 CFR 1001.1001(a)(1))

The PIHP's contract with each provider entity must contain language that requires the provider entity to disclose any such convictions to the PIHP.

34.3 PIHP Responsibility for Notifying MDHHS of Administrative Actions That Could Lead to Formal Exclusion
The PIHP must promptly notify the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS if it has taken any administrative action that limits a provider's participation in the Medicaid program, including any provider entity conduct that results in suspension or termination from the PIHP's provider network.

The United States General Services Administration (GSA) maintains a list of parties excluded from federal programs. The "excluded parties lists" (EPLS) and any rules and/or restrictions pertaining to the use of EPLS data can be found on GSA's web page at the following internet address: http://exclusions.oig.hhs.gov. The state sanctioned list is at:

www.michigan.gov/medicaidproviders click on Billing and Reimbursement, click on List of Sanctioned Providers. Both lists must be regularly checked.

35.0 PUBLIC HEALTH REPORTING

P.A. 368 requires that health professionals comply with specified reporting requirements for communicable disease and other health indicators. The PIHP agrees to ensure compliance with all such reporting requirements through its provider contracts.

36.0 MEDICAID POLICY

PIHPs shall comply with provisions of Medicaid policy developed under the formal policy consultation process, as established by the Medical Assistance Program.

37.0 PROVIDER PROCUREMENT

The PIHP is responsible for the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract. Where the PIHP and its provider network fulfill these responsibilities through subcontracts, they shall adhere to applicable provisions of federal procurement requirements as specified in Attachment P.37.0.1.

In complying with these requirements and in accordance with 42 CFR 438.12, the PIHP:

1. May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification;
2. Must give those providers not selected for inclusion in the network written notice of the reason for its decision;
3. Is not required to contract with providers beyond the number necessary to meet the needs of its beneficiaries, and is not precluded from using different practitioners in the same specialty. Nor is the PIHP prohibited from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to its beneficiaries. In addition, the PIHP's selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. Also, the PIHP must ensure that it does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

38.0 SUBCONTRACTING

The PIHP may subcontract for the provision of any of the services specified in this contract including contracts for administrative and financial management, and data processing. The PIHP shall be held solely and fully responsible to execute all provisions of this contract, whether or not said provisions are directly pursued by the PIHP, or pursued by the PIHP through a subcontract vendor. The PIHP shall ensure that all subcontract arrangements clearly specify the type of services being purchased. Subcontracts shall ensure that the MDHHS is not a party to the contract and therefore not a party to any employer/employee relationship with the subcontractor of the PIHP. Subcontracts entered into by the PIHP shall address such provisions as the PIHP deems necessary for the development of the service delivery system, and shall include standard terms and conditions as MDHHS may develop.

Subcontracts entered into by the PIHP shall address the following:

1. Duty to treat and accept referrals
2. Prior authorization requirements
3. Access standards and treatment time lines
4. Relationship with other providers
5. Reporting requirements and time frames
6. QA/QI Systems
7. Payment arrangements (including coordination of benefits) and solvency requirements
8. Financing conditions consistent with this contract
9. Anti-delegation clause
10. Compliance with Office of Civil Rights Policy Guidance on Title VI “Language Assistance to Persons with Limited English Proficiency"
11. EPSDT requirements
12. In all contracts with health care professionals, the PIHP must comply with the requirements specified in the “Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans”, Attachment P 7.9.1. and require the provider to cooperate with the PIHP's quality improvement and utilization review activities
13. Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy
14. Not prohibit a provider from discussing treatment options with a recipient that may not reflect the PIHP's position or may not be covered by the PIHP
15. Not prohibit a provider from advocating on behalf of the recipient in any grievance or utilization review process, or individual authorization process to obtain necessary health care services
16. Require providers to meet Medicaid accessibility standards as established in Medicaid policy and this contract

All subcontracts entered into by the PIHP must be in writing and, if involving Medicaid funds fulfill the requirements of 42 CFR 434.6 and 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract. All employment agreements, provider contracts, or other arrangements, by which the PIHP intends to deliver services required under this contract, shall be subject to review by the MDHHS at its discretion.

Subcontracts that contain provisions for a financial incentive, bonus, withhold, or sanctions, (including sub-capitations) must include provisions that protect individuals from practices that result in the withholding of services that would otherwise be provided according to medical necessity criteria and best practice standards, consistent with 42 CFR 422.208. The PIHP shall provide a copy of specific contract language used for incentive, bonus, withhold or sanction provisions (including sub-capitations) to MDHHS at least 30 days prior to when the contract is issued to the provider. MDHHS reserves the right to disallow or require amendment of such provisions if the provisions appear to jeopardize individuals’ access to services. MDHHS shall provide notice of approval or disapproval of submitted contract language within 25 days of receipt or else the language shall be deemed approved by MDHHS. The PIHP must provide information on its Provider Incentive Plan (PIP) to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a PIP). The PIHP must provide

information regarding any provider incentive plans to CMS and to any Medicaid beneficiary, as required by 42 CFR 422.210

The PIHP shall provide a listing of all subcontracts for administrative or financial management, or data processing services to the MDHHS within 60 days of signing this contract. The listing shall include the name of the subcontractor, purpose, and amount of contract.

39.0 FISCAL AUDITS AND COMPLIANCE EXAMINATIONS

Required Audit and Compliance Examination

The PIHP shall submit to MDHHS a Single Audit or Financial Statement Audit depending on the level of Federal awards expended, and a Compliance Examination as described below. The PIHP must also submit a Corrective Action Plan for any audit or examination findings that impact MDHHS-funded programs, and the management letter (if issued) with a response.

Single Audit

PIHPs that expend $750,000 or more in Federal awards, during the PIHP's fiscal year shall submit a Single Audit to MDHHS. The Single Audit must comply with the requirements of the Single Audit Act Amendments of 1996, and 2 CFR 200, Subpart F. Also, the PIHP must comply with all requirements contained in the MDHHS Substance Abuse Prevention and Treatment Audit Guidelines, current edition, as issued by the MDHHSBureau of Audit, Reimbursement, and Quality Assurance.

Financial Statement Audit

PIHPs exempt from the Single Audit requirement shall submit to MDHHS a Financial Statement Audit prepared in accordance with generally accepted auditing standards (GAAS).

Compliance Examination

PIHPs shall submit a contract end date (September 30th) Compliance Examination conducted in accordance with the American Institute of CPA's (AICPA's) Statements on Standards for Attestation Engagements (SSAE) 10 - Compliance Attestation (as amended by SSAE 11, 12, and 14), and the Compliance Examination Guidelines contained in Attachment P.39.0.1.

Due Date and Where to Send

The required Single Audit or Financial Statement Audit, Compliance Examination, and any other required submissions (i.e. Corrective Action Plan and management letter with a response) must be submitted to MDHHS within 30 days after receipt of the practitioner's reports, but no later than June 30th following the contract year end by e-mail to MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in a PDF file compatible with Adobe Acrobat (read only). The subject line must state the PIHP name and fiscal year end. MDHHS reserves the right to request a hard copy of the materials if for any reason the electronic submission process is not successful.

Penalty

If the PIHP does not submit the required Single Audit or Financial Statement Audit, Compliance Examination, and applicable Corrective Action Plans by the due date and an extension has not been approved by MDHHS, MDHHS may withhold from the current funding an amount equal to five percent of the audit year's grant funding (not to exceed $200,000) until the required filing is received by MDHHS. MDHHS may retain the amount withheld if the PIHP is more than 120 days delinquent in meeting the filing requirements and an extension has not been approved by MDHHS.

Management Decisions
MDHHS shall issue a management decision on findings, comments, and questioned costs contained in the PIHP Single Audit, Financial Statement Audit, and Compliance Examination Report. The management decision relating to the Single Audit or Financial Statement Audit will be issued within six months after the receipt of a complete and final reporting package. The management decision relating to the Compliance Examination will be issued within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the finding or comment is sustained; the reasons for the decision, and the expected PIHP action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, MDHHS may request additional information or documentation from the PIHP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the PIHP relating to MDHHS management decisions on Compliance Examination findings, comments, and disallowed costs is included in Attachment P.39.0.1.1.

Other Audits
MDHHS or federal agencies may also conduct or arrange for additional audits to meet their needs.

39.1 Reviews and Audits
The MDHHS and federal agencies may conduct reviews and audits of the PIHP regarding performance under this contract. The MDHHS shall make good faith efforts to coordinate reviews and audits to minimize duplication of effort by the PIHP and independent auditors conducting audits and compliance examinations.

These reviews and audits will focus on PIHP compliance with state and federal laws, rules, regulations, policies, and waiver provisions, in addition to contract provisions and PIHP policy and procedure.

MDHHS reviews and audits shall be conducted according to the following protocols, except when conditions appear to be severe and warrant deviation or when state or federal laws supersede these protocols.

39.2 MDHHS Reviews

1. As used in this section, a review is an examination or inspection by the MDHHS or its agent, of policies and practices, in an effort to verify compliance with requirements of this contract.
2. The MDHHS will schedule onsite reviews at mutually acceptable start dates to the extent possible, with the exception of those reviews for which advance announcement is prohibited by rule or federal regulation, or when the deputy director for the Health Care Administration determines that there is demonstrated threat to consumer health and welfare or substantial threats to access to care.
3. Except as precluded in 34.2 (2) above, the guideline, protocol and/or instrument to be used to review the PIHP, or a detailed agenda if no protocol exists, shall be provided to the PIHP at least 30 days prior to the review.

4. At the conclusion of the review, the MDHHS shall conduct an exit interview with the PIHP. The purpose of the exit interview is to allow the MDHHS to present the preliminary findings and recommendations.
5. Following the exit review, the MDHHS shall generate a report within 45 days identifying the findings and recommendations that require a response by the PIHP.
    a. The PIHP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The PIHP may also present new information to the MDHHS that demonstrates it was in compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the exit interview and the POC). When access or care to individuals is a serious issue, the PIHP may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified in (4) above. If, during an MDHHS on-site visit, the site review team member identified an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in seven calendar days.
    b. The MDHHS will review the POC, seek clarifying or additional information from the PIHP as needed, and issue an approval of the POC within 30 days of having required information from the PIHP. The MDHHS will take steps to monitor the PIHP's implementation of the POC as part of performance monitoring.
    c. The MDHHS shall protect the confidentiality of the records, data and knowledge collected for or by individuals or committees assigned a peer review function in planning the process of review and in preparing the review or audit report for public release.
6. MDHHS follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDHHS.

39.3 MDHHS Audits

1. The MDHHS and/or federal agencies may inspect and audit any financial records of the entity or its subcontractors. As used in this section, an audit is an examination of the PIHP's and its contract service providers' financial records, policies, contracts, and financial management practices, conducted by the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance, or its agent, or by a federal agency or its agent, to verify the PIHP's compliance with legal and contractual requirements.
2. The MDHHS will schedule MDHHS audits at mutually acceptable start dates to the extent possible. The MDHHS will provide the PIHP with a list of documents to be audited at least 30 days prior to the date of the audit. An entrance meeting will be conducted with the PIHP to review the nature and scope of the audit.
3. MDHHS audits of PIHPs will generally supplement the independent auditor’s Compliance Examination and may include one or more of the following objectives (The MDHHS may, however, modify its audit objectives as deemed necessary):

a. to assess the PIHP's effectiveness and efficiency in complying with the contract and establishing and implementing specific policies and procedures as required by the contract and;
b. to assess the PIHP's effectiveness and efficiency in reporting their financial activity to the MDHHS in accordance with contractual requirements: applicable federal, state, and local statutory requirements; Medicaid regulations; and applicable accounting standards; and
c. to determine the MDHHS's share of costs in accordance with applicable MDHHS requirements and agreements, and any balance due to/from the PIHP.

To accomplish the above listed audit objectives, MDHHS auditors will review PIHP documentation, interview PIHP staff members, and perform other audit procedures as deemed necessary. The audit report and appeal process is identified in Attachment 39.3.1 and is a part of this contract.

PART II (A)
GENERAL STATEMENT OF WORK

1.0 SPECIFICATIONS

The following sections provide an explanation of the specifications and expectations that the PIHP must meet and the services that must be provided under the contract. The PIHP and its provider network are not, however, constrained from supplementing this with additional services or elements deemed necessary to fulfill the intent of the Managed Specialty Services and Supports Program and SUD Community Grant.

1.1 Targeted Geographical Area for Implementation

The PIHP shall manage the Concurrent 1915(b)/(c) Program, SUD Community Grant, and the Healthy Michigan Plan under the terms of this agreement in the county(ies) of your geographic service area. These county(ies) are identified in Attachment P.8.9.1 and hereafter referred to as "service area" or exclusively as "Medicaid specialty service area."

1.2 Target Population

The PIHP shall serve Medicaid beneficiaries in the service area described in 1.1 above who require the Medicaid services included under: the 1915(b) Specialty Services Waiver; who are eligible for the Healthy Michigan Plan or Community Block Grant, who are enrolled in the 1915(c) Habilitation Supports Waiver; who are enrolled in the MIChild program; or for whom the PIHP has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. The PIHP shall serve individuals covered under the SUD Community Grant.

1.3 Responsibility for Payment of Authorized Services

The PIHP shall be responsible for payment for services that the PIHP authorizes, including Medicaid substance use disorder and SUD Community Grant services. This provision presumes the PIHP and its agents are fulfilling their responsibility to individuals according to terms specified in the contract.

Services shall not be delayed or denied as a result of a dispute of payment responsibility between two or more PIHPs. In the event there is an unresolved dispute between PIHPs, either one may

request MDHHS involvement to resolve the dispute, and make a determination. Likewise, services shall not be delayed or denied as a result of a dispute of payment responsibility between the PIHP and another agency.

The PIHP/PIHP Designee must be contacted for authorization for post-stabilization specialty care. The PIHP is financially responsible for post-stabilization specialty care services obtained within or outside the PIHP that are pre-approved by the PIHP or the plan provider if authorization is delegated to it by the PIHP.

The PIHP is also responsible for post-stabilization specialty care services when they are administered to maintain, improve, or resolve the beneficiary's stabilized condition when:

- The PIHP does not respond to a request for pre-approval within 1 hour;
- The PIHP cannot be contacted; or
- The PIHP representative and the treating physician cannot reach an agreement concerning the beneficiary's care and a PIHP physician is not available for consultation. In this situation, the PIHP must give the treating physician the opportunity to consult with a PIHP physician and the treating physician may continue with care of the patient until a PIHP physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

When the MDHHS office in the PIHP's service area places a child outside of the service area on a non-permanent basis and the child needs specialty supports and services, the PIHP retains responsibility for services unless the family relocates to another service area, in which case responsibility transfers to the PIHP where the family has relocated.

1.4 Behavior Treatment Plan Review Committee

The PIHP shall ensure that its provider network uses a specially-constituted committee, such as a behavior treatment plan review committee, to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. The Committee shall substantially incorporate the standards in Attachment P 1.4.1 Technical Requirement for Behavior Treatment Plans.

2.0 1915(b)/(c) AND HEALTHY MICHIGAN PROGRAMS

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in the Michigan Medicaid Provider Manual:-Mental Health-Substance Abuse section, mental health and intellectual/developmental disabilities services may also be provided in other locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness.

2.1 1915(b) Services

State Plan Services: Under the 1915(b) Waiver component of the 1915(b)/(c) program, the PIHP is responsible for providing the covered services as described in the Michigan Medicaid Provider Manual: Mental Health – Substance Abuse section.

2.2 1915(b)(3) Services

As specified in the most current CMS waiver approval, the services aimed at providing a wider, more flexible, and mutually negotiated set of supports and services; that will enable individuals to exercise and experience greater choice and control will be offered under Michigan's approved 1915(b) Waiver Renewal, using the authority of Section 1915(b)(3) of Title XIX of the Social

Security Act. The PIHP shall use Medicaid capitation payments to offer and provide more individualized, cost-effective supports and services, according to the beneficiary's needs and requests, in addition to provision of the state plan coverage(s) for which the beneficiary qualifies. The listing of these services, their definitions, medical necessity criteria, and amount scope and duration requirements for the 1915(b)(3) services is included in the Michigan Medicaid Provider Manual.

2.3 1915(c) Services

The PIHP is responsible for provision of certain enhanced community support services for those beneficiaries in the service areas who are enrolled in Michigan's 1915(c) Home and Community Based Services Waiver for persons with developmental disabilities. Covered services are described in the Mental Health/Substance Abuse Chapter of the Michigan Medicaid Provider Manual.

2.4 Autism Services

State Plan Services: Under the iSPA and the 1915(b) Waiver component of the 1915(b)/(c) program, the PIHP is responsible for providing the covered services as described in the Michigan Medicaid Provider Manual.

2.5 Healthy Michigan Plan

The PIHP is responsible for providing the covered services described in the Mental Health/Substance Abuse Chapter of the Michigan Medicaid Provider Manual as well as the additional Substance Use Disorder services and supports described in the Medicaid Provider Manual for individuals who are eligible for the Healthy Michigan Plan.

2.6 SUD Community Grant Services

Under the State's SUD Community Agreement between MDHHS and the PIHP, the PIHP is responsible for providing or arranging for the provision of SUD prevention and treatment services to eligible individuals.

2.7 MIChild

The PIHP shall also provide medically necessary defined mental health benefits to children enrolled in the MIChild program.

3.0 SERVICE REQUIREMENTS

The PIHP must limit Medicaid, SUD Community Grant and MIChild services to those that are medically necessary and appropriate, and that conform to accepted standards of care. PIHPs must operate the provision of their Medicaid services consistent with the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the CMS/HCFA State Medicaid & State Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual: Mental Health -Substance Abuse section.

The PIHP shall provide covered state plan or 1915(c) services (for beneficiaries enrolled in the 1915(c) Habilitation Supports Waiver) in sufficient amount, duration and scope to reasonably achieve the purpose of the service. Consistent with 42 CFR 440.210 and 42 CFR 440.220, services to recipients shall not be reduced arbitrarily. Criteria for medical necessity and utilization control procedures that are consistent with the medical necessity criteria/service selection guidelines specified by MDHHS and based on practice standards may be used to place appropriate limits on a service (CFR 42 sec.440.230).

3.1 Program Operation
The PIHP shall provide the necessary administrative, professional, and technical staff for operation of the program.

3.2 Notification of Modifications
Provide timely notification to the Department, in writing, of any action by its governing board or any other funding source that would require or result in significant modification in the provision of services, funding or compliance with operational procedures.

3.3 Software Compliance
The Contractor must ensure software compliance and compatibility with the Department's data systems for services provided under this agreement including, but not limited to: stored data, databases, and interfaces for the production of work products and reports. All required data under this agreement shall be provided in an accurate and timely manner without interruption, failure or errors due to the inaccuracy of the Contractor's business operations for processing date/time data.

4.0 ACCESS ASSURANCE

4.1 Access Standards
The PIHP shall ensure timely access to supports and services in accordance with the Access Standards in Attachment P 4.1.1 and the following timeliness standards, and report its performance on the standards in accordance with Attachment P 7.7.1.1 of this contract.

4.13 Recovery Policy
All Supports and Services provided to individuals with Behavioral Health Disorders (Mental Health and Substance Use Disorders), including those with co-occurring conditions, shall be based in the principles and practices of recovery outlined in Attachment P4.13.1 Recovery Policy to this contract**.**

4.2 Medical Necessity
The definition of medical necessity for Medicaid services is included in the Michigan Medicaid Provider Manual: Mental Health –Substance Abuse section.

4.3 Service Selection Guidelines
The criteria for service selection are included in the in the Michigan Medicaid Provider Manual: Mental Health -Substance Abuse section.

4.4 Person Centered Planning
The Michigan Mental Health Code establishes the right for all individuals to have an Individual Plan of Service (IPS) developed through a person-centered planning process (Section 712, added 1996). The PIHP shall implement person-centered planning in accordance with the MDHHS Person-Centered Planning Practice Guideline (Attachment P 4.4.1.1). This provision is not a requirement of Substance Abuse Services.

4.5 Cultural Competence
The supports and services provided by the PIHP (both directly and through contracted providers) shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community,

as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

To effectively demonstrate such commitment, it is expected that the PIHP has five components in place: (1) a method of community assessment; (2) sufficient policy and procedure to reflect the PIHP's value and practice expectations; (3) a method of service assessment and monitoring; (4) ongoing training to assure that staff are aware of, and able to effectively implement, policy; and (5) the provision of supports and services within the cultural context of the recipient.

The PIHP shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

4.6 Early Periodic Screening, Diagnosis and Treatment (EPSDT)
Under Michigan's 1915(b) specialty service waiver, ISPA and this agreement, the PIHP is responsible for the provision of specialty services Medicaid benefits, and must make these benefits available to beneficiaries referred by a primary EPSDT screener, to correct or ameliorate a qualifying condition discovered through the screening process.

While transportation to EPSDT corrective or ameliorative specialty services is not a covered service under this waiver, the PIHP must assist beneficiaries in obtaining necessary transportation either through the Michigan Department of Health and Human Services or through the beneficiary's Medicaid health plan.

4.7. Self-Determination
It is the expectation that PIHPs will assure compliance among their network of service providers with the elements of the Self-Determination Policy and Practice Guideline dated 10/1/12 contract attachment 4.7.1. This provision is not a requirement of Substance Abuse Services.

4.8 Choice
In accordance with 42 CFR 438.6(m), the PIHP must assure that the beneficiary is allowed to choose his or her health care professional, i.e., physician, therapist, etc. to the extent possible and appropriate. This standard does not apply to SUD Community Grant services.

4.9 Second Opinion
If the beneficiary requests, the PIHP must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the beneficiary to obtain one outside the network, at no cost to the beneficiary. This standard does not apply to SUD Community Grant services.

4.10 Out of Network Responsibility
If the PIHP is unable to provide necessary medical services covered under the contract to a particular beneficiary the PIHP must adequately and timely cover these services out of network for the beneficiary, for as long as the entity is unable to provide them within the network. Since there is no cost to the beneficiary for the PIHP's in-network services, there may be no cost to beneficiary for medically-necessary specialty services provided out-of-network.

4.11 Denials by a Qualified Professional
The PIHP must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition.

4.12 Utilization Management Incentives
The PIHP must assure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

4.13 Recovery Policy
All Supports and Services provided to individuals with mental illness, including those with co-occurring conditions, shall be based in the principles and practices of recovery outlined in the Michigan Recovery Council document "Recovery Policy and Practice Advisory" included as Attachment P4.13.1 to this contract**.**

5.0 SPECIAL COVERAGE PROVISIONS
The following sub-sections describe special considerations, services, and/or funding arrangements that may be required by this contract.

5.1 Nursing Home Placements
The PIHP agrees to provide medically necessary Medicaid specialty services to facilitate placement from or to divert admissions to a nursing home, for eligible beneficiaries determined by the OBRA screening assessment to have a mental illness and/or developmental disability and in need of placement and/or services. Funding allocated for OBRA placement and for treatment services shall continue to be directed to this population.

5.2 Nursing Home Mental Health Services
Residents of nursing homes with mental health needs shall be given the same opportunity for access to PIHP services as other individuals covered by this contract.

5.3 Capitated Payments and Other Pooled Funding Arrangements
Medicaid capitation funds paid to the PIHP under the 1915(b) component of the Concurrent 1915(b)/(c) Waiver Program may be utilized for the implementation of or continuing participation in locally established multi-agency pooled funding arrangements developed to address the needs of beneficiaries served through multiple public systems. Medicaid funds supplied or expensed to such pooled funding arrangements must reflect the expected cost of covered Medicaid services for Medicaid beneficiaries participating in or referred to the multi-agency arrangement or project. Medicaid funds cannot be used to supplant or replace the service or funding obligation of other public programs.

5.4 Payments to FQHCs and RHCs
When the PIHP pays Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for specialty services included in the specialty services waivers the PIHP shall ensure that payments are no less than amounts paid to non-FQHC and RHCs for similar services. This standard does not apply to SUD Community Grant services.

5.5 Special Health Care Needs

Beneficiaries with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4). This standard does not apply to SUD Community Grant services.

5.6 Indian Health Service/Tribally-Operated Facility or program/Urban Indian Clinic (I/T/U)

PIHPs are required to pay any Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic (I/T/U), or I/T/U contractor, whether participating in the PIHP provider network or not, for PIHP authorized medically necessary covered Medicaid managed care services provided to Medicaid beneficiary/Indian enrollees who are eligible to receive services from the I/T/U provider either (1) at a rate negotiated between the PIHP and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

6.0 PIHP ORGANIZATIONAL STRUCTURE

The PIHP shall maintain an administrative and organizational structure that supports a high quality, comprehensive managed care program inclusive of all behavioral health specialty services. The PIHP's management approach and organizational structure shall ensure effective linkages between administrative areas including: provider network services; customer services, service area network development; quality improvement and utilization review; grievance/complaint review; financial management and management information systems. Effective linkages are determined by outcomes that reflect coordinated management.

6.1 Critical Incidents

The PIHP must require all of its residential treatment providers to prepare and file critical incident reports that include the following components:

1. Provider determination whether critical incidents are sentinel events.
2. Following identification as a sentinel event, the provider must ensure that a root cause analysis or investigation takes place.
3. Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.

The PIHP is responsible for oversight of the above processes.

Requirements for reporting data on Sentinel Events are contained in "User Documents", via these reporting requirements are narrower in scope than the responsibility to identify and follow up on critical incidents and sentinel events.

6.2 Administrative Personnel

The PIHP shall have sufficient administrative staff and organizational components to comply with the responsibilities reflected in this contract. The PIHP shall ensure that all staff has training, education, experience, licensing, or certification appropriate to their position and responsibilities.

The PIHP will provide written notification to MDHHS of any changes in the following senior management positions within seven (7) days:

Administrator (Chief Executive Officer)
Medical Director

6.3 Customer Services: General

Customer Services is an identifiable function that operates to enhance the relationship between the individual and the PIHP. This includes orienting new individuals to the services and benefits available including how to access them, helping individuals with all problems and questions regarding benefits, handling individual complaints and grievances in an effective and efficient manner, and tracking and reporting patterns of problem areas for the organization. This requires a system that will be available to assist at the time the individual has a need for help, and being able to help on the first contact in most situations. Standards for customer services are in Attachment P.6.3.1.

The Customer Services Attachment to the PIHP contract requires the PIHP to provide individuals with the information outlined in 42 CFR 438.10(f)(4), which references information identified in 42 CFR 438.10 (f)(6). The information is currently required to be given out annually or sooner if substantial changes have been made. CMS has instructed the Department that 42 CFR 438.10(f)(4) requires that, if the state delegates this function, the PIHP must give each enrollee written notice of any significant change in the information specified in 438.10(f)(6) at least 30 days before the intended effective date of the change. Language regarding the 30-day timeframe will need to be added to the contract.

The PIHP must submit its customer services handbook to the MDHHS for review and approval.

6.3.1 Recipient Rights/Grievance and Appeals

The PIHP shall adhere to the requirements stated in the MDHHS Grievance and Appeal Technical Requirement, which is an attachment to this contract (Attachment P 6.3.1.1) in addition to provisions specified in 42 CFR 438.100.

Individuals enrolled in Medicaid and Healthy Michigan must be informed of their right to an administrative hearing if dissatisfaction is expressed at any point during the rendering of state plan services. While PIHPs may attempt to resolve the dispute through their local processes, the local process must not supplant or replace the individual's right to file a hearing request with MDHHS. The PIHP's grievance or complaint process may, and should, occur simultaneously with MDHHS's administrative hearing process, as well as with the recipient rights process. The PIHP shall follow fair hearing guidelines and protocols issued by the MDHHS.

The PIHP has no responsibility to conduct oversight activity with regards to the ORR(s) operated by CMHSPs in the PIHP's provider network. Recipient rights requirements for SUD services are specified in 2(d).

The PIHP must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

The PIHP must maintain records of grievances and appeals.

6.3.2 Information Requirements

A. Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services shall meet the following standards:

1. All such materials shall be written at the 4th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 4th grade level criteria).
2. All materials shall be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in the PIHPs Region. Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002 Federal Register Vol. 65, August 16, 2002).
3. All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA). Beneficiaries shall be informed of how to access the alternative formats.
4. Material shall not contain false, confusing, and/or misleading information.

B. Additional Information Requirements

1. The PIHP shall ensure that beneficiaries are notified that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. The PIHP shall also ensure that beneficiaries are notified how to access alternative formats.
    a. The PIHP must provide the following information to all beneficiaries who receive specialty supports and services:
        i. A listing of contracted providers that identifies provider name, locations, telephone numbers, any non-English languages spoken, and whether they are accepting new beneficiaries. This includes any restrictions on the beneficiary's freedom of choice among network providers. The listing would be available in the format that is preferable to the beneficiary: written paper copy or on-line. The listing must be kept current and offered to each beneficiary annually.
        ii. Their rights and protections, as specified in “Appeal and Grievance Resolution Processes Technical Requirement.”
        iii. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.
        iv. Procedures for obtaining benefits, including authorization requirements.
        v. The extent to which, and how, beneficiaries may obtain benefits and the extent to which, and how, after-hours crisis services are provided.
        vi. Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost to the PIHP of each covered support and service he/she is receiving. Technical Advisory P 6.3.2.1.B.i provides principles and guidance for transmission of this information.
        vii. The Contractor is required to provide Explanation of Benefits (EOBs) to 5% of the consumers receiving services. The EOB distribution must

comply with all State and Federal regulations regarding release of information as directed by DCH. DCH will monitor EOB distribution annually. A model Explanation of Benefits consistent with Technical Requirement P 6.3.2.1.B.ii is attached to this contract. A PIHP may, but is not required to utilize the model template.

b. The PIHP must give each beneficiary written notice of a significant change in its provider network including the addition of new providers and planned termination of existing providers.
c. The PIHP will make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.
d. The PIHP will provide information to beneficiaries about managed care and care coordination responsibilities of the PIHP, including:
    i. Information on the structure and operation of the MCO or PIHP;
    ii. Physician incentive plans in use by the PIHP or network providers as set forth in 42 CFR 438.6(h).

6.4 Medicaid Services Verification

PIHPs shall perform Verification of Medicaid claims in accordance of operational developments by MDHHS in collaboration with PIHPs and shall be finalized no later than September 30, 2016.

7.0 PROVIDER NETWORK SERVICES

The PIHP is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract. The PIHP remains the accountable party for the Medicaid beneficiaries in its service area, regardless of the functions it has delegated to its provider networks.

In this regard, the PIHP agrees to:

1. Maintain a regular means of communicating and providing information on changes in policies and procedures to its providers. This may include guidelines for answering written correspondence to providers, offering provider-dedicated phone lines, and a regular provider newsletter.
2. Have clearly written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.
3. Provide a copy of the PIHP's prior authorization policies to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to prior authorization policies as changes are made.
4. Provide a copy of the PIHP's grievance, appeal and fair hearing procedures and timeframes to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to those procedures or timeframes.
5. Provide to MDHHS in the format specified by MDHHS, provider agency information profiles that contain a complete listing and description of the provider network available to recipients in the service area.

6. Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility.
7. Assure that network providers do not segregate PIHP individuals in any way from other people receiving their services.

7.1 Provider Credentialing

The PIHP shall have written credentialing policies and procedures for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services. Credentialing shall take place every two years. The PIHP must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state. The PIHP also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the PIHP's standards. Reference Attachment P 7.1.1.

7.2 Collaboration with Community Agencies

PIHPs and their provider network must work closely with local public and private community-based organizations and providers to address prevalent human conditions and issues that relate to a shared customer base to provide a more holistic health care experience for the consumer. Such agencies and organizations may include local health departments, local MDHHS human service offices, Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), community and migrant health centers, nursing homes, Area Agency and Commissions on Aging, Medicaid Waiver agents for the Home Community Based Waiver (HCBW) program, school systems, and Michigan Rehabilitation Services. Local coordination and collaboration with these entities will make a wider range of essential supports and services available to the PIHP individuals. PIHPs will coordinate with these entities through participation in multi-purpose human services collaborative bodies, and other similar community groups.

The PIHP shall have a written coordination agreement with each of the pertinent agencies noted above describing the coordination arrangements agreed to and how disputes between the agencies will be resolved. To ensure that the services provided by these agencies are available to all PIHPs, an individual contractor shall not require an exclusive contract as a condition of participation with the PIHP.

The PIHP shall have a documented policy and set of procedures to assure that coordination regarding mutual recipients is occurring between the PIHP and/or its provider network, and primary care physicians. This policy shall minimally address all recipients of PIHP services for whom services or supports are expected to be provided for extended periods of time (e.g., people receiving case management or supports coordination) and/or those receiving psychotropic medications.

7.3 Medicaid Health Plan (MHP) Agreements

Many Medicaid beneficiaries receiving services from the PIHP will be enrolled in a MHP for their health care services. The MHP is responsible for non-specialty level mental health services. It is therefore essential that the PIHP have a written, functioning coordination agreement with each MHP serving any part of the PIHP's service area. The written coordination agreement shall describe the coordination arrangements, inclusive of but not limited to, the exchange of information, referral procedures, care coordination and dispute resolution. At a minimum these arrangements must address the integration of physical and mental health services provided by the MHP and PIHP for the shared consumer base plans. A model coordination agreement is herein included as Attachment P 7.3.1.

7.4 Integrated Physical and Mental Health Care

The PIHP will initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid beneficiaries. These efforts will focus on persons that have a chronic condition such as a serious and persistent mental health illness, co-occurring substance use disorder or a developmental disability and have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports.

- The PIHP will implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the consumer's MHP as defined in 7.3.
- As authorized by the consumer, the PIHP will include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.
- The PIHP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.

7.5 Health Care Practitioner Discretions

The PIHP may not prohibit, or otherwise restrict a health care professional acting within their lawful scope of practice from advising or advocating in the following areas on behalf of a beneficiary who is receiving services under this contract:

- For the beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- For any information the beneficiary needs in order to decide among all relevant treatment options
- For the risks, benefits, and consequences of treatment or non-treatment
- For the beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

7.6 Home and Community Character

The PIHP must assure that the residential (adult foster care, specialized residential, provider owned/controlled) and non-residential services (skill building, supported employment, community living supports, prevocational, out of home non-vocational) where individuals are supported by funds from the Medicaid 1915(c) waiver programs (Habilitation Supports Waiver, Children’s Waiver, and Children’s SED Waiver, B Waiver) each maintains a “home and community character” as required by federal regulation and the resultant, Michigan-specific, CMS approved plan.

7.7 Management Information Systems

The PIHP shall ensure that Management Information Systems and practices have the capacity that the obligations of this contract are fulfilled by the entity and/or its subcontractors. Management information systems capabilities are necessary for at least the following areas:

1. Monthly downloads of Medicaid eligible information
2. Individual registration and demographic information
3. Provider enrollment
4. Third party liability activity
5. Claims payment system and tracking
6. Grievance and complaint tracking
7. Tracking and analyzing services and costs by population group, and special needs categories as specified by MDHHS
8. Encounter and demographic data reporting
9. Quality indicator reporting
10. HIPAA compliance
11. UBP compliance
12. Individual access and satisfaction

In addition, the PIHP shall meet the following requirements:

1. The PIHP shall utilize Benefit Enrollment and Maintenance (834) and Payment Order Remittance Advice (820) reconciliation files as the primary source for eligibility determination for PIHP functions. Eligibility Inquiry and Response (270/271) is intended as the primary tool for the CMHSP and provider system to determine eligibility, and should rarely be utilized by the PIHP.
2. A PIHP organized as a regional entity shall ensure that health plan information technology functions are clearly defined and separately contracted from any other function provided by a CMHSP. A PIHP organized as a regional entity may have a single CMHSP perform PIHP health plan information technology functions on behalf of the regional entity if each of the following requirements are met:
    a. The contract between the PIHP and the CMHSP clearly describes the CMHSP's contractual responsibility to the PIHP for the health plan information technology related functions.
    b. The contract between the PIHP and the CMHSP for PIHP health plan information technology functions shall be separate from other EHR functions performed as a CMHSP.
3. The PIHP shall analyze claims and encounter data to create information about region wide and CMHSP specific service utilization. The PIHP shall provide regular reports to each CMHSP as to how the CMHSP's individual utilization compares to the PIHP's region as a whole. The PIHP shall utilize this information to inform risk management strategies and other health plan functions.
4. The PIHP shall actively participate with the Department to develop metrics the Department will use to provide useful reports to the PIHPs, i.e., benchmarking individual PIHP's data against statewide data.

5. The PIHP shall participate with the Department and CMHSPs in activities to standardize and consistently implement encounter submissions involving County of Financial Responsibility (COFR) issues, when the CMHSP identified as the COFR is not part of the PIHP's geographic region.

7.7.1 Uniform Data and Information

To measure the PIHP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates, the PIHP must provide the MDHHS with uniform data and information as specified by MDHHS as previously agreed, and such additional or different reporting requirements (with the exemption of those changes required by federal or state law and/or regulations) as the parties may agree upon from time to time. Any changes in the reporting requirements, required by state and federal law, will be communicated to the PIHP at least 90 days before they are effective unless state or federal law requires otherwise. Both parties must agree to other changes, beyond routine modifications, to the data reporting requirements.

The PIHP's timeliness in submitting required reports and their accuracy will be monitored by MDHHS and will be considered by MDHHS in measuring the performance of the PIHP. Regulations promulgated pursuant to the Balance Budget Act of 1997 (BBA) require that the CEO or designee certify the accuracy of the data.

The PIHP must cooperate with MDHHS in carrying out validation of data provided by the PIHP by making available recipient records and a sample of its data and data collection protocols. PIHPs must certify that the data they submit are accurate, complete and truthful. An annual certification from and signed by the Chief Executive Officer or the Chief Financial Officer, or a designee who reports directly to either must be submitted annually. The certification must attest to the accuracy, completeness, and truthfulness of the information in each of the sets of data in this section.

MDHHS and the PIHPs agree to use the Encounter Data Integrity Group (EDIT) for the development of instructions with costing related to procedure codes, and the assignment of Medicaid and non-Medicaid costs. The recommendations from the EDIT group have been incorporated into the Attachment P 7.7.1.1.

7.7.2 Encounter Data Reporting

In order to assess quality of care, determine utilization patterns and access to care for various health care services, affirm capitation rate calculations and estimates, the PIHP shall submit encounter data containing detail for each recipient encounter reflecting all services provided by the PIHP. Encounter records shall be submitted monthly via electronic media in the HIPAA-compliant format specified by MDHHS. Encounter level records must have a common identifier that will allow linkage between MDHHS's and the PIHP's management information systems. Encounter data requirements are detailed in the PIHP Reporting Requirements Attachment P.7.7.1.1 to this contract.

The following ASC X12N 837 Coordination of Benefits loops and segments are required by MDHHS for reporting services provided by and/or paid for by the PIHP and/or CMHSP.
Loop 2320 – Other Subscriber Information
SBR – Other Subscriber Information
DMG – Subscriber Demographic Information
OI – Other Insurance Coverage Information

Loop 2330A – Other Subscriber Name
NM1 – Other Subscriber Name
Loop 2330B – Other Payer Name
NM1 – Other Payer Name
REF – Other Payer Secondary Identifier
Submission of data for any other payer other than the PIHP and/or CMHSP is optional.
Reporting monetary amounts in the ASC X12N 837 version 4010 is optional.

7.7.3 Supports Intensity Scale

The PIHP will:

1. Ensure that each individual age 18 and older with an Intellectual/Developmental Disability is assessed using the Supports Intensity Scale (SIS) at minimum of once every 3 years (or more or if the person experiences significant changes in their support needs). The PIHP will need to assure that a proportioned number of assessments are completed each year to assure that all are done in the 3 year cycle, which began on June 30, 2014.
2. Ensure an adequate cadre of trained and AAIDD recognized as qualified SIS assessors across its region to ensure that all individuals are assessed in the required timeframe.
3. Be responsible to provide for an adequate number of recognized and approved trainers to assure capacity to train new assessors. The State will provide for an initial process to offer training for one trainer in each region.
4. Participate in the Implementation Workgroup
5. Collaborate with BHDDA to plan for and participate in stakeholder SIS related informational forums
6. Collaborate with BHDDA in planning and provision of training to Supports Coordination/Care Management staff
7. SIS assessors must meet state specified required criteria including the following minimum criteria:
    a. Bachelor's Degree in human services or four years of equivalent work experience in a related field
    b. At least one year experience with individuals that have a developmental or intellectual disability
    c. Participation in a minimum of one Periodic Drift Review per year conducted by an AAIDD recognized SIS® Trainer
    d. Maintain annual Interviewer Reliability Qualification Review (IRQR) status at "Qualified" status as determined by an AAIDD recognized SIS® Trainer
    e. Assessors skills will be evaluated as part of quality framework that includes AAIDDA/MORC/Online reports
    f. Attend quarterly Michigan SIS® Assessor conference calls
    g. Attend annual Michigan SIS® Assessor Continuing Education
    h. SIS Assessors must be independent from the current supports and services staff and may not report to the same department within the organization where the individual is being served.
    i. Assessors should not facilitate a SIS® interview for an individual for whom they are providing another ongoing clinical service.

   j. It is acceptable for Interviewers to contract with or be employed by a PIHP, CMHSP, or other provider agency as deemed appropriate by the PIHP and consistent with avoidance of conflict of interest.

8. Ensure that SIS data is entered into or collected using SISOnline, the AAIDD web-based platform designed to support administering, scoring, and retrieving data and generating reports (http://aaidd.org/sis/sisonline) within state specified time frames.
9. Provide for necessary DUA's and related tasks required for use of SIS online.
10. MDHHS will cover all annual licensing and user fees for PIHP use of SISOnline for Medicaid consumers.
11. co-own SIS data with MDHHS
12. have complete access to all SIS data entered on behalf of the PIHP, including both detail and summary level data.

Decisions related to prioritization for individuals to be assessed will be made based on published guidance provided by MDHHS.

Level of Care Utilization System (LOCUS)
The PIHP will:

1. **Ensure that the LOCUS is incorporated into the initial assessment process for all individuals 18 and older seeking supports and services for a severe mental illness using one of the three department approved methods for scoring the tool. Approved methods:**
   a. **Paper and pencil scoring;**
   b. **Use of the online scoring system Service Manager, through Deerfield Behavioral Health, with cost covered by BHDDA through Mental Health and Wellness Commission funding; or**
   c. **Use of software Service Manager purchased through Deerfield Behavioral Health with costs covered by BHDDA through Mental Health and Wellness Commission funding.**
2. **Ensure that each individual 18 years and older with a severe mental illness, who is receiving services on or after October 1, 2016, has a LOCUS completed as part of any re-assessment process during that and subsequent fiscal years.**
3. **Identify a regional trainer that will support regional training needs and participate in BHDDA ongoing training and education activities that will support the ongoing use of the tool.**
4. **Collaborate with BHDDA for ongoing fidelity monitoring on the use of the tool.**
5. **Provide to DHHS the composite score for each LOCUS that is completed in accord with the established reporting guidelines.**

7.7.4. National Core Indicators

The PIHP will provide mailing addresses for the identified participants in their geographic region who have been selected by the Department for the mailed survey (a total of 1,500 will be selected for the entire State of Michigan). The PIHP shall also obtain consents, coordinate appointments, and provide required background information on selected participants as necessary for the Department's identified contractor to complete face to face interviews with identified participants in the PIHP's geographic region (a total of 400 interviews will be completed for the entire State of Michigan). The PIHP shall help with dissemination and use of the NCI data in the PIHP's quality improvement activities.

7.8 Financial Management System: General

The PIHP shall maintain all pertinent financial and accounting records and evidence pertaining to this contract based on financial and statistical records that can be verified by qualified auditors. The PIHP will comply with generally accepted accounting principles (GAAP) for government units when preparing financial statements. The PIHP will use the principles and standards of OMB Circular 2 CFR 200 Subpart E for determining all costs related to the management and provision of Medicaid covered specialty services under the Concurrent 1915(b)/(c) Waiver, SUD Community Grant, Healthy Michigan and MIChild Programs reported on the financial status report. The accounting and financial systems established by the PIHP shall be a double entry system having the capability to identify application of funds to specific funding streams participating in service costs for individuals. The accounting system must be capable of reporting the use of these specific fund sources by major population groups (MIA, MIC, DD and SA). In addition, cost accounting methodology used by the PIHP must ensure consistent treatment of costs across different funding sources and assure proper allocation to costs to the appropriate source.

The PIHP shall maintain adequate internal control systems. An annual independent audit shall evaluate and report on the adequacy of the accounting system and internal control systems.

7.8.1 Rental Costs

The following limitations regarding rental costs1 shall apply to all PIHPs. All rental costs that exceed the limits in this section are not allowable and shall not be charged as a cost to Medicaid.

13. Subject to the limitations in subsection b and c of this section, rental costs are allowable to the extent that the rates are reasonable in light of such factors as: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased. Rental arrangements should be reviewed periodically to determine if circumstances have changed and other options are available.
14. All rental costs are subject to OMB Circular 2 CFR 200 Subpart E.
15. Rental costs under leases which are required to be treated as capital leases under GAAP are allowable only up to the amount (depreciation or use allowance, maintenance, interest, taxes and insurance) that would be allowed had the PIHP purchased the property on the date the lease was executed. Financial Accounting Standards Board Statement 13, Accounting for Leases, shall be used to determine whether a lease is a capital lease. Interest expenses related to the capital leases are allowable to the extent that they meet the criteria in OMB Circular 2 CFR 200 Subpart E. Unallowable costs include amounts paid for profit, management fees, and taxes that would not have been incurred had the PIHP purchased the facility.

7.8.2 Claims Management System

The PIHP shall assure the timely payments to all providers for clean claims. This includes payment at 90% or higher of all clean claims from network subcontractors within 30 days of receipt, and at least 99% of all clean claims within 90 days of receipt, except services rendered under a subcontract in which other timeliness standards have been specified and agreed to by both parties.

A valid claim is a claim for supports and services that the PIHP is responsible for under this contract. It includes services authorized by the PIHP, and those like Medicare co-pays and deductibles that the PIHP may be responsible for regardless of their authorization.

The PIHP shall have an effective provider appeal process to promptly and fairly resolve provider-billing disputes.

7.8.2.1 Post-Payment Review
The PIHP may utilize a post-payment review methodology to assure claims have been paid appropriately. Regardless of method, the PIHP must have a process in place to verify that services were actually provided.

7.8.2.2 Total Payment
The PIHP or its providers shall not require any co-payments, recipient pay amounts, or other cost sharing arrangements unless specifically authorized by state or federal regulations and/or policies. The PIHP's providers may not bill individuals for the difference between the provider's charge and the PIHP's payment for services. The providers shall not seek nor accept additional supplemental payment from the individual, his/her family, or representative, for services authorized by the PIHP. The providers shall not seek nor accept any additional payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if the PIHP provided the services directly.

7.8.2.3 Electronic Billing Capacity
The PIHP must be capable of accepting HIPAA compliant electronic billing for services billed to the PIHP, or the PIHP claims management agent, as stipulated in the Michigan Medicaid Provider Manual. The PIHP may require its providers to meet the same standard as a condition for payment.

7.8.2.4 Third Party Resource Requirements
Medicaid is a payer of last resort. PIHPs and their providers/contractors are required to identify and seek recovery from all other liable third parties in order to make themselves whole. Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a recipient's covered benefit. The PIHP shall collect any payments available from other health insurers including Medicare and private health insurance for services provided to its individuals in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, and the Michigan Mental Health Code and Public Health Code as applicable. The PIHP shall be responsible for identifying and collecting third party liability information and may retain third party collections, as provided for in section 226a of the Michigan Mental Health Code.

The PIHP must report third-party collections as required by MDHHS. When a Medicaid beneficiary is also enrolled in Medicare, Medicare will be the primary payer ahead of any PIHP, if the service provided is a covered benefit under Medicare. The PIHP must make the Medicaid beneficiary whole by paying or otherwise covering all Medicare cost-sharing amounts incurred by the Medicaid beneficiary such as coinsurance, co-pays, and deductibles in accordance with coordination of benefit rules. In relation to Medicare-covered services, this applies whether the PIHP authorized the service or not.

7.8.2.5 Vouchers
Vouchers issued to individuals for the purchase of services provided by professionals may be utilized in non-contract agencies that have a written referral network agreement with the PIHP that specifies credentialing and utilization review requirements. Voucher rates for such services shall be predetermined by the PIHP using the actual cost history for each service category and average local provider rates for like services. These rates represent total payment for services rendered. Those accepting vouchers may not require any additional payment from the individual.

Voucher arrangements for purchase of individual-directed supports delivered by non-professional practitioners may be through a fee-for-service arrangement. The use of vouchers is not subject to the provisions of Section 37.0 (Provider Contracts and Procurement) and Section 38.0 (Subcontracting) of this contract.

7.8.2.6. Programs with Community Inpatient Hospitals
Upon request from MDHHS, the PIHP must develop programs for improving access, quality, and performance with providers. Such programs must include MDHHS in the design methodology, data collection, and evaluation.

7.9 Quality Assessment/Performance Improvement Program and Standards
The PIHP shall have a fully operational Quality Assessment and Performance Improvement Program in place that meets the conditions specified in the Quality Assessment and Performance Improvement Program Technical Requirement," Attachment P 7.9.1.

7.9.1 External Quality Review
The state shall arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the PIHP. The PIHP shall address the findings of the external review through its QAPIP. The PIHP must develop and implement performance improvement goals, objectives and activities in response to the external review findings as part of the PIHP's QAPIP. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in the PIHP's QAPIP and provided to the MDHHS upon request. The MDHHS may also require separate submission of an improvement plan specific to the findings of the external review.

7.9.2 Annual Effectiveness Review
The PIHP shall annually conduct an effectiveness review of its QAPIP. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for recipients as a result of quality assessment and improvement activities and interventions carried out by the PIHP. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of the PIHP's QAPIP must be provided annually to network providers and to recipients upon request. Information on the effectiveness of the PIHP's QAPIP must be provided to the MDHHS upon request.

7.9.3 MDHHS Standard Consent Form
It is the intent of the parties to promote the use and acceptance of the standard release form that was created by MDHHS under Public Act 129 of 2014. Accordingly, the PIHPs have the opportunity to participate in the Department’s annual review of the DCH-3927 and to submit comments to the Department regarding challenges and successes with using DCH-3927.

There are remaining issues to be addressed before the standard consent form can be used to support electronic Health Information Exchange. However, for all non-electronic Health Information Exchange environments, the PIHP shall implement a written policy that requires the PIHP and its provider network to use, accept, and honor the standard release form that was created by MDHHS under Public Act 129 of 2014.

7.10 Service and Utilization Management

The PIHP shall perform utilization management functions sufficient to control costs and minimize risk while assuring quality care. Additional requirements are described in the following subsections.

7.10.1 Beneficiary Service Records

The PIHP shall ensure that providers establish and maintain a comprehensive individual service record system consistent with the provisions of MSA Policy Bulletins, and appropriate state and federal statutes. The PIHP shall ensure that providers maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided. The records shall be retained according to the retention schedules in place by the Department of Management and Budget (DTMB) General Schedule #20 at: http://michigan.gov/dmb/0,4568,7-150-9141_21738_31548-56101--,00.html. This requirement must be extended to all of the PIHP's provider agencies.

7.10.2 Other Service Requirements

The PIHP shall assure that in addition to those provisions specified in Section 4.0 “Access Assurance,” services are planned and delivered in a manner that reflects the values and expectations contained in the following guidelines:

- Inclusion Practice Guideline (Attachment P 7.10.2.1)
- Housing Practice Guideline (Attachment P 7.10.2.2)
- Consumerism Practice Guideline (Attachment P 7.10.2.3)
- Personal Care in Non-Specialized Home Guideline (Attachment P 7.10.2.4)
- Family-Driven and Youth-Guided Policy & Practice Guideline (Attachment P 7.10.2.5)
- Employment Works! Policy (Attachment P 7.10.2.6)

In addition, the PIHP must disseminate all practice guidelines it uses to all affected providers and upon request to beneficiaries. The PIHP must ensure that decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

7.10.3 Jail Diversion

The PIHP shall coordinate with the appropriate entities, services designed to divert beneficiaries that qualify for MH/DD specialty services from a possible jail incarceration, when appropriate. Such services should be consistent with the Jail Diversion Practice Guidelines. The PIHP will collect data reflective of jail diversion activities and outcomes as indicated in the Practice Guideline (Attachment P 7.10.3.1).

7.10.4 School-to Community Transition

The PIHP shall ensure the CMHSPs participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or

developmental disability. Participation shall be consistent with the MDHHS School-to-Community Transition Guideline (Attachment P 7.10.4.1).

7.10.5 Advance Directives
In accordance with 42 CFR 422.128 and 42 CFR 438.6, the PIHP shall maintain written policies and procedures for advance directives. The PIHP shall provide adult beneficiaries with written information on advance directive policies and a description of applicable state law and their rights under applicable laws. This information must be continuously updated to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective. The PIHP must inform individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Customer Services.

7.11 Regulatory Management
The PIHP shall have an established process for carrying out corporate compliance activities across its service area. The process includes promulgation of policy that specifies procedures and standards of conduct that articulate the PIHP's commitment to comply with all applicable Federal and State standards. The PIHP must designate an individual to be a compliance officer, and establish a committee that will coordinate analytic resources devoted to regulatory identification, comprehension, interpretation, and dissemination. The compliance officer, committee members, and PIHP employees shall be trained about the compliance policy and procedures. The PIHP shall establish ongoing internal monitoring and auditing to assure that the standards are enforced, to identify other high-risk compliance areas, and to identify where improvements must be made. There are procedures for prompt response to identified problems and development of corrective actions.

7.12 P.A. 500 and 2013 Application for Participation Requirements

7.12.1 PIHP Boards
The membership of PIHP Boards shall include a representative from substance use disorder services (SUDs).

7.12.2 PIHP Substance Use Disorder Oversight Policy Boards
The PIHP shall establish a SUD Oversight Policy Board by October 1, 2014, through a contractual arrangement with the PIHP and each of the counties served under appropriate state law. The SUD Oversight Policy Boards shall include the members called for in the establishing agreement, but shall have at least one board member appointed by the County Board of Commissioners for each county served by the PIHP. The SUD Oversight Policy Board shall perform the functions and responsibilities assigned to it through the establishing agreement, which shall include at least the following responsibilities:

1. Approval of PIHP budget containing local funds for treatment, prevention, recovery or SUD.
2. Advice and recommendations regarding PIHP budgets for SUD prevention, treatment and recovery using other non-local funding sources.
3. Advice on recommendations regarding contracts with SUD treatment, recovery or prevention providers.
4. Any other terms as agreed to by the participating parties consistent with authorizing legislation.

The PIHP shall provide a list of members and criteria use to make selection of members.

7.12.3 Procedures for Approving Budgets and Contracts
The PIHP must approve budgets and contracts for SUD prevention, treatment and recovery services in accordance with established procedures.

7.12.4 Maintaining Provider Base
The PIHP must maintain the provider base for prevention, treatment, and recovery services under contract as of December 2012 until December 28, 2014.

7.12.5 Reports and Annual Budget Boilerplate Requirements
The PIHP must submit timely reports on annual budget boilerplate requirements including:

1. Legislative Reports (Section 908), FY2016 due by February 28, 2017.
2. Mental Health and Substance Use Disorder Services Integration Status Reports

8.0 CONTRACT FINANCING
The provisions provided in the following subsections describe the financing arrangements in support of this contract.

A PIHP shall accept transfers of all reserve accounts and related liabilities accumulated by PIHPs that formerly operated within the current PIHP's geographic region. A PIHP shall accept transfer of all liabilities accumulated by the PIHPs that formerly operated within the PIHP's geographic region that were incurred and paid on behalf of the new PIHP as pre-award costs.

The PIHP agrees to provide to the MDHHS, for deposit into a separate contingency account, local funds as authorized in the State Appropriations Act. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a CMHSP or an affiliation of CMHSPs. The amount of such funds and payment schedule is included in Attachment P 8.0.1.

The rates included in attachment P 8.0.1 are in effect with the initial contract.
The Department of Health and Human Services (HHS), United States Comptroller General or their representatives must have access to the financial and administrative records of the PIHP related to the activities and timeframes of this contract.

8.1 Local Obligation
The PIHP shall provide the local financial obligation for those Medicaid funds determined to require local match. In the event a PIHP is unable to provide the required local obligation, the PIHP shall notify the MDHHS contract representative immediately.

8.1.1 If a state appropriations Act permits the contribution from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation payments, the PIHP shall provide on a quarterly basis the PIHP obligation for local funds as a bona fide source of match for Medicaid. The payment dates and amounts are shown in a schedule in Attachment P 8.0.1.

8.1.2 MDHHS has determined that the method of payment used for these services provided the 1915(b) waiver and 1915(c) Habilitation Supports Waiver do not require the 10% local obligation.

8.2 Revenue Sources for Local Obligation

The following are potential revenue sources for the PIHP's obligation to provide local funds to match Federal Medicaid.

- **County Appropriations**
  Appropriations of general county funds to the PIHP by the County Board of Commissioners.
- **Other Appropriations and Service Revenues**
  Appropriations of funds to the PIHP or its contract agencies by cities or townships; funds raised by fee-for-service contract agencies and/or network providers as part of the agencies' contractual obligation, the intent of which is to satisfy and meet the local match obligation of the PIHP, as reflected in this contract.
- **Gifts and Contributions**
  Grants, bequests, donations, gifts from local non-governmental sources, charitable institutions or individuals; gifts that specify the use of the funds for any particular individual identified by name or relationship may not be used as local match funds.
- **Special Fund Account**
  Funds of participating CMHSPs from the Community Mental Health Special Fund Account, consistent with Section 226a of the Michigan Mental Health Code. The Supplemental Security Income (SSI) benefit received by some residents in adult foster care homes is a Federal income supplement program designed to help aged, blind, and disabled people, who have little or no income. It provides cash to meet basic needs for food, clothing, and shelter. SSI income shall not be collected or recorded as a recipient fee or third-party reimbursement for purposes of Section 226a of the Mental Health Code. This includes the state supplement to SSI.
- **Investment Interest**
  Interest earned on funds deposited or invested by or on behalf of the PIHP, except as otherwise restricted by GAAP or OMB circular 2 CFR 200 Subpart E. Also, interest earned on MDHHS funds by contract agencies and/or network providers as specified in its contracts with the PIHP.
- **Other Revenues for Mental Health Services**
  As long as the source of revenue is not federal or state funds, revenues from other county departments/funds (such as child care funds) or revenues from public or private school districts for PIHP mental health services.
- **Grants or Gifts Exclusions**
  Local funds exclude grants or gifts received by the county, the PIHP, or agencies contracting with the PIHP, from an individual or agency contracting to provide services to the PIHP. An exception may be made, where the PIHP can demonstrate that such funds constitute a transfer of grants or gifts made for the purposes of financing mental health services, and are not made possible by PIHP payments to the contract agency that are claimed as matchable expenses for the purpose of state financing.

8.3 Local Obligations - Requirement Exceptions

The following Medicaid covered services shall not require the PIHP to provide a local obligation:

- Programs for which responsibility is transferred to the PIHP and the state is responsible for 100% of the cost of the program, consistent with the Michigan Mental Health Code, for example 307 transfers and Medicaid hospital-based services
- Other Medicaid covered specialty services, provided under the Concurrent 1915(b)/(c) Program, as determined by MDHHS
- Services provided to an individual under criminal sentence to a state prison

8.4 MDHHS Funding

MDHHS funding includes both Medicaid funds related to the 1915(b) Waiver the 1915(c) Habilitation Supports Waiver, the MIChild program and the 1115 Healthy Michigan Plan. The financing in this contract is always contingent on the annual Appropriation Act. CMHSPs within a PIHP may, but are not required to, use GF formula funds to provide services not covered under the 1915(b) and 1915(c) Medicaid Habilitation Supports waivers for Medicaid beneficiaries who are individuals with serious mental illness, serious emotional disturbances or developmental disabilities, or underwrite a portion of the cost of covered services to these beneficiaries. MDHHS reserves the right to disallow such use of General Funds if it believes that the CMHSP was not appropriately assigning costs to Medicaid and to General Funds in order to maximize the savings allowed within the risk corridors.

Specific financial detail regarding the MDHHS funding is provided as Attachment P 8.0.1.

8.4.1. Medicaid

The MDHHS shall provide to the PIHP both the state and federal share of Medicaid funds as a capitated payment based upon a per eligible per month (PEPM) methodology. The MDHHS will provide access to an electronic copy of the names of the Medicaid eligible people for whom a capitation payment is made. A PEPM is determined for each of the populations covered by this contract, which includes services for people with a developmental disability, a mental illness or emotional disturbance, and people with a substance use disorder as reflected in this contract. PEPM is made to PIHP for all eligibles in its region, not just those with the above-named diagnoses.

The Medicaid PEPM rates and the annual estimate of current year payments are attached to this contract. The actual number of Medicaid eligibles shall be determined monthly and the PIHP shall be notified of the eligibles in their service area via the pre-payment process.

Beginning with the first month of this contract, the PIHP shall receive a pre-payment equal to one month. The MDHHS shall not reduce the PEPM to the PIHP to offset a statewide increase in the number of beneficiaries. All PEPM rates must be certified as falling within the actuarially sound rate range.

The Medicaid PEPM rates effective October 1, 2016 will be supplied as part of Attachment P 8.0.1. The actual number of Medicaid eligibles shall be determined monthly and the PIHP shall be notified of the eligibles in their service area via the pre-payment process.

The MDHHS shall provide to the PIHP both the state and federal share of Medicaid funds as a capitated payment based upon a per 1915 (c) Habilitation Supports Waiver enrollee per month methodology. The MDHHS will provide access to an electronic copy of the names of the Medicaid eligible and Habilitation Supports waiver enrolled people for whom a 1915 (c) waiver interim payment is made.

8.4.1.1 Medicaid Rate Calculation
The Medicaid financing strategy used by the MDHHS, and stated in the 1915(b) Waiver, is to contain the growth of Medicaid expenditures, not to create savings.

The Medicaid Rate Calculation is based on the actuarial documentation letter from Milliman USA. Three sets of rate calculations are required: 1) one set of factors for the 1915(b) state plan and 1915(b)(3) services; 2) one set of factors for 1915 (c) Habilitation Supports Waiver services; and 3) one set of factors for the 1115 Healthy Michigan Plan.. The Milliman USA letter documents the calculation rate methodology and provides the required certification regarding actuarial soundness as required by the Balanced Budget Act Rules effective August 13, 2002. The chart of rates and factors contained in the actuarial documentation is included in Attachment P.8.0.1.

Several groups of Medicaid eligibles are excluded from the capitation methodology/payments. The groups are identified in sections 8.4.1.3 and 8.4.1.4. In addition, the rate calculations and payments excluded eligibility months associated with periods of retro-eligibility. The PIHP is responsible for service to these individuals and may use their Medicaid funding for such services, except for that period of time each month prior to when the individual is spent-down and thus not Medicaid-eligible.

The MDHHS shall not reduce the 1915(b), 1915(b)(3) PEPM, 1115 Health Michigan Plan PEPM or the C-waiver rates to the PIHP to offset a statewide increase in the number of Medicaid eligibles. All PEPM rates must be certified as falling within the actuarially sound rate range.

8.4.1.2 Medicaid Payments
MDHHS will provide the PIHP two managed care payments each month for the Medicaid covered specialty services.

8.4.1.3 Medicaid State Plan and (b)(3) Payments
The capitation payment for the state plan and (b)(3) Mental Health, Developmental Disability and Substance Abuse services is based on all Medicaid eligibles within the PIHP region, excluding Children's Waiver enrollees, and persons residing in a ICF/IID or individuals enrolled in a Program for All Inclusive Care (PACE) organization, SED waiver enrollees, individuals incarcerated, and individuals with a Medicaid deductible. The capitation payment will be adjusted for recovery of payments for Medicaid eligibles for whom MDHHS has subsequently been notified of their date of death. When applicable, additional payments may be scheduled (i.e. retro-rate implementation). HIPAA compliant 834 and 820 transactions will provide eligibility and remittance information.

8.4.1.4 1915(c) Habilitation Supports Waiver Payments
The 1915(c) Habilitation Supports Waiver (HSW) interim payment will be made to the PIHPs based on HSW beneficiaries who have enrolled through the MDHHS enrollment process and have met the following requirements:

- Has a developmental disability (as defined by Michigan law)
- Is Medicaid-eligible (as defined in the CMS approved waiver)
- Is residing in a community setting
- If not for HSW services would require ICF/IID level of care services
- Chooses to participate in the HSW in lieu of ICF/IID services

- Receives at least one HSW approved service to each month enrolled

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other 1915(c) waiver, such as the Children's Waiver Program (CWP) and Children with Serious Emotional Disturbance Waiver (SEDW). The PIHP will not receive payments for HSW enrolled beneficiaries who reside in an ICF/IID, Nursing Home, CCI, or are incarcerated for an entire month. The PIHP will not receive payments for HSW enrolled beneficiaries enrolled with a Program All Inclusive Care (PACE) organization.

Enrollment Management: The 1915(c) HSW uses an "attrition management" model that allows PIHPs to "fill in behind" attrition with new beneficiaries up to the limits established in the CMS-approved waiver. MDHHS has allocated certificates to each of the PIHPs. The process for filling a certificate involves the following steps: 1) the PIHPs submit applications for Medicaid beneficiaries for enrollment based on vacant certificates within the PIHP and includes required documentation that supports the eligibility for HSW; 2) MDHHS personnel reviews the PIHP enrollment applications; and 3) MDHHS personnel approves (within the constraint of the total yearly number of available waiver certificates and priority populations described in the CMS-approved waiver) those beneficiaries who meet the requirements described above.

The MDHHS may reallocate an existing HSW certificate from one PIHP to another if:

- the PIHP has presented no suitable candidate for enrollment in the HSW within 60 days of the certificate being vacated; and
- there is a high priority candidate (person exiting the ICF/ IID or at highest risk of needing ICF/ IID placement, or young adult aging off CWP) in another PIHP where no certificate is available. MDHHS personnel review all disenrollments from the HSW prior to the effective date of the action by the PIHP excluding deaths and out-of-state moves which are reviewed after the effective date.

HSW Interim Payments: Per attachment P.8.0.1, the HSW interim payment will be based upon:

- Base Rates for HSW
- Residential Living Arrangement factor
- Placement from ICF/ IID – Mt. Pleasant factor
- Multiplicative Factor for geographic region
- For HSW enrollees of a PIHP that includes the county of financial responsibility (COFR), referred to as the "responsible PIHP", but whose county of residence is in another PIHP, referred to as the "residential PIHP", the HSW interim payment will be paid to the COFR within the "responsible PIHP" based on the multiplicative factor for the "residential PIHP".

The HSW interim payment will be scheduled to occur monthly. Adjustments to the payment schedule may occur to accommodate processing around State Holidays. Additional payments may be scheduled as required.

The monthly HSW interim payment will include payment for HSW enrolled beneficiaries who have met eligibility requirements for the current month, as well as retro-payments for HSW enrolled beneficiaries who met eligibility requirements for prior months, e.g., Medicaid deductible and/or retro-Medicaid eligibility. In addition, the HSW payment may be adjusted for:

- Recovery of payments previously made to beneficiaries prior to MDHHS notification of death
- Recovery of payments previously made to beneficiaries, who upon retrospective review, did not meet all HSW enrollment requirements
- Modifications to any of the HSW rate development factors

The PIHP must be able to receive and transmit HIPAA compliant files, such as:

- 834 – Enrollment/Eligibility
- 820 – Payment / Remittance Advice
- 837 – Encounter

Encounters for provision of services authorized in the CMS approved waiver must contain HK modifier to be recognized as valid HSW encounters. Valid HSW encounters must be submitted within 90 days of provision of the service regardless of claim adjudication status in order to assure timely HSW service verification.

The HSW interim payment for a service month will be recouped if there is no HSW-specific service encounter(s) accepted into the warehouse with a date of service for that month since this means that the service provision requirement has not been met. Once the recoupment has taken place, the PIHP should submit any corrected and valid HSW encounters; however, the recouped payment for that service month will not be repaid (e.g., no more final 'sweeps' or subsequent retro payments). It is intended that recoupments will take place in the fourth month following the service month. For example, October payments would be recouped in February.

8.4.1.5 Expenditures for Medicaid 1915 State Plan, 1915(b)(3), 1915(c), MIChild and Healthy Michigan Services

On an ongoing basis, the PIHP can flexibly and interchangeably expend capitation payments received through the five sources or “buckets.” Once capitation payments are received, the PIHP may spend any funds received on 1915(b) state plan, (b)(3), 1115 Healthy Michigan Plan, MIChild or 1915(c) waiver services. All funds must be spent on Medicaid beneficiaries for Medicaid services. These funds cannot be used for expenditures for Healthy Michigan Services.

While there is flexibility in month-to-month expenditures and service utilization related to the five “buckets,” the PIHP must submit encounter data on service utilization - with transaction code modifiers that identify the service as 1915(b) state plan, (b)(3) services, or 1915(c) services – and this encounter data (including cost information) will serve as the basis for future 1915(b) state plan, (b)(3) services, and 1915(c) waiver interim payment rate development.

The PIHP has certain coverage obligations to MIChild enrollees and to Medicaid beneficiaries under the 1915(b) waiver (both state plan and (b)(3) services), and to enrollees under the 1915(c) waiver. It must use capitation payments to address these obligations.

The PIHP must monitor and track revenues and expenditures on 1915(b) state plan services, (b)(3) services, and 1915(c) services and assure that aggregate expenditures for (b)(3) services do not grow or rise faster than the respective aggregate expenditures for 1915(b) state plan and 1915(c) services.

Expenditures for Healthy Michigan Services must be covered by Healthy Michigan Plan capitation payment only.

8.4.1.6 MDHHS Incentive – Monetary Payments

The MDHHS Incentive payment will be made to the PIHPs based on children identified on the Quality Improvement File for whom the PIHP submitted an encounter. For the PIHPs to be eligible for an incentive payment the child must meet the following requirements:

- Have a Serious Emotional Disturbance (as defined by Michigan law)
- Eligible for Medicaid
- Be between the ages of 0 to 18
- Served in the MDHHS Foster Care System or Child Protective Services (Risk Categories I & II)
- Meets one of the following service criteria:
    - Service Criteria 1: At least one of the following services was provided in the eligible month:
        - H2021 – Wraparound Services
        - H0036 – Home Based Services
    - Service Criteria 2: Two or more state plan and/or 1915(b)(3) mental health services covered under the 1915(b) Specialty Supports and Services Waiver, excluding one-time assessments, were provided in the eligible month.

Incentive Payments: The incentive payment will occur quarterly. Each incentive payment will be determined by comparing the PIHP's identified eligible children with the encounter data submitted. Valid encounters must be submitted within 90 days of the provision of the service regardless of the claim adjudication status in order to assure timely incentive payment verification. Once the incentive payment has taken place there will not be any opportunities for submission of eligible children for a quarterly payment already completed.

Quarterly incentive payments will occur as follows:

1. April 2017: Based on eligible children and the supporting encounter data submitted for October 1, 2016 – December 31, 2016.
2. July 2017: Based on eligible children and the supporting encounter data submitted for January 1, 2017 – March 31, 2017.
3. October 2016: Based on eligible children and the supporting encounter data submitted for April 1, 2016 – June 30, 2016.
4. January 2017: Based on eligible children and the supporting encounter data submitted for July 1, 2016 – September 30 2016.

The MDHHS will provide access to an electronic copy of the names of those individuals eligible for incentive payments, which incentive payment amount they are to receive, and the COFR.

The incentive payments will be adjusted upward or downward to ensure that aggregate fiscal year payment matches available funding. Therefore, these incentive payments are contingent upon available funds and can be terminated at any time if funds are not available.

8.4.1.7 Autism Benefit Payments

Payments to the PIHPs under this benefit will occur in two ways and include administrative costs for training and the provision of monthly interim payments. The administrative costs for training will be paid to each of the PIHPs prospectively in the form of a gross adjustment. There will be no cost settlement on the administrative costs for training. For the Applied Behavior Analysis

(ABA) services, monthly interim payments will be paid retrospectively. Each interim payment will be issued at one of two levels, Early Intensive Behavioral Intervention (EIBI) or Applied Behavioral Intervention (ABI), and will be triggered by the combination of meeting the criteria for this benefit at a particular level, as laid out in the MSA Bulletin Number: MSA 13-09 and the 1915 (i) SPA, and having at least one encounter submitted by the end of the fourth month after a particular service month for that month. A cost settlement process will cover the actual costs associated with ABA services, as well as assessments related to potential eligibility for these services, submitted for a particular fiscal year. This process could result in additional payment to or recoupment from each PIHP. That cost settlement process will take place no earlier than the March after the fiscal year being settled.
The rates for the monthly interim payments for the period January 1, 2014 through September 30, 2014 are:

Applied Behavioral Analysis (ABI): $1,925

Early Intensive Behavioral Intervention (EIBI): $2,673

Monthly Interim Payments for relevant PIHP MIChild benefits will be paid in the same manner and at the same rate as the Medicaid interim payment and will be cost settled. There will be no administrative training costs paid for the MIChild benefit.

The cost settlement process will separately settle the Medicaid interim payments and MI Child interim payments against the actual service costs for each category.

8.4.1.8 MIChild

The MDHHS shall provide to the PIHP the Federal and matching share of MIChild funds as a capitated payment based upon actuarially sound Per Enrolled Child Per Month (PECPM) methodology for MIChild-covered mental health services. The primary MIChild payment will be paid monthly. When applicable, additional payments may be scheduled (i.e., retro-rate implementation or adjustments to ensure actuarial soundness resulting from changes in treatment access or scope, duration or intensity of services necessary to meet medical necessity). HIPPA compliant 834 and 820 transactions will provide eligibility and remittance information. See attached P.8.0.1 for the PECPM rates.

8.4.2 Contract Withholds

The Department shall withhold .002 of the approved capitation payment to each PIHP. The withheld funds shall be issued by the Department to the PIHP in the following amounts within 60 days of when the required report is received by the Department:

1. .0004 for timely submission of the Projection Financial Status Report – Medicaid
2. .0004 for timely submission of the Interim Financial Status Report – Medicaid
3. .0004 for timely submission of the Final Medicaid Contract Reconciliation and Cash Settlement
4. .0004 for timely submission of the Medicaid Utilization and Cost Report
5. 0004 for timely submission of encounters (defined in Attachment P 7.7.1.1.)

In accordance with section 105d (18) of Public Act 107 of 2013, the Department shall also withhold 0.75% of payments to PIHPS for the purpose of establishing a performance bonus incentive pool. Distribution of funds from the performance bonus incentive pool will be contingent on the PIHP's completion of the required performance of compliance metrics.

Specific methodologies for implementing and distributing these withheld funds will be established by the Department after consultation with PIHPs and included in an amendment to the FY16 contract.

8.4.2.1. 2016 Performance Bonus Integration of Behavioral Health and Physical Health Services

In an effort to ensure collaboration and integration between Medicaid Health Plans (MHPs) and Pre-paid Inpatient Health Plans (PIHPs), the Department of Health and Human Services has developed the following joint expectations for both entities. This excludes beneficiaries seeking SUD services unless appropriate consent is obtained. Each plan (both PIHP and MHP) will submit a response for each criterion. There are 100 points possible for this initiative in FY2016. FY2016 will be a process year working toward quantifiable results in FY2017. Separate and apart from the processes outlined below, FY2016 MDHHS will pull baseline data on the **Follow-up after Hospitalization for Mental Illness (FUH) measure for shared populations.** Baseline data will be published and a standard set for FY2017. If the processes below are successful, we would expect to see increases in this measure.

Category	Description	Criteria/Deliverables

1. **Identification of and Access to Data on Joint Members** (20 points)	Systems and processes related to regular, meaningful exchange of clinically relevant data between entities
	• Identification of Shared Members
	• Bi-directional Exchange (from Contract)
	• CC360
	  o Regular Reports
	  o Customizable Extracts
	• MiHIN
	  o Use Cases
	  o Active Care Relationship Service
	  o Admission, Discharge, Transfer (ADT) Messaging
		1. By March 1, 2016 PIHP and MHP will attend a meeting convened by MDHHS to discuss CC360 and MiHIN application and potential use as data sources
		2. By April 1, 2016 PIHP and MHP will submit policies/processes to demonstrate that they have systems and processes in place to confidentially do the following:
		  a. On a monthly basis, identify which members are assigned to an MHP and have sought services through the PIHP. This should include but is not limited to the following data elements (name, DOB, Medicaid ID number, providers seen, medications, diagnoses)
		  b. Receive information from electronic sources such as CC360 or HIT/HIE including:
		  ▪ Which reports are received at what

		interval including customizable extracts and how this information is shared between PIHP and MHP c. Participate with MIHIN including: ▪ Which Use Cases they are participating in ▪ Active Care Relationships are being established for shared members ▪ ADT messaging is being received and appropriately shared
2. **Development of Joint Care Management Standards and Processes** (30 points)	Appropriate communication exists and sufficient efforts are being made to support success in integration.	1. By July 1, 2016 plans will submit a narrative description of efforts to develop joint care management standards and processes including dates, attendees, and brief meeting notes to document that a minimum of three meetings took place between MHP and PIHP.
3. **Implementation of Joint Care Management Processes** (50 points)	Collaboration between entities for the ongoing coordination and integration of services	4. By September 1, 2016, MHP and PIHP will demonstrate that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities and have consented to a joint care plan. a. DHHS will generate a random list of members and share with both PIHP and MHP. Plans will submit the joint care plans to DHHS within the specified time frame. 2. By October 1, 2016 MHP and PIHP will submit a narrative description including dates, attendees, and examples of the diagnoses of members discussed to document attendance at monthly care management meetings.

8.5 Operating Practices
The PIHP shall adhere to Generally Accepted Accounting Principles and other federal and state regulations. The final expenditure report shall reflect incurred but not paid claims. PIHP program accounting procedures must comply with:

- Generally Accepted Accounting Principles for Governmental Units.
- Audits of State and Local Governmental Units, issued by the American Institute of Certified Public Accountants (current edition).
- OMB Circular 2 CFR 200 Subpart E

8.6 Financial Planning
In developing an overall financial plan, the PIHP shall consider the parameters of the MDHHS/PIHP shared-risk corridor, the reinvestment of savings, and the strategic approach in the management of risk, as described in the following sub-sections.

8.6.1 Risk Corridor
The shared risk arrangements shall cover all Medicaid 1915, 1915(b)(3), 1115 Healthy Michigan Plan capitation and 1915(c) Habilitation Supports Waiver payments. The risk corridor is administered across all services, with no separation for mental health and substance abuse funding.

A. The PIHP shall retain unexpended risk-corridor-related funds between 95% and 100% of said funds. The PIHP shall retain 50% of unexpended risk-corridor related funds between 90% and 95% of said funds. The PIHP shall return unexpended risk-corridor-related funds to the MDHHS between 0% and 90% of said funds and 50% of the amount between 90% and 95%.
B. The PIHP may retain funds noted in 8.6.1.A, except as specified in Part 1, section 16.0 “Closeout”.
C. The PIHP shall be financially responsible for liabilities incurred above the risk corridor-related operating budget between 100% and 105% of said funds contracted.
D. The PIHP shall be responsible for 50% of the financial liabilities above the risk corridor-related operating budget between 105% and 110% of said funds contracted.
E. The PIHP shall not be financially responsible for liabilities incurred above the risk corridor-related operating budget over 110% of said funds contracted.

The assumption of a shared-risk arrangement between the PIHP and the MDHHS shall not permit the PIHP to overspend its total operating budget for any fiscal year.

The PIHP shall not pass on, charge, or in any manner shift financial liabilities to Medicaid beneficiaries resulting from PIHP financial debt, loss and/or insolvency.

The PIHP financial responsibility for liabilities for costs between 100% and 110% must first be paid from the PIHP’s ISF for risk funding or insurance for cost over-runs. The ISF balance shall be tracked by Medicaid and Healthy Michigan funds contributed. Each portion of the ISF shall retain its character as Medicaid and Healthy Michigan Funds and shall not be used for risk financing across the Medicaid and Healthy Michigan programs. Medicaid ISF amounts shall only be used for Medicaid cost over runs into the risk corridor and Healthy Michigan ISF amounts shall only be used for Healthy Michigan cost over runs into the risk corridor.

If the PIHP's liability exceeds the amount available from ISF and insurance, other funding available to the PIHP may be utilized in accordance with the terms of the PIHP's Risk Management Strategy.

8.6.2 Savings and Reinvestment
Provisions regarding the Medicaid and Healthy Michigan Plan savings and the PIHP reinvestment strategy are included in the following subsections. It should be noted that only a PIHP may earn and retain Medicaid/Healthy Michigan Plan savings. CMHSPs may not earn or retain Medicaid/Healthy Michigan Plan savings. Note that these provisions may be limited or canceled by the closeout provision in Part I, Section 16.0 Closeout, and may be modified by actions stemming from Part II A, Section 9.0 Contract Remedies and Sanctions.

8.6.2.1 Medicaid Savings
The PIHP may retain unexpended Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization. These funds shall be included in the PIHP reinvestment strategy as described below. All Medicaid savings funds reported at fiscal year-end must be expended within one fiscal year following the fiscal year earned for Medicaid services to Medicaid covered consumers. All Healthy Michigan Plan savings funds reported at fiscal year-end must be expended within one fiscal year following the fiscal year earned for Healthy Michigan Plan services to Healthy Michigan Plan covered consumers. If MDHHS and CMS approval is required of the reinvestment plan the savings must be expended by the end of the fiscal year following the year the plan is approved. In the event that a final MDHHS audit report creates new Medicaid/Healthy Michigan Plan savings, the PIHP will have one year following the date of the final audit report to expend those funds according to Section 8.6.2.2. Unexpended Medicaid/Healthy Michigan Plan savings shall be returned to the MDHHS as part of the year-end settlement process. MDHHS will return the federal share of the unexpended savings to CMS.

8.6.2.2 Reinvestment Strategy - Medicaid Savings
The PIHP shall develop and implement a reinvestment strategy for all Medicaid savings realized. The PIHP reinvestment strategy shall be directed to the Medicaid population.

All Medicaid savings must be invested according to the criteria below. Any of these funds that remain unexpended at the end of the fiscal year must be returned to the MDHHS as part of the year-end settlement process.

8.6.2.3 Community Reinvestment Strategy
Services and supports must be directed to the Medicaid population. Community reinvestment plans to provide services contained in the State Medicaid Manual do not require prior approval by CMS and MDHHS. They must be expended in the fiscal year following the year they are earned. Prior approval by MDHHS and CMS is required for plans that include other expenditures in the community reinvestment plan. These must be expended within the fiscal year after the year of the CMS and MDHHS approval. Community reinvestment funds are to be invested in accordance with the following criteria:

Development of new treatment, support and/or service models; these shall be additional 1915(b)(3) services to Medicaid beneficiaries as allowed under the cost savings aspect of the waiver:

- Expansion or continuation of existing state plan or 1915(b)(3) approved treatment, support and/or service models to address projected demand increases.
- Community education, prevention and/or early intervention initiatives.
- Treatment, support and/or service model research and evaluation.
- The PIHP may use up to 15% of Medicaid savings for administrative capacity and infrastructure extensions, augmentations, conversions, and/or developments to: (a) assist the PIHP (as a PIHP) to meet new federal and/or state requirements related to Medicaid or Medicaid-related managed care activities and responsibilities; (b) implement consolidation or reorganization of specific administrative functions related to the Application for Participation and pursuant to a merger or legally constituted affiliation; or (c) initiate or enhance recipient involvement, participation, and/or oversight of service delivery activities, quality monitoring programs, or customer service functions.
- Identified benefit stabilization purposes. Benefit stabilization is designed to enable maintenance of contracted benefits under conditions of changing economic conditions and payment modifications. This enables the PIHP to utilize savings to assure the availability of benefits in the following year.

The reinvestment strategy becomes a contractual performance objective. All Medicaid savings funds must be expended within one fiscal year following CMS approval of the reinvestment plan. The PIHP shall document for audit purposes the expenditures that implement the reinvestment plan. Unexpended Medicaid savings shall be returned to the MDHHS as part of the year-end settlement process.

8.6.3 Risk Management Strategy

Each PIHP must define the components of its risk management strategy that is consistent with general accounting principles as well as federal and state regulations.

8.6.4 PIHP Assurance of Financial Risk Protection

The PIHP must provide to MDHHS upon request, documentation that demonstrates financial risk protections sufficient to cover the PIHP's determination of risk. The PIHP must update this documentation any time there is a change in the information.

The PIHP may use one or a combination of measures to assure financial risk protection, including pledged assets, reinsurance, and creation of an ISF. The use of an ISF in this regard must be consistent with the requirements of OMB Circular 2 CFR 200 Subpart E. Please see attachment P.8.6.4.1 Internal Service Fund Technical Requirement.

The PIHP will submit a specific written Risk Management Strategy to the Department no later than December 3, 2014. The Risk Management strategy will identify the amount of reserves, insurance and other revenues to be used by the PIHP to assure that its risk commitment is met. Whenever General Funds are included as one of the listed revenue sources, MDHHS may disapprove the list of revenue sources, in whole or in part, after review of the information provided and a meeting with the PIHP. Such a meeting will be convened within 45 days after submission of the risk management strategy. If disapproval is not provided within 60 days following this meeting, the use of general funds will be considered to be allowed. Such disapproval will be provided in writing to the PIHP within 60 days of the first meeting between MDHHS and the PIHP. Should circumstances change, the PIHP may submit a revision to its Risk Management Strategy at any time. MDHHS will provide a response to this revision, when

it changes the PIHPs intent to utilize General Funds to meet its risk commitment, within 30 days of submission.

8.7 Finance Planning, Reporting and Settlement
The PIHP shall provide financial reports to the MDHHS as specified in this contract, and on forms and formats specified by the MDHHS. Forms and instructions are posted to the MDHHS website at: http://www.michigan.gov./mdhhs/0,1607,7-132-2941 38765---,00.html (See Finance Planning, Reporting and Settlement section of Attachment P 7.7.1.1)

8.8 Legal Expenses
The following legal expenses are ALLOWABLE:

- Legal expenses required in the administration of the program on behalf of the State of Michigan or Federal Government.
- Legal expenses relating to employer activities, labor negotiation, or in response to employment related issues or allegations, to the extent that the engaged services or actions are not prohibited under federal principles of allowable costs.
- Legal expenses incurred in the course of providing consumer care.

The PIHP must maintain documentation to evidence that the legal expenses are allowable. Invoices with no detail regarding services provided will not be sufficient documentation.

The following legal expenses are UNALLOWABLE:

- Where the Michigan Department of Health and Human Services (MDHHS) or the Centers for Medicare & Medicaid Services (CMS) takes action against the provider by initiating an enforcement action or issuing an audit finding, then the legal costs of responding to the action are allowable in these circumstances.
- The PIHP prevails and the action is reversed. Example: The audit finding is not upheld and the audit adjustment is reversed.
- The PIHP prevails as defined by reduction of the contested audit finding(s) by 50 percent or more. Example: An audit finding for an adjustment of $50,000 is reduced to $25,000. Or, in the case of several audit findings, a total adjustment of $100,000 is reduced to $50,000.
- The PIHP enters into a settlement agreement with MDHHS or CMS prior to any Hearing.
- Legal expenses for the prosecution of claims against the State of Michigan or the Federal Government.
- Legal expenses contingent upon recovery of costs from the State of Michigan or the Federal Government.

8.9 Performance Objectives
PIHP performance objectives are included in Attachment P 8.9.1.

9.0 CONTRACT REMEDIES AND SANCTIONS

The state will utilize a variety of means to assure compliance with contract requirements and with the provisions of Section 330.1232b of Michigan's Mental Health Code, regarding Specialty Prepaid Inpatient Health Plans. The state will pursue remedial actions and possibly sanctions as needed to resolve outstanding contract violations and performance concerns. The application of remedies and sanctions shall be a matter of public record. If action is taken under the provisions

of Section 330.1232b of the Mental Health Code, an opportunity for a hearing will be afforded the PIHP, consistent with the provisions of Section 330.1232b.(6).

The MDHHS will utilize actions in the following order:

A. Notice of the contract violation and conditions will be issued to the PIHP with copies to the Board.
B. Require a plan of correction and specified status reports that becomes a contract performance objective.
C. If previous items above have not worked, impose a direct dollar penalty and make it a non-matchable PIHP administrative expense and reduce earned savings from that fiscal year by the same dollar amount.
D. For sanctions related to reporting compliance issues, MDHHS may delay up to 25% of scheduled payment amount to the PIHP until after compliance is achieved. MDHHS may add time to the delay on subsequent uses of this provision. (Note: MDHHS may apply this sanction in a subsequent payment cycle and will give prior written notice to the PIHP)
E. Initiate contract termination.

The implementation of any of these actions does not require a contract amendment to implement. The sanction notice to the PIHP is sufficient authority according to this provision. The use of remedies and sanctions will typically follow a progressive approach, but the MDHHS reserves the right to deviate from the progression as needed to seek correction of serious, or repeated, or patterns of substantial non-compliance or performance problems. The PIHP can utilize the dispute resolution provision of the contract to dispute a contract compliance notice issued by the MDHHS.

The following are examples of compliance or performance problems for which remedial actions including sanctions can be applied to address repeated or substantial breaches, or reflect a pattern of non-compliance or substantial poor performance. This listing is not meant to be exhaustive, but only representative.

A. Reporting timeliness, quality and accuracy
B. Performance Indicator Standards
C. Repeated Site-Review non-compliance (repeated failure on same item)
D. Substantial inappropriate denial of services required by this contract or substantial services not corresponding to condition. Substantial can be a pattern, large volume or small volume but severe impact.
E. Repeated failure to honor appeals/grievance assurances.
F. Substantial or repeated health and/or safety violations.

<u>Sanctions Non-monetary</u>: PIHPs are required to submit a plan of correction that addressed each review dimension for which there was a finding of partial or non-compliance. If a PIHP receives a repeat citation on a site review dimension, the MDHHS site review team may increase the size of the clinical record review sample for that dimension for the next site review.

Before imposing a sanction on a PIHP, the department shall provide that specialty prepaid inpatient health plan with timely written notice that explains both of the following:

a. The basis and nature of the sanction along with its statutory/regulatory/contractual basis and the objective evidence upon which the finding of fault is based.
b. The opportunity for a hearing to contest or dispute the department's findings and intended sanction, prior to the imposition of the sanction. A hearing under this section is subject to the provisions governing a contested case under the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.201 to 24.328, unless otherwise agreed to in the specialty prepaid health plan contract.

PART II (B)
SUBSTANCE USE DISORDER (SUD) SERVICES

1.0 STATEMENT OF WORK

The following section provides the budget, an explanation of the specifications and expectations that the Prepaid Inpatient Health Plan (PIHP) must meet and the substance use disorder services that must be provided under the contract. The Contractor agrees to undertake, perform and complete the services described in Attachment A, which is part of this agreement through reference.

The general SUD responsibilities of the PIHP under this Agreement, based on P.A. 500 of 2012, as amended, are to:

1. Develop comprehensive plans for substance use disorder treatment and rehabilitation services and substance use disorder prevention services consistent with guidelines established by the Department.
2. Review and comment to the Department of Licensing and Regulatory Affairs on applications for licenses submitted by local treatment, rehabilitation, and prevention organizations.
3. Provide technical assistance for local substance use disorder service programs.
4. Collect and transfer data and financial information from local programs to the Department of Licensing and Regulatory Affairs.
5. Submit an annual budget request to the Department for use of state administered funds for its substance use disorder treatment and rehabilitation services and substance use disorder prevention services in accordance with guidelines established by the Department.
6. Make contracts necessary and incidental to the performance of the department-designated community mental health entity’s and community mental-health services program’s functions. The contracts may be made with public or private agencies, organizations, associations, and individuals to provide for substance use disorder treatment and rehabilitation services and substance use disorder prevention services.
7. Annually evaluate and assess substance use disorder services in the department-designated community mental health entity in accordance with guidelines established by the Department.

1.1 Agreement Amount
The estimate of the funding to be provided by the MDHHS to the PIHP for SUD Community Grant activities is included as part of Attachment P 8.0.1 to this contract.

1.2 Purpose
The focus of the program is to provide for the administration and coordination of substance use disorder (SUD) services within the designated PIHP region.

1.3 Financial Requirements
The financial requirements shall be followed as described in Part II of this agreement and Attachment P.7.7.1.1 which is part of this agreement through reference.

1.4 Performance/Progress Report Requirements
The progress reporting methods, as applicable, shall be followed as described in Attachment P.7.7.1.1, which is part of this agreement through reference.

1.5 General Provisions
The Contractor agrees to comply with the General Provisions outlined in this agreement. The Contractor also agrees to comply with the reporting requirements found in Attachment P.7.7.1.1.and the requirements described in the SUD Services Policy Manual, which is part of this agreement through reference.

1.6 Action Plan
The PIHP will carry out its responsibilities under this Agreement consistent with the PIHP's most recent Action Plan as approved by the Department. The Annual Action Plan Guidelines are available on the MDHHS website at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html

2.0 SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT REQUIREMENTS AND APPLICABILITY TO STATE FUNDS

Federal requirements deriving from Public Law 102-321, as amended by Public Law 106-310, and federal regulations in 45 CFR Part 96 are pass-through requirements. Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requirements that are applicable to states are passed on to PIHPs unless otherwise specified.

42 CFR Parts 54 and 54a, and 45 CFR Parts 96, 260, and 1050, pertaining to the final rules for the Charitable Choice Provisions and Regulations, are applicable to PIHPs as stated elsewhere in this Agreement.

Sections from PL 102-321, as amended, that apply to PIHPs and contractors include but are not limited to:

- 1921(b)
- 1922 (a)(1)(2)
- 1922(b)(1)(2)
- 1923
- 1923(a)(1) and (2), and 1923(b
- 1924(a)(1)(A) and (B
- 1924(c)(2)(A) and (B)

- 1927(a)(1) and (2), and 1927(b)(1)
- 1927(b)(2): 1928(b) and (c)
- 1929
- 1931(a)(1)(A), (B), (C), (D), (E) and (F)
- 1932(b)(1)
- 1941
- 1942(a)
- 1943(b)
- 1947(a)(1) and (2)

2.1 Selected Specific Requirements Applicable to PIHPs

1. Block Grant funds shall not be used to pay for inpatient hospital services except under conditions specified in federal law.
2. Funds shall not be used to make cash payments to intended recipients of services.
3. Funds shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility, or purchase major medical equipment.
4. Funds shall not be used to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding.
5. Funds shall not be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.
6. Funds shall not be used to enforce state laws regarding the sale of tobacco products to individuals under the age of 18.
7. Funds shall not be used to pay the salary of an individual at a rate in excess of Level I of the Federal Executive Schedule, or approximately $199,700.

SAPT Block Grant requirements also apply to the Michigan Department of Health and Human Services (MDHHS) administered state funds, unless a written exception is obtained from MDHHS.

2.2 Program Operation

The PIHP shall provide the necessary administrative, professional, and technical staff for operation of the program.

2.3 Notification of Modifications

The PIHP shall provide timely notification to the Department, in writing, of any action by its governing board or any other funding source that would require or result in significant modification in the provision of services, funding or compliance with operational procedures.

2.4 Software Compliance

The PIHP must ensure software compliance and compatibility with the Department's data systems for services provided under this agreement including, but not limited to: stored data, databases, and interfaces for the production of work products and reports. All required data under this agreement shall be provided in an accurate and timely manner without interruption, failure or errors due to the inaccuracy of the Contractor's business operations for processing date/time data.

2.5 Licensure of Subcontractors

The PIHP shall enter into agreements for substance use disorder prevention, treatment, and recovery services only with providers appropriately licensed for the service provided as required by Section 6234 of P.A. 501 of 2012, as amended.

The PIHP must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state that such providers are accredited per the requirements of this Agreement, and that provider staff are credentialed per the requirements of this Agreement.

2.6 Accreditation of Subcontractors

The PIHP shall enter into agreements for treatment services provided through outpatient, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: The Joint Commission (TJC formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC). The PIHP must determine compliance through review of original correspondence from accreditation bodies to providers.

Accreditation is not needed in order to provide access management system (AMS) services, whether these services are operated by a PIHP or through an agreement with a PIHP or for the provision of broker/generalist case management services. Accreditation is required for AMS providers that also provide treatment services and for case management providers that either also provide treatment services or provide therapeutic case management. Accreditation is not required for peer recovery and recovery support services when these are provided through a prevention license.

If the PIHP plans to purchase case management services or peer recovery and recovery support services, and only these services, from an agency that is not accredited per this agreement, the PIHP may request a waiver of the accreditation requirement.

3.0 SAMHSA/DHHS LICENSE

The federal awarding agency, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services (SAMHSA/DHHS), reserves a royalty-free, nonexclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for federal government purposes: (a) The copyright in any work developed under a grant, sub-grant, or contract under a grant or sub-grant; and (b) Any rights of copyright to which a grantee, sub-grantee or a contractor purchases ownership with grant support.

4.0 MONITORING OF DESIGNATED WOMEN'S SUBCONTRACTORS

In addition to the requirements referenced in number eight above, the PIHP is also required to monitor all Designated Women's Programs (DWP) for the following:

1. Outreach activities to promote and advertise women's programming and priority population status.
2. Gender-Responsive policy for treating the population.
3. Education/Training of staff identified as women's specialty clinicians and supervisors. Required 12 semester hours equivalent to 64 workshop type training hours.

5.0 ADMINISTRATIVE AND FINANCIAL MATCH RULES

Pursuant to Section 6213 of Public Act No. 368 of 1978, as amended, Michigan has promulgated match requirement rules. Rules 325.4151 through 325.4153 appear in the 1981 Annual Administrative Code Supplement. In brief, the rule defines allowable matching fund sources and states that the allowable match must equal at least ten percent of each comprehensive PIHP budget (see Attachment P II B to the Agreement) - less direct federal and other state funds. Per PA 368, Administrative Rules, and contract, direct state/federal funds are funds that come to the PIHP directly from a federal agency or another state source. Funds that flow to the PIHP from the Department are not in this category, such as, SDA, and, therefore, are subject to the local match requirement.

Match requirements apply both to budgeted funds during the agreement period and to actual expenditures at year-end.

"Fees and collections" as defined in the Rule include only those fees and collections that are associated with services paid for by the PIHP.

If the PIHP is found not to be in compliance with Match requirements, or cannot provide reasonable evidence of compliance, the Department may withhold payment or recover payment in an amount equal to the amount of the Match shortfall.

5.1 Unobligated Funds

Any unobligated balance of funds held by the Contractor at the end of the agreement period will be returned to the Department or treated in accordance with instructions provided by the Department.

5.2 Fees

The PIHP shall make reasonable efforts to collect 1st and 3rd party fees, where applicable, and report these as outlined by the Department's fiscal procedures. Any under recoveries of otherwise available fees resulting from failure to bill for eligible services will be excluded from reimbursable expenditures.

5.3 Reporting Fees and Collections Revenues

On the initial Revenues and Expenditures Report (RER), the PIHP is required to report all estimated fees and collections revenue to be received by the PIHP and all estimated fees and collections revenue to be received and reported by its contracted services providers (see Attachment P II B to this Agreement). On the final RER, the PIHP is required to report all actual fees and collections revenue received by the PIHP and all actual fees and collections revenue received and reported by its contracted services providers (see Attachment P.7.7.1.1 to this Agreement). "Fees and collections" are as defined in the Annual Administrative Code Supplement, Rule 325.4151 and in the Match Rule section of this Attachment.

5.4 Management of Department-Administered Funds

The PIHP shall manage all Department-administered funds under its control in such a way as to assure reasonable balance among the separate requirements for each funds source.

5.5 Sliding Fee Scale

The PIHP shall implement a sliding fee scale and attach a copy to the initial application every fiscal year, for Department approval. All treatment and prevention providers shall utilize the PIHP sliding fee scale. The sliding fee scale must be established according to the most recent

year's Federal Poverty Guidelines. It must consist of a minimum of two distinctive fees based upon the income and family size of the individual seeking substance use disorders services.

The PIHP must assure that all available sources of payments are identified and applied prior to the use of Department-administered funds. The PIHP must have written policies and implement procedures to be used by network providers in determining an individual's ability or inability to pay, when payment liability is to be waived, and in identifying all other liable third parties. The PIHP must also have policies and procedures for monitoring providers and for sanctioning noncompliance.

Financial information needed to determine ability to pay (financial responsibility) must be reviewed annually or at a change in an individual's financial status, whichever occurs sooner. The scale must be applied to all persons (except Medicaid, and MIChild, recipients) seeking substance use disorders services funded in whole or in part by the PIHP. The PIHP has the option to charge fees for AMS services, or not to charge. If the PIHP charges for AMS services, the same sliding fee scale as applied to treatment services must be used.

5.6 Inability to Pay

Services may not be denied because of inability to pay. If a person's income falls within the PIHP's regional sliding fee scale, clinical need must be determined through the standard assessment and patient placement process. If a financially and clinically eligible person has third party insurance, that insurance must be utilized to its full extent. Then, if benefits are exhausted, or if the person needs a service not fully covered by that third party insurance, or if the co-pay or deductible amount is greater than the person's ability to pay, Community Grant funds may be applied. Community Grant funds may not be denied solely on the basis of a person having third party insurance.

5.7 Subcontracts with Hospitals

Funds made available through the Department shall not be made available to public or private hospitals which refuse, solely on the basis of an individual's substance use disorder, admission or treatment for emergency medical conditions.

6.0 RESIDENCY IN PIHP REGION

The PIHP may not limit access to the programs and services funded by this portion of the Agreement only to the residents of the PIHP's region, because the funds provided by the Department under this Agreement come from federal and statewide resources. Members of federal and state-identified priority populations must be given access to screening and to assessment and treatment services, consistent with the requirements of this portion of the Agreement, regardless of their residency. However, for non-priority populations, the PIHP may give its residents priority in obtaining services funded under this portion of the Agreement when the actual demand for services by residents eligible for services under this portion of the Agreement exceeds the capacity of the agencies funded under this portion of the Agreement.

7.0 REIMBURSEMENT RATES FOR COMMUNITY GRANT, MEDICAID AND OTHER SERVICES

The PIHP must pay the same rate when purchasing the same service from the same provider, regardless of whether the services are paid for by Community Grant funds, Medicaid funds, or other Department administered funds, including MIChild funds.

8.0 MINIMUM CRITERIA FOR REIMBURSING FOR SERVICES TO PERSONS WITH

CO-OCCURRING DISORDERS

Department funds made available to the PIHP through this Agreement, and which are allowable for treatment services, may be used to reimburse providers for integrated mental health and substance use disorder treatment services to persons with co-occurring substance use and mental health disorders. The PIHP may reimburse a Community Mental Health Services Program (CMHSP) or Pre-paid Inpatient Health Plan (PIHP) for substance use disorders treatment services for such persons who are receiving mental health treatment services through the CMHSP or PIHP. The PIHP may also reimburse a provider, other than a CMHSP or PIHP, for substance use disorders treatment provided to persons with co-occurring substance use and mental health disorders. As always, when reimbursing for substance use disorders treatment, the PIHP must have an agreement with the CMHSP (or other provider); and the CMHSP (or other provider) must meet all minimum qualifications, including licensure, accreditation and data reporting.

9.0 MEDIA CAMPAIGNS

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media. Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. Media campaigns must be compatible with MDHHS values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. The PIHP shall not finance any media campaign using Department-administered funding without prior written approval by the Department.

10.0 NOTICE OF EXCESS OR INSUFFICIENT FUNDS (NEIF)

PIHP's must notify the Department in writing if the amount of State Agreement funding may not be used in its entirety or appears to be insufficient. The notice must be submitted electronically by June 1 to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov

The contract requires that the PIHP expend all allocated funds per the requirements of the SUD contract within the contract year OR notify the Department via the NEIF that spending by year-end will be less than the amount(s) allocated. This requirement applies to individual allocations, earmarks and to the total PIHP allocation. Of particular importance are allocations for Prevention services and Women's Specialty Services (WSS), including the earmarked allocations for the Odyssey programs. The State must closely monitor these expenditures to ensure compliance with the Maintenance of Effort requirement in the federal SAPT Block Grant.

When it has been determined that a PIHP will not expend all of its allocated, WSS State Agreement funds (including the earmarked allocations for the Odyssey programs), these unspent funds must be returned to the Department for reallocation to other PIHPs who can appropriately use these funds for WSS programs within their PIHP regions within the current fiscal year. A PIHP's failure to expend these funds for the purposes for which they are allocated and/or its failure to notify the Department of projected expenditures at levels less than allocated may result in reduced allocations to the PIHP in the subsequent contract year.

11.0 SUBCONTRACTOR INFORMATION TO BE RETAINED AT THE PIHP

1. Budgeting Information for Each Service.
2. Documentation of How Fixed Unit Rates Were Established: The PIHP shall maintain documentation regarding how each of the unit rates used in its agreements was established. The process of establishing and adopting rates must be consistent with

criteria in OMB Circular 2 CFR 200 Subpart E, and with the requirements of individual fund sources.

3. Indirect Cost Documentation: The PIHP shall review subcontractor indirect cost documentation in accordance with OMB Circular 2 CFR 200 Subpart E, as applicable.
4. Equipment Inventories: The PIHP must apply the following to all subcontractors that have budgeted equipment purchases in their contracts with the PIHP:
    a. Any contractor equipment purchases supported in whole or in part through this agreement must be listed in the supporting Equipment Inventory Schedule. Equipment means tangible, non-expendable, personal property having useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. Title to items having a unit acquisition cost of less than $5,000 shall vest with the Contractor upon acquisition. The Department reserves the right to retain or transfer the title to all items of equipment having a unit acquisition cost of $5,000 or more, to the extent that the Department's proportionate interest in such equipment supports such retention or transfer of title.
5. Fidelity Bonding Documentation: The PIHP shall maintain fidelity bonding documentation.

12.0 LEGISLATIVE REPORTS (LRS) AND FINANCIAL REPORTS

If the PIHP does not submit the LR or the final RER (which includes MIChild Year-end Balance Worksheets and Administration / Service Coordination Report) within fifteen (15) calendar days of the due date, the Department may withhold from the current year funding an amount equal to five (5) percent of that funding (not to exceed $100,000) until the Department receives the required report. The Department may retain the amount withheld if the contractor is more than forty-five (45) calendar days delinquent in meeting the filing requirements.

The PIHP must assure that the financial data in these reports are consistent and reconcile between the reports; otherwise, the reports will be considered as not submitted and will be subject to financial penalty, as previously mentioned. Additional financial penalties are applicable to the Notice of Excess and Insufficient Funds.

The Department may choose to withhold payment when any financial report is delinquent by thirty (30) calendar days or more and may retain the amount withheld if the report is sixty (60) or more calendar days delinquent. This does not apply to the LR and final RER, as previously stated.

Financial reports are:

1. Revenues and Expenditures Report—INITIAL and FINAL;
2. Financial Status Report—1st thru 3rd quarter;
3. Financial Status Report—4th quarter;
4. Notice of Excess or Insufficient Funds; and
5. Primary Prevention Expenditures by Strategy Report.

13.0 NATIONAL OUTCOME MEASURES (NOMS)

Complete, accurate, and timely reporting of treatment and prevention data is necessary for the Department to meet its federal reporting requirements. For the SUD Treatment NOMS, it is the PIHP's responsibility to ensure that the client information reported on these records accurately describes each client's status at admission first date of service (admission) and on the last day of service (discharge).

14.0 MICHIGAN PREVENTION DATA SYSTEM (MPDS)

PIHPs are required to collect and report the state-required prevention data elements throughout the prevention provider network either through participation in the MPDS or through an upload of the state-required prevention data records to MPDS on a monthly basis.

PIHPs must assure that all records submitted to the state system are consistent with the MPDS Reference Manual. (See SUD Services Policy Manual.)

It is the responsibility of the PIHPs to ensure that the services reported to the system accurately reflects staff service provision and participant information for all PIHP-administered fund sources. It is the responsibility of the PIHPs to monitor provider completeness, timeliness and accuracy of provider data maintained in the system in a manner which will ensure a minimum of 90 percent accuracy.

15.0 CLAIMS MANAGEMENT SYSTEM

The PIHP shall make timely payments to all providers for clean claims. This includes payment at 90% or higher of clean claims from network providers within 60 days of receipt, and 99% or higher of all clean claims within 90 days of receipt.

A clean claim is a valid claim completed in the format and time frames specified by the PIHP and that can be processed without obtaining additional information from the provider. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A valid claim is a claim for services that the PIHP is responsible for under this Agreement. It includes services authorized by the PIHP.

The PIHP must have a provider appeal process to promptly and fairly resolve provider-billing disputes.

16.0 CARE MANAGEMENT

The PIHP may pay for care management as a service designed to support PIHP resource allocation as well as service utilization. Care management is in recognition that some clients represent such service or financial risk that closer monitoring of individual cases is warranted. Care management must be purchased and reported consistent with the instructions for the Administrative Expenditures Report in Attachment P.7.7.1.1 to this agreement.

17.0 PURCHASING DRUG SCREENS

This item does not apply to medication-assisted services.

Department-administered treatment funds can be used to pay for drug screens, if all of the following criteria are met:

1. No other responsible payment source will pay for the screens. This includes self-pay, Medicaid, and private insurance. Documentation must be placed in the client file;

2. The screens are justified by specific medical necessity criteria as having clinical or therapeutic benefit; and
3. Screens performed by professional laboratories can be paid for one time per admission to residential or detoxification services, if specifically justified. Other than these one-time purchases, Department funds may only be used for in house "dip stick" screens.

18.0 PURCHASING HIV EARLY INTERVENTION SERVICES

Department-administered Community Grant funds (blended SAPT Block Grant and General Fund) cannot be used to pay for HIV Early Intervention Services because Michigan is not a Designated State for HIV.

Per 45 CFR, Part 96, Substance Abuse Prevention and Treatment Block Grant, the definition of Early Intervention Services relating to HIV means:

1. appropriate pretest counseling for HIV and AIDS;
2. testing individuals with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease; appropriate post-test counseling; and
3. providing the therapeutic measures described in Paragraph (b) of this definition.

To review the full document, go to: http://law.justia.com/us/cfr/title45/45-1.0.1.1.53.12.html

19.0 SERVICES

19.1 12-Month Availability of Services

The PIHP shall assure that, for any subcontracted treatment or prevention service, each subcontractor maintains service availability throughout the fiscal year for persons who do not have the ability to pay.

The PIHP is required to manage its authorizations for services and its expenditures in light of known available resources in such a manner as to avoid the need for imposing arbitrary caps on authorizations or spending. “Arbitrary caps” are those that are not adjusted according to individualized determinations of the needs of clients. This requirement is consistent with Medical Necessity Criterion 1.4.3, under Treatment Services.

19.2 Persons Associated with the Corrections System

When the PIHP or its AMS services receives referrals from the Michigan Department of Corrections (MDOC), the PIHP shall handle such referrals as per all applicable requirements in this agreement. This would include determining financial and clinical eligibility, authorizing care as appropriate, applying admissions preferences, and other steps. MDOC referrals may come from probation or parole agents, or from MDOC Central Office staff. In situations where persons have been referred from MDOC and are under their supervision, state-administered funds should be used as the payment of last resort.

When persons who are on parole or probation seek treatment on a voluntary basis from the PIHP’s AMS services or from a panel provider, these self-referrals must be handled like any other self-referral to the MDHHS-funded network. AMS or provider staff may seek to obtain

releases to communicate with a person's probation or parole agent but in no instance may this be demanded as a condition for admission or continued stay.

The PIHP may collaborate with MDOC, and with the Office of Community Alternatives (OCA) within MDOC, on the purchase of substance use disorders services and supports. This may include collaborative purchasing from the same providers, and for the same clients. In such situations, the PIHP must assure that:

a. All collaborative purchasing is supported by written agreements among the participants.
b. Rates paid to providers, whether by a single purchaser or two or more purchasers, do not exceed provider costs.
c. Rates paid to providers are documented and are developed consistent with applicable OMB Circular(s).
d. No duplication of payment occurs.

19.3 State Disability Assistance (SDA) *(Applies Only to Agencies Who Have Allocations for this Program)*

MDHHS continues to allocate SDA funding and to delegate management of this funding to the PIHP. The PIHP is responsible for allocating these funds to qualified providers. Minimum provider qualifications are MDHHS licensure as a residential treatment provider and accreditation by one of the approved accreditation bodies (identified elsewhere in this Agreement). A provider may be located within the PIHP's region or outside of the region. SDA funds shall not be used to pay for room and board in conjunction with sub-acute detoxification services.

When a client is determined to be eligible for SDA funding, the PIHP must arrange for assessment and authorization for SDA room and board funding and must reimburse for SDA expenditures based on billings from providers, consistent with PIHP/provider agreements. In addition, the PIHP may authorize such services for its own residents at providers within or outside its region.

The PIHP shall not refuse to authorize SDA funds for support of an individual's treatment solely on the basis of the individual's current or past involvement with the criminal justice system. For those individuals currently involved with MDOC and receiving services as part of MDOC programming, SDA funds shall only be used as the payment of last resort.

Qualified providers may be reimbursed up to twenty-seven ($27) per day for room and board costs for SDA-eligible persons during their stays in Residential treatment.

To be eligible for MDHHS-administered SDA funding for room and board services in a substance use disorder treatment program, a person must be determined to meet Michigan Department of Health and Human Services' (MDHHS) eligibility criteria; determined by the PIHP or its designee to be in need of residential treatment services; authorized by the PIHP for residential treatment when the PIHP expects to reimburse the provider for the treatment; at least 18 years of age or an emancipated minor, and in residence in a residential treatment program each day that SDA payments are made.

The PIHP may employ either of two methods for determining whether an individual meets MDHHS eligibility criteria:

The PIHP may refer the individual to the local MDHHS human services office. This method must be employed when there is a desire to qualify the individual for an incidental allowance under the SDA program. Or,

The PIHP may make its own determination of eligibility by applying the essential MDHHS eligibility criteria. See this MDHHS link for details: http://www.michigan.gov/mdhhs/0,1607,7-124-5453_5526---,00.html

For present purposes only, these criteria are:

1. Residency in substance use disorders residential treatment.
2. Michigan residency and not receiving cash assistance from another state.
3. U.S. citizenship or have an acceptable alien status.
4. Asset limit of $3,000 (cash assets only are counted).

Regardless of the method used, the PIHP must retain documentation sufficient to justify determinations of eligibility.

The PIHP must have a written agreement with a provider in order to provide SDA funds.

19.4 Persons Involved with the Michigan Department of Health and Human Services (MDHHS)

The PIHP must work with the MDHHS office(s) in its region to facilitate access to prevention, assessment and treatment services for persons involved with MDHHS, including families in the child welfare system and public assistance recipients. The PIHP must develop written agreements with MDHHS offices that specify payment and eligibility for services, access-to-services priority, information sharing (including confidentiality considerations), and other factors as may be of local importance.

19.5 Primary Care Coordination

The PIHP must take all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care. In the case PIHPs that PIHPs contract for the Medicaid substance abuse program, PIHPs are reminded that coordination efforts must be consistent with these contracts.

Treatment case files must include, at minimum, the primary care physician's name and address, a signed release of information for purposes of coordination, or a statement that the client has refused to sign a release.

Care coordination agreements or joint referral agreements, by themselves, are not sufficient to show that the PIHP has taken all appropriate steps related to coordination of care. Client case file documentation is also necessary.

19.6 Charitable Choice

The September 30, 2003 Federal Register (45 CFR part 96) contains federal Charitable Choice SAPT block grant regulations, which apply to both prevention and treatment providers/programs. In summary, the regulations require: 1) that the designation of religious (or faith-based) organizations as such be based on the organization's self-identification as religious (or faith based), 2) that these organizations are eligible to participate as providers—e.g. a "level playing field" with regard to participating in the PIHP provider panel, 3) that a program beneficiary receiving services from such an organization who objects to the religious character of a program

has a right to notice, referral, and alternative services which meet standards of timeliness, capacity, accessibility and equivalency—and ensuring contact to this alternative provider, and 4) other requirements, including-exclusion of inherently religious activities and non-discrimination.

The PIHP is required to comply with all applicable requirements of the Charitable Choice regulations. The PIHP must ensure that treatment clients and prevention service recipients are notified of their right to request alternative services. Notice may be provided by the AMS or by providers that are faith-based. The PIHP must assign responsibility for providing the notice to the AMS, to providers, or both. Notification must be in the form of the model notice contained in the final regulations, or the PIHP may request written approval from MDHHS of an equivalent notice.

The PIHP must also ensure that its AMS administer the processing of requests for alternative services. This is applicable to all face-to-face services funded in whole or part by SAPT Block Grant funds, including prevention and treatment services. The PIHP must submit an annual report on the number of such requests for alternative services made by the agency during the fiscal year, per Attachment C-Required Reports.

The model notice contained in the federal regulations is:

No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice. If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

19.7 Treatment

Refer to Medicaid Manual Using criteria for medical necessity, a PIHP may:

1. Deny services a) that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care: b) that are experimental or investigational in nature: or c) for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support, that otherwise satisfies the standards for medically-necessary services: and/or
2. Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.
3. Not deny SUD services solely based on PRESET limits of the cost, amount, scope, and duration of services: but instead determination of the need for services shall be conducted on an individualized basis. This does not preclude the establishment of quantitative benefit limits that are based on industry standards and consistent with this contract, and that are provisional and subject to modification based on individual clinical needs and clinical progress.

20.0 CLINICAL ELIGIBILITY: DSM - -DIAGNOSIS

In order to be eligible for treatment services purchased in whole or part by state-administered funds under the agreement, an individual must be found to meet the criteria for one or more selected substance use disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM). These disorders are listed below. This requirement is not intended to prohibit use of these funds for family therapy. It is recognized that persons receiving family therapy do not necessarily have substance use disorders.

Cannabis Related Disorders:

305.20	Cannabis Use Disorder – Mild
304.30	Cannabis Use Disorder – Moderate/Severe
292.89	Cannabis Intoxication
292.0	Cannabis Withdrawal
292.9	Unspecified Cannabis-Related Disorder

Hallucinogen Related Disorders:

305.90	Phencyclidine Use Disorder – Mild
304.60	Phencyclidine Use Disorder – Moderate/Severe
305.30	Other Hallucinogen Use Disorder – Mild
304.50	Other Hallucinogen Use Disorder – Moderate/Severe
292.89	Phencyclidine Intoxication
292.89	Other Hallucinogen Intoxication
292.89	Hallucinogen Persisting Perception Disorder
292.9	Unspecified Phencyclidine Related Disorder
292.9	Unspecified Hallucinogen Related Disorder

Inhalant Related Disorders:

305.90	Inhalant Use Disorder – Mild
304.60	Inhalant Use Disorder – Moderate/Severe
292.89	Inhalant Intoxication
292.9	Unspecified Inhalant Related Disorder

Opioid Related Disorder:

305.50	Opioid Use Disorder – Mild
304.00	Opioid Use Disorder – Moderate/Severe
292.89	Opioid Intoxication
292.0	Opioid Withdrawal
292.9	Unspecified Opioid Related Disorder

Sedative, Hypnotic, or Anxiolytic (SHA) Related Disorders

305.40	SHA – Mild
304.10	SHA – Moderate/Severe
292.89	SHA Intoxication
292.0	SHA Withdrawal
292.9	Unspecified SHA Related Disorder

Stimulant Related Disorders:

Stimulant Use Disorder –

305.70	Amphetamine Type – Mild

305.60	Cocaine – Mild
305.70	Other or Unspecified Stimulant – Mild
304.40	Amphetamine Type – Moderate/Severe
304.20	Cocaine – Moderate/Severe

Stimulant Intoxication

292.89	Amphetamine or other stimulant, without perceptual disturbances
292.89	Cocaine, without perceptual disturbances
292.89	Amphetamine or other stimulant, with perceptual disturbances
292.89	Cocaine, with perceptual disturbances
292.0	Stimulant Withdrawal
292.9	Unspecified Stimulant Related Disorder

Alcohol Use Disorders

305.00	Alcohol Use Disorder – Mild
303.90	Alcohol Use Disorder – Moderate/Severe
303.00	Alcohol Intoxication
291.80	Alcohol Withdrawal
291.9	Unspecified Alcohol-Related Disorder

Other (unknown) Substance Related Disorders:

305.90	Other (unknown) Substance Use Disorder – Mild
304.90	Other (unknown) Substance Use Disorder – Moderate/Severe
292.89	Other (unknown) Substance Intoxication
292.0	Other (unknown) Substance Withdrawal
292.9	Unspecified Other (unknown) Substance Related Disorder

21.0 SATISFACTION SURVEYS

The PIHP shall assure that all network subcontractors providing treatment conduct satisfaction surveys of persons receiving treatment at least once a year. Surveys may be conducted by individual providers or may be conducted centrally by the PIHP. Clients may be active clients or clients discharged up to 12 months prior to their participation in the survey. Surveys may be conducted by mail, telephone, or face-to-face. The PIHP must compile findings and results of client satisfaction surveys for all providers, and must make findings and results, by provider, available to the public.

22.0 MI CHILD

The PIHP must assure use of a standardized assessment process, including the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, to determine clinical eligibility for services based on medical necessity.

Substance use disorder services are covered when medically necessary as determined by the PIHP. This benefit should be construed the same as are medical benefits in a managed care program. Inpatient (hospital-based) services are covered, but the PIHP is permitted to substitute less costly services outside the hospital if they meet the medical needs of the patient. In the same way, the PIHP may substitute services for inpatient or residential services if they meet the child's needs and they are more cost effective. Covered services are as follows:

1. Outpatient Treatment
2. Residential Treatment
3. Inpatient Treatment

4. Laboratory and Pharmacy

These benefits apply only when a PIHP's employed or contracted physician writes a prescription for pharmacy items or lab.

22.1 Eligibility
Eligible persons are persons of age 18 or less who are determined eligible for the MIChild program by the MDHHS and enrolled by the Department's administrative vendor and live in the region covered by the PIHP. The PIHP is responsible for determining eligibility and for charging all authorized and allowable services to the MIChild program up to the PIHP's annual MIChild revenues.

22.2 Per Enrolled Child Per Month

Enrollees who receive substance use disorder services must be entered into the Substance Use Disorder Statewide Client Data System following the instructions in the data reporting specifications.

For the required reporting of encounters for MIChild eligible clients, the PIHP e encounters via the 837 as follows:
2000B Subscriber Hierarchical Level
SBR Subscriber Information
SBR04 Insured Group Name: Use "MIChild" for the group name.
MIChild reporting requirement are found in Attachment B, Reporting Requirements, page 14, section A.

23.0 ACCESS TIMELINESS STANDARDS

Access timeliness requirements are the same as those applicable to Medicaid substance use disorders services, as specified in the agreement between MDHHS and the PIHPs. Access must be expedited when appropriate based on the presenting characteristics of individuals.

24.0 INTENSIVE OUTPATIENT TREATMENT – WEEKLY FORMAT

The PIHP may purchase Intensive outpatient treatment (IOP) only if the treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, for at least three days and at least nine hours per week.

25.0 SERVICES FOR PREGNANT WOMEN, PRIMARY CAREGIVER WITH DEPENDENT CHILDREN, CAREGIVER ATTEMPTING TO REGAIN CUSTODY OF THEIR CHILDREN

The PIHP must assure that providers screen and/or assess pregnant women, primary caregivers with dependent children, and primary Caregivers attempting to regain custody of their children to determine whether these individuals need and request the defined federal services that are listed below. All federally mandated services must be made available.

25.1 Federal Requirements
Federal requirements are contained in 45 CFR (Part 96) section 96.124, and may be summarized as:
Providers receiving funding from the state-administered funds set aside for pregnant women and women with dependent children must provide or arrange for the 5 types of services, as listed

below. Use of state administered funds to purchase primary medical care and primary pediatric care must be approved, in writing, in advance, by the Department contract manager.

1. Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such treatment, child care;
2. Primary pediatric care for their children, including immunizations;
3. Gender specific substance use disorders treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and childcare while the women are receiving these services;
4. Therapeutic interventions for children in custody of women in treatment, which may, among other things, address their developmental needs, issues of sexual and physical abuse, and neglect; and
5. Sufficient case management and transportation to ensure that women and their dependent children have access to the above mentioned services.

The above five types of services may be provided through the MDHHS/PIHP agreement only when no other source of support is available and when no other source is financially responsible. MDHHS extends the federal requirements above to primary caregivers attempting to regain custody of their children or at risk of losing custody of their children due to a substance use disorder. These individuals are a priority service population in Michigan and; therefore, the five federal requirements listed above shall be made available to them.

25.2 Requirements Regarding Providers

Women's Specialty Services may only be provided by providers that are designated as gender-responsive by the Department or as gender-competent by the PIHP and that meet standard panel eligibility requirements. The provider may be designated by the Department as Women's Specialty providers, but such designation is not required. The PIHP must continue to provide choice from a list of providers who offer gender-competent treatment and identify providers that provide the additional services specified in the federal requirements.

25.3 Financial Requirements on Quarterly FSRs

On each quarterly FSR, the PIHP must report all allowable Women's Specialty Services expenditures that utilize State Agreement funds. Those funds are Community Grant and/or State Disability Assistance.

25.4 Treatment Episode Data Set SUD (TEDS) and Encounter Reporting Requirements

For SUD TEDS reporting purposes, the Agency must code 'yes' for all women eligible for and receiving qualified women's specialty services. At admission, this can be coded based on eligibility. To qualify, the women must be either pregnant, have custody of a minor child, or be seeking to regain custody of a minor child. At minimum, the provider must be certified by the agency as gender competent. For all services that qualify based on qualifying characteristics both of the women and of the provider, the HD modifier must be used (See SUD Services Policy Manual/Section I Data Requirements: Substance Abuse Encounter Reporting HCPCS and Revenue Codes Chart).

26.0 ADMISSION PREFERENCE AND INTERIM SERVICES

The Code of Federal Regulations and the Michigan Public Health Code define priority population clients. The priority populations are identified as follows and in the order of importance:

1. Pregnant injecting drug user.

2. Pregnant.

Population	Admission Requirement	Interim Service Requirement	Authority
Pregnant Injecting Drug User	1) Screened & referred w/in 24 hrs. 2) Detox, Meth. or Residential – Offer Admission w/in 24 business hrs Other Levels of Care – Offer Admission w/in 48 Business hrs	**Begin w/in 48 hrs:** Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants Effects of alcohol & drug use on the fetus Referral for pre-natal care *Early Intervention Clinical Svc*	CFR 96.121; CFR 96.131; Tx Policy #04 Recommended
Pregnant Substance User	1) Screened & referred w/in 24 hrs 2) Detox, Meth or Residential Offer admission w/in 24 business hrs Other Levels of Care – Offer Admission w/in 48 Business hrs	**Begin w/in 48 hrs** 1. Counseling & education on: A. HIV & TB B. Risks of transmission to sexual partners & infants C. Effects of alcohol & drug use on the fetus 2. Referral for pre-natal care 3. *Early Intervention Clinical Svc*	CFR 96.121; CFR 96.131; Recommended
Injecting Drug User	Screened & Referred w/in 24 hrs; Offer Admission w/in 14 days	**Begin w/in 48 hrs – maximum waiting time 120 days** 1. Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants 2. *Early Intervention Clinical Svc*	CFR 96.121; CFR 96.126 Recommended
Parent at Risk of Losing Children	Screened & referred w/in 24 hrs. Offer Admission w/in 14 days	**Begin w/in 48 business hrs** *Early Intervention Clinical Services*	Michigan Public Health Code Section 6232 **Recommended**
All Others	Screened & referred w/in seven calendar days. Capacity to offer Admission w/in 14 days	**Not Required**	CFR 96.131(a) – sets the order of priority; MDHHS & PIHP contract

3. Injecting drug user.
4. Parent at risk of losing their child(ren) due to substance use.
5. All others.

Access timeliness standards and interim services requirements for these populations are provided in the next section.

27.0 ACCESS TIMELINESS STANDARDS

The following chart indicates the current admission priority standards for each population along with the current interim service requirements. Suggested additional interim services are in italics: Admission Priority Requirements

28.0 EARMARK-FUNDED SPECIAL PROJECTS: REPORTING REQUIREMENTS

The report must contain the following information:

1. The name of the PIHP whose residents were served through the earmarked funds during the year;
2. The number of persons served by that PIHP, through those funds; and
3. The total amount of earmarked funds paid to the provider for those services.

Annual report form and instructions are available on the MDHHS website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html

29.0 PARTNERSHIP FOR SUCCESS II (PFS II)

(Applies Only to Agencies Who Have Allocations for this Program)
The purpose of this grant is to strengthen and expand the SPF five-step, data-driven process in designated counties through enhancement of community-level infrastructure. This enhanced infrastructure will address underage drinking among persons age 12-20 and prescription drug misuse and abuse among persons age 12-25. The project is expected to:

1. Build emotional health, prevent or delay the onset of, and mitigate symptoms and complications from substance abuse related to underage drinking among youth age 12-20; and
2. Build emotional healthy, prevent or delay the onset of, and mitigate symptoms and complications from substance abuse related to reducing prescription drug misuse and abuse among youth and young adults age 12-25.

All participating PIHPs received a Request for Information (RFI) document outlining the process for assessing community needs. Information from the RFI will be used by to develop and complete the Strategic Prevention Framework required. Report forms and instructions are available on the DCH website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html.

29.1 Required Annual Deliverables:

Request for Training and Technical Assistance
Strategic Plan, Cost Detail Schedule, and Program Budget Summary and Justification (must be submitted together)

29.2 Project Requirements

PIHPs will contract with coalitions in the high-need counties to build and enhance the current substance abuse prevention infrastructure to meet the goals of the project. This will be achieved through the strengthening of partnerships with federally qualified health centers (FQHCs), local public health departments (LPHDs), Indian Health Services (IHS) and community college and university health and/or counseling centers (CC&UH/CC). Based on the determined needs in the community, coalitions in each county or jurisdiction will select one of two approved evidence-based programs, Communities that Care or Community Trials, to strengthen these collaborative partnerships. As part of building this capacity, the expectation is that the coalition or a prevention provider will develop mechanisms to implement screening, brief intervention, and problem identification and referral at a primary health clinic. The FQHC, LPHD, IHS, or CC&UH/CC will then assist coalitions in identifying and referring appropriate individuals and families to participate in one of two evidence-based programs: Strengthening Families or Active Parenting for Teens: Families in Action.

PIHPs will work with coalitions in the target counties/jurisdictions to assess data and capacity needs in order to implement the PFS II and achieve the goals of the project, including the need for training and technical assistance. One of the first steps in this process is to distribute a Request for Information (RFI). The RFI will be used for the PIHPs to identify, vet, and select a coalition with the capacity to most effectively achieve the goals outlined in the PFS II grant.

29.3 Role of the PIHP

The PIHPs will be responsible for:

1. Organizing and convening the CEW and CSPPC partners and stakeholders for the purpose of implementing the PFS II project in the target county/jurisdiction.
2. Fostering community-wide and community-based collaborative among stakeholders and partners committed to addressing the priority problems.
3. Administrative activities and project management of PFS II funds including:
    a. Contracting and funding local training and technical assistance recommended by the CEWs and CSPPCs.
    b. Selecting and contracting with coalition/provider to implement the project in the target county/jurisdiction.
    c. Monitoring CEW, CSPPC, and provider progress.
    d. Preparing and submitting required financial and programmatic reports on PFS II program activity per contract requirements.
4. PIHPs will be required to convene a CEW that will conduct a county-level needs assessment utilizing local data derived from the SEOW.
5. Assisting the PFS II Evaluator in providing data services and technical assistance to programs reporting capacity, process, and outcome data.
6. PIHPs will work in collaboration with CSPPCs to develop a community-level and culturally competent Strategic Plan to implement the PFS II project.
7. PIHPs must submit a Request for Training and Technical Assistance form to BHDDA, with documented input of the CSPPC, CEW, and other stakeholders as appropriate.
8. PIHPs must submit a PFS II Strategic Plan to BHDDA with documents input of the CSPPC.

30.0 PREVENTION SERVICES

Prevention funds may be used for needs assessment and related activities. All prevention services must be based on a formal local needs assessment.

The Department's intent is to move toward a community-based, consequence-driven model of prevention. In the meantime, based on needs assessment, prevention activities must be targeted to high-risk groups and must be directed to those at greatest risk of substance use disorders and/or most in need of services within these high-risk groups. PIHPs are not required to implement prevention programming for all high-risk groups. The PIHP may also provide targeted prevention services to the general population.

The high risk subgroups include but are not limited to: children of substance abusers; pregnant women/teens; drop-outs; violent and delinquent youth; persons with mental health problems; economically disadvantaged citizens; persons who are disabled; victims of abuse; persons already using substances; and homeless and/or runaway youth Additionally, children exposed prenatally to ATOD are identified as a high-risk subgroup.

Prevention services must be provided through strategies identified by CSAP**.** These strategies are: information dissemination; education; alternatives; problem identification and referral; community based processes; and environmental change.

Prevention-related funding limitations the PIHP must adhere to are:

1. PIHP expenditure requirements for prevention, including Synar, as stipulated in the PIHP's allocation letter;
2. 90% of prevention expenditures are expected to be directed to programs which are implemented as a result of an evidence-based decision making process:
3. Alternative strategy activities, if provided must reflect evidence-based approaches and best practices such as multi-generational and adult to youth mentoring:
4. State-administered funds used for information dissemination must be part of a multi-faceted regional prevention strategy, rather than independent, stand-alone activity.

The PIHP must monitor and evaluate prevention programs at least annually to determine if the program outcomes, milestones and other indicators are achieved, as well as compliance with state and federal requirements. Indicators may include integrity to prevention best practice models including those related to planning prevention interventions such as risk/protective factor assessment, community assets/resource assessment, levels of community support, evaluation, etc. A written monitoring procedure, which includes requirements for corrective action plans to address issues of concern with a provider, is required.

31.0 SYNAR COVERAGE STUDY: PROTOCOL

Under the Substance Abuse Prevention and Treatment Block Grant requirement, states must conduct annual, unannounced, random inspections of tobacco retailers to determine the compliance rate with laws prohibiting the sale of tobacco products to persons under the age of 18. These Synar surveys involve choosing a random sample of tobacco retail outlets from a well-maintained master tobacco retailer list. Every three years, each state is also required to check the coverage and accuracy of that master list by conducting a coverage study as close as possible to the time of the Synar survey.

"Coverage" indicates how completely the list contains all of the eligible outlets in the state for the Synar survey. The coverage rate is the percentage of all eligible outlets in the state that actually appear on the master list (list frame). The Substance Abuse and Mental Health Services Administration (SAMHSA) recommendation is for a ninety (90) percent coverage rate; however, the actual mandate is for eighty (80) percent coverage. The study will also provide an additional means of checking address accuracy and outlet eligibility, beyond the various methods used to clean the list regularly. This document provides the requirements for the methods and procedures for conducting the Michigan Tobacco Retailer Coverage Study Activity. The Michigan Department of Health and Human Services (MDHHS), Office of Recovery Oriented Systems of

Care (OROSC), formerly MDHHS/BSAAS, coverage study design required approval from the Center for Substance Abuse Prevention (CSAP). Therefore, **variance from these procedures is not allowable.**

MDHHS/OROSC will:

1. Select geographic areas to be sampled.
2. Coordinate the participation of the involved coordinating agencies.
3. Provide protocol and necessary training/technical assistance to selected coordinating agencies.
4. Provide specific starting points and boundaries, with mapped routes, guidance, and designated number of tobacco retailers. OROSC will also provide backup protocol in case the internet maps prove to be in error. (**Note:** Predetermined routes will be used to provide consistency.)
5. Allocate a stipend, contingent upon availability of funds, for each located tobacco retailer, up to the designated number in a contract amendment.
6. Distribute and collect necessary canvassing forms.
7. Determine coverage rate.
8. Update master tobacco retailer list (list frame).
9. Report the results to SAMHSA by December 18th every three years (next coverage study will be in FY 2017).

Coverage indicates how completely the master retail list contains (*covers*) all of the eligible outlets in the State for the Synar survey. An eligible outlet is a retailer that sells tobacco and is accessible to minors. The coverage rate is the percentage of all eligible outlets in the State that actually appear on the list frame. The coverage rate can be estimated through a coverage study, which is a special ty e of survey conducted to measure the coverage or incompleteness of the list. Coverage studies (CS) are conducted every three years as required and prescribed by CSAP. <u>The selection of regional participants is usually based on the PIHPs with the lowest retailer violation rate (RVR) with consideration given to statewide geographic diversity.</u> The goal is to provide the federal government a representative sample of our Master Retail List and verify that the method of updating guarantees that Michigan's list is at least 80% accurate. The last CS was conducted during October 2013. The 2016 CS will occur between August 20 through September 10th, and the reports will be due on September 30, 2016. Only PIHPs that are **selected** are required to canvas their region and report. If not selected, no reporting requirements have to be fulfilled.

PIHPs will:

1. Be responsible for the completion of the coverage study activities within their regions.
2. Provide two-person "field worker" teams (two adults over age 21).
3. Michigan Protocol for Tobacco Retailer Coverage Study Page 2
4. Train, schedule, and supervise the teams in purpose, protocol, routes, and use of canvassing forms.
5. Collect canvassing forms: review for completeness, legibility, and necessary signatures.

Submit canvassing forms and contact information of canvassing team membership every three years (next coverage study will be in FY 2017), by due date specified to:

By Email (preferred): Carolyn Foxall at foxallc@michigan.gov
By Mail (signed forms): Carolyn Foxall, MDHHS/OROSC, 320 S. Walnut, Lewis Cass Bldg. Fifth Floor, Lansing, MI 48913
By Fax: Carolyn Foxall at 517-335-2121.

PIHPs will work with their Designated Youth Tobacco Use Representatives (DYTURs) to establish and identify canvassing teams.

CANVASSING TEAMS will understand that:

1. The purpose of the coverage study is to determine the quality of the master Michigan Tobacco Retailer List (TRL).
2. In no way is the existing TRL or retailers' history to be utilized or considered.
3. These teams will physically canvass all retailers until they have found and recorded **exactly the designated number** of those selling tobacco products, regardless of the number of unvisited retailers and tobacco retailers remaining within the community. Stop when quota is reached.
    a. In some cases, additional communities are listed besides the original selection. This is done to provide an additional location to canvass in case the first selection does not hold enough tobacco retailers to net the desired canvassing total within that county.

CANVASSING TEAMS will:

1. Review protocol; ensure understanding of task and responsibilities.
2. Acquire maps, routes, and canvassing forms from the PIHP.
3. Demonstrate professional etiquette. Understandably, it is expected that canvassers will conduct themselves professionally in a way that reflects well on the PIHP and OROSC. Provide an explanation of the study's purpose utilizing the language in the first paragraph of this document. Thank merchants for their cooperation.
4. Go to the designated starting point in the assigned city/township/village and conduct the coverage study.
5. Utilize the provided map and route to locate all retail businesses and physically enter in the order that they are encountered. CSAP recommends canvassing the entire selected area. Teams may stop when they have reached the quota; however, it is recommended that the Designated Youth Tobacco Use Representatives canvass the entire selected area and submit a complete list. If this cannot be done, please provide an explanation with the report for OROSC records.
6. Make no assumption regarding whether a particular business or a type of business does or does not sell tobacco products – all businesses must be entered and assessed for tobacco sales.

7. Make exceptions to physical entry/visitation only if: 1) exterior signage clearly prohibits entry to the establishment by persons under 18 years of age, or 2) the location is determined to be dangerous to the canvassers' safety. Do not canvass beyond boundaries given. At no time, canvass beyond the county limits.
8. Notify the PIHP Prevention Coordinator **if** the mapped route is in obvious error upon arrival at the starting point. If the team is in a commercial area, secure permission to use the following backup protocol:
    a. At the primary intersection, start in any single direction on one side of the street. Continue on that side for five (5) blocks until all retail establishments have been visited within that area.
    b. Cross the street and work the way back on the opposite side to the primary intersection starting point.

If additional tobacco retailer recordings are needed, this protocol is to be used **ONLY** if the provided primary mapping proves inadequate and **ONLY** after being granted permission from the PIHP. Stay within the boundaries indicated on the provided map, and check establishments while proceeding either:

1. Five (5) blocks forward on the same street.
2. Turn one block to the right or left, and then continue parallel to the first checked street and repeat the process above.
3. Complete the provided form.
4. Legibly record only tobacco retailers that are accessible to persons under 18 years of age. Do not record visited sites that do not sell tobacco products or are not accessible by youth.
5. Include complete data for the contact information: name of store, street number, street name, city, zip code, area code, and phone number. If owner information is available, please add that to back of the form along with the name of store listed on the front. Include their email information if available.
6. Complete the rest of form as directed by column headings.
7. Both canvassers must sign and date each page of the form.
8. Check the form for completeness legibility and signatures.
9. Return the form to the PIHP by the due date requested.

32.0 OPIOID TREATMENT SERVICES

Determination of Needs/Individualized Treatment

Determination of treatment pathway shall be individualized and based on the current clinical status of a patient in conjunction with current research/best practice protocols for their need. There shall be no "automatic" determination of whether a client is served in a drug free or medication-assisted setting.

SUD services to persons who are opioid dependent shall be provided in accordance with one of the three current FDA approved medication assisted treatments for opioid dependence unless medically contraindicated. Medications shall be initiated, adjusted and/or discontinued as medically warranted, but there shall be no arbitrary termination of medication treatment simply because a client has been in care for a specified amount of time. Nor shall dosage be limited or imposed on the basis of policy requirements if they are at odds with current medical practice standards. Treatment of opioid dependence shall combine identified counseling/behavioral health therapies in conjunction with the FDA approved medication.

32.1 Standards for the Provision of Medication Assisted Treatment

The National Institute on Drug Addiction (NIDA), the American Society of Addiction Medicine (ASAM) and the American Medical Association (AMA) have all identified addiction as a chronic and often relapsing brain disease.

All Medication Assisted Treatment (MAT) services provided to individuals identified as opioid dependent/addicted shall:

1) be based on current research related to opioid dependence/addiction.
2) consist of treatment services that are a combination of outpatient therapy utilizing DBT, CBT, Contingency Therapy, and one of the three FDA approved medications as an adjunct therapy (Methadone, Buprenorphine, Naltrexone). Counseling and medication therapies are to be offered within the same facility.
3) utilize individualized treatment/recovery planning driven by the person seeking treatment and based on the current clinical status of a patient in conjunction with current research/best practice protocols for their need. There shall be no “automatic” determination of whether a client is served in a drug free or medication-assisted setting.
4) not use urine drug screens as the sole determination for discharge, or as a predictor of current or future treatment success.
5) acknowledge that relapse is a natural part of the disease of addiction.
6) not consider abstinence as a requirement or the only required goal for treatment. Treatment goals shall address recovery markers such as: employment, participation in school, stable housing, sustained periods using only the MAT medication and other prescribed medication as instructed, taper/reduction in OTP medication, reunification/sustained unification of family, and involvement in the community.
7) comply with the requirements in R 325.14418.

33.0 FETAL ALCOHOL SPECTRUM DISORDERS

Substance abuse treatment programs are in a unique position to have an impact on the fetal alcohol spectrum disorder (FASD) problem in two ways. First, it is required that these programs include FASD prevention within their treatment regimen for those women that are included in the selective or indicated group based on Institute of Medicine (IOM) prevention categories. Second, for those treatment programs that have contact with the children born to women who have used alcohol it is required that the program screen these children for FASD and, if appropriate, refer for further diagnostics services.

33.1 FASD Prevention Activities

FASD prevention should be a part of all substance abuse treatment programs that serve women. Providing education on the risks of drinking during pregnancy and FASD detection and services are easily incorporated into the treatment regimes.

The IOM Committee to Study Fetal Alcohol Syndrome has recommended three prevention approaches. The universal approach involves educating the public and influencing public policies. The selective approach is targeting interventions to groups that have increased risk for FASD problems such as women of childbearing age that drink. The indicated approach looks at groups who have already exhibited risk behaviors, such as, pregnant women who are drinking or who gave birth to a child who has been diagnosed with FASD. This policy recommends using one of the FASD prevention curriculums for women in the selected or indicated group

33.2 FASD Screening

For any treatment program that serves women, it is required that the program complete the FASD prescreen for children that they interact with during their mother's treatment episode. Substance abuse clinicians do not need to be able to diagnose a child with any disorder in the spectrum of FASD, but do need to be able to screen for the conditions of FASD and make the proper referrals for diagnosis and treatment. The decision to make a referral can be difficult. When dealing with the biological family, issues of social stigma, denial, guilt and shame may surface. For adoptive families, knowledge of alcohol use during pregnancy maybe limited. The following guidelines were developed to assist clinicians in making the decision as to whether a referral is needed. Each case should be evaluated individually. However, if there is any doubt, a referral to a FAS diagnostic clinic should be made.

The following circumstances should prompt a clinician to complete a screen to determine if there is a need for a diagnostic referral:

1. When prenatal alcohol exposure is known and other FAS characteristics are present, a child should be referred for a full FASD evaluation when substantial prenatal alcohol use by the mother (i.e., seven or more drinks per week, three or more drinks on multiple occasions, or both) has been confirmed.
2. When substantial prenatal alcohol exposure is known, in the absence of any other positive criteria (i.e., small size, facial abnormalities, or central nervous system problems), the primary care physician should document exposure and monitor the child for developmental problems.
3. When information regarding prenatal exposure is unknown, a child should be referred for a full FASD evaluation for any one of the following:
    a. Any report of concern by a parent or caregiver that a child has or might have FASD
    b. Presence of all three facial features
    c. Presence of one or more facial features with growth deficits in weight, height or both
    d. Presence of one or more facial features with one or more central nervous system problems

   e. Presence of one or more facial features with growth deficits and one or more central nervous system problems
4. There are family situations or histories that also may indicate the need for a referral for a diagnostic evaluation. The possibility of prenatal exposure should be considered for children in families who have experienced one or more of the following:
   a. Premature maternal death related to alcohol use (either disease or trauma)
   b. Living with an alcoholic parent
   c. Current or history of abuse or neglect
   d. Current or history of involvement with Child's Protective Services
   e. A history of transient care giving institutions
   f. Foster or adoptive placements (including kinship care)

The Fetal Alcohol Syndrome (FAS) Pre-Screen Form can be used to complete the screening process. It also lists the fetal alcohol diagnostic clinics located in Michigan with telephone numbers for easy referral. These clinics complete FASD evaluations and diagnostic services. The clinics also identify and facilitate appropriate health care, education and community services needed by persons diagnosed with FAS.

34.0 SUB-ACUTE DETOXIFICATION

Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required. Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate.

Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM PPC 2-R and individualized determination of client need. The following combinations of sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM PPC 2-R.

<u>Outpatient Setting</u>

- Ambulatory Detoxification without extended on-site monitoring corresponding to ASAM Level I-D, or ambulatory detoxification with extended on-site monitoring (ASAM Level II-D).
- Outpatient setting sub-acute detoxification must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed. ASAM Level II-D ambulatory detoxification services must be monitored by appropriately certified and licensed nurses.

Residential Setting

- Clinically Managed Residential Detoxification - Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level III.2-D). These services must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed.
- Medically Managed Residential Detoxification - Freestanding Detoxification Center: These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician (ASAM LevelIII.7-D).

This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.

35.0 RESIDENTIAL TREATMENT

Residential treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate certified professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day. The clinical program must be provided under the supervision of a Substance Abuse Treatment Specialist with either full licensure or limited licensure as a psychologist, master's social worker, professional counselor, marriage and family therapist or physician. Services may be provided by a substance abuse treatment specialist or a non-degreed staff.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

36.0 DISCRETIONARY AND CATEGORICAL GRANTS FROM OROSC

For all current discretionary and categorical grants, e.g., Partnerships for Success II Grant, distributed through OROSC to sub-recipient PIHPs for counties identified for impact, the PIHPs shall continue to commit to the identified communities for a seamless and efficient process during the planning, transition and implementation periods. Substance use and mental health disorder Issues identified by the target communities (counties) must be maintained.

36.1 Addressing a Strategic Prevention Planning Framework

All prevention program planning, including mental health promotion must be conducted utilizing the SAMHSA Strategic Planning Framework (SPF) which features a data guided approach to developing strategic plans for SUD prevention and mental health promotion. PIHPs must, at a minimum, address the prevention strategic priority areas listed in the OROSC Strategic Plan - underage drinking, prescription drug abuse and youth access to tobacco - in their strategic plans

utilizing the SPF process in a culturally competent manner. The PIHPs must also plan, implement and synchronize their prevention plans with interventions proven to be effective in reducing infant mortality and obesity.

For a complete description of the SPF and the OROSC publications: *Transforming Cultural and Linguistic Theory into Action; A Toolkit for Communities* and *Guidance Document; Selecting, Planning and Implementing Evidence-based Interventions for the Prevention of SUDs*, see the OROSC Prevention Website.

The development and implementation of prevention prepared communities (PPCs) will be the primary mechanism used to meet prevention goals associated with the OROSC Strategic Plan Priority Focus Areas. A PPC is a community equipped to use a comprehensive mix of data-driven prevention strategies, interventions, and programs across multiple sectors to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco), and suicide among youth, tribal communities, and military families.

36.2 Addressing Prevention and Mental Health Promotion Programming

Prevention programming is intended to reduce the consequences of SUDs in communities by preventing or delaying the onset of use, and reducing the progression of SUDs in individuals. Prevention is an ordered set of steps along a continuum that promotes individual, family and community health; prevents mental and behavioral disorders; supports resilience and recovery; and reinforces treatment principles to prevent relapse.

This multi-component and strategic approach should cover all age groups including support for children, senior citizens, all socio-economic classes, diverse cultures, minority and under-served populations, service men and women, gender-specific and targeted high-risk groups.

A minimum of 90 percent of the prevention services funded by the PIHPs must be evidence-based. For reference, see evidence-based guidance document.

Prevention service providers receiving community grant and other federal funding via PIHPs must evaluate prevention services implemented in the PIHP catchment areas as specified by contract and/or grant reporting requirements.

PART III
RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

1.0 RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The MDHHS shall be responsible for administering the public mental health system and public substance abuse system. It will administer contracts with PIHPs, monitor contract performance, and perform the following activities:

1.1 General Provisions

1. Notify the PIHP of the name, address, and telephone number, if available, of all Medicaid, MI Child and Healthy Michigan eligibles in the service area. The PIHP will be notified of changes, as they are known to the MDHHS.
2. Provide the PIHP with information related to known third-party resources and any subsequent changes as the department becomes aware of said information. Notify the PIHP of changes in covered services or conditions of providing covered services.
3. Protect against fraud and abuse involving MDHHS funds and recipients in cooperation with appropriate state and federal authorities.
4. Administer a Medicaid fair hearing process consistent with federal requirements.
5. Collaborate with the PIHP on quality improvement activities, fraud and abuse issues, and other activities that impact on the services provided to individuals.
6. Review PIHP Customer Services Manuals.
7. Apply contract remedies necessary to assure compliance with contract requirements.
8. Monitor the operation of the PIHP to ensure access to quality care for all individuals in need of and qualifying for services.
9. Monitor quality of care provided to individuals who receive PIHP services and supports.
10. Refer local issues back to the PIHP.
11. Monitor, in aggregate, the availability and use of alternative services.
12. Coordinate efforts with other state departments involved in services to the population.
13. When repeated health and welfare issues/emergencies are raised or concerns regarding timely implementation of medically necessary services the MDHHS authority to take action is acknowledged by the PIHP.

1.2 Contract Financing

MDHHS shall pay, to the PIHP, Medicaid funds as agreed to in the contract.

The MDHHS shall immediately notify the PIHP of modifications in funding commitments in this contract under the following conditions:

1. Action by the Michigan State Legislature or by the Center for Medicare and Medicaid Services that removes any MDHHS funding for, or authority to provide for, specified services.
2. Action by the Governor pursuant to Const. 1963, Art. 5, 320 that removes the MDHHS's funding for specified services or that reduces the MDHHS's funding level below that required to maintain services on a statewide basis.
3. A formal directive by the Governor, or the Michigan Department of Management and Budget (State Budget Office) on behalf of the Governor, requiring a reduction in expenditures.

In the event that any of the conditions specified in the above items A through C occur, the MDHHS shall issue an amendment to this contract reflective of the above condition.

2.0 FRAUD AND ABUSE REPORTING RESPONSIBILITIES

The MDHHS has responsibility and authority to make fraud and/or abuse referrals to the Office of the Attorney General, Health Care Fraud Division. Contractors who have any suspicion or knowledge of fraud and/or abuse within any of the MDHHS's programs must report directly to the MDHHS by calling 1(855) MI FRAUD (643-7283) or by sending a memo to:

Michigan Department of Health and Human Services
Office of the Inspector General
P. O. Box 30062
Lansing, MI 48909

When reporting suspected fraud and/or abuse, the contractor should provide, if possible, the following information to MDHHS:

- Nature of the complaint
- The name of the individuals or entity involved in the suspected fraud and abuse, including name, address, phone number and Medicaid identification number and/or any other identifying information

The contractor shall not attempt to investigate or resolve the reported alleged fraud and/or abuse. The contractor must cooperate fully in any investigation by the MDHHS or Office of the Inspector General, and with any subsequent legal action that may arise from such investigation.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITITIES ADMINISTRATION
Technical Requirement
For Behavior Treatment Plan Review Committees
Revision FY'12

Application:

Prepaid Inpatient Health Plans (PIHPs)
Community Mental Health Services Programs (CMHSPs)
Public mental health service providers

Exception: State operated or licensed psychiatric hospitals or units when the individual's challenging behavior is due to an active substantiated Axis I diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or successor edition published by the American Psychiatric Association.

Preamble:

It is the expectation of the Michigan Department of Health and Human Services (MDHHS) that all public mental health agencies shall have policies and procedures for intervening with an individual receiving public mental health services who exhibits seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of harm. These policies and procedures shall include protocols for using the least intrusive and restrictive interventions for unprecedented and unpredicted crisis or emergency occurrences of such behaviors. For all other non-emergent or continuing occurrences of these behaviors, the public mental health service agency will first conduct appropriate assessments and evaluations to rule out physical, medical, and environmental (e.g., trauma, interpersonal relationships) conditions that might be the cause of the behaviors.

MDHHS will not tolerate violence perpetrated on the individuals served by the public mental health system in the name of intervening when individuals exhibit certain potentially harmful behaviors. If and when interventions are to be used for the purpose of treating, managing, controlling or extinguishing predictable or continuing behaviors that are seriously aggressive, self-injurious, or that place the individual or others at risk of harm, the public mental health agency shall develop an individual behavior treatment plan to ameliorate or eliminate the need for the restrictive or intrusive interventions in the future (R. 330.7199[2]][g]) and that:

- Adheres to any legal psychiatric advance directive that is present for an adult with serious mental illness;
- Employs positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches;
- Considers other kinds of behavior treatment or interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions, if positive behavior supports and interventions are documented to be unsuccessful; or

- As a last resort, when there is documentation that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee.

MDHHS requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code.

I. POLICY

It is the policy of MDHHS that all publicly-supported mental health agencies shall use a specially-constituted committee, often referred to as a "behavior treatment plan review committee" called for the purposes of this policy the "Committee." The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions, as defined here, with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards herein, including those for its appointment, duties, and functions.

II. DEFINITIONS

Aversive Techniques: Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety, masturbatory satiation for paraphilias) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is **prohibited.**

Consent: a written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.

Functional Behavioral Assessment (FBA): an approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a

particular behavior and guide the development of an effective and efficient behavior plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the behavior itself so that a new behavior or skill will be substituted to provide the same function or meet the identified need. Functional assessments should also identify situations and events that precede positive behavior to provide more information for a positive behavior support plan.

Emergency Interventions: There are only two emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention. Each agency shall have protocols specifying what physical management techniques are approved for use.

Imminent Risk: an event/action that is about to occur that will likely result in the potential harm to self or others.

Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage, control or extinguish an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. se of intrusive techniques as defined here requires the review and approval by the Committee.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individual's resistance in order to prevent him or her from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. The following are examples to further clarify the definition of physical management:

- Manually guiding down the hand/fists of an individual who is striking his or her own face repeatedly causing risk of harm IS considered physical management if he or she resists the physical contact and continues to try and strike him or herself. However, it IS NOT physical management if the individual stops the behavior without resistance.

- When a caregiver places his hands on an individual's biceps to prevent him or her from running out the door and the individual resists and continues to try and get out the door, it IS considered physical management. However, if the individual no longer attempts to run out the door, it is NOT considered physical management.

Physical management involving prone immobilization of an individual, as well as any physical management that restricts a person's respiratory process, for behavioral control purposes is **prohibited under any circumstances.** Prone immobilization is extended physical management of an individual in a prone (face down) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position.

Positive Behavior Support: A set of research-based strategies used to increase opportunities for an enhanced *quality of life* and decrease seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, property destruction, and pica. Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

Practice or Treatment Guidelines: Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.

Proactive Strategies in a Culture of Gentleness: strategies within a Positive Behavior Support Plan used to prevent seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm from occurring, or for reducing their frequency, intensity, or duration. Supporting individuals in a culture of gentleness is an ongoing process that requires patience and consistency. As such, no precise strategy can be applied to all situations. Some examples of proactive strategies include: unconditional valuing, precursor behaviors, redirection, stimulus control, and validating feelings. See the [prevention guide] for a full list of proactive strategies and definitions.

Reactive Strategies in a Culture of Gentleness: strategies within a Positive Behavior Support Plan used to respond when individuals begin feeling unsafe, insecure, anxious or frustrated. Some examples of reactive strategies include: reducing demanding interactions, increasing warm interactions, redirection, giving space, and blocking. See the [prevention guide] for a full list of reactive strategies and definitions.

Request for Law Enforcement Intervention: calling 911 and requesting law enforcement assistance as a result of an individual exhibiting a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance **only when**: caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

Restraint: the use of a physical or mechanical device to restrict an individual's movement at the order of a physician. The use of physical or mechanical devices used as restraint is **prohibited** except in a state-operated facility or a licensed hospital. This definition excludes:

- Anatomical or physical supports that are ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving an individual's physical functioning

- Protective devices which are defined as devices or physical barriers to prevent the individual from causing serious self-injury associated with documented and frequent incidents of the behavior and which are incorporated in the written individual plan of services through a behavior treatment plan which has been reviewed and approved by the Committee and received special consent from the individual or his/her legal representative.

- Medical restraint, i.e. the use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.

- Safety devices required by law, such as car seat belts or child car seats used while riding in vehicles.

Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include: limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.

Seclusion: The placement of an individual in a room alone where egress is prevented by any means. Seclusion is **prohibited** except in a hospital or center operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.

Special Consent: Obtaining the written consent of the individual, the legal guardian, the parent with legal custody of a minor child, or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the individual, guardian or parent of a minor may only occur when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.

III. COMMITTEE STANDARDS

A. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. A psychiatric hospital, psychiatric unit or psychiatric partial hospitalization program licensed under 1974 PA 258, MCL 330.1137, that receives public funds under contract with the CMHSP and does not have its own Committee must also have access to and use of the services of the CMHSP Committee regarding a behavior treatment plan for an individual receiving services from that CMHSP. If the CMHSP delegates the functions of the Committee to a contracted mental health service provider, the CMHSP must monitor that Committee to assure compliance with this Technical Requirement.

B. The Committee shall be comprised of at least three individuals, one of whom shall be a licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, with the specified training; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

C. The Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms.

D. The Committee shall meet as often as needed.

E. Expedited Review of Proposed Behavior Treatment Plans:

Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. “Expedited” means the plan is reviewed and approved in a short time frame such as 24 or 48 hours.

The most frequently-occurring example of the need for expedited review of a proposed plan in emergent situations occurs as a result of the following AFC Licensing Rule:

Adult Foster Care Licensing R 400.14309 Crisis intervention
(1) Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been insufficient time to develop a specialized intervention plan to reduce the behavior causing the crisis. <u>If the [individual] requires the repeated or prolonged use of crisis intervention procedures, the licensee must contact the [individual’s] designated representative and the responsible agency … to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan</u>. (Emphasis added)

Expedited plan reviews may be requested when, based on data presented by the professional staff (Psychologist, RN, Supports Coordinator, Case Manager), the plan requires immediate implementation. The Committee Chair may receive, review and approve such plans on behalf of the Committee. The Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan. Upon approval, the plan may be implemented. All plans approved in this manner must be subject to full review at the next regular meeting of the Committee.

F. The Committee shall keep all its meeting minutes, and clearly delineate the actions of the Committee.

G. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision-making.

H. The functions of the Committee shall be to:
   1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
   2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques [see definitions].
   3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately

pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.

4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.
5. Assure that inquiry has been made about any known medical, psychological or other factors that the individual has, which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
6. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the individuals served.

Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan (see limitations in definition of special consent) has been obtained from the individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate, it becomes part of the person's written IPOS. The individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan. (MCL 330.1712 [2])

I. On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
   1. Dates and numbers of interventions used.
   2. The settings (e.g., individual's home or work) where behaviors and interventions occurred
   3. Observations about any events, settings, or factors that may have triggered the behavior.
   4. Behaviors that initiated the techniques.
   5. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
   6. Description of positive behavioral supports used.
   7. Behaviors that resulted in termination of the interventions.
   8. Length of time of each intervention.

9. Staff development and training and supervisory guidance to reduce the use of these interventions.
10. Review and modification or development, if needed, of the individual's behavior plan.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's QAPIP or the CMHSP's QIP, and be available for MDHHS review. Physical management and/or involvement of law enforcement, permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

J. In addition, the Committee may:
   1. Advise and recommend to the agency the need for specific staff or home-specific training in a culture of gentleness, positive behavioral supports, and other individual-specific non-violent interventions.
   2. Advise and recommend to the agency acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an individual who has never displayed or been predicted to display seriously aggressive, self-injurious or other behaviors that place the individual or others at risk or harm.
   3. At its discretion, review other formally developed behavior treatment plans, including positive behavioral supports and interventions, if such reviews are consistent with the agency's needs and approved in advance by the agency.
   4. Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices.
   5. Provide specific case consultation as requested by professional staff of the agency.
   6. Assist in assuring that other related standards are met, e.g., positive behavioral supports.
   7. Serve another service entity (e.g., subcontractor) if agreeable between the involved parties.

IV. BEHAVIOR TREATMENT PLAN STANDARDS

A. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan needs to be developed and where there is documentation that functional behavioral assessments have been conducted to rule out physical, medical or environmental causes of the behavior; and that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the behavior.

B. Behavior treatment plans must be developed through the person-centered planning process and written special consent must be given by the individual, or his/her guardian on his/her behalf if one has been appointed, or the parent with

legal custody of a minor prior to the implementation of the behavior treatment plan that includes intrusive or restrictive interventions.

C. Behavior treatment plans that propose to use physical management and/or involvement of law enforcement in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law shall be disapproved by the Committee.

   Utilization of physical management or requesting law enforcement may be evidence of treatment/supports failure. Should use occur more than 3 times within a 30 day period the individual's written individual plan of service must be revisited through the person-centered planning process and modified accordingly, if needed. MDHHS and DHS Administrative Rules prohibit emergency interventions from inclusion as a component or step in any behavior plan. The plan may note, however, that should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.

D. Behavior treatment plans that propose to use restrictive or intrusive techniques as defined by this policy shall be reviewed and approved (or disapproved) by the Committee.

E. Plans that are forwarded to the Committee for review shall be accompanied by:
   1. Results of assessments performed to rule out relevant physical, medical and environmental causes of the challenging behavior.
   2. A functional behavioral assessment.
   3. Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.
   4. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been used to ameliorate the behavior and have proved to be unsuccessful.
   5. Evidence of continued efforts to find other options.
   6. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
   7. References to the literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the plan is the best option available. Citing of common procedures that are well researched and utilized within most behavior treatment plans is not required.
   8. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

Legal References

1997 federal Balanced Budget Act at 42 CFR 438.100

MCL 330.1712, Michigan Mental Health Code
MCL 330.1740, Michigan Mental Health Code
MCL 330.1742, Michigan Mental Health Code
MDHHS Administrative Rule 7001(l)
MDHHS Administrative Rule 7001(r)
Department of Community Health Administrative Rule 330.7199(2)(g)

PREPAID INPATIENT HEALTH PLANS AND COMMUNITY MENTAL HEALTH SERVICES PROGRAMS

ACCESS SYSTEM STANDARDS

Revised: September, 2015

Preamble

It is the expectation of the Michigan Department of Health and Human Services (MDHHS) that Prepaid Inpatient Health Plans' (PIHPs) and Community Mental Health Services Programs' (CMHSPs) access systems function not only as the front doors for obtaining services from their helping systems but that they provide an opportunity for residents with perceived problems resulting from trauma, crisis, or problems with functioning to be heard, understood and provided with options. The Access System is expected to be available and accessible to all individuals on a telephone and a walk-in basis. Rather than screening individuals "in" or "out" of services, it is expected that access systems first provide the person "air time," and express the message: "How may I help you?" This means that individuals who seek assistance are provided with guidance and support in describing their experiences and identifying their needs in their own terms, then assistance with linking them to available resources. CMHSPs and PIHPs are also expected to conduct active outreach efforts throughout their communities to assure that those in need of behavioral health services are aware of service entry options and encouraged to make contact. In order to be welcoming to all who present for services, the access systems must be staffed by workers who are skilled in listening and assisting the person with trauma, crisis or functioning difficulties to sort through their experience and to determine a range of options that are, in practical terms, available to that individual. Access Systems are expected to be capable of responding to all local resident groups within their services area, including being culturally-competent, able to address the needs of persons with co-occurring disorders and substance use disorders. Furthermore, it is expected that the practices of access systems and conduct of their staff reflect the philosophies of support and care that MDHHS promotes and requires through policy and contract, including person-centered, self-determined, recovery-oriented, trauma-informed, and least restrictive environments.

Functions

The key functions of an access system are to:

1. **Welcome** all individuals by demonstrating empathy and providing opportunity for the person presenting to describe situation, problems and functioning difficulties, exhibiting excellent customer service skills, and working with them in a non-judgmental way.
2. **Screen** individuals who approach the access system to determine whether they are in crisis and, if so, assure that they receive timely, appropriate attention.
3. **Determine** individuals' eligibility for Medicaid specialty services and supports, MIChild, Healthy Michigan Plan, Substance Abuse Block Grant (SABG) or,

for those who do not have any of these benefits as a person whose presenting needs for behavioral health services make them a priority to be served.

4. **Collect information** from individuals for decision-making and reporting purposes.
5. **Refer** individuals in a timely manner to the appropriate behavioral health practitioners for assessment, person-centered planning, and/or supports and services; or, if the individual is not eligible for PIHP or CMHSP services, to community resources that may meet their needs.
6. **Inform** individuals about all the available mental health and substance abuse services and providers and their due process rights under Medicaid, or MIChild, Healthy Michigan Plan, SABG and the Michigan Mental Health Code.
7. **Conduct outreach** to under-served and hard-to-reach populations and be accessible to the community-at-large.

STANDARDS

These standards apply to all PIHPs and CMHSPs, whether the access system functions are directly provided by the PIHP or CMHSP, or are 'delegated' in whole or in part to a subcontract provider(s). Hereinafter, the above entities are referred to as "the organization." These standards provide the framework to address all populations that may seek out or request services of a PIHP or CMHSP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorder.

I. WELCOMING

a. The organization's access system services shall be available to all residents of the State of Michigan, regardless of where the person lives, or where he/she contacts the system. Staff shall be welcoming, accepting and helping with all applicants for service[1].
b. The access system shall operate or arrange for an access line that is available 24 hours per day, seven days per week; including in-person and by-telephone access for hearing impaired individuals. Telephone lines are toll-free; accommodate Limited English Proficiency (LEP); are accessible for individuals with hearing impairments; and have electronic caller identification, if locally available[2].
    i. Callers encounter no telephone "trees," and are not put on hold or sent to voicemail until they have spoken with a live representative from the access system and it is determined, following an empathetic opportunity for the caller to express their situation and circumstances, that their situation is not urgent or emergent.
    ii. All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back.

[1] MDHHS Specialty Pre-Paid Health Plan 2002 Application for Participation (AFP), Section 3.1
[2] 42 CFR § 438.10 and 438.206. Michigan Mental Health Code, P.A. 258 of 1974 (MHC) §330.1206. MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.2. MDHHS AFP, Section 3.1.8

iii. For non-emergent calls, a person's time on-hold awaiting a screening must not exceed **three minutes** without being offered an option for callback or talking with a non-professional in the interim.
iv. All non-emergent callbacks must occur within **one business day** of initial contact.
v. For organizations with decentralized access systems, there must be a mechanism in place to forward the call to the appropriate access portal without the individual having to re-dial.

c. The access system shall provide a timely, effective response to all individuals who walk in.
   i. For individuals who walk in with urgent or emergent needs[3], an intervention shall be immediately initiated.
   ii. Those individuals with routine needs must be screened or other arrangements made within **thirty minutes**.
   iii. **It is expected that the Access Center/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.**
d. The access system shall maintain the capacity to immediately accommodate individuals who present with:
   i. LEP and other linguistic needs
   ii. Diverse cultural and demographic backgrounds
   iii. Visual impairments
   iv. Alternative needs for communication
   v. Mobility challenges[4]
e. The access system shall address financial considerations, including county of financial responsibility as a secondary administrative concern, only after any urgent or emergent needs of the person are addressed. Access system screening and crisis intervention shall never require prior authorization; nor shall access system screening and referral ever require any financial contribution from the person being served[5].
f. The access system shall provide applicants with a summary of their rights guaranteed by the Michigan Mental Health Code, including information about their rights to the person-centered planning process and assure that they have access to the pre-planning process as soon as the screening and coverage determination processes have been completed[6].

g. The access system shall provide information regarding confidentiality (42 CFR) and recipient rights of substance use disorder clients to all individuals requesting services.

[3] For definition of emergent and urgent situations, see MHC §330.1100a and 1100d
[4] 42 CFR § 438.10. MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.2. MDHHS AFP, Section 3.1.8
[5] 42 CFR §438.114
[6] MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.1 and Attachment 3.4.1.1; MCL 330.1706

II. SCREENING FOR CRISES

a. Access system staff shall first determine whether the presenting mental health need is urgent, emergent or routine and, if so, will address emergent and urgent need first. To assure understanding of the problem from the point of view of the person who is seeking help, methods for determining urgent or emergent situations must incorporate "caller or client-defined" crisis situations. Workers must be able to demonstrate empathy as a key customer service method.

b. The organization shall have emergency intervention services with sufficient capacity to provide clinical evaluation of the problem; to provide appropriate intervention; and to make timely disposition to admit to inpatient care or refer to outpatient services[7]. The organization may use: telephonic crisis intervention counseling, face-to-face crisis assessment, mobile crisis team, and dispatching staff to the emergency room, as appropriate. The access system shall perform or arrange for inpatient assessment and admission, or alternative hospital admissions placements, or immediate linkage to a crisis practitioner for stabilization, as applicable[8].

c. The access system shall inquire as to the existence of any established medical or psychiatric advance directives relevant to the provision of services[9].

d. The organization shall assure coverage and provision of post stabilization services for Medicaid beneficiaries once their crises are stabilized[10]. Individuals who are not Medicaid beneficiaries, but who need mental health services and supports following crisis stabilization, shall be referred back to the access system for assistance.

III. PRIORITY POPULATION MANAGEMENT

a. The Substance Abuse Block Grant (SABG) requirements indicate that clients who are pregnant or injecting drug users have admission preference over any other client accessing the system and are identified as a priority population. Priority population clients must be admitted to services as follows: [11]

[7] MDHHS Administrative Rule 330.2006
[8] MHC § 330.1206 and 1409
[9] 42 CFR §438.6; MCL 700.5501 et seq
[10] 42 CFR §438.114. MDHHS/PIHP Contract, Part I, Section 1
[11] 45 CFR §96.131, MHC §333.6232

Population	**Admission Requirement**	**Interim Service Requirement**
Pregnant Injecting Drug User	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. d) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Pregnant Substance Use Disorders	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of transmission to sexual partners and infants. c) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours – maximum waiting time 120 days:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. 2. Early intervention clinical services.
Parent At-Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 business hours:* Early intervention clinical services.
All Others	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	Not required.

b. It is the expectation that the PIHP provide substance use disorder services to priority population clients before any other non-priority client is admitted for any other treatment services. Exceptions can be made when it is the client's choice to wait for a program that is at capacity.

III. DETERMINING COVERAGE ELIGIBILITY FOR PUBLIC MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT SERVICES

a. The organization shall ensure access to public mental health services in accordance with the MDHHS/PIHP and MDHHS/CMHSP contracts[12] and:
   i. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the individual is a Medicaid beneficiary.
   ii. The MIChild Provider Manual if the individual is a MIChild beneficiary.
   iii. The Michigan Mental Health Code and the MDHHS Administrative Rules, if the individual is not eligible for Medicaid or MIChild[13]. For mental health services, CMHSPs shall serve individuals with serious mental illness, serious emotional disturbance and developmental disabilities, giving priority to those with the most serious forms of illness and those in urgent and emergent situations. Once the needs of these individuals have been addressed, MDHHS expects that individuals with other diagnoses of mental disorders with a diagnosis found in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM)[14], will be served based upon agency priorities and within the funding available.

b. The responsible organization shall ensure access to public substance abuse treatment services in accordance with the MDHHS/PIHP contract[15] and:
   i. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the individual is a Medicaid beneficiary.
   ii. The MIChild Provider Manual if the individual is a MIChild beneficiary.
   iii. The priorities established in the Michigan Public Health Code, if the individual is not eligible for Medicaid or MIChild[16].
   iv. Provisional diagnostic impression using all five axes of the current version of the DSM of Mental Disorders.
   v. Medical necessity and level of care determination criteria utilizing the American Society of Addiction Medicine (ASAM) Criteria.
      1. Dimension 1 – Alcohol Intoxication and/or Withdrawal Potential.
      2. Dimension 2 – Biomedical Conditions and Complications.
      3. Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications.
      4. Dimension 4 – Readiness to Change.

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[12] MDHHS/PIHP & CMHSP Contracts, Part II, Section 3
[13] MHC §330.1208
[14] The **Diagnostic and Statistical Manual of Mental Disorders** (**DSM**) is an American handbook for mental health professionals that lists different categories of mental disorders and the criteria for diagnosing them, according to the publishing organization the American Psychiatric Association
[15] MDHHS/CA contract, Attachment A, Statement of Work, and Attachment E, Methadone Enrollment Criteria and Access Management Policy
[16] Public Health Code P.A. 368 of 1978 §333.6100 and 6200 and MDHHS Administrative Rule 325.14101

5. Dimension 5 – Relapse, Continued Use or Continued Problem Potential.
6. Dimension 6 – Recovery Environment.

c. The organization shall ensure that screening tools and admission criteria are based on eligibility criteria in parts III.a. and III.b. above, and are valid, reliable, and uniformly administered[17].
d. The organization shall be capable of providing the Early Periodic Screening, Diagnostic and Treatment (EPSDT) corrective or ameliorative services that are required by the MDHHS/PIHP specialty services and supports contract[18].
e. When clinical screening is conducted, the access system shall provide a written (hard copy or electronic) screening decision of the person's eligibility for admission based upon established admission criteria. The written decision shall include:
    i. Identification of presenting problem(s) and need for services and supports.
    ii. Initial identification of population group (DD, MI, SED, or SUD) that qualifies the person for public mental health and substance use disorder services and supports.
    iii. ASAM Criteria
    iv. Legal eligibility and priority criteria (where applicable).
    v. Documentation of any emergent or urgent needs and how they were immediately linked for crisis service.
    vi. Identification of screening disposition.
    vii. Rationale for system admission or denial.
f. The access system shall identify and document any third-party payer source(s) for linkage to an appropriate referral source, either in network, or out-of-network.
g. The organization shall not deny an eligible individual a service because of individual/family income or third-party payer source[19].
h. The access system shall document the referral outcome and source, either in-network or out-of-network.
i. The access system shall document when a person with mental health needs, but who is not eligible for Medicaid or MIChild, is placed on a 'waiting list' and why[20].
j. The organization shall assure that an individual who has been discharged back into the community from outpatient services, and is requesting entrance back into the PIHP/CMHSP or provider, within one year, will not have to go through the duplicative screening process. They shall be triaged for presenting mental health needs per urgent, emergent or routine.

[17] MDHHS AFP, Section 3.1.5
[18] MDHHS/PIHP Contract, Part II, Section 3.4.3. Michigan Medicaid Provider Manual, Practitioner Chapter
[19] MHC §330.1208
[20] MHC §330.1226

IV. COLLECTING INFORMATION

a. The access system shall avoid duplication of screening and assessments by using assessments already performed or by forwarding information gathered during the screening process to the provider receiving the referral, in accordance with applicable federal/state confidentiality guidelines (e.g. 42 CFR Part 2 for substance use disorders).
b. The access system shall have procedures for coordinating information between internal and external providers, including Medicaid Health Plans and primary care physicians[21].
c. Coordination of Care with the Court System[22]
    i. The access system must be able to utilize the substance use disorder screening information and treatment needs provided by district court probation officer assessments when the probation officer has the appropriate credentialing through the Michigan Certification Board for Addiction Professionals (MCBAP). A release of information form must accompany the district court probation officer referral. The information provided by the probation officer should supply enough information to the access system to apply ASAM Criteria to determine LOC and referral for placement. In situations where information is not adequate, the release of information will allow the access system to contact the district court probation officer to obtain other needed information. The access system must be able to authorize these services based on medical necessity, so PIHP funds can be used to pay for treatment.

V. REFERRAL TO PIHP or CMHSP PRACTITIONERS

a. The access system shall assure that applicants are offered appointments for assessments with mental health professionals of their choice within the MDHHS/PIHP and CMHSP contract-required standard timeframes[23]. Staff follows up to ensure the appointment occurred.
b. The access system shall ensure that, at the completion of the screening and coverage determination process, individuals who are accepted for services have access to the person-centered planning process[24].
c. The access system shall ensure that the referral of individuals with co-occurring mental illness and substance use disorders to PIHP or CMHSP or other practitioners must be in compliance with confidentiality requirements of 42 CFR.

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[21] 42 CFR §438.208
[22] 45 CFR §96.132
[23] Choice of providers: 42 CFR §438.52. MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.4. Timeframes for access: Section 3.1
[24] MDHHS AFP, Section 3.2. MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.1 and Attachment 3.4.1.1

VI. REFERRAL TO COMMUNITY RESOURCES

a. The access system shall refer Medicaid beneficiaries who request mental health services, but do not meet eligibility for specialty supports and services, to their Medicaid Health Plans[25] or Medicaid fee-for-service providers.
b. The access system shall refer individuals who request mental health or substance abuse services but who are neither eligible for Medicaid, Healthy Michigan Plan, or MIChild mental health and substance abuse services, nor who meet the priority population to be served criteria in the Michigan Mental Health Code or the Michigan Public Health Code for substance abuse services, to alternative mental health or substance abuse treatment services available in the community.
c. The access system shall provide information about other non-mental health community resources or services that are not the responsibility of the public mental health system to individuals who request it[26].

VII. INFORMING INDIVIDUALS

a. **General**
    i. The access system shall provide information about, and help people connect as needed with, the organization's Customer Services Unit, peer supports specialists and family advocates; and local community resources, such as: transportation services, prevention programs, local community advocacy groups, self-help groups, service recipient groups, and other avenues of support, as appropriate[27].
b. **Rights**
    i. The access system shall provide Medicaid, Healthy Michigan Plan and MIChild beneficiaries information about the local dispute resolution process and the state Medicaid Fair Hearing process[28]. When an individual is determined ineligible for Medicaid specialty service and supports, Healthy Michigan Plan or MIChild mental health services, he/she is notified both verbally and in-writing of the right to request a second opinion; and/or file an appeal through the local dispute resolution process; and/or request a state Fair Hearing.
    ii. The access system shall provide individuals with mental health needs or persons with co-occurring substance use/mental illness with information regarding the local community mental health Office of Recipient Rights (ORR)[29]. The access system shall provide individuals with substance use disorders, or persons with co-occurring substance use/mental illness with information

[25] 42 CFR §438.10
[26] MDHHS AFP, Section 2.9
[27] MDHHS AFP, Section 2.9
[28] 42 CFR § 438.10. MDHHS/PIHP Contract, Part II, Section 6.3.2 and Attachment 6.3.2.1
[29] MHC §330.1706

regarding the local substance abuse coordinating Office of Recipient Rights[30].

iii. When an individual with mental health needs who is not a Medicaid beneficiary is denied community mental health services, for whatever reason, he/she is notified of the right under the Mental Health Code to request a second opinion and the local dispute resolution process[31].

iv. The access system shall schedule and provide for a timely second opinion, when requested, from a qualified health care professional within the network, or arrange for the person to obtain one outside the network at no cost. The person has the right to a face-to-face determination, if requested[32].

v. The access system shall ensure the person and any referral source (with the person's consent) are informed of the reasons for denial, and shall recommend alternative services and supports or disposition[33].

c. **Services and Providers Available**

i. The access system shall assure that applicants are provided comprehensive and up-to-date information about the mental health and substance abuse services that are available and the providers who deliver them[34].

ii. The access system shall assure that there are available alternative methods for providing the information to individuals who are unable to read or understand written material, or who have LEP[35].

VIII. ADMINISTRATIVE FUNCTIONS

a. The organization shall have written policies, procedures and plans that demonstrate the capability of its access system to meet the standards herein.

b. Community Outreach and Resources

i. The organization shall have an active outreach and education effort to ensure the network providers and the community are aware of the access system and how to use it.

ii. The organization shall have a regular and consistent outreach effort to commonly un-served or underserved populations who include children and families, older adults, homeless persons, members of ethnic, racial, linguistic and culturally-diverse groups, persons with dementia, and pregnant women.[36]

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[30] MDHHS Administrative Rule 325.14302
[31] MHC §330.1706, MDHHS/CMHSP Contract, Part II, Attachment 6.3.2.1
[32] MDHHS/PIHP & CMHSP Contract, Part II, Section 3.4.5
[33] 42 CFR § 438.10
[34] 42 CFR § 438.10, MDHHS/PIHP Contract, Part II, Section 6.3.3. MDHHS AFP, Section 3.1.1
[35] 42 CFR § 438.10, MDHHS/PIHP Contract, Part II, Section 6.3.3
[36] MDHHS AFP, Section 3.1.2

iii. The organization shall assure that the access system staff are informed about, and routinely refer individuals to, community resources that not only include alternatives to public mental health or substance abuse treatment services, but also resources that may help them meet their other basic needs.

iv. The organization shall maintain linkages with the community's crisis/emergency system, liaison with local law enforcement, and have a protocol for jail diversion.

c. Oversight and Monitoring

i. The organization's Medical Director shall be involved in the review and oversight of access system policies and clinical practices.

ii. The organization shall assure that the access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, MIChild Provider Manual, the Michigan Mental Health Code, the Michigan Public Health Code, and this contract[37].

iii. The organization shall have mechanisms to prevent conflict of interest between the coverage determination function and access to, or authorization of, services.

iv. The organization shall monitor provider capacity to accept new individuals, and be aware of any provider organizations not accepting referrals at any point in time[38].

v. The organization shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointments and referrals. Any resulting performance issues are addressed through the organization's Quality Improvement Plan.

vi. The organization shall assure that the access system maintains medical records in compliance with state and federal standards[39].

vii. The organization staff shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation[40].

d. Waiting Lists

i. The organization shall have policies and procedures for maintaining a waiting list for individuals not eligible for Medicaid or MIChild, and who request community mental health services but cannot be immediately served[41]. The policies and procedures shall minimally assure:

[37] 42 CFR §438.214. MDHHS/PIHP Contract, Part II, Attachment 6.7.1.1
[38] 42 CFR §438.10
[39] Michigan Medicaid Provider Manual, General Information Chapter, Section 13.1
[40] MDHHS AFP, Section 3.1.10
[41] MHC §330.1124

1. No Medicaid or MIChild beneficiaries are placed on waiting lists for any medically necessary Medicaid or MIChild service.
2. A local waiting list shall be established and maintained when the CMHSP is unable to financially meet requests for public mental health services received from those who are not eligible for Medicaid, , or MIChild[42]. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
3. Persons who are not eligible for Medicaid, or MIChild, who receive services on an interim basis that are other than those requested shall be retained on the waiting list for the specific requested program services. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
4. Use of a defined process, consistent with the Mental Health Code, to prioritize any service applicants and recipients on its waiting list.
5. Use of a defined process to contact and follow-up with any individual on a waiting list who is awaiting a mental health service.
6. Reporting, as applicable, of waiting list data to MDHHS as part of its annual program plan submission report in accordance with the requirements of the Mental Health Code.
7. The PIHP is responsible for maintaining a SABG waiting list by contacting clients who are placed on it every 30 days to check their status/well-being and continued interest in services until they are linked with the appropriate level of care. Attempts and contacts shall be documented to ensure that the list is properly maintained. Those clients who are not able to be contacted, or who do not respond after 90 days, may be removed.
8. Priority population clients placed on a waiting list are required to be offered interim services[43]. Interim services must minimally include:
    a. Counseling and education about the human immunodeficiency virus (HIV) and tuberculosis (TB).
    b. The risks of needle sharing.

[42] MHC §330.1208
[43] section 96.121 of the Substance Abuse Block Grant

c. The risks of transmission to sexual partners, infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
d. HIV or TB treatment service referrals.
e. Counseling on the effects of alcohol and drug use on a fetus and referral for prenatal care are required for pregnant women.

Michigan Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration
Person-Centered Planning Policy and Practice Guideline
3/15/2011

"Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. MCL 330.1700(g)

I. Introduction

A. Summary/Background

The purpose of the community mental health system is to support adults and children with developmental disabilities, adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance to live successfully in their communities—achieving community inclusion and participation, independence, and productivity. Person-centered planning (PCP) enables individuals to achieve their personally defined outcomes. As described below, PCP for minors (family-driven and youth-guided practice) accommodates the entire family.

Person-centered planning is a way for individuals to plan their lives with the support and input from those who care about them. The process is used for planning the life that the individual aspires to have—taking the individual's goals, hopes, strengths, and preferences and weaving them in plans for a life with meaning. PCP is used anytime an individual's goals, desires, circumstances, preferences, or needs change.

Through the PCP process, an individual and those who support him or her:

a. Focus on the individual's life goals, interests, desires, preferences, strengths and abilities as the foundation for the planning process.
b. Identify outcomes based on the individual's life goals, interests, strengths, abilities, desires and preferences.
c. Make plans for the individual to work toward and achieve identified outcomes.
d. Determine the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.

e. Develop an Individual Plan of Service (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

Meaningful PCP is at the heart of supporting individual choice and control. Person-centered planning focuses on the goals, interests, desires and preferences of the individual, while still exploring and addressing an individual's needs within an array of established life domains (including, but not limited to those listed in the Michigan Mental Health Code (the Code): the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation). As appropriate for the individual, the PCP process may involve other MDHHS policies and initiatives including, but limited to, Recovery, Self-Determination, Culture of Gentleness, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning.

PCP focuses on services and supports necessary (including medically necessary services and supports funded by the CMHSP) for the individual to work toward and achieve their personal goals rather than being limited to authorizing the individual to receive existing programs.

For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach (see the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline). A family-driven, youth-guided approach recognizes the importance of family in the lives of children and that supports and services impact the entire family. In the case of minor children, the child/family is the focus of planning and family members are integral to success of the planning process. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the individual reaches adulthood, his or her needs and goals become primary.

There are a few circumstances where the involvement of a minor's family may be not appropriate:

a. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Mental Health Code;
b. The minor is emancipated; or
c. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process as stated in the Code. Justification of the

exclusion of parents shall be documented in the clinical record.

B. Michigan Mental Health Code—Definition

PCP, as defined by the Code, "means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires." MCL 330.1700(g).

The Code also requires use of PCP for development of an Individual Plan of Service:

> "(1) The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan." MCL 330.1712.

C. PCP Values and Principles

Person-centered planning is a highly <u>individualized</u> process designed to respond to the expressed needs/desires of the individual.

- Every individual is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community.

- Every individual has strengths, can express preferences, and can make choices.

- The individual's choices and preferences are honored and considered, if not always implemented.

- Every individual contributes to his or her community, and has the ability to choose how supports and services enable him or her to meaningfully participate and contribute.

- Through the person-centered planning process, an individual maximizes independence, creates community connections, and works towards achieving his or her chosen outcomes.

- An individual's cultural background is recognized and valued in the person-centered planning process.

D. Implementation of Person-Centered Planning

While the Code requires that PCP be used to develop an Individual Plan of Service (IPOS) that includes community mental health services and supports, the purpose of person-centered planning is a process for an individual to define the life that he or she wants and what components need to be in place for the individual to have, work toward or achieve that life. Depending on the individual, community mental health services and supports may play a small or large role in supporting an him or her in having the life he or she wants. When an individual is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life the he or she desires to have.

Individuals are going to be at different points in the process of achieving the life to which they aspire and the PCP process should be individualized to meet the needs of the individual for whom planning is done, e.g. meeting an individual where he or she is. Some people may be just beginning to define the life they want and initially the PCP process may be lengthy as the individual's goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once this initial work is completed, it does not need to be redone unless so desired by the individual. Once an IPOS is developed, subsequent use of the planning process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent that the IPOS is updated will be determined by the needs and desires of the individual. If and when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs and desires of the individual when he or she has them.

II. Essential Elements for Person-Centered Planning

The following characteristics are essential to the successful use of the PCP process with an individual and his/her allies.

1. **Person-Directed.** The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

2. **Person-Centered.** The planning process focuses on the individual, not the system or the individual's family, guardian, or friends. The individual's goals, interests, desires, and preferences are identified with an optimistic view of the future and plans for a satisfying life. The planning process is used whenever the individual wants or needs it, rather than viewed as an annual event.

3. **Outcome-Based.** Outcomes in pursuit of the individual's preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.

4. **Information, Support and Accommodations.** As needed, the individual receives comprehensive and unbiased information on the array of mental health services, community resources, and available providers. Support and accommodations to assist the individual to participate in the process are provided.

5. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process. See Section III below

6. **Pre-Planning.** The purpose of pre-planning is for the individual to gather all of the information and resources (e.g. people, agencies) necessary for effective person-centered planning and set the agenda for the process. Each individual (except for those individuals who receive short-term outpatient therapy only, medication only, or those who are incarcerated) is entitled to use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used

   The following items are addressed through pre-planning with sufficient time to take all necessary/preferred actions (i.e. invite desired participants):

a. When and where the meeting will be held,
b. Who will be invited (including whether the individual has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support),
c. What will be discussed and not discussed,
d. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication),
e. Who will facilitate the meeting,
f. Who will record what is discussed at the meeting.

7. **Wellness and Well-Being.** Issues of wellness, well-being, health and primary care coordination or integration, supports needed for an individual to continue to live independently as he or she desires, and other concerns specific to the individual's personal health goals or support needed for the individual to live the way they want to live are discussed and plans to address them are developed. If so desired by the individual, these issues can be addressed outside of the PCP meeting.

8. **Participation of Allies.** Through the pre-planning process, the individual selects allies (friends, family members and others) to support him or her through the person-centered planning process. Pre-planning and planning help the individual explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

III. Independent (External) Facilitation

In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator of the person-centered planning process, unless the individual is receiving short-term outpatient therapy or medication only. The CMHSP must make available a choice of at least two independent facilitators to individuals interested in using independent facilitation. The facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The facilitator helps the individual with the pre-planning activities and co-leads any PCP meeting(s) with the individual.

The independent facilitator must not have any other role within the CMHSP. The independent facilitator must personally know or get to know the individual who is the focus of the planning including what he or she likes and dislikes as well as personal preferences, goals, modes of communication, and who supports or is important to the individual. The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called "Treatment Planning" MPM MH&SAA Chapter, Section 3.25. If the independent facilitator is paid for the provision of these activities, the PIHP may report the service under the code H0032. It is advisable that the CMHSP support independent facilitators in obtaining training in PCP, regardless of whether the independent facilitator is paid or unpaid.

IV. Individual Plan of Service

The Code establishes the right for all individuals to develop individual plans of services (IPOS) through a person-centered planning process regardless of disability or residential setting. However, an IPOS needs to be more than the services and supports authorized by the community mental health system; it must include all of the components described below. The PCP process must be used at any time the individual wants or needs to use the process. The agenda for each PCP meeting should be set by the individual through the pre-planning process, not by agency or by the fields or categories in a form or an electronic medical record

Once an individual has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the individual's needs, changes in the individual's condition as determined through the PCP process or changes in the individual's preferences for support). Assessment may be used to inform the PCP process, but is not a substitute for the process.

The individual and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. An individual or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually through the PCP process to review progress toward goals and objectives and to assess beneficiary satisfaction. Reviews will work from the existing plan to amend or update it as circumstances, needs, preferences or goals change or to develop a completely new plan if so desired by the individual. Use of the PCP process in the review of the plan incorporates all of the Essential Elements as desired by the individual.

The individual decides who will take notes or minutes about what is discussed during the person-centered planning process. In addition, documentation maintained by the CMHSP within the Individual Plan of Service must include:

(1) A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports;
(2) The outcomes identified by the individual and how progress toward achieving those outcomes will be measured;
(3) The services and supports needed by the individual to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports;
(4) The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.
(5) The estimated/prospective cost of services and supports authorized by the community mental health system.
(6) The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.
(7) Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

The individual must be provided with a written copy of his or her plan within 15 business days of conclusion of the PCP process. This timeframe gives the case manager/ supports coordinator a sufficient amount of time to complete the documentation described above.

V. Organizational Standards

The following characteristics are essential for organizations responsible for providing supports and services through PCP:

- Individual Awareness and Knowledge—The organization provides accessible and easily understood information, support and when necessary, training, to individuals using services and supports and those who assist them so that they are aware of their right to PCP, the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).
- Person-Centered Culture–The organization provides leadership, policy direction, and activities for implementing person-centered planning at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.

- Training—The organization has a process to identify and train staff at all levels on the philosophy of PCP. Staff who are directly involved in PCP are provided with additional training.
- Roles and Responsibilities—As an individualized process, PCP allows each individual to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.
- Quality Management—The QA/QM System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful person-centered planning. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and standards are in place to assure support the individual directs the PCP process and ensures that PCP is consistently done well.

VI. Dispute Resolution

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). Other options are available to all recipients of Michigan mental health services and supports. Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate dispute resolution processes.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration
SELF-DETERMINATION POLICY & PRACTICE GUIDELINE[i]

INTRODUCTION

Self-determination is the value that people served by the public mental health system must be supported to have a meaningful life in the community. The components of a meaningful life include: work or volunteer activities that are chosen by and meaningful to person, reciprocal relationships with other people in the community, and daily activities that are chosen by the individual and support the individual to connect with others and contribute to his or her community. With arrangements that support self-determination, individuals have control over an individual budget for their mental health services and supports to live the lives they want in the community. The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.

Person-centered planning (PCP) is a central element of self-determination. PCP is the crucial medium for expressing and transmitting personal needs, wishes, goals and aspirations. As the PCP process unfolds, the appropriate mix of paid/non-paid services and supports to assist the individual in realizing/achieving these personally defined goals and aspirations are identified.

The principles of self-determination recognize the rights of people supported by the mental health system to have a life with freedom, and to access and direct needed supports that assist in the pursuit of their life, with responsible citizenship. These supports function best when they build upon natural community experiences and opportunities. The person determines and manages needed supports in close association with chosen friends, family, neighbors, and co-workers as a part of an ordinary community life.

Person-centered planning and self-determination underscore a commitment in Michigan to move away from traditional service approaches for people receiving services from the public mental health system. In Michigan, the flexibility provided through the Medicaid 1915(b) Managed Specialty Supports and Services Plan (MSSSP), together with the Mental Health Code requirements of PCP, have reoriented organizations to respond in new and more meaningful ways. Recognition has increased among providers and professionals that many individuals may not need, want, or benefit from a clinical regimen, especially when imposed without clear choice. Many provider agencies are learning ways to better support the individual to choose, participate in, and accomplish a life with personal meaning. This has meant, for example, reconstitution of segregated programs into non-segregated options that connect better with community life.

Self-determination builds upon the choice already available within the public mental health system. In Michigan, all Medicaid beneficiaries who services through the public

mental health system have a right under the Balanced Budget Act (BBA) to choose the providers of the services and supports that are identified in their individual plan of service "to the extent possible and appropriate." Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel. Within the PIHP, choice of providers must be maintained at the provider level. The individual must be able to choose from at least two providers of each covered support and service and must be able to choose an out-of-network provider under certain circumstances. Provider choice, while critically important, must be distinguished from arrangements that support self- determination. The latter arrangements extend individual choice to his/her control and management over providers (i.e., directly employs or contracts with providers), service delivery, and budget development and implementation.

In addition to choice of provider, individuals using mental health services and supports have access to a full-range of approaches for receiving those services and supports. Agencies and providers have obligations and underlying values that affirm the principles of choice and control. Yet, they also have long-standing investments in existing programs and services, including their investments in capital and personnel resources. Some program approaches are not amenable to the use of arrangements that support self-determination because the funding and hiring of staff are controlled by the provider (for example, day programs and group homes) and thus, preclude individual employer or budget authority.

It is not anticipated that every person will choose arrangements that support self-determination. Traditional approaches are offered by the system and used very successfully by many people. An arrangement that supports self-determination is one method for moving away from predefined programmatic approaches and professionally managed models. The goals of arrangements that support self-determination, on an individual basis, are to dissolve the isolation of people with disabilities, reduce segregation, promote participation in community life and realize full citizenship rights.

The Department of Health and Human Services supports the desire of people to control and direct their specialty mental health services and supports to have a full and meaningful life. At the same time, the Department knows that the system change requirements, as outlined in this policy and practice guideline, are not simple in their application. The Department is committed to continuing dialogue with stakeholders; to the provision of support, direction and technical assistance so the system may make successful progress to resolve technical difficulties and apparent barriers; and to achieve real, measurable progress in the implementation of this policy. This policy is intended to clarify the essential aspects of arrangements that promote opportunity for self-determination and define required elements of these arrangements.

PURPOSE

I. To provide policy direction that defines and guides the practice of self-

determination within the public mental health system (as implemented by Prepaid Inpatient Health Plans/Community Mental Health Services Programs (PIHP/CMHSPs)[1] in order to assure that arrangements that support self-determination are made available as a means for achieving personally-designed plans of specialty mental health services and supports.

CORE ELEMENTS

I. People are provided with information about the principles of self-determination and the possibilities, models and arrangements involved. People have access to the tools and mechanisms supportive of self-determination, upon request. Self-determination arrangements commence when the PIHP/CMHSP and the individual reach an agreement on an individual plan of services (IPOS), the amount of mental health and other public resources to be authorized to accomplish the IPOS, and the arrangements through which authorized public mental health resources will be controlled, managed, and accounted for.

II. Within the obligations that accompany the use of funds provided to them, PIHP/CMHSPs shall ensure that their services planning and delivery processes are designed to encourage and support individuals to decide and control their own lives. The PIHP/CMHSP shall offer and support easily-accessed methods for people to control and direct an individual budget. This includes providing them with methods to authorize and direct the delivery of specialty mental health services and supports from qualified providers selected by the individual.

III. People receiving services and supports through the public mental health system shall direct the use of resources in order to choose meaningful specialty mental health services and supports in accordance with their IPOS as developed through the person-centered planning process.

IV. Fiscal responsibility and the wise use of public funds shall guide the individual and the PIHP/CMHSP in reaching an agreement on the allocation and use of funds comprising an individual budget. Accountability for the use of public funds must be a shared responsibility of the PIHP/CMHSP and the person, consistent with the fiduciary obligations of the PIHP/CMHSP.

V. Realization of the principles of self-determination requires arrangements that are partnerships between the PIHP/CMHSP and the individual. They require the active commitment of the PIHP/CMHSP to provide a range of options for

CORE ELEMENTS, continued

individual choice and control of personalized provider relationships within an

[1] Both PIHPs and CMHSPs are referenced throughout the document because the both have contractual obligations to offer and support implementation of arrangements that support self-determination. However, it is understood that, on an individual basis, self-determination agreements are executed at the CMHSP level.

overall environment of person-centered supports.

VI. In the context of this partnership, PIHP/CMHSPs must actively assist people with prudently selecting qualified providers and otherwise support them with successfully using resources allocated in an individual budget.

VII. Issues of wellness and well-being are central to assuring successful accomplishment of a person's IPOS. These issues must be addressed and resolved using the person-centered planning process, balancing individual preferences and opportunities for self-determination with PIHP/CMHSP obligations under federal and state law and applicable Medicaid Waiver regulations. Resolutions should be guided by the individual's preferences and needs, and implemented in ways that maintain the greatest opportunity for personal control and direction.

VIII. Self-determination requires recognition that there may be strong inherent conflicts of interest between a person's choices and current methods of planning, managing and delivering specialty mental health services and supports. The PIHP/CMHSP must watch for and seek to minimize or eliminate either potential or actual conflicts of interest between itself and its provider systems, and the processes and outcomes sought by the person.

IX. Arrangements that support self-determination are administrative mechanisms, allowing a person to choose, control and direct providers of specialty mental health services and supports. With the exception of fiscal intermediary services, these mechanisms are not themselves covered services within the array of state plan and mental health specialty services and supports. Self-determination arrangements must be developed and operated within the requirements of the respective contracts between the PIHPs and CMHSPs and the Michigan Department of Health and Human Services and in accordance with federal and state law. Using arrangements that support self-determination does not change an_individual's eligibility for particular specialty mental health services and supports.

X. All of the requirements for documentation of Medicaid-funded supports and services, financial accountability for Medicaid funds, and PIHP/CMHSP monitoring requirements apply to services and supports acquired using arrangements that support self-determination.

XI. Arrangements that support self-determination involve mental health specialty services and supports, and therefore, the investigative authority of the Recipient Rights office applies.

POLICY

I. Opportunity to pursue and obtain an IPOS incorporating arrangements that support self-determination shall be established in each PIHP/CMHSP, for adults with developmental disabilities and adults with mental illness. Each PIHP/CMHSP shall develop and make available a set of methods that provide opportunities for the person to control and direct their specialty mental health services and supports arrangements.

A. Participation in self-determination shall be a voluntary option on the part of each person.

B. People involved in self-determination shall have the authority to select, control and direct their own specialty mental health services and supports arrangements by responsibly controlling the resources allotted in an individual budget, towards accomplishing the goals and objectives in their IPOS.

C. A PIHP/CMHSP shall assure that full and complete information about self-determination and the manner in which it may be accessed and applied is provided to everyone receiving mental health services from its agency. This shall include specific examples of alternative ways that a person may use to control and direct an individual budget, and the obligations associated with doing this properly and successfully.

D. Self-determination shall not serve as a method for a PIHP/CMHSP to reduce its obligations to a person or avoid the provision of needed specialty mental health services and supports.

E. Each PIHP/CMHSP shall actively support and facilitate a person's application of the principles of self-determination in the accomplishment of his/her IPOS.

II. Arrangements that support self-determination shall be made available to each person for whom an agreement on an IPOS along with an acceptable individual budget has been reached. A person initiates this process by requesting the opportunity to participate in self-determination. For the purposes of self-determination, reaching agreement on the IPOS must include delineation of the arrangements that will, or may, be applied by the person to select, control and direct the provision of those services and supports.

A. Development of an individual budget shall be done in conjunction with development of an IPOS using a person-centered planning process.

B. As part of the planning process leading to an agreement about self-

POLICY Section II. continued

determination, the arrangements that will, or may, be applied by the person to pursue self-determination shall be delineated and agreed to by the person and the PIHP/CMHSP.

C. The individual budget represents the expected or estimated costs of a concrete approach to accomplishing the person's IPOS.

D. The amount of the individual budget shall be formally agreed to by both the person and the PIHP/CMHSP before it may be authorized for use by the person. A copy of the individual budget must be provided to the person prior to the onset of a self-determination arrangement.

E. Proper use of an individual budget is of mutual concern to the PIHP/CMHSP and the person.

1. Mental Health funds included in an individual budget are the assets and responsibility of the PIHP/CMHSP, and must be used consistent with statutory and regulatory requirements. Authority over their direction is delegated to the individual, for the purpose of achieving the goals and outcomes contained in the individual's IPOS. The limitations associated with this delegation shall be delineated to the individual as part of the process of developing the IPOS and authorizing the individual budget.

2. An agreement shall be made in writing between the PIHP/CMHSP and the individual delineating the responsibility and the authority of both parties in the application of the individual budget, including how communication will occur about its use. The agreement shall reference the IPOS and individual budget, which shall all be provided to the person. The directions and assistance necessary for the individual to properly apply the individual budget shall be provided to the individual in writing when the agreement is finalized.

3. An individual budget, once authorized, shall be provided to the individual. An individual budget shall be in effect for a specified period of time. Since the budget is based upon the individual's IPOS, when the IPOS needs to change, the budget may need to be reconsidered as well. In accordance with the Person-Centered Planning Policy and Practice Guideline, the IPOS may be reopened and reconsidered whenever the individual, or the PIHP/CMHSP, feels it needs to be reconsidered.

4. The individual budget is authorized by the PIHP/CMHSP for the purpose of providing a defined amount of resources that may be

POLICY Section II.E.4 continued

directed by a person to pursue accomplishing his/her IPOS. An individual budget shall be flexible in its use.

a. When a person makes adjustments in the application of funds in an individual budget, these shall occur within a framework that has been agreed to by the person and the PIHP/CMHSP, and described in an attachment to the person's self-determination agreement.

b. A person's IPOS may set forth the flexibility that an individual can exercise to accomplish his or her goals and objectives. When a possible use of services and supports is identified in the IPOS, the person does not need to seek prior approval to use the services in this manner.

c. If a person desires to exercise flexibility in a manner that is not identified in the IPOS, then the IPOS must be modified before the adjustment may be made. The PIHP/CMHSP shall attempt to address each situation in an expedient manner appropriate for the complexity and scope of the change.

d. Funds allotted for specialty mental health services may not be used to purchase services that are not specialty mental health services. Contracts with providers of specialty mental health services should be fiscally prudent.

5. Either party—the PIHP/CMHSP or the person—may terminate a self-determination agreement, and therefore, the self-determination arrangement. Common reasons that a PIHP/CMHSP may terminate an agreement after providing support and other interventions described in this guideline, include, but are not limited to: failure to comply with Medicaid documentation requirements; failure to stay within the authorized funding in the individual budget; inability to hire and retain qualified providers; and conflict between the individual and providers that results in an inability to implement IPOS. Prior to the PIHP/CMHSP terminating an agreement, and unless it is not feasible, the PIHP/CMHSP shall inform the individual of the issues that have led to consideration of a discontinuation or alteration decision, in writing, and provide an opportunity for problem resolution. Typically resolution will be conducted using the person-centered planning process, with termination being the option of choice if other mutually-agreeable solutions cannot be found. In any instance of PIHP/CMHSP discontinuation or alteration of a self-determination arrangement, the

POLICY Section II.E.5 continued

local processes for dispute resolution may be used to address and resolve the issues.

6. Termination of a Self-Determination Agreement by a PIHP/CMHSP is not a Medicaid Fair Hearings Issue. Only a change, reduction, or termination of Medicaid services can be appealed through the Medicaid Fair Hearings Process, not the use of arrangements that support self-determination to obtain those services.

7. Discontinuation of a self-determination agreement, by itself, shall neither change the individual's IPOS, nor eliminate the obligation of the PIHP/CMHSP to assure specialty mental health services and supports required in the IPOS are provided.

8. In any instance of PIHP/CMHSP discontinuation or alteration, the person must be provided an explanation of applicable appeal, grievance and dispute resolution processes and (when required) appropriate notice.

III. Assuring authority over an individual budget is a core element of self-determination. This means that the individual may use, responsibly, an individual budget as the means to authorize and direct their providers of services and supports. A PIHP/CMHSP shall design and implement alternative approaches that people electing to use an individual budget may use to obtain individual-selected and -directed provider arrangements.

A. Within prudent purchaser constraints, a person shall be able to access any willing and qualified provider entity that is available to provide needed specialty mental health services and supports.

B. Approaches shall provide for a range of control options up to and including the direct retention of individual-preferred providers through purchase of services agreements between the person and the provider. Options shall include, upon the individual's request and in line with their preferences:

1. Services/supports to be provided by an entity or individual currently operated by or under contract with the PIHP/CMHSP.

2. Services/supports to be provided by a qualified provider chosen by the individual, with the PIHP/CMHSP agreeing to enter into a contract with that provider.

3. Services/supports to be provided by an individual-selected provider with whom the individual executes a direct purchase-of-services

POLICY Section III.B.3 continued

agreement. The PIHP/CMHSP shall provide guidance and assistance to assure that agreements to be executed with individual-selected providers are consistent with applicable federal regulations governing provider contracting and payment arrangements.

a. Individuals shall be responsible for assuring those individuals and entities selected and retained meet applicable provider qualifications. Methods that lead to consistency and success must be developed and supported by the PIHP/CMHSP.

b. Individuals shall assure that written agreements are developed with each provider entity or individual that specify the type of service or support, the rate to be paid, and the requirements incumbent upon the provider.

c. Copies of all agreements shall be kept current, and shall be made available by the individual, for review by authorized representatives of the PIHP/CMHSP.

d. Individuals shall act as careful purchasers of specialty mental health services and supports necessary to accomplish their IPOS. Arrangements for services shall not be excessive in cost. Individuals should aim for securing a better value in terms of outcomes for the costs involved. Existing personal and community resources shall be pursued and used before public mental health system resources.

e. Fees and rates paid to providers with a direct purchase-of-services agreement with the individual shall be negotiated by the individual, within the boundaries of the authorized individual budget. The PIHP/CMHSP shall provide guidance as to the range of applicable rates, and may set maximum amounts that a person may spend to pay providers of specific services and supports.

f. Conflicts of interest that providers may have must be considered. For example, a potential provider may have a competing financial interest such as serving as the individual's landlord. If a provider with a conflict of interest is used, the conflict must be addressed in the relevant agreements. The Medicaid Provider Manual has directly

POLICY Section III.B.3 continued

addressed one conflict stating that, individuals cannot hire or contract with legally responsible relatives (for an adult, the individual's spouse) or with his or legal guardian.

4. A person shall be able to access one or more alternative methods to choose, control and direct personnel necessary to provide direct support, including:

   a. Acting as the employer of record of personnel.

   b. Access to a provider entity that can serve as employer of record for personnel selected by the individual (Agency with Choice).

   c. PIHP/CMHSP contractual language with provider entities that assures individual selection of personnel, and removal of personnel who fail to meet individual preferences.

   d. Use of PIHP/CMHSP-employed direct support personnel, as selected and retained by the individual.

5. A person using self-determination shall not be obligated to utilize PIHP/CMHSP-employed direct support personnel or a PIHP/CMHSP-operated or -contracted program/service.

6. All direct support personnel selected by the person, whether she or he is acting as employer of record or not, shall meet applicable provider requirements for direct support personnel, or the requirements pertinent to the particular professional services offered by the provider.

7. A person shall not be required to select and direct needed provider entities or his/her direct support personnel if she or he does not desire to do so.

IV. A PIHP/CMHSP shall assist a person using arrangements that support self-determination to select, employ, and direct his/her support personnel, to select and retain chosen qualified provider entities, and shall make reasonably available, consistent with MDHHS Technical Advisory instructions, their access to alternative methods for directing and managing support personnel.

   A. A PIHP/CMHSP shall select and make available qualified third-party entities that may function as fiscal intermediaries to perform employer

POLICY Section IV.A continued

agent functions and/or provide other support management functions as described in the Fiscal Intermediary Technical Requirement (Contract Attachment P3.4.4), in order to assist the person in selecting, directing and controlling providers of specialty services and supports.

B. Fiscal intermediaries shall be under contract to the PIHP/CMHSP or a designated sub-contracting entity. Contracted functions may include:

1. Payroll agent for direct support personnel employed by the individual (or chosen representative), including acting as an employer agent for IRS and other public authorities requiring payroll withholding and employee insurances payments.

2. Payment agent for individual-held purchase-of-services and consultant agreements with providers of services and supports.

3. Provision of periodic (not less than monthly) financial status reports concerning the individual budget, to both the PIHP/CMHSP and the individual. Reports made to the individual shall be in a format that is useful to the individual in tracking and managing the funds making up the individual budget.

4. Provision of an accounting to the PIHP/CMHSP for the funds transferred to it and used to finance the costs of authorized individual budgets under its management.

5. Assuring timely invoicing, service activity and cost reporting to the PIHP/CMHSP for specialty mental health services and supports provided by individuals and entities that have a direct agreement with the individual.

6. Other supportive services, as denoted in the contract with the PIHP/CMHSP that strengthen the role of the individual as an employer, or assist with the use of other agreements directly involving the individual in the process of securing needed services.

For a complete list of functions, refer to the Fiscal Intermediary Technical Requirement (Contract Attachment P3.4.4),

C. A PIHP/CMHSP shall assure that fiscal intermediary entities are oriented to and supportive of the principles of self-determination, and able to work with a range of personal styles and characteristics. The PIHP/CMHSP shall exercise due diligence in establishing the qualifications,

POLICY Section IIV.C continued

characteristics and capabilities of the entity to be selected as a fiscal intermediary, and shall manage the use of fiscal intermediaries consistent with the Fiscal Intermediary Technical Requirement and MDHHS Technical Assistance Advisories addressing fiscal intermediary arrangements.

D. An entity acting as a fiscal intermediary shall be free from other relationships involving the PIHP/CMHSP or the individual that would have the effect of creating a conflict of interest for the fiscal intermediary in relationship to its role of supporting individual-determined services/supports transactions. These other relationships typically would include the provision of direct services to the individual. The PIHP/CMHSP shall identify and require remedy to any conflicts of interest of the entity that, in the judgment of the PIHP/CMHSP, interfere with the performance of a fiscal intermediary.

E. A PIHP/CMHSP shall collaborate with and guide the fiscal intermediary and each individual involved in self-determination to assure compliance with various state and federal requirements and to assist the individual in meeting his/her obligations to follow applicable requirements. It is the obligation of the PIHP/CMHSP to assure that fiscal intermediaries are capable of meeting and maintaining compliance with the requirements associated with their stated functions, including those contained in the Fiscal Intermediary Technical Requirement.

F. Typically, funds comprising an individual budget would be lodged with the fiscal intermediary, pending appropriate direction by the individual to pay individual-selected and contracted providers. Where a person selected and directed provider of services has a direct contract with the PIHP/CMHSP, the provider may be paid by the PIHP/CMHSP, not the fiscal intermediary. In that case, the portion of funds in the individual budget would not be lodged with the fiscal intermediary, but instead would remain with the PIHP/CMHSP, as a matter of fiscal efficiency.

DEFINITIONS

Agency with Choice
A provider agency that serves as employer of record for direct support personnel, yet enables the person using the supports to hire, manage and terminate workers.

CMHSP
For the purposes of this policy, a Community Mental Health Services Program is an entity operated under Chapter Two of the Michigan Mental Health Code, or an entity under contract with the CMHSP and authorized to act on its behalf in providing access to, planning for, and authorization of specialty mental health services and supports for people eligible for mental health services.

Fiscal Intermediary
A fiscal Intermediary is an independent legal entity (organization or individual) that acts as a fiscal agent of the PIHP/CMHSP for the purpose of assuring fiduciary accountability for the funds comprising an individual budget. A fiscal intermediary shall perform its duties as specified in a contract with a PIHP/CMHSP or its designated sub-contractor. The purpose of the fiscal intermediary is to receive funds making up an individual budget, and make payments as authorized by the individual to providers and other parties to whom an individual using the individual budget may be obligated. . A fiscal intermediary may also provide a variety of supportive services that assist the individual in selecting, employing and directing individual and agency providers. Examples of entities that might serve in the role of a fiscal intermediary include: bookkeeping or accounting firms and local Arc or other advocacy organizations.

Individual/Person
For the purposes of this policy, “Individual” or “person” means a person receiving direct specialty mental health services and supports. The person may select a representative to enter into the self-determination agreement and for other agreements that may be necessary for the person to participate in arrangements that support-self-determination. The person may have a legal guardian. The role of the guardian in self-determination shall be consistent with the guardianship arrangement established by the court. Where a person has been deemed to require a legal guardian, there is an extra obligation on the part of the CMHSP and those close to the person to assure that the person’s preferences and dreams drive the use of self-determination arrangements, and that the best interests of the person are primary.

Individual Budget
An individual budget is a fixed allocation of public mental health resources denoted in dollar terms. These resources are agreed upon as the necessary cost of specialty mental health services and supports needed to accomplish a person’s IPOS. The individual served uses the funding authorized to acquire, purchase, and pay for specialty mental health services and supports in his or her IPOS.

IPOS
An IPOS means the individual's individual plan of services and/or supports, as developed using a person-centered planning process.

PIHP
For the purposes of this policy, a Prepaid Inpatient Health Plan (PIHP) is a managed care entity that provides Medicaid-funded mental health specialty services and supports in an area of the state.

Qualified Provider
A qualified provider is an individual worker, a specialty practitioner, professional, agency or vendor that is a provider of specialty mental health services or supports that can demonstrate compliance with the requirements contained in the contract between the Department of Health and Human Services and the PIHP/CMHSP, including applicable requirements that accompany specific funding sources, such as Medicaid. Where additional requirements are to apply, they should be derived directly from the person-centered planning process, and should be specified in the IPOS, or result from a process developed locally to assure the health and well-being of individuals, conducted with the full input and involvement of local individuals and advocates.

Self-Determination
Self-determination incorporates a set of concepts and values that underscore a core belief that people who require support from the public mental health system as a result of a disability should be able to define what they need in terms of the life they seek, have access to meaningful choices, and have control over their lives in order to build lives in their community (meaningful activities, relationships and employment). Within Michigan's public mental health system, self-determination involves accomplishing system change to assure that services and supports for people are not only person-centered, but person-defined and person-controlled. Self-determination is based on four principles. These principles are:

> **FREEDOM:** The ability for individuals, with assistance from significant others (e.g., chosen family and/or friends), to plan a life based on acquiring necessary supports in desirable ways, rather than purchasing a program. This includes the **freedom** to choose where and with whom one lives, who and how to connect to in one's community, the opportunity to contribute in one's own ways, and the development of a personal lifestyle.
>
> **AUTHORITY:** The assurance for a person with a disability to control a certain sum of dollars in order to purchase these supports, with the backing of their significant others, as needed. It is the **authority** to control resources.
>
> **SUPPORT:** The arranging of resources and personnel, both formal and informal, to assist the person in living his/her desired life in the community, rich in community associations and contributions. It is the **support** to develop a life

dream and reach toward that dream.

RESPONSIBILITY: The acceptance of a valued role by the person in the community through employment, affiliations, spiritual development, and caring for others, as well as accountability for spending public dollars in ways that are life-enhancing. This includes the **responsibility** to use public funds efficiently and to contribute to the community through the expression of responsible citizenship.

A hallmark of self-determination is assuring a person the opportunity to direct a fixed amount of resources, which is derived from the person-centered planning process and called an individual budget. The person controls the use of the resources in his/her individual budget, determining, with the assistance of chosen allies, which services and supports he or she will purchase, from whom, and under what circumstances. Through this process, people possess power to make meaningful choices in how they live their life.

Specialty Mental Health Services
This term includes any service/support that can legitimately be provided using funds authorized by the PIHP/CMHSP in the individual budget. It includes alternative services and supports as well as Medicaid-covered services and supports.

FISCAL INTERMEDIARY TECHNICAL REQUIREMENT

I. Background

Fiscal Intermediary (FI) services are an essential component of providing financial accountability and Medicaid integrity for the individual budgets authorized for individuals using arrangements that support self-determination. Prepaid Inpatient Health Plans/Community Mental Health Service Programs (PIHP/CMHSPs) have been contractually required to offer arrangements that support self-determination to adults who use mental health services and supports since January 1, 2009 (90 days after the publication of the Choice Voucher System Technical Advisory version 2.0) (dated September 30, 2008) (CVS TA)[i]. PIHP/CMHSPs are also required to offer choice voucher arrangements to families of minor children on the Children's Waiver Program (CWP) and the Habilitation Supports Waiver (HSW) and may elect to provide choice voucher arrangements to other families of minor children. Entities that provide FI services also provide critical support to individuals who use arrangements that support self-determination that allow them to control and manage their arrangements effectively.

The primary role of the FI is to provide fiscal accountability for the funds in the individual budget. "The individual budget represents the expected or estimated costs of a concrete approach to accomplishing the person's IPOS." Self-Determination Policy and Practice Guideline (October 1, 2012) (SD Policy), Section II.C. "Development of an individual budget shall be done in conjunction with development of an IPOS using a person-centered planning process. As part of the planning process leading to an agreement about self-determination, the arrangements that will, or may, be applied by the person to pursue self-determination shall be delineated and agreed to by the person and the PIHP/CMHSP." SD Policy II.A &B.[i] The role of the FI is not to develop the individual budget or direct how services and supports are used, but to ensure that the payments it makes are correspond with the IPOS and the individual budget.

FI services were first identified in the SD Policy. "A fiscal Intermediary is an independent legal entity (organization or individual) that acts as a fiscal agent of the PIHP/CMHSP for the purpose of assuring fiduciary accountability for the funds comprising an individual budget SD Guideline Glossary. A PIHP/CMHSP shall select and make available qualified third-party entities that may function as fiscal intermediaries to perform employer agent functions and/or provide other support management functions." SD Policy IV.A Fiscal Intermediary Services was later made a 1915(b) waiver service (Medicaid Provider Manual, Mental Health/Substance Abuse §17.3.0) and can be billed as an administrative activity for families using choice voucher arrangements under the Children's Waiver Program.

The purpose of this Technical Requirement is to clarify the qualifications, role and functions of entities that provide FI services as well as the requirements that PIHP/CMHSPs have in procuring and contracting with entities to provide FI services.

II. PIHP/CMHSP Requirements

Each PIHP/CMHSP is required to contract with at least one entity to provide FI services. In procuring and contracting with entities to provide FI services, the PIHP/CMHSP must ensure that the entities meet all of qualifications set forth in this technical requirement. The PIHP/CMHSP also must assure that fiscal intermediaries are oriented to and supportive of the principles of self-determination and able to work with a range of consumer styles and characteristics. PIHP/CMHSPs have an obligation to Identify and require remedy to any conflicts of interest that, in the judgment of the PIHP/CMHSP, interfere with the performance of the role of the entity providing FI services (see Section III Qualification for FI Entities below).

Contracts with entities providing FI services must identify the functions and scope of FI services, set forth accounting methods and methods for assuring timely invoicing, service activity and cost reporting to the PIHP/CMHSP for specialty mental health services, require indemnification and professional liability insurance for non-performance or negligent performance of FI duties (general business or liability insurance is insufficient), and identify a contact person or persons at the PIHP/CMHSP and at the FI entity for troubleshooting problems and resolving disputes. The PIHP/CMHSP should provide individuals using FI services and their allies with the opportunity to provide input into the development the scope of the FI services and the implementation of those services. In addition to the required functions identified in Section IV below, PIHP/CMHSPs may choose to contract with the entities to provide other supportive functions (such as verification of employee qualifications (background checks, provider qualification checks, etc.)) that are identified in the Self-Determination Implementation Technical Advisory (SDI TA), Appendix C, List of Fiscal Intermediary Functions, Section II Employment Support Functions. PIHP/CMHSPs may only pay entities that provide FI services on a flat rate basis or another basis that does not base compensation on a percentage of individual budgets.

In addition to contracting and procurement, each PIHP/CMHSP must monitor the performance of entities that provide FI services on an annual basis just as it monitors the performance of all other service providers. Minimally, this annual performance monitoring must include:

- Verification that the FI is fulfilling contractual requirements;
- Verification of demonstrated competency in safeguarding, managing and disbursing Medicaid and other public funds;
- Verification that indemnification and required insurance provisions are in place and updated as necessary;

- Evaluation of feedback (experience and satisfaction) from individuals using FI services and other FI performance data with alternate methods for collections data from individuals using services (more than mailed surveys); and
- An audit of a sample of individual budgets to compare authorizations versus expenditures.

III. Required Qualifications for FI Entities

Entities that provide FI services must have a positive track record of managing and accounting for funds. These entities must be independent and free from conflicts of interest. In other words, they cannot be a provider of any other mental health services and supports or any other publicly funded services (such as, but not limited to Home Help services available through the Department of Human Services (DHS)). In addition, FI entities cannot be a guardian, conservator, or trust holder or have any other compensated fiduciary relationship with any individual receiving mental health services and supports except for representative payee[i].

IV. Required Fiscal Intermediary Functions

Required FI functions include Financial Accountability functions and Employer Agent functions. Other possible functions are identified within the Administrative Functions and Employment Support Functions in the List of Fiscal Intermediary Functions (SDI TA, Appendix C).

A. Financial Accountability Functions

For all individuals using arrangements that support self-determination and families of minor children using choice voucher arrangements, entities providing FI services must:

- Have a mechanism to crosscheck invoices with authorized services and supports in each individual plan of service (IPOS) and individual budget and a procedure for handling invoices for unauthorized services and supports.
- Pay only invoices approved by the individual (or family of a minor child) for services and supports explicitly authorized in the IPOS and individual budget.
- Have a system in place for tracking and monitoring individual budget expenditures and identifying potential over- and under-expenditures that minimally includes the following:
    - Provide monthly financial status reports to the supports coordinator (and anyone else at the PIHP/CMHSP identified in the contract to receive monthly budget reports) and the individual (or the family of a minor child) by no later than 15 days after the end of month.
    - Contact the supports coordinator by phone or e-mail in the case of an over expenditure of 10 percent in one month prior to making payment for that expenditure.
    - Contact the supports coordinator by phone or e-mail in the case of under expenditure of the pro rata share of the individual budget for the month

that indicates that the individual is not receiving the services and supported in the IPOS.

- Have policies and procedures in place to assure adherence to federal and state laws and regulations (especially requirements related to Medicaid integrity) and ensure compliance with documentation requirements related to management of public funds.
- Have policies and procedures in place to assure financial accountability for the funds comprising the individual budgets, indemnify the PIHP/CMHSP for any amounts paid in excess of the individual budget and maintain required insurance for nonperformance or negligent performance of FI functions
- Assure timely invoicing, service activity and cost reporting to the PIHP/CMHSP for specialty mental health services as required by the contract between the PIHP/CMHSP and the entity providing FI services.

B. Employer Agent Functions

For all individuals using arrangements that support self-determination and families of minor children using choice voucher arrangements who are directly employing workers, entities providing FI services must facilitate the employment of service workers by the individual or family of a minor child, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting. These Employer Agent functions include:

- Obtain documentation from the participants and file it with the IRS so that the FI can serve as Employer Agent for individuals directly employing workers, and meet the requirements of state and local income tax authorities and unemployment insurance authorities.
- Have a mechanism in place to crosscheck timesheets for directly employed workers with authorized services and supports in the IPOS and individual budget and a mechanism to handle over-expenditures that exceed 10 percent of the individual budget prior to making payroll payments (such contacting the PIHP/CMHSP to determine if an additional authorization is necessary and/or notifying the employer that he or she is responsible for the costs related to approved timesheets in excess of the authorizations in the IPOS and individual budget).
- Issue payroll payments to directly employed workers for authorized services and supports that comport with the individual budget or have approval from the PIHP/CMHSP for payment.
- Withhold income, Social Security, and Medicare taxes from payroll payments and make payments to the appropriate authorities for taxes withheld.
- Make payments for unemployment taxes and worker’s compensation insurance to the appropriate authorities, when necessary.
- Issue W-2 forms and tax statements.
- Assist the individual directly employing workers with purchasing worker’s compensation insurance as required.

V. References

Michigan Self-Determination Policy and Practice Guideline, July 18, 2003
http://www.michigan.gov/documents/SelfDeterminationPolicy_70262_7.pdf

Michigan Medicaid Provider Manual
http://www.michigan.gov/MDHHS/0,1607,7-132--87572--,00.html

Choice Voucher System Technical Advisory, Version 2.0, September 30, 2008
http://www.michigan.gov/documents/MDHHS/Choice_Voucher_System_Transmittal_9_30_08_251403_7.pdf

Self-Determination Implementation Technical Advisory, January 1, 2013

TECHNICAL REQUIREMENT FOR SED CHILDREN
FINAL REVISED April 10, 2012
(10/2/15) revised 11/5/15

REGARDING: 1) MEDICAID ELIGIBILITY CRITERIA FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE; AND 2) ESTABLISING GENERAL FUND PRIORITY FOR MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

General Considerations:

This requirement provides a framework to be used by Prepaid Inpatient Health Plans (PIHPs) for determining eligibility for Medicaid specialty mental health services for children with serious emotional disturbance (SED). The criteria for Medicaid eligibility for specialty mental health services for children is based on the definition of serious emotional disturbance delineated in the Mental Health Code (Section 330.1100d) which includes the three dimensions of diagnosis, functional impairment and duration.

A key feature of the Medicaid eligibility criteria in the Technical Requirement is that diagnosis alone is not sufficient to determine eligibility for Medicaid specialty mental health services. This means that the practice of using a defined or limited set of diagnoses to determine Medicaid eligibility, for services should cease. As stated in the Mental Health Code, any diagnosis in the DSM can be used (with the exception of developmental disorder, substance abuse disorder or “V” codes unless these disorders occur in conjunction with another diagnosable serious emotional disorder), and should be coupled with functional impairment and duration criteria for determination of serious emotional disturbance in a child.

The Medicaid eligibility criteria delineated in this document is intended to: (1) assist Prepaid Inpatient Health Plans (PIHPs) in determining severity, complexity and duration that would indicate a need for specialty mental health services and supports for Medicaid children, and (2) bring more uniformity to these decisions for children across the system. Children meeting the criteria delineated in this document are considered to have a serious emotional disturbance, as defined in the Mental Health Code. (Please note that the criteria contained in this document presently do not apply to MIChild beneficiaries because PIHPS are the sole provider of the mental health benefit for MIChild beneficiaries who are to be provided medically necessary mental health services by PIHPs regardless of functional impairment, however at January 1, 2016, MIChild beneficiaries will become Medicaid recipients and eligibility for services by PIHP will be determined as a child with serious emotional disturbance.

Selection of Services

For Medicaid children, once an eligibility determination has been made based on the criteria delineated in this document, selection of services is determined based on person-centered planning and family-centered practice. Selection of services should also be made based on medical necessity criteria, and, where applicable, the service-specific criteria, coverage policy and decision parameters contained in the most recent version of the Medical Services Administration's Medicaid Policy Manual. However, decisions regarding access/eligibility should not be based on medical necessity criteria or service-specific criteria since these decisions are a separate and subsequent process to eligibility determinations.

Special Note: For Direct Prevention Services Models (CCEP, School Success Program, Infant Mental Health, Parent Education) with a family or child care provider regarding an individual child, the service should be noted in the child's plan of services as "medically necessary" and should be reported using the child's beneficiary identification number. PIHPs typically use "unspecified" diagnosis codes found in the ICD-9 for infants, young children and individuals who receive one-time crisis intervention.

Definition of Child with Serious Emotional Disturbance 7 through 17 Years

The definition of SED for children 7 through 17 years delineated below is based on the Mental Health Code, Section 330.1100d. In addition, extensive reviews and examinations of Child and Adolescent Functional Assessment Scale (CAFAS) data submitted by CMHSPs for the children currently served were undertaken to establish functioning criteria consistent with the Michigan Mental Health Code definition of serious emotional disturbance.[1] The parameters delineated below do not preclude the diagnosis of and the provision of services to an adult beneficiary who is a parent and who has diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance.

The following is the criteria for determining when a child 7 through 17 years is considered to have a serious emotional disturbance. All of the dimensions must be considered when determining whether a child is eligible for mental health services and supports as a child with serious emotional disturbance. The child shall meet each of the following:

Diagnosis

[1] The recommendations for the CAFAS scores as detailed under the functioning dimension described in this document would capture about 84.2% of the children currently being served by CMHSPs.

Serious emotional disturbance means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment as indicated below. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) a substance abuse disorder, (b) a developmental disorder, or (c) ”V” codes in the diagnostic and statistical manual of mental disorders.

Degree of Disability/Functional Impairment

Functional impairment that substantially interferes with or limits the minor’s role or results in impaired functioning in family, school, or community activities. This is defined as:

- A total score of 50 (using the eight subscale scores on the Child and Adolescent Functional Assessment Scale (CAFAS), or
- Two 20s on any of the first eight subscales of the CAFAS, or
- One 30 on any subscale of the CAFAS, except for substance abuse only.

Duration/History

Evidence that the disorder exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

Definition of Child with Serious Emotional Disturbance, 4 through 6 Years (48 through 71 months)

For children 4 through 6 years of age, decisions should utilize similar dimensions to older children to determine whether a child has a serious emotional disturbance and is in need of mental health services and supports. The dimensions include:

(1) a diagnosable behavioral or emotional disorder;
(2) functional impairment/limitation of major life activities; and
(3) duration of condition.

However, as with infants and toddlers (birth through age three years), assessment must be sensitive to the critical indicators of development and functional impairment for the age group. Impairments in functioning are revealed across life domains in the

young child's regulation of emotion and behavior, social development (generalization of relationships beyond parents, capacity for peer relationships and play, etc.), physical and cognitive development, and the emergence of a sense of self. All of the dimensions must be considered when determining whether a young child is eligible for mental health services and supports as a child with serious emotional disturbance.

The parameters delineated below do not preclude the provision of services to an adult beneficiary of a young child who is a parent and who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance.

The following is the criteria for determining when a young child beneficiary is considered to have a serious emotional disturbance. All of the dimensions must be considered when determining whether a young child is eligible for mental health services and supports.

The child shall meet each of the following:

Diagnosis

A young child has a mental, behavioral, or emotional disturbance sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the department that has resulted in functional impairment as delineated below. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Degree of Disability/Functional Impairment

Interference with, or limitation of, a young child's proficiency in performing developmentally appropriate tasks, when compared to other children of the same age, across life domain areas and/or consistently within specific domains as demonstrated by at least one indicator drawn from at least three of the following areas:

<u>Area I</u>:

Limited capacity for self-regulation, inability to control impulses, or modulate emotions as indicated by:

Internalized Behaviors:

- prolonged listlessness or sadness
- inability to cope with separation from primary caregiver
- shows inappropriate emotions for situation
- anxious or fearful
- cries a lot and cannot be consoled
- frequent nightmares
- makes negative self statements that may include suicidal thoughts

Externalized Behaviors:

- frequent tantrums or aggressiveness toward others, self and animals
- inflexibility and low frustration tolerance
- severe reaction to changes in routine
- disorganized behaviors or play
- shows inappropriate emotions for situation
- reckless behavior
- danger to self including self mutilation
- need for constant supervision
- impulsive or danger seeking
- sexualized behaviors inappropriate for developmental age
- developmentally inappropriate ability to comply with adult requests
- refuses to attend child care and/or school
- deliberately damages property
- fire starting
- stealing

Area II:

Physical symptoms, as indicated by behaviors that are not the result of a medical condition, include:

- bed wetting

- sleep disorders
- eating disorders
- encopresis
- somatic complaints

Area III:

Disturbances of thought, as indicated by the following behaviors:

- inability to distinguish between real and pretend
- difficulty with transitioning from self-centered to more reality-based thinking
- communication is disordered or bizarre
- repeats thoughts, ideas or actions over and over
- absence of imaginative play or verbalizations commonly used by preschoolers to reduce anxiety or assert order/control on their environment

Area IV:

Difficulty with social relationships as indicated by:

- inability to engage in interactive play with peers
- inability to maintain placements in child care or other organized groups
- frequent suspensions from school
- failure to display social values or empathy toward others
- threatens or intimidates others
- inability to engage in reciprocal communications
- directs attachment behaviors non-selectively

Area V:

Care-giving factors that reinforce the severity or intractability of the childhood disorder and the need for intervention strategies such as:

- a chaotic household/constantly changing care-giving environments
- parental expectations are inappropriate considering the developmental age of the young child

- inconsistent parenting
- subjection to others' violent or otherwise harmful behavior
- over-protection of the young child
- parent/caregiver is insensitive, angry and/or resentful to the young child
- impairment in parental judgment or functioning (mental illness, domestic violence, substance use, etc.)
- failure to provide emotional support to a young child who has been abused or traumatized

The standardized assessment tool specifically targeting social-emotional functioning for children 4 through 6 years of age recommended for use in determining degree of functional impairment is the Pre-School and Early Childhood Functional Assessment Scale (PECFAS).

Duration/History

The young age and rapid transition of young children through developmental stages makes consistent symptomatology over a long period of time unlikely.

However, indicators that a disorder is not transitory and will endure without intervention include one or more of the following:

(1) Evidence of three continuous months of illness; or
(2) Three months of symptomatology/dysfunction in a six-month period; or
(3) Conditions that are persistent in their expression and are not likely to change without intervention; or
(4) A young child has experienced a traumatic event involving actual or threatened death or serious injury or threat to the physical or psychological integrity of the child, parent or caregiver, such as abuse (physical, emotional, sexual), medical trauma and/or domestic violence.

Definition of Child with Serious Emotional Disturbance, Birth through 3 Years (47 months of age)

Unique criteria must be applied to define serious emotional disturbance for the birth through age three population, given:

- the magnitude and speed of developmental changes through pregnancy and infancy and early childhood;
- the limited capacity of the very young to symptomatically present underlying disturbances;

- the extreme dependence of infants and toddlers upon caregivers for their survival and well-being; and
- the vulnerability of the very young to relationship and environmental factors.

Operationally, the above parameters dictate that the mental health professional must be cognizant of:

- the primary indicators of serious emotional disturbance in infants and toddlers, and
- the importance of assessing the constitutional/physiological and/or care- giving/environmental factors that reinforce the severity and intractability of the infant-toddler's disorder.

Furthermore, the rapid development of infants and toddlers results in transitory disorders and/or symptoms, requiring the professional to regularly re-assess the infant-toddler in the appropriate developmental context.

The access eligibility criteria delineated below do not preclude the provision of services to an adult beneficiary who is a parent of an infant or toddler and who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the infant or toddler at high risk for serious emotional disturbance.

The following is the criteria for determining when an infant or toddler beneficiary is considered to have a serious emotional disturbance or is at high risk for serious emotional disturbance and qualifies for mental health services and supports. All of the dimensions must be considered when determining eligibility.

The child shall meet each of the following:

Diagnosis

An infant or toddler has a mental, behavioral, or emotional disturbance sufficient to meet the diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association consistent with the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition* (see attached crosswalk) that has resulted in functional impairment as indicated below. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Degree of Disability/Functional Impairment

Interference with, or limitation of, an infant or toddler's proficiency in performing developmentally appropriate skills as demonstrated by at least one indicator drawn from two of the following three functional impairment areas:

Area I:

General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems. Indicators are:

- uncontrollable crying or screaming
- sleeping and eating disturbances
- disturbance (over or under expression) of affect, such as pleasure, displeasure, joy, anger, fear, curiosity, apathy toward environment and caregiver
- toddler has difficulty with impulsivity and/or sustaining attention
- developmentally inappropriate aggressiveness toward others and/or toward self
- reckless behavior(s)
- regression as a consequence of a trauma
- sexualized behaviors inappropriate for developmental age

Area II:

Behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibit the infant or toddler's daily adaptation and relationships. Behavioral indicators are:

- a restricted range of exploration and assertiveness
- severe reaction to changes in routines
- tendency to be frightened and clinging in new situations
- lack of interest in interacting with objects, activities in their environment, or relating to others and infant or toddler appears to have one of the following reactions to sensory stimulation:
    - hyper-sensitivity
    - hypo-sensitive/under-responsive
    - sensory stimulating-seeking/impulsive

Area III:

Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of infant/toddler, parent/caregiver and environmental characteristics. Indicators in the infant or toddler are:

- does not meet developmental milestones (i.e., delayed motor, cognitive, social/emotional speech and language) due to lack of critical nurturing,
- has severe difficulty in relating and communicating,
- disorganized behaviors or play,
- directs attachment behaviors non-selectively,
- resists and avoids the caregiver(s) which may include childcare providers,
- developmentally inappropriate ability to comply with adult requests,
  disturbed intensity of emotional expressiveness (anger, blandness or is apathetic) in the presence of a parent/caregiver who often interferes with infant's goals and desires, dominates the infant or toddler through over-control, does not reciprocate to the infant or toddler's gestures, and/or whose anger, depression or anxiety results in inconsistent parenting. The parent/caregiver may be unable to provide critical nurturing and/or be unresponsive to the infant or toddler's needs due to diagnosed or undiagnosed peri-natal depression, other mental illness, etc.

The standardized assessment tool specifically targeting social-emotional functioning for infants and is the Devereaux Early Childhood Assessment (Infant, Toddler or Clinical Version). Duration/History

The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endure without intervention include one or more of the following:

(1) The infant or toddler's disorder(s) is affected by persistent multiple barriers to normal development (inconsistent parenting or care-giving, chaotic environment, etc.); or
(2) The infant or toddler has been observed to exhibit the functional impairments for more days than not for a minimum of two weeks (see Areas I-III above); or
(3) An infant or toddler has experienced a traumatic event involving actual or threatened death or serious injury or threat to the physical or psychological integrity of the child, parent or caregiver, such as abuse (physical, emotional, sexual), medical trauma and/or domestic violence.

Diagnostic Thinking Process

Assessment Framework: All Axis Crosswalk between DC:0-3R and DSM-5

October, 2015

Introduction

This diagnostic thinking process includes a crosswalk that is intended to help overcome the limited applicability of classification systems such as DSM and ICD for assessment and diagnostic formulation with clients in the birth through 5 age range. The assessment framework imbedded in the DC: 0-3R promotes diagnostic thinking that identifies contributions of constitutional (physical health), medical/developmental, relational, psychosocial and functional social-emotional factors to clinical understanding of the child's presentation of challenges and competencies. Each axis supports assessment of significant features of a young child's symptoms and history. For example, a child's difficulties may be diagnosed as issues that focus on interaction processes, relationship challenges, and/or functional developmental challenges highlighting the importance of including functional developmental processes (Axis V) and relationship dynamics (Axis II). Use of all DC: 0-3R axes promotes a thorough assessment process that is a foundation for clinical formulation of the factors that are contributing to overall child functioning and capacity to successfully cope with the challenges of daily life. Integration of the data represented by the axes helps to establish a strong connection between diagnostic formulation and treatment planning. Furthermore, this assessment framework supports identification of risks/stresses that threaten to derail overall developmental and social-emotional progress or contribute to significant deterioration in areas of life functioning or adaptive capacity. This breadth of perspective highlights limitations of DSM and ICD Axis I for diagnostic formulation in work with young children and their families.

This crosswalk invites the clinician to work through a comprehensive set of assessment questions to guide a two-step process of a) DC:0-3R diagnostic formulation of primary presenting problems, then b) crosswalk to DSM-5 billable diagnosis. Two caveats: **Do not start with Axis I**; **Evaluate all axes**. Choose the diagnosis/diagnoses that characterize the focus of treatment.

Overview of assessment framework:

Part 1: Are the presenting problems primarily or substantially reactions to severe stress or related to issues of coping with psychosocial stressors that are affecting the family, undermining the caregivers' capacities, and challenging the child's adaptive capacities? Have these stressors undermined the caregiver's capacity to be protective? The presenting problems may indicate stresses or cumulative risk (Axis IV). Is the presentation of symptoms related to stress or risk a focus of treatment?

Part 2: What is the role of physical health (constitutional), medical diagnoses, health care needs, or developmental factors (disorders) in determining the child's difficulties (Axis III). Is the child struggling with daily tasks due to health or developmental problems? Note that developmental disorder diagnoses are included on DC: 0-3R Axis III - diagnoses used by developmental specialists (e.g., speech/language, OT, PT, special education)

Part 3: Does the child demonstrate age level emotional and social functioning across the routines and settings of daily life and in interactions with all caregivers? Does the child struggle with maintaining functional levels of competencies in interactions with only some caregivers? With all caregivers? Are there difficulties with specific developmental skills that undermine functional competency and limit the child's capacity to adapt successfully to solve the problems of his/her daily life (See Axis III, disorders in language, motor, cognition)? Are these functional competency challenges a focus of treatment?

Part 4: What is the role/contribution of relational dynamics: are there patterns of rigidity in parent-child interactions, tension, conflict that tends to be unresolvable? Do these relational factors contribute to undermining the child's functional competencies, and possibly impact the child's developmental trajectory; the caregiver's functioning? Axis II describes problems that appear to be specific to a relationship. Is the relational dynamic a focus of treatment?

Part 5: Are the child's difficulties pervasive, occurring across settings and across relationships? This overarching question of pervasiveness (severity, duration, impairment) guides assessment questions that will help to distinguish DC:0-3R Axis I diagnoses from difficulties that occur only in certain circumstances or in relation to a particular person. Does the symptom pattern meet criteria for a diagnosis on Axis I of the DC: 0-3 R? How will that diagnosis guide the focus of treatment? For example, has the child experienced major traumatic events that contribute to a pervasive presentation of symptoms?

In absence of a primary Axis I diagnosis, are the presenting symptoms adequately captured and characterized by clinical formulation of risk/stress (Axis IV), physical and developmental health (Axis III), dynamics specific to a relationship (Axis II), and/or functional competencies (Axis V)?

Part 1

For risks, cumulative, or chronic stress, consider the context for enduring and significant adjustment challenges. A child's behavioral difficulties may be an indication of the child's struggles to cope with the impact of stresses affecting daily life with family/caregivers.

Develop full DC:0-3R formulation (reviewing each axis for salient assessment findings)	**Select DSM crosswalk diagnosis for billing purposes**	
DC 0-3 R	**DSM-5 Code**	**DSM-5**
Psychosocial Risk/Stressors	Note: Axis IV Checklist in DC: 0-3R does not focus exclusively on risk factors that have been identified in risk/resiliency research as factors in cumulative risk. Many check list items are more specific stress factors in family life. Cumulative daily stress can be a significant risk factor.	
Risk, cumulative risk, imminent risk- Distinguish history from chronic and current stressors.	309.9	Adjustment Disorder, Unspecified (Unspecified Trauma- and Stressor-Related Disorder) • New dx criteria E: *Once the stressors or its consequences have terminated,* the symptoms do not persist for more than an additional 6 months.
300 Adjustment Disorder	309.xx 309.9	Adjustment Disorder, (specify) 309.0 With depressed mood 309.24 With anxiety 309.28 With anxiety and depressed mood Adjustment Disorder, Unspecified (309.3 RESERVED –this code is reserved for 240 Mixed Disorder of Emotional Expressiveness- Axis I)

		(309.4 RESERVED - this code is reserved for Axis II, Relationship Disorder)
If traumatic events meet DC: 0-3R Axis I criteria and child's symptom presentation is pervasive across situations and relationships, evaluate:		From DSM-5 Trauma and Stressor Related Disorders
100 Post Traumatic Stress Disorder	309.81	Post Traumatic Stress Disorder
150 Deprivation/Maltreatment Disorder	313.89	Reactive Attachment Disorder
	313.89	Disinhibited Social Engagement Disorder
	308.3	Acute Stress Disorder

Part 2

The presence of specific physical health (constitutional), developmental or learning challenges undermines a child's functional competencies, strains capacities for coping, and contributes to a context of chronic adjustment challenges that undermine developmental trajectory. Many psychiatric conditions may be indications of (co-occurring) medical conditions that may also undermine a child's capacity for successful adjustment.

AXIS III Medical and Developmental Disorders and Conditions		
DC:0-3 R - Developmental, Health/Medical disorders are recorded on Axis III	**DSM-5 Code**	**DSM-5**
For a primary diagnosis, crosswalk to:	309.9	Adjustment Disorder, Unspecified
	315.9	Unspecified Neurodevelopmental Disorder
If needed for secondary diagnosis		Crosswalk to DSM-5 Axis I and record as Secondary Diagnosis 307.9 Unspecified Communication Disorder 315.39 Social (Pragmatic) Communication Disorder 315.9 Unspecified Neurodevelopmental Disorder 315.4 Developmental Coordination Disorder 315.8 Global Developmental Delay (under age 5) 319 Unspecified Intellectual Disability
Codes are not needed for health/medical conditions. Provide descriptive information about medical/ health issues. Distinguish history, chronic conditions and current issues.		

AXIS III Medical and Developmental Disorders and Conditions		
DC:0-3 R - Developmental, Health/Medical disorders are recorded on Axis III	**DSM-5 Code**	**DSM-5**
Identify names of specific current and chronic medical diagnoses, e.g. asthma; obesity; ear infections; prematurity; genetic syndromes such as Fragile X, Prader Willis; sleep apnea.		

Part 3

Consider the child's capacity to participate in meaningful everyday family routines and interactions.
Does this child demonstrate functional limitations in capacities to integrate emotional, cognitive, communicative competencies to meet emotionally meaningful goals, to "problem solve" effectively, to express wants, needs, likes, dislikes? Does this child use age level developmental skills in daily life routines with each of the important persons in his daily life?

AXIS V – Functional Social-Emotional Capacities	**Functional competency may differ significantly from standardized test performance. Functional competency may differ in unstructured contexts that allow child to be in lead compared to structured contexts in which child is expected to follow another's ideas or respond to directions.** **Challenges presented in a child's functional competencies may involve many factors. If the child's functional competencies are not at age level, then the child does not have age level expected capacities for "problem-solving" responses to challenges of daily life, will need special supports, and will face ongoing challenges to adjustment**	
DC: 0-3R	**DSM-5 Code**	**DSM-5**
IF not at age-level in any one or more of the capacities:	309.9	Adjustment Disorder, Unspecified (Unspecified Trauma and Stressor Related Disorder)
	315.9	Unspecified Neurodevelopmental Disorder
Treatment planning requires assessment to identify contribution of the factors undermining child's functional competency. Child's functional challenges may be context specific vulnerabilities, immaturity, selective deficit, and may reflect constitutional issues. In addition, functional difficulties may, in turn, contribute to regulatory problems, anxieties, relationship problems. For treatment planning, specify the developmental processes that are not at age level and identify factors that are involved in or affected by functional competencies, e.g., specific developmental delays or disorders, relational dynamics, or health issues. See Axis IV, III above and Axis II below.		

Part 4

What are the patterns of flexibility, tension and conflict in the interactions of this child with each of the important persons in his/her daily life (PIR-GAS rating)? Do these patterns of difficult interactions affect more than one or two of the routines of daily life If possible, determine when these patterns were first established. How long have features of distress/conflict affected multiple daily routines? Is the relationship context of conflicted interactions a primary contributor to the child's difficulties with developmental progress, functioning in daily routines, adjustment?

DC: 0-3R Axis II Relationship Classification	**If a specific relationship is characterized by patterns of difficult interactions between child and this adult, (lack of flexibility, tension, and unresolvable conflict) then the child's behavioral problems may reflect the presence of ongoing challenges to the child's adjustment. Undermining of Axis V functional competencies may be specific to a relationship. Difficulties in interaction may also create a context of risk or features of disorder that may indicate increased risk of developing a relationship disorder or other problems.**	
	DSM-5 Code	**DSM-5**
900 Relationship Disorder – **If PIR-GAS of 40 or below, dx of relationship disorder**	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct; Chronic
If PIR-GAS of 41- 80 - Features of Disorder **Difficulties may not yet be ingrained.** **Interventions may be focused on addressing risks of deterioration in child's adaptive functioning or development.**	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct; Chronic
		Note: Specific relationship disorder may co-occur with other diagnoses.

Part 5

Is (some part of) the child's problem/symptom presentation pervasive, that is, across relationships and across settings, instead of specific to a relationship or selectively expressed in only some contexts?

In addition to difficulties identified above, is there a DC:0-3 R Axis I diagnosis	DSM-5 Codes	DSM-5
DC:0-R Clinical Disorders		
100 Post Traumatic Stress Disorder	309.81	Post Traumatic Stress Disorder
150 Deprivation/Maltreatment Disorder	313.89	Reactive Attachment Disorder
	313.89	Disinhibited Social Engagement Disorder
	308.3	Acute Stress Disorder
DC: 0-3R 200 Disorders of Affect		
210 Prolonged Bereavement/Grief Reaction	309.0	Adjustment Disorder with Depressed Mood
	309.9	Adjustment Disorder, Unspecified (Unspecified Trauma and Stressor Related Disorder)
220 Anxiety Disorders		
221 Separation Anxiety	309.21	Separation Anxiety Disorder
222 Specific Phobia	300.01	Panic disorder
223 Social Anxiety Disorder	300.23	Social Anxiety Disorder (Social Phobia)
224 Generalized Anxiety Disorder	300.02	Generalized Anxiety Disorder
225 Anxiety Disorder NOS	300.00	Unspecified Anxiety Disorder
230 Depression of Infancy and Early Childhood		
231 Type I Major Depression	296.99	Disruptive Mood Dysregulation Disorder
	296.20	Major Depressive Disorder, Single Episode, Unspecified
232 Type II Depressive Disorder NOS	311	Unspecified Depressive Disorder
240 Mixed disorder of emotional expressiveness	309.3	Adjustment Disorder with disturbance of conduct

DC:0-3R 300 Adjustment Disorder	309.xx 309.9	Adjustment Disorder, (specify) 309.0 With depressed mood 309.24 With anxiety 309.28 With anxiety and depressed mood Adjustment Disorder, Unspecified (309.3 RESERVED –this code is reserved for 240 Mixed Disorder of Emotional Expressiveness-above) (309.4 RESERVED - this code is reserved for Axis II, Relationship Disorder)
400 Regulation Disorders of Sensory Processing	315.9	Same DSM-5 code for all subtypes Unspecified Neurodevelopmental Disorder
410 Hypersensitive		
411 Type A – Fearful/cautious		
412 Type B – Negative/Defiant		
420 Hyposensitive/Underresponsive		
430 Sensory stimulations-seeking/Impulsive		
500 Sleep Behavior Disorder Note: *IF primary diagnosis, the Sleep Disorder is not a symptom related to or secondary to other problems*.		NOTE: Medicaid rules exclude Sleep Disorders as primary diagnosis. Can Sleep Disorder be a Secondary Diagnosis?– yes
510 Sleep onset disorder 520 Night-waking disorder	309.9	Adjustment Disorder, Unspecified
If needed for Secondary diagnosis	780.52	Insomnia Disorder
	780.59	Unspecified Sleep-Wake Disorder
600 Feeding Behavior Disorder	307.59	(Same DSM-5 Code for all DC:0-3R subtypes) Unspecified Feeding or Eating Disorder Note: *IF primary diagnosis, the Feeding Disorder is not a symptom related to or secondary to other problems*.
601 Feeding Disorder of State Regulation		
602 Feeding Disorder of Caregiver-Infant Reciprocity (this dx is specific to feeding interactions so is less pervasive than a relationship disorder)		

603 Infantile Anorexia		
604 Sensory Food Aversions		
605 Feeding Disorder associated with concurrent medical conditions		
606 Feeding disorder associated with insults to gastrointestinal tract		
700 Disorders of Relating and Communicating (Referred to as PDD in the DSM classification.)		NOTE: A mental health diagnosis for a child who also suffers from a Disorder of Relating and Communicating (PDD) may focus treatment on related symptoms, e.g., anxieties, interaction problems with family members, functional competencies, etc. Autism (299.00) may be a secondary diagnosis within mental health.
DC:0-3R guides clinicians to diagnose differently for children age 2 and over and those under age 2. 710 Multisystem Developmental Disorder is limited to under age 2.		DC:0-3R age distinctions do not apply in crosswalk.
710 Multisystem Developmental Disorder (MSDD)	299.80	Pervasive developmental disorder NOS – can be primary dx
	300.00	Unspecified Anxiety Disorder
	315.9	Unspecified Neurodevelopmental Disorder
For Secondary Diagnosis if needed This may be important for advocacy work with other service providers, agencies.		299.00 Autistic Disorder Can be Secondary Diagnosis, but not a primary diagnosis. Specify severity: Level 3 -Requiring very substantial support Level 2- Requiring substantial support Level 1- Requiring support
800 Other Disorders -- Not relevant to Medicaid billing crosswalk		This code would be used to include diagnostic codes from the ICD, DSM or other classifications into a DC: 0-3R formulation; in that context, the DC:0-3R would serve as the primary system for diagnostic classification & no crosswalk would be needed.
If a DC: 0-3R Axis I Diagnosis has not been identified - First, re-consider assessment areas above	This crosswalk includes directions for all DC:0-3R axes to ICD-9 Axis I Codes. See Above.	
If no DC:0-3R Axis I diagnosis but significant concerns that indicate need for monitoring or further assessment, then for eligibility, consider these diagnoses and develop a plan for further assessment activities.		

	315.9	Unspecified neurodevelopmental disorder
	309.9	Adjustment Disorder, Unspecified
	309.9	Unspecified Trauma- and Stressor-Related Disorder

Diagnostic Thinking Process

Assessment Framework: All Axis Crosswalk between DC: 0-3R and ICD-10 CM

October, 2015

Introduction

This diagnostic thinking process includes a crosswalk that is intended to help overcome the limited applicability of classification systems such as DSM and ICD for assessment and diagnostic formulation with clients in the birth through 5 age range. The assessment framework imbedded in the DC: 0-3R promotes diagnostic thinking that identifies contributions of constitutional (physical health), medical/developmental, relational, psychosocial and functional social-emotional factors to clinical understanding of the child's presentation of challenges and competencies. Each axis supports assessment of significant features of a young child's symptoms and history. For example, a child's difficulties may be diagnosed as issues that focus on interaction processes, relationship challenges, and/or functional developmental challenges highlighting the importance of including functional developmental processes (Axis V) and relationship dynamics (Axis II). Use of all DC:0-3R axes promotes a thorough assessment process that is a foundation for clinical formulation of the factors that are contributing to overall child functioning and capacity to successfully cope with the challenges of daily life. Integration of the data represented by the axes helps to establish a strong connection between diagnostic formulation and treatment planning. Furthermore, this assessment framework supports identification of risks/stresses that threaten to derail overall developmental and social-emotional progress or contribute to significant deterioration in areas of life functioning or adaptive capacity. This breadth of perspective highlights limitations of DSM and ICD Axis I for diagnostic formulation in work with young children and their families.

This crosswalk invites the clinician to work through a comprehensive set of assessment questions to guide a two-step process of a) DC: 0-3R diagnostic formulation of primary presenting problems, then b) crosswalk to ICD-10 billable diagnosis. Two caveats: **Do not start with Axis I**; **Evaluate all axes**. Choose the diagnosis/diagnoses that characterize the focus of treatment:

Overview of assessment framework:

Part 1: Are the presenting problems primarily or substantially reactions to severe stress or related to issues of coping with psychosocial stressors that are affecting the family, undermining the caregivers' capacities, and challenging the child's adaptive capacities? Have these stressors weakened the caregiver's capacity to be protective? The presenting problems may indicate risk or cumulative stress (Axis IV). Is the presentation of risk a focus of treatment?

Part 2: What is the role of physical health (constitutional), medical diagnoses, health care needs, or developmental factors (disorders) in determining the child's difficulties (Axis III). Is the child struggling with daily tasks due to health or developmental problems? Note that

developmental disorder diagnoses are included on DV: 0-3R Axis III - diagnoses used by developmental specialists, e.g., speech/language, OT, PT, special education)

Part 3: Does the child demonstrate age level emotional and social functioning across the routines and settings of daily life and in interactions with all caregivers? Does the child struggle with maintaining functional levels of competencies in interactions with only some caregivers? With all caregivers? Are there difficulties with specific developmental skills that undermine functional competency and limit the child's capacity to adapt successfully to solve the problems of his/her daily life (See Axis III, disorders in language, motor, cognition)? Are these functional competency challenges a focus of treatment?

Part 4: What is the role/contribution of relational dynamics: are there patterns of rigidity in parent-child interactions, tension, conflict that tends to be unresolvable? Do these relational factors contribute to undermining the child's functional competencies, and possibly impact the child's developmental trajectory; the caregiver's functioning? Axis II describes problems that appear to be specific to a relationship. Is the relational dynamic a focus of treatment?

Part 5: Are the child's difficulties pervasive, occurring across settings and across relationships? This overarching question of pervasiveness (severity, duration, impairment) guides assessment questions that will help to distinguish DC:0-3R Axis I diagnoses from difficulties that occur only in certain circumstances or in relation to a particular person. Does the symptom pattern meet criteria for a diagnosis on Axis I of the DC: 0-3 R? How will that diagnosis guide the focus of treatment? For example, has the child experienced major traumatic events that contribute to a pervasive presentation of symptoms?

In absence of a primary Axis I diagnosis, are the presenting symptoms adequately captured and characterized by clinical formulation of risk/stress (Axis IV), physical and developmental health (Axis III), dynamics specific to a relationship (Axis II), and/or functional competencies (Axis V)?

Part 1

For risks, cumulative or chronic stress, consider the context for enduring and significant adjustment challenges. A child's behavioral difficulties may be an indication of the child's struggles to cope with the impact of stresses affecting daily life with family/caregivers.

Develop full DC0-3R formulation (reviewing each axis for salient assessment findings)	Select ICD-10 crosswalk diagnosis for billing purposes	
DC 0-3 R	**ICD-10 Code**	**ICD-10**
Psychosocial Risk/Stressors	Note: Axis IV Checklist in DC: 0-3R does not focus exclusively on Risk factors that have been identified in risk/resiliency research as factors in cumulative risk. Many check list items are "daily hassles." Cumulative daily stress can be a significant risk factor.	
Risk, cumulative risk, imminent risk- Distinguish history from chronic and current stressors.	F43.9	Reaction to severe stress, unspecified.

300 Adjustment Disorder	F43.20 F43.21 F43.22 F43.23	Adjustment disorder, unspecified with depressed mood with anxiety with mixed anxiety and depressed mood (F43.24 RESERVED-– this code is reserved for 240 Mixed Disorder of Emotional Disturbance – Axis I) (F43.25 RESERVED- that code is reserved for Axis II, Relationship Disorder-See Axis II Relationship Disorder)
If stress/risk events meet DC: 0-3R Axis I criteria, and child's symptom presentation is pervasive across situations and relationships, evaluate:		
100 Post Traumatic Stress Disorder	F43.10	Post traumatic stress disorder, unspecified F43.11 acute F43.12 chronic
150 Deprivation/Maltreatment Disorder	F94.1	Reactive attachment disorder of childhood (inhibited form)
	F94.2	Reactive attachment disorder of childhood (disinhibited form)
		NOTE: These two diagnoses (94.1 and 94.2) are mutually exclusive – i.e., cannot co-occur

Part 2

The presence of specific physical health (constitutional), developmental or learning challenges undermines a child's functional competencies, strains capacities for coping, and contributes to a context of chronic adjustment challenges that undermine developmental trajectory. Many psychiatric conditions may be indications of (co-occurring) medical conditions that may also undermine a child's capacity for successful adjustment.

AXIS III Medical and Developmental Disorders and Conditions		
DC: 0-3 R - Developmental, Health/Medical disorders are recorded on Axis III	**ICD-10 Code**	**ICD-10**
For a primary diagnosis, crosswalk to:	F43.20	Adjustment disorder, unspecified

AXIS III Medical and Developmental Disorders and Conditions		
DC: 0-3 R - Developmental, Health/Medical disorders are recorded on Axis III	**ICD-10 Code**	**ICD-10**
	F93.9	Childhood emotional disorder, unspecified
If needed for secondary diagnosis		For Secondary Diagnosis: F80.1 Expressive language disorder F80.2 Mixed expressive-receptive language disorder F80.9 Development disorder of speech and language, unspecified F81.9 Developmental disorder of scholastic skills, unspecified F82 Specific developmental disorder of motor function F79 Unspecified intellectual disabilities
ICD-10 codes are not needed for physical health/medical conditions. Provide descriptive information about medical/ health issues. Distinguish history, chronic conditions and current issues. Identify names of specific current and chronic medical diagnoses, e.g. asthma; obesity; ear infections; prematurity; genetic syndromes such as Fragile X, Prader Willis; sleep apnea		

Part 3

Consider the child's capacity to participate in meaningful everyday family routines and interactions.
Does this child demonstrate functional limitations in capacities to integrate emotional, cognitive, communicative competencies to meet emotionally meaningful goals, to "problem solve" effectively, to express wants, needs, likes, dislikes? Does this child use age level developmental skills in daily life routines with each of the important persons in his daily life?

AXIS V – Functional Social-Emotional Capacities	**Functional competency may differ significantly from standardized test performance. Functional competency may differ in unstructured contexts that allow child to be in lead compared to structured contexts in which child is expected to follow another's ideas or respond to directions.** **Challenges presented in a child's functional competencies may involve many factors. If the child's functional competencies are not at age level, then the child does not have age level expected capacities for "problem-solving" responses to challenges of daily life, will need special supports, and will face ongoing challenges to adjustment.**	
DC: 0-3R	**ICD-10 Code**	**ICD-10**
If not at age-level in any one or more of the capacities:	F94.9	Childhood disorder of social functioning
	F99	Not otherwise specified

Treatment planning requires assessment to identify the contributing factors undermining a child's functional competency. Standardized testing may be indicated. Child's functional challenges may be context specific vulnerabilities, immaturity, selective deficit, and may reflect constitutional /physical health issues.

In addition, functional difficulties may, in turn, contribute to regulatory problems, anxieties, relationship problems.

For treatment planning, specify the developmental processes that are not at age level and identify factors that are involved in or affected by functional competencies, e.g., specific developmental delays or disorders, relational dynamics, or health issues. See Axis IV, III above and Axis II below.

Part 4

What are the patterns of flexibility, tension and conflict in the interactions of this child with each of the important persons in his/her daily life (PIR-GAS rating)? Do these patterns of difficult interactions affect more than one or two of the routines of daily life If possible, determine when these patterns were first established. How long have features of distress/conflict affected multiple daily routines? Is the relationship context of conflicted interactions a primary contributor to the child's difficulties with developmental progress, functioning in daily routines, adjustment?

DC: 0-3R Axis II Relationship Classification	If a specific relationship is characterized by patterns of difficult interactions between child and this adult, (lack of flexibility, tension, and unresolvable conflict) then the child's behavioral problems may reflect the presence of ongoing challenges to the child's adjustment. Undermining of Axis V functional competencies may be specific to a relationship. Difficulties in interaction may also create a context of risk or features of disorder that may indicate increased risk of developing a relationship disorder or other problems.	
DC: 0-3R	**ICD-10 Code**	**ICD-10**
900 Relationship Disorder – If PIR-GAS of 40 or below, dx of relationship disorder	F43.25	Adjustment disorder with mixed disturbance of emotions and conduct
If PIR-GAS of 41- 80 - Features of Disorder Difficulties may not yet be ingrained. Interventions may be focused on addressing risks of deterioration in child's adaptive functioning or development.	F43.25	Adjustment disorder with mixed disturbance of emotions and conduct
		Note: Specific relationship disorder may co-occur with other diagnoses.

Part 5

Is (some part of) the child's problem/symptom presentation pervasive, that is, across relationships and across settings, instead of specific to a relationship or selectively expressed in only some contexts?

DC: 0-3 R	ICD-10 Code	ICD-10
In addition to difficulties identified above, is there a DC: 0-3 R Axis I diagnosis		
DC:0-3 Clinical Disorders		
100 Post Traumatic Stress Disorder	F43.10	Post traumatic stress disorder, unspecified F43.11 acute F43.12 chronic
150 Deprivation/Maltreatment Disorder	F94.1	Reactive attachment disorder of childhood (inhibited form)
	F94.2	Reactive attachment disorder of childhood (disinhibited form)
		NOTE: These two diagnoses (94.1 and 94.2) are mutually exclusive – i.e., cannot co-occur
200 Disorders of Affect		
210 Prolonged Bereavement/Grief Reaction	F43.20	Adjustment disorder, unspecified
	F43.9	Reaction to severe stress, unspecified
220 Anxiety Disorders		
221 Separation Anxiety	F93.0	Separation anxiety disorder of childhood
222 Specific Phobia	F40.9	Phobic anxiety disorder, unspecified
223 Social Anxiety Disorder	F40.10	Social phobia, unspecified
224 Generalized Anxiety Disorder	F41.1	Generalized anxiety disorder
225 Anxiety Disorder NOS	F41.9	Anxiety disorder, unspecified
230 Depression of Infancy and Early Childhood		

DC: 0-3 R	ICD-10 Code	ICD-10
231 Type I Major Depression	F32.9	Major depressive disorder, single episode, unspecified
	F33.9	Major depressive disorder, recurrent, unspecified
232 Type II Depressive Disorder NOS	F34.9	Persistent mood (affective) disorder, unspecified
240 Mixed disorder of emotional expressiveness	F43.24	Adjustment disorder with disturbance of conduct
300 Adjustment Disorder		See Axis IV Above
400 Regulation Disorders of Sensory Processing	F41.9	Anxiety disorder, unspecified
410 Hypersensitive		
411 Type A – Fearful/cautious		
412 Type B – Negative/Defiant		
420 Hyposensitive/Under-responsive		
430 Sensory stimulations-seeking/Impulsive		
500 Sleep Behavior Disorder Note: *the Sleep difficulties are not symptoms related to or secondary to other problems*.	F43.20	Adjustment disorder, unspecified
NOTE: Medicaid rules exclude Sleep Disorders as primary diagnosis.		
If needed for secondary diagnosis:		Can Sleep Disorder be a Secondary Diagnosis?– yes
510 Sleep onset disorder		G47.50 Parasomnia, unspecified
520 Night waking disorder		G47.9 Sleep disorder, unspecified
		F51.4 Sleep terrors (night terrors)
600 Feeding Behavior Disorder		(Same ICD-10 Code for all DC:0-3R subtypes)
601 Feeding Disorder of State Regulation		

DC: 0-3 R	ICD-10 Code	ICD-10
602 Feeding Disorder of Caregiver-Infant Reciprocity (this dx is specific to feeding interactions so is less pervasive than a relationship disorder)	F98.2	Other feeding disorders of infancy and early childhood Note: *IF primary diagnosis, the feeding difficulties are not a symptom related to or secondary to other problems*.
603 Infantile Anorexia		
604 Sensory Food Aversions		
605 Feeding Disorder associated with concurrent medical conditions		
606 Feeding disorder associated with insults to gastrointestinal tract		
700 Disorders of Relating and Communicating (Referred to as PDD in the ICD-10 classification.)		NOTE: A mental health diagnosis for a child who also suffers from a Disorder of Relating and Communicating (PDD) may focus treatment on related symptoms, e.g., anxieties, interaction problems with family members, functional competencies, etc. Autism (F84.0) may be a secondary diagnosis within mental health.
DC:0-3R guides clinicians to diagnose differently for children age 2 and over and those under age 2. 710 Multisystem Developmental Disorder is limited to under age 2.		DC: 0-3R age distinctions do not apply in crosswalk.
710 Multisystem Developmental Disorder (MSDD)	F84.9	Pervasive developmental disorder , unspecified Note: *can be primary diagnosis*
	F41.9	Anxiety disorder, unspecified
For Secondary Diagnosis if needed This may be important for advocacy work with other service providers, agencies.		F84.0 Autistic disorder Note: Can be Secondary Diagnosis, but not a primary diagnosis.
800 Other Disorders	Not relevant to Medicaid billing crosswalk	This code would be used to include diagnostic codes from the ICD, DSM or other classifications into a DC: 0-3R formulation; in that context, the DC:0-3R would serve as the primary system for diagnostic classification and no crosswalk would be needed.

DC: 0-3 R	ICD-10 Code	ICD-10
If a DC:0-3R Axis I Diagnosis has not been identified - First, re-consider assessment areas above		This crosswalk includes directions for all DC:0-3R axes to ICD-9 Axis I Codes. See Above.
If no DC:0-3R Axis I diagnosis but significant concerns that indicate need for monitoring or further assessment, then for eligibility, consider these diagnoses and develop a plan for further assessment activities.		
	F99	Unspecified mental disorder
	F93.9	Childhood emotional disorder, unspecified
	F94.9	Childhood disorder of social functioning, unspecified

Transformation Steering Committee, Recovery Oriented System of Care
Recovery Policy and Practice Advisory
Version: 10.15.15

Purpose and Application

It is the policy of Michigan Department of Health and Human Services (MDHHS) that services and supports provided to individuals with behavioral health disorders (the term 'behavioral health' equates to substance use and mental health disorders) are based in recovery and embedded within a recovery oriented system of care. This policy and practice guideline specifies the expectations for the Pre-paid Inpatient Health Plans (PIHPs), Community Mental Health Service Programs (CMHSPs) and their provider networks. It is the culmination of a series of intentional milestones that include: the creation and evolution of the Recovery Oriented System of Care (ROSC) Transformation Steering Committee (TSC); the intension inclusion of persons with lived experience within all aspects of the behavioral health system (to give voice); establishment of Michigan Recovery Voices (to share resources) and the development of a peer workforce to provide services and supports (to enhance the recovery services system).

In order to move toward a recovery-based system of services, the beliefs and knowledge about recovery must be strengthened. MDHHS has worked diligently over the past several years toward the goal of effective transformation of behavioral health services to be recovery oriented and based in a recovery oriented system. To that end, MDHHS requested that the ROSC/TSC to develop and has adopted the following recovery statement, guiding principles and expectations for systems change:

Recovery Statement

[An individual's] **Recovery from Mental Disorders and/or Substance Use Disorders:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA 2012) (ROSC/TSC 2015)

Recovery oriented *system* of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities. (ROSC TSC 2010)

Guiding Principles of Recovery

The following principles outline essential features of recovery for the individual, as well for creating and enhancing a behavioral health recovery oriented system of care in which to embed recovery services and supports:

Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that people and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

The system of care promotes person driven recovery will be individualized, person/family/community-centered, comprehensive, stage-appropriate, and flexible. It will adapt to the needs of individuals and communities, rather than requiring them to adapt to it. Individuals receiving services will have access to a menu of stage-appropriate choices that fit their needs throughout the recovery process. The approach will change from an acute, episode-based model to one that helps people manage this chronic disorder throughout their lives. Prevention services will be developmentally appropriate and engage the multiple systems and settings that have an impact on health and wellness. Prevention efforts will be individualized based on the community's needs, resources, and concerns.

Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experience—that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is nonlinear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery

pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

This system will offer a continuum of care that includes prevention, early intervention, treatment, continuing care, and support throughout recovery. Individuals will have a full range of stage-appropriate services to choose from at any point in the recovery process. Prevention services will involve the development of coordinated community systems that provide ongoing support, rather than isolated, episodic programs.

Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

This system of care will promote ongoing involvement of peers, through peer support opportunities for youth and families and peer recovery support services for individuals with behavioral health disorders. Individuals with relevant lived experiences will assist in providing these valuable supports and services.

Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

The system of care will be culturally sensitive, gender competent, and age appropriate. There will be recognition that beliefs and customs are diverse and can impact the outcomes of prevention and treatment efforts.

Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

The system of care that fosters this dynamic will acknowledge the important role that families, significant others and communities can play in promoting wellness for all and recovery for those with behavioral health disorder challenges. It will be incorporated, whenever it is appropriate, into needs-assessment processes, community planning efforts, recovery planning and

all support processes. In addition, our system will provide prevention, treatment, and other support services for the family members and significant others of people with behavioral health disorders.

Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great
courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

Inclusion of the voices and experiences of recovering individuals, youth, family, and community members

The voices and experiences of all community stakeholders will contribute to the design and implementation of our system. People in recovery, youth, and family members will be included among decision-makers and have oversight responsibilities for service provision. Recovering individuals, youth, family, and community members will be prominently and authentically represented on advisory councils, boards, task forces, and committees at state and local levels.

Integrated strength-based services

The system will coordinate and/or integrate efforts across service systems, particularly with primary care services, to achieve an integrated service delivery system that responds effectively to the individual's or the community's unique constellation of strengths, desires, and needs. An integral aspect of this system is the partnership/consultant model that focuses more on collaboration and less on hierarchy. Systems will be designed so that individuals, families, and communities feel empowered to direct their own journeys of recovery and wellness.

Services that promote health and wellness will take place within the community

Our system of care will be centered within the community, to enhance its availability and support the capacities of families, intimate social networks, community-based institutions, and other people in recovery. By strengthening the positive social support networks and addressing environmental determinants to health in which individuals participate, we can increase the chances for successful recovery and community wellness.

Outcomes-driven

Our system will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery and with the community. Outcome measures will be diverse and encompass measures of community wellness as well as the long-term global effects of the recovery process on the individual, family, and community – not just the remission of behavioral and biomedical symptoms. Outcomes will focus on individual, family, and community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

System-wide education and training

Our behavioral health system will seek to ensure that concepts of prevention, recovery, and wellness are foundational elements of curricula, certification, licensure, accreditation, and testing mechanisms. The workforce also requires continuing education, at every level, to reinforce the tenets of ROSC. Our education and training commitments are reinforced through policy, practice, and the overall service culture.

Research-based

Our system will be data driven and informed by research. Additional research with individuals in recovery, recovery venues, and the processes of recovery (including cultural and spiritual aspects) will be essential to these efforts. Research related to Behavioral health disorders will be supplemented by the experiences of people in recovery.

Expectations for Implementation of Recovery Practices

Based on the above guiding principles, the ROSC/TSC established the following expectations to guide organizations at all levels in creating an environment and system of behavioral health services and supports that foster recovery and create a recovery oriented system of care:

1. Promote changes in state law and policies at all levels to create a system with an expanded recovery service array that can be easily accessed via many pathways by individuals needing services and supports.

   Requirements:

- Provide ongoing education to stakeholders on recovery principles and practices in conjunction with state level policies influencing recovery service and supports.

- Develop and maintain a plan to educate and increase communication within the broader community using guidance and leadership from local and regional service providers, community prevention advocates, and recovery committees/councils.

- Provide knowledge and education in partnership with the ROSC/TSC to stakeholders on recovery related policies and practices**.**

2. Develop policies and procedures that ensure seamless and timely entry and re-entry into services and supports.

   Requirements:

   - Utilize data and electronic recordkeeping to facilitate confidential access to individual information and service records that will expedite access to services and supports, and reduce excess and duplicative information gathering and redundant paperwork.

   - Assure pathways are in place for expedited reentry into services for individuals who have been away from services, but once again need services and supports from the public behavioral health system.

   - Provide guidance during ongoing recovery planning including verbal and written information on how to access behavioral health and other community based services.

3. Align policies, procedures and practices to; 1) foster and protect individual choice, control, and self-determination; 2) assure the provision of services that are holistic, culturally based and influenced, strength- and research-based, and trauma informed, and 3) are inclusive of person-centered planning process, community based services and supports, and enhanced collaborative partnerships.

   Requirements:

- Develop and enhance recovery planning processes using baseline data and ongoing regional recovery survey results to improve and expand the behavioral health recovery services system of care, and to strengthen the quality and delivery of recovery services and supports.

- Assess an estimate the impact on cost of services annually, when significant changes occur to the individualized services plan via person-centered selection of culturally influenced, research and strength based services within a recovery oriented environment.

- Provide training and mentoring opportunities to individuals receiving services/peers to become independent facilitators of both person-centered planning and self-determination practices.

4. Encourage the availability of peer services and supports including the option of working with Certified Peer Support Specialists (CPSS) and/or Recovery Coaches as a choice for individuals throughout the service array, and within the individualized planning process.

   Requirements:
   - Develop and implement an educational approach with written materials to provide information to stakeholders on peer services and supports.

   - Provide information on the choices and options of working with peers in a journey of recovery including CPSS/Recovery Coaches as part of the person-centered planning process.

   - Collect baseline data on the number of individuals who receive peer services and supports - include a proactive plan on increasing the number of individuals utilizing these serves.

5. Align services and supports to promote and ensure access to quality health care and the integration of behavioral and physical health care. Specific services and concerns to address include: screening; increased risk assessments; holistic health education; primary prevention; smoking cessation and weight reduction.

   Requirements:

- Regularly offer and provide classes ideally promoted**,** led and encouraged by peers related to whole health, including Personal Action Toward Health (PATH), Wellness Recovery Action Planning (WRAP), physical activity**,** smoking cessation, weight loss and management etc.

- Collect information on behavioral health morbidity, mortality and co-morbid conditions with a strategic planning process to address and decrease risk factors associated with early death. Include information on identified community resources for healthcare services.

- Provide referrals and outreach to assist individuals with meeting their basic needs, including finding affordable housing, having enough income to address risk factors associated with poverty, employment and education assistance, etc.

- Identify, develop and strengthen community partnerships to promote models and access for the integration of physical and behavioral health.

- Discuss and coordinate transportation for individuals to attend appointments, classes and health-related activities discussed in the person-centered planning process.

6. Assess and continually improve recovery promotion, competencies, and the environment in organizations throughout the recovery services system of care.

   Requirements:

   - Complete a strategic planning process that builds on the actions of and information from the ROSC/TSC, including results from the recovery survey implementation and review identified as part of the statewide RFA process.

   - Provide ongoing education on recovery services, recovery oriented systems of care, and environments that promote recovery with all staff (executive management, psychiatrists, physicians, case managers, clinicians/counselors, support staff), leadership, board members, recovery councils, community members, etc.

   - Include a list of recovery oriented competencies (protocols and practice) in employee job descriptions and performance evaluations.

- Work in partnership with individuals receiving services, CPSS/Recovery Coaches, program staff (medical, clinical, supervisory/administrative, support), and community and family members in all aspects of the development and delivery of recovery-oriented services and supports, needed trainings and recovery oriented activities.

How Michigan's Efforts Align with Federal Policy

MDHHS recognizes that recovery is highly individualized and requires support form a recovery oriented system of care. It is also a process, vision, conceptual framework that should adhere to guiding principles, but most importantly it is recognized and supported through a series of initiatives, trainings, and educations resources as well as state and national policies. Recovery emphasizes individual circumstances and needs, the strong voice and advocacy of people with lived experience, a broad array of services and supports within a recovery oriented system of care, and the commitment of partners and key stakeholders. By drawing on a combination of personal experiences, a knowledgeable services system that promotes and supports recovery, communities committed to health and wellness, a driving force for recovery oriented systems transformation is created and maintained.

In 2012, the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) published this definition of recovery from Mental Disorders and/or Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. This definition along with Guiding Principles of Recovery, including those from SAMHSA are provided earlier in this Policy and Practice Advisory, and are at the core of Michigan's behavioral health recovery system and infrastructure.

After the review of recovery and recovery oriented systems of care definitions and guiding principles, the ROSC TSC has identified the following Elements of ROSC/Recovery to be adhered to by those providing behavioral health services.

Elements of a ROSC/Recovery:

- Holistic and integrated services beyond symptom reduction
- Person-Driven
- Continuity of care - assertive outreach and engagement; and ongoing monitoring and support
- Culturally responsive services.
- Occurs via many pathways
- Peer supports and services
- Community health and wellness.
- Family and Significant Other Involvement

- Systems/services anchored in the community
- Evidence- and Strength- based practices
- Trauma informed
- Based in respect

True change will require a series of legislative actions, state and federal policies and Mental Health and Public Health Code changes intentionally designed to promote the construct and elements of recovery supports and services. Few states, Michigan included, have developed a policy and practice guideline on recovery, thus, MDHHS relied on the work, ideas of the now disbanded Michigan Recovery Council and the ongoing work and initiatives of the ROSC/TSC to craft this document.

Successful implementation of these guiding principles and recommendations for systems change will demand an active response from MDHHS, the Behavioral Health and Developmental Disabilities Administration, the Pre-paid Inpatient Health Plans, the CMHSPs, and the behavioral health provider system, with active support form persons with lived experience, persons in recovery, and communities across the state. This policy and practice advisory must be treated like recovery itself, with meaning, purpose, and dedication to support individual and system change that will support recovery as “ongoing personal and unique journey of hope, growth, resilience and wellness.” Great effort will be required to ensure that this policy and practice advisory is embraced and implemented. The ROSC/TSC and MDHHS look forward to assessing progress toward these principles every year.

Behavioral Health

Individual Recovery and Recovery Oriented Systems of Care

Planning, Reporting, and Evaluating

This document contains:
Information, directions, and forms for continued Recovery/ROSC transformation planning, reporting and evaluating;
and
An attachment to be utilized for educational and informational purposes

Table of Contents

Information, Directions, and Forms for Recovery/ROSC Transformation Planning and Reporting

Proposed Contract Language.....Page 3
Utilizing the Alignment and Phase Matrix/Instruction.....Pages 4 – 6
Table 1: ROSC Framework for the Transformation Process.....Pages 6 - 7
Table 2: Plan and Report on Action/Progress toward ROSC/Recovery
Implementation and Enhancement.....Pages 8 - 9
Utilizing the RSA Recovery Survey Tool to Assess Progress and Change.....Pages 10 - 11
Utilizing the REE Recovery Survey Tool to Assess Progress and Change.....Pages 12 - 13

Attachment: Framework and Infrastructure for Recovery Oriented Systems of Care and Individual Recovery Initiatives

Orientation and Definitions.....Page 14
Recovery and ROSC Elements, Guidelines and Priorities.....Pages 15 - 18
Reasoning and Philosophy to Gain Insight That Will Motivate Change.....Pages 18 - 20

Proposed Contract Language

To assure inclusion and application of recovery principles: PIHPs are required to continue implementation and enhancement of recovery services and systems development through the use of Conceptual, Practice, and Contextual alignment.

See attached forms and instructions.

Utilizing the Alignment Framework:
A Tool for Planning, Implementation, Enhancement, Reporting and Evaluating
Instructions

This framework to guide the recovery transformation Planning, Implementation, Enhancement, Reporting and Evaluating process is the transformation framework developed by Achara-Abrahams, Evans, & King, 2001). It involves three primary strategies that must be implemented in a way that promotes a culturally competent service delivery system.

Conceptual Alignment: This alignment targets the promotion of conceptual and philosophical clarity regarding the system's collective vision of transformation. During this process, the core values, principles, and ideas upon which a recovery oriented system of care will be built are defined through an inclusive process.

Practice Alignment: This focuses on changing stakeholder behaviors and processes across the system, so that they are consistent with the stated vision of recovery and resilience. Change leaders are focused on developing mechanisms to translate the theoretical concepts of recovery and resilience into concrete practices at various levels and in diverse parts of the system.

Contextual Alignment: Activities are designed to sustain the transformation over time. While practice changes constitute a necessary part of the process, these changes cannot be implemented in a vacuum. To be sustained over time, they must be accompanied by contextual changes that will facilitate their long-term success. Many of these changes in context include policy, regulatory, and fiscal changes; increased political advocacy; activities that increase community support for people in recovery; and efforts that address stigma and strengthen the health of the community for all people.

These strategies are not linear, and at each phase of the transformation process there will be a continued need to align thinking, practices, and the fiscal/policy environment with the vision for the system. During some phases, however, certain strategies play a more prominent role. For example, in the initial stages of the transformation process, it is critical that sufficient time be invested in developing a shared vision for the system.

Moving forward to transform, enhance, and maintain recovery services and a system that embraces and supports recovery, it is important to be mindful of the efforts used to strengthen the services/system as we proceed. The need to successfully grow a recovery oriented system of care populated with services that facilitate individual recovery is incumbent on all parts of the behavioral health system. To bring structure to this process and make easier the regions planning and actions in this regard, the Behavioral Health and Developmental Disabilities Administration (BHDDA) is providing a mechanism and process for planning, (implementation, enhancement) reporting and evaluating the regions ROSC/Recovery initiative and general progress.

Utilizing the framework described above, and providing a matrix to be used for planning and reporting on ROSC/Recovery transformation and growth efforts the BHDDA is implementing this process to create consistency in the manner in which the ten PIHP Regions address continuing transformation and growth process.

Table 1: provides structure and guidance on the planning and reporting of Recovery/ROSC transformation and growth by defining the three types of alignments (conceptual, practice, and contextual); and this Table delineates the kinds of initiatives that should be undertaken within the scope of each alignment (beginning, intermediate, and advanced) to advance and enhance Recovery/ROSC.

Table 2 is the actual matrix on which you will record your planning efforts and report the results of these initiatives. Portions of Table 2 are pre-filled utilizing the elements of ROSC/Recovery as identified within the guidelines for the same. These include: holistic and integrated services beyond symptom reduction; person-driven; continuity of care – assertive outreach and engagement, and ongoing monitoring and support; culturally responsive services; occurs via many pathways; peer supports and services; community health and wellness; family and significant other involvement; systems/services anchored in the community; evidence- and strength-based services; trauma informed; and based in respect. These elements are provided down the vertical axis at the left of the page. Within the horizontal access you will find the three alignment types: conceptual, practice, and contextual as well as the phases of early, intermediate and advanced levels of those alignment activities.

While planning services related to the elements of ROSC/Recovery consideration must also be given to the priorities for the direction of ROSC/behavioral health services, which are: behavioral health and primary healthcare integration; community health promotion; recovery support services that are peer-based; prevention services that are environmental and population-based; and services and supports whose focus is expanded, including both the continuum of care (from pre-treatment services to post-treatment services and supports) and the content of care (beyond supporting abstinence) to promoting community health and helping people build meaningful lives in the community.

Also within the matrix you will find some pre-filled examples of how to complete an item within a cross-hatched box – a cross-hatched box being the point at which a line originated from the vertical axis intersects with a column from the horizontal axis. To assist in identifying where these examples are located: there is one located in the cross-hatch box of Community Health and Wellness x Conceptual Alignment – Advanced. A second and third can be found in cross-hatch boxes Peer Supports and Services x Practice Alignment – Advanced, and Family and Significant Other Involvement x Practice Alignment - Early, respectively. Within the cross-hatch boxes, for each planned/reported activity, there needs to be: 1) the appropriate general type of initiative (selected from table 1); whether this activity is at the early, intermediate or advanced stage of this process within the region; and 3) the activity/initiative itself. If there are multiple activities/initiatives listed within the same cross-hatch box please number them consecutively. Again, the examples will assist in clarifying how to complete the plan/report.

It is the PIHP that will complete **the plan** and/or the report matrices in Table 2 for their region. The plan however, is intended to be developed by a team of intentionally selected, well informed individuals within the region, representing: behavioral health, other agency/organizations, key stakeholders, community members/leadership, and persons with lived experience. **The report** will require the gathering of related information for each of the planned items, and a synthesis of this information when reporting on each planned, numbered item in the populated cross-hatched boxes.

The BHDDA intentionally developed a system that would complement surveys selected by the regions to measure progress in ROSC/Recovery efforts. The surveys selected by each region, and approved by BHDDA, include one or more of the following, which were identified during the RFA process: Recovery Self Assessment (RSA) – Person in recovery version; Recovery Self Assessment (RSA) –Family/significant other/advocate version; Recovery Self Assessment (RSA) – Provider version;

Recovery Self Assessment (RSA) – CEO/Agency director version; and the REE-MI. To link the questions on the RSA and REE surveys, each question was associated (by a team of individuals) to one of the three alignment types from planning/reporting Tables 1 and 2. Each survey questions response selection had a number scale for grading responses with the exception of the REE-MI. In the case of that survey a number scale was assigned for this purpose. For all of the conceptual, practice and contextual alignment type questions, add up the points for each question/alignment type, then divide by the total number of questions of the same alignment type to determine an average score for that alignment – EXAMPLE: to begin let's assume that the following represent the scores for all of the practice alignment type questions: 3, 4, 3, 1, 3, 2, 3, and these number scores were taken from the seven practice alignment type questions identified on one of the RSA surveys. Then add the score from these seven questions, which equals 19, and dividing 19 by seven (the number of practice alignment questions) - this results in the average score of 2.71 for practice alignment. Continue this process until scores have been determine for the three alignment types for all Recovery/ROSC surveys that you utilize. While this correlation and scoring process may take some time up front, the information received will be of great value.

The next step in this process is to enter these results into Table 3a for all RSA surveys and Table 3b for the REE-MI survey. The tables are clearly marked with the name of the survey, the type of alignment, and provides a place for previous survey scores, current survey scores, and the variance between the two. Please note: This is the first year that you are being required to use this process and these forms. Therefore, you are only required to enter information the current year's survey results. Having made that clarification, if you would like to enter results from a previous implementation of these surveys, that would provide you with variance information that may aid in planning for next fiscal year, but this is not required. In the future (beyond this year's survey results), you will be required to enter this year (as the previous year) and the new current year information and provide the variance.

By engaging in this process each PIHP region will be able to assess progress/growth, stagnation or decline in each ROSC/Recovery alignment area. While this information will be reported to BHDDA, it will be used for informational purposes only, and to identify what technical assistance and training with regard to ROSC/Recovery may be of use to the different PIHP regions.
Planning, Reporting and Evaluation Due Dates:
Table 2: Annual Planning matrices are due, 0December 31, 2016
Table 2: Annual Reporting matrices are due by February 28, 2018
Table 3a and 3b: Annual Survey Information forms are due October 31, 2017

Table 1: ROSC Framework for the Transformation Process

	Phase I **Beginning**	**Phase II** **Intermediate**	**Phase III** **Advanced**
Conceptual Alignment (Develop consensus; promote an in-depth understanding of a culturally competent ROSC)	Increase awareness of the need for the development of a ROSC in Michigan Develop a shared vision for change among all stakeholders	Increase awareness of the implications of a ROSC for other systems (e.g., criminal justice, child welfare) Increase stakeholder understanding of effective ways of implementing recovery-oriented services and supports	Increase awareness of the types of services and supports within Michigan that are leading to better outcomes Realign the vision for the system based on lessons learned, successes, and challenges [through communication with the TSC]

	Develop ROSC definition and guiding principles that apply to treatment and prevention Increase [regional and Local] stakeholder understanding of the differences between a ROSC and a traditional system, including implications for treatment and prevention		
Practice Alignment (Align services and supports with a recovery, resilience and culturally competent orientation)	Identify initial recovery-oriented practices that will be prioritized in the transformation process Disseminate information about practices throughout the system [and regionally/locally] Conduct baseline assessments Identify/initiate potential pilots Mobilize the recovery community and other community stakeholders	Support the implementation of recovery-oriented practices through the development of technical advisories, training, technical assistance, relevant work groups, etc. Support the implementation of pilot projects Conduct rapid-cycle change projects Collaborate across systems to promote practice alignment	Conduct outcome assessments Disseminate lessons learned Provide advanced training and technical assistance Increase collaboration with other systems around the provision of recovery-oriented services Identify additional recovery-oriented practices that will be prioritized
Contextual Alignment (Change policy, fiscal, regulatory and administrative infrastructure so that it supports the sustainability of Michigan's culturally competent ROSC)	Identify fiscal, policy and regulatory barriers to delivering services and supports that promote recovery and resilience Identify strategies for addressing barriers to implementation Develop strategies to engage the community to support ROSC	Align fiscal and policy infrastructure to support recovery-oriented services Identify and address contextual challenges that arise within the pilot projects	Conduct cost/benefit analyses in various parts of the system Identify ongoing policy/fiscal challenges Increase expectations around the delivery of recovery-oriented care, through changes in contract language, inclusion in RFPs Actively address regulatory barriers to the full implementation of practice changes

Table 2: Plan and Report on Action/Progress toward ROSC/Recovery Implementation and Enhancement

Select the Appropriate Option: ___ Annual Plan or ___ Quarterly Reporting Form

Elements of ROSC/Recovery	Conceptual Alignment Phase 1: Early Phase 2: Intermediate Phase 3: Advanced *When reporting Indicate to which phase your activity/accomplishment is associated*	Practice Alignment Phase 1: Early Phase 2: Intermediate Phase 3: Advanced *When reporting Indicate to which phase your activity/accomplishment is associated*	Contextual Alignment Phase 1: Early Phase 2: Intermediate Phase 3: Advanced *When reporting Indicate to which phase your activity/accomplishment is associated*
	(Develop consensus; promote an in-depth understanding of a ROSC/Recovery)	(Align services and supports with a ROSC/Recovery and resilience orientation)	(Change policy, fiscal, regulatory and administrative infrastructure so that it supports the sustainability of ROSC/Recovery)
▪ Holistic and integrated services beyond symptom reduction			
▪ Person-Driven			
▪ Continuity of care - assertive outreach and engagement; and ongoing monitoring and support			
▪ Culturally responsive services.			
▪ Occurs via many pathways			
▪ Peer supports and services		**Example:** [Identify additional recovery oriented practices that will be prioritized] Advanced: Continue the availability of effective peer run organizations which provide varying levels of peer support services.	
▪ Community health and wellness	**Example:** [Increase awareness of the types of services and supports within Michigan that are leading to better outcomes] Advanced: Established an advisory Council inclusive of persons with lived experience, to make		

	recommendations on environmental prevention strategies to improve community wellness		
▪ Family and Significant Other Involvement		**Example:** [Conducting baseline assessments] Early: Implemented Region –wide the Recovery Self-Assessment (RSA) – Family, Significant Other, Advocate Version	
▪ Systems/services anchored in the community			
▪ Evidence- and Strength- based practices			
▪ Trauma informed			
▪ Based in respect			

Utilizing the Recovery Survey Tools

Process for the RSA Survey User(s):

Identify each question on the individual RSA surveys tool as being associated to Conceptual, Practice, or Contextual Alignment. For each type of alignment add up the scores given to each of those questions, then divide that total number by the number of that alignments questions…EXAMPLE: let's say that the RSA Provider survey has five Practice Alignment questions and the survey responses to these five quests are – 3.0, 4.0, 1.0, 4.0, and 4.0. Adding the response numbers together you get 16.0., then divide by 5 and the average score for Practice alignment is 3.2. For those who have done baseline or previous usage of this survey utilize the same scoring process for that survey.

Once you have totaled the information from the previous and current survey periods compare the two number totals, and identify the differences so as to show progressive or regressive outcomes for transformation efforts related to each alignment. Use this information to inform your future planning initiatives targeting areas of regression or little to no progression. It may take some time to calculate your base line and current survey numbers, however, this will provide you with good information for planning and showing progress in your transformation efforts.

Identify each of the RSA survey forms being used in your region, please show the previous survey result numbers compared to the current survey result numbers and the progressive or regressive variance.

Table 3a: RSA Survey Forms Information			
	Previous RSA Survey Alignment Scores Date of Survey: _____	**Current RSA Survey Alignment Scores Date of Survey: _____**	**Variance between Previous and Current RSA Survey Scores**
RSA Survey – Individual Recovery			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			
RSA Survey - Program Provider			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			
RSA Survey – Management/Administration			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			

RSA Survey – Family and Significant Others			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			

RSA Survey Forms Table - EXAMPLE			
	Previous RSA Survey Alignment Scores Date of Survey: _____	**Current RSA Survey Alignment Scores Date of Survey:** _____	**Variance between Previous and Current RSA Survey Scores**
RSA Survey – Family and Significant Others			
Type of Alignment			
Conceptual Alignment	28.0	35.0	+7
Practice Alignment	16.0	12.0	-4
Contextual Alignment	21.0	21.0	No Change

Process for the REE Survey User(s):

Beginning with section three of the REE Survey and going through section five identify each question on the individual RSA surveys tool as being associated to Conceptual, Practice, or Contextual Alignment. Then using the following scoring key assign every numbered and lettered question the numeric value identified in the key, i.e., a "strongly agree" response would be assigned the number four.

Strongly Agree (SA) = 4.0
Agree (A) = 3.0
Disagree (D) = 2.0
Strongly Disagree (SD) = 1.0

Next, for each type of alignment add up the scores given to each of those questions, then divide that total number by the number of that alignments questions…EXAMPLE: let's say that the REE survey, section three has five Practice Alignment questions and the survey responses value to these five quests are – 3.0, 4.0, 1.0, 4.0, and 4.0. Adding the response numbers together you get 16.0., then divide by 5 and the average score for Practice alignment is 3.2. For those who have done baseline or previous usage of this survey utilize the same scoring process for that survey so that you can do a comparative analysis.

Once you have totaled the information from the previous and current survey periods compare the two number totals, and identify the differences so as to show progressive or regressive outcomes for transformation efforts related to each alignment. Use this information to inform your future planning initiatives targeting areas of regression or little to no progression. It may take some time to calculate your base line and current survey numbers, however, this will provide you with good information for planning and showing progress in your transformation efforts.

Table 3b: REE-MI Survey Form Information

	Previous REE Survey Alignment Scores Date of Survey: _____	Current REE Survey Alignment Scores Date of Survey: _____	Variance between Previous and Current REE Survey Scores
REE Survey – Section III			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			
REE Survey – Section IV			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			
REE Survey – Section V			
Type of Alignment			
Conceptual Alignment			

Practice Alignment			
Contextual Alignment			
REE Survey Form Table - EXAMPLE			
	Previous REE Survey Alignment Scores Date of Survey: _____	**Current REE Survey Alignment Scores Date of Survey:** _____	**Variance between Previous and Current REE Survey Scores**
REE Survey – Section III			
Type of Alignment			
Conceptual Alignment	28.0	35.0	+7
Practice Alignment	16.0	12.0	-4
Contextual Alignment	21.0	21.0	No Change

Attachment:
Framework and Infrastructure for
Recovery Oriented Systems of Care and Individual Recovery Initiatives

Effective pursuit and support of recovery has a dual focus: 1) the development and maintenance of a recovery oriented services system anchored in the community and 2) a process that is dedicated to supporting personal recovery through the provision of necessary and needed services and supports. One cannot exist without the other.

A ROSC is not a program; it is a philosophical construct by which a behavioral health system (SUD and mental health) shapes its perspective on how they will address recovery from alcoholism, addiction and other disorders. A ROSC approach is the basis of the development of the behavioral health service system. Its philosophy completely encompasses all aspects of SUD and Mental Health prevention and treatment services, including program structure and content, agency staffing, collaborations, partnerships, policies, regulations, trainings and staff/peer/volunteer orientation.

Within a ROSC, SUD and mental health service entities, as well as their collaborators and partners, cooperatively provide a flexible and fluid array of services in which individuals can move. People should be able to move among and within the system's service opportunities, without encountering rigid boundaries or silo-embedded services, to obtain the assistance needed to pursue recovery, and approach and maintain wellness. In Michigan we believe that behavioral health recovery is possible and can be achieved by individuals, families and communities.

As PIHPs develop recovery plans for their region, it is this type of system of care and this type of service array that should be considered.

An individual's recovery relies on the existence of a recovery oriented system of care. Without a services system built on recovery practices, policies, and programs, providing the infrastructure to support an individual's recovery efforts there would be no foundation from which to work and flourish.

'Recovery is a process not an event'

Recovery is possible when a multi-faceted infrastructure of services and supports exists to enable and enhance the recovery efforts and environments of individuals, families and communities.

BHDDA Recognized Definitions:

***[An individual's]* Recovery from Mental Disorders and/or Substance Use Disorders:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA 2012
Accepted by BHDDA 2013

Recovery oriented *system* of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities.

Adopted by TSC, Sept. 30, 2010

Elements of a ROSC/Recovery:

- Holistic and integrated services beyond symptom reduction
- Person-Driven
- Continuity of care - assertive outreach and engagement; and ongoing monitoring and support
- Culturally responsive services.
- Occurs via many pathways
- Peer support and services
- Community health and wellness.
- Family and Significant Other Involvement
- Systems/services anchored in the community
- Evidence- and Strength- based practices
- Trauma informed
- Based in respect

Individual Recovery and Recovery Oriented *System* of Care Guiding Principles:

These Guiding Principles will be utilized by BHDDA and the TSC to support and guide the development of a recovery oriented behavioral health services system.

SAMHSA's Ten Guiding Principle of Recovery *[for individual recovery]* and Additional Guiding Principles for Recovery Oriented Systems of Care:

The numbered Guiding Principles, items one through ten, are those identified by SAMHSA. In instances where there two separate statements under one number the second statement is an enhancement to include additional recovery systems information to the guiding principle. Guiding principles eleven through sixteen are additional principles to enhance the connection between an individual's personal recovery and the services systems that support their efforts.

1) Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that people and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Five ROSC Priority Areas:

1. Behavioral health and primary healthcare integration.
2. Community health promotion.
3. Recovery support services that are peer-based.
4. Prevention services that are environmental and population-based.
5. Services and supports whose focus is expanded, including both the continuum of care (from pre-treatment services to post-treatment services and supports) and the content of care (beyond supporting abstinence) to promoting community health and helping people build meaningful lives in the community.

2) Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

The system of care promotes person driven recovery will be individualized, person/family/community-centered, comprehensive, stage-appropriate, and flexible. It will adapt to the needs of individuals and communities, rather than requiring them to adapt to it. Individuals receiving services will have access to a menu of stage-appropriate choices that fit their needs throughout the recovery process. The approach will change from an acute, episode-based model to one that helps people manage this chronic disorder throughout their lives. Prevention services will be developmentally appropriate and engage the multiple systems and settings that have an impact on health and wellness. Prevention efforts will be individualized based on the community's needs, resources, and concerns.

3) Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experience—that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is nonlinear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

4) Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

This system will offer a continuum of care that includes prevention, early intervention, treatment, continuing care, and support throughout recovery. Individuals will have a full range of stage-appropriate services to choose from at any point in the recovery process. Prevention services will involve the development of coordinated community systems that provide ongoing support, rather than isolated, episodic programs.

5) Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

This system of care will promote ongoing involvement of peers, through peer support opportunities for youth and families and peer recovery support services for individuals with behavioral health disorders. Individuals with relevant lived experiences will assist in providing these valuable supports and services.

6) Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

7) Recovery is culturally-based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

The system of care will be culturally sensitive, gender competent, and age appropriate. There will be recognition that beliefs and customs are diverse and can impact the outcomes of prevention and treatment efforts.

8) Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

9) Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

The system of care that fosters this dynamic will acknowledge the important role that families, significant others and communities can play in promoting wellness for all and recovery for those with behavioral health disorder challenges. It will be incorporated, whenever it is appropriate, into needs-assessment processes, community planning efforts, recovery planning and all support processes. In addition, our system will provide prevention, treatment, and other support services for the family members and significant others of people with behavioral health disorders.

10) Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

11) **Inclusion of the voices and experiences of recovering individuals, youth, family, and community members**

The voices and experiences of all community stakeholders will contribute to the design and implementation of our system. People in recovery, youth, and family members will be included among decision-makers and have oversight responsibilities for service provision. Recovering individuals, youth, family, and community members will be prominently and authentically represented on advisory councils, boards, task forces, and committees at state and local levels.

12) Integrated strength-based services

The system will coordinate and/or integrate efforts across service systems, particularly with primary care services, to achieve an integrated service delivery system that responds effectively to the individual's or the community's unique constellation of strengths, desires, and needs. An integral aspect of this system is the partnership/consultant model that focuses more on collaboration and less on hierarchy. Systems will be designed so that individuals, families, and communities feel empowered to direct their own journeys of recovery and wellness.

13) Services that promote health and wellness will take place within the community

Our system of care will be centered within the community, to enhance its availability and support the capacities of families, intimate social networks, community-based institutions, and other people in recovery. By strengthening the positive social support networks and addressing environmental determinants to health in which individuals participate, we can increase the chances for successful recovery and community wellness.

14) Outcomes-driven

Our system will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery and with the community. Outcome measures will be diverse and encompass measures of community wellness as well as the long-term global effects of the recovery process on the individual, family, and community – not just the remission of behavioral and biomedical symptoms. Outcomes will focus on individual, family, and community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

15) System-wide education and training

Our behavioral health system will seek to ensure that concepts of prevention, recovery, and wellness are foundational elements of curricula, certification, licensure, accreditation, and testing mechanisms. The workforce also requires continuing education, at every level, to reinforce the tenets of ROSC. Our education and training commitments are reinforced through policy, practice, and the overall service culture.

16) Research-based

Our system will be data driven and informed by research. Additional research with individuals in recovery, recovery venues, and the processes of recovery (including cultural and spiritual aspects) will be essential to these efforts. Research related to Behavioral health disorders will be supplemented by the experiences of people in recovery.

Embracing the Reasoning and Philosophy Behind Recovery and Recovery Oriented Systems of Care:

Gaining Insight that will Motivate Change

Information to Support the Need for Behavioral Health Systems and Services Recovery Transformation

What is known about Mental Health and Substance Use Disorders, and why the system needs change:

1. People typically enter treatment after ten years of active addiction. The longer people use, the more difficult it is for them to enter and sustain recovery.
2. The longer the use, due to Substance Use Disorders, the higher the negative impacts for families and communities.
3. 90 percent of persons with mental health or substance use disorders have experienced trauma. 100 percent of persons with co-occurring disorders have experienced trauma.
4. Genetic and Social predisposition increase risk behavior and risk of developing the disease of addiction. [Look for data for co-occurring and co-morbidity]
5. Risk for suicide is higher among those with mental health, substance use, and co-occurring disorders.

Why we need change:

1. Fifty percent of clients entering treatment have already had at least one prior episode of care.
2. SUD is a chronic condition, but we currently have an acute care treatment model. This model does not sustain the support necessary to stabilize recovery. All of our resources are needed to change this.
3. Cycling in and out of a series of disconnected treatment episodes is a product of the challenges within the current system – an inability to support sustained recovery.
4. Scope of the system of services needs to be broadened.
5. Coordination of prevention, follow up and continuing care lacks integration and needs enhancement.
6. Working together in partnership and collaboration is the only way to provide all services needed to achieve and sustain recovery.
7. Limited Attraction: Less than 10% of people who meet the DSM (current version) criteria for a SUD currently seek treatment.
8. Poor Engagement and Retention: Less than half of those in treatment complete their treatment program.
9. Lack of Continuing Care: Post-discharge continuing care can enhance recovery outcomes, but only one in five receives it.
10. High Rates of Relapse: The majority of people completing addiction treatment resume alcohol and other drug use within one year, and most within 90 days following discharge.
11. Resource Expenditures: Most resources are expended on a small portion of the population requesting services.
12. Readiness for Change: Services are not aligned with the client's readiness for change.
13. Data is not utilized in a manner that enhances services and monetary support- we need to empower change and enforce accountability.
14. Current system is fragmented and not cost effective. There is poor use of resources and lack of communication between systems – separate locations for services create challenges.
15. Society, legislators, law enforcement, and physicians have a negative perception of individuals with mental health and/or substance use disorders along with a low expectation of change.
16. Significant stigma exists within the behavioral health and primary health care systems.
17. It takes four to five years for the risk of SUD relapse to drop below 15%.
18. Current services system focuses on acute treatment.

19. Admission and discharge protocols compromise fluidity of service provision.

What we know about services that support recovery and resilience.

Effective ROSC services focus on:

1. Greater emphasis on continuity of care: effective prevention, assertive outreach and engagement, treatment, and ongoing monitoring and support.
2. Continuum of care in which services are holistic and integrated, culturally responsive, and with systems that are anchored in the community.
3. Expanded availability of non-clinical services such as: peer supports, prevention, faith-based initiatives, etc.
4. Resources to help prevent the onset of substance use disorders.
5. A public health approach being taken to help create healthy communities.
6. More assertive outreach to families and communities impacted by substance use disorders.
7. More assertive post-treatment monitoring and support is provided.
8. A partnership/consultation approach rather than an expert/patient model.
9. Valued lives and experiences of other people in recovery used to help others on their journey.
10. Person-centered self-directed approach to recovery,
11. Use of peer support services to sustain an individualized recovery effort.
12. Use of services that build on each individual's recovery capital.
13. Sustained relationships help to maintain engagement.
14. Ongoing recovery activities are critical for sustaining recovery efforts.
15. Expanded knowledge and increased education efforts regarding all populations served.

Examples of how a ROSC differs from traditional service systems:

1. Treatment goals extend beyond abstinence or symptom management to helping people achieve a full, meaningful life in the community.
2. Prior treatment is not viewed as a predictor of poor treatment outcomes and is not used as grounds for denial of treatment.
3. People are not discharged from treatment for relapsing and confirming their original diagnosis of addiction, which is a chronic and often relapsing brain disease.
4. Post-treatment continuing care services are an integrated part of the service continuum rather than an afterthought.
5. Focus is on all aspects of the individual and the environment, using a strength-based perspective and emphasizing assessment of recovery capital.
6. Service system includes not just behavioral health providers but collaborators, stakeholders, and community partners as well.
7. Expansion to include innovative services that are comprehensive, dynamic, and always evolving.
8. Utilization of multi-disciplinary teams personalized to the individual's needs and goals (strength-based).
9. Provider/client relationship is key and partner oriented – not hierarchal.
10. Streamlined documentation and consistent reimbursement.

What are some implications for recovery services and supports?

1. Greater emphasis on outreach, pre-treatment supports, and engagement.
2. More diverse menu of services and supports available for people to choose from based on their needs.
3. A more assertive effort by providers to connect individuals to families and natural supports.
4. Expanded availability of non-clinical/peer-based recovery supports.
5. Post-treatment recovery check-ups.
6. Service relationships shift from an expert/patient model to a partnership/consultation approach.

7. Understanding of the impact of trauma.
8. Reduction of recidivism.
9. Reduction of stigma.

Embracing the philosophy, perspective and practice of Recovery/ROSC by:

1. Establishing a proactive partnership with the individual, that is person-centered.
2. Establishing and maintaining a system of care that is recovery oriented and supports recovery services.
3. Establishing and nurturing relationships with other community support service providers.
4. Creating the expectation that full recovery is a life-long pursuit sustained through service intervention and community support.
5. Acknowledging that multiple episodes needing treatment do occur and are reasonable, considering the nature of behavioral health disorders.
6. Respecting that recovery requires ongoing relationships rather than brief interventions.
7. Being open to new and innovative approaches.
8. Confronting stigma whenever encountered.

PIHP CUSTOMER SERVICES STANDARDS
Revised: February, 2014

Preamble

It is the function of the customer services unit to be the front door of the pre-paid inpatient health plan (PIHP), and to convey an atmosphere that is welcoming, helpful and informative*. *These standards apply to the PIHP and to any entity to which the PIHP has delegated the customer services function, including affiliate CMHSP(s), or provider network.

Functions

A. Welcome and orient individuals to services and benefits available, and the provider network.
B. Provide information about how to access mental health, primary health, and other community services.
C. Provide information about how to access the various rights processes.
D. Help individuals with problems and inquiries regarding benefits.
E. Assist people with and oversee local complaint and grievance processes.
F. Track and report patterns of problem areas for the organization.

Standards

1. There shall be a designated unit called “Customer Services.”
2. There shall be at the PIHP a minimum of one FTE (full time equivalent) performing the customer services functions whether within the customer service unit or elsewhere within the PIHP. If the function is delegated, affiliate CMHSPs, and network providers, as applicable, shall have additional FTEs (or fractions thereof) as appropriate to sufficiently meet the needs of the people in the service area.
3. There shall be a designated toll-free customer services telephone line with access to alternative telephonic communication methods (such as Relays, TTY, etc). The customer services numbers shall be displayed in agency brochures and public information material.
4. Telephone calls to the customer services unit shall be answered by a live voice during business hours. Telephone menus are not acceptable. A variety of alternatives may be employed to triage high volumes of calls as long as there is response to each call within one business day.
5. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized. **It is expected that the customer services/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.**
6. The customer handbook shall contain the state-required topics (See P.6.3.1.1.A)
7. The Medicaid coverage name and the state’s description of each service shall be printed in the customer handbook.
8. The customer handbook shall contain a date of publication and revision(s).
9. Affiliate CMHSP, or network provider names, addresses, phone numbers, TTYs, E-mails, and web addresses, as well as whether the provider speaks any non-

English language and if they are accepting new patients, shall be contained in the customer handbook.

10. Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area, including plan or program name, locations, and telephone numbers, shall be provided in the handbook.
11. Customer services unit shall maintain current listings of all providers, both organizations and practitioners, with whom the PIHP has contracts, the services they provide, any non-English languages they speak, any specialty for which they are known, and whether they are accepting new patients. This list must include independent PCP facilitators. Beneficiaries shall be given this list annually unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer services line is acceptable.
12. Customer services unit shall have access to information about the PIHP including each CMHSP affiliate annual report, current organizational chart, CMHSP board member list, meeting schedule and minutes. Customer services will provide this information in a timely manner to individuals upon their requests.
13. Upon request, the customer services unit shall assist beneficiaries with filing grievances and appeals, accessing local dispute resolution processes, and coordinate as appropriate with Fair Hearing Officers and the local Office of Recipient Rights.
14. Customer services staff shall be trained to welcome people to the public mental health system and to possess current working knowledge, or know where in the organization detailed information can be obtained in at least the following:
    a. *The populations served (serious mental illness, serious emotional disturbance, developmental disability and substance use disorder) and eligibility criteria for various benefits plans (e.g., Medicaid, Healthy Michigan Plan, MIChild)
    b. *Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services
    c. Person-centered planning
    d. Self-determination
    e. Recovery & Resiliency
    f. Peer Specialists
    g. *Grievance and appeals, Fair Hearings, local dispute resolution processes, and Recipient Rights
    h. Limited English Proficiency and cultural competency
    i. *Information and referral about Medicaid-covered services within the PIHP as well as outside to Medicaid Health Plans, Fee-for-Services practitioners, and Department of Human Services
    j. The organization of the Public Mental Health System
    k. Balanced Budget Act relative to the customer services functions and beneficiary rights and protections
    l. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies)
    m. Public Health Code (for substance abuse treatment recipients if not delegated to the PIHP)

*Must have a working knowledge of these areas, as required by the Balanced Budget Act

PIHP CUSTOMER SERVICES HANDBOOK
REQUIRED STANDARD TOPICS
Revised: February 2014

Each pre-paid inpatient health plan (PIHP) must have a customer services handbook that is provided to Medicaid beneficiaries when they first come to service. Thereafter, PIHPs shall offer the most current version of the handbook annually at the time of person-centered planning, or sooner if substantial changes have been made to the handbook. The list below contains the topics that shall be in each PIHP's customer services handbook. The PIHP may determine the order of the topics as they appear in the handbook and may add more topics. In order that beneficiaries receive the same information no matter where they go in Michigan, the topics with asterisks (*) below must use the standard language templates contained in this requirement. PIHPs should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates. Information in the handbook should be easily understood, and accommodations available for helping beneficiaries understand the information. The information must be available in the prevalent non-English language(s) spoken in the PIHP's service area.

Per direction from the federal Centers for Medicare and Medicaid Services, MDHHS must approve all customer services handbooks to assure compliance with the Balanced Budget Act. After initial approval, it is necessary to seek MDHHS approval only when a PIHP makes significant changes (i.e., beyond new address or new providers) to the customer services handbook.

PIHP's are required to produce supplemental materials (inserts, stickers) to their handbooks if/when MDHHS contractual requirements are updated so that a previously approved handbook continues to meet requirements. Supplemental materials must be provided to individuals with their copy of the customer services handbook.

*Must use boilerplate language in templates (attached)

<u>Topics Requiring Template Language</u> (not necessarily in this order)
*Confidentiality and family access to information
*Coordination of care
*Emergency and after-hours access to services
*Glossary
*Grievance and appeal
*Language accessibility/accommodation
*Payment for services
*Person-centered planning
*Recipient rights
*Recovery
*Service array, eligibility, medical necessity, & choice of providers in network
*Service authorization

<u>Other Required Topics</u> (not necessarily in this order)
Access process
Access to out-of-network services

Affiliate [for Detroit-Wayne, the MCPNs] the names, addresses and phone numbers of the following personnel:

- Executive director
- Medical director
- Recipient rights officer
- Customer services
- Emergency

Community resource list (and advocacy organizations)
Index
Right to information about PIHP operations (e.g., organizational chart, annual report)
Services not covered under contract
Welcome to PIHP
What is customer services and what it can do for the individual; hours of operation and process for obtaining customer assistance after hours?

Other Suggested Topics
Customer services phone number in the footer of each page
Safety information

Template #1: Confidentiality and Family Access to Information

You have the right to have information about your mental health treatment kept private. You also have the right to look at your own clinical records and add a formal statement about them if there is something with which you do not agree. Generally, information about you can only be given to others with your permission. However, there are times when your information is shared in order to coordinate your treatment or when it is required by law.

Family members have the right to provide information to [PIHP] about you. However, without a Release of Information signed by you, the [PIHP] may not give information about you to a family member. For minor children under the age of 18 years, parents/guardians are provided information about their child and must sign a release of information before information can be shared with others.

If you receive substance abuse services, you have rights related to confidentiality specific to substance abuse services.

> Under HIPAA (Health Insurance Portability and Accountability Act), you will be provided with an official Notice of Privacy Practices from your community mental health services program. This notice will tell you all the ways that information about you can be used or disclosed. It will also include a listing of your rights provided under HIPAA and how you can file a complaint if you feel your right to privacy has been violated.

If you feel your confidentiality rights have been violated, you can call the Recipient Rights Office where you get services.

[Note to PIHP: you may add additional information to this template]

Template #2: Coordination of Care

To improve the quality of services, [PIHP name] wants to coordinate your care with the medical provider who cares for your physical health. If you are also receiving substance abuse services, your mental health care should be coordinated with those services. Being able to coordinate with all providers involved in treating you improves your chances for recovery, relief of symptoms and improved functioning. Therefore, you are encouraged to sign a “Release of Information” so that information can be shared. If you do not have a medical doctor and need one, contact the [Customer Services Unit] and the staff will assist you in getting a medical provider.

[Note to PIHP: you may add additional information to this template]

Template #3: Emergency and After-Hours Access to Services

A “mental health emergency” is when a person is experiencing symptoms and behaviors that can reasonably be expected in the near future to lead him/her to harm self or another; or because of his/her inability to meet his/her basic needs he/she is at risk of harm; or the person’s judgment is so impaired that he or she is unable to understand the need for treatment and that their condition is expected to result in harm to him/herself or another individual in the near future. You have the right to receive emergency services at any time, 24-hours a day, seven days a week, without prior authorization for payment of care.

If you have a mental health emergency, you should seek help right away. At any time during the day or night call:

[PIHP insert local emergency telephone numbers and place(s) to go for help]

Please **note: if you utilize a hospital emergency room, there may be health-care services provided** to you as part of the hospital treatment that you receive for which you may receive a bill and may be responsible for depending on your insurance status. These services may not be part of the PIHP emergency services you receive. Customer Services can answer questions about such bills.

Post-Stabilization Services
After you receive emergency mental health care and your condition is under control, you may receive mental health services to make sure your condition continues to stabilize and improve. Examples of post-stabilization services are crisis residential, case management, outpatient therapy, and/or medication reviews. Prior to the end of your emergency-level care, your local CMH will help you to coordinate your post-stabilization services.

Template #4: Glossary or Definition of Terms

MENTAL HEALTH GLOSSARY

Access: The entry point to the Prepaid Inpatient Health Plan (PIHP), sometimes called an "access center," where Medicaid beneficiaries call or go to request mental health services.

Amount, Duration, and Scope: Terms to describe how much, how long, and in what ways the Medicaid services that are listed in a person's individual plan of service will be provided.

Beneficiary: An individual who is eligible for and enrolled in the Medicaid program in Michigan.

CMHSP: An acronym for Community Mental Health Services Program. There are 46 CMHSPs in Michigan that provide services in their local areas to people with mental illness and developmental disabilities. May also be referred to as CMH.

Fair Hearing: A state level review of beneficiaries' disagreements with CMHSP, or PIHP denial, reduction, suspension or termination of Medicaid services. State administrative law judges who are independent of the Michigan Department of Health and Human Services perform the reviews.

Deductible (or Spend-Down): A term used when individuals qualify for Medicaid coverage even though their countable incomes are higher than the usual Medicaid income standard. Under this process, the medical expenses that an individual incurs during a month are subtracted from the individual's income during that month. Once the individual's income has been reduced to a state-specified level, the individual qualifies for Medicaid benefits for the remainder of the month. Medicaid applications and deductible determinations are managed by the Michigan Department of Health and Human Services – independent of the PIHP service system.

Developmental Disability: Is defined by the Michigan Mental Health code as either of the following: (a) If applied to a person older than five years, a severe chronic condition that is attributable to a mental or physical impairment or both, and is manifested before the age of 22 years; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration; (b) If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in a developmental disability.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): This legislation is aimed, in part, at protecting the privacy and confidentially of patient information. "Patient" means any recipient of public or private health care, including mental health care, services.

MDHHS : An acronym for Michigan Department of Health and Human Services . This state department, located in Lansing, oversees public-funded services provided in local communities and state facilities to people with mental illness, developmental disabilities and substance use disorders.

Medically Necessary: A term used to describe one of the criteria that must be met in order for a beneficiary to receive Medicaid services. It means that the specific service is expected to help the beneficiary with his/her mental health, developmental disability or substance use (or any other medical) condition. Some services assess needs and some services help maintain or improve functioning. PIHP's are unable to authorize (pay for) or provide services that are not determined as medically necessary for you.

Michigan Mental Health Code: The state law that governs public mental health services provided to adults and children with mental illness, serious emotional disturbance and developmental disabilities by local community mental health services programs and in state facilities.

MIChild: A Michigan health care program for low-income children who are not eligible for the Medicaid program. This is a limited benefit. Contact the [Customer Services Unit] for more information.

PIHP: An acronym for Prepaid Inpatient Health Plan. A PIHP is an organization that manages the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic area under contract with the State. There are 10 PIHPs in Michigan and each one is organized as a Regional Entity or a Community Mental Health Services Program according to the Mental Health Code.

Recovery: A journey of healing and change allowing a person to live a meaningful life in a community of their choice, while working toward their full potential.

Resiliency: The ability to "bounce back." This is a characteristic important to nurture in children with serious emotional disturbance and their families. It refers to the individual's ability to become successful despite challenges they may face throughout their life.

Specialty Supports and Services: A term that means Medicaid-funded mental health, developmental disabilities and substance abuse supports and services that are managed by the Pre-Paid Inpatient Health Plans.

SED: An acronym for Serious Emotional Disturbance, and as defined by the Michigan Mental Health Code, means a diagnosable mental, behavioral or emotional disorder affecting a child that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders; and has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

Serious Mental Illness: Is defined by the Michigan Mental Health Code to mean a diagnosable mental, behavioral or emotional disorder affecting an adult that exists or

has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders; and that has resulted in function impairment that substantially interferes with or limits one or more major life activities.

Substance Use Disorder (or substance abuse): Is defined in the Michigan Public Health Code to mean the taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

[Note to PIHP: you may add additional information to this template]

Template #5: Grievance and Appeals Processes

Grievances

You have the right to say that you are unhappy with your services or supports or the staff who provide them, by filing a "grievance." You can file a grievance *any time* by calling, visiting, or writing to the [Customer Services Office.] Assistance is available in the filing process by contacting _____. You will be given detailed information about grievance and appeal processes when you first start services and then again annually. You may ask for this information at any time by contacting the [Customer Services Office]. *

Appeals

You will be given notice when a decision is made that denies your request for services or reduces, suspends or terminates the services you already receive. You have the right to file an "appeal" when you do not agree with such a decision. There are two ways you can appeal these decisions. There are also time limits on when you can file an appeal once you receive a decision about your services.

You may:

- Ask for a "Local Appeal" by contacting _____ at _____. and/or
- You can ask at any time for a Medicaid Fair Hearing before an administrative law judge (a state appeal).

Your appeal will be completed quickly, and you will have the chance to provide information or have someone speak for you regarding the appeal. You may ask for assistance from [Customer Services] to file an appeal.

*[Note to PIHPs: you may add detailed information about grievance and appeals to this template. In that case, you may wish to modify this last sentence.]

Template #6: Language assistance and accommodations

Language Assistance

If you are a person who is deaf or hard of hearing, , you can utilize the Michigan Relay Center (MRC) to reach your PIHP, CMHSP or service provider. Please call 7-1-1 and ask MRC to connect you to the number you are trying to reach. If you prefer to use a TTY, please contact [customer services] at the following TTY phone number: (number).

If you need a sign language interpreter, contact the [customer services office] at (number) as soon as possible so that one will be made available. Sign language interpreters are available at no cost to you.

If you do not speak English, contact the [customer services office] at (number) so that arrangements can be made for an interpreter for you. Language interpreters are available at no cost to you.

[Note to PIHP: you should add in the handbook any other language assistance they have available]

Accessibility and Accommodations

In accordance with federal and state laws, all buildings and programs of the (PIHP name) are required to be physically accessible to individuals with all qualifying disabilities. Any individual who receives emotional, visual or mobility support from a qualified/trained and identified service animal such as a dog will be given access, along with the service animal, to all buildings and programs of the (PIHP name). If you need more information or if you have questions about accessibility or service/support animals, contact [customer services] at (phone number).

If you need to request an accommodation on behalf of yourself or a family member or a friend, you can contact [customer services] at (phone). You will be told how to request an accommodation (this can be done over the phone, in person and/or in writing) and you will be told who at the agency is responsible for handling accommodation requests.

[Note to PIHP: you may add additional information to this template. To accommodate multiple affiliates or provider networks, it is acceptable to format names and numbers in the most logical way]

Template #7: Payment for Services

If you are enrolled in Medicaid and meet the criteria for the specialty mental health and substance abuse services the total cost of your authorized mental health or substance abuse treatment will be covered. No fees will be charged to you.

If you are a Medicaid beneficiary with a deductible ("spend-down"), as determined by the Michigan Department of Health and Human Services (MDHHS) you may be responsible for the cost of a portion of your services.

[Note to PIHP: you may add additional information to this template]

Template #8: Person-Centered Planning

The process used to design your individual plan of mental health supports, service, or treatment is called "Person-centered Planning (PCP)." PCP is your right protected by the Michigan Mental Health Code.

The process begins when you determine whom, beside yourself, you would like at the person-centered planning meetings, such as family members or friends, and what staff from [name of PIHP] you would like to attend. You will also decide when and where the person-centered planning meetings will be held. Finally, you will decide what assistance you might need to help you participate in and understand the meetings.

During person-centered planning, you will be asked what are your hopes and dreams, and will be helped to develop goals or outcomes you want to achieve. The people attending this meeting will help you decide what supports, services or treatment you need, who you would like to provide this service, how often you need the service, and where it will be provided. You have the right, under federal and state laws, to a choice of providers.

After you begin receiving services, you will be asked from time to time how you feel about the supports, services or treatment you are receiving and whether changes need to be made. You have the right to ask at any time for a new person-centered planning meeting if you want to talk about changing your plan of service.

You have the right to "independent facilitation" of the person-centered planning process. This means that you may request that someone other than the [name of PIHP] staff conduct your planning meetings. You have the right to choose from available independent facilitators.

Children under the age of 18 with developmental disabilities or serious emotional disturbance also have the right to person-centered planning. However, person-centered planning must recognize the importance of the family and the fact that supports and services impact the entire family. The parent(s) or guardian(s) of the children will be involved in pre-planning and person-centered planning using "family-centered practice" in the delivery of supports, services and treatment to their children.

Topics Covered during Person-Centered Planning

During person-centered planning, you will be told about psychiatric advance directives, a crisis plan, and self-determination (see the descriptions below). You have the right to choose to develop any, all or none of these.

Psychiatric Advance Directive

Adults have the right, under Michigan law, to a **"psychiatric advance directive."** A psychiatric advance directive is a tool for making decisions before a crisis in which you may become unable to make a decision about the kind of treatment you want and the kind of treatment you do not want. This lets other people, including family, friends, and service providers, know what you want when you cannot speak for yourself.

If you do not believe you have received appropriate information regarding Psychiatric Advance Directives from your PIHP, please contact the customer services office to file a grievance.

Crisis Plan
You also have the right to develop a **"crisis plan."** A crisis plan is intended to give direct care if you begin to have problems in managing your life or you become unable to make decisions and care for yourself. The crisis plan would give information and direction to others about what you would like done in the time of crisis. Examples are friends or relatives to be called, preferred medicines, or care of children, pets, or bills.

Self-determination
Self-determination is an option for payment of medically necessary services you might request if you are an adult beneficiary receiving mental health services in Michigan. It is a process that would help you to design and exercise control over your own life by directing a fixed amount of dollars that will be spent on your authorized supports and services, often referred to as an "individual budget." You would also be supported in your management of providers, if you choose such control.

[Note to PIHP: you may add additional information to this template]

Template #9: Recipient Rights

Every person who receives public mental health services has certain rights. The Michigan Mental Health Code protects some rights. Some of your rights include:

- The right to be free from abuse and neglect
- The right to confidentiality
- The right to be treated with dignity and respect
- The right to treatment suited to condition

More information about your many rights is contained in the booklet titled "Your Rights." You will be given this booklet and have your rights explained to you when you first start services, and then once again every year. You can also ask for this booklet at any time.

You may file a Recipient Rights complaint *any time* if you think staff violated your rights. You can make a rights complaint either orally or in writing.

If you receive substance abuse services, you have rights protected by the Public Health Code. These rights will also be explained to you when you start services and then once again every year. You can find more information about your rights while getting substance abuse services in the "Know Your Rights" pamphlet.

You may contact your local community mental health services program to talk with a Recipient Rights Officer with any questions you may have about your rights or to get help to make a complaint. Customer Services can also help you make a complaint. You can contact the Office or Recipient Rights at: or Customer Services at: _____.

Freedom from Retaliation

If you use public mental health or substance abuse services, you are free to exercise your rights, and to use the rights protection system without fear of retaliation, harassment, or discrimination. In addition, under no circumstances will the public mental health system use seclusion or restraint as a means of coercion, discipline, convenience or retaliation.

[Note to PIHP: you may add additional information to this template]

Template #10: Recovery & Resiliency

"Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential."
Recovery is an individual journey that follows different paths and leads to different locations. Recovery is a process that we enter into and is a lifelong attitude. Recovery is unique to each individual and can truly only be defined by the individual themselves. What might be recovery for one person may be only part of the process for another. Recovery may also be defined as wellness. Mental health supports and services help people with mental illness in their recovery journeys. The person-centered planning process is used to identify the supports needed for individual recovery.

In recovery there may be relapses. A relapse is not a failure, rather a challenge. If a relapse is prepared for, and the tools and skills that have been learned throughout the recovery journey are used, a person can overcome and come out a stronger individual. It takes time, and that is why **Recovery** is a process that will lead to a future that holds days of pleasure and the energy to persevere through the trials of life.

Resiliency and development are the guiding principles for children with serious emotional disturbance. Resiliency is the ability to "bounce back" and is a characteristic important to nurture in children with serious emotional disturbance and their families. It refers to the individual's ability to become successful despite challenges they may face throughout their life.

[Note to PIHP: you may add additional information to this template]

Template #11: Service Array

MENTAL HEALTH MEDICAID SPECIALTY SUPPORTS AND SERVICES DESCRIPTIONS

Note: If you are a Medicaid beneficiary and have a serious mental illness, or serious emotional disturbance, or developmental disabilities, or substance use disorder, you may be eligible for some of the Mental Health Medicaid Specialty Supports and Services listed below.

Before services can be started, you will take part in an assessment to find out if you are eligible for services. It will also identify the services that can best meet your needs. You need to know that not all people who come to us are eligible, and not all services are available to everyone we serve. If a service cannot help you, your Community Mental Health will not pay for it. Medicaid will not pay for services that are otherwise available to you from other resources in the community.

During the person-centered planning process, you will be helped to figure out the medically necessary services that you need and the sufficient amount, scope and duration required to achieve the purpose of those services. You will also be able to choose who provides your supports and services. You will receive an individual plan of service that provides all of this information.

In addition to meeting medically necessary criteria, services listed below marked with an asterisk (*) require a doctor's prescription.

Note: the Michigan Medicaid Provider Manual contains complete definitions of the following services as well as eligibility criteria and provider qualifications. The Manual may be accessed at:

http://www.michigan.gov/mdhhs/0,4612,7-132-2945_42542_42543_42546_42553-87572--,00.html

Customer Service staff can help you access the manual and/or information from it.

Assertive Community Treatment (ACT) provides basic services and supports essential for people with serious mental illness to maintain independence in the community. An ACT team will provide mental health therapy and help with medications. The team may also help access community resources and supports needed to maintain wellness and participate in social, educational and vocational activities. ACT may be provided daily for individuals who participate.

Assessment includes a comprehensive psychiatric evaluation, psychological testing, substance abuse screening, or other assessments conducted to determine a person's level of functioning and mental health treatment needs. Physical health assessments are not part of this PIHP service.

***Assistive Technology** includes adaptive devices and supplies that are not covered under the Medicaid Health Plan or by other community resources. These devices help

individuals to better take care of themselves, or to better interact in the places where they live, work, and play.

Behavior Treatment Review: If a person's illness or disability involves behaviors that they or others who work with them want to change, their individual plan of services may include a plan that talks about the behavior. This plan is often called a "behavior treatment plan." The behavior management plan is developed during person-centered planning and then is approved and reviewed regularly by a team of specialists to make sure that it is effective and dignified, and continues to meet the person's needs.

Clubhouse Programs are programs where members (consumers) and staff work side by side to operate the clubhouse and to encourage participation in the greater community. Clubhouse programs focus on fostering recovery, competency, and social supports, as well as vocational skills and opportunities.

Community Inpatient Services are hospital services used to stabilize a mental health condition in the event of a significant change in symptoms, or in a mental health emergency. Community hospital services are provided in licensed psychiatric hospitals and in licensed psychiatric units of general hospitals.

Community Living Supports (CLS) are activities provided by paid staff that help adults with either serious mental illness or developmental disabilities live independently and participate actively in the community. Community Living Supports may also help families who have children with special needs (such as developmental disabilities or serious emotional disturbance).

Crisis Interventions are unscheduled individual or group services aimed at reducing or eliminating the impact of unexpected events on mental health and well-being.

Crisis Residential Services are short-term alternatives to inpatient hospitalization provided in a licensed residential setting.

***Enhanced Pharmacy** includes doctor-ordered nonprescription or over-the-counter items (such as vitamins or cough syrup) necessary to manage your health condition(s) when a person's Medicaid Health Plan does not cover these items.

***Environmental Modifications** are physical changes to a person's home, car, or work environment that are of direct medical or remedial benefit to the person. Modifications ensure access, protect health and safety, or enable greater independence for a person with physical disabilities. Note that all other sources of funding must be explored first, before using Medicaid funds for environmental modifications.

Family Support and Training provides family-focused assistance to family members relating to and caring for a relative with serious mental illness, serious emotional disturbance, or developmental disabilities. "Family Skills Training" is education and training for families who live with and or care for a family member who is eligible for the Children's Waiver Program.

Fiscal Intermediary Services help individuals manage their service and supports budget and pay providers if they are using a "self-determination" approach.

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

Healthy Michigan Plan is an 1115 Demonstration project that provides health care benefits to individuals who are: aged 19-64 years; have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology; do not qualify or are not enrolled in Medicare or Medicaid; are not pregnant at the time of application; and are residents of the State of Michigan. Individuals meeting Health Michigan Plan eligibility requirements may also be eligible for mental health and substance abuse services. The Michigan Medicaid Provider Manual contains complete definitions of the available services as well as eligibility criteria and provider qualifications. The Manual may be accessed at:

http://www.michigan.gov/mdhhs/0,4612,7-132-2945_42542_42543_42546_42553-87572--,00.html

Customer Service staff can help you access the manual and/or information from it.

Home-Based Services for Children and Families are provided in the family home or in another community setting. Services are designed individually for each family, and can include things like mental health therapy, crisis intervention, service coordination, or other supports to the family.

Housing Assistance is assistance with short-term, transitional, or one-time-only expenses in an individual's own home that his/her resources and other community resources could not cover.

Intensive Crisis Stabilization is another short-term alternative to inpatient hospitalization. Intensive crisis stabilization services are structured treatment and support activities provided by a mental health crisis team in the person's home or in another community setting.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) provide 24-hour intensive supervision, health and rehabilitative services and basic needs to persons with developmental disabilities.

Medication Administration is when a doctor, nurse, or other licensed medical provider gives an injection, or an oral medication or topical medication.

Medication Review is the evaluation and monitoring of medicines used to treat a person's mental health condition, their effects, and the need for continuing or changing their medicines.

Mental Health Therapy and Counseling for Adults, Children and Families includes therapy or counseling designed to help improve functioning and relationships with other people.

Nursing Home Mental Health Assessment and Monitoring includes a review of a nursing home resident's need for and response to mental health treatment, along with consultations with nursing home staff.

***Occupational Therapy** includes the evaluation by an occupational therapist of an individuals' ability to do things in order to take care of themselves every day, and treatments to help increase these abilities.

Partial Hospital Services include psychiatric, psychological, social, occupational, nursing, music therapy, and therapeutic recreational services in a hospital setting, under a doctor's supervision. Partial hospital services are provided during the day – participants go home at night.

Peer-delivered and Peer Specialist Services. Peer-delivered services such as drop-in centers are entirely run by consumers of mental health services. They offer help with food, clothing, socialization, housing, and support to begin or maintain mental health treatment. Peer Specialist services are activities designed to help persons with serious mental illness in their individual recovery journey and are provided by individuals who are in recovery from serious mental illness. Peer mentors help people with developmental disabilities.

Personal Care in Specialized Residential Settings assists an adult with mental illness or developmental disabilities with activities of daily living, self-care and basic needs, while they are living in a specialized residential setting in the community.

***Physical Therapy** includes the evaluation by a physical therapist of a person's physical abilities (such as the ways they move, use their arms or hands, or hold their body), and treatments to help improve their physical abilities.

Prevention Service Models (such as Infant Mental Health, School Success, etc.) use both individual and group interventions designed to reduce the likelihood that individuals will need treatment from the public mental health system.

Respite Care Services provide short-term relief to the unpaid primary caregivers of people eligible for specialty services. Respite provides temporary alternative care, either in the family home, or in another community setting chosen by the family.

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

***Speech and Language Therapy** includes the evaluation by a speech therapist of a person's ability to use and understand language and communicate with others or to manage swallowing or related conditions, and treatments to help enhance speech, communication or swallowing.

Substance Abuse Treatment Services (descriptions follow the mental health services)

Supports Coordination or Targeted Case Management: A Supports Coordinator or Case Manager is a staff person who helps write an individual plan of service and makes sure the services are delivered. His or her role is to listen to a person's goals, and to help find the services and providers inside and outside the local community mental health services program that will help achieve the goals. A supports coordinator or case manager may also connect a person to resources in the community for employment, community living, education, public benefits, and recreational activities.

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

Transportation may be provided to and from a person's home in order for them to take part in a non-medical Medicaid-covered service.

Treatment Planning assists the person and those of his/her choosing in the development and periodic review of the individual plan of services.

Wraparound Services for Children and Adolescents with serious emotional disturbance and their families that include treatment and supports necessary to maintain the child in the family home.

Services for Only Habilitation Supports Waiver (HSW) and Children's Waiver Participants

Some Medicaid beneficiaries are eligible for special services that help them avoid having to go to an institution for people with developmental disabilities or nursing home. These special services are called the Habilitation Supports Waiver and the Children's Waiver. In order to receive these services, people with developmental disabilities need to be enrolled in either of these "waivers." The availability of these waivers is very limited. People enrolled in the waivers have access to the services listed above as well as those listed here:

Goods and Services (for HSW enrollees) is a non-staff service that replaces the assistance that staff would be hired to provide. This service, used in conjunctions with a self-determination arrangement, provides assistance to increase independence, facilitate productivity, or promote community inclusion.

Non-Family Training (for Children's Waiver enrollees) is customized training for the paid in-home support staff who provide care for a child enrolled in the Waiver.

Out-of-home Non-Vocational Supports and Services (for HSW enrollees) is assistance to gain, retain or improve in self-help, socialization or adaptive skills.

Personal Emergency Response devices (for HSW enrollees) help a person maintain independence and safety, in their own home or in a community setting. These are devices that are used to call for help in an emergency.

Prevocational Services (for HSW enrollees) include supports, services and training to prepare a person for paid employment or community volunteer work.

Private Duty Nursing (for HSW enrollees) is individualized nursing service provided in the home, as necessary to meet specialized health needs.

Specialty Services (for Children's Waiver enrollees) are music, recreation, art, or massage therapies that may be provided to help reduce or manage the symptoms of a child's mental health condition or developmental disability. Specialty services might also include specialized child and family training, coaching, staff supervision, or monitoring of program goals.

Services for Persons with Substance Use Disorders

The Substance Abuse treatment services listed below are covered by Medicaid. These services are available through the PIHP.

Access, Assessment and Referral (AAR) determines the need for substance abuse services and will assist in getting to the right services and providers.

Outpatient Treatment includes therapy/counseling for the individual, and family and group therapy in an office setting.

Intensive/Enhanced Outpatient (IOP or EOP) is a service that provides more frequent and longer counseling sessions each week and may include day or evening programs.

Methadone and LAAM Treatment is provided to people who have heroin or other opiate dependence. The treatment consists of opiate substitution monitored by a doctor as well as nursing services and lab tests. This treatment is usually provided along with other substance abuse outpatient treatment.

Sub-Acute Detoxification is medical care in a residential setting for people who are withdrawing from alcohol or other drugs.

Residential Treatment is intensive therapeutic services which include overnight stays in a staffed licensed facility.

If you receive Medicaid, you may be entitled to other medical services not listed above. Services necessary to maintain your physical health are provided or ordered by your primary care doctor. If you receive Community Mental Health services, your local community mental health services program will work with your primary care doctor to coordinate your physical and mental health services. If you do not have a primary care doctor, your local community mental health services program will help you find one.

Note: **Home Help Program** is another service available to Medicaid beneficiaries who require in-home assistance with activities of daily living, and household chores. In order to learn more about this service, you may call the local Michigan Department of Human Services' number below or contact the [Customer Services Office] for assistance.
[Name and phone number of the local MDHHS Human Services office]

Medicaid Health Plan Services

If you are enrolled in a Medicaid Health Plan, the following kinds of health care services are available to you when your medical condition requires them.

- Ambulance
- Chiropractic
- Doctor visits
- Family planning
- Health check ups
- Hearing aids
- Hearing and speech therapy
- Home Health Care
- Immunizations (shots)
- Lab and X-ray
- Nursing Home Care
- Medical supplies
- Medicine
- Mental health (limit of 20 outpatient visits)
- Physical and Occupational therapy
- Prenatal care and delivery
- Surgery
- Transportation to medical appointments
- Vision

If you already are enrolled in one of the health plans [listed below] you can contact the health plan directly for more information about the services listed above. If you are not enrolled in a health plan or do not know the name of your health plan, you can contact the [Customer Services Office] for assistance.
[List of health plans and contact numbers

Template #12: Service Authorization

Services you request must be authorized or approved by [the PIHP or its designee]. That agency may approve all, some or none of your requests. You will receive notice of a decision within 14 calendar days after you have requested the service during person-centered planning, or within 3 business days if the request requires a quick decision.

Any decision that denies a service you request or denies the amount, scope or duration of the service that you request will be made by a health care professional who has appropriate clinical expertise in treating your condition. Authorizations are made according to medical necessity. If you do not agree with a decision that denies, reduces, suspends or terminates a service, you may file an appeal.

[Note to PIHP: you may add additional information to this template]

GRIEVANCE AND APPEAL TECHNICAL REQUI REMENT
PIHP GRIEVANCE SYSTEM FOR MEDICAID BENEFICIARIES

January, 2016

TABLE OF CONTENTS

PAGE

I. PURPOSE AND BACKGROUND…….....2

II. DEFINITIONS.....3

III. GRIEVANCE SYSTEM GENERAL REQUIREMENTS……5

IV. SERVICE AUTHORIZATION DECISIONS……..5

V. NOTICE OF ACTION……...6

VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT……...9

VII. STATE FAIR HEARING APPEAL PROCESS……10

VIII. LOCAL APPEAL PROCESS……10

IX. LOCAL GRIEVANCE PROCESS…….12

X. RECORDKEEPING REQUIREMENTS…….13

XI. RECIPIENT RIGHTS COMPLAINT PROCESS……..13

EXHIBIT A ADEQUATE NOTICE OF ACTION (SAMPLE FORM)……...14

EXHIBIT B ADVANCE NOTICE OF ACTION. (SAMPLE FORM)……16

I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with Medicaid Beneficiary Grievance System requirements for grievances and appeals contained in Part 11, 6.3.2 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services (MDHHS). These requirements are applicable to all PIHPs, Community Mental Health Services Programs (CMHSPs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance System processes required for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

The term "Grievance system," as used in the federal regulations refers to the overall system for Medicaid beneficiary grievances and appeals, required in the Medicaid managed care context. Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, as defined in this document, and those challenging anything else. A challenge to an action is called an **appeal.** Any other type of complaint is considered a **grievance.**

The Due Process Clause of the U.S. Constitution guarantees that Medicaid beneficiaries must receive "due process" whenever benefits are denied, reduced or terminated. Due Process includes: (1) prior written notice of the adverse action (2) a fair hearing before an impartial decision maker (3) continued benefits pending a final decision and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements.

Consumers of mental health services who are Medicaid beneficiaries eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act (BBA) of 1997.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Beneficiaries, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the 'Code") Chapters 7,7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705)

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

Action: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **45 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **three (3) working days** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Note: The term "action" is also referred to as an "adverse action" in this document.

Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as **"B3"** waiver services.

Adequate Notice of Action: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid **services requested.** Notice is provided to the Medicaid beneficiary **on the same date** the action takes effect, or at the time of the signing of the individual plan of services/supports.

Advance Notice of Action: Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided.** Notice to be provided/mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

Appeal: Request for a review of an 'action" as defined above.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Expedited Appeal: The expeditious review of an action, requested by a beneficiary or the beneficiary's provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP must grant the request.

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing".

Grievance: Medicaid Beneficiary's expression of dissatisfaction about PIHP/CMHSP service issues, **other than an action.** Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

Grievance Process: Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues **other than an action.**

Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

Local Appeal Process: Impartial local level PIHP review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Disposition: Written statement of the PIHP decision for each local appeal and/or grievance, provided to the beneficiary.

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

111. GRIEVANCE SYSTEM GENERAL REQUIREMENTS

Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts with PIHPs, that each PIHP has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438.

The grievance system must provide Medicaid beneficiaries:

- A local PIHP appeal process for challenging an "action" taken by the PIHP or one of its agents.
- Access to the state level fair hearing process for an appeal of an "action".
- A local PIHP grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an 'action".
- The right to **concurrently** file a PIHP level appeal of an action, **and** request a State fair hearing on an action, **and** file a PIHP level grievance regarding other service complaints.
- The right to request a State fair hearing **before exhausting** the PIHP level appeal of an 'action".
- The right to request, and have, Medicaid benefits continued while a local PIHP appeal and/or state fair hearing is pending.
- The right to have a provider, acting on the beneficiary's behalf and with the beneficiary's written consent, file an appeal to the PIHP. The provider may file a grievance or request for a state fair hearing on behalf of the beneficiary **only if** the State permits the provider to act as the beneficiary's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the beneficiary’s behalf with the beneficiary’s written consent to do so.

IV. SERVICE AUTHORIZATION DECISIONS

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP **must provide** the beneficiary written service authorization decision within specified timeframes and as expeditiously as the beneficiary's health condition requires. The service authorization must meet the requirements for either **standard** authorization or **expedited** authorization:

- **Standard Authorization:** Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and **no later than 14 calendar days** following receipt of a request for service.

  If the beneficiary or provider requests an extension **OR** if the PIHP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the **14 calendar** day time period by up to **14 additional calendar days.**

Expedited authorization: In cases in which a provider indicates, or the PIHP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

If the beneficiary requests an extension, or if the PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the three (3) working day time period by up to **14 calendar days.**

When a **standard or expedited** authorization of services decision is extended, the PIHP must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

V. NOTICE OF ACTION

A Notice of Action must be provided to a Medicaid beneficiary when a service authorization decision constitutes an **"action"** by authorizing a service in amount, duration or scope other than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP has taken, or intends to take and the process available to appeal the decision.

PIHP Notice of Action requirements include:

The notice of action to the beneficiary must be in writing and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).

- The requesting provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the provider is not required to be in writing.
- **If** the beneficiary or representative requests a local appeal or a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the appeal.
- **If** the beneficiary's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.
- **If** the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units),

any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an action, **and requires** a written notice of action.

The notice of action must be either Adequate or Advance:

- **Adequate notice:** is a written notice provided to the beneficiary **at the time of EACH** action. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate notice provisions.
- **Advance notice:** is a written notice required when an action is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed **12 calendar days** before the intended action takes effect.

The content of both adequate and advance notices must include an explanation of:

What action the PIHP has taken or intends to take,

- The reason(s) for the action and the policy relied upon to make your determination,
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,
- The beneficiary's or provider's right to file a PIHP appeal, and instructions for doing so,
- The beneficiary's right to request a State fair hearing, and instructions for doing so,
- The circumstances under which expedited resolution can be requested, and instructions for doing so,
- An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend or other spokesman.

The content of an advance notice must also include an explanation of:

The circumstances under which services will be continued pending resolution of the appeal,

- How to request that benefits be continued, and
- The circumstances under which the beneficiary may be required to pay the costs of these services.

NOTE: Examples of adequate and advance notices containing required content are in Exhibits A and B at the end of this document.

There are limited exceptions to the advance notice requirement. The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF:**

- The PIHP has factual information confirming the death of the beneficiary.

- The PIHP receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
- The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
- The beneficiary's whereabouts are unknown and the post office returns PIHP mail directed to him/her indicating no forwarding address.
- The PIHP establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
- A change in the level of medical care is prescribed by the beneficiary's physician
- The date of the action will occur in less than **10 calendar days.**

The Notice of Action must be mailed within the following timeframes:

- **At least 12 calendar days before** the date of an action to terminate suspend or reduce previously authorized Medicaid covered services(s) (Advance)
- **At the time of the decision** to deny payment for a service (Adequate)
- **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services (Adequate).
- **Within 3 working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

If the PIHP is unable to complete either a standard or expedited service authorization to deny or limit services within the timeframe requirement, the timeframe may be **extended up to an additional 14 calendar days.**

If the PIHP extends the timeframe, it must:

- Give the beneficiary written notice, no later than the date the current timeframe expires, of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision; and
- Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

The PIHP **must** continue Medicaid services previously authorized while the PIHP appeal and/or State fair hearing are pending **if:**

- The Beneficiary specifically requests to have the services continued, and
- The Beneficiary or provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and

- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

When the PIHP continues or reinstates the beneficiary's services while the appeal is pending, the services must be continued until one of the following occurs:

- The beneficiary withdraws the appeal.
- **Twelve calendar** days pass after the PIHP mails the notice of disposition providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **12 day** timeframe, has requested a State fair hearing with continuation of services until a State fair hearing decision is reached.
- A State fair hearing office issues a hearing decision adverse to the beneficiary. The time period or service limits of the previously authorized service has been met.

If the PIHP, or the MDHHS fair hearing administrative law judge **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations.

If the PIHP, or the MDHHS fair hearing administrative law judge **reverses a decision** to deny, limit, or delay services that were **not furnished** while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

VII. STATE FAIR HEARING APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

- A Medicaid beneficiary has the right to request a fair hearing when the PIHP or its contractor takes an "action", or a grievance request is not acted upon within **60 calendar days.** The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary. (See section VI above for Notice information.)
- The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- Beneficiaries are given **90 calendar days** from the date of the notice to file a request for a fair hearing.
- If the beneficiary, or representative, requests a fair hearing not more than 12 **calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the action.

- The parties to the state fair hearing include the PIHP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
- Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at: www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html

VIII. LOCAL APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP appeals, like those for fair hearings, are initiated by an "action". The beneficiary may request a local appeal under the following conditions:

- The beneficiary has **45 calendar days** from the date of the notice of action to request a local appeal.
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution.
  The beneficiary may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary, or representative, requests a local appeal not more than 12 **calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing.

When a beneficiary requests a local appeal, the PIHP is required to:

- Give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
  Acknowledge receipt of each appeal.
- Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program. Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues.
- Provide the beneficiary, or representative with:
  - Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;

- Opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process;
- Opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate;
- Information regarding the right to a fair hearing and the process to be used to request the hearing.

Notice of Disposition requirements:

- The PIHP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution. The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:
  - The right to request a state fair hearing, and how to do so;
  - The right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request; and
  - That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action.

The Notice of Disposition must be provided within the following timeframes:

- **Standard Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP receives the appeal.

- **Expedited Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties no longer than **three** (3) **working** days after the PIHP receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.
- The PIHP may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.
- I f the PIHP denies a request for expedited resolution of an appeal, it must:
  - Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP receives the appeal;

  - Make reasonable efforts to give the beneficiary **prompt oral notice** of the denial, and
  - Give the beneficiary follow up **written notice** within **two (2) calendar days.**

IX. LOCAL GRIEVANCE PROCESS

Federal regulations provide Medicaid beneficiaries the right to a local grievance process for **issues that are not "actions".**

Beneficiary grievances:

- Shall be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.
- **Do not** have access to the state fair hearing process **unless,** the PIHP fails to respond to the grievance **within 60 calendar days.** This constitutes an 'action", and can be appealed for fair hearing to the MDHHS Administrative Tribunal.

For each grievance filed by a beneficiary, the PIHP is required to:

- Give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability
- Acknowledge receipt of the grievance;
- Log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program.
- Ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on the grievance are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance:
  - Involves clinical issues, or
  - Involves the denial of an expedited resolution of an appeal (of an action).
- Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written **notice of disposition** not to exceed **60 calendar days** from the day PIHP received the grievance/complaint. The content of the notice of disposition must include:
  - The results of the grievance process
  - The date the grievance process was concluded.
  - The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance and
  - How to access the fair hearing process.

X. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy.

PIHP Grievance System records should contain sufficient information to accurately reflect:

- The process in place to track requests for Medicaid services denied by the PIHP or any of its providers.
- The volume of denied claims for services in the most recent year.

XI. RECIPIENT RIGHTS COMPLAINT PROCESS

Medicaid beneficiaries, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.

EXHIBIT A ADEQUATE NOTICE OF ACTION (SAMPLE FORM)

ADEQUATE ACTION NOTICE

Date
Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear

Following a review of the mental health services for which you have applied, it has been determined that the following service(s) shall not be authorized.

Service(s)	Effective Date

The reason for this action is <reason and related policy citation> . The legal basis for this decision is <provide policy relied upon> and 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Administrative Hearing System fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the "Request for Hearing" form and mail to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 30763
LANSING, MI 48909-

ADEQUATE ACTION NOTICE
Page 2

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

If you do not agree with this action, you may request a local appeal, either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number - Voice>
<Phone Number - **FAX>**

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Michigan Administrative Hearing System, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:
Hearing Request Form
Return Envelope

EXHIBIT B ADVANCE NOTICE OF ACTION (SAMPLE FORM)

ADVANCE ACTION NOTICE

Date

Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear

Following a review of mental health services and supports that you are currently receiving, it has been determined that the following service(s) shall be <reduced, terminated or suspended> effective <date>.

Service(s)	Effective Date

The reason for this action is <reason and related policy citation>. The legal basis for this decision is <provide policy relied upon> and 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Administrative Hearing System fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the enclosed "Request for Hearing" form and mail to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 30763
LANSING, MICHIGAN 48909-

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

ADVANCE ACTION NOTICE

Page 2

You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a fair hearing you may be required to repay the benefits. This may occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

If you do not agree with this action, **you may also request a local appeal,** either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number - Voice>
<Phone Number - **FAX>**

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Michigan Administrative Hearing System, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:
Hearing Request Form
Return Envelope

GRIEVANCE AND APPEAL TECHNICAL REQUI REMENT
PIHP GRIEVANCE SYSTEM FOR MEDICAID BENEFICIARIES

January, 2016

TABLE OF CONTENTS

PAGE

I. PURPOSE AND BACKGROUND…….....2

II. DEFINITIONS.....3

III. GRIEVANCE SYSTEM GENERAL REQUIREMENTS……5

IV. SERVICE AUTHORIZATION DECISIONS……..5

V. NOTICE OF ACTION……...6

VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT……...9

VII. STATE FAIR HEARING APPEAL PROCESS……10

VIII. LOCAL APPEAL PROCESS……10

IX. LOCAL GRIEVANCE PROCESS…….12

X. RECORDKEEPING REQUIREMENTS…….13

XI. RECIPIENT RIGHTS COMPLAINT PROCESS……..13

EXHIBIT A ADEQUATE NOTICE OF ACTION (SAMPLE FORM)……...14

EXHIBIT B ADVANCE NOTICE OF ACTION. (SAMPLE FORM)……16

I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with Medicaid Beneficiary Grievance System requirements for grievances and appeals contained in Part 11, 6.3.2 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services (MDHHS). These requirements are applicable to all PIHPs, Community Mental Health Services Programs (CMHSPs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance System processes required for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

The term "Grievance system," as used in the federal regulations refers to the overall system for Medicaid beneficiary grievances and appeals, required in the Medicaid managed care context. Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, as defined in this document, and those challenging anything else. A challenge to an action is called an **appeal.** Any other type of complaint is considered a **grievance.**

The Due Process Clause of the U.S. Constitution guarantees that Medicaid beneficiaries must receive "due process" whenever benefits are denied, reduced or terminated. Due Process includes: (1) prior written notice of the adverse action (2) a fair hearing before an impartial decision maker (3) continued benefits pending a final decision and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements.

Consumers of mental health services who are Medicaid beneficiaries eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act (BBA) of 1997.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Beneficiaries, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the 'Code") Chapters 7,7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705)

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

Action: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **45 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **three (3) working days** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Note: The term "action" is also referred to as an "adverse action" in this document.

Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as **"B3"** waiver services.

Adequate Notice of Action: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid **services requested.** Notice is provided to the Medicaid beneficiary **on the same date** the action takes effect, or at the time of the signing of the individual plan of services/supports.

Advance Notice of Action: Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided.** Notice to be provided/mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

Appeal: Request for a review of an 'action" as defined above.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Expedited Appeal: The expeditious review of an action, requested by a beneficiary or the beneficiary's provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP must grant the request.

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing".

Grievance: Medicaid Beneficiary's expression of dissatisfaction about PIHP/CMHSP service issues, **other than an action.** Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

Grievance Process: Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues **other than an action.**

Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

Local Appeal Process: Impartial local level PIHP review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Disposition: Written statement of the PIHP decision for each local appeal and/or grievance, provided to the beneficiary.

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

111. GRIEVANCE SYSTEM GENERAL REQUIREMENTS

Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts with PIHPs, that each PIHP has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438.

The grievance system must provide Medicaid beneficiaries:

- A local PIHP appeal process for challenging an "action" taken by the PIHP or one of its agents.
- Access to the state level fair hearing process for an appeal of an "action".
- A local PIHP grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an 'action".
- The right to **concurrently** file a PIHP level appeal of an action, **and** request a State fair hearing on an action, **and** file a PIHP level grievance regarding other service complaints.
- The right to request a State fair hearing **before exhausting** the PIHP level appeal of an 'action".
- The right to request, and have, Medicaid benefits continued while a local PIHP appeal and/or state fair hearing is pending.
- The right to have a provider, acting on the beneficiary's behalf and with the beneficiary's written consent, file an appeal to the PIHP. The provider may file a grievance or request for a state fair hearing on behalf of the beneficiary **only if** the State permits the provider to act as the beneficiary's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the beneficiary’s behalf with the beneficiary’s written consent to do so.

IV. SERVICE AUTHORIZATION DECISIONS

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP **must provide** the beneficiary written service authorization decision within specified timeframes and as expeditiously as the beneficiary's health condition requires. The service authorization must meet the requirements for either **standard** authorization or **expedited** authorization:

- **Standard Authorization:** Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and **no later than 14 calendar days** following receipt of a request for service.

  If the beneficiary or provider requests an extension **OR** if the PIHP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the **14 calendar** day time period by up to **14 additional calendar days.**

Expedited authorization: In cases in which a provider indicates, or the PIHP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

If the beneficiary requests an extension, or if the PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the three (3) working day time period by up to **14 calendar days.**

When a **standard or expedited** authorization of services decision is extended, the PIHP must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

V. NOTICE OF ACTION

A Notice of Action must be provided to a Medicaid beneficiary when a service authorization decision constitutes an **"action"** by authorizing a service in amount, duration or scope other than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP has taken, or intends to take and the process available to appeal the decision.

PIHP Notice of Action requirements include:

The notice of action to the beneficiary must be in writing and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).

- The requesting provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the provider is not required to be in writing.
- **If** the beneficiary or representative requests a local appeal or a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the appeal.
- **If** the beneficiary's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.
- **If** the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units),

any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an action, **and requires** a written notice of action.

The notice of action must be either Adequate or Advance:

- **Adequate notice:** is a written notice provided to the beneficiary **at the time of EACH** action. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate notice provisions.
- **Advance notice:** is a written notice required when an action is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed **12 calendar days** before the intended action takes effect.

The content of both adequate and advance notices must include an explanation of:

What action the PIHP has taken or intends to take,

- The reason(s) for the action and the policy relied upon to make your determination,
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,
- The beneficiary's or provider's right to file a PIHP appeal, and instructions for doing so,
- The beneficiary's right to request a State fair hearing, and instructions for doing so,
- The circumstances under which expedited resolution can be requested, and instructions for doing so,
- An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend or other spokesman.

The content of an advance notice must also include an explanation of:

The circumstances under which services will be continued pending resolution of the appeal,

- How to request that benefits be continued, and
- The circumstances under which the beneficiary may be required to pay the costs of these services.

NOTE: Examples of adequate and advance notices containing required content are in Exhibits A and B at the end of this document.

There are limited exceptions to the advance notice requirement. The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF:**

- The PIHP has factual information confirming the death of the beneficiary.

- The PIHP receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
- The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
- The beneficiary's whereabouts are unknown and the post office returns PIHP mail directed to him/her indicating no forwarding address.
- The PIHP establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
- A change in the level of medical care is prescribed by the beneficiary's physician
- The date of the action will occur in less than **10 calendar days.**

The Notice of Action must be mailed within the following timeframes:

- **At least 12 calendar days before** the date of an action to terminate suspend or reduce previously authorized Medicaid covered services(s) (Advance)
- **At the time of the decision** to deny payment for a service (Adequate)
- **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services (Adequate).
- **Within 3 working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

If the PIHP is unable to complete either a standard or expedited service authorization to deny or limit services within the timeframe requirement, the timeframe may be **extended up to an additional 14 calendar days.**

If the PIHP extends the timeframe, it must:

- Give the beneficiary written notice, no later than the date the current timeframe expires, of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision; and
- Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

The PIHP **must** continue Medicaid services previously authorized while the PIHP appeal and/or State fair hearing are pending **if:**

- The Beneficiary specifically requests to have the services continued, and
- The Beneficiary or provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and

- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

When the PIHP continues or reinstates the beneficiary's services while the appeal is pending, the services must be continued until one of the following occurs:

- The beneficiary withdraws the appeal.
- **Twelve calendar** days pass after the PIHP mails the notice of disposition providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **12 day** timeframe, has requested a State fair hearing with continuation of services until a State fair hearing decision is reached.
- A State fair hearing office issues a hearing decision adverse to the beneficiary. The time period or service limits of the previously authorized service has been met.

If the PIHP, or the MDHHS fair hearing administrative law judge **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations.

If the PIHP, or the MDHHS fair hearing administrative law judge **reverses a decision** to deny, limit, or delay services that were **not furnished** while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

VII. STATE FAIR HEARING APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

- A Medicaid beneficiary has the right to request a fair hearing when the PIHP or its contractor takes an "action", or a grievance request is not acted upon within **60 calendar days.** The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary. (See section VI above for Notice information.)
- The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- Beneficiaries are given **90 calendar days** from the date of the notice to file a request for a fair hearing.
- If the beneficiary, or representative, requests a fair hearing not more than 12 **calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the action.

- The parties to the state fair hearing include the PIHP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
- Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at: www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html

VIII. LOCAL APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP appeals, like those for fair hearings, are initiated by an "action". The beneficiary may request a local appeal under the following conditions:

- The beneficiary has **45 calendar days** from the date of the notice of action to request a local appeal.
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution.
  The beneficiary may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary, or representative, requests a local appeal not more than 12 **calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing.

When a beneficiary requests a local appeal, the PIHP is required to:

- Give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability.
  Acknowledge receipt of each appeal.
- Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program. Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues.
- Provide the beneficiary, or representative with:
  - Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;

- Opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process;
- Opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate;
- Information regarding the right to a fair hearing and the process to be used to request the hearing.

Notice of Disposition requirements:

- The PIHP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution. The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:
  - The right to request a state fair hearing, and how to do so;
  - The right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request; and
  - That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action.

The Notice of Disposition must be provided within the following timeframes:

- **Standard Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP receives the appeal.

- **Expedited Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties no longer than **three** (3) **working** days after the PIHP receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.
- The PIHP may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.
- I f the PIHP denies a request for expedited resolution of an appeal, it must:
  - Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP receives the appeal;

  - Make reasonable efforts to give the beneficiary **prompt oral notice** of the denial, and
  - Give the beneficiary follow up **written notice** within **two (2) calendar days.**

IX. LOCAL GRIEVANCE PROCESS

Federal regulations provide Medicaid beneficiaries the right to a local grievance process for **issues that are not "actions".**

Beneficiary grievances:

- Shall be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.
- **Do not** have access to the state fair hearing process **unless,** the PIHP fails to respond to the grievance **within 60 calendar days.** This constitutes an 'action", and can be appealed for fair hearing to the MDHHS Administrative Tribunal.

For each grievance filed by a beneficiary, the PIHP is required to:

- Give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability
- Acknowledge receipt of the grievance;
- Log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program.
- Ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on the grievance are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance:
  - Involves clinical issues, or
  - Involves the denial of an expedited resolution of an appeal (of an action).
- Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written **notice of disposition** not to exceed **60 calendar days** from the day PIHP received the grievance/complaint. The content of the notice of disposition must include:
  - The results of the grievance process
  - The date the grievance process was concluded.
  - The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance and
  - How to access the fair hearing process.

X. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy.

PIHP Grievance System records should contain sufficient information to accurately reflect:

- The process in place to track requests for Medicaid services denied by the PIHP or any of its providers.
- The volume of denied claims for services in the most recent year.

XI. RECIPIENT RIGHTS COMPLAINT PROCESS

Medicaid beneficiaries, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.

EXHIBIT A ADEQUATE NOTICE OF ACTION (SAMPLE FORM)

ADEQUATE ACTION NOTICE

Date
Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear

Following a review of the mental health services for which you have applied, it has been determined that the following service(s) shall not be authorized.

Service(s)	Effective Date

The reason for this action is <reason and related policy citation> . The legal basis for this decision is <provide policy relied upon> and 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Administrative Hearing System fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the "Request for Hearing" form and mail to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 30763
LANSING, MI 48909-

ADEQUATE ACTION NOTICE
Page 2

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

If you do not agree with this action, you may request a local appeal, either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number - Voice>
<Phone Number - **FAX>**

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Michigan Administrative Hearing System, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:
Hearing Request Form
Return Envelope

EXHIBIT B ADVANCE NOTICE OF ACTION (SAMPLE FORM)

ADVANCE ACTION NOTICE

Date

Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear

Following a review of mental health services and supports that you are currently receiving, it has been determined that the following service(s) shall be <reduced, terminated or suspended> effective <date>.

Service(s)	Effective Date

The reason for this action is <reason and related policy citation>. The legal basis for this decision is <provide policy relied upon> and 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Administrative Hearing System fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the enclosed "Request for Hearing" form and mail to:

MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
P.O. BOX 30763
LANSING, MICHIGAN 48909-

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

ADVANCE ACTION NOTICE

Page 2

You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a fair hearing you may be required to repay the benefits. This may occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

If you do not agree with this action, **you may also request a local appeal,** either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number - Voice>
<Phone Number - **FAX>**

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Michigan Administrative Hearing System, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:
Hearing Request Form
Return Envelope

Technical Advisory for Estimated Cost of Services
Effective 10/1/14

Attachment P6.3.2.1.B.i is a template that can be used to provide cost information to Medicaid beneficiaries. The template and guidance were developed with a committee comprised of MDHHS, individuals receiving services, advocates and agency providers. The committee's recommendations are as follows:

1. The annual budget is directly related to goals in the individual plan of service (IPOS) developed through the person-centered planning process.

2. Specific services and supports are listed and separated out from bundled services.

3. The estimated annual budget is provided in conjunction with information on self-determination.

4. The document is described as an explanation of cost of services and is not a bill that requires payment.

5. The annual budget estimate is a good faith estimate.

6. Information provided is part of the electronic medical record with changes made as necessary and printed out at any time when requested by the beneficiary.

7. A new estimate is provided when the IPOS is changed, modified and/or addendums added.

8. Annual budgets do not include urgent or emergent services such as crisis or inpatient services, and is subject to change based on the needs of the individual.

9. The beneficiary signs the annual budget and a copy is retained in the records.

Estimated Cost of Services Template

TO:

As part of your individual plan of service that you completed through a person-centered planning process, listed below, is the cost for each service and support. The costs per month are an estimate. This is not a bill required to be paid. It is subject to change based on your needs.

Service/Support (Insert services in the spaces below Categories will be the ones listed in Cost of Service template, May 24, 2011. Categories are understood to be the categories in the MDHHS document "PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes")	**Total Estimated Annual Cost (Total cost of services in the category for the plan period.)**

For the goals that are in your individual plan of service you may receive mental health services and supports that have costs that are covered by public funds.

Goal number one, you are working on:
The services you receive are estimated at:

Goal number two, you are working on:
The services you receive are estimated at:

***Estimated cost of your services per year:**

If you have any questions about your individual plan of service and/or the estimated costs, please contact:

**This is an estimate cost of services and not a bill required to be paid. It is subject to change based on your needs.*

Technical Requirement for Explanation of Benefits
Effective 10/1/12

Attachment P 6.3.2.1.B.ii is a model for PIHP's to utilize for the Explanation of Benefits requirement in Section 6.3.3 of the Contract. The following guidelines were developed to assist PIHPs:

1. The PIHP must ensure that the most complete picture of services be provided to the Consumer.
2. For the "Service Description" – The intent of the EOB is not to use specific procedure or diagnosis codes but rather a description of the service that is understandable for the consumer.
3. The EOB would include all services over a select or standard date range. The list could include services from many providers on a single document. Some services would be limited to a specific date. Some services would cover a range of dates. Other services are individually provided as encounters but occur multiple times over the selected date range. These could be grouped together with a first and last date of service. The last column reflects the count of these services (unique dates of services – encounters).
4. The "Unique Dates of Services" column interprets the services in each line into a count of unique encounters. This is NOT a unit count. For example:
    a. Inpatient Community Hospital – Each stay is uniquely identified as a separate row in the EOB. The "Unique Dates of Services" will be the equivalent of the length of stay for that inpatient episode.
    b. Partial Hospitalization is typically referred over a date range but the actual encounters may not be contiguous. In this case the "Unique Dates of Services" would indicate the count of encounters.
    c. Specialized Residential – This would be the total count of days in Specialized residential over the time period.
    d. In the case of other common services, the "Unique Dates of Services" is a total of all of those encounters over the EOB time frame.
5. It is recommended that the PIHP coordinate the development of a cover sheet introducing the documents.

PIHP : _____

EXPLANATION OF BENEFITS

CONSUMER NAME *STREET ADDRESS* *CITY, STATE ZIP CODE*	**Your Medicaid #** **Your Consumer ID:**

THIS IS NOT A BILL – KEEP this notice for your records

SERVICES PROVIDED FROM: **THROUGH:**

Service Provided By	Dates of Services	Service Description	Unique Dates of Service

General Information:
This list of services may not be a complete list as some services may not have been added to the chart prior to the running of this report.

You have the right to make a request in writing for an itemized statement which details each service you have received from your service provider. Please contact them directly, in writing, if you would like an itemized statement.

Compare the services you have received with those that appear on this Medicaid Summary Notice. If you have questions, call your service provider. If you feel further investigation is needed due to possible fraud and abuse, call the phone number in the Customer Service Information Box.

CUSTOMER SERVICE INFORMATION

If you have questions, please contact us at:
TTY for Hearing Impaired:

Or write to us at:

THIS IS NOT A BILL – KEEP this notice for your records

IMPORTANT INFORMATION ABOUT YOUR SERVICES

WHEN OTHER INSURANCE PAYS FIRST: All services are covered on the condition that you have no other insurance or your insurance will pay for the services first. Type of insurance that should pay first include Medicare, any health plans, no-fault insurance, automobile medical insurance, liability insurance and worker's compensation. Notify your provider right away if you have filed or could file a claim with your insurance.

HELP STOP MEDICAID FRAUD: Fraud is a false representation by a person or business to get Medicaid payments. Some examples of fraud include:

Offers of goods or money in exchange for your Medicaid Number.

Telephone or door-to-door offers for free medical services or items.

Claims for Medicaid services/items you did not receive.

If you think a person or business is involved in fraud, you should call the Customer Service telephone number listed in the "General Information" Section of this Summary of Services

MEDICAID SERVICES VERIFICATION – TECHNICAL REQUIREMENTS

I. SUMMARY

This guideline establishes operational policy; minimum procedures and reporting requirements for verification of Medicaid/Healthy Michigan claims/encounters provided to beneficiaries under this contract. Sampling Universe shall be in a fiscal year period of Medicaid/Healthy Michigan claims/encounters.

II. APPLICATION

Prepaid Inpatient Health Plans (PIHPs) and Medicaid/Healthy Michigan Programs only. It does not apply to Substance Use Disorder Block Grant and P.A. 2 funded services.

III. PROCEDURES

A. Verification procedures must be performed by qualified PIHP staff as determined by the PIHP or a qualified contract agency, including another PIHP as determined by the PIHP. Verification procedures may not be delegated to providers, Core Providers, CMHSPs, or MCPNs. PIHPs must perform or contract for this function for ALL Providers including those under contract to the agencies listed above.

- PIHP methodology must include a process for identifying staff or contracted agencies that may have a conflict of interest regarding the provider of services being verified.

- PIHP/CMHSP stand-alone agencies (counties of Wayne, Oakland, and Macomb) may have an inherent conflict of interest related to any of its staff and internally provided services. A qualified independent contractor, including a PIHP, must be selected to perform verification procedures in these circumstances.

B. Verification procedures must include testing of claims/encounters to determine validity.

- PIHP methodology must include data analytics to identify claims/encounters that cannot be valid or are more likely not valid.

  Examples: Multiple per diem inpatient claims/encounters on the same day, multiple providers providing the same service to the consumer in one day, individual clinicians providing an unexpectedly high daily volume.

- PIHP methodology must include testing data elements from individual claims/encounters to be validated against clinical records. The PIHP must include/test a) code is approved under this contract, b) eligibility of the beneficiary on the date of service, c) service is included in the beneficiaries

individual plan of service, d) the date/time of service, e) service provided by a qualified practitioner and falls within the scope of the code billed/paid, f) amount billed does not exceed the payer (PIHP or CMHSP) contracted amount, and g) amount paid does not exceed the payer (PIHP or CMHSP) contracted amount.

Note: The PIHPs are encouraged to include additional elements in this review to support the PIHP's quality improvement efforts around claims/encounters data.

C. Verification procedures must utilize statistically sound sampling methodology in accordance with OIG standards.

- PIHP methodology must identify and document the sampling methodology used to determine sampling and describe any tools used to assist in the sample determination process.

  Note: The OIG of HHS provides a tool to assist users in selecting random samples which can be obtained at https://oig.hhs.gov/compliance/rat-stats/index.asp. PIHPs are not required to utilize this tool.

- In general, minimum sample sizes for testing of claims/encounters must comply with the OIG standards. Alternative minimum sample sizes should be documented to indicate how an acceptable confidence level is achieved.

- Probe samples and claims verifications are to be used. In the event a probe sample result is less than 90% accurate, a larger sample with greater veracity shall occur, per HHS-OIG claims verification guidance.

D. Verification procedures must take into consideration significant variations in the source of the claims/encounters.

- Separate sampling and verification must be performed at each major provider in the PIHP network, as well as a single test encompassing all remaining providers. Major providers include ALL providers paid via a sub-capitation arrangement and any other providers that represent more than 25% of the PIHP claims/encounters in either unit volume or dollar value, whether direct contracted through the PIHP or subcontracted through a CMH, Core Provider, or MCPN.

- Separate sampling and verification must be performed for claims/encounters generated by a provider's employees and claims/encounters generated through subcontracts of the provider.

IV. CORRECTIVE ACTION AND RECOUPMENT

A. Corrective actions are required for providers who are found not to be in substantial compliance in their Medicaid Verification scores.

- PIHP methodology must describe the corrective action process, including method of communication, timeframes for correction and follow up review, penalties for inaction, and an appeals process.

B. Recoupment must be required and collected from providers whose claims/encounters are determined to be invalid.

- PIHP methodology must describe the recoupment process, including method of communication, timeframes for recovery of funds, any appeals process, and how the recoupment will be reflected as a credit against the MDHHS contract.

V. REPORTING

The PIHP is required to submit an annual report, due December 31, covering the claims/encounters verification process for the prior fiscal year. This report must encompass/include the following items:

- Cover letter on PIHP letterhead
- Describe the methodology used by the PIHP, including all required elements previously described.
- Summary of the results of procedures performed, including:
  - Population of providers
  - Number of providers tested
  - Number of providers put on corrective action plans
  - Number of providers on corrective action for repeat/continuing issues
  - Number of providers taken off corrective action plans
  - Population of claims/encounters tested (units & dollar value)
  - Claims/Encounters tested (units & value)
  - Invalid claims/encounters identified (units & dollar value)

VI. DOCUMENTATION

The PIHP must maintain all documentation supporting the verification process for 7 years.

Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration

CREDENTIALING AND RE-CREDENTIALING PROCESSES

A. Overview

This policy covers credentialing, temporary/provisional credentialing and re-credentialing processes for those individual and organizational providers directly or contractually employed by Prepaid Inpatient Health Plans (PIHPs), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Medicaid program. The policy does not establish the acceptable scope of practice for any of the identified providers, nor does it imply that any service delivered by the providers identified in the body of the policy is Medicaid billable or reimbursable. PIHPS are responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements. Please reference the applicable licensing statutes and standards, as well as the Medicaid Provider Manual should you have questions concerning scope of practice or whether Medicaid funds can be used to pay for a specific service.

Note: The individual practitioner and organizational provider credentialing process contains two primary components: initial credentialing and re-credentialing. MDHHS recognizes that PIHPs may have a process that permits initial credentialing on a provisional or temporary basis, while required documents are obtained or performance is assessed. The standards that govern these processes are in the sections that follow.

B. Credentialing Individual Practitioners

The PIHP must have a written system in place for credentialing and re-credentialing individual practitioners included in their provider network who are not operating as part of an organizational provider.

1. Credentialing and re-credentialing must be conducted and documented for at least the following health care professionals:
    a. Physicians (M.D.s and D.O.s)
    b. Physician's Assistants
    c. Psychologists (Licensed, Limited License, and Temporary License)
    d. Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians
    e. Licensed Professional Counselors
    f. Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses
    g. Occupational Therapists and Occupational Therapist Assistants
    h. Physical Therapists and Physical Therapist Assistants
    i. Speech Pathologists

2. The PIHP must ensure:
    a. The credentialing and re-credentialing processes do not discriminate against:
        i. A health care professional, solely on the basis of license, registration or certification; or

ii. A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available on their website at http://exclusions.oig.hhs.gov. A complete list of sanctioned providers is available on the Michigan Department of Health and Human Services website at www.michigan.gov/MDHHS. (Click on Providers, click on Information for Medicaid Providers, click on List of Sanctioned Providers)

3. If the PIHP delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this policy, it must retain the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services a provider selected by that entity and meet all requirements associated with the delegation of PIHP functions. The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions.

4. Compliance with the standards outlined in this policy must be demonstrated through the PIHP's policies and procedures. Compliance will be assessed based on the PIHP's policies and standards in effect at the time of the credentialing/re-credentialing decision.

5. The PIHP's written credentialing policy must reflect the scope, criteria, timeliness and process for credentialing and re-credentialing providers. The policy must be approved by the PIHP's governing body, and
   a. Identify the PIHP administrative staff member and/or entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineate their role;
   b. Describe any use of participating providers in making credentialing decisions;
   c. Describe the methodology to be used by PIHP staff members or designees to provide documentation that each credentialing or re-credentialing file was complete and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation;
   d. Describe how the findings of the PIHP's Quality Assessment Performance Improvement Program are incorporated into the re-credentialing process.

6. PIHPs must ensure that an individual credentialing/re-credentialing file is maintained for each credentialed provider. Each file must include:
   a. The initial credentialing and all subsequent re-credentialing applications;
   b. Information gained through primary source verification; and
   c. Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and re-credentialing standards.

C. Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of the individual practitioners must require:

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

2. An evaluation of the provider's work history for the prior five years.

3. Verification from primary sources of:
    a. Licensure or certification.
    b. Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.
    c. Documentation of graduation from an accredited school.
    d. National Practitioner Databank (NPDB)/ Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
        i. Minimum five-year history of professional liability claims resulting in a judgment or settlement;
        ii. Disciplinary status with regulatory board or agency; and
        iii. Medicare/Medicaid sanctions.
    e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a), (b), and (c) above.

D. Temporary/Provisional Credentialing of Individual Practitioners

Temporary or provisional credentialing of individual practitioners is intended to increase the available network of providers in underserved areas, whether rural or urban. PIHPs must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of Medicaid Beneficiaries that providers be available to provide care prior to formal completion of the entire credentialing process. Temporary or provisional credentialing shall not exceed 150 days.

The PIHP shall have up to 31 days from receipt of a complete application, accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.

For consideration of temporary or provisional credentialing, at a minimum a provider must complete a signed application that must include the following items:

1. Lack of present illegal drug use.
2. History of loss of license, registration, or certification and/or felony convictions.
3. History of loss or limitation of privileges or disciplinary action.
4. A summary of the provider's work history for the prior five years.

5. Attestation by the applicant of the correctness and completeness of the application.

The PIHP must conduct primary source verification of the following:
1. Licensure or certification;
2. Board certification, if applicable, or the highest level of credential attained; and
3. Medicare/Medicaid sanctions.

The PIHP's designee must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification as outlined in this Section, should be completed.

E. Re-credentialing Individual Practitioners

At a minimum, the re-credentialing policies for physicians and other licensed, registered, or certified health care providers must identify procedures that address the re-credentialing process and include requirements for each of the following:
1. Re-credentialing at least every two years.

2. An update of information obtained during the initial credentialing.

3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
    a. Medicare/Medicaid sanctions.
    b. State sanctions or limitations on licensure, registration or certification.
    c. Member concerns which include grievances (complaints) and appeals information.
    d. PIHP Quality issues.

F. Credentialing Organizational Providers

For organizational providers included in its network:
1. Each PIHP must validate, and re-validate at least every two years, that the organizational provider is licensed or certified as necessary to operate in the State, and has not been excluded from Medicaid or Medicare participation.

2. The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and re-credential their directly employed and subcontract direct service providers in accordance with the PIHP's credentialing/re-credentialing policies and procedures (which must conform to MDHHS's credentialing process).

G. Deemed Status

Individual practitioners or organizational providers may deliver healthcare services to more than one PIHP. A PIHP may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where a PIHP chooses to accept the credentialing decision of another PIHP, they must maintain copies of the credentialing PIHP's decisions in their administrative records.

H. Notification of Adverse Credentialing Decision

An individual practitioner or organizational provider that is denied credentialing or re-credentialing by the PIHP shall be informed of the reasons for the adverse credentialing decision in writing by the PIHP.

I. Appeal of Adverse Credentialing Decision

Each PIHP shall have an appeal process that is available when credentialing or re-credentialing is denied, suspended or terminated for any reason other than lack of need. The appeal process must be consistent with applicable federal and state requirements.

J. Reporting Requirements

The PIHP must have procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from the PIHP's provider network to appropriate authorities (i.e., DCH, the provider's regulatory board or agency, the Attorney General, etc.). Such procedures shall be consistent with current federal and state requirements, including those specified in the DCH Medicaid Managed Specialty Supports and Services Contract.

Definitions

National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB) The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. HRSA. They can be located on the Internet at www.npdb-hipdb.hrsa.gov/.

Organizational providers are entities that directly employ and/or contract with individuals to provide health care services. Examples of organizational providers include, but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units and partial hospitalization programs; substance abuse programs; and home health agencies.

PIHP is a Prepaid Inpatient Health Plan under contract with the Department of Health and Human Services to provide managed behavioral health services to eligible individuals.

Provider is any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.

PIHP-MHP Model Agreement

Coordinating Agreement Between <PIHP> and <MHP> For the county(ies) of: <X>

<DATE>

This agreement is made and entered into this ___ day of _____, in the year ____ by and between _____ (Health Plan) and _____ (PIHP) for the county(ies) of X, Y, Z.

RECITALS

Whereas, PIHPs are designated as providers of specialized mental health and developmental disability services under contract with the MDHHS consistent with the Mental Health Code; and

Whereas, PIHPs manage the Medicaid Specialty Services and Supports in a specified geographic region; and

Whereas, MHPs and PIHPs desire to coordinate and collaborate their efforts in order to protect and promote the health of the shared Medicaid-enrolled population;

Now, therefore, the MHP and the PIHP agree as follows.

A. Definitions

“MDHHS” means the Michigan Department of Health and Human Services.

“MHP” means Medicaid (Medical) Health Plan.

“PCP” means Primary Care Physician/Practitioner.

“PIHP” means Prepaid Inpatient Health Plan.

B. Roles and Responsibilities

The parties acknowledge that the primary guidance concerning their respective roles and responsibilities stem from the following, as applicable:

- Medicaid Waivers
- Medicaid State Plan and Amendments
- Medicaid Manual
- MDHHS, MHP and PIHP Contracts. See Attachment A for specific provisions of said contracts.
- Medical Services Administration (MSA) Medicaid *L-Letter 10-21*

http://www.michigan.gov/documents/MDHHS/L_10-21_with_attachment_322809_7.pdf

C. Term of Agreement, Amendments and Cancellation

This Agreement is effective the date upon which the last party signs this Agreement until amended or cancelled. The Agreement is subject to amendment due to changes in the contracts between the MDHHS and the MHP or the PIHP. All Amendments shall be executed in writing. Either party may cancel the agreement upon thirty (30) days written notice.

D. Purpose, Administration and Point of Authority

The purpose of this Agreement is to address the integration of physical and mental health services provided by the MHP and PIHP for common Medicaid enrollees. Specifically, to improve Medicaid enrollee's health status, improve the Medicaid enrollee's experience of care, and to reduce unnecessary costs.

The MHP and PIHP designate below the respective persons who have authority to administer this Agreement on behalf of the MHP and PIHP:

<MHP Name, Address, Phone, Signatory, and Agreement Authority with contact information>

<PIHP Name, Address, Phone, Signatory, and Agreement Authority with contact information>

E. Areas of Shared Responsibility

1. Exchange of Information

   a. Each party shall inform the other of current contact information for their respective Medicaid enrollee Service Departments.

   b. MHP shall make electronically available to the PIHP its enrolled common/shared Medicaid enrollee list together with their enrolled Medicaid enrollee's PCP and PCP contact information, on a monthly basis.

c. The parties shall explore the prudence and cost-benefits of Medicaid enrollee information exchange efforts. If Protected and/or Confidential Medicaid enrollee Information are to be exchanged, such exchanges shall be in accordance with all applicable federal and state statutes and regulations.

d. The parties shall encourage and support their staff, PCPs and provider networks in maintaining integrative communication regarding mutually served Medicaid enrollees.

e. Prior to exchanging any Medicaid enrollee information, the parties shall obtain a release from the Medicaid enrollee, as required by federal and/or state law.

2. Referral Procedures

a. The PIHP shall exercise reasonable efforts to assist Medicaid enrollees in understanding the role of the MHP and how to contact the MHP. The PIHP shall exercise reasonable efforts to support Medicaid enrollees in selecting and seeing a Primary Care Practitioner (PCP).

b. The MHP shall exercise reasonable efforts to assist Medicaid enrollees in understanding the role of the PIHP and how to contact the PIHP. The MHP shall exercise reasonable efforts to support Medicaid enrollees in selecting and seeing a Primary Care Practitioner (PCP).

c. Each party shall exercise reasonable efforts to rapidly determine and provide the appropriate type, amount, scope and duration of medically necessary services as guided by the Medicaid Manual.

3. Medical and Care Coordination; Emergency Services; Pharmacy and Laboratory Services Coordination; Quality Assurance Coordination

a. Each party shall exercise reasonable efforts to support Medicaid enrollee and systemic coordination of care. The parties shall explore and consider the prudence and cost-benefits of systemic and Medicaid enrollee focused care coordination efforts. If care coordination efforts involve the exchange of Medicaid enrollees' health information, the exchange shall be in accordance with applicable federal and state statutes and regulations related thereto. Each shall make available to the other contact information for case level medical and care coordination.

b. Neither party shall withhold emergency services and each shall resolve payment disputes in good faith.

c. Each party shall take steps to reduce duplicative pharmacy and laboratory services and agree to abide by L-Letter 10-21 and other related guidance for payment purposes.

d. Each party agrees to consider and may implement by mutual agreement Quality Assurance Coordination efforts.

F. Grievance and Appeal Resolution

Each agrees to fulfill its Medicaid enrollee rights and protections grievance and appeal obligations with Medicaid enrollees, and to coordinate resolutions as necessary and appropriate.

G. Dispute Resolution

The parties specify below the steps that each shall follow to dispute a decision or action by the other party related to this Agreement:

1) Submission of a written request to the other party's Agreement Administrator for reconsideration of the disputed decision or action. The submission shall reference the applicable Agreement section(s), known related facts, argument(s) and proposed resolution/remedy; and

2) In the event this process does not resolve the dispute, either party may appeal to their applicable MDHHS Administration Contract Section representative.

Where the dispute affects a Medicaid enrollee's current care, good faith efforts will be made to resolve the dispute with all due haste and the receiving party shall respond in writing within three (3) business days.

Where the dispute is in regards to an administrative or retrospective matter the receiving party shall respond in writing within thirty (30) business days.

H. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all applicable federal, state, and local statutes and regulations. Where federal or state statute, regulation or policy is contrary to the terms and conditions herein, statute, regulation and policy shall prevail without necessity of amendment to this Agreement.

I. Merger and Integration

This Agreement expresses the final understanding of the parties regarding the obligations and commitments which are set forth herein, and supersedes all prior and contemporaneous negotiations, discussions, understandings, and agreements between them relating to the services, representations and duties which are articulated in this Agreement.

J. Notices

All notices or other communications authorized or required under this Agreement shall be given in writing, either by personal delivery or by certified mail (return receipt requested). A notice to the parties shall be deemed given upon delivery or by certified mail directed to the addresses shown below.

Address of the PIHP:

_____

_____

_____

Attention: _____

Address of the MHP:

_____

_____

_____

Attention: _____

K. Headings

The headings contained in this Agreement have been inserted and used solely for ease of reference and shall not be considered in the interpretation or construction of this Agreement.

L. Severability

In the event any provision of this Agreement, in whole or in part (or the application of any provision to a specific situation) is held to be invalid or unenforceable, such provision shall, if possible, be deemed written and revised in a manner which eliminates the offending language but maintains the overall intent of the Agreement. However, if that is not possible, the offending language shall be deemed removed with the Agreement otherwise remaining in effect, so long as

doing so would not result in substantial unfairness or injustice to either of the parties. Otherwise, the party adversely affected may terminate the Agreement immediately.

M. No Third Party Rights

Nothing in this Agreement, express or implied, is intended to or shall be construed to confer upon, or to give to, any person or organization other than the parties any right, remedy or claim under this Agreement as a third party beneficiary.

N. Assignment

This Agreement shall not be assigned by any party without the prior written consent of the other party.

O. Counterparts

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute the one in the same instrument.

P. Signatures

The parties by and through their duly authorized representatives have executed and delivered this Agreement. Each person signing this Agreement on behalf of a party represents that he or she has full authority to execute and deliver this Agreement on behalf of that party with the effect of binding the party.

IN WITNESS WHEREOF, the parties hereto have entered into, executed, and delivered this Agreement as of the day and year first written above.

PIHP

By: _____

Its:_____

Date:_____

MHP

By: _____

Its:_____

Date:_____

INTRODUCTION

A. Basis:

Current contract language requires that Prepaid Inpatient Health Plans (PIHPs) and Medicaid Health Plans (MHPs) "have a written, functioning coordination agreement with "plans serving any part of each organization's respective service area". The written coordination agreement shall describe the coordination arrangements, inclusive of but not limited to, the exchange of information, referral procedures, care coordination and dispute resolution. "At a minimum these arrangements must address the integration of physical and mental health services provided by the MHP and PIHP for the shared consumer base plans."[1]

A Coordination Agreement, currently exists and is in force between contractors (MHPs and PIHPs). The RFP issued by Michigan DHHS on May 8, 2015 to guide its Medicaid Health Plan re-procurement includes language specifying requirements for MHP and PIHP alignment that are expected to be included as contract language for both PIHPs and MHPs as of January 1, 2016. This includes the following: "Contractors must, in collaboration with Coordinating (PIHPs/MHPs), update the Coordinating Agreement to incorporate any necessary remedies to improve continuity of care, care management, and the provision of health care services, at least annually"[2].

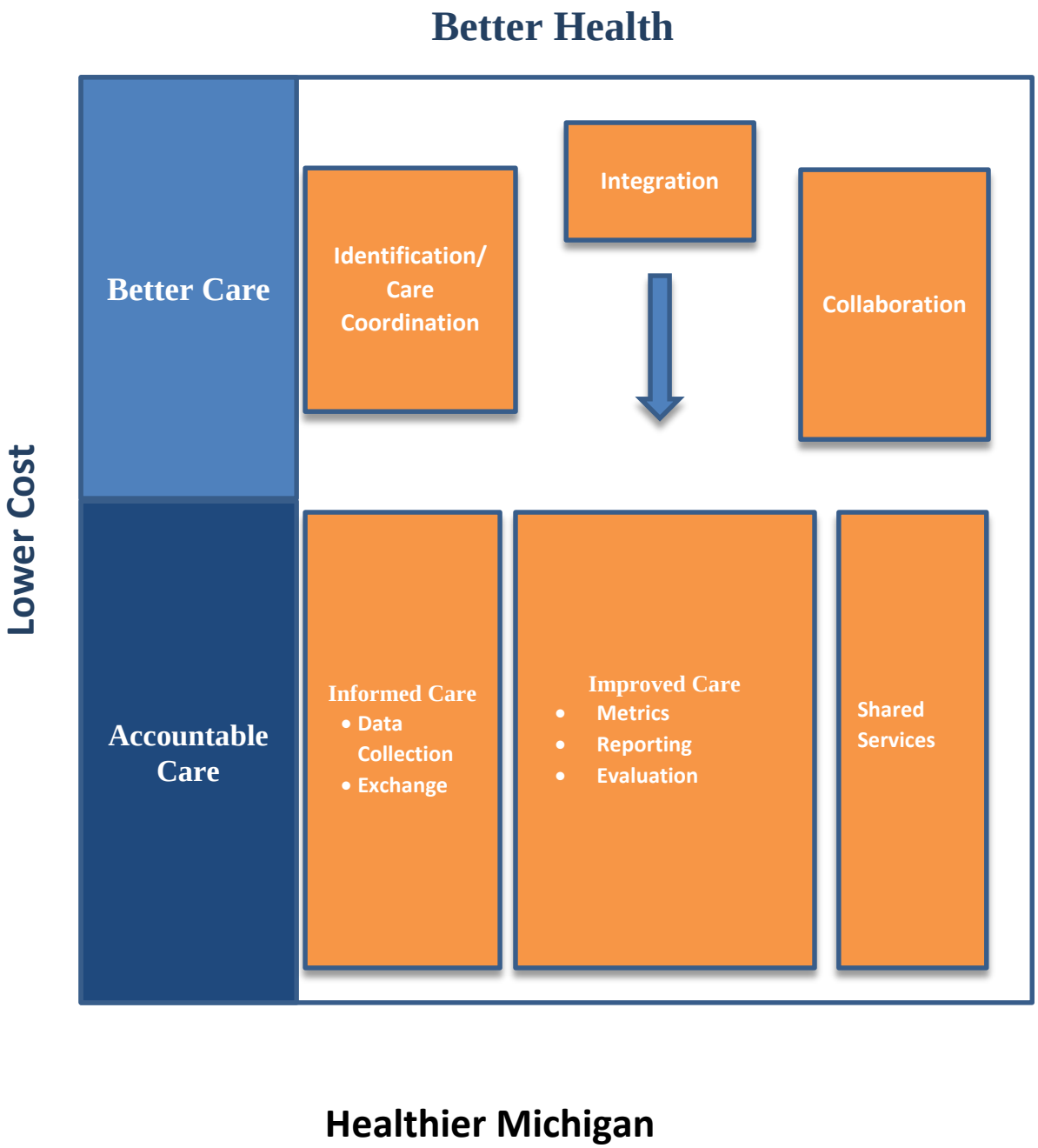
Greater system integration across physical and behavioral health care delivery systems, as well as provision of community-based social support services, is a primary goal of Michigan's Medicaid and broad State Innovation Plan health care reforms. Fundamentally, operationalizing processes for streamlined care management and continuity of care will serve as the foundation by which this greater integration can be achieved. As illustrated in Figure 1, the end result will be a healthier Michigan population, served by an accountable, value-based health system for the state. Michigan's contracting MHPs and PIHPs recognize the value of continuing to update and enhance its Coordinating Agreement to reflect quality improvement efforts and incorporate provisions that will define and strengthen levels of streamlined collaboration.

This document serves as an attachment to the master Coordinating Agreement that must be updated on a regular and ongoing basis to further clarify, enhance and expand aspects of PIHP and MHP coordination that benefit Michigan Medicaid beneficiaries.

[1] PIHP Contract section 7.3

[2] MHP RFP Behavioral Health Integration Section I.C.1.c

Figure 1



3

[3] Based Upon Michigan Blueprint for Health Innovation 2014

B. Definitions

Continuity of Care:

"Continuity of care" means the quality of care over time, including both the patient's experience of a 'continuous caring relationship' with an identified health care professional and the delivery of a 'seamless service' through integration, coordination and the sharing of information between different providers.[4]

Care Management:
"Care Management" means the application of systems, science, incentives, and information to improve practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.[5]

Care Coordination:

"Care Coordination" means a set of activities designed to ensure needed, appropriate and cost effective care for beneficiaries. As a component of overall care management, care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between Responsible Plans. Major priorities for care coordination in the context of a care management plan include:

- Outreach and contacts/communication to support patient engagement,
- Conducting screening, record review and documentation as part of Evaluation and Assessment,
- Tracking and facilitating follow up on lab tests and referrals,
- Care Planning,
- Managing transitions of care activities to support continuity of care,
- Address social supports and making linkages to services addressing housing, food, etc., and
- Monitoring, Reporting and Documentation.

For purposes of this document, Care Coordination also refers to the levels of coordinated care management and care coordination activities carried out under the

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[4] Journal for Health Services Research and Policy. 2006 Oct;11 (4):248-50.**What is 'continuity of care'?**

[5] Center for Health Care Strategies: Care Management Definition and Framework, 2007

auspices of PIHP and MCO contractors.

"Contractors" means Medicaid Health Plans and Prepaid Inpatient Health Plans.

"Responsible Plans" means Contractors with responsibility for Medicaid beneficiaries within the shared service area.

Clarifying Operational Standards for MCO-PIHP Coordination

C. Population Identification and Stratification

Identification and stratification is necessary to align resources across Responsible Plans to those beneficiaries exhibiting the greatest needs.

Standards to Operationalize:

1) Contractors agree to work collaboratively with Responsible Plans serving shared Enrollees to meet the requirements in this section for identifying and coordinating the provision of services to Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.[6]

2) Contractor must work with the Responsible Plans to jointly create and implement a method for stratifying Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.[7]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting methodology

- Define responsibility and timing required to achieve the required action.
- Assess any existing capacity/methodology within responsible plans.
- Identify strengths and gaps of existing approaches, including availability of/access to needed data.
- Define and test methodology.
- Ensure evaluation/revision process is in place.
- Consider provider network (PIHP and MHP) input, impact.
- Determine how findings will be used collaboratively to align resources and improve population health.

D. Care Coordination:

[6] MHP RFP Behavioral Health Integration Section I.C.3.a

[7] MHP RFP Behavioral Health Integration Section I.C.3.b

Background: MHPs are required to arrange for a robust care management program that meet national best practice standards (i.e. NCQA and/or URAC accreditation standards) and all requirements in this section to all Enrollees requiring intensive care management.[8]

Standards to Operationalize:

1) Contractors must work to jointly develop care management standards for providing care management services to Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities based on patient needs and goals.[9]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting standards:

- Define responsibility and timing required to achieve the required action.
- Establish a process for drafting standards including stakeholder input, approval and adoption.
- Ensure compatibility w/ NCQA/URAC standards.
- Ensure compatibility w/ PIHP/CMHSP standards.
- Ensure compatibility w/ MHP standards.
- Ensure evaluation/revision process is in place.

2) Contractors must work to jointly develop and implement processes for providing coordinated complex care management services to Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.[10]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting processes:

- Define responsibility and timing required to achieve the required action.
- Establish a plan for developing a service description including stakeholder input, approval and adoption.
- Ensure compatibility w/ NCQA/URAC processes.
- Assess/Ensure compatibility w/ PIHP/CMHSP processes.
- Assess/Ensure compatibility w/ MHP processes.
- Ensure compatibility with Duals Pilot processes.
- Ensure evaluation/revision process is in place.

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[8] MHP RFP Behavioral Health Integration Section I.A.1.

[9] MHP RFP Behavioral Health Integration Section I.C.3.c

[10] MHP RFP Behavioral Health Integration Section I.C.3.d

3) Contractors must work to jointly create a care management tool used by staff from each organization to document a jointly created care plan and to track contacts, issues, and services regarding Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.[11]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting tool:

- Define responsibility and timing required to achieve the required action.
- Define the process for selection/development, including stakeholder input, approval and adoption.

- Assess/Ensure compatibility w/ PIHP/CMHSP tools.
- Assess/Ensure compatibility w/ MHP tools.
- Ensure evaluation/revision process is in place.

4) Contractors' care managers must hold case reviews at least monthly during which the care managers and other team members, including community health workers, pharmacists, medical directors and behavioral health providers, must discuss Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities, and develop shared care management interventions.[12]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting process for case reviews:

- Plan for process development and adoption, including stakeholder input and timeline.
- Define process members and responsibilities.
- Assess/Ensure compatibility w/ PIHP/CMHSP processes.
- Assess/Ensure compatibility w/ MHP processes.
- Clarify process for documented accountability and monitoring of defined interventions.

E. Integration of Physical and Behavioral Health:

Integration of Physical and Behavioral Health improves the beneficiaries Continuity of Care and promotes improved health outcomes.

[11] MHP RFP Behavioral Health Integration Section I.C.3.e

[12] MHP RFP Behavioral Health Integration Section I.C.3.f

Standards to Operationalize:

1) Contractor must collaborate with Responsible Plans serving its Enrollees to improve integration of behavioral health and physical health services by meeting the following requirements:

a) Facilitate the placement of primary care clinicians in community mental health centers (CMHC) to enable Enrollees to receive both primary care services and behavioral health services at the location where they are most comfortable and incorporate principles of shared decision-making.[13]

b) Facilitate placement of behavioral health clinicians in primary care settings and providing training on treating patients in a holistic manner, using a single treatment plan that addresses both physical and mental health needs and taking into account unmet needs such as substance abuse treatment; and also helping the individual access his/her natural community supports based on his/her strengths and preferences;[14]

c) Develop and implement initiatives to improve communication and collaboration between Contractors' provider networks (MHP network and PIHP's contracted CMHSPs and other behavioral health providers).[15]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting plan to facilitate placements and improve communication:

- Define responsibility and timing required to achieve the required action.
- Establish selection criteria for primary care clinician/ behavioral health clinician placements.
- Assess the strengths and weaknesses of current communication and coordination efforts to assure efficiency and effectiveness.
- Define how collaboration/coordination with provider networks will occur.
- Ensure evaluation/revision process is in place.

F. Collaboration:

Collaboration is based upon joint expectations, relationships and the ongoing exchange of information to address mutually agreed upon goals.

Standards to Operationalize:

[13] MHP RFP Behavioral Health Integration Section I.C.4.a.1

[14] MHP RFP Behavioral Health Integration Section I.C.4.a.2

[15] MHP RFP Behavioral Health Integration Section I.C.4.a.3

1) Contractors must establish key contact personnel in each Responsible Plan and develop or jointly participate in a MDHHS-approved community-based public health initiative or project and report the project results to MDHHS.
   a) Responsible Plans must meet for this purpose at least quarterly.
   b) Responsible Plans must include, to the extent possible, key clinical leads at CMHSPs and other stakeholders.
   c) Responsible Plans must report projects and ongoing results to MDHHS at least annually.[16]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting plan to fulfill and report on public health initiatives:

- Identify Key Staff (if staff differ from contacts in Model Coordination Agreement).
- Establish quarterly meeting calendar and recommended agenda items.
- Define meeting participant roles and responsibilities.
- Assign responsibility for reporting to MDHHS as required.

2) Contractors must maintain an electronic bidirectional exchange of information with each Responsible Plan.[17]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process to ensure information exchange:

- Define responsibility and timing required to achieve the required action.
- Assess any existing capacity/methodology within responsible plans.
- Identify strengths and gaps of existing approaches, including availability of/access to needed data.
- Assess provider network (PIHP and MHP) input, impact.

- Define and test methodology.
- Ensure legal and compliance review.
- Ensure evaluation/revision process is in place.

G. Data Collection/Performance Reporting:

Informed, accountable care and management requires the collection, sharing, and reporting of actionable data. Performance Improvement requires the assessment, prioritization and development of strategies to address this data.

[16] MHP RFP Behavioral Health Integration Section I.C.1.d.i-iii

[17] MHP RFP Behavioral Health Integration Section I.C.2.b.

Standards to Operationalize:

1) Contractors must work collaboratively and with MDHHS to share data and develop a process to produce, at intervals designated by MDHHS, a list of Enrollees who have significant behavioral health issues and complex physical comorbidities.[18]
2) Contractors must separately track and report all grievances and appeals for Enrollees jointly served.[19]
3) Contractors must work collaboratively with primary care providers, and MDHHS to develop and implement performance improvement projects involving shared metrics and incentives for performance.[20]
4) Contractors agree to report to MDHHS the results of shared metric performance incentive programs in a manner determined by MDHHS.[21]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting a plan for joint performance improvement and reporting plan:

- Define responsibility and timing required to achieve the required action.

- Assess existing capacity/methodology within responsible plans.
- Identify strengths and gaps of existing approaches, including availability of/access to needed data.
- Assess provider network (PIHP and MHP) input, impact

- Draft collaborative performance improvement process and structure, including assignment of responsibility, and process for project selection.
- Identify required reports/metrics.
  - Recommend consideration of nationally normed and validated measures with existing data sources (e.g. hospital readmissions, ED utilization, primary care engagement)
- Jointly develop data definitions, test and implement the reporting processes.
- Ensure evaluation/revision process is in place.

H. Optional Services:

This section creates the opportunity to individualize arrangements between the responsible plans to more efficiently and effectively meet contractual standards. Potential areas/standards for additional agreements include:

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[18] MHP RFP Behavioral Health Integration Section I.A.2.

[19] MHP RFP Behavioral Health Integration Section I.C.1.b.

[20] MHP RFP Behavioral Health Integration Section I.C.3.g.

[21] MHP RFP Behavioral Health Integration Section I.C.3.h.

MHP Integration Requirements from RFP:

1) Contractor agrees to provide primary care training on evidence-based behavioral health service models for primary care providers, such as Screening, Brief Intervention and Referral to Treatment (SBIRT). [22]

2) Community Health Workers (CHWs) -

- Contractor must provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to Enrollees who have significant behavioral health issues and complex physical co-morbidities who will engage with and benefit from CHW or peer-support specialist services. Examples of CHW services include but are not limited to:
    - Conduct home visits to assess barriers to healthy living and accessing health care
    - Set up medical and behavioral health office visits
    - Explain the importance of scheduled visits to clients
    - Remind clients of scheduled visits multiple times
    - Accompany clients to office visits, as necessary
    - Participate in office visits, as necessary
    - Advocate for clients with providers
    - Arrange for social services (such as housing and heating assistance) and surrounding support services
    - Track clients down when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care
    - Help boost clients' morale and sense of self-worth
    - Provide clients with training in self-management skills
    - Provide clients with someone they can trust by being reliable, non-judgmental, consistent, open, and accepting
    - Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives[23]

- Contractor agrees to establish a reimbursement methodology for outreach, engagement, education and coordination services provided by community health workers or peer support specialists to promote behavioral health integration.[24]

Standards to Operationalize – PIHP Contract:

- The PIHP will initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid beneficiaries. These efforts will

[22] MHP RFP Behavioral Health Integration Section I.B.1.a.

[23] MHP RFP Behavioral Health Integration Section I.B.2.a.i-xiii

[24] MHP RFP Behavioral Health Integration Section I.B.2.b.

focus on persons that have a chronic condition such as a serious and persistent mental health illness, co-occurring substance use disorder or a developmental disability and have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports.

- The PIHP will implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the consumer's MHP as defined in 7.3.

- The PIHP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.[25]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process to assess and prioritize opportunities for shared services:

- Inclusive of, but not limited to, requirements above.
- Assessment of ability to more effectively and efficiently meet requirements.
- Prioritize and develop plan to implement prioritized opportunities.

I) Dispute Resolution Mechanisms:

Recommend: As defined in attachment 7.3.1., but consider opportunities to assign responsibility for problem solving prior to formal dispute to lead contacts from Responsible Parties.

J) Evaluation:

Evaluation is a key component to performance improvement and necessary to ensure the ongoing improvement of integration and coordination efforts.

Standards to Operationalize:

[25] PIHP Contract Section 7.4

- Contractors must collaboratively update the Coordinating Agreement to incorporate any necessary remedies to improve continuity of care, care management, and the provision of health care services, at least annually[26]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting process to evaluate each area, above, and agreement overall:

- Define responsibility and timing required to achieve the required action.
- Define Evaluation domains and process.
- Recommend initial evaluation at 3 and 6 months due to new requirements.
- Report results.
- Incorporate Evaluation into performance improvement processes.
- Identify improvements to evaluation process.
- Evaluate annually thereafter.

Do we need/want to add a Planning and Reporting format, instructions, and schedule?

[26] MHP RFP Behavioral Health Integration Section I.C.1.c.

Michigan Department of Health & Human Services
Prepaid Inpatient Health Plans
Specialty Mental Health and Substance Use Disorder Services and Supports
Network Management Reciprocity & Efficiency
Policy

POLICY

The Michigan Department Health and Human Services (MDHHSHS), along with its contracted statewide system of 10 (ten) regional PIHPs (Pre-Paid Inpatient Health Plans), is interested in promoting system efficiencies at all levels of service delivery and management. It is recognized that any subcontracting service providers connected to more than one regional PIHP system or more than one CMHSP (Community Mental Health Service Program) organization, greatly benefit from a statewide reciprocity expectation of MDHHS. PIHP systems benefit from reciprocity policies and procedures that create efficiencies for both the funding organizations and the service providers. Prevention of duplication of effort or unnecessary repetitive use of scarce public resources at all levels of management and operation of provider networks is desired.

MDHHS requires that certain network management functions be conducted to ensure compliance with state and federal regulations and mandates, and to ensure overall quality and consistency of provider management. PIHPs involved in the Michigan community mental health and substance use disorder programs, and engaged in the provision of various network management functions – including training, credentialing, procurement, contracting/subcontracting, provider monitoring and service delivery provision oversight - have finite resources to either conduct such functions or to create or accept alternatives that will fully meet MDHHS requirements. At the same time, MDHHS recognizes that each specific, responsible organization and/or system is structurally and operationally unique. MDHHS also recognizes that each unique organization bears the accountability for provider competency and network compliance as well as the risk for the actions of assigned individuals engaged in service and support provision with persons with disabilities.

This policy seeks to: 1) identify statewide standards for service provider reciprocity, 2) offer fairness to all service providers in areas of reciprocity, 3) address both internal and external reciprocity within and between PIHPs, and 4) allow flexibility for all systems in the methods for reciprocity actions.

APPLICATION

This policy and the contained standards are applicable to all MDHHS contracted PIHPs and their service provider networks in Michigan, comprising all contractors and subcontractors involved in the management and provision of specialty mental health and substance use disorder services and supports, including services directly provided by a PIHP or CMHSP. This policy does not apply to non-service contractors of PIHPs or CMHSPs.

It is understood that applicable BBA Standards and applicable national accreditation standards guide and supersede these requirements.

STANDARDS

1. GENERAL STANDARDS

A. MDHHS requires that each PIHP system demonstrate internal and external reciprocity efforts, as follows:

   1) Written policy(ies) and procedure(s); reciprocity may be referenced content in other broader network management related policies.
   2) Identified position(s) and/or processes to oversee and conduct reciprocity activities.
   3) Proofs of the occurrence of reciprocity actions and activities where indicated.
   4) Efforts to offer provider efficiencies within and for PIHP structures/regions, as well as between PIHP systems.

B. Each organization or system must have a means to collect, review and implement improvements in the areas of reciprocity and efficiencies as part of quality improvement efforts.

C. Each PIHP must adopt a common Provider Network Management function policy or policies to be used throughout the regional PIHP, consistently applicable to all service contractors and subcontractors.

D. Providers, including but not limited to those who are engaged in multi-CMHSP or multi-PIHP business, are encouraged to suggest or share useful examples of reciprocity practices at any time, however it is up to each PIHP system to develop and maintain their own methods to support reciprocity within and external to their regions, including PIHP delegation to CMHSPs.

E. Reciprocity is made available to service providers where applicable for the same provider/organization, the same individual staff or the same services. Where relevant provider differences occur, partial reciprocity or expedited processes will be offered when feasible. (For example, a provider who contracts for one service in one system and seeks to contract for another service in another system may be only offered partial reciprocity, given the difference in the type of services.)

2. PROCUREMENT

A. Providers will be offered efficiencies in purchasing processes within or between PIHP systems, which may include any of the following:

1) Readily available centralized provider application processes and procurement information, such as through PIHP websites and/or CMHSP website links.
2) CMHSP (or PIHP) cross sharing of provider application information or provision of common elements within PIHPs/between CMHSPs.
3) Publication of provider selection processes for the PIHP region.
4) Readily available PIHP or CMHSP contact information for specific provider contracting and selection procedures.
5) Readily available PIHP and/or CMHSP provider manual summary or complete content.
6) Uniform level of care or other standards wherever feasible.
7) References for providers in good standing will be readily given between PIHPs when providers seek to apply for new service arrangements; reference information provided will be shared with the applicable provider.

3. PROVIDER/PROGRAM MONITORING

A. It is recognized that each PIHP may have developed unique tools for provider performance and compliance oversight and monitoring, due to the decentralized service delivery and network management in the state.

B. For provider monitoring as required by MDHHS or other routine on-site compliance reviews or monitoring**,** PIHP systems or CMHSP organizations are expected to have a process, where at minimum, providers in good standing and/or at acceptable levels of performance are allowed a review waiver and/or modified/streamlined review experience at some regular interval. This may include verifying the existence of a comparable review report or summary verifying the provider's good standing with another comparable organization/system.

C. For purposes of this policy, it is recognized that service provider performance across a contracted provider system may vary from county to county or site to site, creating varied responses from PIHPs/CMHSPs on reasonable monitoring conditions and appropriate reciprocity. It is further recognized that this transparency of shared information about providers across PIHP systems may include the provision of both strengths and weaknesses of a provider's performance.

D. Expedited provider program/site reviews using reciprocal procedures could include any combination of the following:

1) PIHP/CMHSP sharing of recent review reports or outcomes conducted by another system.
2) Reduction of the depth of a review in any given cycle based on positive provider performance/compliance.
3) Verification of limited, priority only, review elements and/or conduction through a remote, off site process.

4) Simplified review protocols for programs which are located in the jurisdiction of another primary system or under contract for a larger volume of services, such as out of county consumer placements or off panel service purchases.
5) Joint or split system audits of provider program/sites coordinated by two or more systems/organizations which reduces more than one site visit to one site visit only
6) On-line audit processes and/or other methods which otherwise reduce the total amount of time spent by providers in such activities with funding CMHSPs and PIHPs.

E. PIHPs or CMHSP delegates will identify lead contact persons and/or share processes to help facilitate this provider monitoring reciprocity and readily share provider program or site review documents upon request in order to waive or conduct more limited reviews whenever possible.

F. This policy does not usurp the ability of the funding PIHP/CMHSP to conduct ad hoc audits or reviews of provider programs where needed or indicated at any time based on reported performance or as required by external entities.

G. MDHHS will accept use of shared or mutual PIHP or CMHSP reviews according to the PIHP/CMHSP procedure to meet annual provider site visit standards and/or ongoing monitoring needs as referenced in MDHHS contracts.

H. PIHPs/CMHSPs are expected to seek and consider routine provider feedback regarding on site review content and processes, such as through post review evaluation form completion.

I. PIHPs/CMHSPs are expected to include reference source(s) for specific monitoring or audit standards, as well as revise/streamline standards/protocols on a regular basis for necessity, value and efficiency.

J. PIHPs/CMHSPs, when adding new monitoring items to review processes, are expected to review the necessity of existing items, and whenever possible consider reducing or eliminating items of less value.

K. MDHHS expects to see meaningful consumer involvement in the monitoring activities of service providers.

4. <u>TRAINING/CONTINUING EDUCATION</u>

A. For mandatory required training, each responsible organization must have reasonable provisions for facilitating the acceptance of validated training - and where possible if indicated, offering expedited alternatives - for individuals for whom relevant, comparable training was provided by similar systems or sources. PIHP and/or CMHSP policy for acceptance may generally include any of the following considerations or combinations:

1) Length of time the individual worked in any prior similar role.

2) Length of time since the last validated training and/or work experience.
3) Comparableness of curriculum content elements, including detail and depth of content.
4) Employer recommendations relative to individual or program performance.
5) Partial training credit/validation for acceptable training content and/or proofs where possible.
6) Testing out for competency in relevant training areas.
7) Abbreviated training options (such as, refresher or renewal trainings) shorter in length of time required to demonstrate competency.
8) Self-study and/or on line (non-classroom based) trainings which the individual could complete on a flexible, individual schedule.
9) Conditions that might apply on a time-limited basis to all persons of a specific site or work program which may place limits on PIHP/CMHSP reciprocity considerations (such as, part of a state corrective plan, recipient rights finding response or other non-compliance, below-standard performance finding area(s)

B. Training reciprocity and efficiencies are made available to all levels of service providers and staff members, including those in professional and direct care roles.
C. Each PIHP/CMHSP will have a designated, qualified person assigned and/or a defined process for the oversight of reciprocal training approvals and to facilitate cross system training reciprocity related communications.

D. For trainings for which reciprocity applies, any organization responsible for conducting routine, required training programs, will have written protocols, which include:
1) scope,
2) content areas summaries,
3) key objectives,
4) length and mode(s) of training,
5) competency testing process,
6) intended audience(s),
7) frequency offered,
8) prerequisites (if any),
9) trainer qualifications, and
10) renewal requirements (if any)

E. Any organization which conducts training will issue or provide access to validated training proofs to participants on a routine and as needed basis, and directly to PIHPs/CMHSPs upon request.

F. PIHPs and CMHSPs will share training protocols/curriculums on a regular basis with other PIHPs/CMHSPs and all service providers upon request.

G. This policy does not usurp the ability of the PIHP/CMHSP system to conduct or require specific or new training programs unique to that regions need or priorities.

H. This policy does not usurp the ability of any specific employer/supervisor to require an individual staff member or group of staff to receive additional training in a certain area if needed or indicated.

I. PIHP/CMHSP systems/organizations will focus on efforts to help ensure demonstrated competency in training efforts, rather than other potentially arbitrary measures such as number of hours of training or classroom time.

J. It is recognized that for individuals who may move from one system to another, or who are engaged in service delivery for more than one organization or system simultaneously, the provision of training and reciprocity for prior training should be determined based on each individual's circumstance, so as to avoid duplication of effort and help to ensure most reasonable use of system resources.

K. For mandatory/core trainings commonly provided across systems, PIHPs/CMHSPs will seek to accept as many elements of comparable curriculum content as possible, and provide at least minimum levels of training reciprocity wherever feasible for providers.

L. The PIHP or CMHSP may reserve the right to require additional action if 'testing out' results are not satisfactory.

5. PROVIDER CONTRACTING

A. Contracts executed within PIHPs and/or CMHSPs and subcontractors within a region shall be consistent in terms of provider expectations, and have, at minimum, shared common elements or language to provide some consistency and efficiency for providers, although actual complete documents may differ among CMHSPs.

B. PHIPs/CMHSPs will have mechanisms for sharing application materials, provider monitoring/auditing reports, and provider training and credentialing when contracting with common providers within a region, and external to a region whenever feasible.

C. Integration of contracts will be pursued whenever feasible, such as a single contract for several or more services being purchased and/or when more than one population is being served.

D. New providers will be offered orientation to contracting requirements, with opportunities to ask questions at any time to support provider understanding of expectations and help promote strong compliance.

6. CREDENTIALING & BACKGROUND CHECKS

A. MDHHS recognizes that organizations may have credentialing reciprocity limitations due to direct source verification necessity and/or requirements. The importance of direct source verification of academic and/or licensing credentials and background checks is recognized by this policy, including pre-employment/pre contract needs, accrediting body standards, and other 'point-in-time' needs.

B. Each PIHP/CMHSP will have a mechanism available to providers to provide some level of reciprocity for credentials related to the provision of mental health and substance use disorder services and supports, including, required training, certifications, or completion of other requirements for the provision of a specific evidence-based model of treatment or intervention.

C. Where feasible to offer credentialing reciprocity, PIHPs/CMHSPs will seek and maintain validated records of accepted credentials for individuals and programs from other PIHPs/CMHSPs.

DEFINITIONS

Competency - Having the requisite or adequate abilities or qualities as well as the capacity to appropriately function and respond, as defined by demonstration, observation, checklist completion and/or testing.

Efficiencies - Reduction in or best use of staff time, cost or other resources.

Good Standing – Providers who are at a current acceptable level of performance and/or are in substantial compliance with PIHP/CMHSP requirements. (Examples of providers who may **not** be considered in good standing could include: those who have an active, written, formal sanction, those who are on 'probationary status', those who have an outstanding corrective action plan overdue, or those who have demonstrated current, chronic poor quality as documented by a PIHP and/or CMHSP. Providers who have minor or routine corrective actions in process as part of a regular quality review or monitoring schedule are considered to be in good standing.)

Reasonable - Non excessive, logical, moderate (expectations or standards); feasible, possible, practical, realistic, achievable.

Reciprocity - Process whereby corresponding status is mutually granted by one system to the other.

Validated - Directly verified as accurate and true with the originating/ issuing source. (Also often referred to as direct source verification.)

REFERENCES

Michigan Association of Community Mental Health Boards (MACMHB) – website:
www: macmhb.org, member information.

Michigan Department of Community Health – PIHP/CMHSP contract language including attachments relevant to credentialing, procurement, contracting and provider network management areas; MDHHS Administrative Rules; MDHHS Application for Participation for Specialty Prepaid Inpatient Health Plans and Notice of Intent to Apply, 2013.

Michigan Department of Human Services – www.mi.gov/afchfa, direct care staff training information for certified specialized residential facilities

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PIHP REPORTING REQUIREMENTS
Effective 10-1-16
Table of Contents

REPORTING REQUIREMENTS **2**

FINANCIAL PLANNING, REPORTING AND SETTLEMENT **3**

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS **5**

BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS) COLLECTION/RECORDING AND REPORTING REQUIREMENTS **7**

PROXY MEASURES FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES **10**

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER BENEFICIARY **16**

ENCOUNTER TIMELINESS CALCULATION **20**

FY'14 PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT **22**

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM **22**

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES **25**

CONSUMER SATISFACTION SURVEY **26**

CRITICAL INCIDENT REPORTING **26**

EVENT NOTIFICATION **27**

ANNUAL FRAUD AND ABUSE COMPLAINT REPORT **28**

NOTIFICATION OF PROVIDER NETWORK CHANGES **28**

FY 2016 MDHHS/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT

REPORTING REQUIREMENTS

Introduction

The Michigan Department of Community Health reporting requirements for the FY2017 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs or substance use disorder programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

- "Supplemental Instructions for Encounter Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes. Code list that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDHHS and EDIT have assigned to them The code list also includes instructions on use of modifiers; the acceptable activities that may be reflected in the cost of each procedure; and whether an activity needs to be face-to-face in order to count.
- "Establishing Managed Care Administrative Costs" that provides instructions on what managed care functions should be included in the allocation of expenditures to managed care administration.
- "Michigan's Mission-Based Performance Indicator System, is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators.
- SUD Guidelines and instructions as found in the Agreement

These documents are posted on the MDHHS web site and are periodically updated when federal or state requirements change, or when in consultation with representatives of the public mental health system it deemed necessary to make corrections or clarifications. Question and answer documents are also produced from time to time and posted on the web site.

Collection of each element contained in the master contract attachment is required. Data reporting must be received by 5 p.m. on the due dates (where applicable) in the acceptable format(s) and by the MDHHS staff identified in the instructions. Failure to meet this standard will result in contract action.

The reporting of the data by PIHPs described within these requirements meets several purposes at MDHHS including:

PIHP REPORTING REQUIREMENTS

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management
- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- External Quality Review
- Actuarial activities

Individual consumer level data received at MDHHS is kept confidential and published reports will display only aggregate data. Only a limited number of MDHHS staff have access to the database that contains social security numbers, income level, and diagnosis, for example. Individual level data will be provided back to the agency that submitted the data for encounter data validation and improvement. This sharing of individual level data is permitted under the HIPAA Privacy Rules, Health Care Operations.

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

The PIHP shall provide the financial reports to MDHHS as listed below. Forms and instructions are posted to the MDHHS website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html

Submit completed reports electronically (Excel or Word) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov except for reports noted in table below.

Due Date	**Report Title**	**Report Period**
10/1/2016	Projection SUD Supplement FSR (formerly RER)	October 1 to September 30
1/31/2017	SUD – Financial Status Report	October 1 to December 31
4/16/2017	SUD – Women Specialty Services (WSS) Mid-Year Expenditure Report	October 1 to March 31
4/30/2017	SUD – Financial Status Report	January 1 to March 31
5/31/2017	Mid-Year Status Report	October 1 to March 31
6/01/2017	SUD – Notice of Excess or Insufficient Funds	October 1 to September 30
7/31/2017	SUD – Financial Status Report	April 1 to June 30
8/15/2017	SUD – Charitable Choice Report	October 1 to September 30
8/15/2017	Projection Financial Status Report – Medicaid	October 1 to September 30
8/15/2017	Projection Medicaid – Shared Risk Calculation & Risk Financing	October 1 to September 30
8/15/2017	Projection Medicaid – Internal Service Fund	October 1 to September 30
8/15/2017	Projection Medicaid Contract Settlement Worksheet	October 1 to September 30
8/15/2017	Projection Medicaid Contract Reconciliation & Cash Settlement	October 1 to September 30

PIHP REPORTING REQUIREMENTS

9/XX/2017	SUD – Preliminary Closeout Report (REREXP-Obligation)	October 1 to September 30 (Due date will be determined by Budget Office in August for year-end closing)
10/1/2017	Medicaid Year End Accrual Schedule	October 1 to September 30
10/1/2017	SUD YEC Accrual Form	October 1 to September 30
10/1/2017	Projection SUD Supplement FSR (formerly RER)	October 1 to September 30
11/10/2017	Interim Financial Status Report – Medicaid	October 1 to September 30
11/10/2017	Interim Medicaid – Shared Risk Calculation & Risk Financing	October 1 to September 30
11/10/2017	Interim Medicaid – Internal Service Fund	October 1 to September 30
11/10/2017	Interim Medicaid Contract Settlement Worksheet	October 1 to September 30
11/10/2017	Interim Medicaid Contract Reconciliation & Cash Settlement v 2009-2	October 1 to September 30
11/30/2017	SUD – Financial Status Report (Final)	July 1 to September 30
1/31/2018	Annual Report on Fraud and Abuse Complaints	October 1 to September 30
2/28/2018	SUD – Primary Prevention Expenditures by Strategy Report	October 1to September 30
2/28/2018	SUD – Revenue & Expenditure Report – (RER) Final	October 1 to September 30
2/28/2018	SUD – Legislative Report/Section 408	October 1 to September 30
2/28/2018	SUD – Special Projects, Earmark funded: Flint Odyssey House Sacred Heart Rehab Center Hispanic Services Saginaw Odyssey House (Applies only to PIHP's who have earmarked allocations for these Programs)	October 1 to September 30
2/28/2018	Final Financial Status Report – Medicaid	October 1 to September 30
2/28/2018	Final Shared Risk Calculation & Risk Financing	October 1 to September 30
2/28/2018	Final Medicaid – Internal Service Fund	October 1 to September 30
2/28/2018	Final Medicaid Contract Settlement Worksheet	October 1 to September 30
2/28/2018	Final Medicaid Contract Reconciliation & Cash Settlement	October 1 to September 30
2/28/2018	Medicaid Utilization and Cost Report (MUNC)	See Attachment P 6.5.1.1 Submit report to: QMPMeasures@michigan.gov
2/28/2018	Medicaid Community Inpatient Psychiatric Services Expenditure Report	FY 14 expenditures
2/28/2018	Administrative Cost Report	For the fiscal year ending October 1 to September 30
2/28/2018	Executive Administrative Expenditures Survey for Sec. 904(2)(k)	October 1 to September 30, 2016
3/31/2018	SUD - Maintenance of Effort (MOE) Report	October 1 to September 30
6/30/2018	SUD – Audit Report	October 1 to September 30 (Due 9 months after close of fiscal year)

30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter. Compliance exam and plan of correction	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov

NOTE: To submit via DEG to MDHHS/MIS Operations
Client Admission and Discharge client records must be sent electronically to:
Michigan Department of Health and Human Services
Michigan Department of Technology, Management & Budget
Data Exchange Gateway (DEG)
For admissions: put c:/4823 4823@dchbull
For discharges: put c:/4824 4824@dchbull

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS

The PIHP shall provide the following reports to MDHHS as listed below.

Due Date	**Report Title**	**Report Period**
1/31/2017	Children Referral Report	October 1 to December 31
2/19/2017	SUD Master Retail List	October 1 to September 30
03/31/2017	Performance Indicators (2)	
04/30/2017	SUD – Sentinel Events Data Report (residential treatment only)	October 1 to March 31
4/30/2017	Children Referral Report	January 1 to March 31
06/30/2017	Performance Indicators	
7/11/2017	Compliance Check Report (CCR) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov	Email OROSC backup to: ohs@michigan.gov and cc foxallc@michigan.gov
07/11/2017	SUD – Tobacco/Formal Synar Inspections – To be reported in Youth Access to Tobacco (YAT) Compliance Checks Report	June 1 to 30 Coverage study activities should be conducted between Aug. 29 to Sept. 17, 2016
7/31/2017	Children Referral Report	April 1 to June 30
08/31/2017	Consumer Satisfaction raw data	
09/30/2017	Performance Indicators	
10/31/2017	Children Referral Report	July 1 to September 30
10/31/2017	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30
10/31/2017	SUD – Sentinel Events Data Report (residential treatment only)	April 1 to September 30
10/31/2017	SUD – Synar Coverage Study Canvassing Forms	October 1 to September 30

PIHP REPORTING REQUIREMENTS

11/30/2017	SUD – Communicable Disease (CD) Provider Information Report (Must be submitted only if PIHP funds CD services)	October 1 to September 30 (e-mail to mdhhs-BDDHA@michigan.gov)
11/30/2017	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2017	Performance Indicators	
Quarterly	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 – September 30 – Due end of month following the last month of the quarter.
Monthly	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30 – Due end of month following the month in which the exception occurred (must submit even if no data to report)
Monthly (Last day each month)	SUD - Treatment Episode Data Set (TEDS)	October 1 to September 30 (Via DEG to MDHHS/MIS Operations – see note below)
Monthly (Last day of month following the month in which the data was uploaded)	SUD - Michigan Prevention Data System (MPDS)	October 1 to September 30 (submit to: mdhhs.sudpds.com)
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 (Via DEG to MDHHS/MIS Operations – see note below)
Monthly	Consumer level** a. Quality Improvement (1) b. Encounter (1)	October 1 to September 30
Monthly	Critical Incidents (3)	
Annually (Same due date as Annual Plan)	SUD - Communicable Disease (CD) Provider Information Plan (Must be submitted only if PIHP funds CD services)	October 1 to September 30

**Consumer level data must be submitted within 30 days following adjudication of claims for services provided, or in cases where claims are not part of the PIHP's business practices, within 30 days following the end of the month in which services were delivered.

NOTE: To submit via DEG to MDHHS/MIS Operations
Client Admission and Discharge client records must be sent electronically to:
Michigan Department of Health and Human Services
Michigan Department of Technology, Management & Budget
Data Exchange Gateway (DEG)
For admissions: put c:/4823 4823@dchbull
For discharges: put c:/4824 4824@dchbull

1. Send data to MDHHS MIS via DEG (see above)
2. Send data to MDHHS, BHDDA, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDHHS web site at www.michigan.gov/mdhhs/bhdda and click on Reporting Requirements

PIHP REPORTING REQUIREMENTS

BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS) COLLECTION/RECORDING AND REPORTING REQUIREMENTS

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at: http://www.michigan.gov/mdhhs/0,4612,7-132-2941_38765---,00.html

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

-BH-TEDS Discharge/Update/End Records (due monthly)

A. Basis of Data Reporting

The basis for data reporting policies for Michigan behavioral health includes:

1. Federal funding awarded to Michigan through the Combined SABG/MHBG Behavioral Health federal block grant.

2. SAMHSA's Behavioral Health Services Information Systems (BHSIS) award agreement administered through Synectics Management, Inc that awards MDHHS a contracted amount of funding if the data meet minimum timeliness, completeness and accuracy standards

.

3 Legislative boilerplate annual reporting and semi-annual updates

B. Policies and Requirements Regarding Data

BH TEDS Data reporting will encompass Behavioral Health services provided to persons supported in whole or in part with MDHHS-administered funds.

Policy:

Reporting is required for all persons whose services are paid in whole or in part with state administered funds regardless of the type of co-pay or shared funding arrangement made for the services.

For purposes of MDHHS reporting, an admission, or start, is defined as the formal acceptance of a client into behavioral health services. An admission or start has occurred if and only if the person begins receiving behavioral health services.

PIHP REPORTING REQUIREMENTS

1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

2. All SUD data collected and recorded on BH-TEDS shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDHHS at the program level.

3. .

4. There must be a unique Person identifier assigned and reported. It must be 11 characters in length, and alphanumeric. This same number is to be used to report data for BH-TEDS and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.

5. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.

6. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDHHS.

7. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

8. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.

9. Statements of MDHHS policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

Method for submission: BH-TEDS data are to be submitted in a fixed length format, per the file specifications.

Due dates: BH TEDS data are due monthly. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

Who to report: The PIHP must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and substance use disorders who receive services funded in whole or in part with MDHHS-administered funding. PIHPs participating in the Medicare/Medicaid integration project are not to report BH-TEDS records for beneficiaries for whom the PIHP's financial responsibility is to a non-contracted provider during the 180-day continuity of care.

PROXY MEASURES FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

For FY16, the PIHPs are required to report a limited set of data items in the Quality Improvement (QI) file for consumers with an intellectual or developmental disability. The required items and instructions are shown below. Detailed file specifications are (will be) available on the MDHHS web site at: xxxxxxx

Instructions*: The following elements are proxy measures for people with developmental disabilities. The information is obtained from the individual's record and/or observation. Complete when an individual begins receiving public mental health services for the first time and update at least annually. Information can be gathered as part of the person-centered planning process.*

For purposes of these data elements, when the term "support" is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- *"Limited" means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.*
- *"Moderate" means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.*
- *"Extensive" means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.*
- *"Total" means the person is unable to complete the activity and the caregiver is providing 100% support.*

Fields marked with an asterisk * cannot be blank or the file will be rejected.

***** ***Reporting Period*** **(REPORTPD)**
The last day of the month in which the consumer data is being updated**.** Report year, month, day: yyyymmdd.

***** ***PIHP Payer Identification Number*** **(PIHPID)**
The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transmissions.

***** ***CMHSP Payer Identification Number*** **(CMHID)**
The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all data transmissions.

***** ***Consumer Unique ID*** **(CONID)**
A numeric or alphanumeric code, of 11 characters that enables the consumer and related

services to be identified and data to be reliably associated with the consumer across all of the PIHP's services. The identifier should be established at the PIHP level so agency level or sub-program level services can be aggregated across all program services for the individual. The consumer's unique ID must not be changed once established since it is used to track individuals, and to link to their encounter data over time. **A single shared unique identifier must match the identifier used in 837 encounter for each consumer.**

Social Security Number **(SSNO)**
The nine-digit integer must be recorded, if available.
Blank = Unreported [Leave nine blanks]

Medicaid ID Number **(MCIDNO)**
Enter the ten-digit integer for consumers with a Medicaid number.
Blank = Unreported [Leave ten blanks]

MIChild Number (CIN)
Blank = Unreported [Leave ten blanks]

Gender (GENDER)
Identify consumer as male or female.
M = Male
F = Female

Date of birth **(DOB)**
Date of Birth - Year, month, and day of birth must be recorded in that order. Report in a string of eight characters, no punctuation: YYYYMMDD using leading zeros for days and months when the number is less than 10. For example, January 1, 1945 would be reported as 19450101.

. Predominant Communication Style (People with developmental disabilities only)
(COMTYPE) 95% completeness and accuracy required

Indicate from the list below how the individual communicates **most of the time**:

1= English language spoken by the individual
2= Assistive technology used (includes computer, other electronic devices) or symbols such as Bliss board, or other "low tech" communication devices.
3= Interpreter used - this includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.
4= Alternative language used - this includes a foreign language, or sign language without an interpreter.
5= Non-language forms of communication used – gestures, vocalizations or behavior.
6= No ability to communicate.

Blank= Missing

. *Ability to Make Self Understood (People with developmental disabilities only)* (EXPRESS) 95% completeness and accuracy required.

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff

1= Always Understood – Expresses self without difficulty
2= Usually Understood – Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
3= Often Understood – Difficulty communicating AND prompting usually required
4= Sometimes Understood - Ability is limited to making concrete requests or understood only by a very limited number of people
5= Rarely or Never Understood – Understanding is limited to interpretation of very person-specific sounds or body language
Blank= Missing

. *Support with Mobility (People with developmental disabilities only)* (MOBILITY) 95% completeness and accuracy required

1= Independent - Able to walk (with or without an assistive device) or propel wheelchair and move about
2= Guidance/Limited Support - Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support.
3= Moderate Support - May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed
4= Extensive Support - Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed
5= Total Support - Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day
Blank= Missing

. *Mode of Nutritional Intake (People with developmental disabilities only)* (INTAKE) 95% completeness and accuracy required

1= Normal – Swallows all types of foods
2= Modified independent – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
3= Requires diet modification to swallow solid food – e.g., mechanical diet (e.g., purée, minced) or only able to ingest specific foods
4= Requires modification to swallow liquids – e.g., thickened liquids
5= Can swallow only puréed solids AND thickened liquids
6= Combined oral and parenteral or tube feeding
7= Enteral feeding into stomach – e.g., G-tube or PEG tube
8= Enteral feeding into jejunem – e.g., J–tube or PEG-J tube
9= Parenteral feeding only—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN**)**
Blank = Missing

PIHP REPORTING REQUIREMENTS

***Support with Personal Care (People with developmental disabilities only)* (PERSONAL) 95% completeness and accuracy required.**

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score a "2" to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

1= Independent - Able to complete all personal care tasks without physical support
2= Guidance/Limited Support - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity
3= Moderate Physical Support - Able to perform personal care tasks with moderate support of another person
4= Extensive Support - Able to perform personal care tasks with extensive support of another person
5= Total Support – Requires full support of another person to complete personal care tasks (unable to participate in tasks)
Blank = Missing

. *Relationships (People with developmental disabilities only)* (RELATION) 95% completeness and accuracy required

Indicate whether or not the individual has "natural supports" defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

1= Extensive involvement, such as daily emotional support/companionship
2= Moderate involvement, such as several times a month up to several times a week
3= Limited involvement, such as intermittent or up to once a month
4= Involved in planning or decision-making, but does not provide emotional support/companionship
5= No involvement
Blank = Missing

***Status of Family/Friend Support System (People with developmental disabilities only)* (SUPPSYS) 95% completeness and accuracy required**

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

1= Care giver status is not at risk
2= Care giver is likely to reduce current level of help provided
3= Care giver is likely to cease providing help altogether
4= Family/friends do not currently provide care
5= Information unavailable
Blank = Missing

. *Support for Accommodating Challenging Behaviors (People with developmental disabilities only)* (BEHAV) 95% completeness and accuracy required

PIHP REPORTING REQUIREMENTS

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging behaviors" include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

1= No challenging behaviors, or no support needed
2= Limited Support, such as support up to once a month
3= Moderate Support, such as support once a week
4= Extensive Support, such as support several times a week
5= Total Support – Intermittent, such as support once or twice a day
6= Total Support – Continuous, such as full-time support
Blank = Missing

. *Presence of a Behavior Plan (People with developmental disabilities only)* (PLAN) 95% accuracy and completeness required

Indicate the presence of a behavior plan during the past 12 months.

1= No Behavior Plan
2= Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
3= Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
Blank = Missing

. *Use of Psychotropic Medications (People with developmental disabilities only)* 95% accuracy and completeness required

Fill in the number of anti-psychotic and other psychotrophic medications the individual is prescribed. See the codebook for further definition of "anti-psychotic" and "other psychotropic" and a list of the most common medications.

51.1: Number of Anti-Psychotic Medications **(AP) ___**
Blank = Missing
51.2: Number of Other Psychotropic Medications **(OTHPSYCH) ___**
Blank = Missing

***Major Mental Illness (MMI) Diagnosis (People with developmental disabilities only)* 95% accuracy and completeness required**

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each "x" in the codes.

1= One or more MMI diagnosis present
2= No MMI diagnosis present
Blank = Missing

PIHP REPORTING REQUIREMENTS

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

Purpose: In the past basic consumer information from the QI (MH) and TEDS (SUD) files were sent to CHAMPS to be used as a validation that the consumer being reported in the Encounters is a valid consumer for the reporting PIHP. With QI eventually being phased out during FY16 and TEDS ending on 9/30/2015, BHTEDS will be replacing them both beginning 10/1/2015. To use BHTEDS to create the CHAMPS validation file would be difficult as there would be three different types of records – mental health substance use disorder and co-occurring.

Requirement: To simplify the process of creating this validation file, BHDDA is introducing a new file called the Behavioral Health Registry file. For this file, PIHPs are required to report five fields of data with only three being required. The required fields are: PIHP Submitter ID, Consumer ID and Begin Date (date less than or equal to first Date of Service reported in Encounters.) The following two fields will only be reported if the consumer has either: Medicaid ID and MIChild ID.

The file specifications and error logic for the Registry are (will be) available on the MDHHS web site at: xxxxxx

Submissions of the BH Registry file by CHAMPS will be ready by 10/1/2015.

Data Record

Record Format: rc1041.06									
Element #	**Data Element Name**	**Picture**	**Usage**	**Format**	**From**	**To**	**Validated**	**Required**	**Definition**
1	Submitter ID	Char(4)	4		1	4	Yes	Yes	Service Bureau ID (DEG Mailbox ID)
2	Consumer ID	Char(11)	11		5	15	No	Yes	Unique Consumer ID
3	Medicaid ID	Char(10)	10		16	25	Yes	Conditional	Must present on file if available.
4	MIChild ID	Char(10)	10		26	35	Yes	Conditional	MICHILD ID [CIN] Must present on file if available.
5	Begin Date	Date	8	YYYYM MDD	36	43	Yes	Yes	

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER BENEFICIARY

DATA REPORT

Due dates: Encounter data are due within 30 days following adjudication of the claim for the service provided, or in the case of a PIHP whose business practices do not include claims payment, within 30 days following the end of the month in which services were delivered. It is expected that encounter data reported will reflect services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the PIHP. Submit the encounter data for an individual on any claims adjudicated, regardless of whether there are still other claims outstanding for the individual for the month in which service was provided. In order that the department can use the encounter data for its federal and state reporting, it must have the count of units of service provided to each consumer during the fiscal year. Therefore, the encounter data for the fiscal year must be reconciled within 90 days of the end of the fiscal year. Claims for the fiscal year that are not yet adjudicated by the end of that period, should be reported as encounters with a monetary amount of "0." Once claims have been adjudicated, a replacement encounter must be submitted.

Who to Report: The PIHP must report the encounter data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area for all services provided under MDHHS benefit plans. The PIHP must report the encounter data for all substance use disorder Medicaid beneficiaries in its service area.Encounter data is collected and reported for every beneficiary for which a claim was adjudicated or service rendered during the month by the PIHP (directly or via contract) regardless of payment source or funding stream. PIHP's and CMHSPs that contract with another PIHP or CMHSP to provide mental health services should include that consumer in the encounter data set. . In those cases the PIHP or CMHSP that provides the service via a contract should not report the consumer in this data set. Likewise, PIHPs or CMHSPs that contract directly with a Medicaid Health Plan, or sub-contract via another entity that contracts with a Medicaid Health Plan to provide the Medicaid mental health outpatient benefit, should not report the consumer in this data set.

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all consumer level data reported after October 16, 2002 must be compliant with the transaction standards.

A summary of the relevant requirements is:

- Encounter data (service use) is to be submitted electronically on a Health Care Claim 5010.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837 includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
-

PIHP REPORTING REQUIREMENTS

- Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

The information on HIPAA contained in this contract relates only to the data that MDHHS is requiring for its own monitoring and/or reporting purposes, and does not address all aspects of the HIPAA transaction standards with which PIHPs must comply for other business partners (e.g., providers submitting claims, or third party payers). Further information is available at www.michigan.gov/mdhhs.

Data that is uploaded to CHAMPS must follow the HIPAA-prescribed formats for encounter data. The 837/5010 includes header and trailer information that identifies the sender and receiver and the type of information being submitted. If data does not follow the formats, entire files could be rejected by the electronic system.

HIPAA also requires that procedure codes, revenue codes and modifiers approved by the CMS be used for reporting encounters. Those codes are found in the Current Procedural Terminology (CPT) Manual, Fifth Edition, published by the American Medical Associations, the Health Care Financing Administration Common Procedure Coding System (HCPCS), the National Drug Codes (NDC), the Code on Dental Procedures and Nomenclature (CDPN), the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), ICD-10 and the Michigan Uniform Billing Manual. The procedure codes in these coding systems require standard units that must be used in reporting on the 837/5010.

MDHHS has produced a code list of covered Medicaid specialty and Habilitation Supports waiver supports and services names (as found in the Medicaid Provider Manual) and the CPT or HCPCS codes/service definition/units as soon as the majority of mental health services have been assigned CPT or HCPCS codes. This code list is available on the MDHHS web site.

The following elements reported on the 837/5010 encounter format will be used by MDHHSQuality Management and Planning Division for its federal and state reporting, the Contracts Management Section and the state's actuary. The items with an ** are required by HIPAA, and when they are absent will result in rejection of a file. Items with an ** must have 100% of values recorded within the acceptable range of values. Failure to meet accuracy standards on these items will result in contract action.
Refer to HIPAA 837 transaction implementation guides for exact location of the elements. Please consult the HIPAA implementation guides, and clarification documents (on MDHHS's web site) for additional elements required of all 837/5010 encounter formats. The Supplemental Instructions contain field formats and specific instructions on how to submit encounter level data.

****1.a. *PIHP Plan Identification Number* (PIHPID) or PIHP CA Function ID**
The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transactions.

1.b. *CMHSP Plan Identification Number* (CMHID)

The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

****2**. ***Identification Code/Subscriber Primary Identifier (please see the details in the submitter's manual)***
Ten-digit Medicaid number must be entered for a **Medicaid or MIChild** beneficiary.
If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.
If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID.**

****3. *Identification Code/Other Subscriber Primary Identifier (please see the details in the submitter's manual)***
Enter the consumer's unique identification number (**CONID**) assigned by the CMHSP **regardless** of whether it has been used above**.**

****4. *Date of birth***
Enter the date of birth of the beneficiary/consumer.

*****5. Diagnosis***
Enter the ICD-9 primary diagnosis of the consumer.

*****6. EPSDT***
Enter the specified code indicating the child was referred for specialty services by the EPSDT screening.

*****7. Encounter Data Identifier***
Enter specified code indicating this file is an encounter file.

*****8. Line Counter Assigned Number***
A number that uniquely identifies each of up to 50 service lines per claim.

*****9. Procedure Code***
Enter procedure code from code list for service/support provided. The code list is located on the MDHHS web site. Do not use procedure codes that are not on the code list.

****10. Procedure Modifier Code***
Enter modifier as required for Habilitation Supports Waiver services provided to enrollees; for Autism Benefit services under 1915 iSPA; for Community Living Supports and Personal Care levels of need; for Nursing Home Monitoring; and for evidence-based practices. See Costing per Code List.

****11. Monetary Amount (effective 1/1/13)***:

Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

*****12. Quantity of Service***
Enter the number of units of service provided according to the unit code type. **Only whole numbers should be reported.**

13. Place of Service Code
Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc. (See PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes Chart at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements, then the codes chart)

14. Diagnosis Code Pointer
Points to the diagnosis code at the claim level that is relevant to the service.

*****15. Date Time Period***
Enter date of service provided (how this is reported depends on whether the Professional, or the Institutional format is used).

*****16. Billing Provider Name***
Enter the name of the Billing Provider for all encounters. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

*****17. Rendering Provider Name***
Enter the name of the Rendering Provider when different from the Billing Provider (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

*****18. Provider National Provider Identifier (NPI), Employer Identification Number (EIN) or Social Security Number (SSN)*** Enter the appropriate identification number for the Billing Provider, and as applicable, the Rendering Provider. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

ENCOUNTER TIMELINESS CALCULATION

Requirements

1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service.
2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below).

Logic

Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month.

The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission.

These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse.

Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve.

The Department plans on continuing these test analyses through November 2014. The first production analyses will be run in December 2014.

FY'14 PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDHHS management of PIHP contracts and rate-setting by the actuary. In the case of a regional entity, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its CMHSP partners. This report includes Medicaid Substance Use Disorder services provided in the service area. The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries, **except** Children's Waiver beneficiaries. Refer to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual for the complete and specific requirements for coverage for the State Plan, Additional services provided under the authority of Section 1915(b)(3) of the Social Security Act, and the Habilitation Supports Waiver. All of the aforementioned Medicaid services and supports provided in the PIHP service area must be reported on this utilization and cost report. Instructions and current templates for completing and submitting the MUNC report may be found on the MDHHS web site at www.michigan.gov/mdhhs. Click on Mental Health and Substance Abuse, then Reporting Requirements.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0 FOR PIHPS

The purposes of the Michigan Mission Based Performance Indicator System (version 1.0) are:

- To clearly delineate the dimensions of quality that must be addressed by the Public Mental Health System as reflected in the Mission statements from Delivering the Promise and the needs and concerns expressed by consumers and the citizens of Michigan. Those domains are: ACCESS, EFFICIENCY, and OUTCOME.
- To develop a state-wide aggregate status report to address issues of public accountability for the public mental health system (including appropriation boilerplate requirements of the legislature, legal commitments under the Michigan Mental Health Code, etc.)
- To provide a data-based mechanism to assist MDHHS in the management of PIHP contracts that would impact the quality of the service delivery system statewide.
- To the extent possible, facilitate the development and implementation of local quality improvement systems; and
- To link with existing health care planning efforts and to establish a foundation for future quality improvement monitoring within a managed health care system for the consumers of public mental health services in the state of Michigan.

All of the indicators here are measures of PIHP performance. Therefore, performance indicators should be reported by the PIHP for all the Medicaid beneficiaries for whom it is responsible. Medicaid beneficiaries who are not receiving specialty services and supports (1915(b)(c) waivers) but are provided outpatient services through contracts with Medicaid Health Plans, or sub-contracts with entities that contract with Medicaid Health Plans are not covered by the performance indicator requirements.

Due dates for indicators vary and can be found on the table following the list of indicators. Instructions and reporting tables are located in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by MDHHS six weeks prior to the due date and also available on the MDHHS website: www.michigan.gov/mdhhs. Click on Mental Health and Substance Abuse, then Reporting Requirements.

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**

2. The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SUD). **Standard = 95% in 14 day**s.

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults, DD children, and Medicaid SUD) **Standard = 95% in 14 days**

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults (MI, DD) and all Medicaid SUD (sub-acute de-tox discharges) **Standard = 95% in seven days**

5. The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SUD)

ADEQUACY/APPROPRIATENESS

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

EFFICIENCY

7. The percent of total expenditures spent on managed care administrative functions for PIHPs.

OUTCOMES

8. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who are in competitive employment.

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who earn state minimum wage or more from employment activities (competitive, self-employment, or sheltered workshop).

10. The percent of children and adults with MI and DD readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.

12. The percent of adults with developmental disabilities served, who live in a private residence alone, or with spouse or non-relative.

13. The percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative.

14. The percent of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and respite.

Note: Indicators #2, 3, 4, and 5 include Medicaid beneficiaries who receive substance use disorder services managed by the PIHP.

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
5. Medicaid penetration*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
6. HSW services*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
7. Admin. Costs*	10/01 to 9/30	1/31							MDHHS
8. Competitive employment*	10/01 to 9/30								MDHHS
9. Minimum wage*	10/01 to 9/30								MDHHS
10. Readmissions	10/01 to 9/30	3/31	1/01 to 3/31	6/30	4-01 to 6-30	9/30	7/01 to 9/30	12/31	PIHPs
11. RR complaints	10/01 to 9/30	12/31							PIHPs
12. & 13. Living arrangements	10/1 to 9/30	N/A							MDHHS
14. Children with DD	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS

*Indicators with * mean MDHHS collects data from encounters, quality improvement or cost reports and calculates performance indicators

STATE LEVEL DATA COLLECTION

CONSUMER SATISFACTION SURVEY

Adults with Serious Mental Illness & Children with Serious Emotional Disturbance
-An annual survey using MHSIP 44 items for adults with MI and SUD, and MHSIP Youth and Family survey for families of children with SED will be conducted. Surveys are available on the MHSIP web site and have been translated into several languages. See www.mhsip.org/surveylink.htm
-The PIHPs will conduct the survey in the month of May for all people (regardless of medical assistance eligibility) currently receiving services in specific programs.
-Programs to be selected annually by QIC based on volume of units, expenditures, complaints and site review information.
-The raw data is due August 31st to MDHHS each year on an Excel template to be provided by MDHHS.

CRITICAL INCIDENT REPORTING

PIHPs will report the following events, except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on consumer ID, event date, and event type:

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- **Non-suicide death** for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.
- **Emergency Medical treatment due to Injury or Medication Error** for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.

- **Hospitalization due to Injury or Medication Error** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- **Arrest of Consumer** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

Methodology and instructions for reporting are posted on the MDHHS web site at www.michigan.gov/mdhhs. Click on Mental Health and Substance Abuse, then "Reporting Requirements"

EVENT NOTIFICATION

The PIHP shall immediately notify MDHHS of the following events:

1. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:
    a. Name of beneficiary
    b. Beneficiary ID number (Medicaid, MiChild)
    c. Consumer I (CONID) if there is no beneficiary ID number
    d. Date, time and place of death (if a licensed foster care facility, include the license #)
    e. Preliminary cause of death
    f. Contact person's name and E-mail address
2. Relocation of a consumer's placement due to licensing suspension or revocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

Except for deaths, notification of the remaining events shall be made telephonically or other forms of communication within five (5) business days to contract management staff members in MDHHS's Behavioral Health and Developmental Disabilities Administration.

ANNUAL FRAUD AND ABUSE COMPLAINT REPORT

The PIHP must report the following to the MDHHS on an annual basis:

1. Number of complaints of fraud and abuse made to the state that warrants preliminary investigation.
2. For each instance that warrants investigation, supply the:
    a. Name
    b. ID number
    c. Source of complaint
    d. Type of provider
    e. Nature of complaint
    f. Approximate dollars involved, and
    g. Legal & administrative disposition of the case
    h. Funding Source(s)

The annual report on fraud and abuse complaints is due to MDHHS on January 31st, and should cover complaints filed with the state during the fiscal year. It should be filed electronically at MDHHS-MHSA-Contracts-MGMT@michigan.gov. Nothing in this Section is intended to preclude the PIHP from fulfilling its obligations under Part III, Section 2.0 of the contract.

NOTIFICATION OF PROVIDER NETWORK CHANGES

The PIHP shall notify MDHHS within seven (7) days of any changes to the composition of the provider network organizations that negatively affect access to care. PIHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDHHS determines to negatively affect recipient access to covered services may be grounds for sanctions.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PRE-PAID INPATIENT HEALTH PLANS

FY 2017

The State requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a quality assessment and performance improvement program (QAPIP) which meets the standards below. These standards are based upon the Guidelines for Internal Quality Assurance Programs as distributed by then Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002. This document also reflects: concepts and standards more appropriate to the population of persons served under Michigan's current 1915(b) specialty services and supports waiver; Michigan state law; and existing requirements, processes and procedures implemented in Michigan.

Michigan Standards

I. The PIHP must have a written description of its QAPIP which specifies 1) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2) the components and activities of the QAPIP, including those as required below; 3) the role for recipients of service in the QAPIP; and 4) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement.

II. The QAPIP must be accountable to a Governing Body that is a PIHP Regional Entity. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

   A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.

   B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.

   C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.

   D. The Governing Body submits the written annual report to MDHHS following its review. The report will include a list of the members of the Governing Body.

III. There is a designated senior official responsible for the QAPIP implementation.

IV. There is active participation of providers and consumers in the QAPIP processes.

V. The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

   A. PIHP must utilize performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as established

in contract.

B. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.

VI. The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur.

VII. The PIHP's QAPIP includes affiliation-wide performance improvement projects that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction.

A. Performance improvement projects must address clinical and non-clinical aspects of care.

1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.

2. Non-clinical areas would include, but not be limited to, appeals, grievances and trends and patterns of substantiated Recipient Rights complaints; and access to, and availability of, services.

B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.

C. Performance improvement projects may be directed at state or PIHP-established aspects of care. Future state-directed projects will be selected by MDHHS with consultation from the Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.

D. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department.

E. The PIHP must engage in at least two projects during the waiver renewal period.

VIII. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put people at risk of harm.

A. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of

the event.

B. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
2. Involvement of medical personnel in the mortality reviews
3. Documentation of the mortality review process, findings, and recommendations
4. Use of mortality information to address quality of care
5. Aggregation of mortality data over time to identify possible trends.

* "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

D. Following immediate event notification to MDHHS (See Section 6.1 of this contract) the PIHP will submit information on relevant events through the Critical Incident Reporting System described below.

E. Critical Incident Reporting System
The critical incident reporting system collects information on critical incidents that can be linked to specific service recipients. This critical incident reporting system became fully operational and contractually required October 1, 2011 (see Attachment 7.7.1.1).

The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. The population on which these events must be reported differs slightly by type of event.

The QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events (see below) to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits.

MDHHS has developed formal procedures for analyzing the event data submitted through this system. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up with individual PIHPs.

F. Risk Events Management
The QAPIP has a process for analyzing additional critical events that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits.
These events minimally include:

- Actions taken by individuals who receive services that cause harm to themselves
- Actions taken by individuals who receive services that cause harm to others
- Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period

Following immediate event notification to MDHHS (See Section 6.1 of this contract) the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service.

IX. The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have (see F above) been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and accessibility of care.

B. As a result of the assessments, the organization:
1. Takes specific action on individual cases as appropriate;
2. Identifies and investigates sources of dissatisfaction;
3. Outlines systemic action steps to follow-up on the findings; and
4. Informs practitioners, providers, recipients of service and the governing body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization insures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports

coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served.

XII. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. The PIHP must have written policies and procedures for the credentialing process which are in compliance with MDHHS's Credentialing and Re-credentialing Processes, Attachment P.7.1.1, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also insure, regardless of funding mechanism (e.g., voucher):

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

    a. Educational background
    b. Relevant work experience
    c. Cultural competence
    d. Certification, registration, and licensure as required by law

2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.

3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

XIII. The written description of the PIHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates (as applicable***),*** providers and subcontractors.

1. The PIHP must submit to the state for approval its methodology for verification.

2. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.

XIV. The organization operates a utilization management program.

A. Written Plan - Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to identify and correct under-utilization as well as over-utilization.

C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:
   1. Review decisions are supervised by qualified medical professionals. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.
   2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
   3. The reasons for decisions are clearly documented and available to the member.
   4. There are well-publicized and readily-available appeals mechanisms for both providers and service recipients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal.
   5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
   6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
   7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

XV. The PIHP annually monitors its provider network(s), including any affiliates or sub-contractors to which it has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any provider network monitoring of its subcontractors.

XVI. The PIHPs, shall continually evaluate its oversight of “vulnerable” people in order to determine opportunities for improving oversight of their care and their outcomes. MDHHS will continue to work with PIHP to develop uniform methods for targeted monitoring of vulnerable people.

The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

INCLUSION PRACTICE GUIDELINE

I. SUMMARY

This guideline establishes policy and standards to be incorporated into the design and delivery of all public mental health services. Its purpose is to foster the inclusion and community integration of recipients of mental health service.

II. APPLICATION

a. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).
b. Regional centers for developmental disabilities and community placement agencies operated by MDHHS .
c. Children's psychiatric hospitals operated by MDHHS .
d. Special facilities operated by MDHHS .
e. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) as specified in their contracts with MDHHS .

III. POLICY

It is the policy of the department to support inclusion of all recipients of public mental health services.

No matter where people live or what they do, all community members are entitled to fully exercise and enjoy the human, constitutional and civil rights which collectively are held in common. These rights are not conditional or situational; they are constant throughout our lives. Ideally they are also unaffected if a member receives services or supports from the public mental health system for a day, or over a lifetime. In addition, by virtue of an individual's membership in his or her community, he or she is entitled to fully share in all of the privileges and resources that the community has to offer.

IV. DEFINITIONS

Community: refers to both society in general, and the distinct cities, villages, townships and neighborhoods where people, under a local government structure, come together and establish a common identity, develop shared interests and share resources.

Inclusion: means recognizing and accepting people with mental health needs as valued members of their community.

Integration: means enabling mental health service recipients to become, or continue to be, participants and integral members of their community.

INCLUSION PRACTICE GUIDELINE

Normalization: means rendering services in an environment and under conditions that are culturally normative. This approach not only maximizes an individual's opportunities to learn, grow and function within generally accepted patterns of human behavior but it also serves to mitigate social stigma and foster inclusion.

Self-determination: means the right of a recipient to exercise his or her own free will in deciding to accept or reject, in whole or in part, the services which are being offered. Individuals can not develop a sense of dignity unless they are afforded the freedom and respect that comes from exercising opportunities for self-determination.

Self-representation: means encouraging recipients, including those who have guardians or employ the services of advocates, to express their own point of view and have input regarding the services that are being planned or provided by the RMHA.

V. STANDARDS

a. Responsible PIHPs and CMHSPs shall design their programs and services to be congruent with the norms of their community.

   This includes giving first consideration to using a community's established conventional resources before attempting to develop new ones that exclusively or predominantly serve only mental health recipients.

   Some of the resources which can be used to foster inclusion, integration and acceptance include the use of the community's public transportation services, leisure and recreation facilities, general health care services, employment opportunities (real work for real pay), and traditional housing resources.

b. PIHPs and CMHSPs shall organizationally promote inclusion by establishing internal mechanisms that:
   i. assure all recipients of mental health services will be treated with dignity and respect.
   ii. assure all recipients, including those who have advocates or guardians, have genuine opportunities for consumer choice and self-representation.
   iii. provide for a review of recipient outcomes.
   iv. provide opportunities for representation and membership on planning committees, work groups, and agency service evaluation committees.
   v. invite and encourage recipient participation in sponsored events and activities of their choice.

INCLUSION PRACTICE GUIDELINE

c. PIHPs and CMHSPs shall establish policies and procedures that support the principle of normalization through delivery of clinical services and supports that:
   i. address the social, chronological, cultural, and ethnic aspects of services and outcomes of treatment.
   ii. help recipients gain social integration skills and become more self reliant.
   iii. encourage and assist adult recipients to obtain and maintain integrated, remunerative employment in the labor market(s) of their communities, irrespective of their disabilities. Such assistance may include but is not limited to helping them develop relationships with co-workers both at work and in non-work situations. It also includes making use of assistive technology to obtain or maintain employment.
   iv. assist adult recipients to obtain/ maintain permanent, individual housing integrated in residential neighborhoods.
   v. help families develop and utilize both informal interpersonal and community based networks of supports and resources.
   vi. provide children with treatment services which preserve, support and, in some instances, create by means of adoption, a permanent, stable family.

d. PIHP and CMHSPs shall establish procedures and mechanisms to provide recipients with the information and counsel they need to make informed treatment choices. This includes helping recipients examine and weigh their treatment and support options, financial resources, housing options, education and employment options. In some instances, this may also include helping recipients:
   i. learn how to make their own decisions and take responsibility for them.
   ii. understand his or her social obligations.

VI. REFERENCES AND LEGAL AUTHORITY

MCL 330.116, et seq. MCL 330.1704, et seq.

HOUSING PRACTICE GUIDELINE

NOTE: Replicated from the MDHHS Housing Guideline as included in the Public Mental Health Manual, Volume III, Section 1708, Subject GL-05, Chapter 07-C, Dated 2/14/95.

I. SUMMARY

This guideline establishes policy and procedure for ensuring that the provision of mental health services and supports are not affected by where consumers choose to live: their own home, the home of another or in a licensed setting. In those instances when public money helps subsidize a consumer's living arrangement, the housing unit selected by the consumer shall comply with applicable occupancy standards.

II. APPLICATION

a. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).
b. Special facilities operated by MDHHS.
c. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) as specified in their contracts with MDHHS.

III. POLICY

The Michigan Department of Health and Human Services recognizes housing to be a basic need and affirms the right of all consumers of public mental health services to pursue housing options of their choice. Just as consumers living in licensed dependent settings may require many different types of services and supports, persons living in their own homes or sharing their household with another may have similar service needs. RHMAs shall foster the provision of services and supports independent of where the consumer resides.

When requested, RHMAs shall educate consumers about the housing options and supports available, and assist consumers in locating habitable, safe, and affordable housing. The process of locating suitable housing shall be directed by the consumer’s interests, involvement and informed choice. Independent housing arrangements in which the cost of housing is subsidized by the PIHP and CMHSP are to be secured with a lease or deed in the consumer's name.

This policy is not intended to subvert or prohibit occupancy in or participation with community based treatment settings such as an adult foster care home when needed by an individual recipient.

IV. DEFINITIONS

Affordable: is a condition that exists when an individual’s means or the combined household income of several individuals is sufficient to pay for food, basic clothing, health care, and personal needs and still have enough left to cover all housing related costs including rent/mortgage, utilities, maintenance, repairs, insurance and property taxes. In situations

where there are insufficient resources to cover both housing costs and basic living costs, individual housing subsidies may be used to bridge the gap when they are available.

Habitable and safe: means those housing standards established in each community that define and require basic conditions for tenant/resident health, security, and safety.

Housing: refers to dwellings that are typical of those sought out and occupied by members of a community. The choices a consumer of mental health services makes in meeting his or her housing needs are not to be linked in any way to any specific program or support service needs he or she may have.

Responsible Mental Health Agency (RMHA): means the MDHHS hospital, center, PIHP or CMHSP responsible for providing and contracting for mental health services and/or arranging and coordinating the provision of other services to meet the consumer's needs.

V. **STANDARDS**

RMHAs shall develop policies and create mechanisms that give predominant consideration to consumers' choice in selecting where and with whom they live. These policies and mechanisms shall also:

A. Ensure that RMHA-supported housing blends into the community. Supported housing units are to be scattered throughout a building, a complex, or the community in order to achieve community integration when possible. Use of self-contained campuses or otherwise segregated buildings as service sites is not the preferred mode.

B. Promote and support home ownership, individual choice, and autonomy. The number of people who live together in RMHA-supported housing shall not exceed the community's norms for comparable living settings.

C. Assure that any housing arranged or subsidized by the RMHA is accessible to the consumer and in compliance with applicable state and local standards for occupancy, health, and safety.

D. Be sensitive to the consumer's cultural and ethnic preferences and give consideration to them.

E. Encourage and support the consumer's self-sufficiency.

F. Provide for ongoing assessment of the consumer's housing needs.

G. Provide assistance to consumers in coordinating available resources to meet their basic housing needs. RMHAs may give consideration to the use of housing subsidies when

consumers have a need for housing that cannot be met by the other resources which are available to them.

VI. REFERENCES AND LEGAL AUTHORITY

MCL 330.1116(j)

VII. EXHIBITS

Federal Housing Subsidy Quality Standards based on 24 CFR § 882.10

CONSUMERISM PRACTICE GUIDELINE
6/27/96

I. SUMMARY

This guideline sets policy and standards for consumer inclusion in the service delivery design and delivery process for all public mental health services. This guideline ensures the goals of a consumer-driven system which gives consumers choices and decision-making roles. It is based on the active participation by primary consumers, family members and advocates in gathering consumer responses to meet these goals.

This participation by consumers, family members and advocates is the basis of a provider's evaluation. Evaluation also includes how this information guides improvements.

II. APPLICATION

A. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).
B. Centers for persons with developmental disabilities and community placement agencies operated by the MDHHS.
C. Children's psychiatric hospitals operated by the MDHHS.
D. Special facilities operated by the MDHHS.
E. Community Mental Health Services Programs (CMHSPs) and Prepaid Inpatient Health Plans under contract with MDHHS.
F. All providers of mental health services who receive public funds, either directly or by contract, grant, third party payers, including managed care organizations or other reimbursements.

III. POLICY

This policy supports services that advocate for and promote the needs, interests, and well-being of primary consumers. It is essential that consumers become partners in creating and evaluating these programs and services. Involvement in treatment planning is also essential.

Services need to be consumer-driven and may also be consumer-run. This policy supports the broadest range of options and choices for consumers in services. It also supports consumer-run programs which empower consumers in decision-making of their own services.

All consumers need opportunities and choices to reach their fullest potential and live independently. They also have the rights to be included and involved in all aspects of society.

Accommodations shall be made available and tailored to the needs of consumers as specified by consumers for their full and active participation as required by this guideline.

IV. DEFINITIONS

Informed Choice: means that an individual receives information and understands his or her options.

Primary Consumer: means an individual who receives services from the Michigan Department of Health and Human Services , Prepaid Inpatient Health Plan or a Community Mental Health Services Program. It also means a person who has received the equivalent mental health services from the private sector.

Consumerism: means active promotion of the interests, service needs, and rights of mental health consumers.

Consumer-Driven: means any program or service focused and directed by participation from consumers.

Consumer-Run: refers to any program or service operated and controlled exclusively by consumers.

Family Member: means a parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer. It is also any individual upon whom a primary consumer depends for 50 percent or more of his or her financial support.

Minor: means an individual under the age of 18 years.

Family Centered Services: means services for families with minors which emphasize family needs and desires with goals and outcomes defined. Services are based on families' strengths and competencies with active participation in decision-making roles.

Person-Centered Planning: means the process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life. It honors the individual's preferences, choices, and abilities.

Person-First Language: refers to a person first before any description of disability.

Recovery: means the process of personal change in developing a life of purpose, hope, and contribution. The emphasis is on abilities and potentials. Recovery includes positive expectations for all consumers. Learning self-responsibility is a major element to recovery.

V. STANDARDS

A. All services shall be designed to include ways to accomplish each of these standards.

1. "Person-First Language" shall be utilized in all publications, formal communications, and daily discussions.
2. Provide informed choice through information about available options.
3. Respond to an individual's ethnic and cultural diversities. This includes the availability of staff and services that reflect the ethnic and cultural makeup of the service area. Interpreters needed in communicating with non-English and limited-English-speaking persons shall be provided.

4. Promote the efforts and achievements of consumers through special recognition of consumers.
5. Through customer satisfaction surveys and other appropriate consumer related methods, gather ideas and responses from consumers concerning their experiences with services.
6. Involve consumers and family members in evaluating the quality and effectiveness of service. Administrative mechanisms used to establish service must also be evaluated. The evaluation is based upon what is important to consumers, as reported in customer satisfaction surveys.
7. Advance the employment of consumers within the mental health system and in the community at all levels of positions, including mental health service provision roles.

B. Services, programs, and contracts concerning persons with mental illness and related disorders shall actively strive to accomplish these goals.

1. Provide information to reduce the stigma of mental illness that exists within communities, service agencies, and among consumers.
2. Create environments for all consumers in which the process of "recovery" can occur. This is shown by an expressed awareness of recovery by consumers and staff.
3. Provide basic information about mental illness, recovery, and wellness to consumers and the public.

C. Services, programs, and contracts concerning persons with developmental disabilities shall be based upon these elements.

1. Provide personal preferences and meaningful choices with consumers in control over the choice of services and supports.
2. Through educational strategies: promote inclusion, both personal and in the community; strive to relieve disabling circumstances; actively work to prevent occurrence of increased disability; and promote individuals in exercising their abilities to their highest potentials.
3. Provide roles for consumers to make decisions in polices, programs, and services that affect their lives including person-centered planning processes.

D. Services, programs, and contracts concerning minors and their families shall be based upon these elements:

1. Services shall be delivered in a family-centered approach, implementing comprehensive services that address the needs of the minor and his/her family.
2. Services shall be individualized and respectful of the minor and family's choice of services and supports.
3. Roles for families to make decisions in policies, programs and services that affect their lives and their minor's life.

E. Consumer-run programs shall receive the same consideration as all other providers of mental health services. This includes these considerations:

1. Clear contract performance standards.
2. Fiscal resources to meet performance expectations.
3. A contract liaison person to address the concerns of either party.
4. Inclusion in provider coordination meetings and planning processes.
5. Access to information and supports to ensure sound business decisions.

F. Current and former consumers, family members, and advocates must be invited to participate in implementing this guideline. Provider organizations must develop collaborative approaches for ensuring continued participation.

Organizations' compliance with this guideline shall be locally evaluated. Foremost, this must involve consumers, family members, and advocates. Providers, professionals, and administrators must be also included. The CMHSP shall provide technical assistance. Evaluation methods shall provide constructive feedback about improving the use of this guideline. This guideline requires that it be part of the organizations' Continuous Quality Improvement.

VI. REFERENCES AND LEGAL AUTHORITY

Act 258, Section 116(e), Public Acts of 1974 as amended, being MCL 330.1116, 1704, 1708.

PERSONAL CARE IN NON-SPECIALIZED RESIDENTIAL SETTINGS TECHNICAL REQUIREMENT

NOTE: Replicated from the MDHHS Personal Care in Non-Specialized Residential Settings Guideline as included in the Public Mental Health Manual, Volume 01-C, Section 11 16(j), Subject GL-00, Chapter 01, Dated 10/9/96.

I. SUMMARY

This guideline establishes operational policy; program and clinical documentation requirements for issuing payments through the Adult Services Automated Payment (ASAP) (formerly Model Payment Program) program for mental health recipients who need personal care services when placed in a non-specialized residential foster care setting.

II. APPLICATION

A. Community Mental Health Services Programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs) as specified in their contracts with the Michigan Department of Health and Human Services (MDHHS).

B. Psychiatric Hospitals and Centers operated by, or under contract with the MDHHS.

C. Special facilities operated by the MDHHS.

D. Children's units operated by the MDHHS.

III. POLICY

Upon placement of a mental health recipient into a non-specialized residential foster care setting, the Responsible Mental Health Agency (RMHA) shall insure that any need for personal care services are identified in their plan is addressed in keeping with Medicaid (MA) standards. In addition, RMHA shall take the required action(s) to further insure that payment(s) for personal care services are issued, and all payment problems are resolved.

IV. DEFINITIONS

Client Services Management: a related set of activities which link the recipient to the public mental health system and which staff coordinate to achieve a successful outcome.

Family Member: means a parent or step-parent of a minor child or spouse.

Individual Plan of Service (IPS): a written plan which identifies mental health services; as defined in Section 712, Act 290 of the Public Acts of 1995.

Medicaid (MA) Designated Case Manager: case manager must be either a qualified mental retardation professional (QMRP) as defined in 42 CFR 483.430, or a qualified mental health professional (QMHP) as defined in Michigan's Medicaid Provider Manual.

Non-Specialized Residential Foster Care Setting: a licensed dependent living arrangement which provides room, board and supervision, but does not provide in-home specialized mental health services.

Personal Care Services: services provided in accordance with an individualized plan of service that assist a recipient by hands-on assistance, guiding, directing, or prompting of Personal Activities of Daily Living (PADL) in at least one of the following activities:

A. EATING/FEEDING: the process of getting food by any means from the receptacle(plate, cup, glass) into the body. This item describes the process of eating after food is placed in front of an individual.

B. TOILETING: the process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleansing self after elimination, and adjusting clothes.

C. BATHING: the process of washing the body or body parts, including getting to or obtaining the bathing water and or equipment, whether this is in bed, shower or tub.

D. GROOMING: the activities associated with maintaining personal hygiene and keeping one's appearance neat, including care of teeth, hair, nails, skin, etc.

E. DRESSING: the process of putting on, fastening and taking off all items of clothing, braces and artificial limbs that are worn daily by the individual, including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual.

F. TRANSFERRING: the process of moving horizontally and or vertically between the bed, chair, wheelchair and or stretcher.

G. AMBULATION: the process of moving about on foot or by means of a device with wheels.

H. ASSISTANCE WITH SELF-ADMINISTERED MEDICATION: the process of assisting the client with medications that are ordinarily self-administered, when ordered by the client's physician.

V. STANDARDS

A. Recipient must be Medicaid active during effective dates of service.

B. Providers of non-specialized residential services must be licensed and meet minimum requirements of the Michigan Department of Human Services (MDHS) and MDHHS as defined and contained therein, Act 117, Public Acts of 1973, as amended and Act 2 18, Public Acts of 1979, as amended, for non-specialized residential settings such as: homes for the aged, adult foster care family home, adult foster care small group home, adult foster care large group home, adult foster care congregate facility, foster family home, foster family group home, and child caring institutions.

C. Personal care services are covered when ordered by a physician or Medicaid (MA) designated case manager based upon face to face contact with recipient, and in accordance an Individual Plan of Service (IPS) and rendered by a qualified person who is not a member of the individual family.

D. Supervision of personal care services is required, and may be provided by a registered nurse, physician assistant, a MA designated case manager supervisor or a MA designated case manager other than the case manager who ordered services. Supervision of personal care services is a two-part/sign-off process which includes:

1. Approval of covered personal care services, occurs after a Medicaid designated case manager or physician has ordered personal care services, which must be either written in the IPS or on a program approved form.

2. A re-evaluation or review of personal care services must occur within a calendar year of the last plan for personal care services or last re-evaluation or review whichever occurred last, based upon either a face-to-face contact with recipient or an administrative review of plan of service. A Medicaid designated case manager shall initiate a re-evaluation or review on a program approved form.

E. Provider of service must maintain a service log that documents specific days on which personal care services were delivered consistent with the recipients individual plan of services.

F. Compliance with the Personal Care/Adult Services Automated Payment standards of MDHHS.

VI. REFERENCES AND LEGAL AUTHORITY

A. Social Security Act, Section 1905(a) (17).
B. 42 CFR 440.170 and 42 CFR 483.430.
C. Act 258 of the Public Acts of 1974 (MCLA -330.1 116) and Act 290 of the Public Acts of 1995 (MCLA -330.1712).
D. Michigan's Medicaid' state provisions for Title XIX of the Social Security Act.
E. Michigan Department of Health & Human Services, Service Manual, Adult and Family Services Item -314 and 372, Home Help Adult, Community Placement and Personal Care Services, Adults Foster Care (AFC) and Homes for the Aged (HA), Personal Care/Supplemental Payments.

F. Michigan Department of Health and Human Services, Personal Care/Adult Services Automated Payment Manual, 1996.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION FAMILY-DRIVEN AND YOUTH-GUIDED POLICY AND PRACTICE GUIDELINE

A. Summary/Background

The purpose of this policy guideline is to establish standards for the Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs) and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children and their families. This policy guideline will outline essential elements of family-driven and youth-guided policy and practice at the child and family level, system level and peer-delivered level.

Person-centered planning is the method for individuals served by the community mental health system to plan how they will work toward and achieve personally defined outcomes in their own lives. The Michigan Mental Health Code established the right for all individuals to develop individual plans of services through a person-centered planning process regardless of disability or residential setting.

For children and families, the Person-Centered Planning Policy Guideline states: "The Michigan Department of Health and Human Services (MDHHS) has advocated and supported a family-driven and youth-guided approach to service delivery for children and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family; not just the identified youth receiving mental health services. In the case of minors, the child and family is the focus of service planning, and family members are integral to a successful planning process. The wants and needs of the child and his/her family are considered in the development of the Individual Plan of Service." As the child matures toward transition age, services and supports should become more youth-guided.

As a result of the effort to develop family-driven and youth-guided services, the Substance Abuse and Mental Health Administration (SAMSHA) in partnership with the Federation of Families for Children's Mental Health, has developed a set principles (described in section C of this policy) which serve as the basis for the delivery of family-driven and youth-guided services. These principles comprise the standards which should guide the delivery of services to children and their families and are essential to development of an effective system of care.

This policy is consistent with the "Application for Renewal and Recommitment (ARR) to Quality and Community in the Michigan Public Mental Health System," as issued by MDHHS on February 1, 2009. The ARR formally introduced new and enhanced

expectations of performance and revitalized MDHHS's commitment to excellence in partnership with PIHPs and CMHSPs.

While agencies are expected to collaborate, they are not intended to be the primary decision-makers on behalf of a child or family. It is important for systems to actively engage families in leading all decisions about the care of their child. Similarly, as appropriate, based on their age and functioning, youth should have opportunities to make decisions about their own care. Family and youth involvement is also important on a broader level, with an expectation that they are active participants in system-level governance and planning (Wilder Foundation, Snapshot: Mental Health Systems of Care for Children, August 2009).

B. Policy

It is the policy of MDHHS that all publicly-supported mental health agencies and their contact agencies shall engage in family-driven and youth-guided approaches to services with children and families and will engage family members and youth at the governance, evaluation, and service delivery levels as key stakeholders.

How this policy will be supported:

- MDHHS staff in partnership with the family organizations will work with PIHPs, CMHSPs, and contract agencies to support successful implementation of the family-driven and youth-driven policy guideline.
- MDHHS will work with other system partners at the state level to ensure PIHPs, CMHSPs and contract agencies can build an effective system of care.\
- Through ARR progress reviews, updates and technical assistance. The different sections of the ARR have applicability to family-driven and youth-guided care, e.g., stakeholder involvement, developing an effective system of care, improving the quality of services and supports, assuring active engagement, etc.

C. Family-Driven and Youth-Guided Principles

Family-driven and youth-guided principles should be measured at several different levels: the child and family level, the system level and the peer-to-peer level. These principles incorporate all levels, and will be detailed under section D: Essential Elements.

- Families and youth, providers and administrators share decision-making and responsibility for outcomes.
- Parents, caregivers and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their family as a whole.
- All children, youth and families (parents) have a biological, adoptive, foster, or surrogate family voice advocating on their behalf.

- Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
- Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
- Providers take the initiative to change policy and practice from provider-driven to family-driven and youth-guided.
- Administrators allocate staff, training, support and resources to make family-driven and youth-guided practice work at the point where services and supports are delivered to children, youth and families.
- Community attitude change efforts focus on removing barriers and discrimination crated by stigma.
- Communities and public and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.
- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of diverse populations are appropriately addressed.

D. <u>Essential Elements for Family-Driven and Youth-Guided Care</u>

1. "Family-driven" means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community. This includes
    - Being given the necessary information to make informed decisions regarding the care of their children
    - Choosing culturally and linguistically competent supports, services, and providers
    - Setting goals
    - Designing, implementing and evaluating programs
    - Monitoring outcomes
    - Partnering in funding decisions.
2. "Youth-guided" means that young people have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).
3. "Family-run organization" means advocacy and support organizations that are led by family members with lived experience raising children with SED and/or DD thus creating a level of expertise. These organizations provide peer-to-peer support, education, advocacy, and information/referral services to reduce isolation for family members,

gather and disseminate accurate information so families can partner with providers and make informed decisions, and strengthen the family voice at the child and family level, and systems level.

4. Child and Family-Level Action Strategies:
    - Strength and Culture Discovery – Children, youth and family strengths will be identified and linked to treatment strategies within the plan of service
    - Cultural Preferences – The plan of service will incorporate the cultural preference unique to each youth and family.
    - Access – Children, youth and families are provided usable information to make informed choices regarding services and supports and have a voice in determining the services they receive. Services and supports are delivered in the home and community whenever possible.
    - Voice – Children, youth and families are active participants in the treatment process, their voice is solicited and respected, and their needs/wants are written into the plan in language that indicates their ownership.
    - Ownership – The plan compliments the strengths, culture and prioritized needs of the child, youth and family.
    - Outcome-based – Plans are developed to produce results that the youth and family identify. All services, supports and interventions support outcomes achievement.
    - Parent/Youth/Professional Partnerships – Parents and youth are recognized for having expertise, are engaged as partners in the treatment process, and share accountability for outcomes.
    - Increase Confidence and Resiliency – The plan will identify specific interventions that maximize the strengths of the child, youth, and family, increase the skills of the youth to live independently and advocate for self, and equip the family with skills to successfully navigate systems and manage the needs of their child and family.
    - Participation in Planning Meetings – Youth and families determine who participates in the planning meetings.
    - Crisis and Safety Planning – Crisis and safety plans should be developed to decrease safety risks, increase confidence of the youth and family, and respect the needs/wants of the youth and family.

5. System-level Action Strategies:
    - Agencies have policies that ensure that all providers of services to children, youth, and families incorporate parent/caregivers and youth on decision-making groups, boards and committees that support family-driven and youth-guided practice.

- Agencies have policies that ensure training, support, and compensation for parents and youth who participate on decision-making groups, boards and committees and serve as co-facilitators/trainers.
- Policies are in place within the agency to support employment of youth and parents.
- Youth and parents are part of the program and service design, evaluation, and implementation of services and supports.
- Children, youth and families are provided opportunities to participate in and co-facilitate training and education opportunities.
- Services are delivered where the children, youth and family feel most comfortable and in a way that is relevant to the family culture.
- All stakeholder groups include diverse membership including youth and family members who represent the population the agency/community serves.

6. Peer-delivered Action Strategies:
    - Parents/caregivers, youth who have first-hand experience with the public mental health system are recruited, trained and supported in their role as parent/peer support partners.
    - Family Organizations are involved in the recruiting, supporting, and training of family members and youth peer-to-peer support partners. They may also serve as the contract employers of the parent support partners.
    - Peer-to-peer support models approved by MDHHS for parents and youth are available.

E. <u>Biography</u>

National Technical Assistance and Evaluation Center. A Closer Look: Family Involvement in Public Child Welfare Driven Systems of Care. February 2008

https://www.childwelfare.gov/pubs/acloserlook/familyinvolvement/familyinvolvement.pdf

http://www.samhsa.gov/

ACMH Youth Advisory Council Focus Group (January 16, 2010)

ACMH Staff Retreat (December 14, 2009)

June 7, 2011,

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)

FROM: Cynthia Kelly, Director, Bureau of State Hospitals & Behavioral Health Administrative Operations

SUBJECT: *Employment Works!* Policy

MDHHS recognizes that employment is an essential element of quality of life for most people, including individuals with a serious mental illness or a developmental disability; including persons with the most significant disability. Therefore, it is the policy of MDHHS that:

Each eligible working age individual over 14 years old (to correlate with transition planning and related MDHHS policy 1915(b)/(c) Waiver Program Attachment P.7.10.4.1) and ongoing to the age of their chosen retirement-generally seen as around 65 years old) will be supported to pursue his or her own unique path to work and a career. All individuals will be afforded the opportunity to pursue competitive, integrated work. MDHHS shall define "competitive employment" and "integrated setting" using the definitions of those terms listed in title 34, Code of Federal Regulations, section 361".

- (11) Competitive employment means work-
  - (i) In the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and
  - (ii) For which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled.

- (33) Integrated setting,--
  - (i) With respect to the provision of services, means a setting typically found in the community in which applicants or eligible individuals interact with non-disabled individuals other than non-disabled individuals who are providing services to those applicants or eligible individuals;
  - (ii) With respect to an employment outcome, means a setting typically found in the community in which applicants or eligible individuals interact with non-disabled individuals, other than non-disabled individuals who are providing services to those applicants or eligible individuals, to the same extent that non-disabled individuals in comparable positions interact with other persons.

Each time a pre-planning meeting is held to prepare for a person's plan of service (at least annually); a person's options for work will be encouraged as noted in Contract Attachment P 4.4.1.1 and will be documented during the pre-planning meeting. After exploration of competitive employment options, it is recognized that some individuals may choose other work options such as Ability One contracts, integrated community group employment, self-employment, transitional employment, volunteering, education/training, or unpaid internships as a means leading to future competitive, integrated work.

In the case of employment for persons with mental illness, MDHHS has adopted the evidence-based practice of Individual Placement and Support (IPS). The definition for the outcome of competitive employment for this specific population remains; individual jobs that anyone can apply for rather than jobs created specifically for people with disabilities. These jobs pay at least minimum wage or the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled. Further, the jobs do not have artificial time limits imposed by the social service agency.

This proposed policy shall support persons with serious mental illness and developmental disabilities to receive services and supports to achieve and maintain competitive employment. It is imperative that this *Employment Works!* Policy be shared and reinforced as an expectation with staff responsible for employment services and outcomes and with all supports coordinators and case managers.

In order to measure employment outcomes, MDHHS will compare baseline numbers for all competitive, integrated employment-both individual and group. Additionally, MDHHS will measure facility-based employment each year. It is expected that the total percentage of individuals competitively employed in integrated settings will increase-both individual, integrated employment and group, integrated employment. It is also expected that as both of these types of employment increase, the percentage of individuals in facility-based employment will decrease. This policy supports the incentive for increased competitive, integrated employment for people with disabilities, as written into contract language.

Expectations for MDHHS:

- Establish a permanent state-level staff member who has responsibility for further development and overseeing its implementation of the *Employment Works!* Policy.
- Provide technical assistance to the field for program implementation and sustainability and to also provide opportunities for training and development.
- Review existing employment data sources, and establish a strategy for collecting and sharing accurate employment outcome data with stakeholders.
- Establish specific employment goals for the PIHP/CMHSP system data.
- Strengthen the strategy and agreements with Michigan Rehabilitation Services (MRS) and the Michigan Commission for the Blind (MCB) to improve the consistency of MRS/MCB supports for PIHP/CMHSP consumers.
- Encourage and promote the use of best employment practices, including employment practices recognized in the most current Medicaid Provider Manual under Supported Employment Services. (Examples include the evidence based supported employment, customized employment, self-employment, etc.)
- Identify CMHSPs with best employment outcomes, learn from their successes, and highlight these practices.
- Assist PIHPs/CMHSPs in developing expertise in benefits planning.
- Strengthen the role of existing employment working group(s) by establishing a standing employment leadership team.

Expectations for PIHPs/CMHSPs:

- Designate a local staff member who shall be responsible for implementation of the *Employment Works!* Policy. Designate this staff member and an alternate to participate in a standing employment leadership team.
- Provide timely and accurate employment outcome data to MDHHS to review and determine employment strategies at least annually.
- Achieve established employment goals/increases.
- Establish strategies and enhance cash match agreements, partnership plus and/or other strategies with MRS and MCB to improve consistency of MRS/MCB supports for PIHP/CMHSP consumers.
- Embrace and promote the use of best employment practices, including EBP SE.
- Share local best employment practices across the PIHP/CMHSP network through conferences, webinars, conference calls, newsletters, cross-agency presentations, etc.
- Designate at least one (preferably two) staff with proven expertise in benefits planning or clear capacity to access timely and accurate information to address immediate employment interests of persons with disabilities.

Adult Jail Diversion Policy Practice Guideline
February 2005

I. Statement of Purpose

There is a general consensus with the principle that the needs of the community and society at large are better served if persons with serious mental illness, serious emotional disturbance or developmental disability who commit crimes are provided effective and humane treatment in the mental health system rather than be incarcerated by the criminal justice system. It is recognized that many people with serious mental illness have a co-occurring substance disorder.

This practice guideline reflects a commitment to this principle and conveys Michigan Department of Health and Human Services (MDHHS) jail diversion policy and resources for Community Mental Health Services Programs (CMHSPs). The guideline is provided as required under the authority of the Michigan Mental Health Code, PA 258 of 1974, Sec. 330.1207 - Diversion from jail incarceration (Add. 1995, Act 290, Effective March 28, 1996).

Section 207 of the Code states:

> "Each community mental health service program shall provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. These services shall be consistent with policy established by the department."

The guideline outlines CMHSP responsibilities for providing jail diversion programs to prevent incarceration of individuals with serious mental illness or developmental disability who come into contact with the criminal justice system. A separate practice guideline will address Juvenile Diversion of children with serious emotional disturbance.

Jail diversion programs are intended for individuals alleged to have committed misdemeanors or certain, usually non-violent, felonies and who voluntarily agree to participate in the diversion program.

II. Definitions

The following terms and definitions are utilized in this Practice Guideline:

Arraignment: The stage in the court process where the person is formally charged and enters a plea of guilty or not guilty.

Booking: The stage in the law enforcement custody process following arrest, when the individual is processed for formal admission to jail.

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

Co-Occurring Disorder: A dual diagnosis of a mental health disorder and a substance disorder.

MDHHS: Michigan Department of Health and Human Services.

GAINS Center: The National GAINS Center for People with Co-Occurring Disorders in the Justice System is a national center for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system. The GAINS Center is operated by Policy Research Inc. (PRI), through a cooperative agreement administered by the National Institute of Corrections (NIC). (GAINS Center website at www.gainsctr.com).

In-jail Services: Programs and activities provided in the jail to address the needs of people with serious mental illness, including those with a co-occurring substance disorder, or a developmental disability. These programs or activities vary across the state and may include crisis intervention, screening, assessment, diagnosis, evaluation, case management, psychiatric consultation, treatment, medication monitoring, therapy, education and training. Services delivered are based on formal or informal agreements with the justice system.

Jail Diversion Training: Cross training of law enforcement, court, substance abuse and mental health personnel on the diversion system and how to recognize and treat individuals exhibiting behavior warranting jail diversion intervention.

Jail Diversion Program: A program that diverts individuals with serious mental illness (and often co-occurring substance disorder) or developmental disability in contact with the justice system from custody and/or jail and provide linkages to community-based treatment and support services. The individual thus avoids or spends a significantly reduced time period in jail and/or lockups on the current charge. Depending on the point of contact with the justice system at which diversion occurs, the program may be either a **pre-booking or post-booking** diversion program. Jail diversion programs are intended for individuals alleged to have committed misdemeanors or certain, usually non-violent, felonies and who voluntarily agree to participate in the diversion program.

Post-booking Diversion program: Diversion occurs after the individual has been booked and is in jail, out on bond, or in court for arraignment. Often located in local jails or arraignment courts, post- booking jail diversion programs staff work with stakeholders such as prosecutors, attorneys, community corrections, parole and probation officers, community-based mental health and substance abuse providers and the courts to develop and implement a plan that will produce a disposition outside the jail. The individual is then linked to an appropriate array of community-based mental health and substance abuse treatment services.

Pre-booking Diversion Program: Diversion occurs at the point of the individual's contact with law enforcement officers before formal charges are brought and relies heavily on effective interactions between law enforcement officers and community mental health and substance abuse services. Most pre-booking programs are characterized by specialized training for law enforcement officers. Some model programs include a 24-hour crisis drop-off center with a no-refusal policy that is available to receive persons brought in by the law enforcement officers. The individual is then linked to an appropriate array of community-based mental health and substance abuse treatment services.

Screening: Evaluating a person involved with the criminal justice system to determine whether the person has a serious mental illness, co-occurring substance disorder, or a developmental

disability, and would benefit from mental health services and supports in accordance with established standards and local jail diversion agreements.

TAPA Center for Jail Diversion: The Technical Assistance and Policy Analysis Center is a branch of the National GAINS Center focusing on the needs of communities in developing programs to divert people with mental illness from jail into community-based treatment and supports. (TAPA website at www.tapacenter.org).

III. Background Summary

During the 1990s, CMHSPs and MDHHS focused resources on development of in-jail and in-detention services. In-jail services provided by most community mental health services program (CMHSPs) included services ranging from crisis intervention, assessment, counseling, consultation, and other mental health services. Some CMHSPs provided similar services in detention centers. An effective prototype for adults using the Assertive Community Treatment (ACT) model for persons exiting state prison, county jail or an alternative treatment program was also developed. These programs are important for assuring that individuals with mental health needs receive services while incarcerated and are linked to appropriate services and supports upon release. While in-jail services are an important part of the comprehensive service array provided by CMHSPs, they **are not** considered to constitute a jail diversion program, **unless** they have been specifically designed as part of a "fast track" release to community treatment within a post-booking diversion program.

Some individuals with serious mental illness or developmental disability must be held in jail because of the seriousness of the offense and should receive mental health treatment within the jail. However, other individuals who have been arrested may be more appropriately diverted to community-based mental health programs. In response to views of consumers, advocates and policy makers, the requirement for a jail diversion program in each CMHSP was included in the 1996 amendments to the Michigan Mental Health Code, P.A. 258 of 1974.

The first MDHHS Jail Diversion Best Practice Guideline was promulgated as an administrative directive in 1998. The directive defined the department's jail diversion procedures and set forth conditions for establishing and implementing an integrated and coordinated program as required by the 1996 Code amendments. New information has been used to update the guideline and to incorporate suggestions for improving current practice.

Effective programs support cross-system collaboration and recognize that all sectors of the criminal justice system need to have access to training. Training should be available to police officers, sheriffs, jail personnel, parole and probation officers, judges, prosecutors, and the defense bar.

The availability of a comprehensive, community-based service array is essential for jail diversion programs to be effective, and may allow many individuals to avoid criminal justice contact altogether. People who receive appropriate mental health treatment in the community usually have a better long-term prognosis and less chance of returning to jail for a similar offense.

The National GAINS Center for People with Co-Occurring Disorders in the Justice System is a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with

the justice system. The Center gathers information designed to influence the range and scope of mental health and substance abuse services provided in the justice system, tailors these materials to the specific needs of localities, and provides technical assistance to help them plan, implement, and operate appropriate, cost-effective programs. The GAINS Center is a federal partnership between two centers of the Substance Abuse and Mental Health Services Administration-the Center for Substance Abuse Treatment and the Center for Mental Health Services-and the National Institute of Corrections (NIC). More recently, this federal partnership has expanded to include the Office of Justice Programs and the Office of Juvenile Justice and Delinquency Prevention. The Center is operated by Policy Research, Inc. of Delmar, New York in collaboration with the Louis de la Parte Florida Mental Health Institute.

Based on the results of field research and program evaluations, the National GAINS Center asserts that the "best diversion programs see detainees as citizens of the community who require a broad array of services, including mental health care, substance abuse treatment, housing and social services. They recognize that some individuals come into contact with the criminal justice system as a result of fragmented services, the nature of their illnesses and lack of social supports and other resources. They know that people should not be detained in jail simply because they are mentally ill. Only through diversion programs that fix this fragmentation by integrating an array of mental health and other support services, including case management and housing, can the unproductive cycle of decompensation, disturbance and arrest be broken."

Strategies for creating effective diversion programs are also highlighted in the report from the "New Freedom Commission on Criminal Justice" published in June 2004. This report was published as part of the President's New Freedom Commission on Mental Health.

Several key factors are recognized as being important components of an effective jail diversion program. An effective program should:

- Recognize the complex and different needs of the population; be designed to meet the different needs of various groups within the population (such as individuals with a co-occurring substance disorder); **and** be culturally sensitive.
- Integrate all the services individuals need at the community level, including corrections, the courts, mental health care, substance abuse treatment, and social services (such as housing and entitlements), with a high level of cooperation among all parties.
- Incorporate regular meetings among the key players to encourage coordination services and sharing of information. Meetings should begin in the early stages of planning and implementing the diversion program, and should continue regularly.
- Utilize liaisons to bridge the barriers between the mental health and criminal justice systems and to manage the interactions between corrections, mental health, and judicial staff. These individuals need to have the trust and recognition of key players from each of the systems to be able to effectively coordinate the diversion effort.
- Have a strong leader with good communication skills and an understanding of the systems involved and the informal networks needed to put the necessary pieces in place.
- Provide for early identification of individuals with mental health treatment needs who meet the diversion program's criteria. This is done through the initial screening and evaluation that usually takes place in the arraignment court, at the jail, or in the

community for individuals out on bond. It is important to have a process in place that assures that people with mental illness are screened in the first 24 to 48 hours of detention.

- Utilize case managers who have experience in both the mental health and justice systems and who are culturally and racially similar to the clients they serve. An effective case management program is one of the most important components of successful diversion. Such a program features a high level of contact between clients and case managers, in places where clients live and work, to insure that clients will not get lost along the way.

IV. **Essential Elements for Michigan CMHSPs**

A. CMHSPs shall provide a pre-booking and a post-booking jail diversion program intended for individuals:
   1. alleged to have committed misdemeanors or certain, usually non-violent, felonies, and,
   2. who voluntarily agree to participate in the diversion program.

B. Offenses considered appropriate for diversion shall be negotiated at the local level.

C. Pre-booking jail diversion programs shall:
   1. Restrict eligibility to individuals who have or are suspected of having a serious mental illness, including those with a co-occurring substance disorder, or a developmental disability who have committed a minor or serious offense that would likely lead to arrest, or have been removed from a situation that could potentially lead to arrest.
   2. Have a diversion mechanism or process that clearly describes the means by which an individual is identified at some point in the arrest process and diverted into mental health services. Specific pathways of the pre-booking diversion programs are defined and described in an interagency agreement for diversion.
   3. Assign specific staff to the pre-booking program to serve as liaisons to bridge the gap between the mental health, substance abuse, and criminal justice systems, and to manage interactions between these systems. It is important to have a strong leader with good communication skills and understanding of the systems involved and the informal networks needed to put the necessary pieces in place.
   4. Provide cross training for, and actively promote attendance of, law enforcement and mental health personnel on the pre-booking jail diversion program, including but not limited to: target group for diversion; specific pathways for diversion; key players and their responsibilities; data collection requirements; and other information necessary to facilitate an effective diversion program.
   5. Maintain a management information system that is HIPAA compliant and that can identify individuals brought or referred to the mental health agency as a result of a pre-booking diversion. Include the unique consumer ID as assigned by the CMHSP and the date of diversion, the type of crime, and the diagnosis. The unique ID can be used to link to the encounter data to obtain information regarding services. The CMHSP must be prepared to share its jail diversion data with the department upon request.

6. Outline the program and processes in a written inter-agency agreement, or document efforts to establish an inter-agency agreement, with every law enforcement entity in the service area. Inter-agency agreements shall include but not be limited to the following information: identification of the target population for pre-booking jail diversion; identification of staff and their responsibilities; plan for continuous cross-training of mental health and criminal justice staff; specific pathways for the diversion process; description of specific responsibilities/services of the participating agencies at each point in the pathway; data collection and reporting requirements; and process for regular communications including regularly scheduled meetings.

D. Post-booking jail diversion programs shall:

1. Restrict eligibility to individuals who have or are suspected of having a serious mental illness, including those with a co-occurring substance disorder, or a developmental disability who have been arrested for the commission of a crime.

2. Have a clearly described mechanism or process for screening jail detainees for the presence of a serious mental illness, co-occurring substance disorder, or developmental disability within the first 24 to 48 hours of detention. The process shall include:
   - Evaluating eligibility for the program;
   - Obtaining necessary approval to divert;
   - Linking eligible jail detainees to the array of community-based mental health and substance abuse services.

3. Assign specific staff to program including liaisons to bridge the barriers between the mental health, substance abuse and criminal justice systems, and to manage interactions between these systems. It is important to have a strong leader with good communication skills and understanding of the systems involved and the informal networks needed to put the necessary pieces in place.

4. Establish regular meetings among the key players, including police/sheriffs, court personnel, prosecuting attorneys, judges, and CMHSP representatives to encourage coordination of services and the sharing of information.

5. Include case managers and other clinical staff who have experience in both the mental health and criminal justice systems whenever possible. If this is not possible, documentation of recruitment efforts must be documented, and an intensive training program with specific criminal justice focus must be in place for case managers. Case managers and other clinical staff must provide care in a culturally competent manner.

6. Provide cross training for, and actively promote attendance of, law enforcement and mental health personnel on the post-booking jail diversion program, including but not limited to: target group for diversion; specific pathways for diversion; key players and their responsibilities; data collection requirements; and other information necessary to facilitate an effective diversion program.

7. Maintain a management information system that is HIPAA compliant and that can identify individuals brought or referred to the mental health agency as a result of a post-booking diversion. Include the unique consumer ID as assigned by the CMHSP and the date of diversion, the type of crime, and the diagnosis. The unique ID can be used to link to the encounter data to obtain information regarding services. The CMHSP must be prepared to share its jail diversion data with the department upon request.

8. Outline the program and processes in a written inter-agency agreement, or document efforts to establish an inter-agency agreement, with every law enforcement entity in the service area. Inter-agency agreements shall include but not be limited to the following information: identification of the target population for post-booking jail diversion; identification of staff and their responsibilities; plan for continuous cross-training of mental health and criminal justice staff: specific pathways for the diversion process, description of specific responsibilities/services of the participating agencies at each point in the pathway; data collection and reporting requirements; and process for regular communications including regularly scheduled meetings.

V. **Resources**

Council of State Governments Criminal Justice/Mental Health Consensus Project Report, June 2002
www.consensusproject.org/infocenter

The National GAINS Center for People with Co-Occurring Disorders in the Justice System
www.gainsctr.com

The President's New Freedom Commission on Mental Health Achieving the Promise: Transforming Mental Health Care in America Final Report, July 2003
www.mentalhealthcommission.gov/reports/FinalReport

The Technical Assistance and Policy Analysis Center for Jail Diversion (TAPA)
www.tapacenter.org

SPECIAL EDUCATION-TO-COMMUNITY TRANSITION PLANNING PRACTICE RECOMMENDATION GUIDELINE

I. Statement of Purpose

The purpose of this practice recommendation guideline is to provide community mental health service programs (CMHSPs) direction and guidance in planning for the transition of students with disabilities from special education programs to adult life as required by the MI Mental Health Code Section 330.1227, School-to-Community Transition Services. Section 330.1100d(11) of the MI Mental Health Code states: "Transition services means a coordinated set of activities for a special education student designed within an outcome-oriented process that promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living, or community participation." This practice guideline provides information about state and federal statutes relevant to school services and the CMHSPs responsibilities. In addition, information is being provided regarding key elements of school programs which appear to better prepare students with disabilities for transition from special education to adult life.

Although this guideline focuses only on special education to community transition, it is important to note CMHSP responsibilities described in Section 208 of the Mental Health Code: "(1) Services provided by a community mental health service program shall be directed to individuals who have a serious mental illness, serious emotional disturbance, or developmental disability. (3) Priority shall be given to the provision of services to persons with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability." In addition, any Medicaid recipient requiring medically necessary services must also be served.

Children meeting the criteria described above, but not in special education, also face issues of transition to adult life. These may include sub-populations of youth such as runaway youth, children with emotional disturbance at risk of expulsion from school, and youth who "age out" of: 1) the DSM diagnosis for which they are receiving mental health services; 2) Children's Waiver; 3) Children's Special Health Care Services plan; and 4) foster care placement, making them at risk for being homeless. The Michigan Department of Health and Human Services (MDHHS) recognizes the importance of these issues and is seeking service models to assist CMHSPs to meet the needs of this population. For example, Dr. Hewitt "Rusty" Clark of the Florida Mental Health Institute, a national expert on transition, has presented and discussed issues regarding transition to independent living for youth and young adults with emotional and behavioral disturbances with department staff and Michigan stakeholders. In addition, the MDHHS funded three interagency transition services pilot programs targeted at this population in FY 99. While it is recognized that these are important issues which need attention and guidance, they are not the focus of this transition guideline document.

II. Summary

The completion of school is the beginning of adult life. Entitlement to public education ends, and young people and their families are faced with many options and decisions about the future. The most common choices for the future are pursuing vocational training or further academic education, getting a job, and living independently.

The Michigan Mental Health Code requires: "Each community mental health service program shall participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. This planning and development shall be done in conjunction with the individual's local school district or intermediate school district as appropriate and shall begin not later than the school year in which the individual student reaches 16 years of age. These services shall be individualized. This section is not intended to

increase or decrease the fiscal responsibility of school districts, community mental health services programs, or any other agency or organization with respect to individuals described in this section."

The effectiveness of primary and secondary school programming for students with disabilities directly affects services and financial planning of CMHSPs. Schools that best prepare students with disabilities to live and work in the community and to access generic community services such as transportation and recreation create fewer demands on the adult services system and foster better community participation for individuals with disabilities. It is important for CMHSPs to develop a knowledge base of the federal statutes underlying school programming in order to assess whether students with mental health-related disabilities are receiving school services that will lead to independence, employment, and community participation when their school experience ends.

CMHSPs have a responsibility to provide information about eligibility requirements, types of services, and person-centered planning in the public mental health system to students, families, caregivers, and school systems.

III. Development

For the past two years, the MDHHS has been involved in activities to increase the knowledge base and to become more familiar with the issues of transition. Activities have included:

1. Membership on the Transition Network Team, a statewide project comprised of representatives from state agencies, selected school systems, Social Security Administration and advocacy groups. The goal of the Transition Network Team is to resolve policy issues and barriers so that community partners can work collaboratively.

2. Review of the Transition Initiative findings with the project evaluator. The Transition Initiative was a five-year, federally-funded grant to the State of Michigan focused on transition services.

3. Attendance at a training program on the Individuals with Disabilities Education Act (IDEA) amendments of 1997, sponsored by CAUSE and provided by the Center for Law and Education of Boston, Massachusetts.

4. Attendance at annual School-To-Work conferences.

5. Attendance at the Michigan Association of Transition Services Personnel conference.

In July1999, the MDHHS convened a work group consisting of department staff and representatives of seven CMHSPs with experience in planning and facilitating transition initiatives in their local communities. The work group presented and discussed current field practices and reviewed articles and research related to transition.

IV. Practice

A. Current CMHSP Involvement

There is a broad range of CMHSP involvement with schools around transition services. Generally, CMHSPs are concerned with knowing the number of students who will be completing their school program and who are projected to need services from the CMHSP, such as case management (resource coordination), housing, therapy(ies), employment (placement and/or supports), and social/recreational opportunities. To a lesser degree, CMHSPs participate in the final Individual Educational Program (IEP) prior to the student completing their school program.

Some CMHSPs actively participate with the schools and other community services providers. In a few communities, employment services are well coordinated with the student maintaining the same community job after completion of their school program. A few of these individuals keep

the same vocational services provider. In addition, there may be social and recreational programs that are available to persons with disabilities who are still in school, as well as for those who are out of school. There is a need for more CMHSP involvement to promote: 1) Local school systems implementing the values of IDEA, with particular focus on integration, early vocational exploration and community-based work experiences; and 2) CMHSPs becoming more knowledgeable regarding desirable components of school programs which appear to lead to students with disabilities being more successful in their transition to adult life.

For CMHSPs to know if local school systems are providing appropriate programming, CMHSPs must have some knowledge of the applicable laws and must have knowledge of local school programming. CMHSPs also have a responsibility to provide students, caregivers and school systems information regarding eligibility for services from the public mental health system. Clearly part of that responsibility involves presenting the mental health service principles of person-centered planning, self-determination, inclusion and recovery.

B. Major Federal Legislation Regarding Transition

1. Education of the Handicapped Act (EHA) The EHA, Public Law (P.L.) 94-142, is the primary legislation which guides school services. This Act, passed in 1975, is better known through its latest amendments, as the Individuals with Disabilities Education Act (IDEA).

   P.L. 94-142 established the concept of a free and appropriate (public) education for all children. The following points are presented to show that the public laws guiding school services for students with disabilities match up well with Michigan Mental Health Code principles:

   - All children with disabilities, regardless of the severity of their disability will receive a Free (and) Appropriate Public Education (FAPE) at public expense.
   - Education of children and youth with disabilities will be based on a complete and individual evaluation and assessment of the specific, unique needs of each child.
   - An Individualized Education Program (IEP), or an Individualized Family Services Plan (IFSP), will be drawn up for every child or youth found eligible for special education or early intervention services, stating precisely what kinds of special education and related services, or the types of early intervention services, each infant, toddler, preschooler, child or youth will receive.
   - To the maximum extent appropriate, all children and youth with disabilities will be educated in the regular education environment.
   - Children and youth receiving special education have the right to receive the related services necessary to benefit from special education instruction. Related services include: Transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education that includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation (including therapeutic recreation), early identification and assessment of disabilities in children, counseling services (including rehabilitation counseling), and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

2. P.L. 98-524, the Vocational Education Act of 1984 (the Carl D. Perkins Act)
   The Perkins Act has a goal to improve the access of students with disabilities to vocational education. The Act requires vocational education be provided for students with disabilities.
3. P.L. 93-112, the Rehabilitation Act of 1973

The Rehabilitation Act of 1973 is primarily important because of Section 504. Section 504 states no person shall be excluded from participation in, denied the benefits of, or subjected to discrimination under any program or activity receiving federal financial assistance by means of a disability.

The full history of the related Public Laws is available through the National Information Center for Children and Youth with Disabilities (NICHCY). Their web site is a good source of past and current information (http://www.aed/nichcy).

C. Review of the Literature

A publication by the Transition Research Institute, University of Illinois at Urbana-Champaign, authored by Paula D. Kohler, Ph.D. and Saul Chapman, Ph.D., dated March 1999 and updated in April 1999, reviewed 106 studies which have attempted to empirically validate transition practices used by school systems. The report indicates that a "rigorous screening" narrowed the field to 20 studies for further review. The report found that there were many problems with the studies reviewed, including: Not enough information about specific interventions and practices; specific practices not directly tested making it difficult to establish specific outcomes to specific practices; studies focused on higher functioning students; lack of random sampling; lack of baseline data; too many subjects lost during the studies, and lack of use of appropriate evaluation methods. A conclusion from this report states "...there is some evidence to support various practices but also that no strong body of evidence exists that unequivocally confirms any particular approach to transition, nor is there any strong evidence to support individual practices."

The NICHCY publishes a variety of resources on transition. The resources include ideas and information on how students, families, school personnel, service providers and others can work together to help students make a smooth transition. In particular, the focus is on creative transition planning and services that use all of the resources that exist in communities, not just agencies that have traditionally been involved.

These practice guidelines incorporate certain practices and models which, while not empirically validated, are consistent with MDHHS values and principles. These practices and models are being utilized across the country by many schools and these schools consider these practices to be positive. It appears that many transition practices for students with disabilities are practices being utilized as part of the School-To-Work services for all students. Simply assuring that students with disabilities are included in the broader programming at the same time as other students is a positive practice.

V. Philosophy and Values

The MDHHS deems that CMHSP transition services must be based on values that reflect person-centered planning, and services and supports that promote individuals to be:

- empowered to exercise choice and control over all aspects of their lives
- involved in meaningful relationships with family and friends
- supported to live with family while children and independently as adults
- engaged in daily activities that are meaningful, such as school, work, social, recreational, and volunteering
- fully included in community life and activities

VI. Essential Elements

MI Mental Health Code 330.1227, Sec 227 requires that "transition planning begin no later than the school year in which the individual student reaches 16 years of age." CMHSPs, however, should be involved with schools early enough to develop a mutual relationship based on the principles of

inclusion, self-determination and age appropriateness which underlie both IDEA and the MI Mental Health Code. The practice(s) that would lead to the most consistent relationships between schools and CMHSPs for students under 16 years of age, or more than two years away from graduation, are:

A. **Early and Active Involvement with the Schools.**

1. Current federal regulation requires that IEP (transition) planning for students with disabilities must begin at age 14. IEPs must be held once a year plus when there is a significant change in programming. Rather than attending each IEP, particularly early in an individual student's educational career, a better strategy for CMHSPs would be to look more broadly at the type of programming each individual school system is providing to students with disabilities.
2. Key questions to consider when reviewing school programming for students with disabilities include: Are all students with disabilities being included with all students in School-To-Work (STW) activities? Are all students with disabilities being given opportunities to experience community-based work and independent living activities? Are all students with disabilities being experientially taught how to access generic community services? Are all students with disabilities learning about making choices as they move into adulthood?
3. Examples of STW activities in school systems are career days, job shadowing, student portfolios of work and educational achievements, summer work experiences, student internships, and student co-op experiences. All students with disabilities should be participating in these activities simultaneously with other students their own age.
4. All available community resources should be pursued, particularly for out-of-school and summer programming. The Michigan Department of Career Development, Rehabilitation Services (DCD-RS) is very active in many parts of the state working with students with disabilities. The DCD-RS is a particularly valuable resource for career/employment-related services for students exiting secondary schools.

B. **Participating in IEP Meetings and Sharing Information with Schools**

While CMHSPs need not attend all IEP meetings, they do need to ensure that schools, students, families and caregivers have basic knowledge of what CMHSPs can provide to persons with disabilities and eligibility criteria for those services. It is also important that

CMHSPs provide information on the MDHHS requirement that all CMHSP services be based on a person-centered plan. There are a variety of mechanisms available to CMHSPs for providing information. Brochures, community information events, direct mailings, special group presentations, local media, etc. Based on CMHSP experience to date, no one or two methods will be adequate.

CMHSPs shall provide schools with the following information through the CMHSP customer services efforts:

1. Values governing public mental health services including:
    - Recovery
    - Self-determination
    - Full community inclusion
    - Person-centered planning

2. Eligibility criteria
    - MI Mental Health Code priority populations
    - Medicaid
    - Specialty medically necessary services (including the boundary with the Qualified Health Plans)

- Children's Waiver
- Local service selection guidelines/protocols/etc.

3. Local service array for both adult and child service providers
4. The name and telephone number for a CMHSP liaison to the school for systemic service-related issues

C. **Providing Information about CMHSP Service Populations** CMHSPs have the responsibility to provide information to appropriate local school staff about specific conditions which would indicate the likelihood that a student would need assessment and/or service from the CMHSP upon graduation.

Students classified under the school system as Severely Multiply Impaired (SXI), Trainable Multiply Impaired (TMI), Severely Mentally Impaired (SMI) and Educable Mentally Impaired (EMI) are generally eligible for CMHSP services. Other student classifications would indicate a closer look by CMHSPs to determine eligibility for adult services from the CMHSP. The classification of Autistically Impaired (AI) covers students with a very broad range of skills and abilities often necessitating further assessment to determine eligibility for CMHSP services. Students classified as Emotionally Impaired (EI) would have to be assessed for eligibility for adult services from the CMHSP. In the mental health system, Emotional Impairment, by definition, ends at the age of 18. Students classified as EI as well as Learning Disabled (LD) and Physically or Otherwise Health Impaired (POHI) would need to assessed for an appropriate developmental disability or mental illness diagnosis. Where the school diagnosis is not appropriate, it is the responsibility of the CMHSP to provide an assessment. CMHSPs must look at factors in addition to diagnosis. Other factors include: risk for expulsion from school, need for assistance in multiple life domains, or absence of a stable natural support network.

D. **Using Local Councils and Committees**
CMHSPs can also use Multi-Purpose Collaborative Bodies (MPCBs) to address issues regarding the systemic implementation of transition services and to identify additional community resources for transition services. Regional Inter-Agency Coordination Committees (RICC) and Transition Councils are additional local bodies which may be used for the same purpose.

The following are the practice protocols that would lead to the most consistent relationship between CMHSPs and the schools for students 16 years of age, or two years away from completion of their school program.

For students within two years of completing their school program, or for students where the CMHSP is already providing or arranging services, the CMHSP shall:

E. **Request Information from Schools**
It is expected that CMHSPs will need the following from the schools to determine future needs and manage available resources including, but not limited to, information for each student age 16 or older who is expected to receive a diploma more than two years from the present:

- special education classification
- whether or not it is expected the student will need assistance in multiple life domains
- the stability of the student's natural support system
- any transition services currently being provided
- any mental health related services being provided by the school (e.g. school based Medicaid services)
- post-graduation goals, if identified

Based on this information and the CMHSP's knowledge of, and relationship with, the school district, the CMHSP may decide to initiate contact with the school for specific students.

F. **Initiate Transition Planning**

1. The CMHSP shall identify for the school, the student and his/her family a contact person at the CMHSP to act as a contact for the student's transition plan.

2. The CMHSP shall initiate CMHSP transition planning as part of each student's IEP. In the event that the student/family does not want the CMHSP to have a representative present, the CMHSP shall work with the school district to assure that the CMHSP has input into the student's transition plan and to obtain the necessary information (such as that outlined in E above) so that future services can be projected. CMHSPs shall plan to participate in individual IEP meetings for students who meet the eligibility criteria in section E above, and those students who may need assessment or services from the CMHSP as they near completion of their school program. Attendance or other active participation at IEP meetings the last two years will ensure that the student and the CMHSP have sufficient time to prepare for transition.

3. The CMHSP shall provide mental health services as part of a comprehensive transition plan which promotes movement from school to the community, including: vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living or community participation. It should be noted that the CMHSP does not have sole responsibility for any of these post-school activities and it may not use its state or federal funds to supplant the responsibility of another state agency. It is highly recommended that CMHSPs look at cooperative agreements and the pooling of resources to develop the best services possible for students with disabilities.

VII. **Definitions**

Carl D. Perkins Act, P.L. 98-524, the Vocational Education Act of 1984, also known as the Carl D. Perkins Act--The Perkins Act has a goal to improve the access of students with disabilities to vocational education. The Act requires that vocational education be made available as appropriate for students with disabilities.

CAUSE - Citizens Alliance to Uphold Special Education--A statewide parent training and information center for special education-related activities.

CMHSP - Community Mental Health Service Program

EHA - Education of the Handicapped Act, P. L. 94-142--The primary legislation which guides school services for students with disabilities. Passed in 1975, it is better known as IDEA, based on later amendments labeled as the "Individuals with Disabilities Education Act."

EI - Emotionally Impaired--An impairment determined through manifestation of behavioral problems primarily in the affective domain, over an extended period of time, which adversely affect the person's education to the extent that the person cannot profit from regular learning experiences without special education support.

EMI - Educable Mentally Impaired--An impairment which is manifested through all of the following characteristics:

- Development at a rate approximately two to three standard deviations below the mean as determined through intellectual assessment

- Lack of development primarily in the cognitive domain
- Impairment of adaptive behavior

FAPE - Free and Appropriate Public Education

IDEA -See EHA

IEP - Individualized Education Program--A program developed by an individualized educational planning committee which shall be reviewed (at least) annually.

IEPT - Individualized Educational Planning Team--A committee of persons appointed and invited by the superintendent to determine a person's eligibility for special education programs and services and, if eligible, to develop an individualized education program.

Inclusion - A MDHHS value which directs funding organizations and service providers to enable persons with disabilities to participate in the community, i.e., use community transportation, work in real paid jobs, access generic community social and recreation opportunities and live in their own apartments and houses. Inclusion includes the availability of flexible professional and natural supports that reinforce the individual's own strengths, and expands their opportunities and choices.

NICHCY - National Information Center for Children and Youth with Disabilities

Multi-Purpose Collaborative Body - An inclusive planning and implementation body of stakeholders at the county or multi-county level, focused on a shared vision and mission to improve outcomes for children and families

Person-Centered Planning - A highly individualized process designed to respond to the expressed needs/desires of the individual. The Michigan Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a person-centered planning process regardless of age, disability or residential setting. Person-centered planning is based on the following values and principles:

- Each individual has strengths, and the ability to express preferences and to make choices.
- The individual's choices and preferences shall always be considered if not always granted. Professionally trained staff will play a role in the planning delivery of treatment and may play a role in the planning and delivery supports. Their involvement occurs if the individual has expressed or demonstrated a need that could be met by professional intervention.
- Treatment and supports identified through the process shall be provided in environments that promote maximum independence, community connections and quality of life.
- A person's cultural background shall be recognized and valued in the decision-making process.

Recovery - Recovery is the nonlinear process of living with psychiatric disability in movement toward a quality life. The Recovery model for individuals involves the movement from anguish, awakening, insight action plan and determined commitment for wellness. The external factors influencing recovery are support, collaboration, building trust, respect, and choice and control. The development of hope provided by caregivers and generated from within the individual is a base for transformation into well-being and recovery.

The concept of recovery was introduced in the lay writings of consumers beginning in the 1980s. It was inspired by consumers who had themselves recovered to the extent that they were able to write about their experiences of coping with symptoms, getting better, and gaining an identity. Recovery also was fueled by longitudinal research uncovering a more positive course for a significant number of patients with severe mental illness. Recovery is variously called a process, an outlook, a vision, a guiding principle.

There is neither a single agreed-upon definition of recovery nor a single way to measure it. But the overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity, and on attaining meaningful roles in society.

Self-Determination - Self-determination incorporates a set of concepts and values which underscore a core belief that people who require support from the public mental health system as a result of a disability should be able to define what they need in terms of the life they seek, should have access to meaningful choices, and control over their lives. Within Michigan's public mental health system, self-determination involves accomplishing major system change which can assure that services and supports for people are not only person-centered, but person-defined and person-controlled. Self-determination is based on the following four principles:

- FREEDOM The ability for individuals, with assistance from their allies (chosen family and/or friends), to plan a life based on acquiring necessary supports in desirable ways, rather than purchase a program.
- AUTHORITY The assurance for a person with a disability to control a certain sum of dollars in order to purchase these supports, with the backing of their allies, as needed.
- SUPPORT The arranging of resources and personnel, both formal and informal, to assist the person to live their desired life in the community, rich in community associations and contributions.
- RESPONSIBILITY The acceptance of a valued role by the person in their community through employment, affiliations, spiritual development, and caring for others, as well as accountability for spending public dollars in ways that are life-enhancing.

A hallmark of self-determination is assuring a person the opportunity to control a fixed sum of dollars which is derived from the person-centered planning process and called an individual budget. The person, together with their allies controls the use of the resources in their individual budget, determining themselves which services and supports they will purchase from whom, and under what circumstances.

SMI - Severely Mentally Impaired--An impairment manifested through all of the following behavioral characteristics:

1. Development at a rate approximately four and one-half or more standard deviations below the mean as determined through intellectual assessment
2. Lack of development primarily in the cognitive domain
3. Impairment of adaptive behavior

Supported Employment - Competitive work in integrated settings for persons with the most significant disabilities for whom competitive work has not traditionally occurred or has been interrupted as a result of a significant disability.

SXI - Severely Multiply Impaired--An impairment determined through the manifestation of either of the following:

1. Development at a rate of two to three standard deviations below the mean and two or more of the following conditions:
    - a hearing impairment so severe that the auditory channel is not the primary means of developing speech and language skills
    - a visual impairment so severe that the visual channel is not sufficient to guide independent mobility
    - a physical impairment so severe that activities of daily living cannot be achieved without assistance
    - a health impairment so severe that the student is medically at risk

2. Development at a rate of three or more standard deviations below the mean, or students for whom evaluation instruments do not provide a valid measure of cognitive ability and one or more of the following conditions:
    - a hearing impairment so severe that the auditory channel is not the primary means of developing speech and language skills
    - a visual impairment so severe that the visual channel is not sufficient to guide independent mobility
    - a physical impairment so severe that activities of daily living cannot be achieved without assistance
    - a health impairment so severe that the student is medically at risk

TMI - Trainable Mentally Impaired--An impairment manifested through all of the following behavioral characteristics: 1) Development at a rate approximately three to four and one-half standard deviations below the mean as determined through intellectual assessment 2) Lack of development primarily in the cognitive domain 3) Impairment of adaptive behavior

Transition Services - A coordinated set of activities for a student which is designed within an outcome-oriented process and which promotes movement from school to post-school activities, including: Post-secondary education; vocational training; integrated employment including supported employment; continuing and adult education; adult services; independent living; or community participation. The coordinated set of activities shall be based on the individual student's needs and shall take into account the student's preferences and interests, and shall include needed activities in all of the following areas: 1) Instruction 2) Community experiences 3) Development of employment and other post-school adult living objectives 4) If appropriate, acquisition of daily living skills and functional vocational evaluation

VIII. Literature and Resources

ARTICLES AND PAPERS

Clark, H.B. Transition to Independence Process (TIP): TIP System Development and Operations Manual Florida Mental Health Institute, University of South Florida, 1998 (Revised)

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Deschenes, Nicole, Clark, Hewitt B. Seven Best Practices in Transition Programs for Youth Reaching Today's Youth Summer 1998

Everson, Jane M., Moon, M. Sherril Transition Services for Young Adults with Severe Disabilities: Defining Professional and Parental Roles and Responsibilities Virginia Commonwealth University Reprinted in September 1987 from the Journal of the Association of Persons with Severe Handicaps (JASH)

Halpern, A.S. Transition: Is It Time for Another Rebottling? Paper presented at the 1999 Annual OSEP Project Director's Meeting Washington D.C. June 1999

Kohler, Paula D. Ph.D. Facilitating Successful Student Transitions from School to Adult Life An analysis of Oklahoma Policy and Systems Support Strategies March 1999

Sale, P., Metzler, H.D., Everson, J.M., Moon, M.S. Quality Indicators of Successful Transition Programs Journal of Vocational Rehabilitation: 1(4): 47-63

NEWSLETTERS

C.E.N. Newsline Eaton Intermediate School District 1790 East Packard Highway Charlotte, MI 48813

Networks National Technical Assistance Center for State Mental Health Planning 66 Canal Center Plaza, Suite 302 Alexandria, VA 22314

Special Education Mediation Reporters Michigan Special Education Mediation Program SCAO 309 N. Washington Square, P.O. Box 30048 Lansing, MI 48909

Transition The College of Education & Human Development Transition Technical Assistance Project Institute on Community Integration University of Minnesota 109 Pattee Hall, 150 Pillsbury Dr., S.E. Minnesota, MN 55455

Transitions Michigan Transition Services Association John Murphy, Charlevoix-Emmet ISD 08568 Mercer Blvd. Charlevoix, Michigan 49720

UCP Pathways United Cerebral Palsy Association of Michigan, Inc. 320 N. Washington Sq., Suite #60 Lansing, MI 48933

WEB SITES

http://www.ed.wuc.edu/sped/tri/institute.html
Transition Research Institute at Illinois, NTA Headquarters 117 Children's Research Center, 51 Gerty Drive Champaign, IL 61820

http://www.ici.coled.umn.edu/schooltowork/profiles.html
School-to-Work Outreach Project Institute on Community Integration (UAP), University of Minnesota 111 Pattee Hall, 150 Pillsbury Drive SE Minneapolis, MN 55455

http://www.mde.state.mi.us/off/sped/index.html
Michigan Department of Education Office of Special Education and Early Intervention Services
P.O. Box 30008, Lansing, MI 48909

http://www.nichcy.org
National Information Center for Children and Youth with Disabilities
P.O. Box 1492 Washington, D.C. 20013-1492

http://www.vcu.edu/rrteweb/facts
Virginia Commonwealth University, Rehabilitation Research and Training Center on Supported Employment

IX. Authority

Mental Health Code, Act 258 MI, Sec. 330.1208 - Individuals to which service directed; priorities; denial of service prohibited

Mental Health Code, Act 258 MI, Sec.330.1227 - School-to-Community Transition (1974 & Supp 1996)

Mental Health Code, Act 258 MI, Sec. 330.1712 - Individualized written plan of service (1974 & Am. 1996)

CONTRACT FINANCING

1. **Insert Milliman Rate Certification letter for the time period covered by the contract.**

2. **Insert Milliman Paid Rate letter for the time period covered by the contract.**

3. **Insert 428 Schedule**

4. **Insert SUD Community Grant Authorization**

SUD COMMUNITY GRANT AGREEMENT AMOUNT

The total amount of this agreement is $_____. The Department under the terms of this agreement will provide funding not to exceed $_____. The federal funding provided by the Department is $_____, as follows:

Federal Program Title	Catalog of Federal Domestic Assistance (CFDA)	CFDA #	Federal Agency Name	Federal Grant Award Number	Award Phase	Amount
SAPT Block Grant	Block Grant for Prevention & TX of Substance Abuse	93.959	Department of Health & Human Services/SAMHSA	13 B1 MI SAPT	2017	
					Total FY 2017 Federal Funding	

_____sub-recipient relationship; or
_____vendor relationship.

The grant agreement is designated as:
_____Research and development project; or
_____Not a research and development project

INTERNAL SERVICE FUND TECHNICAL REQUIREMENT

Purpose

The establishment of an Internal Service Fund (ISF) is one method for securing funds as part of the overall strategy for covering risk exposure under the MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract (MDHHS/PIHP Contract). The ISF should be kept at a minimum to assure that the overall level of PIHP funds are directed toward consumer services. General provisions and restrictions for establishing an ISF are outlined below:

General Provisions

A. PIHPs may establish an ISF for risk corridor financing in accordance with shared risk provisions contained in the MDHHS/PIHP Contract with the Michigan Department of Health and Human Services .

B. An ISF may be established for the purpose of securing funds necessary to meet expected risk corridor financing requirements under the MDHHS/PIHP Contract.

C. When establishing an ISF, the PIHP may apply any method it considers appropriate to determine the amounts to be charged to the various funds covered by the ISF provided that:

   The total amount charged to the various funds does not exceed the amount of the estimated liability determined pursuant to Governmental Accounting Standards Board (GASB) Statement No.10, *General Principles of Liability Recognition*, or such other authoritative guidance as issued by the American Institute of Certified Public Accountants (AICPA); and

D. Non-compliance with the provisions of GASB Statement No. 10 and 2 CFR 200 Subpart E Cost Principles relative to any applicable matter herein will cause the ISF charges to be unallowable for purposes of the MDHHS/CMHSP Contract.

E. The ISF shall not be used to finance any activities or costs other than ISF eligible expenses.

F. All programs exposed to the risk corridor shall be charged their proper share of the ISF charges to the extent that those programs are covered for the risk of financial loss. Such charges must be allocated to the various programs/cost categories based on the relative proportion of the total contractual obligation, actual historical cost experience, or reasonable historical cost assumptions. If actual historical cost experiences or reasonable historical cost assumptions are used, they must cover, at a minimum, the most recent two years in which the books are closed.

G. A set of self-balancing accounts shall be maintained for the ISF in compliance with generally accepted accounting principles (GAAP).

H. The PIHP shall restrict the use of the ISF to the defined purpose.

I. The amount of funds paid to the ISF shall be determined in compliance with reserve requirements as defined by GAAP and applicable federal and state financing provisions contained in the MDHHS/PIHP Contract.

J. To establish an adequate funding level to cover risk corridor requirements, the PIHP may make payments up to the lesser of: (1) the total potential liability relative to the risk corridor and the overall risk management strategy of the PIHP's operating budget; or (2) the risk reserve requirements determined under paragraph C above and the applicable financing provisions contained in the MDHHS/PIHP Contract.

K. The PIHP shall establish a policy and procedure for increasing payments to the ISF in the event that it becomes inadequate to cover future losses and related expenses.

L. Payments to the ISF shall be based on either actuarial principles, actual historical cost experiences, or reasonable historical cost assumptions, pursuant to the provisions of OMB Circular A-87, Attachment B, paragraph 2 2(d)(3). If actual historical cost experiences or reasonable historical cost assumptions are utilized, they must cover, at a minimum, the most recent two years in which the books have been closed.

M. Payments and funding levels of the ISF shall be analyzed and updated at least biannually pursuant to the provisions of 2 CFR 200 Subpart E Cost Principles.

N. If the ISF becomes over-funded, it shall be reduced within one fiscal year through the abatement of current charges or, if such abatements are inadequate to reduce the ISF to the appropriate level, it shall be reduced through refunds in accordance with 2 CFR 200 Subpart E Cost Principles.

O. Upon contract cancelation or expiration, any funds remaining in the ISF and all of the related claims and liabilities shall be transferred to the new PIHP that encompasses the existing PIHPs region. When existing PIHPs geographic regions overlap more than one new PIHP region MDHHS will provide the percentage allocation to each new PIHP.

General Restrictions

Use of funds held in the ISF shall be restricted to the following:

A. The PIHP shall restrict the use of the ISF to the defined purpose. The defined purpose of the ISF is to secure funds necessary to meet expected future risk corridor requirements established in accordance with the MDHHS/PIHP Contract between the PIHP and the Michigan Department of Health and Human Services . All expenses, for the purpose intended to be financed from the ISF, shall be made from the ISF. No expenses from this fund will be match able--only the payments to the ISF will be match able. No other expenses may be paid from the ISF.

B. Payment of the PIHP's risk corridor obligation.

C. The PIHP may invest ISF funds in accordance with statutes regarding investments (e.g., *Mental Health Code* 330.1205, Sec. 205(g). The earnings from the investment of ISF funds shall be used to fund the risk reserve requirements of the ISF in accordance with 2 CFR 200 Subpart E Cost Principles.

D. The ISF may not loan or advance funds to any departments, agencies, governmental funds, or other entities in accordance with 2 CFR 200 Subpart E.

E. Funds paid to the ISF shall not be used to meet federal cost sharing or used to match federal or state funds pursuant to 2 CFR 200 Subpart E.

F. State funds paid to the ISF shall retain its character as state funds in accordance with the Mental Health Code and shall not be used as local funds.

General Accounting Standards

The ISF shall be established and accounted for in compliance with the following standards:

A. Generally accepted accounting principles (GAAP).

B. GASB Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues***,** or other current standards.

C. Financial Accounting Standards Board (FASB) Statement No. 60, *Accounting and Reporting by Insurance Enterprises*, or other current standards.

D. FASB Statement No.5, *Accounting for Contingencies*, or other current standards.

E. 2 CFR 200 Subpart E, *Cost Principles*, or other current standards.

F. Other financing provisions contained in the MDHHS/PIHP Contract.

G. The financial requirements set forth in the HCFA Federal 1915(b) waiver.

Community Mental Health

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Health and Human Services

Fiscal Year End September 30, 2017

V2017-1

TABLE OF CONTENTS

INTRODUCTION 1
RESPONSIBILITIES 3
MDHHS Responsibilities 3
PIHP Responsibilities 4
CMHSP Responsibilities 5
EXAMINATION REQUIREMENTS 6
Practitioner Selection 6
Examination Objective 6
Practitioner Requirements 6
Practitioner's Report 7
Examination Report Submission 8
Examination Reporting Package 9
Penalty 9
Incomplete or Inadequate Examinations 9
Management Decision 9
COMPLIANCE REQUIREMENTS 9
A. FSR Reporting 10
B. CRCS Reporting 12
C. Real Property Disposition 12
D. Administration Cost Report 12
E. Procurement 12
F. Rate Setting and Ability to Pay 12
G. Internal Service Fund (ISF) 13
H. Medicaid Savings and General Fund Carryforward 13
I. Match Requirement 13
J. Fee for Service Billings (CWP and SED Waiver Program) 13
K. CMHS Block Grant - Activities Allowed or Unallowed 14
L. CMHS Block Grant - Cash Management 14
M. CMHS Block Grant - Subrecipient Management and Monitoring 14
N. SAPT Block Grant – Activities Allowed or Unallowed 14
O. SAPT Block Grant – Cash Management 15
P. SAPT Block Grant – Subrecipient Management and Monitoring 15
RETENTION OF WORKING PAPERS AND RECORDS 15
EFFECTIVE DATE AND MDHHS CONTACT 15
GLOSSARY OF ACRONYMS AND TERMS 16

INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Health and Human Services (MDHHS) to assist independent audit personnel, Prepaid Inpatient Health Plan (PIHP) personnel, and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDHHS and PIHPs or CMHSPs, and to assure examinations are completed in a consistent and equitable manner.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDHHS to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, and Substance Use Disorder Community Grant Programs (hereinafter referred to as "Medicaid Contract"); the contracts between CMHSPs and MDHHS to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208 (hereinafter referred to as "GF Contract"); and, in certain circumstances, contracts between CMHSPs or PIHPs and MDHHS to manage the Community Mental Health Services Block Grant Program (hereinafter referred to as "CMHS Block Grant Program"). These CMH Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a PIHP or CMHSP expends $750,000 or more in federal awards[1], the PIHP or CMHSP must obtain a Single Audit.

PIHPs are ultimately responsible for the Medicaid funds received from MDHHS, and are responsible for monitoring the activities of network provider CMHSPs as necessary to ensure expenditures of Medicaid Contract funds are for authorized purposes in compliance with laws, regulations, and the provisions of contracts. Therefore, PIHPs must either require their independent auditor to examine compliance issues related to the Medicaid funds awarded to the network provider CMHSPs, or require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 8, 9, & 10).

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2017 and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

[1] Medicaid payments to PIHPs and CMHSPs for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended for the purposes of determining Single Audit requirements.

Failure to meet the requirements contained in these CMH Compliance Examination Guidelines may result in the withholding of current funds or the denial of future awards.

RESPONSIBILITIES

MDHHS Responsibilities

MDHHS must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code, and federal and state audit requirements; and to ensure the **COMPLIANCE REQUIREMENTS** contained in the CMH Compliance Examination Guidelines are complete and accurately represent requirements of PIHPs and CMHSPs; and distribute revised CMH Compliance Examination Guidelines to PIHPs and CMHSPs.
2. Review the examination reporting packages submitted by PIHPs and CMHSPs to ensure completeness and adequacy within eight months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination reporting package within eight months after the receipt of a complete and final reporting package.
4. Monitor the activities of PIHPs and CMHSPs as necessary to ensure the Medicaid Contract, GF Contract, and CMHS Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Contract, and GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely on PIHP or CMHSP Single Audits or the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure CMHSP Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS may, however, determine it is necessary to also perform a limited scope compliance examination or review of selected areas. Any additional reviews or examinations shall be planned and performed in such a way as to build upon work performed by other auditors. The following are some examples of situations that may trigger an MDHHS examination or review:
    a. Significant changes from one year to the next in reported line items on the FSR.
    b. A PIHP entering the MDHHS risk corridor.
    c. A large addition to an ISF per the cost settlement schedules.
    d. A material non-compliance issue identified by the independent auditor.
    e. The CPA that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.
    f. The CPA issued an adverse opinion on compliance due to their inability to draw conclusions because of the condition of the agency's records.

PIHP Responsibilities

PIHPs must:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200 , the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines is properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the PIHP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The PIHP shall <u>not</u> file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS and the PIHP will be notified of any required action in the management decision.
8. Monitor the activities of network provider CMHSPs as necessary to ensure the Medicaid Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. PIHPs must either (a.) require the PIHP's independent auditor (as part of the PIHP's examination engagement) to examine the records of the network provider CMHSP for compliance with the Medicaid Contract provisions, or (b.) require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. If the latter is chosen, the PIHP must incorporate the examination requirement in the PIHP/CMHSP contract and develop Compliance Examination Guidelines specific to their PIHP/CMHSP contract. Additionally, if the latter is chosen, the CMHSP examination must be completed in sufficient time so that the PIHP auditor may rely on the CMHSP examination when completing their examination of the PIHP if they choose to.
9. If requiring an examination of the network provider CMHSP, review the examination reporting packages submitted by network provider CMHSPs to ensure completeness and adequacy.

10. If requiring an examination of the network provider CMHSP, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in network provider CMHSP's examination reporting packages.

CMHSP Responsibilities

(as a recipient of Medicaid Contract funds from PIHP and a recipient of GF funds from MDHHS and a recipient of CMHS Block Grant funds from MDHHS)

CMHSPs must:

1. Maintain internal control over the Medicaid Contract, GF Contract, and CMHS Block Grant Program that provides reasonable assurance that the CMHSP is managing the Medicaid Contract, GF Contract, and CMHS Block Grant Program in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid Contract, GF Contract, and CMHS Block Grant Program.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract, GF Contract, and CMHSP Block Grant Program. Examples of these would include, but not be limited to: the Medicaid Contract, the Managed Mental Health Supports and Services Contract (General Fund Contract), the CMHS Block Grant Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines, and any examination required by the PIHP from which the CMHSP receives Medicaid Program funds are properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The CMHSP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS, and the CMHSP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

PIHPs under contract with MDHHS to manage the Medicaid Contract and CMHSPs under contract with MDHHS to manage the GF Contract are required to contract annually with a certified public accountant in the practice of public accounting (hereinafter referred to as a practitioner) to examine the PIHP's or CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 10 – Compliance Attestation – AT 601 (Codified Section of AICPA Professional Standards), as amended by SSAE Nos. 11, 12, and 14, (hereinafter referred to as an examination engagement). The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Additionally, CMHSPs under contract with MDHHS to provide CMHS Block Grant Program services with a total contract amount of greater than $100,000 are required to ensure the above referenced examination engagement includes an examination of compliance with specified requirements related to the CMHS Block Grant Program **IF** the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program. The specified requirements and specified criteria related to the CMHS Block Grant Program are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Practitioner Selection

In procuring examination services, PIHPs and CMHSPs must engage an independent practitioner, and must follow the Procurement Standards contained in 2 CFR 200.318 through 200.320. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, the results of MDHHS reviews, and price. When possible, PIHPs and CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the PIHP's or CMHSP's compliance with specified requirements is to express an opinion on the PIHP's or CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that the PIHP or CMHSP complied, in all material respects, based on the specified criteria.

Practitioner Requirements

The practitioner should exercise due care in planning, performing, and evaluating the results of his or her examination procedures; and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected.

The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements." In the examination of the PIHP's or CMHSP's compliance with specified requirements, the practitioner should:

1. Obtain an understanding of the specified compliance requirements (See AT 601.40).
2. Plan the engagement (See AT 601.41 through 601.44).
3. Consider the relevant portions of the PIHP's or CMHSP's internal control over compliance (See AT 601.45 through 601.47).
4. Obtain sufficient evidence including testing compliance with specified requirements (See AT 601.48 through 601.49).
5. Consider subsequent events (See AT 601.50 through 601.52).
6. Form an opinion about whether the entity complied, in all material respects with specified requirements based on the specified criteria (See AT 601.53).

Practitioner's Report

The practitioner's examination report on compliance should include the information detailed in AT 601.55 and 601.56, which includes the practitioner's opinion on whether the entity complied, in all material respects, with specified requirements based on the specified criteria. When an examination of the PIHP's or CMHSP's compliance with specified requirements discloses noncompliance with the applicable requirements that the practitioner believes have a material effect on the entity's compliance, the practitioner should modify the report as detailed in AT 601.64 through AT 601.67.

In addition to the above examination report standards, the practitioner must prepare:

1. A Schedule of Findings that includes the following:
    a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant Program.
    b. Material noncompliance with the provisions of laws, regulations, or contract provisions related to the Medicaid Contract, GF Contract, and/or CMHS Block Grant Program.
    c. Known fraud affecting the Medicaid Contract, GF Contract, and/or CMHS Block Grant Program.

    Finding detail must be presented in sufficient detail for the PIHP or CMHSP to prepare a corrective action plan and for MDHHS to arrive at a management decision. The following specific information must be included, as applicable, in findings:

    a. The criteria or specific requirement upon which the finding is based including statutory, regulatory, contractual, or other citation. **The Compliance Examination Guidelines should NOT be used as criterion.**
    b. The condition found, including facts that support the deficiency identified in the finding.

c. Identification of applicable examination adjustments and how they were computed.
d. Information to provide proper perspective regarding prevalence and consequences.
e. The possible asserted effect.
f. Recommendations to prevent future occurrences of the deficiency(ies) noted in the finding.
g. Views of responsible officials of the PIHP/CMHSP when there is a disagreement with the finding.
h. Planned corrective actions.
i. Responsible party(ies) for the corrective action.
j. Anticipated completion date.

2. A schedule showing final **reported** Financial Status Report (FSR) amounts, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below)], and examined FSR amounts. **All examination adjustments must be explained and must have a corresponding finding or comment.** This schedule is called the "Examined FSR Schedule." Note that Medicaid FSRs must be provided for PIHPs. All applicable FSRs must be included in the practitioner's report regardless of the lack of any examination adjustments.

3. A schedule showing a revised cost settlement for the PIHP or CMHSP based on the Examined FSR Schedule. This schedule is called the "Examined Cost Settlement Schedule." This must be included in the practitioner's report regardless of the lack of any examination adjustments.

4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant program; and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency. The list of details required for findings (a. through j. above) must also be provided for the comments.

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDHHS within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The PIHP or CMHSP must submit the reporting package by e-mail to MDHHS at MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. MDHHS reserves the right to request a hard copy of the compliance examination report materials if for any reason the electronic submission process is not successful.

Examination Reporting Package

The reporting package includes the following:

1. Practitioner's report as described above;
2. Corrective action plan prepared by the PIHP or CMHSP.

Penalty

If the PIHP or CMHSP fails to submit the required examination reporting package by June 30th following the contract year end and an extension has not been granted by MDHHS, MDHHS may withhold from current funding five percent of the examination year's grant funding (not to exceed $200,000) until the required reporting package is received. MDHHS may retain the withheld amount if the reporting package is delinquent more than 120 days from the due date and MDHHS has not granted an extension.

Incomplete or Inadequate Examinations

If MDHHS determines the examination reporting package is incomplete or inadequate, the PIHP or CMHSP, and possibly its independent auditor will be informed of the reason of inadequacy and its impact in writing. The recommendations and expected time frame for resubmitting the corrected reporting package will be provided to the PIHP or CMHSP.

Management Decision

MDHHS will issue a management decision on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination report within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the examination finding and/or comment is sustained; the reasons for the decision and the expected PIHP or CMHSP action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, MDHHS may request additional information or documentation from the PIHP or CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the PIHP or CMHSP is included in the applicable contract.

If there are no findings, comments, and/or questioned costs, MDHHS will notify the PIHP or CMHSP when the review of the examination reporting package is complete and the results of the review.

COMPLIANCE REQUIREMENTS

The practitioner must examine the PIHP's or CMHSP's compliance with the A-J specified requirements based on the specified criteria stated below related to the Medicaid Contract and GF Contract. If the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the K-M specified requirements based on the specified criteria stated

below that specifically relate to the CMHS Block Grant, but only if the CMHSP's total contract amount for the CMHS Block Grant is greater than $100,000. If the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the N-P specified requirements based on the specified criteria stated below that specifically relate to the SAPT Block Grant.

COMPLIANCE REQUIREMENTS A-J
(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

The final FSRs (entire reporting package applicable to the entity) comply with contractual provisions as follows:

a. FSRs agree with agency financial records (general ledger) as required by the reporting instructions. (Reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).
b. FSRs include only allowed activities as specified in the contracts; allowable costs as specified in the Federal cost principles (located at 2 CFR 200, Subpart E)(GF Contract, Section 6.6.1; and Medicaid Contract, Section 7.8); and allowed activities and allowable costs as specified in the Mental Health Code, Sections 240, 241, and 242.
c. FSRs include revenues and expenditures in proper categories and according to reporting instructions.

Differences between the general ledger and FSRs should be adequately explained and justified. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule." Any reported expenditures that do not comply with the Federal cost principles, the Code, or contract provisions must be shown on the auditor's "Examined FSR Schedule."

The following items should be considered in determining allowable costs:
Federal cost principles (2 CFR 200.402) require that for costs to be allowable they must meet the following general criteria:

a. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under the principles.
b. Conform to any limitations or exclusions set forth in the principles or in the Federal award as to types or amount of cost items.
c. Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
d. Be accorded consistent treatment.
e. Be determined in accordance with generally accepted accounting principles.

f. Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period.
g. Be adequately documented.

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness criteria of 2 CFR Part 200, Subpart E – Cost Principles, 200.404 was met. If subcontractors are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). When the PIHP pays FQHCs and RHCs for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported rental costs for **less-than-arms-length transactions** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (c)). For example, the agency may rent their office building from the agency's board member/members, but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in 2 CFR Part 200.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (b)).

Capital asset purchases that cost greater than $5,000 must be capitalized and depreciated over the useful life of the asset rather than expensing it in the year of purchase (2 CFR Part 200, Subpart E – Cost Principles, 200.436 and 200.439). All invoices for a remodeling or renovation project must be accumulated for a total project cost when determining capitalization requirements; individual invoices should not simply be expensed because they are less than $5,000.

Costs must be allocated to programs in accordance with relative benefits received. Accordingly, **Medicaid costs must be charged to the Medicaid Program and GF costs must be charged to the GF Program**. Additionally, **administrative/indirect costs** must be distributed to programs on bases that will produce an equitable result in consideration of relative benefits derived in accordance with 2 CFR Part 200, Appendix VII.

Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported in accordance with the standards listed in 2 CFR Part 200, Subpart E – Cost Principles, 200.430 (i).

B. CRCS Reporting

The final CRCSs comply with reporting instructions contained in the contract (General Fund Contract, Section 7.8; and Medicaid Contract, Section 8.7, and reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).

C. Real Property Disposition

The PIHP's or CMHSP's real property disposition (for property acquired with Federal funds) complied with the requirements contained in 2 CFR 200.311.

D. Administration Cost Report

The most recently completed PIHP's or CMHSP's Administration Cost Report complies with the applicable CMHSP/PIHP Administration Cost Reporting Instructions and the applicable standards in ESTABLISHING ADMINISTRATIVE COSTS WITHIN AND ACROSS THE CMHSP SYSTEM and contract provisions (instructions located at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html and reference guidelines located at http://www.michigan.gov/documents/mdch/Establishing_Admin_costs_480633_7.pdf).

E. Procurement

The PIHP or CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326. The PIHP or CMHSP ensured that organizations or individuals selected and offered contracts have not been debarred or suspended or otherwise excluded from or ineligible for participation in Federal assistance programs as required by 45 CFR 92.35.

F. Rate Setting and Ability to Pay

The PIHP/CMHSP determined responsible parties' insurance coverage and ability to pay before, or as soon as practical after, the start of services as required by MCL 330.1817. Also, the PIHP/CMHSP annually determined the insurance coverage and ability to pay of individuals who continue to receive services and of any additional responsible party as required by MCL 330.1828. Also, the PIHP/CMHSP completed a new determination if informed of a significant change in a responsible party's ability to pay as required by MCL 330.1828. Medicaid eligible consumers are deemed to have zero ability to pay so there is no need to determine their ability to pay. The one exception is during the period when a Medicaid eligible consumer has a deductible. In that case, an ability to pay determination does apply.

The PIHP's or CMHSP's charges for services represent the lesser of ability to pay determinations or cost of services according to MCL 330.1804. Cost of services means the total operating and capital costs incurred according to MCL 330.1800. In the comparison of cost to ability to pay the practitioner may consider a cost based rate sheet or other documentation that is supported by cost records as evidence of costs of services.

G. Internal Service Fund (ISF)

The PIHP's Internal Service Fund complies with the Internal Service Fund Technical Requirement contained in Contract Attachment P 8.6.4.1 with respect to funding and maintenance.

H. Medicaid Savings and General Fund Carryforward

The PIHP's Medicaid Savings was expended in accordance with the PIHP's reinvestment strategy as required by Sections 8.6.2.2 and 8.6.2.3 of the Contract. The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

I. Match Requirement

The PIHP or CMHSP met the local match requirement, and all items considered as local match actually qualify as local match according to Section 7.2 of the General Fund Contract and Section 8.2 of the Medicaid Contract. Some examples of funds that do NOT qualify as local match are: (a.) revenues (such as workers' compensation refunds) that should be offset against related expenditures, (b.) interest earned from ISF accounts, (c.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (d.) donations of funds from subcontractors of the PIHP or CMHSP, (e.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSP's actual costs, and (f) donations of items that would not be an item generally provided by the PIHP or CMHSP in providing plan services.

If the PIHP or CMHSP does not comply with the match requirement in the Mental Health Code, Section 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

J. Fee for Service Billings (CWP and SED Waiver Program)

The CMHSP's billings to MDHHS for the Children's Waiver Program (CWP) and the Waiver for Children with Serious Emotional Disturbances (SED Waiver Program) represent the actual direct cost of providing the services in accordance with Sections 4.7 (SED Waiver) and 6.9.7. (CWP) of the CMHSP Contract. The actual direct cost of providing the services include amounts paid to contractors for providing services, and the costs incurred by the CMHSP in providing the services as determined in accordance

with 2 CFR Part 200. Benefit plan administrative costs are not to be included in the billings. Benefit plan administrative costs related to providing services must be covered by general fund or local revenue, and while reported with program costs they must be covered by redirects of non-federal funds on the FSR MDHHS provides reimbursement for the actual direct costs or the Medicaid fee screen amount, whichever is less, according to the approved Waiver documents.

COMPLIANCE REQUIREMENTS K-M

(APPLICABLE TO PIHPs/CMHSPs WITH A CMHS BLOCK GRANT OF GREATER THAN $100,000 THAT DID NOT HAVE A SINGLE AUDIT OR THE CMHS BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

K. CMHS Block Grant - Activities Allowed or Unallowed

The CMHSP expended CMHS Block Grant (CFDA 93.958) funds only on allowable activities in accordance with Federal Block Grant provisions and the Grant Agreement between MDHHS and the CMHSP.

L. CMHS Block Grant - Cash Management

The CMHSP complied with the applicable cash management compliance requirements contained in the Federal Block Grant Provisions. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by CMHSP funds before reimbursement is requested from MDHHS.

M. CMHS Block Grant - Subrecipient Management and Monitoring

If the CMHSP contracts with other subrecipients ("subrecipient" per the 2 CFR Part 200.330 definition) to carry out the Federal CMHS Block Grant Program, the CMHSP complied with the Subrecipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h)

COMPLIANCE REQUIREMENTS N-P

(APPLICABLE TO PIHSs/CMHSPs WITH A SAPT BLOCK GRANT of Greater than $100,000 THAT DID NOT HAVE A SINGLE AUDIT OR THE SAPT BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

N. SAPT Block Grant – Activities Allowed or Unallowed

The CMHSP expended SAPT Block Grant (CFDA 93.959) funds only on allowable activities in accordance with the Federal Block Grant Provisions and the Grant Agreement between MDHHS and the CMHSP.

O. SAPT Block Grant – Cash Management

The CMHSP complied with the applicable cash management compliance requirements that are contained in the Federal Block Grant Provisions. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by CMHSP funds before reimbursement is requested from MDHHS.

P. SAPT Block Grant – Subrecipient Management and Monitoring

If the CMHSP contracts with other subrecipients ("subrecipient" per the 2 CFR Part 200.330 definition) to carry out the Federal SAPT Block Grant Program, the CMHSP complied with the Subrecipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h).

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDHHS. Also, PIHPs are required to keep affiliate CMHSP's reports on file for three years from date of receipt. All examination working papers must be accessible and are subject to review by representatives of the Michigan Department of Health and Human Services, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and provider network CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2016/2017 examinations. Any questions relating to these guidelines should be directed to:

John Duvendeck, Director
Division of Program Development, Consultation & Contracts
Bureau of Hospitals and Behavioral Health Administration
Michigan Department of Health and Human Services
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Lansing, Michigan 48913
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Phone: (517) 241-5218 Fax: (517) 335-5376

GLOSSARY OF ACRONYMS AND TERMS

AICPA.....American Institute of Certified Public Accountants.

Children's Waiver.....The Children's Waiver Program that provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the program who, if not for the availability and provisions of the Waiver, would otherwise require the level of care and services provided in an Intermediate Care Facility for the Mentally Retarded. Payment from MDHHS is on a fee for service basis.

CMHS Block Grant Program.The program managed by CMHSPs under contract with MDHHS to provide Community Mental Health Services Block Grant program services under CFDA 93.958.

CMHSP.....Community Mental Health Services Program (CMHSP). A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended.

Examination Engagement.....A PIHP or CMHSP's engagement with a practitioner to examine the entity's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 10 – Compliance Attestation – AT 601 (Codified Section of AICPA Professional Standards).

GF Program.....The program managed by CMHSPs under contract with MDHHS to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.

MDHHS .....Michigan Department of Health and Human Services

Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by PIHPs under contract with MDHHS.

PIHP.....Prepaid Inpatient Health Plan. In Michigan a PIHP is an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the

requirements of 42 CFR Part 438. The PIHP, also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program, also manages the Autism iSPA, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.

Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.

Serious Emotional Disturbances Waiver.....The Waiver for Children with Serious Emotional Disturbances Program that provides services to children who would otherwise require hospitalization in the State psychiatric hospital to remain in their home and community. Payment from MDHHS is on a fee for service basis.

SSAE.....AICPA's Statements on Standards for Attestation Engagements.

SAPT Block Grant Program ..The program managed by PIHPs under contract with MDHHS to provide Substance Use Services Block Grant program services under CFDA 93.959.

SUD Services.....Substance Use Disorder Services funded by Medicaid, Healthy Michigan, and the "Community Grant" which consists of Federal SAPT Block Grant funds and State funds.

REGION#

2013 Application for Participation

For Specialty Prepaid Inpatient Health Plans

Michigan Department of Health & Human Services Behavioral Health & Developmental Disabilities Administration
2/6/2013

Table of Contents

A. Introduction **Page 3**

B. Instructions **Page 9**

C. MDCH Decisions **Page 11**

D. The Application

1. Governance **Page 13**

2. Administrative Functions

- **2.1. General Management** **Page 19**
- **2.2. Financial Management** **Page 23**
- **2.3. Information Systems Management** **Page 24**
- **2.4. Provider Network Management** **Page 28**
- **2.5. Utilization Management** **Page 30**
- **2.6. Customer Services** **Page 31**
- **2.7. Quality Management** **Page 32**

3. Accreditation Status **Page 33**

4. External Quality Review **Page 34**

5. Public Policy Initiatives

- **5.1. Regional Crisis Response Capacity** **Page 35**
- **5.2. Health and Welfare** **Page 38**
- **5.3. Olmstead Compliance** **Page 41**
- **5.4. Substance Use Disorder Prevention & Treatment** **Page 48**
- **5.5. Recovery** **Page 50**

A. INTRODUCTION

The purpose of the Michigan Department of Health & Human Services (MDHHS) 2013 Application for Participation (AFP) for re-procurement of Medicaid Specialty Prepaid Inpatient Health Plans (PIHPs) is to describe the necessary information and documentation that will be required from the applicant to determine whether the Urban Cooperation Act (UCA) formed entity or the Regional Entity applicant, (jointly governed by the sponsoring Community Mental Health Services Programs(CMHSPs)), meets the MDCH requirements for selection to be certified to Center for Medicare and Medicaid Services as a PIHP effective January 1, 2014.

The AFP is the official vehicle which begins solicitation and selection for the PIHPs for the state-defined regions. Specifically, the AFP identifies the plan for meeting the required functions of the PIHP, including identification of functions that are to be direct-operated, delegated and/or contracted within and outside the sponsoring CMHSPs.

The AFP requires response in the following areas: Governance, Administrative Functions including general management and financial, Information Systems Management, Provider Network Management, Utilization Management, Customer Service, Quality Management, Accreditation, External Quality Review, and Public Policy initiatives including crisis response capacity, health and welfare, Olmstead compliance, substance abuse prevention and treatment capacity, and recovery.

In recognition of the short timeframe between issuance of this AFP and the April 1st due date for the response, MDHHS will allow an extended response time, up to 5 p.m. on July 1st, for some items so noted in this document. However, an application is not considered complete until all items requested in the AFP are submitted.

Similar to the 2002 Application for Participation, this AFP is targeted first exclusively to entities comprised of Michigan CMHSPs in compliance with Michigan's application for renewal of its 1915(b) Specialty Services and Supports Waiver. In the waiver application, Michigan proposed that a first opportunity should be afforded to CMHSPs since these entities have the necessary expertise with the target populations and strong coordination linkages with other community agencies; control other resource streams (e.g., state funds); sustain local systems of care; have already made durable investments in specialized care management strategies and unique service/support arrangements; and have statutorily prescribed protection, equity and justice functions important to individuals, policymakers and Michigan's citizens.

This AFP is intended to re-procure the PIHPs based on new regional boundaries drawn by the MDHHS. There will be one PIHP selected per region, and that PIHP will manage the Medicaid specialty benefit for the entire region defined by the MDHHS. The PIHP will contract with CMHSPs and other providers within the region to deliver services. It is relevant to note that beginning October 1, 2013, plans for merging Coordinating Agency functions within the CMHSP system must be developed and initiated, with full compliance (merger of functions) with the law (P.A. 500 and 501) by October 1, 2014. This application response will supply information regarding the activities aimed at reaching these goals, and expected roles and timeframes, as much as they are known to the applicant and member CMHSPs at the time of response.

The only acceptable legal arrangements for affiliation going forward will be either UCA agreements or creation of a regional entity under Section 1204b of the Mental Health Code. In either case, such intergovernmental affiliation formations result in the creation of a new legal entity jointly "owned" and governed by the sponsoring CMHSPs. It is this entity that will be considered, recognized and designated as the PIHP (for a region consisting of more than one CMHSP).

As described in the November 26, 2012, "Discussion Draft", the key objective of this new management entity is to balance and obtain the best two opposites while avoiding the limits of each. The new regional structure must consolidate authority and core functions, while simultaneously promoting local responsiveness. (Please reference the "Discussion Draft-Version 2, November 26, 2012, for further details).

Policies and procedures for "Provider Network Services," "Provider Procurement," "Provider Credentialing" and "Customer Services" must be maintained by the regional entity, with common provider application processes throughout the region. The processes and functions MAY be decentralized among more than one entity or CMHSP, but each decentralized unit will be acting under the common policies and procedures of the UCA/Regional Entity. A provider then, moving from one CMHSP to another to provide service should not experience repeated and different application and procurement processes to become a Medicaid provider in a new CMHSP within the same regional entity.

The regional entity policies and procedures for Provider Services need to include the full breadth of what may be needed by any single CMHSP to respond to local need and to take advantage of increasing opportunity for participating in accountable and integrated systems of care with local partners. An individual CMHSP should not be hindered from participating in opportunities to provide integrated and accountable care to serve the Medicaid population in its catchment area. The objective of this new entity is to balance and obtain the best of both opposites (local control/responsiveness and regional standards/consistency), while avoiding the limits of each.

As with the original AFP, this application process differs from typical request for proposal processes because a) the bid does not include pricing; and b) the process is not competitive at this stage. Applicants are indicating their capacity and commitment to performance in a variety of areas. Pricing is determined by the MDHHS in compliance with Medicaid regulations, the 1915(b) waiver, and state appropriations and will be shared with applicants prior to contract negotiations to commence in the Spring of 2013.

Other significant MDHHS policy decisions impacting applicants that need to be considered are as follows:

1. Capitation Payments and Data Files

   The base capitation rates and methodology are currently under evaluation by actuaries. The MDHHS intends to re-develop rate structures, methodologies and adjusters that increase the percentage of the ratio reflecting morbidity and decrease the percentage that is based on history/geography. In the 2012-2013 year, the ratio is 50/50 morbidity/geography. MDHHS will be increasing the percentage of the ratio that reflects morbidity each year. Ultimately, MDHHS will be moving to methodologies that are built on a common statewide rate structure where adjusters are entirely based on morbidity differences or cost of living methodologies common to other areas of health care. MDHHS will utilize common actuarial methodologies statewide, as approved by CMS. The concurrent 1915(c) Habilitation Supports Waiver allocation of certificates will also be adjusted based on factors such as the number of people with developmental disabilities served within the region, thus moving away from current historical allocation.

   The data files distributed will be a single file for each consolidated service area. This file will be available only to the PIHP. The PIHP must have the capacity to provide information to and collect information from the individual CMHSPs within the region in compliant, efficient and helpful formats for use by the CMHSPs in understanding the broad scope of enrollees, trends and utilization of the individual CMHSP and as it compares to the other members within the region.

   Single CMHSP PIHPs will be required to report both the administrative cost of PIHP functions borne directly by the PIHP and those PIHP functions carried out by the CMHSP, CMHSP core providers, and managed comprehensive provider networks (MCPNs). To promote full transparency of PIHP and administrative costs, MDHHS will require reporting of administrative costs of both the PIHP itself, and administrative costs for direct services for the CMHSP. MDHHS intends to place a cap on the administrative cost percentage for CMHSP direct services.

2. Sub-capitation

An applicant may sub-capitate for shared risk with its provider network, including CMHSPs, MCPNs, and core providers. The actuarially-sound methodology and rates for sub-capitation, by contractor, must be submitted to MDHHS. MDHHS retains the right to disapprove any sub-capitation arrangement that is determined not to be actuarially sound or where the arrangement has a high probability to adversely impact the State's risk-sharing. Sub-capitation rates shall be reasonable when compared to other service rates for similar services. Sub-capitation shall not contribute to risk reserve accumulation that exceeds seven and one-half percent (7.5 percent) of annual per eligible/per month, or an amount consistent with Governmental Accounting Standards Board Statement 10, whichever is less, within the applicant's region.

3. Internal Service Fund (ISF)

The ISF risk reserves that exist on December 31, 2013, for PIHPs whose geographically boundaries have not changed may be continued under the new contract, up to the level justifiable by Governmental Accounting Standards Board Statement 10 and the current ISF Technical Requirement (MDHHS/PIHP Contract Attachment 7.7.4.1). For PIHP regions where the geography has changed, (such as individual CMHSPs entering and exiting PIHP regions and PIHP regions combining), MDHHS will work with actuaries to determine the percentage of the ISF that shall move to the new PIHP for purpose of servicing the enrollees that move to the new PIHP region. It is expected that the actuarially-determined amount of the ISF to be transferred to the new PIHP will be based on prior fiscal years enrollee data, summarized by diagnoses for those belonging to the exiting CMHSP.

4. Integrated Care

All PIHPS will be required to have and provide upon request, signed agreements with all the Medicaid Health Plans (MHPs) in the region. The PIHPs and MHPs shall use the model coordination agreement provided in the contract as a foundational template. The Medicaid Health Plan contracts will contain the same requirement to have signed agreements with the PIHPs. Over the period of the upcoming waiver renewal cycle, new opportunities for integration with physical health care may become available in Michigan. MDHHS is exploring options such as Medicaid Health Homes (ACA section 2703) and Integrated Care Dual Eligible Demonstrations (Medicare/Medicaid). Four of the new PIHP regions have been selected as the Dual Eligible Demonstration sites: Regions 1, 4, 7 and 9; others may be selected to participate in the integrated care opportunities. If approved by CMS, both the dual eligible and Medicaid Health Home opportunities will require contract amendments for PIHP regions selected to participate. The PIHPs in the Dual Eligibles regions will also require contracts with the Integrated Care Organizations in order to accomplish the Care Bridge functions and desired outcomes of integrated Medicare and Medicaid-funded behavioral health and physical health care.

5. Performance Monitoring and Incentives

MDHHS will be implementing a performance incentive structure for the Medicaid PIHPs. During each contract year, MDHHS will withhold a portion of the approved capitation payment from each PIHP (range to be determined, but likely to be between .02 and .015). These funds will be used for the PIHP performance incentive awards. These awards will be made to PIHPs according to criteria pre-established by MDHHS. The criteria will include assessment of performance from areas such as: access, health and welfare, and compliance with the Balanced Budget Act (BBA) per External Quality Review, including performance measure data validation. In 2014, the two areas of focus will be PIHP proper and complete reporting of monetary amounts and billing/rendering provider; and completeness of Quality Improvement health conditions and developmental disabilities characteristics data.

6. Program Integrity and Compliance

A strong compliance and program integrity system is critical to all managed care systems. All PIHPs shall comply with 42 CFR 438.608 Program Integrity requirements. This includes key functions to be owned by the PIHP such as: designation of a compliance officer for the PIHP, region wide policies and procedures showing commitment to comply with federal and state laws, training and education for the compliance officer and employees, clear lines of communication with the compliance officer, discipline and enforcement, internal monitoring and auditing and prompt response to detected offenses. The state is seeking more detail on program integrity and compliance programs than has been required in past applications.

7. Sanctions

MDHHS will utilize a variety of means to assure compliance with applicable requirements. MDHHS will pursue remedial actions and possibly sanctions, including intermediate sanctions as described in 42 CFR 438.700, as needed, to resolve outstanding contract violations and performance concerns. The use of remedies and sanctions will typically follow a progressive approach, but MDHHS reserves the right to deviate from the progression, as needed, to seek correction of serious, repeated, or patterns of substantial non-compliance or performance problems. The application of remedies and sanctions shall be a matter of public record.

The range of contract remedies and sanctions MDHHS will utilize include:

A. Issuing a notice of the contract violation and conditions to the PIHP with copies to the Board.

B. Requiring a plan of correction and status reports that becomes a contract performance objective.

C. Imposing a direct dollar penalty, making it a non-matchable PIHP administrative expense and reducing earned savings from that fiscal year by the same dollar amount.

D. Imposing intermediate sanctions (as described in 42 CFR 438.700) that may include the following civil monetary penalties:

- A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to beneficiaries or health care providers.
- A maximum of $100,000 for each determination of discrimination or misrepresentation or false statements to CMS or the State.

E. For sanctions related to reporting compliance issues, MDHHS may delay up to 25% of scheduled payment amount to the PIHP until after compliance is achieved. MDHHS may add time to the delay on subsequent uses of this provision. (Note: MDHHS may apply this sanction in a subsequent payment cycle and will give prior written notice to the PIHP.)
F. Initiate contract termination.

The following are examples of compliance or performance problems for which remedial actions, including sanctions, can be applied to address repeated or substantial breaches, or reflect a pattern of non-compliance or substantial poor performance. This listing is not meant to be exhaustive, but only representative.

A. Reporting timeliness, quality and accuracy.
B. Performance Indicator Standards.
C. Repeated Site-Review non-compliance (repeated failure on same item).
D. Failure to complete or achieve contractual performance objectives.
E. Substantial inappropriate denial of services required by this contract or substantial services not corresponding to condition. Substantial can be a pattern, large volume or small volume but severe impact.
F. Repeated failure to honor appeals/grievance assurances.
G. Substantial or repeated health and/or safety negligence.

8. Transition To State Defined Regions:

The applications submitted in response to the AFP must demonstrate that the PIHPs are able to meet, or have viable plans with specified dates for completion of requirements. Because of the complexity and transition time needed to move some functions from single CMHSPs as PIHPs to fewer and regional entities as PIHPs, this AFP allows the applicant to specify target dates beyond April 1, 2013, for some of the functions.

MDHHS reserves the right to require the milestone target dates be adjusted in order for a conditional (or provisional) award to be granted. Should the milestone target dates not be met, MDHHS reserves the right to notify CMS the PIHP no longer meets requirements for continuing to function as the PIHP. MDHHS may then give notice of termination of the contract and proceed to seek another entity to manage the PIHP functions for that region. A new managing entity could be either a neighboring PIHP or a non-CMHSP-governed entity selected to manage the region through a competitive process (with assurances to maintain the statutory purposes the local CMHSP).

B. INSTRUCTIONS

Since 2002, the PIHPs have managed Medicaid specialty services and supports and carried out their responsibilities for ensuring beneficiary freedom, opportunities for achievement, equity, and participation consistent with the history and mission of CMHSPs. MDHHS has been responsible for assuring that PIHPs are in compliance with federal laws and regulations, state Medicaid policy, the Michigan Mental Health Code and Administrative Rules, and the contract between MDHHS and the PIHPs. To that end, MDHHS will use the results of performance and contract monitoring and external quality reviews for existing PIHP (where the new entity adopts the policies of an existing PIHP) and, as applicable, for CMHPs to inform its review of an applicant's suitability to become a new PIHP.
In 2009, MDHHS and the PIHPs engaged in a comprehensive quality improvement effort called "Focusing a Partnership for Renewal and Recommitment to Quality and Community in the Michigan Public Mental Health System" referred to as the ARR). The ARR addressed updated (from 2002) public policy considerations. PIHPs with the assistance of community stakeholders, performed environmental scans and developed plans for improvement where they found the need. MDHHS and PIHP staff worked together as PIHPs made progress in achieving their own goals.

The 2002 AFP and the 2008 ARR are the foundation of the Medicaid Specialty Supports and Services program and the vision and values, and public policy they addressed – such as person-centered planning and self-determination, and culture of gentleness– are still highly regarded, and while not addressed in this AFP, will continue to be part of the contracts between MDHHS and the new PIHPs to fulfill provider network adequacy and capacity requirements for the covered specialty services.

This 2013 AFP is also built upon documents that have been the foundation of the Specialty Services and Supports Program since 2002: the FY'12-13 amended 1915(b) Waiver for Specialty Services and Supports, and the FY'13 MDHHS/PIHP contracts and the attachments. Finally, it is expected that the applicants are compliant or are able to become compliant with the 1997 Balanced Budget Act, 42 CFR Part 438, and the External Quality Review Protocols.

This 2013 AFP addresses primarily those public policy areas that are new or evolving; and raises expectations for certain administrative capabilities that a mature specialty managed care system such as Michigan's should be able to demonstrate. This AFP solicits applicant information in the following: Governance; Administrative Functions including General Management, Financial Management, Information Systems Management, Provider Network Management, Utilization Management, Customer Service, Quality Management; Accreditation Status; External Quality Review; and the following Public Policy initiatives: Crisis Response Capacity, Health and Welfare, ADA/Olmstead Compliance, Substance Use Disorder Prevention and Treatment, and Recovery.

We have placed links to documents referred to on this page and other helpful resources identified throughout this AFP on the MDHHS web site's Mental Health and Substance Abuse page.

Responses to this AFP shall be entered in the electronic version of this document in the boxes, tables and spaces provided. Supplementary information shall be attached as instructed and labeled with the requested Attachment number.

Certain items in the application may be submitted subsequent to the April 1st due date but **no later than 5 p.m. on July 1, 2013. However, the applicant is cautioned that an application will not be considered complete until all items requested have been submitted.** An incomplete application as of July 2, 2013, will result in loss of first opportunity to CMHSPs in the region (through Urban Cooperation Act or Regional Entities). The state will then proceed to open the region to competitive bid.

Please adhere to the page count limitation specified for text boxes and use no smaller than 12-point font. Some text boxes have limits on the number of characters that can be inserted.

Label each attachment with the Region number and item number, save all attachments in PDF into one document, and submit as instructed below.

Responses must be submitted electronically to Marlene Simon at SimonM4@michigan.gov by 5 p.m. on April 1, 2013. Items submitted electronically between April 1, 2013 and July 1, 2013 are to be labeled with the applicant's region number, the AFP section number and are to adhere to the page count limitation.

C. MDCH DECISIONS

Applications will be reviewed by MDHHS staff in the two weeks following submission. MDHHS reserves the right to conduct a short site review to interview staff or stakeholders, and/or to follow up on any responses received via this application that are unclear or incomplete.

The review of applications, scoring, and site visits will result in one of three decisions below that will be announced by the Department following the conclusion of these activities:

1. Award without conditions means that MDHHS will contract with the applicant without changes required in the application and without any conditions for meeting target dates for milestone activities. This action will be announced in early June 2014. Announcement may be as late as July 2, 2013, where items from the application noted as allowable for two-part submission are delayed. Contracts will be signed in December 2013, effective January 1, 2014.

2. Award with conditions means that MDHHS requires that either or both: a) certain improvements must be completed or plans of correction approved before it will contract with the applicant; b) certain milestones must be met by target dates for initiating contract and/or continued contracting as the PIHP for the region. This action will be announced in July 2013, where application is incomplete due to awaiting legal documents or other specifically noted items. Conditions must be met by a date specified in the award announcement. In Wayne County condition may also include transition to authority status by October 1, 2013, as per Public Acts (P.A.) 375 and 376 of 2012. Following the MDHHS acceptance of improvements or plans of correction needing resolution prior to January 1, 2014, contracts will be signed in December 2013, effective January 1, 2014.

3. Unsuccessful application means one or more of the following:
   a. The application was received after the deadline and will be returned to the sender immediately.
   b. The application did not pass the Governance Section. The application contained section(s) that failed to meet standards, and for which acceptable target milestones and timeframes were not provided. Notification of such a situation will be made within one week following the review of the application (approximately three weeks after the due date). If the application is incomplete due to items with allowable extended due date of July 1, 2013, notice of unsuccessful application will be made the first week of July 2013.
   c. The application lacked signatures from all CMHSPs in the state-defined region as authorized by appropriate action of all individual boards.
   d. Required legal documents (Urban Cooperation Act, Regional Entity) were not filed with the county clerks before July 1, 2013, for multi CMH regions.

e. Wayne County authority not created by October 1, 2013, as required by PA 375 and 376 of 2012.

4. Open Competitive Process means the following:
   a. In the event an unsuccessful application is received from a region, MDHHS will proceed with an open competitive bid process specifically for that region.
   b. The vendor selected for a particular region via MDHHS's open competitive process will be the PIHP for that region, and will be required to report contractually to MDCH.
   c. An award of a bid via the open competitive bid process to an entity other than an Urban Cooperative Act or Regional Entity formed by the CMHSPs in that region will not require that PIHP to have CMHSP representation on its board.

Applicants may appeal the decisions in number three above by delivering or faxing a letter requesting reconsideration, within two days of receipt of the notification, to:

Lynda Zeller, Deputy Director
Michigan Department of Health & Human Services
Lewis Cass Building, Fifth Floor
320 S. Walnut Street
Lansing, Michigan 48913
FAX (517) 335-4798

D. THE APPLICATION

1. GOVERNANCE

This section will receive a "pass" or "fail" determination. If any one item receives a fail determination, it will stop the application from further consideration. A fail determination will result from the applicant's answer of either **"no" without sufficient justifiable narrative included** or **an answer of N/A (not applicable) for an application consisting of an affiliation of CMHSPs**. Failed applicants will be notified within one week following review of the application (approximately three weeks after the due date).

The AFP affords initial consideration for specialty prepaid inpatient health plan designation to qualified single county or regional entities (organized under Section 1204b of the Mental Health Code or Urban Cooperation Act). Therefore, the first and most basic requirement is that the organization submitting an application, be comprised of and jointly, representatively governed by all CMHSPs in the region pursuant to Section 204 or 205 of Act 258 of the Public Acts of 1974, as amended in the Mental Health Code.

Check all boxes that are appropriate to the applicant as it will be January 1, 2014

1.1 ☐ Applicant is the sole CMHSP in a state-defined region and is currently one of the following:

- 1.1.2 ☐ County CMH Agency.
- 1.1.3 ☐ Community Mental Health Organization.
- 1.1.4 ☐ Community Mental Health Authority (Required for Wayne County).

OR

1.2 ☐ Applicant is an entity jointly governed by all CMHSPs in a state-defined region and has one of the following legal arrangements:

- 1.2.1 ☐ Section 1204b Regional Entity as defined in Mental Health Code
- 1.2.2 ☐ Urban Cooperation Act (UCA)

1.3 ☐ In Attachment 1.3 is a plan for the legal entity to be finalized with action steps, responsible parties, and timeframes. By no later than 5 p.m. on July 1, 2013, the legal entity shall have by-laws filed with the county clerk, and all member CMHSP board approvals have been completed.

An application for a region comprised of more than one CMHSP shall submit, no later than 5 p.m. on July 1, 2013, one hard copy of the original signed legal documents that establish or validate that the entity making application has status as a Regional Entity under Section 1204b of the Mental Health Code or through Urban Cooperation Act and, where applicable, has the legal basis to enter into a contractual commitment with the Department for a consolidated application for multiple CMHSP service areas. *(These items need not be scanned and submitted electronically. They must, however, be appropriately labeled with the Region number and suitable cover sheets.)* Note: where an application is being made by a single CMHSP, appropriate documentation is currently on file with the MDHHS, with the exception of Wayne County which will require proof of Authority Status no later than

October 1, 2013. **Submit the hard copy legal documents to Thomas Renwick, Director, Bureau of Community Mental Health Services, 5th Floor Lewis Cass Building, 320 South Walnut Street, Lansing, Michigan 48913.**

1.4 ☐ An original signed paper copy of the legal document(s) including by laws and enabling resolutions that establish or validate that the entity making application has a status as a Regional Entity or entity formed by Urban Cooperation Act has been submitted concurrent with this application.

OR

1.5 ☐ The legal document(s) will be submitted no later than 5 p.m. on July 1, 2013. **The application will not be considered complete until the legal document(s) have been submitted to MDHHS, no later than 5 p.m. on July 1, 2013.**

The legal document(s) addresses the following:

1.4.1 ☐ The relationship between the parties.
1.4.2 ☐ The roles of each party to the agreement.
1.4.3 ☐ The rights of each party to the agreement.
1.4.4 ☐ Governance arrangements and conditions.
1.4.5 ☐ Functional consolidation of administrative activities.
1.4.6 ☐ Assurances that all members will comply with federal and state standards and regulation and what processes exist to address non-compliance.
1.4.7 ☐ The financial arrangements and interests of each party to the agreement including, but not limited to: cost-sharing, cost-allocations, local match obligations related to Medicaid funds, fund transfers, re-purchase (contracting back) arrangements, resource/asset claims, liability obligations, risk obligations, risk management, contingencies, areas of limitations, and areas of exclusions.
1.4.8 ☐ Established dispute resolution mechanism(s) between the affiliates.
1.4.9 ☐ Identification of the designated regional entity to act as the prepaid inpatient health plan by all CMHSPs within the region.

1.6 ☐ In the text box below is a list of the PIHP board member categories (e.g., person who receives services, family member of a person who receives services, person with a disability, advocate, provider, county commissioner, CMH representative, community member), the number of people to serve in each category, their affiliation (e.g., county), and if known at the time of application, but no later than July 1, 2013, the name of each PIHP board member.
1.6

MDHHS shall review the applicant's, and CMHSP member status regarding compliance with certification criteria, Section 232 of the Mental Health Code. In order to assure adequate specialty services network and capacity, applications will be reviewed to assure all CMHSPs within the consolidated application meet the criteria. To be referred for scoring of the

proposal, applicants must have substantial or provisional certification for each participant CMHSP within the region at the time of application.

MDHHS shall review the applicant's status regarding MCLA 330.1232a (6); Recipient Rights System. In order to assure adequate specialty services network and capacity, applications will be reviewed to assure all CMHSPs within the region have overall assessment scores of substantial compliance. To be referred for scoring of the proposal, applicants must be determined to have scores of substantial compliance with Recipient Rights System standards.

1.7 ☐ Assessment scores meet substantial compliance.

Because MDHHS continues to value and promote community involvement, there must be documentation that individuals who receive services, family members, and/or advocates representing each service area of the region, if applicable, and all populations served, including, adults with serious mental illness, children with serious emotional disturbance, children and adults with developmental disabilities, and children and adults with substance use disorders were involved in the development of this application.

1.8 ☐ In Attachment 1.8 is a signed statement attesting to consumer/stakeholder involvement.

1.9 ☐ In Attachment 1.9 is a narrative of no more than three pages that defines the vision and values of the stand-alone applicant, or of the UCA/regional entity. Include within the narrative a description of how the affiliation arrangement will actualize this vision and build upon the existing strengths of member CMHSPs. Explain how the PIHP will bring any members with deficits up to standard or acceptable performance.

1.10 ☐ In Attachment 1.10 is a curriculum vitae for the executive director of the applicant organization that verifies that the executive director of the applicant organization meets or exceeds the qualifications of an executive director as specified in Section 226(1) (k) of the Mental Health Code.

OR

1.11 ☐ The executive director of the applicant organization is unknown at the time of the submission of this application. The name and curriculum vitae will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

1.12 ☐ All text boxes are completed and all attachments required to be submitted are included with this Application for Participation response.

OR

1.13 ☐ Not all text boxes are completed and/or not all required attachments are being submitted with this AFP but will be submitted no later than 5 p.m. on July 1, 2013. It is understood that this is considered an *incomplete application.*

1.14 ☐ Name of contact person who can answer questions about this application: , telephone number: , E-mail address:

Additional Governance Responses Required of Wayne County:

MDHHS seeks a stable transition and the least disruption possible from County oversight to the newly authorized Authority beginning October 2013. No sooner than six months, but no later than nine months, after the Authority begins oversight and operations of the existing MCPN system, the Authority shall submit a written Plan (the Plan) for approval by MDHHS, for the re-procurement and implementation of specialty provider networks that will be administered by two or three Managers of Comprehensive Provider Networks (MCPNs). To achieve better integration and efficiency of administration, the Plan shall include requirements for at least two but no more than three MCPNs to oversee specialty networks that will provide a comprehensive array of services for each of the two primary target populations: (1) people with mental illnesses, substance use disorders, and serious emotional disturbance and 2) people with intellectual/developmental disabilities. Each of the MCPNs shall deliver person-centered, behavioral health or I/DD services, and coordinate those services with the physical health services to be delivered by Integrated Care Organizations in the State's demonstration for people with Medicare and Medicaid eligibility. The Plan shall be reviewed by the MDHHS. MDHHS shall approve the Plan once the MDHHS is confident in the stability of Authority's operations and has ensured that the Plan meets the requirements of this document.

1.14.1 ☐ The Wayne County applicant attests that it will submit, within the time frame noted above, the written Plan for re-procurement of MCPNs that includes all of the following:

a. A description of the process to ensure that there is always a choice of MCPNs (not less than two) for eligible recipients from the two population groups. The Plan shall also include policies and procedures that allow individuals the opportunity to move between MCPNs if they choose.
b. The proposed scope of services for the MCPN contract and procurement. It shall describe the structure and functions of the MCPNs, any legal requirements for corporate status, governance requirements, individual and family representation, financing and reimbursement, and other elements described below. The Plan shall describe the process for re-procurement of the MCPNs to achieve efficiency and care integration goals. The Plan shall include standards for MCPNs and their specialty provider networks on enrollment, person centered planning, care management, clinical service and utilization review standards, provider standards and physical and behavioral health service coordination and integration. The Plan shall also describe required administrative functions including provider network management, accounting, claims, data systems, reporting, after-hours coverage, quality improvement, member services and any other delegated responsibilities. Evidence (copies of public comment) that The Plan was made available for public review prior to submission to the MDHHS shall be provided. This shall include review by consumers, families and other advocacy groups. The Plan shall be approved by the CMHSP Board of Directors and any other applicable Boards and Authorities.
c. Evidence that the MCPNs shall be governed by provider members, members of the community or individuals with specialized experience. The Plan shall also

include plans for involving people with lived experience (either as consumers and or family members) in the governance of the PIHP, the MCPNs and perhaps in an advisory role for the specialty provider networks. The Plan shall also outline how the applicant and the MCPNs will employ people who have lived experience in key positions.

d. Identification of the functions that will be provided by the applicant, other public agencies and those delegated to the MCPNs. Specifically this shall include general management/administrative, financial management, information systems management, provider network management, utilization management, customer services, and quality management. The applicant shall demonstrate that it has examined the effects of this decision on care coordination, quality, cost, and availability. Particular attention will be paid to ways to minimize overall administrative costs. The applicant has also examined the implications of these plans for apparent or real conflicts of interest and has adjusted its policies and procedures as needed to minimize conflict.
e. Assurance that each MCPN or its provider network provides coverage to its target population a comprehensive and similar set of services for the entire geographic service area. The Plan may exempt MCPNs from providing certain highly-specialized or culturally-specific services (that may be provided centrally by the applicant or through other contracts) in order to ensure access to unique providers. The Plan shall outline steps to ensure that similar services and management activities are provided across the MCPNs while allowing for innovative approaches by each MCPN. This will include a common set of benefits and consistent policies for credentialing, care coordination, and access to care.
f. A description of the applicant's procedures for reimbursing the MCPNs, including how rates will be established for services for each population group and what incentives will be used to reimburse MCPNs and providers. This will also include a process for assessing the financial soundness of rates that are set on a capitated or case rate basis. MCPNs shall manage a population that is of sufficient size so that the rates are actuarially sound. The Plan shall also address how financial solvency of the MCPNs will be assessed upon selection and during their contract.
g. The process for MCPN oversight and monitoring. This shall include the implementation of sanctions, including corrective action plans, termination of MCPN enrollment, financial sanctions and contract termination, when the MCPN or its provider network no longer meets the applicant's requirement or standards.
h. Standards for MCPN reporting of data and a uniform set of performance measures and quality improvement protocols. These shall support all of the reporting that are consistent with the requirements for the PIHPs reporting to the MDHHS.
i. A description of how substance abuse (SA) services will be delivered to people in the service area. Specifically the Plan shall include language about the SA services that will be delivered by the MCPNs that focus on the behavioral health

population, and those that may be delivered by other organizations within the CMHSP and the PIHP.

j. Non-Compete terms that do not restrict the rights of MCPNs to contract with any qualified provider for their specialty networks if they meet the standards and criteria established by the applicant. Similarly, the Plan and MCPN contract terms shall ensure that no provisions of an MCPN's contracts shall restrict otherwise qualified providers from participating in more than one MCPN. However, providers may not have an ownership interest or governance relationship in more than one MCPN in which they also provide services.

k. Assurance that all provisions of the MDHHS's Application for Participation for procurement of Medicaid Specialty Prepaid Inpatient Health Plans (PIHP) are either retained as the responsibility of the PIHP or explicitly delegated by contractual terms to the MCPNs. Assurance that each of the re procured MCPNs will be fully operational not later than January 1, 2015.

l. The competitive procurement methodology which assures best value. The Plan shall outline a proposed process for a re-procurement of the existing MCPNs. The actual re-procurement shall be subject to MDHHS approval and will be implemented in the first year of this AFP. The re-procurement shall include policies and procurement criteria that ensure an adequate provider network, stakeholder and community input, and adherence to public policies and service standards that are unique to the needs of each target population.

1.14.2 ☐ Until the Plan is implemented, the Wayne County Authority applicant will have executed contracts with the existing MCPNs so that they are fully operational on January 1, 2014.

2. ADMINISTRATIVE FUNCTIONS

Descriptions and activities of the managed care administrative functions may be found in the document "Establishing Administrative Costs within and across the CMHSP System, December 2011" located at this site: www.michigan.gov/documents/mdch/Establishing_Admin_Costs_12-11_374192_7.pdf

Instructions: check the box provided to attest to the fact. Enter narrative in text boxes where instructed. Attach documents with labels as instructed at the end of the application.

2.1 General Management Functions

The four chief officers below shall be 100% dedicated to the general management functions of the applicant PIHP only. In other words, they may not have a concurrent role at a CMHSP. It is understood that a chief officer might have dual roles within the PIHP, such as managing the finance function AND the information systems function; or may be responsible for the operations function AND provider network management. Likewise the applicant may choose not to have a Chief Operating Officer.

MDHHS prefers that the chief officers are direct employees of the applicant PIHP. However, MDHHS will not prohibit arrangements that lease the officer from another entity, or that contract with a staffing agency. In such cases, MDHHS requires assurances that the officer is accountable solely to the applicant PIHP for purposes of fulfilling PIHP executive functions, and that there are protections against conflict of interest when decisions are made by the officer that impact the entity from which he/she is leased or contracted. The Regional Entity/UCA accepts full responsibility for managing conflicts and compliance with all laws and regulations including but not limited to those of the Internal Revenue Service. The Regional Entity/UCA accepts full responsibility for any and all liabilities resulting from a PIHP executive whose employer of record is a member CMH in the region.
In the boxes below the applicant shall attest that each chief officer is 100% dedicated to the applicant PIHP; that the CEO will be hired, supervised, and terminated, as necessary, by the PIHP governing board; and other chief officers will be hired, supervised, and terminated, as necessary, by the CEO.

2.1.1. **Chief Executive Officer (CEO)**

2.1.1.1 ☐ The chief executive officer is 100% dedicated to the applicant PIHP functions

2.1.1.2 ☐ The chief executive officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.1.2.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP CEO and the entity from

whom he/she is leased or contracted. The PIHP governing board will annually certify to MDHHS that it monitors the CEO and assures there are no conflicts of interest in decision-making and that it understands it maintains full responsibility for compliance with all laws and regulations including IRS and any consequences or liabilities resulting from the leased or contracted arrangement.

2.1.1.3 ☐ The chief executive officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and procedures, if applicable, will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.1.2. **Chief Operating Officer (COO)**

2.1.2.1. ☐ There will be no chief operating officer (if box is checked, applicant may skip to #2.1.3).

2.1.2.2 ☐ The chief operating officer is 100% dedicated to the applicant PIHP functions.

2.1.2.3 ☐ The chief operating officer is: % FTE; if less than 100%, identify the other functions that the chief operating officer will perform:

2.1.2.4 ☐ The chief operating officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.2.4.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP COO and the entity from whom he/she is leased or contracted.

2.1.2.5 ☐ The chief operating officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and procedures, if applicable, will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.1.3. **Chief Financial Officer (CFO)**

2.1.3.1 ☐ The chief financial officer is 100% dedicated to the applicant PIHP functions.

2.1.3.2 ☐ The chief financial officer is: % FTE; if less than 100% identify the other functions that the chief financial officer will perform:

2.1.3.3 ☐ The chief financial officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP,

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.3.3.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP CFO and the entity from whom he/she is leased or contracted.

2.1.3.4 ☐ The chief financial officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and

procedures, if applicable, will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.1.4. **Chief Information Officer (CIO)**

2.1.4.1 ☐ The chief information officer is 100% dedicated to the applicant PIHP functions.

2.1.4.2 ☐ The chief information officer is: % FTE; if less than 100% identify the other functions that the chief information officer will perform:

2.1.4.3 ☐ The chief information officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.4.3.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP CIO and the entity from whom he/she is leased or contracted

2.1.4.4 ☐ The chief information officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and procedures, if applicable, will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.1.5. **Other Executive Staff**

General Management of PIHP	% FTE Dedicated to the PIHP Function	Names (if known)* or "Unknown"	Employer of Record (If not PIHP, indicate whether leased or contracted by PIHP)
Medical Director			
Substance Use Disorder Prevention & Treatment Director			
Human Resources Director			
Compliance Officer/Program Integrity			

*☐ The name(s) is "unknown," it will be submitted to MDHHS along with the Employer of Record no later than 5 p.m. on July 1, 2013.

2.1.5.1 ☐ In Attachment 2.1.5.1 is an organizational chart that depicts the lines of supervision of each position from the PIHP Board and/or CEO.

2.1.5.2 ☐ The applicant attests that it will adopt one set of common General Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.1.5.3 ☐ The applicant attests that the General management policies and procedures used throughout the region will include Program Integrity and Compliance components outlined in 42 CFR 438.602 and 42 CFR 438.608.

2.1.5.4 ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.1.5.4. lists the General Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.1.5.5 ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.1.5.4. will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.2 Financial Management Functions

Financial management functions typically include: 1) budgeting – general accounting and financial reporting, 2) revenue analyses, 3) expense monitoring and management, 4) service unit and recipient-centered, 5) cost analyses and rate-setting, 6) risk analyses, risk modeling and underwriting, 7) insurance, re-insurance and management of risk pools, 8) supervision of audit and financial consulting relationships, 9) claims adjudication and payment, and 10) audits. The responses below should take into account those functions, and any other the applicant has identified.

2.2.1 ☐ In Attachment2.2.1 is an organizational chart that depicts the lines of supervision from executive staff and oversight of each of the ten Financial Management Functions above and any others the PIHP will be adding.

2.2.2 ☐ The applicant attests that it will adopt one set of common Financial Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.2.3 ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.2.3, lists the Financial Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.2.4 ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.2.4 will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.3 Information Systems Management

Overview

The PIHP must have an information management system that supports the core administrative activities of the region including:

a. The ability to accept on behalf of entire region of CMHSPs/CAs, enrollment and revenue files, in HIPAA compliant formats, from the State of Michigan.
b. The ability to accept clinical, financial, utilization, demographic, quality and authorization information from CMHSP/CA sources (including providers) in standard electronic formats (i.e., HIPAA Administrative Simplification X12N). Note if the CMHSP/CA/provider source is capable of sending in standard electronic formats, the PIHP must receive via standard electronic means versus requiring direct entry or non-standard format.
c. The ability to accept clinical, financial, utilization, demographic, quality and authorization information through clearinghouses and other viable, secure and efficient means when requested by CMHSP/CA sources and providers.
d. The ability to analyze, integrate and report clinical, financial, utilization, demographic, quality and authorization information.
e. The ability to submit QI and encounter data in compliant formats as specified by MDCH. Data must pass all required data quality edits prior to being accepted into CHAMPS before it is sent to the warehouse.
f. The ability to identify, analyze and report costs and revenues for service components, including, but not limited to, analysis and reporting by regions and CMHSP/CA sources and providers.
g. The ability to detect and correct errors in data receipt, transmissions and analyses. This includes screening for completeness, logic, and consistency; and identifying and tracking fraud and abuse.
h. The ability (within limits of law) to safely and securely send and receive data to and from other systems. This includes, but is not limited to, the State of Michigan, health plans and providers systems including physical health and non-healthcare support systems of care. (Note: If the PIHP region is selected to participate in Medicaid Health Homes and/or Integrated Care For Dual Eligibles demonstrations, the PIHP must be able to interface with health plans and provider systems).

For new entities representing multiple CMHSPs in a state-defined region:

a. The Information Technology Policies, Procedures and systems from one of the existing hub-PIHP/CMHSPs may be utilized as the foundation of the system for the new entity. (Note: this will allow former hub-PIHP/CMHSP performance as verified by MDHHS and external quality review organization to be considered in review of application submission).
b. The PIHP must have the ability to directly transmit and receive data from and to all individual CMHSP/CA sources without the additional step of going through

former hub-PIHP/CMHSP systems for sub-groups of CMHSPs in that same region. If more time is required for smooth transition to a single PIHP IT system supporting all CMHSPs/CAs in the region, then the applicant will list target date for completion. Award and contract with the PIHP entity will include successful transition by target date as a condition of the award and continuing contract past target date.

Response Criteria

Note: For PIHPs representing regions containing more than one CMHSP for each separate response below list the specific name of the former hub PIHP/CMHSP whose policies, procedures, processes and technologies are being adopted as the foundation for the new entity to be deployed region wide. This will allow past performance (as determined by MDHHS monitoring and/or third party reviewer) of a hub CMHSP as PIHP to be considered in review of application submission. This is expected to significantly decrease the length of response needed in this application submission and decrease additional information that may be requested by MDHHS during review of submission.

2.3.1 ☐ In Attachment 2.3.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each Information Systems function.

2.3.2 ☐ The applicant attests that it will adopt one set of common Information Systems Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.3.3 ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.3.3., lists the Information Systems Management policies and procedures and the PIHP(s) from which they were adopted.

OR

☐ The common policies and procedures are in development at the time of application, and the Attachment 2.3.3. will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.3.4 ☐ In the text box below is a two-page description, of the applicant's process detailing how behavioral health and I/DD data (clinical, encounter, claims, demographics, quality, outcomes) aggregated from all CMHSP/CA sources and providers will be:

a. Tested for accuracy and completeness prior to submission to MDCH. Also, describe the process of that submission.
b. Submitted in a timely fashion to MDHHS.
c. A consistent region-wide process by January 1, 2014.

2.3.4

2.3.5 ☐ More time is needed for transition, the date by which full transition from former PIHPs to new PIHP will be completed is: . In the one-page text box below are the action steps and milestone dates toward achieving a consistent region-wide process:

2.3.5.

2.3.6 ☐ In the text box below is a one-page description of the protection and security features of the PIHP's information management system to ensure confidentiality, data integrity and protection from intrusion. It includes:

a. The risk mitigation and management procedures for a loss of confidential data or security breach to include notification of affected consumers.
b. Confirmation that this will be a consistent region-wide process by January 1, 2014. If more time is needed for transition, list date by which full transition from former PIHPs to new PIHP will be completed: **(date)**

2.3.6

2.3.7 ☐ In Attachment 2.3.7. is a process/information flow diagram(s) and in the text box below is a one-page narrative explaining the following:

d. How individual information will be aggregated, stored and compiled by the PIHP from CMHSP/CA and provider network sources.
e. How data completeness, validation, timeliness and accuracy will be confirmed and coordinated with CMHSPs/CAs to ensure accurate and timely submission to MDCH (QI, encounter).
f. How eligibility/enrollment information will be received from the State and then parsed by the PIHP for use by the CMHSP(s)/CAs in the region.
g. How the PIHP information management system supports authorization and utilization management processes both those delegated and not delegated by the PIHP.

2.3.7

FUNCTIONS SUPPORTING INTEGRATED CARE (Physical, Behavioral/I/DD Supports and Services):

2.3.8 ☐ In the text box below is a one-page description of the steps that will be taken to exchange behavioral healthcare data with local/community partners, Sub-state HIEs (health information exchange), and/or MiHIN/NwHIN (Michigan Health Information Network/Nationwide Health Information Network) that includes:

a. Whether the PIHP will maintain a role in the exchange of HL7 CCD formats on behalf of CMHSPs in the region. If so, there is a description of the process to be used and how consent management will be engaged.
b. How the PIHP will use state and national standards for the transfer and interface of behavioral healthcare data (MI/DD/SUD clinical, encounter, claims, demographics, outcomes) between disparate systems (e.g., Care Bridge, Sub-state HIEs/MiHIN/NwHIN, health plans, providers, etc.).

2.3.8

2.3.9. ☐ In the text box below is a half-page description of the PIHP's capability and/or plan to conduct population-level data analytics from multiple healthcare sources (both primary and behavioral). This includes dashboard indicators and other data mining capabilities that facilitate population management (historical and predictive capacity for assessing cost/risk), utilization management, and care coordination activities.
2.3.9

2.3.10. ☐ In the text box below is a half-page description of the planned actions for engaging standards (statewide/national) that improve care coordination, reduce error, eliminate duplicative data entry efforts, and behavioral healthcare data access to the consumer (promoting meaningful use).
2.3.10

2.3.11. In the table below, name the CMHSPs and core providers who are utilizing EHRs. The name of the EHR software in use at each and whether purchased or developed in-house, and whether nationally certified should also be entered in the third column.

Note: It is not required to have a certified EHR at the PIHP level, but if one is available to the CMHSPs for use, owned by the PIHP, please make note. It is also understood that EHR certification standards are still evolving for purposes of behavioral health.

Table 2.3.11

CMHSP, MCPN, Core Provider Utilizing EHRs	EHR Software Used	Purchased or Developed In-House, and note if Certified

2.4 Provider Network Management

Provider Network Management typically includes the functions of 1) network development and procurement (and re-procurement), 2) provider contract management (including oversight), 3) network policy development, 4) credentialing, privileging and primary source verification of professional staff, and 5) background checks and qualifications of non-credentialed staff. The "provider network" of the PIHP includes as applicable, the member CMHSPs, MCPNs, Core Providers, or any other provider with which the PIHP has a direct contract to deliver a covered service. It is the responsibility of the PIHP to perform the functions above, and to assure that its provider network performs these functions in the management of any providers it procures.

In the text boxes below, provide a half-page description of how the PIHP will oversee the five functions listed above:

2.4.1. Network development and procurement.

2.4.2. Provider contract management and oversight.

2.4.3. Network policy development.

2.4.4. Credentialing, privileging and primary source verification of professional staff.

2.4.5. Background checks and qualifications of non-credentialed staff.

2.4.6. ☐ In Attachment 2.4.6. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.4.7. ☐ The applicant attests that it will adopt one set of common Provider Network Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.4.8. ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.4.8., lists the Provider Network Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.4.9. ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.4.9. will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.4.10. ☐ In the text box below is a one-page description of how the applicant will assure that the capacity of the provider network is sufficient to make available all the specialty services and supports in the entire region. Include how capacity will be measured. Include how the applicant will assure that existing standards for geographic access and timeliness of access to the services will be met within the region in accordance with 42 CFR 438.206.

2.4.10.

2.4.11. ☐ In the text box below is a one-page description of how the applicant will perform oversight of its provider network to assure the health and welfare of the region's service recipients.

2.4.11.

2.5 Utilization Management

Utilization management typically includes the following functions: 1) access and eligibility determination, 2) utilization management protocols, 3) service authorization, and 4) utilization review. The functions may be fully or partially-delegated to the PIHP's provider network.

2.5.1. ☐ In Attachment 2.5.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.5.2. ☐ The function will not be delegated.

OR

2.5.3. ☐ The function will be fully or partially delegated. In the text box below is a one-page description of each function that will be delegated and to what entity it will be delegated; and how the governing structure and CEO will provide monitoring and oversight of the delegated functions.

2.5.3

2.5.4. ☐ The applicant attests that it will adopt one set of common Utilization Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.5.5. ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.5.5., lists the Utilization Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.5.6. ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.5.5. will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.6 Customer Services

Customer services functions are typically: 1) information services that are compliant with 42 CFR 438.10, 2) maintenance and annual provision of the Customer Services Handbook that has been approved by MDHHS, 3) facilitation of consumer empowerment and participation in PIHP planning and monitoring, 4) customer complaint, grievances and appeals, and 5) community benefit. While functions number one and two are the responsibility of the PIHP, the other three functions may be delegated in part or in full.

2.6.1. ☐ In Attachment 2.6.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.6.2. ☐ The functions will not be delegated.

OR

2.6.3. ☐ The function will be fully or partially delegated. In the text box below is a one-page description of each function that will be delegated and to what entity it will be delegated; and how the governing structure and CEO will provide monitoring and oversight of the delegated functions.
2.6.3.

2.6.4. ☐ The applicant attests that the Customer Services Handbook that reflects the applicant region will be submitted to MDHHS for approval no later than October 1, 2013, and that it will be ready for delivery to the beneficiaries no later than January 1, 2014.

OR

2.6.5. ☐ The applicant attests that the PIHP region is not changing in 2014 and that the current Customer Services Handbook is up-to-date and has been approved by MDCH.

2.6.6. ☐ The applicant attests that it will adopt one set of common Customer Services policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.6.7. ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.6.7., lists the Customer Services policies and procedures and the PIHP(s) from which they were adopted.

OR

2.6.8. ☐ The common policies and procedures are in development at the time of application, and the Attachment XX will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

2.7 Quality Management

Quality Management typically includes the following functions: 1) developing an annual Quality Assessment and Performance Improvement Program (QAPIP) plan and report, 2) standard-setting, 3) conducting performance assessments, 4) conducting on-site monitoring of providers in the provider network, 5) managing regulatory and corporate compliance, 6) managing outside entity review processes (e.g., external quality review, PIHP accreditation), 7) conducting research, 8) facility quality improvement process , 9) facility provider education and oversight, and 10) analyzing critical incidents and sentinel events. MDHHS expects that the PIHP will not delegate these functions and understands that some of the functions will be performed in addition by the provider network (member CMHSPs, MCPNs, or core providers).

2.7.1. ☐ In Attachment 2.7.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.7.2. ☐ The functions will not be delegated.

OR

2.7.3. ☐ The function will be fully or partially delegated. In the text box below is a one-page description of any of the ten functions that will be delegated and to what entity it will be delegated; and how the governing structure and CEO will provide monitoring and oversight of the delegated functions.
2.7.3.

2.7.4. ☐ The applicant attests that the QAPIP plan that reflects the applicant region will be submitted to MDHHS no later than October 1, 2013, and that it will be ready for implementation by January 1, 2014.

OR

2.7.5. ☐ The applicant attests that the PIHP region is not changing in 2014 and that the current QAPIP plan is up-to-date and has been submitted to MDHHS.

2.7.6. ☐ The applicant attests that it will adopt one set of common Quality Management policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.7.7. ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.7.7., lists the Quality Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.7.8. ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.7.7. will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

ACCREDITATION STATUS

As evidenced by developments in federal and Michigan policy, the ability to perform managed care functions to industry standards while also assuring program integrity with federal and state funds is an expectation for the Regional Entity or Urban Cooperation Act PIHPs. MDHHS will determine by October 1, 2013, the specific accreditation requirements including NCQA or URAC category options for PIHPs. It is recognized that accreditation is neither quick nor easy; nor inexpensive. Given these realities MDCH is carefully considering the best course of action and required timeframes for accreditation of PIHPs. It should be noted that the "health plan" categories of accreditation for both NCQA and URAC provide the closest match to federal and state requirements for managed care organizations including PIHPs.

3.1. ☐ In the text box below is a half-page description of the status of any URAC or NCQA accreditation of current (2013) PIHP(s) in the applicant's region.

3.1

3.2. ☐ In the text box below is a half-page description of the status of activity, viewpoints, options or plans in this applicant's new region to obtain URAC or NCQA accreditation. Make note of specific categories or programs within NCQA or URAC being considered or evaluated. (examples of categories: URAC-Health Plan, URAC-Health Network, NCQA-MBHO, NCQA-Health Plan). Include target application date if known.

3.2

3. **EXTERNAL QUALITY REVIEW**

Beginning January 1, 2015, the external quality review organization (EQRO) will a) review the new PIHPs' compliance with the Balance Budget Act (BBA) standards; b) validate the performance measures; and c) validate the new mandatory performance improvement project that will commence January 1, 2014. Until then, MDHHS will rely on the performance, as measured by the EQRO, of existing PIHP(s) in each new region. Where there are weaknesses in an existing PIHP, MDHHS expects that applicant to address how performance will be improved. Below is the applicant's assessment of the performance of existing PIHP(s) in the applicant's region.

4.1.1. ☐ All BBA standards in FY'11-12 were determined by Health Services Advisory Group (HSAG) to meet or exceed 95% compliance in any current (FY'13) PIHP in the new region.

OR

4.2. ☐ In the text box below is any BBA standard(s) for which, in FY'11-12, there was less than 95% compliance by one or more current PIHPs in the new region; AND a description of the plan with action steps, responsible staff, and timeframes for the applicant achieving a minimum of 95% compliance with every BBA standard by January 1, 2015.

4.2

4.3. ☐ All Performance Measures were designated "fully compliant" in FY'11-12 for all current PIHPs in the new region.

OR

4.4. ☐ In the text box below is any Performance Measure that, in FY'11-12, received an EQRO audit designation of less than "fully compliant" by one or more current PIHPs in the new region; AND a description of the plan with action steps, responsible staff, and timeframes for the applicant achieving a minimum of fully compliant on all performance measures by January 1, 2015.

4.4

4.5. ☐ All current PIHPs in the new region scored 100% the Performance Improvement Project Validation for FY'11-12 on *Evaluation Element* Met and *Critical Elements* Met.

OR

4.6 ☐ In the text box below is any EQRO score of less than 100% on the Evaluation Elements *Met,* and any score of less than 100% on Critical Elements *Met* on the Performance Improvement Project validation for FY'11-12 by any current PIHP in the new region; AND a description of the plan with action steps, responsible staff, and timeframes for the applicant achieving a minimum of 100% *Met* on both Evaluation Elements and Critical elements by January 1, 2015.

4.6

5. PUBLIC POLICY INITIATIVES

The public policy initiatives outlined below reflect MDHHS's need to certify to CMS that the PIHP assures the full array of specialty services and supports is available and that it maintains adequate provider network capacity to serve the region's Medicaid beneficiaries (42 CFR 438.207). In addition, these public policies address the need to protect the vulnerable people served and at the same time to offer them opportunities to successfully live in the community, to work, and to develop and maintain meaningful relationships.

5.1 Regional Crisis Response Capacity

Crisis Response Capacity comprises three concepts: 1. Ongoing tracking and trending of critical incidents[1] and sentinel events;[2] 2) employing strategies to prevent critical incidents and sentinel events; and 3) having in place the capacity to regionally respond to behavioral or medical crises. The first concept is not new to Michigan's public mental health system, and it is expected that the applicant is in compliance with the Quality Assessment and Performance Improvement Program (QAPIP) standards where those activities are required and are measured by the External Quality Review and the Medicaid Site Review.

For the past few years MDHHS has provided tools to the public mental health system for prevention of, and early intervention in, crises. [See MDCH/PIHP FY'13 Contract Attachment 1.4.1 Technical Requirement for Behavior Treatment Plan Review Committees; Prevention Guide, June 2011 at www.michigan.gov/Mental Health and Substance Abuse (page); Transition Guide for Placement into AFCs; and Center for Positive Living Supports www.positivelivingsupport.org].

Thus the applicant attests that in the region there are common established processes which demonstrate that the provider network effectively:

5.1.1. ☐ Evaluates the systemic factors involved in any occurrence of critical incidents and at-risk health conditions, and behavioral and medical crises.

5.1.2. ☐ Identifies any individual precursors to potential behavioral or medical crises that can serve as a warning to care givers and staff.

5.1.3. ☐ Identifies and implements actions to eliminate or lessen the risk that critical incidents, sentinel events, and behavioral crises will occur.

For this new AFP, it is expected that the applicant describe the crisis response capacity that will be fully available in each PIHP region by January 1, 2015. Crisis response capacity includes clinical expertise that can be immediately accessed for mental health or behavioral crises. That expertise may be a team or teams of clinicians who are available for telephonic consultation and on-site observation and consultation, and have the training and experience to address the needs of children and adults with serious mental illness (SMI/SED) and children and adults with intellectual/developmental disabilities (I/DD), and children and adults with co-occurring SMI/SED and I/DD. This crisis response capacity

[1] Critical incidents as defined by the FY'13 MDCH/PIHP contract Attachments 6.5.1.1 and 6.7.1.1

[2] Sentinel event - an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

must also have a residential or inpatient component to which an individual can be transported, reside for a short period, and receive treatment or intervention until his/her crisis stabilizes. This capacity could be **intensive crisis stabilization or crisis residential services in** a free-standing licensed adult foster care facility and a free-standing licensed children's foster care facility, staffed with clinicians and workers who are specially trained to respond effectively to behavioral crises exhibited by adults or children with SMI/SED or adults with I/DD. This capacity could alternatively be an agreement with a regional inpatient psychiatric unit that is willing and able to receive any individual (SMI, SED or I/DD, adult or child) who is exhibiting a behavioral crisis. This capacity must include emergency admission.

5.1.4. ☐ In table 5.1.4 below is a regional analysis of people who are at risk with answers to the five questions following.

OR

☐ The table below will be completed, with the five questions answered, and submitted to MDHHS no later than 5 p.m. on July 1, 2013.

Identify the number of individuals identified as at-risk of crisis placement as determined by experiencing within the last six months: more than one 911 call for police intervention, more than one temporary placement in a crisis home, an on-site visit from the CPLS mobile team, more than one visit to the ER for behavioral episode, an admission to a psych in-patient unit, one or more requests for inpatient admission to a state psychiatric facility. Sort by age (child, adult 18-64, 65+) and disability designation (SED, SMI and I/DD).

Table 5.1.4

	911 calls	**Temporary placements in crisis home**	**On-site visit by CPLS mobile team**	**ER visit**	**Admission to psych inpatient unit**	**Request for inpatient admission to state facility**
Child with SED						
Adult with SMI 18-64						
Adult with SMI 65+						
Child with I/DD*						

	911 calls	Temporary placements in crisis home	On-site visit by CPLS mobile team	ER visit	Admission to psych inpatient unit	Request for inpatient admission to state facility
Adult with I/DD* 18-64						
Adult with I/DD* 65+						

***Count people on the Autism Spectrum Disorder or people with co-occurring SMI/SED and I/DD in this category**

5.1.5. ☐ In text box below are the numbers of individuals who have:

5.1.5.1. A current (within the last 12 months) behavioral treatment plan with restrictive or intrusive interventions approved by the Behavior Treatment Plan Review Committee:

5.1.5.2. Experienced (within the last 12 months) an injury requiring emergency room visit or hospital admission due to an intervention that occurred during a behavioral episode:

5.1.6. ☐ Beds are available in secure settings (e.g., psych unit in a community or private hospital) in the region and organizations "owning" the beds are willing to make them available to people with SMI, SED or I/DD with behaviors.

5.1.7. ☐ In text box below is percent of staff in the region who have participated in the Culture of Gentleness Working with People training:

5.1.7.1. Direct care workers:

5.1.7.2. Group home managers:

5.1.7.3. Supports coordinators/case managers:

5.1.7.4. Or other more advanced training such as Culture of Gentleness Practicum or Mentor Training :

5.1.8. ☐ In the text box below is a two-page description of:

a. The identification of at least one point person in the region who is available 24/7, 365 days/year to respond to crises that require immediate attention and who has the authority to arrange for temporary placement, regional crisis team or CPLS team consultation or visit.
b. Agreement(s) between the PIHP and hospitals or licensed AFCs in the region that will be available for short-term crisis placement.
c. Any plans for developing crisis residential programs.
d. Target dates for achieving full crisis response capacity by January 1, 2015.

5.1.8.

5.2 Health and Welfare

5.2.1. Health

One of MDCH four main strategic priorities for MDHHS is to "Improve the Health of the Population". This includes promoting 4x4 wellness activities to reduce obesity and targeting chronic care "hot spots" in population and geography. The public mental health system serves people who are among the most vulnerable of Michigan's citizens, It is well documented that longevity for persons with mental illness is 25 years shorter than persons without mental illness. MDHHS is seeking greater integration of systems of care to promote healthy behaviors and management of chronic conditions and all aspects of health: physical health, behavioral health, and habilitation.

Primary behavioral health conditions and disabilities frequently are complicated by co-occurring disabilities (e.g., a developmental disability plus epilepsy, swallowing disorder, respiratory or bowel issues), and by co-occurring chronic diseases (e.g., asthma, hypertension, obesity). These conditions, disabilities and diseases usually require frequent and ongoing intervention, treatment and monitoring by health care professionals.

In the absence of ambulatory and preventive care, treatment and monitoring, people use expensive emergency room services or are hospitalized for acute episodes of their conditions. [Please review the Health Services Advisory Group's "2010-2011 Coordination of Care/Medical Services Utilization Focused Study Report, March 2012" at www.michigan.gov/documents/MDHHS/MI2010-11_FocusedStudy_SMI-DD_Report_F1_382152_7.pdf] While PIHPs are not paid to provide primary health care, it is expected that PIHPs assure that individuals being served receive appropriate, culturally-relevant and timely healthcare; that medical care providers are knowledgeable in how to approach and treat individuals with mental illness and/or intellectual/developmental disabilities; and that the PIHPs' provider networks are partners on the health care team for health care planning and monitoring purposes.

The applicant attests to the following:

5.2.1.1 ☐ Reporting on Health Conditions (MDHHS/PIHP FY'13 Contracts, Attachment 6.5.1.1, Quality Improvement Reporting, Elements #39 through 41) is currently at 95% or more completeness for all populations served in the region.

OR

5.2.1.2 ☐ A plan that has action steps, responsible staff, and timeframes has been developed for achieving 95% or more completeness by January 1, 2014.

5.2.1.3 ☐ By January 1, 2014, person-centered planning (as documented in the individual plan of service) for each beneficiary will address:

a. Current physical health conditions.
b. Existence of health care practitioners that are treating any physical health conditions.

c. Any assistance (e.g., referral, coordination, transportation) that the beneficiary needs in accessing health care practitioners.

5.2.1.4 ☐ In Attachment 5.2.1A., is a description of no more than 4 pages, of how the applicant plans to assure coordination between the provider network and the beneficiaries' primary care practitioners to assure that appropriate preventative and ambulatory care are provided; existing health care conditions are treated and monitored by the health care team; and incidents of emergency room visits (for physical health or mental health crises) and hospital admissions (for physical health or mental health episodes) are immediately communicated among the health care team members; and that medical care providers are knowledgeable in how to approach and treat individuals with mental illness and/or intellectual/developmental disabilities. The description includes:

a. Any electronic methodology(ies) that will be used to share information among the health care team members.
b. How follow-up care (to emergency room visits and hospitalization) will be coordinated among the health care team members.
c. Steps to be taken to reduce or prevent recurrence of the issue(s) that have required avoidable emergency room visits and hospital admissions, including staff training and professional(s) identified for monitoring and oversight.
d. Plans for assuring adequate capacity to serve individuals with high medical needs, including the ability to assure smooth and timely transitions for individuals being discharged from the hospital.

OR

5.2.1.5 ☐ The plan noted in number 5.2.1.4 above is in development, and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

5.2.2 Welfare

Many individuals served by the public mental health system are victims of abuse, neglect, and exploitation intermittently or for long periods throughout their lives. These traumatizing events have a profound impact on an individual's ability to recover, to learn new skills to improve functioning, to develop and maintain relationships, and to live and work successfully in the community. For many years, MDHHS has provided leadership on evidence-based trauma-informed care.

There are many legal obligations to report abuse, neglect and exploitation to various law enforcement and public entities that will not be repeated here. Assuring welfare goes beyond reporting incident as they occur and includes a robust process for analyzing risk factors and reported incidents by individual beneficiary, population, and provider entity, if applicable. There must be close monitoring and oversight to prevent incidents of abuse, neglect, exploitation and other critical/sentinel events from occurring in the first place whenever possible. Monitoring should include information from other sources, such as licensing reports for group homes where individuals served by the PIHP reside [see Office of Inspector General Report on Home and Community-Based Services in Assisted Living Facilities on the MDHHS web site at Mental Health and Substance Abuse page]. Assuring welfare also includes seeing to the immediate safety of the individual and others, as well as

acting promptly and decisively when an incident is substantiated to prevent future occurrences for that individual or others.

The applicant attests to the following:

5.2.2.1 ☐ A signed agreement between each CMHSP in the region and their local Department of Human Services office and the Bureau of Child and Adult Licensing (BCAL) will be in effect on 1/1/14 to coordinate investigations as applicable.

5.2.2.2 ☐ Percent of staff in the region who have participated in the Trauma-Informed Care training:

a. Direct care workers:
b. Group home managers:
c. Supports coordinators/case managers:
d. Other:

5.2.2.3 ☐ In Attachment 5.2.2.3., is a description of no more than four pages, of how the applicant plans to assure the welfare of beneficiaries. The description includes how the applicant assures that its provider network will:

a. analyze risk factors and reported incidents by individual beneficiary and provider entity if applicable to identify patterns and trends;
b. provide close monitoring and oversight, including the staff responsible and frequency of monitoring and oversight ;
c. assure the immediate safety of the individual and others who may be affected when incidents occur, e.g., provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.

OR

5.2.2.4 ☐ The plan described above is in development and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

5.3 Olmstead Compliance

5.3.1 Community Living

Title II's integration mandate of the Americans with Disabilities Act requires that the "services, programs, and activities" of a public entity be provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR 35.130(d). Such a setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 CFR 35, App. B at 673. [Please refer to the recent activities of the Civil Rights Division of the U.S. Department of Justice that has been working with state and local governmental officials to insure ADA and Olmstead compliance: www.ada.gov/olmstead/index.htm]

A state or local government must eliminate any eligibility criteria for participation in programs, activities, and services that screen out or tend to screen out persons with disabilities, unless it can establish that the requirements are necessary for the provision of the service, program, or activity. The state or local government may, however, adopt legitimate safety requirements necessary for safe operation if they are based on real risks, not on stereotypes or generalizations about individuals with disabilities. Finally, a public entity must reasonably modify its policies, practices, or procedures to avoid discrimination. If the public entity can demonstrate that a particular modification would fundamentally alter the nature of its service, program, or activity, it is not required to make that modification.

Michigan has been a long-time leader in developing community-based living supports and services, so the provisions of the Olmstead decision related to community living and working are not new to the public mental health system.

Respond with the applicant's assurances to the attestations below:

5.3.1.1 ☐ The applicant has a written policy defining the standards the region's provider network will follow in releasing people from institutions. The provider network's treatment professionals must determine that the placement is appropriate; the individual must not object to being released from the institution; and the provider is able to provide supports and services that enable them to live successfully in the community.

OR

5.3.1.2 ☐ The written policy is in development and will be completed by this date:

5.3.1.3 ☐ The applicant has a written regional policy in place that calls for treatment professionals to respect and support the housing preferences and choices of people with disabilities and truly fulfill the mandates of the ADA with respect to community integration.

OR

5.3.1.4 ☐ The written regional policy is in development and will be completed by this date:

5.3.1.5 ☐ There will be a regional plan commencing no later than January 1, 2014 to establish partnerships with local housing agencies and housing providers. The goal of these collaborations should be to develop interagency strategies that increase affordable, community-based, integrated housing options for people with disabilities that meet their preferences and needs.

5.3.1.6 ☐ In the three tables below are regional analyses of the numbers of people served who at the time of application live in the settings noted.

OR

5.3.1.7 ☐ The tables below will be completed and submitted to MDHHS no later than 5 p.m. on July 1, 2013.

Table 5.3.1.6 A

Number of all individuals by children (up to age 18), adults (18-64) and seniors (65+) and primary disability – serious mental illness, serious emotional disturbance, and intellectual/developmental disability living in any licensed setting.

	# in licensed setting <6 beds	**# in licensed setting – 6 beds**	**# in licensed setting 7-12 beds**	**# in licensed setting 13+ beds**	**# in Skilled Nursing Facilities**	**Total # per population**	**Percent of Total Served**
Children w/ SED							
Adults SMI 18-64							
Adults SMI 65+							
Children w/ I/DD							
Adults I/DD 18-64							
Adults I/DD 65+							
Total							

Note: If a beneficiary lives in a group home licensed for six beds but that home is located on a campus with other group homes, report the total number of licensed beds for that provider at that campus location.

Table 5.3.1.6 B
Number of individuals by children (up to age 18), adults (18-64) and seniors (65+) and primary disability – serious mental illness, serious emotional disturbance, and intellectual/developmental disability living in a licensed setting *outside* the PIHP region.

	# in licensed setting <6 beds	# in licensed setting – 6 beds	# in licensed setting 7-12 beds	# in licensed setting 13+ beds	Total # per population	Percent of Total Served
Children w/ SED						
Adults SMI 18-64						
Adults SMI 65+						
Children w/ I/DD						
Adults I/DD 18-64						
Adults I/DD 65+						
Total						

Table 5.3.1.6 C
The number of adults who live independently, with or without supports, with or without house/roommates. Home/apartment is not a licensed facility and is owned or leased by the individual.

	Independent without supports	Independent with supports	Independent with house/roommates	Independent without house/roommates
Adults SMI 18-64				
Adults SMI 65+				
Adults I/DD 18-64				
Adults I/DD 65+				

5.3.1.8.☐ In the text box below is a narrative of no more than two pages that describes:

a. How informed choice of type of setting, provider, roommates/housemates are guaranteed in the annual person-centered planning process.
b. The transition planning process undertaken to assure that there is the right match between the individual and the licensed setting.

c. How individual opportunities for community integration and inclusion, and productivity are addressed and guaranteed in licensed settings (See Keys Amendment at 1915.1616(e) of the Social Security Act that pertains to social security income recipients living in facilities (e.g., group homes, congregate living arrangements).
d. The determinants of the frequency of PIHP monitoring of individuals living in licensed settings differentiated by Specialized Residential settings, and General AFCs. Include how issues or deficiencies are addressed when noted.
e. Plans with action steps, responsible staff, timeframes and numbers of people for developing increased regional alternative (to licensed AFC) residential capacity. 5.3.1.8

OR

☐ The narrative description above will be submitted no later than July 1, 2013.

5.3.1.9 ☐ In Attachment 5.3.1.10., is a plan with action steps and timeframes for developing capacity for bringing [the number] of people currently living out of the region, or transitioned to another PIHP if chosen by the person, back to live within the region. This may be a phased-in approach, but must commence October 1, 2014.

OR

5.3.1.10 ☐ The plan described above is in development and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

Olmstead Compliance:

5.3.1 **Employment and Community Activities**

CMS underscores that the competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is the **optimal** outcome of Pre-Vocational/Skill-building services. All pre-vocational and supported employment service options should be reviewed and considered as a component of an individual plan of services (IPOS) developed through a person-centered planning process, no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the choice and preferred outcomes of the individual's goals and reflected in the IPOS. [Center for Medicaid and CHIP Service (CMCS) Informational Bulletin, September 16, 2011. Also see MDCH Employment Works! Policy, revised July 2012.]

Work is a key component to recovery through Evidence-based Practice/Individual Placement Supports. MDCH also strongly recognizes that employing Peer Specialists and Peer Mentors can help organizations improve their service delivery systems.

MDHHS is initiating an employment data dashboard to track various employment settings (individual, group, Ability One, Clubhouse, and other employment) by wages per hour, and hours per month as well as expected movement toward competitive, integrated community employment. Accurate, timely, and effective federal and state benefits planning related to working is a key to acquiring and maintaining employment.

MDHHS expects that each PIHP will embrace the above tenets and encourage its provider network to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Respond with the applicant's attestations below:

5.3.2.1 ☐ The applicant will have a regional policy in place no later than January 1, 2014 that assures consistency across the applicant's service area in the provision of competitive, integrated employment services for the individuals served. This policy will be available for review prior to that date.

5.3.2.2 ☐ The applicant will have in place no later than January 1, 2013 a regional policy that assures there are affirmative efforts are in place to increase agency and subcontractor employment of individuals with disabilities including recruitment, placement and development of pay scales including fringe benefits and training. Applicant has individuals who have disclosed they have disabilities on staff:
#FTEs.

5.3.2.3 ☐ The applicant assures that its provider networks will link beneficiaries to accurate and timely information about the continuation of federal and state benefits in preparation for and while they are competitively employed.

5.3.2.4 ☐ In the two tables below are regional analyses of the numbers of people served who at the time of application are engaged in the ways noted.

OR

5.3.2.5 ☐ The tables below will be completed and submitted to MDHHS no later than 5 p.m. on July 1, 2013.

Table 5.3.2.4 A

In this table is a regional analysis of the number of adults in age ranges and with disability designation below who are in each activity solely. If in multiple activities, count the activity where the most time per year is spent.

	Sheltered Workshop	**Supported Employment***	**Integrated Employment***	**Volunteer job**	**No volunteer or paid work activity, includes retired**	**Total served**
Adults SMI 18-64						
Adults SMI 65+						
Adults I/DD 18-64						
Adults I/DD 65+						

*Refer to the FY13 MDCH/PIHP Contract for definitions of supported and integrated employment

Table 5.3.2.4. B

In this table is a regional analysis of the number of adults in age ranges and with disability designation below who are involved in the community activities with the general public below *at least once a month*.

	Clubs, Social events, visiting friends/relative	**Continuing Education, Classes**	**Athletic/recreational participant**	**Attendance at sporting, arts, theater, movies**	**No extra-curricular activity**	**Total served**
Adults SMI 18-64						
Adults SMI 65+						

	Clubs, Social events, visiting friends/relative	**Continuing Education, Classes**	**Athletic/recreational participant**	**Attendance at sporting, arts, theater, movies**	**No extra-curricular activity**	**Total served**
Adults I/DD 18-64						
Adults I/DD 65+						

5.3.2.6 ☐ In the text box below Attachment is a narrative, of no more than two pages, that describes:

a. How informed choice of a) the type of work and b) community activities are guaranteed in the annual person-centered planning process.
b. How individual opportunities for community integration and inclusion, and productivity are addressed and guaranteed as a result of person-centered planning.
c. The determinants of the frequency of PIHP monitoring of individuals who participate in segregated activities that include day programs, workshops. Include how issues or deficiencies are addressed when noted.

5.3.2.6

OR

☐ The narrative description is being developed and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

5.3.2. ☐ In Attachment 5.3.2.8. is a regional plan with action steps, responsible staff, timeframes and numbers of people for developing increased regional alternatives to segregated day programs and workshops. This may be a phased-in approach, but must commence October 1, 2014.

OR

5.3.2 ☐ The regional plan is in development and will be submitted to MDHHS no later than 5 p.m. on July 1, 2013.

5.4 Substance Use Disorder Prevention and Treatment

Michigan's publicly funded Substance Use Disorder (SUD) Service System is committed to a transformational change that promotes and sustains wellness and recovery for individuals, families, and communities. This change to a recovery-oriented system of care (ROSC) employs strategies to:

- prevent the development of new substance use disorders.
- reduce the harm caused by addiction.
- help individuals make the transition from brief experiments in recovery initiation to sustained recovery maintenance via diverse holistic services.
- promote good quality of life and improve community health and wellness.

Additional information can be found in Michigan's Recovery Oriented System of Care (ROSC) Implementation Plan at http://www.michigan.gov/documents/mdhhs/ROSC_Implementation_Plan_357360_7.pdf.
To develop a holistic and effective SUD Service System that promotes recovery and resilience, PIHPs shall implement a ROSC. In addition, PIHPs shall implement recent Mental Health Code changes, per Public Acts 500 and 501 of 2012, to incorporate SUD administrative functions. Accordingly, the applicant attests to the following:

5.4.1 ☐ Adoption of ROSC's sixteen guiding principles (pages 14-16 of ROSC Implementation Plan).

5.4.2 ☐ Lead person named for transition of SUD administrative functions into the PIHP by April 1, 2013. The lead person's name is:

5.4.3 ☐ Implementation plan made no later than October 1, 2013, for merger of SUD functions into the PIHP to be completed by October 1, 2014. For reference see the, Coordinating Agency contract (http://egrams-mi.com/dch/user/categoryprograms.aspx?CategoryCode=SA&CatDesc=Substance%20Abuse).

5.4.4 ☐ Adherence of federal Substance Abuse Prevention and Treatment Block Grant (SAPT BG) requirements and maintain staff to support.

5.4.5 ☐ Acceptance of fiduciary and local oversight for federally funded discretionary grants.

5.4.6 ☐ Adherence to PA 258 of 1974, Mental Health Code, section 287 by:
- Establishing an SUD Oversight Policy Board by October 1, 2014.
- Providing a list of members and criteria used to make selection.
- Developing procedures for approving budget and contracts by October 1, 2014.
- Attesting to maintaining provider base (as of December 28, 2012) until December 28, 2014.

5.4.7 ☐ Development of a three-year SUD prevention, treatment and recovery plan to be submitted by August 1, 2014, for fiscal years (FY) 2015 to 2017.

5.4.8 ☐ Implementation of evidence-based prevention, treatment, and recovery services.

5.4.9 ☐ Maintenance of a separate Recipient Rights process for SUD service recipients.

5.4.10 ☐ Submission of timely reports on annual budget boilerplate requirements, including:

a. Legislative Report (Section 408), FY2013 due by January 31, 2014
b. Mental Health and Substance Use Disorder Services Integration Status Report (Sections 407 and 470), FY2013 due by January 31, 2014

Note: boilerplate requirements and due dates are subject to change with appropriations

5.5 Recovery

The vision in the *Description of a Good and Modern Addictions and Mental Health Service System* addresses elements necessary for a recovery environment including determinants of health, health promotion, prevention, screening, early intervention, treatment system and service coordination, resilience and recovery support to promote social integration, health and productivity. A good and modern system provides a full range of services to meet the needs of the population with strong integrated efforts between behavioral health and primary care. Integration must be based in a model of community participation, inclusion, and integration with the foundation of trauma informed and recovery oriented supports. The Michigan plan of Bringing Recovery Support to Scale vision for health and wellness includes every person with substance use disorder and/or mental illness will having equal access to and opportunity for person-centered, recovery based services which respect that there are multiple pathways and sources of engagement and support that are dependent on each individual's preference and learning style.

The new working definition published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) discusses recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA has delineated four major dimensions and ten guiding principles that support a life in recovery:

- ***Health***: overcoming or managing one's disease(s) or symptoms—and making informed, healthy choices that support and promote physical and emotional wellbeing.
- ***Home:*** a stable and safe place to live;
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- ***Community***: relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s).

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.
Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.
Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are keys in determining a person's journey and unique pathway to recovery.
Recovery is supported by addressing trauma: Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.
Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.
Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

5.5.1 ☐ In the text box below is a two-page explanation of how the applicant's mission and vision support the dimensions and principles of recovery according to the SAMHSA working definition. Explain how substance use disorder and mental health recovery are both supported by the mission and vision.

5.5.1

5.5.2 ☐ The applicant will select a region-wide behavioral health recovery survey tool as a Continuous Quality Improvement project in partnership with a group of stakeholders that includes providers and users of services with a majority of members being people with lived experience. By January 2014 the tool will be submitted and approved by MDCH.

5.5.3 ☐ The applicant assures that its provider network employs a sufficient workforce of individuals with lived experiences throughout all levels of the agency who are paid fair and competitive wages, have multiple opportunities for a balance of full and part-time positions and are offered a viable career ladder.

5.5.4 ☐ By January 1, 2014, applicant's provider network's position descriptions for all paid employees and volunteers contain language of recovery. Job responsibilities will outline recovery-based, person-centered and culturally competent practices. Job qualifications will specify that lived experiences with behavioral health issues are desired.

5.5.5 ☐By October 1, 2013, the applicant will present to MDHHS a plan for sustaining positions currently supported by federal Mental Health Block Grant funding after the grant has ended. The plan specifically identifies positions that are supporting SUD prevention and Women's Specialty Services for SUD.

5.5.6 ☐ By January 1, 2014, the applicant will have region-wide policies, procedures and a process in place that support and encourage the opportunity to for individuals with serious mental illness to participate in a self-determined arrangement.

5.5.7 ☐ By January 1, 2014, the applicant's provider network will have region-wide explicit policies and procedures for admission, discharge, referral, collaborative care that supports individual choice, person centered, culturally competent, trauma informed practice and the attainment of self-directed goals. The policies and procedures will incorporate SUD provider/recovery networks into the service delivery system.

5.5.8 ☐ By January 1, 2014, the applicant will develop and implement region-wide policies and procedures to support the provision of collaborative work between substance use, mental health and primary care providers resulting in an integrated care plan for individuals.

PROCUREMENT TECHNICAL REQUIREMENT

PROCUREMENT AND SELECTIVE CONTRACTING UNDER MANAGED CARE

Introduction

The assumption of managed care responsibilities for specialized Medicaid mental health, developmental disabilities and/or substance abuse services has implications for the procurement and selective contracting activities of Prepaid Inpatient Health Plans (PIHPs). Soliciting providers and programs for the service delivery system, acquiring claims processing capabilities, enhancements to management information system capacity, or obtaining general management's services to assist in the administration of the managed care program, must be done with due deliberation and sensitivity to procurement and contracting issues.

Procurement of Automatic Data Processing Services and Comprehensive Administrative or Management Services

The Michigan Department of Health and Human Services 's (MDHHS) plan to make sole source "sub-awards" for the administration and provision of Medicaid mental health, developmental disability and substance abuse services raises questions about the applicability of federal procurement regulations to CMHSP and RSACA procurement and contracting activities. Federal regulations regarding procurement are described in the Code of Federal Regulations, (2 CFR Sections 318-326), Office of Management and Budget Circular2 CFR 200 Subpart E Cost Principles, and State Medicaid Manual Part 2 (Sections 2083 through 2087).

In general, these regulations and requirements give the State fairly wide latitude in determining the procedural aspects and applicable circumstances for procurement processes. However, the MDHHS's preliminary interpretation of these regulations suggests that procurement for significant automatic data processing services related to the operation of the Medicaid carve-out program, and contracts for comprehensive management services (so-called MSO or ASO arrangements) must be conducted in compliance with federal procurement requirements outlined in the documents listed above.

Procurement and Contracting for Service Providers

PIHPs will also be soliciting providers to furnish programs, services and/or supports for Medicaid recipients needing mental health, developmental disability or substance abuse services. When soliciting providers, it should be the objective of each PIHP to acquire needed services and supports at fair and economical prices, with appropriate attention to quality of care and maintenance of exiting-care relationships and service networks currently used by Medicaid recipients. Procurement processes should be used to solicit such services. Depending on the circumstances (e.g., local area market conditions, kind or quantity of services needed, etc.) various methods for selecting providers may be used including:

1. Procurement for Selective Contracting[1]

[1] Competitive procurement is usually pursued through either a COMPETITIVE SEALED BIDDING method (the process of publicizing government needs, inviting bids, conducting public bid openings, and awarding a

The PIHP (as the managing entity) purchases services from a limited number of providers who agree to fulfill contractual obligations for an agreed upon price. The managing entity identifies the specific services to be provided, seeks proposals/price bids, and awards contracts to the best bidders. Contracts are let only with a sufficient number of providers to assure adequate access to services. The prospect of increased volume induces providers to bid lower prices.

2. Procurement to Obtain Best Prices Without Selective Contracting

Under an "any willing and qualified provider" process, bids can be solicited and used to set prices for a service, and then contracts or provider agreements can be offered to any qualified provider that is willing to fulfill the contract and meet the bid price.

(NOTE: A procurement process must be used when the managing entity is planning to restrict or otherwise limit the number of providers who can participate in the program.)

3. Non-Competitive Solicitation and/or Selection of Providers

Under certain circumstances, the managing entity may select providers without a competitive procurement process. These circumstances are:

- The service is available only from a single source;
- There is a public exigency or emergency, and the urgency for obtaining the service does not permit a delay incident to competitive solicitation;
- After solicitation of a number of sources, competition is determined inadequate;
- The services involved are professional services (e.g., psychological testing) of limited quantity or duration;
- The services are unique (e.g., financial intermediaries for consumers using vouchers or personal service budgets) and/or the selection of the service provider has been delegated to the consumer under a self-determination program; and

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contract to the lowest responsive and responsible bidder) or a COMPETITIVE SEALED PROPOSAL process (method of publicizing government needs, requesting proposals, evaluating proposals received, negotiating proposals with acceptable or potentially acceptable offerors, and awarding the contract after consideration of evaluation factors in the RFP and the price offered).

- Existing residential service systems, where continuity of care arrangements are of paramount concern.

In these situations, the managing entity may employ noncompetitive negotiation to secure the needed services. The single- or limited-source procurement process involves soliciting interest and negotiating with a single or limit set of providers. Again, this may be used where competition for a service is deemed inadequate or when the uniqueness of the services or other considerations limits competitive procurement possibilities.

Whether a competitive procurement or noncompetitive solicitation process is used, the managing entity must ensure that organizations or individuals selected and offered contracts have not been previously sanctioned by the Medicaid program resulting in prohibition of their participation in the program.

Checklists for Procurement
(adapted from Section 2087 of the State Medicaid Manual)

This checklist is provided as a guide for planning procurement activities. Use is not mandatory.

1. Planning Checklist
   - Has an analysis been conducted to determine if a procurement process should be initiated (need for services, available providers, likelihood of cost savings, etc.)? Have consumers and family members been involved in this analysis?
   - If a procurement process is warranted, what form should it take?
   - Automatic data processing (ADP) services, significant management information system enhancements, comprehensive management support functions
   - Full Compliance with CFR regulations, OMB Circulars and HCFA State Medicaid Manual
   - Acquisition of Service Provider Capacity - Network Participation
   - Competitive Sealed Bids
   - Competitive Negotiation
   - Non-Competitive Negotiations (if solicitation falls under the exception criteria listed above

2. Request for Proposals Checklist (Competitive Procurement for Providers)
   - Have consumers and families been involved in developing the request for proposals?
   - Are the major time frames of the RFP for response by competitors, evaluation period, award, contract negotiation, implementation and contract start-up time adequate to assure interested contractors a sufficient period to prepare a proposal and assume operations in an orderly manner?
   - Does the RFP contain a detailed and clear description of the scope of work to be contracted?

- Does the RFP provide for:
  i. Answering written questions from a prospective bidder about the RFP?
  ii. Acceptance of a late or alternate proposal or withdrawal of a proposal?
  iii. Evidence of adequate financial stability of the bidder and of any parent organization?
  iv. Performance standards?
  v. A time-frame requirement for guarantee of all prices quoted in the proposal?
  vi. Acceptance by a bidder of any reduction in payments for nonperformance?
  vii. A bidders' conference?
  viii. The general overall evaluation criteria, including maximum points available by category?
  ix. A reference to applicable code requirements, administrative rules, board policies, and managed care program stipulations?
- Does the RFP provide for open solicitation of all technically competent contractors?
- Does the RFP list procedures for handling changes to the RFP that occur after some proposals are submitted, identify who will be notified of the changes, and describe how they will be made?
- Are there any requirements in the RFP that would unduly or unfairly restrict or limit competition among prospective bidders?
- Does the RFP include a copy of the Managing Entity's proposed contract?

3. Proposal Evaluation Plan (PEP) Checklist
   - Does the PEP consider the following in the evaluation of proposals?
     i. Contractor Capability
        Staff qualifications and general experience; Experience with Title XIX or similar programs; Experience in service to the target populations; Contractor stability (including financial stability and reputation in the field); Evaluation by previous clients.
     ii. Technical Approach
        Understanding of the scope, objectives, and requirements; Proper emphasis on various job elements; Responsiveness to specifications; Clarity of statement of implementation plan.
     iii. Financial Aspects
        Realism of total cost estimate and cost breakdown; Realism of estimated hours of staff time; Hourly rate structure; Reasonableness of implementation costs; Reasonableness of turnover costs.

4. Report of the Selection Committee Checklist
   - Are consumers and family members included on the proposal evaluation team?
   - If a contractor that did not submit the lowest offer was selected, was its selection justified as being most advantageous to the CMHSP or RSACA?
   - Is the selection committee's tabulation of proposal scores complete and accurate?
   - Is the evaluation process free of bias?

- Is a meeting for debriefing of unsuccessful bidders offered after the announcement of the contract award?
- Did the evaluation committee substantiate reasons a prospective bidder was determined to be non-responsive?
- Did the evaluation committee document valid reasons for not awarding the maximum points in each category and/or the reasons for awarding bonus points?

Community Mental Health

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Health and Human Services

Fiscal Year End September 30, 2017

V2017-1

TABLE OF CONTENTS

INTRODUCTION 1
RESPONSIBILITIES 3
MDHHS Responsibilities 3
PIHP Responsibilities 4
CMHSP Responsibilities 5
EXAMINATION REQUIREMENTS 6
Practitioner Selection 6
Examination Objective 6
Practitioner Requirements 6
Practitioner's Report 7
Examination Report Submission 8
Examination Reporting Package 9
Penalty 9
Incomplete or Inadequate Examinations 9
Management Decision 9
COMPLIANCE REQUIREMENTS 9
A. FSR Reporting 10
B. CRCS Reporting 12
C. Real Property Disposition 12
D. Administration Cost Report 12
E. Procurement 12
F. Rate Setting and Ability to Pay 12
G. Internal Service Fund (ISF) 13
H. Medicaid Savings and General Fund Carryforward 13
I. Match Requirement 13
J. Fee for Service Billings (CWP and SED Waiver Program) 13
K. CMHS Block Grant - Activities Allowed or Unallowed 14
L. CMHS Block Grant - Cash Management 14
M. CMHS Block Grant - Subrecipient Management and Monitoring 14
N. SAPT Block Grant – Activities Allowed or Unallowed 14
O. SAPT Block Grant – Cash Management 15
P. SAPT Block Grant – Subrecipient Management and Monitoring 15
RETENTION OF WORKING PAPERS AND RECORDS 15
EFFECTIVE DATE AND MDHHS CONTACT 15
GLOSSARY OF ACRONYMS AND TERMS 16

INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Health and Human Services (MDHHS) to assist independent audit personnel, Prepaid Inpatient Health Plan (PIHP) personnel, and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDHHS and PIHPs or CMHSPs, and to assure examinations are completed in a consistent and equitable manner.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDHHS to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, and Substance Use Disorder Community Grant Programs (hereinafter referred to as "Medicaid Contract"); the contracts between CMHSPs and MDHHS to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208 (hereinafter referred to as "GF Contract"); and, in certain circumstances, contracts between CMHSPs or PIHPs and MDHHS to manage the Community Mental Health Services Block Grant Program (hereinafter referred to as "CMHS Block Grant Program"). These CMH Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a PIHP or CMHSP expends $750,000 or more in federal awards[1], the PIHP or CMHSP must obtain a Single Audit.

PIHPs are ultimately responsible for the Medicaid funds received from MDHHS, and are responsible for monitoring the activities of network provider CMHSPs as necessary to ensure expenditures of Medicaid Contract funds are for authorized purposes in compliance with laws, regulations, and the provisions of contracts. Therefore, PIHPs must either require their independent auditor to examine compliance issues related to the Medicaid funds awarded to the network provider CMHSPs, or require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 8, 9, & 10).

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2017 and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

[1] Medicaid payments to PIHPs and CMHSPs for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended for the purposes of determining Single Audit requirements.

Failure to meet the requirements contained in these CMH Compliance Examination Guidelines may result in the withholding of current funds or the denial of future awards.

RESPONSIBILITIES

MDHHS Responsibilities

MDHHS must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code, and federal and state audit requirements; and to ensure the **COMPLIANCE REQUIREMENTS** contained in the CMH Compliance Examination Guidelines are complete and accurately represent requirements of PIHPs and CMHSPs; and distribute revised CMH Compliance Examination Guidelines to PIHPs and CMHSPs.
2. Review the examination reporting packages submitted by PIHPs and CMHSPs to ensure completeness and adequacy within eight months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination reporting package within eight months after the receipt of a complete and final reporting package.
4. Monitor the activities of PIHPs and CMHSPs as necessary to ensure the Medicaid Contract, GF Contract, and CMHS Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Contract, and GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely on PIHP or CMHSP Single Audits or the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure CMHSP Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS may, however, determine it is necessary to also perform a limited scope compliance examination or review of selected areas. Any additional reviews or examinations shall be planned and performed in such a way as to build upon work performed by other auditors. The following are some examples of situations that may trigger an MDHHS examination or review:
    a. Significant changes from one year to the next in reported line items on the FSR.
    b. A PIHP entering the MDHHS risk corridor.
    c. A large addition to an ISF per the cost settlement schedules.
    d. A material non-compliance issue identified by the independent auditor.
    e. The CPA that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.
    f. The CPA issued an adverse opinion on compliance due to their inability to draw conclusions because of the condition of the agency's records.

PIHP Responsibilities

PIHPs must:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200 , the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines is properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the PIHP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The PIHP shall <u>not</u> file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS and the PIHP will be notified of any required action in the management decision.
8. Monitor the activities of network provider CMHSPs as necessary to ensure the Medicaid Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. PIHPs must either (a.) require the PIHP's independent auditor (as part of the PIHP's examination engagement) to examine the records of the network provider CMHSP for compliance with the Medicaid Contract provisions, or (b.) require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. If the latter is chosen, the PIHP must incorporate the examination requirement in the PIHP/CMHSP contract and develop Compliance Examination Guidelines specific to their PIHP/CMHSP contract. Additionally, if the latter is chosen, the CMHSP examination must be completed in sufficient time so that the PIHP auditor may rely on the CMHSP examination when completing their examination of the PIHP if they choose to.
9. If requiring an examination of the network provider CMHSP, review the examination reporting packages submitted by network provider CMHSPs to ensure completeness and adequacy.

10. If requiring an examination of the network provider CMHSP, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in network provider CMHSP's examination reporting packages.

CMHSP Responsibilities

(as a recipient of Medicaid Contract funds from PIHP and a recipient of GF funds from MDHHS and a recipient of CMHS Block Grant funds from MDHHS)

CMHSPs must:

1. Maintain internal control over the Medicaid Contract, GF Contract, and CMHS Block Grant Program that provides reasonable assurance that the CMHSP is managing the Medicaid Contract, GF Contract, and CMHS Block Grant Program in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid Contract, GF Contract, and CMHS Block Grant Program.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract, GF Contract, and CMHSP Block Grant Program. Examples of these would include, but not be limited to: the Medicaid Contract, the Managed Mental Health Supports and Services Contract (General Fund Contract), the CMHS Block Grant Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines, and any examination required by the PIHP from which the CMHSP receives Medicaid Program funds are properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The CMHSP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS, and the CMHSP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

PIHPs under contract with MDHHS to manage the Medicaid Contract and CMHSPs under contract with MDHHS to manage the GF Contract are required to contract annually with a certified public accountant in the practice of public accounting (hereinafter referred to as a practitioner) to examine the PIHP's or CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 10 – Compliance Attestation – AT 601 (Codified Section of AICPA Professional Standards), as amended by SSAE Nos. 11, 12, and 14, (hereinafter referred to as an examination engagement). The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Additionally, CMHSPs under contract with MDHHS to provide CMHS Block Grant Program services with a total contract amount of greater than $100,000 are required to ensure the above referenced examination engagement includes an examination of compliance with specified requirements related to the CMHS Block Grant Program **IF** the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program. The specified requirements and specified criteria related to the CMHS Block Grant Program are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Practitioner Selection

In procuring examination services, PIHPs and CMHSPs must engage an independent practitioner, and must follow the Procurement Standards contained in 2 CFR 200.318 through 200.320. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, the results of MDHHS reviews, and price. When possible, PIHPs and CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the PIHP's or CMHSP's compliance with specified requirements is to express an opinion on the PIHP's or CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that the PIHP or CMHSP complied, in all material respects, based on the specified criteria.

Practitioner Requirements

The practitioner should exercise due care in planning, performing, and evaluating the results of his or her examination procedures; and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected.

The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements." In the examination of the PIHP's or CMHSP's compliance with specified requirements, the practitioner should:

1. Obtain an understanding of the specified compliance requirements (See AT 601.40).
2. Plan the engagement (See AT 601.41 through 601.44).
3. Consider the relevant portions of the PIHP's or CMHSP's internal control over compliance (See AT 601.45 through 601.47).
4. Obtain sufficient evidence including testing compliance with specified requirements (See AT 601.48 through 601.49).
5. Consider subsequent events (See AT 601.50 through 601.52).
6. Form an opinion about whether the entity complied, in all material respects with specified requirements based on the specified criteria (See AT 601.53).

Practitioner's Report

The practitioner's examination report on compliance should include the information detailed in AT 601.55 and 601.56, which includes the practitioner's opinion on whether the entity complied, in all material respects, with specified requirements based on the specified criteria. When an examination of the PIHP's or CMHSP's compliance with specified requirements discloses noncompliance with the applicable requirements that the practitioner believes have a material effect on the entity's compliance, the practitioner should modify the report as detailed in AT 601.64 through AT 601.67.

In addition to the above examination report standards, the practitioner must prepare:

1. A Schedule of Findings that includes the following:
    a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant Program.
    b. Material noncompliance with the provisions of laws, regulations, or contract provisions related to the Medicaid Contract, GF Contract, and/or CMHS Block Grant Program.
    c. Known fraud affecting the Medicaid Contract, GF Contract, and/or CMHS Block Grant Program.

    Finding detail must be presented in sufficient detail for the PIHP or CMHSP to prepare a corrective action plan and for MDHHS to arrive at a management decision. The following specific information must be included, as applicable, in findings:

    a. The criteria or specific requirement upon which the finding is based including statutory, regulatory, contractual, or other citation. **The Compliance Examination Guidelines should NOT be used as criterion.**
    b. The condition found, including facts that support the deficiency identified in the finding.

c. Identification of applicable examination adjustments and how they were computed.
d. Information to provide proper perspective regarding prevalence and consequences.
e. The possible asserted effect.
f. Recommendations to prevent future occurrences of the deficiency(ies) noted in the finding.
g. Views of responsible officials of the PIHP/CMHSP when there is a disagreement with the finding.
h. Planned corrective actions.
i. Responsible party(ies) for the corrective action.
j. Anticipated completion date.

2. A schedule showing final **reported** Financial Status Report (FSR) amounts, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below)], and examined FSR amounts. **All examination adjustments must be explained and must have a corresponding finding or comment.** This schedule is called the "Examined FSR Schedule." Note that Medicaid FSRs must be provided for PIHPs. All applicable FSRs must be included in the practitioner's report regardless of the lack of any examination adjustments.

3. A schedule showing a revised cost settlement for the PIHP or CMHSP based on the Examined FSR Schedule. This schedule is called the "Examined Cost Settlement Schedule." This must be included in the practitioner's report regardless of the lack of any examination adjustments.

4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant program; and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency. The list of details required for findings (a. through j. above) must also be provided for the comments.

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDHHS within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The PIHP or CMHSP must submit the reporting package by e-mail to MDHHS at MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. MDHHS reserves the right to request a hard copy of the compliance examination report materials if for any reason the electronic submission process is not successful.

Examination Reporting Package

The reporting package includes the following:

1. Practitioner's report as described above;
2. Corrective action plan prepared by the PIHP or CMHSP.

Penalty

If the PIHP or CMHSP fails to submit the required examination reporting package by June 30th following the contract year end and an extension has not been granted by MDHHS, MDHHS may withhold from current funding five percent of the examination year's grant funding (not to exceed $200,000) until the required reporting package is received. MDHHS may retain the withheld amount if the reporting package is delinquent more than 120 days from the due date and MDHHS has not granted an extension.

Incomplete or Inadequate Examinations

If MDHHS determines the examination reporting package is incomplete or inadequate, the PIHP or CMHSP, and possibly its independent auditor will be informed of the reason of inadequacy and its impact in writing. The recommendations and expected time frame for resubmitting the corrected reporting package will be provided to the PIHP or CMHSP.

Management Decision

MDHHS will issue a management decision on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination report within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the examination finding and/or comment is sustained; the reasons for the decision and the expected PIHP or CMHSP action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, MDHHS may request additional information or documentation from the PIHP or CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the PIHP or CMHSP is included in the applicable contract.

If there are no findings, comments, and/or questioned costs, MDHHS will notify the PIHP or CMHSP when the review of the examination reporting package is complete and the results of the review.

COMPLIANCE REQUIREMENTS

The practitioner must examine the PIHP's or CMHSP's compliance with the A-J specified requirements based on the specified criteria stated below related to the Medicaid Contract and GF Contract. If the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the K-M specified requirements based on the specified criteria stated

below that specifically relate to the CMHS Block Grant, but only if the CMHSP's total contract amount for the CMHS Block Grant is greater than $100,000. If the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the N-P specified requirements based on the specified criteria stated below that specifically relate to the SAPT Block Grant.

COMPLIANCE REQUIREMENTS A-J
(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

The final FSRs (entire reporting package applicable to the entity) comply with contractual provisions as follows:

a. FSRs agree with agency financial records (general ledger) as required by the reporting instructions. (Reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).
b. FSRs include only allowed activities as specified in the contracts; allowable costs as specified in the Federal cost principles (located at 2 CFR 200, Subpart E)(GF Contract, Section 6.6.1; and Medicaid Contract, Section 7.8); and allowed activities and allowable costs as specified in the Mental Health Code, Sections 240, 241, and 242.
c. FSRs include revenues and expenditures in proper categories and according to reporting instructions.

Differences between the general ledger and FSRs should be adequately explained and justified. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule." Any reported expenditures that do not comply with the Federal cost principles, the Code, or contract provisions must be shown on the auditor's "Examined FSR Schedule."

The following items should be considered in determining allowable costs:
Federal cost principles (2 CFR 200.402) require that for costs to be allowable they must meet the following general criteria:

a. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under the principles.
b. Conform to any limitations or exclusions set forth in the principles or in the Federal award as to types or amount of cost items.
c. Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
d. Be accorded consistent treatment.
e. Be determined in accordance with generally accepted accounting principles.

f. Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period.
g. Be adequately documented.

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness criteria of 2 CFR Part 200, Subpart E – Cost Principles, 200.404 was met. If subcontractors are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). When the PIHP pays FQHCs and RHCs for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported rental costs for **less-than-arms-length transactions** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (c)). For example, the agency may rent their office building from the agency's board member/members, but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in 2 CFR Part 200.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (b)).

Capital asset purchases that cost greater than $5,000 must be capitalized and depreciated over the useful life of the asset rather than expensing it in the year of purchase (2 CFR Part 200, Subpart E – Cost Principles, 200.436 and 200.439). All invoices for a remodeling or renovation project must be accumulated for a total project cost when determining capitalization requirements; individual invoices should not simply be expensed because they are less than $5,000.

Costs must be allocated to programs in accordance with relative benefits received. Accordingly, **Medicaid costs must be charged to the Medicaid Program and GF costs must be charged to the GF Program**. Additionally, **administrative/indirect costs** must be distributed to programs on bases that will produce an equitable result in consideration of relative benefits derived in accordance with 2 CFR Part 200, Appendix VII.

Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported in accordance with the standards listed in 2 CFR Part 200, Subpart E – Cost Principles, 200.430 (i).

B. CRCS Reporting

The final CRCSs comply with reporting instructions contained in the contract (General Fund Contract, Section 7.8; and Medicaid Contract, Section 8.7, and reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).

C. Real Property Disposition

The PIHP's or CMHSP's real property disposition (for property acquired with Federal funds) complied with the requirements contained in 2 CFR 200.311.

D. Administration Cost Report

The most recently completed PIHP's or CMHSP's Administration Cost Report complies with the applicable CMHSP/PIHP Administration Cost Reporting Instructions and the applicable standards in ESTABLISHING ADMINISTRATIVE COSTS WITHIN AND ACROSS THE CMHSP SYSTEM and contract provisions (instructions located at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html and reference guidelines located at http://www.michigan.gov/documents/mdch/Establishing_Admin_costs_480633_7.pdf).

E. Procurement

The PIHP or CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326. The PIHP or CMHSP ensured that organizations or individuals selected and offered contracts have not been debarred or suspended or otherwise excluded from or ineligible for participation in Federal assistance programs as required by 45 CFR 92.35.

F. Rate Setting and Ability to Pay

The PIHP/CMHSP determined responsible parties' insurance coverage and ability to pay before, or as soon as practical after, the start of services as required by MCL 330.1817. Also, the PIHP/CMHSP annually determined the insurance coverage and ability to pay of individuals who continue to receive services and of any additional responsible party as required by MCL 330.1828. Also, the PIHP/CMHSP completed a new determination if informed of a significant change in a responsible party's ability to pay as required by MCL 330.1828. Medicaid eligible consumers are deemed to have zero ability to pay so there is no need to determine their ability to pay. The one exception is during the period when a Medicaid eligible consumer has a deductible. In that case, an ability to pay determination does apply.

The PIHP's or CMHSP's charges for services represent the lesser of ability to pay determinations or cost of services according to MCL 330.1804. Cost of services means the total operating and capital costs incurred according to MCL 330.1800. In the comparison of cost to ability to pay the practitioner may consider a cost based rate sheet or other documentation that is supported by cost records as evidence of costs of services.

G. Internal Service Fund (ISF)

The PIHP's Internal Service Fund complies with the Internal Service Fund Technical Requirement contained in Contract Attachment P 8.6.4.1 with respect to funding and maintenance.

H. Medicaid Savings and General Fund Carryforward

The PIHP's Medicaid Savings was expended in accordance with the PIHP's reinvestment strategy as required by Sections 8.6.2.2 and 8.6.2.3 of the Contract. The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

I. Match Requirement

The PIHP or CMHSP met the local match requirement, and all items considered as local match actually qualify as local match according to Section 7.2 of the General Fund Contract and Section 8.2 of the Medicaid Contract. Some examples of funds that do NOT qualify as local match are: (a.) revenues (such as workers' compensation refunds) that should be offset against related expenditures, (b.) interest earned from ISF accounts, (c.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (d.) donations of funds from subcontractors of the PIHP or CMHSP, (e.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSP's actual costs, and (f) donations of items that would not be an item generally provided by the PIHP or CMHSP in providing plan services.

If the PIHP or CMHSP does not comply with the match requirement in the Mental Health Code, Section 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

J. Fee for Service Billings (CWP and SED Waiver Program)

The CMHSP's billings to MDHHS for the Children's Waiver Program (CWP) and the Waiver for Children with Serious Emotional Disturbances (SED Waiver Program) represent the actual direct cost of providing the services in accordance with Sections 4.7 (SED Waiver) and 6.9.7. (CWP) of the CMHSP Contract. The actual direct cost of providing the services include amounts paid to contractors for providing services, and the costs incurred by the CMHSP in providing the services as determined in accordance

with 2 CFR Part 200. Benefit plan administrative costs are not to be included in the billings. Benefit plan administrative costs related to providing services must be covered by general fund or local revenue, and while reported with program costs they must be covered by redirects of non-federal funds on the FSR MDHHS provides reimbursement for the actual direct costs or the Medicaid fee screen amount, whichever is less, according to the approved Waiver documents.

COMPLIANCE REQUIREMENTS K-M

(APPLICABLE TO PIHPs/CMHSPs WITH A CMHS BLOCK GRANT OF GREATER THAN $100,000 THAT DID NOT HAVE A SINGLE AUDIT OR THE CMHS BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

K. CMHS Block Grant - Activities Allowed or Unallowed

The CMHSP expended CMHS Block Grant (CFDA 93.958) funds only on allowable activities in accordance with Federal Block Grant provisions and the Grant Agreement between MDHHS and the CMHSP.

L. CMHS Block Grant - Cash Management

The CMHSP complied with the applicable cash management compliance requirements contained in the Federal Block Grant Provisions. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by CMHSP funds before reimbursement is requested from MDHHS.

M. CMHS Block Grant - Subrecipient Management and Monitoring

If the CMHSP contracts with other subrecipients ("subrecipient" per the 2 CFR Part 200.330 definition) to carry out the Federal CMHS Block Grant Program, the CMHSP complied with the Subrecipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h)

COMPLIANCE REQUIREMENTS N-P

(APPLICABLE TO PIHSs/CMHSPs WITH A SAPT BLOCK GRANT of Greater than $100,000 THAT DID NOT HAVE A SINGLE AUDIT OR THE SAPT BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

N. SAPT Block Grant – Activities Allowed or Unallowed

The CMHSP expended SAPT Block Grant (CFDA 93.959) funds only on allowable activities in accordance with the Federal Block Grant Provisions and the Grant Agreement between MDHHS and the CMHSP.

O. SAPT Block Grant – Cash Management

The CMHSP complied with the applicable cash management compliance requirements that are contained in the Federal Block Grant Provisions. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by CMHSP funds before reimbursement is requested from MDHHS.

P. SAPT Block Grant – Subrecipient Management and Monitoring

If the CMHSP contracts with other subrecipients ("subrecipient" per the 2 CFR Part 200.330 definition) to carry out the Federal SAPT Block Grant Program, the CMHSP complied with the Subrecipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h).

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDHHS. Also, PIHPs are required to keep affiliate CMHSP's reports on file for three years from date of receipt. All examination working papers must be accessible and are subject to review by representatives of the Michigan Department of Health and Human Services, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and provider network CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2016/2017 examinations. Any questions relating to these guidelines should be directed to:

John Duvendeck, Director
Division of Program Development, Consultation & Contracts
Bureau of Hospitals and Behavioral Health Administration
Michigan Department of Health and Human Services
Lewis Cass Building
320 S. Walnut Street
Lansing, Michigan 48913
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Phone: (517) 241-5218 Fax: (517) 335-5376

GLOSSARY OF ACRONYMS AND TERMS

AICPA.....American Institute of Certified Public Accountants.

Children's Waiver.....The Children's Waiver Program that provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the program who, if not for the availability and provisions of the Waiver, would otherwise require the level of care and services provided in an Intermediate Care Facility for the Mentally Retarded. Payment from MDHHS is on a fee for service basis.

CMHS Block Grant Program.The program managed by CMHSPs under contract with MDHHS to provide Community Mental Health Services Block Grant program services under CFDA 93.958.

CMHSP.....Community Mental Health Services Program (CMHSP). A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended.

Examination Engagement.....A PIHP or CMHSP's engagement with a practitioner to examine the entity's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 10 – Compliance Attestation – AT 601 (Codified Section of AICPA Professional Standards).

GF Program.....The program managed by CMHSPs under contract with MDHHS to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.

MDHHS .....Michigan Department of Health and Human Services

Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by PIHPs under contract with MDHHS.

PIHP.....Prepaid Inpatient Health Plan. In Michigan a PIHP is an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the

requirements of 42 CFR Part 438. The PIHP, also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program, also manages the Autism iSPA, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.

Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.

Serious Emotional Disturbances Waiver.....The Waiver for Children with Serious Emotional Disturbances Program that provides services to children who would otherwise require hospitalization in the State psychiatric hospital to remain in their home and community. Payment from MDHHS is on a fee for service basis.

SSAE.....AICPA's Statements on Standards for Attestation Engagements.

SAPT Block Grant Program ..The program managed by PIHPs under contract with MDHHS to provide Substance Use Services Block Grant program services under CFDA 93.959.

SUD Services.....Substance Use Disorder Services funded by Medicaid, Healthy Michigan, and the "Community Grant" which consists of Federal SAPT Block Grant funds and State funds.

APPEAL PROCESS FOR COMPLIANCE EXAMINATION MANAGEMENT DECISIONS

The following process shall be used to appeal MDHHS management decisions relating to the Compliance Examinations that are required in Section 39.0 of the Master Contract.

STEP 1: MANAGEMENT DECISION

MDHHS Office of Audit	Within eight months after the receipt of a complete and final Compliance Examination, MDHHS shall issue to the PIHP/CMHSP a management decision on findings, comments, and examination adjustments contained in the PIHP/CMHSP examination report. The management decision will include whether or not the examination finding/comment is sustained; the reasons for the decision; the expected PIHP/CMHSP action to repay disallowed costs, make financial adjustments, or take other action; and a description of the appeal process available to the PIHP/CMHSP.

STEP 2: SETTLEMENT AND DISPUTE OF FINDINGS AND QUESTIONED COSTS

PIHP/CMHSP	1. Within 30 days of receipt of the management decision: A. Submits payment to MDHHS for amounts due other than amounts resulting from disputed items; and B. If disputing items. i. Requests a conference with the Director of the Operations Administration, or his or her designee, to attempt to reach resolution on the audit findings, or submits to the MDHHS Administrative Tribunal & Appeals Division a request for the Medicaid Provider Reviews and Hearings Process pursuant to MCL 400.1, et seq. and MAC R400.3401, et seq. as specified in ii below. Any resolution as a result of a conference with the Director of the MDHHS Operations Administration would not be binding upon either party unless both parties agree to the resolution reached through these discussions. If the parties agree to a resolution the terms will be reduced to a written settlement agreement and signed by both parties. If no resolution is reached then there will be no obligation on the part of MDHHS to produce

	a report of the conference process. Matters that remain unresolved after these discussions, would move to the Administrative Hearing process, at the discretion of the CMHSP/PIHP. Administrative Hearing process ii. Submits to the MDHHS Administrative Tribunal & Appeals Division a request for the Medicaid Provider Reviews and Hearings Process pursuant to MCL 400.1, et seq. and MAC R 400.3401, et seq. This process will be used for all PIHP/CMHSP disputes involving Compliance Examinations whether they involve Medicaid funds or not. Requests must identify the specific item(s) under dispute, explain the reason(s) for the disagreement, and state the dollar amount(s) involved, if any. The request must also include any substantive documentary evidence to support the position. Requests must specifically identify whether the agency is seeking a preliminary conference, a bureau conference or an administrative hearing. If MDHHS does not receive a request for a preliminary conference, a bureau conference or an administrative hearing within 30 days of the date of the management decision, the management decision will constitute MDHHS's Final Determination Notice according to MAC R 400.3405. C. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDHHS Office of Audit, MDHHS Contract Management, and MDHHS Accounting.
MDHHS Accounting	2. If the PIHP/CMHSP has not requested a conference with the Director of Operations Administration or the Medicaid Provider Reviews and Hearings Process within the timeframe specified, implements the adjustments as outlined in the management decision. If repayment is not made, recovers funds by withholding future payments.

MDHHS Contract Management Unit	3. Ensures audited PIHP/CMHSP resolves all findings in a satisfactory manner. Works with the audited PIHP/CMSHP on developing performance objectives, as necessary.

STEP 3. MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS

MDHHS Administrative Tribunal & Appeals Division	Follows the rules contained in MAC R 400.3401, et seq., and various internal procedures regarding meetings, notifications, and decisions.

MDHHS AUDIT REPORT & APPEAL PROCESS

The following process shall be used to issue audit reports, and appeal audit findings and recommendations. Established time frames may be extended by mutual agreement of the parties involved.

STEP 1: AUDIT / PRELIMINARY ANALYSIS / RESPONSE

MDHHS Office of Audit	1. Completes audit of PIHP and holds an exit conference with PIHP management. 2. Issues a preliminary analysis within 60 days of the exit conference. The preliminary analysis is a working document and is not subject to Freedom of Information Act requests.
Audited PIHP	3. Within 10 days of receipt of the preliminary analysis, requests a meeting with the MDHHS Office of Audit to discuss disputed audit findings and conclusions in the preliminary analysis. Since the preliminary analysis serves as the basis for the final report, the PIHP shall take advantage of this opportunity to ensure that any factual disagreements or wording changes are considered before the final report is issued.
MDHHS Office of Audit	4. <u>If a meeting is requested</u>, convenes a meeting to discuss concerns regarding the preliminary analysis.
Audited PIHP	5. Within 14 days of the meeting with the MDHHS Office of Audit to discuss the preliminary analysis, submits to the MDHHS Office of Audit any additional evidence to support its arguments.
MDHHS Office of Audit	6. Within 30 days of either the meeting to discuss the preliminary analysis, or receipt of additional information from the PIHP, whichever is later, revises and issues the preliminary analysis as appropriate based on factual information submitted at the meeting or other supporting documentation provided subsequent to the meeting.
Audited PIHP	7. Within 30 days of receipt of the revised preliminary analysis, submits a brief written response indicating agreement or disagreement with each finding and recommendation. If there is disagreement, the response shall explain the basis or rationale for the disagreement and shall include additional documentation if appropriate. If there is agreement, the response shall briefly describe the actions to be taken to correct the deficiency and an expected

	completion date. Include responses on the Corrective Action Plan Forms included in the preliminary analysis. 8. If a meeting is not requested, within 30 days of receipt of the preliminary analysis, submits a brief written response to each finding and recommendation as described in STEP 1, #7 above.

STEP 2: FINAL AUDIT REPORT

MDHHS Office of Audit	1. Within 30 days of receipt of the PIHPs response to the preliminary analysis, prepares and issues final audit report incorporating paraphrased PIHP's responses, and Office of Audit responses where deemed necessary. 2. Forwards final audit report to audited PIHP and other relevant parties. The letter bound with the final audit report describes the audited PIHP's appeal rights.

STEP 3: SETTLEMENT AND DISPUTE OF FINDINGS

Audited PIHP	1. Within 30 days of receipt of the final audit report: A. Submits payment to MDHHS for amounts due other than amounts resulting from disputed findings; and B. If disputing findings, submits to the MDHHS Administrative Tribunal & Appeals Division a request for the Medicaid Provider Reviews and Hearings Process pursuant to MCL 400.1 et seq. and MAC R 400.340 1, et seq. This process will be used for all CMHSP audits regarding the Specialty Service Contract whether they involve Medicaid funds or not. Requests must identify the specific audit adjustment(s) under dispute, explain the reason(s) for the disagreement, and state the dollar amount(s) involved, if any. The request must also include any substantive documentary evidence to support the position. Requests must specifically identify whether the agency is seeking a preliminary conference, a bureau conference or an administrative hearing. If MDHHS does not receive a request for a preliminary conference, a bureau conference or an administrative hearing within 30 days of the date of the letter transmitting the final audit report, the letter will constitute MDHHS's Final Determination

	Notice according to MAC R 400.3405. C. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDHHS Office of Audit, MDHHS Contract Management, and MDHHS Accounting.
MDHHS Accounting	2. If the PIHP has not requested the Medicaid Provider Reviews and Hearings Process within the time frame specified, implements the adjustments as outlined in the final report. If repayment is not made, recovers funds by withholding future payments.
MDHHS Contract Management Unit	3. Ensures audited PIHP resolves all findings in a satisfactory manner. Works with the audited PIHP on developing performance objectives, as necessary.

STEP 4: MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS

MDHHS Administrative Tribunal & Appeals Division	Follows the rules contained in MAC R 400.3401, et seq., and various internal procedures regarding meetings, notifications, documentation, and decisions.

MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Use Disorder (SUD) Services Policy Manual

Effective October 1, 2016

Table of Contents

I. DATA REQUIREMENTS....2
II. METHADONE REQUIREMENTS....11
III. PREVENTION REQUIREMENTS....69
IV. CREDENTIALING & STAFF QUALIFICATION REQUIREMENTS....78
V. TECHNICAL ADVISORIES....97
VI. TREATMENT REQUIREMENTS....151

I. DATA REQUIREMENTS

Data Collection/Recording and Reporting Requirements – Revised July 2014

Encounter Reporting Via Health Insurance Portability and Accountability Act (HIPPA) 837 Standard Transactions—

August 2011

Children Referral Form and Instructions – Amendment #1

Michigan Prevention Data System (MPDS) Reference Manual – Effective October 1, 2007; Revised June 2, 2010

Substance Use Disorder Services Encounter Reporting; HCPCS and Revenue Codes—August 2007; Revised August 2011

SUD DATA COLLECTION/RECORDING AND REPORTING REQUIREMENTS

Overview of Reporting Requirements
The reporting of substance abuse services data by the PIHP as described in this material meets several purposes at MDHHS including:

-Federal data reporting for the SAPT Block Grant application and progress report, as well as for the treatment episode data set (TEDS) reported to the federal Office of Applied Studies, SAMHSA.

-Managed Care Contract Management

-System Performance Improvement

-Statewide Planning

-CMS Reporting

-Actuarial activities

Special reports or development of additional reporting requirements beyond the initial data and reports required by the Department may be requested within the established parameters of the contract. The PIHP will likely maintain, for management and local decision-making, additional information to that specified in the reporting requirements.

Standards for collecting and reporting data continue to evolve. Where standards and data definitions exist, it is expected that each PIHP will meet those standards and use the definitions in order to assure uniform reporting across the state. Likewise, it is imperative that the PIHP employs quality control measures to check the integrity of the data before it is submitted to MDHHS. Error reports generated by MDHHS will be available to the submitting PIHP the day following a DEG submission. MDHHS's expectation is that the records that receive error Ids will be corrected and resubmitted as soon as possible. The records in the error file are cumulative and will remain errors until they have been corrected.

Individual services recipient data received at MDHHS are kept confidential and are always reported out in aggregate. Only a limited number of MDHHS staff can access the data that contains any possible individual client identifiers. (Social Security number, date of birth,

diagnosis, etc.) All persons with such data access have signed assurances with MDHHS indicating that they are knowledgeable about substance abuse services confidentiality regulations and agree to adhere to these and other departmental safeguards and protections for data.

A. Basis of Data Reporting

The basis for data reporting policies for Michigan substance abuse services includes:

1. Federal funding awarded to Michigan through the Substance Abuse Prevention and Treatment (SAPT) federal block grant to share in support of substance abuse treatment and prevention requires submission of proposed budgets and plans. Resources and plans must be reviewed and considered by the State in light of statewide needs for substance abuse services.

2. Public Act 368 of 1978, as amended, requires that the department develop:

   A comprehensive State plan through the use of federal, State, local, and private resources of adequate services and facilities for the prevention and control of substance abuse and diagnosis, treatment, and rehabilitation of individuals who are substance abusers.

   In addition, the department shall:

   Establish a statewide information system for the collection of statistics, management data, and other information required.

   Collect, analyze and disseminate data concerning substance abuse treatment and rehabilitation services and prevention services.

   Conduct and provide grant-in-aid funds to conduct research on the incidence, prevalence, causes, and treatment of substance abuse and disseminate this information to the public and to substance abuse services professionals.

3. Comprehensive planning requires statewide needs assessments to include identification of the extent and characteristics of both risks for development and current substance abuse problems for the citizens of Michigan.

B. Policies and Requirements Regarding Data

Treatment Data reporting will encompass Substance Abuse (SA) services provided to

clients supported in whole or in part with state administered funds through funds for SA services to Medicaid recipients included in PIHP contracts.

Definitions:
State administered funds: Any state or federal funding provided by the MDHHS/DSAGS/SA contract. Funds provided include federal SAPT Block Grant, state general funds, MIChild, and other categorical or special funds. Medicaid funds that are covered under the MDHHS/PIHP contract are considered state administered funds.

Data: Client admission and discharge records (for treatment services), and client institutional and professional encounter records, and backup required to produce this information (e.g. billings from providers, services logs, etc.). Prevention services data are not addressed herein.

Services: Substance abuse treatment (residential, residential detox, intensive outpatient, outpatient, including pharmacological supports as part of above), substance abuse assessment (screening, assessment, referral and follow-up) provided by appropriately state licensed programs. Prevention services data are not addressed herein.

Supported in whole or in part: Describes those services for which the PIHP pays, inclusive of co-pays with other sources of funds (e.g. first party, third party insurance, and/or other funding sources).

Policy:
Reporting is required for all clients whose services are paid in whole or in part with state administered funds regardless of the type of co-pay or shared funding arrangement made for the services. This includes both co-pay arrangements where public funds are applied from the starting date of admission to a service, as well as those where public funds are applied subsequent to the application of other funding or payments.

For purposes of MDHHS reporting, an admission is defined as the formal acceptance of a client into substance abuse treatment. An admission has occurred if and only if the client begins treatment.

A client is defined as a person who has been admitted for treatment of his/her own drug problem. A co-dependent (a person with no alcohol or drug abuse problem who is seeking services because of problems arising from his or her relationship with an alcohol or drug user) who has been formally admitted to a treatment unit and who has his/her own client record also should be reported with the record indicating his/her co-dependency.

A client's episode of treatment is tracked by service category and by license number. The first

event at a new provider or in a new service category is an admission and the last event is a discharge.

Any change in service and/or provider during a treatment episode should be reported as a discharge, with transfer given as the reason for discharge. For reporting purposes, "completion of treatment" is defined as the completion of ALL planned treatment for the current episode.
Completion of treatment at one level of care or with one provider is not "completion of treatment" if there is additional treatment planned or expected as part of the current episode. The reason for discharge given in all instances where the treatment has not been terminated should be

06 (Transfer-Continuing in Treatment). The code of 06 will identify the fact that the client's treatment episode did not terminate on the date reported.

1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

2. All data collected and recorded on admission and discharge forms shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDHHS at the program level **(along with the National Provider Identifier (NPI).**

3. Combined reporting of client data in data uploads from more than one license site number is not acceptable or allowable, regardless of how a PIHP funds a provider organization.

4. Failure to assure initial set up and maintenance of the proper site license number and PIHP code will result in data that will be treated as errors by MDHHS. Any data submitted to MDHHS with improper license numbers will be rejected in full. The necessary corrections and data resubmissions will be the sole responsibility of the PIHP in cooperation with the involved service providers.

5. There must be a unique Substance Abuse client identifier assigned and reported. It can be up to 11 characters in length, all numeric. This same number is to be used to report data for all admissions and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of

how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.

6. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Failure to maintain corresponding data at the PIHP and program levels will result in data audit exceptions on discovery of discrepancies during an MDHHS on-site data audit/review. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.

7. Providers of residential and/or detoxification services must maintain a daily client census log that contains a listing of each individual client in treatment. This listing can be made in client name or using the client identification number. Census must be taken at approximately the same time each day, such as when residents are expected to be in bed. MDHHS or the PIHP will review the daily client census logs in data auditing site visits.

8. Providers of pharmacological support services (either methadone or buprenorphine) must maintain a log that contains a listing of each client in treatment, and their daily dosages of these medications provided by the program. MDHHS or the PIHP will review these logs in data auditing site visits

9. Diagnosis coding on client data forms shall be consistent with the client's substance abuse treatment plan. If there is more than one substance abuse diagnosis determined, then the secondary diagnosis code should be reported accordingly. Diagnosis codes on the data records must be consistent with those listed on other client documentation (such as billing forms, etc.). Codes should be entered using only the proper DSM definitions for substance abuse and other related problems that are being treated.

10. The primary diagnosis should correspond to the primary substance of abuse reported at admission. The secondary diagnosis may or may not be consistent with the secondary substance of abuse if another diagnosis better reflects a more serious secondary problem than the secondary substance.

11. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDHHS.

12. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly and quarterly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

13. Treatment clients may be admitted to more than one program or one service category at the same time.

14. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.

15. Statements of MDHHS policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

16. Treatment clients who have not had any treatment activity in a 45-day period shall be considered inactive and their case discharged. A treatment discharge record should be completed and submitted; the effective date of discharge will be the last date of actual contact with the program. The record should be completed and submitted based on the client's status as of the last date of service; records with all data items marked as unknown or left blank are not acceptable.

Encounter Reporting
Via
Health Insurance Portability and Accountability Act (HIPPA)
837 Standard Transactions

For the first quarter of FY 2012, the X12 version 40101A of the 837 Encounter will be accepted (as it has been for the last three years). However:

Effective January 1, 2012, must submit electronic healthcare transactions using the X12 version 5010. Those who do not convert to the version 5010 by the compliance date will have their encounters and other transactions rejected. Reimbursement delays and resubmission costs could occur.

Please reference this single web page for up-to-date instructions and guidance:

http://ww.michigan.gov/mdhhs/0,1607,7-132-2945_42542_42543_42546_42552_42696-256754--,00.html

Relevant documents at this site are the following:

1. HIPPA 5010A1 EDI Companion Guide for ANSI ASC X12N 837P Professional Encounter
   Regional PIHPs
2. HIPPA 5010A1 EDI CDI Companion Guide for ANSI ASC X12N 837I Institutional Encounter
   Regional PIHPs
3. Michigan Department of Health & Human Services Electronic Submission Manual March 18, 2011
4. HIPPA 5010A1EDI Companion Guide for ANSI ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

PIHP Region: _____

Quarter (check one): 1st ☐ 2nd ☐ 3rd ☐ 4th ☐

	Prevention services	Treatment Services	MH services	Other
# of children referred to:				
# of children who accessed:				
# who refused services				

* For children who "enter" services with their mother. Child might not be physically present, but clinician and case manager should be asking about any concerns regarding the child/children, and noting and tracking all referrals made for services

320 SOUTH WALNUT STREET • LANSING, MICHIGAN 48913
www.michigan.gov/mdhhs • 517-373-3740

II. METHADONE REQUIREMENTS

Treatment Policy #03, Buprenorphine—
Effective October 1, 2006

Treatment Policy #04, Off-site Dosing Requirements for
Medication-Assisted Treatment—

Effective December 1, 2006

Treatment Policy #05, Criteria for Using Methadone for
Medication assisted Treatment and Recovery--

Effective October 1, 2012

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

MEMORANDUM

Date: June 28, 2006

To: Regional Coordinating Agencies
Opioid Treatment Programs

From: Doris Gellert, Director
Bureau of Substance Abuse and Addiction Services
Office of Drug Control Policy

Subject: Revised Treatment Policy # 03: *Buprenorphine*

Enclosed is Revised Treatment Policy # 03: *Buprenorphine*. This revised policy incorporates the Medicaid primary health care pharmacy benefit.

Policy compliance will be reviewed as part of program site visits. Please direct any questions to Marilyn Miller, Treatment Specialist, at 517-241-2608, via fax at 517-335-2121, or via email at MillerMar@michigan.gov.

DG/MM/mlf

Enclosure

LEWIS CASS BUILDING • FIFTH FLOOR • 320 SOUTH WALNUT STREET • LANSING, MICHIGAN 48913
www.michigan.gov/odcp • (517) 373-4700

TREATMENT POLICY # 03

SUBJECT: Buprenorphine

ISSUED: **August 2004, revised June 6, 2006**

EFFECTIVE: September 1, 2004, revision effective October 1, 2006

PURPOSE:

This policy establishes standards for the use of buprenorphine when used as adjunct therapy in the treatment of opioid addiction for clients receiving substance abuse services administered through the Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (MDHHS/OROSC). PIHPs are required to provide additional reports so the overall cost and experience gleaned from the use of buprenorphine as adjunct to treatment can be used to determine future planning and policy.

SCOPE:

PIHPs may choose to fund the cost of the buprenorphine/naloxone medication as adjunct therapy for opioid addiction in treatment services including residential, intensive outpatient, outpatient, and methadone programs. Allowable funding consists of federal block grant, state general funding, and local funding. Medicaid reinvestment savings may also be used if part of a Medicaid reinvestment plan submitted by the Pre-paid Inpatient Health Plan (PIHP) and approved by Centers for Medicare and Medicaid Services (CMS) and MDHHS/OROSC. PIHPs may use clients on a discretionary basis after covered services have been paid.

Clients with Medicaid coverage may have access to the pharmacy benefit for buprenorphine/naloxone. It must be preauthorized through the Medicaid pharmacy plan.

Opioid Treatment Programs (OTPs) providing services must conform to the Federal opioid treatment standards set forth under 42 C.F.R. Part 8, including off-site dosing when dispensing buprenorphine/naloxone. There is no limit to the number of clients to whom buprenorphine can be dispensed from an OTP.

Private physicians who have the Substance Abuse and Mental Health Services Administration (SAMHSA) waiver for prescribing buprenorphine/naloxone are limited to managing 30 clients on buprenorphine at any one time. An OTP physician who has the SAMHSA waiver may prescribe the medication for off-site use as if the physician were in private practice. The maximum number of active clients would be 30 clients.

BACKGROUND:

The Food and Drug Administration (FDA) approved Buprenorphine hydrochloride (Subutex®) and buprenorphine hydrochloride/naloxone hydrochloride (Suboxone®) on October 8, 2002 for the treatment of opioid addiction. Both buprenorphine and buprenorphine/naloxone are administered in sublingual tablets (placed under the tongue) and gradually absorbed. Prior to their approval and subsequent scheduling as Schedule III medications, the only prescription medications approved for opioid substitution agents were methadone and LAAM, both Schedule II medications. Schedule II medications must be prescribed to patients enrolled in OTPs. Because of the numerous federal and state regulations with respect to OTPs, the addition of Schedule III medications as adjunctive treatment greatly increases access to services for potential opioid treatment clients because they can now receive medication for opioid addiction treatment through a qualified physician's office.

Buprenorphine has a ceiling effect for toxicity because of its antagonist properties. Once a certain dose or receptor occupancy level is reached, additional dosing does not produce further toxicity. Studies have shown that buprenorphine plateaus at the equivalent of 40 to 60 milligrams of methadone. Because of the maximum for toxicity, respiratory depression and/or death from overdose are less common than with opiate agonists, such as heroin, oxycodone, or methadone. Concurrent use of buprenorphine with alcohol, benzodiazepines, or other respiratory depressants can still result in overdose. Naloxone (Narcan) is added to buprenorphine by the manufacturer to prevent diversion because, although the naloxone will have no effect when absorbed under the tongue, crushing and injecting the medication will result in sudden and intense withdrawal symptoms. The ceiling effect also restricts the medication's effectiveness in treating patients who have a need for high levels of opioid replacement medication. Studies are currently being done to determine the safety of buprenorphine/naloxone in pregnancy as well as breastfeeding.

REQUIREMENTS:

Program Requirements

1. The client must have a Diagnostic Statistical Manual (DSM) impression of opioid dependency as determined by the Access Management System (AMS). All six dimensions of the current American Society of Addiction Medicine (ASAM) Patient Placement Criteria must be used. The client must meet medical necessity criteria as determined by a physician who has a SAMHSA waiver to prescribe or dispense buprenorphine.

2. Buprenorphine/naloxone must be used as adjunct to opioid treatment throughout the continuum of care (OP, IOP, Residential, sub-acute detoxification, and methadone adjunctive treatment as part of a detoxification regimen). It cannot be used without counseling.

3. Toxicology screens must be done at intake and then on a random, at least weekly, frequency until three (3) consecutive screens are negative. Thereafter, they must be done on a monthly, random frequency. Screens must assay for opioids, cocaine, amphetamines, cannabinoids, benzodiazepines, and

methadone metabolites. Screens must be random for days of the week and days since last screen was administered.

4. As an adjunctive medication for the treatment of opioid addiction, the PIHP cannot pay for the buprenorphine/naloxone alone. The medication must be used in conjunction with counseling at a substance abuse treatment program under contract with the PIHP. The PIHP must develop a plan in which the substance abuse treatment program, a qualified physician, and a pharmacy are involved.

Reporting Requirements

The data system has been modified to accommodate reporting for clients receiving buprenorphine/naloxone.

Data system:

- **Admission and discharge Treatment Episode Data Set (TEDS) records must be submitted as is routine with other clients. In the client admission record, the field OPIOD TREATMENT PROGRAM (1= Methadone, 2= No, and 3= Buprenorphine) must be coded with "3" for all clients receiving buprenorphine/naloxone, regardless of service category.**
- **Buprenorphine/naloxone daily dosages and associated cost must be reported with HCPCS Code of H0033 as required in the 837 Professional Encounter record.**

PROCEDURE:

Prescribing Policy

1. All physicians, including those at an OTP, must have a waiver from SAMHSA permitting them to prescribe or dispense buprenorphine/naloxone (e.g., Suboxone®).

2. Buprenorphine/naloxone (Suboxone®) must be used as an adjunctive treatment within an individualized treatment plan for opioid addiction. It is not appropriate as a stand-alone treatment procedure.

3. The target populations for buprenorphine/naloxone are the following:

   - Clients who are being transferred from methadone as part of a detoxification regimen;

   - Clients that have been opioid dependent less than one year, but for whom adjunctive therapy is deemed medically necessary; and

   - Clients that are eligible for methadone adjunctive therapy within the 40-60 milligrams therapeutic range.

4. In accordance with FDA regulations, buprenorphine is not currently approved for pregnant women.

5. The combination medication buprenorphine/naloxone (Suboxone®) is the only medication approved for use under these guidelines. No "off-label" or experimental use of buprenorphine/naloxone is permitted under these policies.

REFERENCES:

American Psychiatric Association. (2000). *The Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, Washington, DC.

American Society of Addiction Medicine. (2001). *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition-Revised, ASAM UPC-2R, Chevy Chase, Maryland.

Certification of Opioid Treatment Programs: United States Code of Federal Regulations, Title 42, Part 8, Washington, D.C. (2003).

Drug Addiction Treatment Act of 2000: PL106-310, Section 3502, United States House, 105th Congress, Washington, DC. (October 17, 2000).

Food and Drug Administration. (October 8, 2002). *Subutex and Suboxone Approved to Treat Opiate Dependence*, FDA Talk Paper, Washington, DC.

Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction; Addition of Buprenorphine and Buprenorphine Combination to List of Approved Opioid Treatment Medications: Federal Register, Volume 68, Number 99, pp 27937-27939, Interim final rule, United States Superintendent of Documents. (May 22, 2003).

Schuster, C and Seine, S. (October 8, 2002). *Interview*. University Psychiatric Clinic, Wayne State University, Detroit Michigan.

APPROVED BY: ___*SIGNED*_____

Donald L. Allen, Jr., Director
Office of Drug Control Policy

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

DATE: November 30, 2006

TO: Regional Coordinating Agencies
Opioid Treatment Programs

FROM: Doris Gellert, Director
Bureau of Substance Abuse and Addiction Services
Office of Drug Control Policy

SUBJECT: Revised Treatment Policy-04: Off-Site Dosing Requirements for Medication Assisted Treatment

Enclosed is the final version of the Michigan Department of Community Health/Office of Drug Control Policy (MDCH/ODCP) Treatment Policy #4 – Off-Site Dosing Requirements for Medication Assisted Treatment

There were no comments from the field. The following changes were made by MDCH/ODCP staff:

1. Labeling- page 5 – because Suboxone® is in tablet form rather than liquid like methadone, it can be dispensed for multiple days in the same bottle.

2. Out of Country Travel, page 9 – Center for Substance Abuse Treatment/Division of Pharmacologic Therapies (CSAT/DPT) approval is no longer necessary solely because the client wishes to travel outside the country. MDCH/ODCP approval is still required.

Reminder: Extranet submissions are required. The use of the Extranet, which is maintained by CSAT, will be the only manner in which exception requests will be accepted by MDCH/ODCP effective January 1, 2007. Call 1-866-687-2728 to sign up for the Extranet. For those OTPs that do not have Internet capability, a waiver of this requirement can be obtained by submitting a request, in writing, to ODCP. Fax the request to the attention of Marilyn Miller at 517-335-2121. This request should state the reasons why use of the Extranet cannot start on the effective date and the planned date for starting.

Should you have any questions or require further clarification of any issues in this policy, please contact Marilyn Miller at 517-241-2608, or by email at millermar@michigan.gov.

Enclosure

TREATMENT POLICY 04

SUBJECT: **Off-Site Dosing Requirements for Medication Assisted Treatment**

ISSUED: September 1, 2004, revised March 1, 2006, revised November 13, 2006

EFFECTIVE: **December 1, 2006**

PURPOSE:

The purpose of this policy is to clarify the rules and procedures pertaining to off-site dosing of opioid treatment medication by clients in Opioid Treatment Programs (OTP).

SCOPE:

This policy pertains to off-site dosing for all clients who are receiving medication-assisted treatment as an adjunct in an OTP in Michigan, regardless of the funding source. Due to the complexities of off-site usage and the variety of rules and regulations involved, in situations where there is a conflict between state and federal rules not otherwise addressed in this policy, the most stringent rule applies. Off-site dosing is a privilege, not an entitlement, nor a right.

BACKGROUND:

The use of methadone and buprenorphine, through an OTP, as adjunct therapies in substance abuse treatment, is highly regulated. Clients must attend the OTP daily for on-site supervised dispensing of their medication until they have met certain specified criteria for the privilege of reduced attendance and dosing off site. Safety is the driving force behind the strict regulations for off site dosing with the goal of preventing diversion of the medication to the general public and the accidental ingestion of the medication by children.

Off-site dosing can be used on a temporary basis in cases when the clinic is closed for business, such as Sundays and holidays. On an individual basis, off-site dosing may be temporary or

permanent. As specified in this policy, some off-site dosing may need approval from the Michigan Department of Health & Human Services/Office of Recovery Oriented Systems of Care (MDHHS/OROSC) and/or the Center for Substance Abuse Treatment/Division of Pharmacologic Therapies (CSAT/DPT).

REQUIREMENTS:

OTP program physicians and other designated OTP staff must ensure that clients are responsible for managing off-site dosing prior to granting the privilege. The amount of time in treatment, progress towards meeting the treatment goals, as well as exceptional circumstances or physical/medical issues are used to determine the number of doses of methadone allowed off site. Exceptions to these rules are allowed with approval from the State Methadone Authority (SMA) at MDHHS/OROSC and, where federal law requires, CSAT/DPT approval.

On-Site OTP Clinic Attendance Requirements

A client in maintenance treatment must ingest the medication under observation, at the OTP clinic, for not less than six days a week for a minimum of the first 90 days in treatment (R 325.14417 Part 417[1]). If a client discontinues treatment and later returns, the time in treatment is restarted as if the client was newly admitted to treatment, unless there are extenuating circumstances.

When a client transfers from another OTP, the cumulative time in treatment must be used in calculating the client's time if the gap in treatment time is less than 90 days (R 325.14417 Part 417[4]).

After 90 days of treatment, a client may be allowed to reduce on-site dosing to three times weekly while receiving no more than two doses at one time for off-site dosing (R 325.14417 Part 417[2]).

After two years in treatment, a client may be allowed to reduce the on-site dosing to two times weekly while receiving no more than three doses at one time for off-site dosing (R 325.14417 Part 417[3]).

The inability of the client to qualify for off-site dosing or to maintain an off-site dosing schedule must be addressed as part of the client's individualized treatment plan. Dosage adjustments, establishment of compliance contracts, additional counseling sessions, specialized treatment groups, or assessment for another level of care must be considered. OTPs must coordinate sanctions with the prior authorization source such as an Access Management System (AMS) agency for funded clients or other involved third party as appropriate.

Off-Site Dosing Requirements

Rules that Apply to All Off-Site Dosing:

All clients who are dispensed medication for off-site dosing must be deemed responsible for handling the medication. This includes when the program is closed for business, such as Sundays and holiday observances as well as other qualified times. If the client is deemed not to be responsible for any of these times, other arrangements must be made for the client to be dosed on site at their current OTP or at another OTP. If a client needs to go to another program to be dosed, coordination between both programs is required to ensure the client is only dosing at one OTP for days when the client's OTP of record is closed.

Client Criteria:

Medication for off-site dosing may only be given to a client who, in the reasonable clinical judgment of the program physician, is responsible in the handling of opioid substitution medication. Before reducing the frequency of on-site dosing, the rationale for this decision must be documented in the client's treatment record by a program physician or a designated staff. If a designated staff member records the rationale for the decision, a program physician must review, countersign, and date the client's record (R 325.14416 Part 416[1] and 42 CFR Part 8.12[I][3]). The client's off-site dosing schedule is to be reviewed every sixty days while the client receives doses for off-site use.

The program physician must utilize all of the following information in determining whether or not a client is responsible to handle opioid medication off site:

- Background and history of the client: the client is employed, actively seeking employment as evidenced by a sign-off sheet from potential employers, or disabled and unable to work as evidenced by a Social Security Income or Social Security Income Disability or Workmen's Compensation checks; and the client has appropriately handled off-site dosing in the past such as on Sundays and holidays or other off-site situations.

- General and specific characteristics of the client and the community in which the client resides (the client is working toward or maintaining treatment goals; the client has taken measures to ensure that third parties do not have access to the medication).

- An absence of current and/or recent abuse (within 90 days) of drugs, including alcohol on the basis of toxicology screens that must include opioids, methadone metabolites, barbiturates, amphetamines, cocaine, cannabinoids, benzodiazepines and any other drugs as appropriate for individual clients. Alcohol testing must be conducted by the use of a Breathalyzer or other standard testing means if alcohol is suspected at the time of dosing. (Clients who appear to be under the influence of

any drug or alcohol will not be dosed until safe to do so. Clients should not be allowed to drive under this condition.) Any evidence of alcohol abuse in the client's chart within the past 90 days will be considered as positive for alcohol, as will any legal charges related to alcohol consumption. The need to verify toxicology tests or the need for more frequent toxicology tests must be components of the clinic rules. Legally prescribed drugs, including controlled substances, will not be considered as illicit substances, provided the OTP has verification the drug(s) were prescribed for the client. Such documentation must be included in the client's chart. Prescription documentation for all prescribed medication must be updated at least every 60 days until discontinued. Prescription medication documentation must be updated in the client's chart at the first opportunity – preferably at the next clinic visit – when the client is prescribed a medication or a medication is renewed. A copy of the prescription label, a printout from the pharmacy, or the information recorded in the chart from viewing the patient's prescription bottle shall constitute documentation. All medications are to be considered within the context of coordinating care with other prescribing healthcare providers, and the safety considerations of granting off-site dosing privileges.

- Regularity of clinic attendance.
- Absence of serious behavioral problems in the clinic.
- Stability of the client's home environment and social relationships.
- Absence of recent known criminal activity.
- Length of time in opioid substance abuse treatment with medication as an adjunct.
- Assurance that medication can be safely stored off site, particularly with respect to prevention of accidental ingestion by children.
- The rehabilitative benefit to the client derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion.

R 325.14416 Part 416[3] and 42CFR Part 8.12 [I][2][i-viii]

Clients must receive a copy of the clinic's rules pertaining to responsible handling of off-site doses and the reasons for revoking them. Clinic rules must include a list of graduated sanctions such as decreasing and rescinding of all off-site dosing. A form signed by the client acknowledging receipt of this information must be included in the

client file.

Product Preparation:

Methadone for off-site dosing must be dispensed in a liquid, oral form and formulated in such a way to minimize use by injection. The methadone must contain a preservative so refrigeration is not required.

Methadone must be dispensed in disposable, single use bottles, and must be packaged in childproof containers pursuant to section 3 of the Poison Prevention Packaging Act, 15 USC Part 1472. (R 325.14415 Part 415) In cases when clients take medication twice daily (split dosing), two separate childproof containers must be utilized. These efforts will help minimize the likelihood of accidental ingestion by children.

Buprenorphine/naloxone must be packaged in childproof containers and labeled similar to methadone. However, because buprenorphine/naloxone is in tablet form, a maximum of 30-day supply can be contained in the same bottle. The dose(s) dispensed for unsupervised off-site use must adhere to 42 CFR Part 8 unless an exception request has been approved. (MCL 333.17745)

Labeling:

Medication for off-site administration must be labeled as follows:

- The name of the medication
- The strength of the medication
- The quantity dispensed
- The OTP's name, address, and phone number
- Client's name or code number
- Medical director's/prescriber's name
- Directions for use
- The date dispensed and the date to be used
- A cautionary statement that the medication should be kept out of the reach of children
- Statement that this medication is only intended for the person to whom it was prescribed

R 325.14415 Part 415(2)
MCL 333.17745(7)(a-h)

Security:

The client is expected to secure all take home medication in a locked box prior to leaving the OTP. It is expected that the client store this box in a manner that will prevent the key or combination from being readily available to children and/or others who could be harmed from accidental use and to prevent diversion to or by third parties. Clients should be able to explain the process that will be used to secure the medications that are taken home when asked by an OTP staff member. This process should be recorded in the client's record and updated when the client's take home status is reviewed every 60 days. Empty and unused bottles are to be returned to the OTP in the locked box for proper disposal. Failure to do so could result in revocation of take home privileges.

Temporary Off-Site Dosing:

Special circumstances such as a client's physical/medical needs or other exceptional circumstances, situations in which a program is closed such as Sundays and Holidays, or emergency situations may result in cases when the client is allowed to dose off site for a temporary time period.

Physical/Medical Necessity:

If a client's physician provides written documentation that reduced attendance at the clinic is necessary due to physical/medical necessity of the client and the OTP physician concurs, off-site dosing of up to 13 doses within a 14-day time frame is allowed without prior MDHHS/OROSC approval unless the request exceeds the CSAT/DPT amounts allowed. (See Section entitled "CSAT/DPT Approval Required.")

The written documentation from the client's physician must include a medical diagnosis and whether the condition is permanent or temporary. If the condition is temporary, the date the client can return to his/her usual clinic attendance must be indicated. Whenever possible, the client's personal physician and the OTP physician should coordinate care including the prescribing of medication that interacts with methadone.

Temporary exceptions need to be reviewed and reissued if the exception is needed beyond the initial time frame. All exceptions must be reviewed during the usual 60-day OTP physician's review. All documentation must be maintained in the client's chart (R 325.14417 Part 417(5)). Requirements for counseling sessions and toxicology screens must be coordinated with CAs if the client is funded.

Exceptional Circumstances:

Medication for off-site dosing may only be given to a client who has an exceptional circumstance as indicated in this section and who, in the reasonable clinical judgment of the program physician, is responsible in the handling of opioid substitution medication. The exceptional circumstance must be clearly documented and any supportive documentation should be included in the client's chart.

Clients who have been in OTP treatment for at least 6 months and who are eligible for a 3-times a week schedule may be permitted up to three consecutive off-site doses within a specific 7-day period, depending on the situation, without prior approval from MDHHS/OROSC, for the following exceptional circumstances:

- Employment schedule conflicts
- Educational training schedule conflicts
- Medical or mental health appointment conflicts
- Appointments with other agencies relative to the client's treatment goals

Clients who have been in OTP treatment for at least nine months may be permitted up to six off-site doses within a 7-day time period without prior approval from MDHHS/OROSC for the following exceptional circumstance:

- Travel hardship (at least 60 miles or 60 minutes one way from an OTP). The actual mileage must be documented in the client's chart with the city of origin listed.

Vacations are a special type of exceptional circumstance and shall be limited to six days within a 7-day period for clients who have been in treatment for at least nine months and 13 days within a 14-day period for clients who have been in treatment for one year or more without prior MDHHS/OROSC approval. Sunday and holiday doses must be included in the specified off-site amounts (R 325.14416 Part 417[6]). Documentation must be included in the chart verifying the client did travel to the planned destination(s) as indicated on the exception request.

Allowable Program Closures:

Medication for off-site dosing due to program closure may only be given to a client who, in the reasonable clinical judgment of the program physician, is responsible in the handling of opioid substitution medication.

Sunday Dosing

OTPs may be closed on Sundays without prior approval from MDHHS/OROSC.

Holiday Observances

- OTPs may be closed for the following holidays without prior MDHHS/OROSC approval:

New Year's Day	Labor Day
Martin Luther King, Jr. Birthday	Veterans' Day
Presidents' Day	Thanksgiving Day
Memorial Day	Christmas Day
Independence Day – July 4	

- Should the holiday fall on a Sunday, OTPs may be closed the following Monday without prior MDHHS/OROSC approval.
- A day in which the OTP has abbreviated hours in which methadone will be dispensed will not be considered as a program closure.
- If the OTP wishes to close for more than two consecutive days (including Sundays and holidays), the SMA at MDHHS/OROSC and CSAT/DPT must approve a plan. The plan must meet the following criteria:
  - The request must be for each circumstance. OTPs may request all holidays for the entire year at once. No approvals will be automatically approved from year to year.
  - The request must be submitted for each individual OTP.

- The plan must be submitted to the SMA at MDHHS/OROSC at least 10 working days prior to the first day the program wishes to close. MDHHS/OROSC is not obligated to approve any plans submitted that do not meet the 10 day criteria. Fax the request to the current number for MDHHS/OROSC– (517) 335-2121.

- Be written on OTP letterhead.

- Be signed by the OTP sponsor or administrator.

- Name holidays to be closed.

- List dates to be closed including the holiday as well as a Sunday, if applicable.

- Describe how clients who lack 90 days in treatment and those clients who do not meet the criteria for unsupervised dosing will be dosed face-to-face.

MDHHS/OROSC will approve and forward the request to CSAT/DPT for their approval. Should MDHHS/OROSC not approve the plan, the OTP will be notified. This notification will include the reason(s) for the denial.

Emergency Situations

OTPs must have written plans and procedures which include how dosing clients on-site, as well as dispensing doses for off-site use, will be accomplished in emergency situations. Emergency situations include power failures, natural disasters, and other situations in which the OTP cannot operate as usual. This plan must also include how the security of the medication and client records will be maintained.

PROCEDURE:

MDHHS/OROSC Approval Required:

MDHHS/OROSC approval for off-site dosing is needed for clients who do not meet the criteria for approval at the OTP level and for all those cases where federal approval is needed. In addition, any client taking medication out of the country must have MDHHS/OROSC approval. Note: medication transported out of the country is subject to that country's jurisdiction.

CSAT/DPT Approval Required:

CSAT/DPT approval is needed for clients not meeting the following federal off-site criteria for length of time in treatment:

- Less than 90 days in treatment - 1 dose plus the Sunday dose
- 90 to 180 days in treatment - 2 doses plus the Sunday dose
- 180 to 270 days in treatment - 3 doses plus the Sunday dose
- 270 to 360 days in treatment - 6 doses (includes the Sunday dose)
- One year in continuous treatment - 14 doses (includes the Sunday dose)

Submission Of Exception Requests:

As the CSAT/DPT Extranet system is in place and functioning well, the hard copy and fax method may only be used when the Extranet system is temporarily unavailable. The Extranet system is more efficient and allows for faster responses by MDHHS/OROSC and CSAT/DPT and provides better confidentiality and eliminates the chance of not being able to read a hand written request due to fax quality and/or legibility. Programs must not submit both hard copy and Extranet-based forms for the same exception request. Programs may request a short-term waiver from the use of the Extranet from the SMA at MDHHS/OROSC. Each request will be considered on a case-by-case basis.

Extranet System:

The CSAT/DPT Extranet System was designed to facilitate the processing of Exception and Record of Justification Forms nationwide. Instructions for using this system are the responsibility of CSAT/DPT. The Extranet form will be available as directed by CSAT/DPT on a Website designated by SAMHSA. OTPs must submit all exception requests using this method, even those that only require MDHHS/OROSC approval. In those cases, CSAT/DPT will indicate, “Decision not required.”

MDHHS/OROSC requires that all exception requests be submitted by using the Extranet system. Faxed forms will only be accepted if the system is down or in special, pre-approved situations.

Extranet Downtime Procedure for Hard Copy Forms and Faxing:

All downtime exceptions to the rules for off-site dosing must be submitted to

MDHHS/OROSC on the "MDHHS/OROSC Methadone Exception Request and Record of Justification" form (Attachment A). **This is the only form that will be accepted by MDHHS/OROSC.** In urgent situations, such as funerals, illness, immediate work and travel hardships, this form can be used but the OTP should call the SMA so this exception can be obtained quickly. The SMA reserves the right to determine if the situation is urgent enough to warrant not using the Extranet and may request it is made in that manner.

MDHHS/OROSC will identify those exception requests that also need CSAT/DPT approval by marking the appropriate box on the form when it is sent back. It is the responsibility of the OTPs to complete the SMA-168 "Exception Request and Record of Justification" (Attachment D) – **this is not the same form that is sent to** MDHHS/OROSC– and fax it to CSAT/DPT at their current fax number for exceptions. As indicated on this form, the current fax number is (240) 276-1630. A copy of the approved MDHHS/OROSC Exception Request and Record of Justification Form must be submitted along with this form. Attachment D was included in this policy as a convenience to the OTPs. However, OTPs are responsible for using the most current CSAT/DPT form and fax number. This information can be located on the SAMHSA Website, www.dpt.samhsa.gov.

Delivery of Methadone to a Client by a Third Party or to Another Facility

***Delivery of Methadone to a Client by a Third Party*:**

Documentation must be kept in the client's file that the client meets the criteria for off-site dosing as indicated in R 325.14416 (3) (a)-(k) and 42CFR Part 8.12 (i)(2)(i-viii). In addition, a "MDHHS/OROSC Delivery to a Client by a Third Party" form (Attachment B) must be completed and maintained at the program. A copy of the form signed by the person receiving the methadone must be returned to the program so that the chain of custody can be documented before another supply is issued. A maximum of 7 doses may be delivered to a client for self-administration. The methadone must be secured in a locked box before leaving the OTP. Empty and unused bottles must be returned to the OTP.

***Delivery of Methadone to Another Facility Form*:**

A "MDHHS/OROSC Delivery of Methadone to Another Facility Form" (Attachment C) must be completed and maintained at the program. A copy of the form signed by the person receiving the methadone must be returned to the program so that the chain of custody can be documented before another supply is issued. A staff member of the facility in which the client is housed may obtain a maximum of 14 doses. The facility will transport, secure, and administer the methadone, as well as dispose of empty and unused bottles, according to that facility's protocols for the use of medications that are controlled substances.

Exception Verification for PIHPs:

Funded OTPs must submit a copy of approved MDHHS OROSC Methadone Exception and Record of Justification Form to their respective PIHPs when requested to do so.

Monitoring For Compliance:

Site visits to OTPs by MDHHS/OROSC will include a review of documentation verifying that clients meet the criteria for off-site dosing. Probation or rescinding of off-site dosing privileges, when the client has not followed the rules for off-site usage, will also be reviewed. This document must include the coordination of sanctions and any changes to the treatment plan or services authorized by the PIHP or AMS for funded clients. OTPs must have a system to readily identify those clients issued doses for off-site use.

REFERENCES:

American Society of Addiction Medicine (for Buprenorphine information). http://www.asam.org/

Certification of Opioid Treatment Programs: United States Code of Federal Regulations, Title 42, Part 8, Washington, D.C. (s003) http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl

Division of Pharmacologic Therapies. (2002). *Patient Exceptions SMA-168-Exception Request and Record of Justification under 42 CFR § 8.12.* Retrieved from the Substance Abuse and Mental Health Services Administration website at http://dpt.samhsa.gov/webintro.htm

Drug Addiction Treatment Act of 2000: Public Law 106-310, Section 3502, United States House, 106th Congress, Washington, DC. (October 17, 2000).

Labeling and Dispensing of Prescription Medication. *Public Health Code:* 1978 Public Act 369, as amended, Article 6. MCL 333.17745, Michigan Legislature, 1977-78 Legislative Session, Lansing, Michigan. (September 30, 1978). http://www.legislature.mi.gov/mileg.aspx?page=getObject&objectName=mcl-333-17745

Methadone Treatment and Other Chemotherapy: Michigan Administrative Code, Rules 325.14401-325.14423, State Office of Administrative Hearings and Rules. Lansing, Michigan. (September 10, 1971). http://www.michigan.gov/documents/cis_bhs_fhs_sa_part4_37163_7.pdf

Poison Prevention Packaging Act of 1970: Public Law 91-601, 84 Stat. 1670, as amended, 90th Congress, Washington, DC. (December 30, 1970). http://www.cpsc.gov/businfo/pppatext.html

Public Health Code: 1978 Public Act 368, as amended, MCL 333.1100-333.25211, Michigan Legislature, 1977-1978 Legislative Session, Lansing, Michigan. (September 30, 1978). http://www.legislature.mi.gov/mileg.aspx?page=getobject&objectname=mcl-act-368-of-1978

APPROVED BY: ___*Signed*_____
Donald L. Allen, Jr., Director
Office of Drug Control Policy

EXHIBIT A

MDHHS/OROSC METHADONE EXCEPTION REQUEST AND RECORD OF JUSTIFICATION FORM

DIRECTIONS FOR COMPLETING THE FORM:

NOTE: This form is only to be used during Extranet downtime and may be used in rare urgent situations at the SMAs discretion.

Program ID: Type the I-SATS Number.

City: Fill in the location of the program.

Client ID: Fill in the client's ID number.

Program Telephone: Type the program's phone number.

E-mail Address: Type the program's e-mail address if available.

Name and Title of Requestor: Type name and title of requestor.

Client's admission date: Fill in the patient's admission date to the program.

If transfer from another program-original date: If the client transferred from another OTP, use that program's admission date in addition to the admission date to your program if the gap between services is less than 90 days. If there has been a 90-day or more gap in treatment, leave this blank.

Client's dosage level: Fill in the patient's dosage level.

Client's program attendance schedule per week: Circle appropriate days.

Client is: employed, unemployed, student, other (specify): Circle appropriate category. If other, explain.

Client is disabled (specify): Specify and provide an explanation of the disability.

Permanent Decrease in Attendance to: Circle days.

Temporary Change in Attendance: Temporary Change in Attendance (please explain). Fill in the explanation.

Justification for request: Describe the justification for request. Be as specific as possible without providing any patient identifying information. Travel hardships must include the city and the roundtrip mileage. If visiting another city, indicate city and state and why guest dosing is not being done. Any criterion that is not in compliance must be explained. A positive toxicology screen for drugs other than methadone metabolites must be documented as having a prescription for that time period. Toxicology screens must be positive for methadone or methadone metabolites.

DO NOT SUBMIT DOCUMENTATION TO MDHHS/OROSCOR CSAT/DPT UNLESS IT IS SPECIFICALLY REQUESTED. ENSURE THAT ALL CLIENT IDENTIFYING INFORMATION IS REMOVED FROM THE DOCUMENTS.

Dates of Exception: Fill in the date of the first and last off-site doses.

Number of doses to be dispensed: Fill in number of doses to be dispensed.

Has the client been informed of the dangers of children ingesting methadone: Circle the correct response.

Does the client meet the criteria used to determine if the patient is responsible in handling methadone as outlined in MDHHS/OROSC Policy-04, Administrative Rules of Substance Abuse Treatment Programs in Michigan – R 325.14416 Part 416(3)(a-k) and 42 CFR Part 8.12(i)(2) (i-viii):
Circle the correct response. If no, the explanation must be included under the justification.

Name of Concurring Physician: Type the name of the concurring physician and MD or DO.

Signature of Physician: Signature by physician along with MD or DO.

DO NOT WRITE BELOW THIS LINE: Leave Blank.

MDHHS/OROSC will approve or deny the Exception Request. Denials will be explained.

This Exception Request Also Requires Federal Approval. MDHHS/OROSC will identify those Exception Requests that also need CSAT/DPT approval. IT IS THE RESPONSIBILITY OF THE OTP TO COMPLETE FEDERAL FORM SMA-168 EXCEPTION REQUEST AND RECORD OF JUSTIFICATION AND FAX IT TO CSAT/DPT AT 240-276-1630 ALONG WITH A COPY OF THE SIGNED MDHHS/OROSC FORM. SUBMIT ONLY THOSE REQUESTS THAT NEED CSAT/DPT APPROVAL.

TO: State Methadone Authority, MDHHS/OROSC Fax: 517-335-2121 **DATE_____**

FROM: Program Name_____ **FAX _____**

MDHHS/OROSCEXCEPTION REQUEST AND RECORD OF JUSTIFICATION

NOTE: This form is only to be used during Extranet downtime and may be used in rare urgent situations at the SMAs discretion.

Program ID: _____City: _____ Client ID: _____

Program Telephone: _____ E-Mail Address_____

Name & Title of requestor _____

Client's admission date _____ If transfer, original admission date _____ Client's dosage level_____

Client's program attendance schedule per week S M T W T F S (circle days)

Client is: Employed Unemployed Student Other (Circle) (specify)_____

Client has a disability (please

explain)_____

Permanent Decrease in Attendance to S M T W T F S (circle days)

Temporary Change in Attendance (please

explain)_____

Justification for

request:_____

Dates of Exception ___/___/___ to ___/___/___ Number of doses to be dispensed

_____

Has the client been informed of the dangers of children ingesting methadone? Yes No (circle)

Does the client meet the criteria used to determine if the client is responsible in handling methadone as outlined in MDHHS/OROSC

Policy-04, Administrative Rules of Substance Abuse Treatment Programs in Michigan – R 325.14416 part 416(3)(a-k) and 42 CFR § 8.12(i) (2) (i-viii)? Yes No (circle)

_____ _____

Print Name of Concurring Physician Signature of Physician

_____

STATE USE ONLY

Approved Denied Date ___/___/___ _____

State Methadone Authority or Designee

ODCP (517) 373-4700

Explain:_____

_____

☐ **This Exception Request Also Needs Federal Approval.** Complete Form SMA-168 for federal approval and fax Form SMA-168 and this state approved request to CSAT per Form SMA-168 instructions.

State Comments:_____

_____

Confidentiality Notice: "The documents contain information from the Michigan Department of Health & Human Services/Office of Recovery Oriented Systems of Care (OROSC) which is confidential in nature. The information is for the sole use of the intended recipient(s) named on the coversheet. If you are not the intended recipient, you are hereby notified that any disclosure, distribution or copying, or the taking of any action in regard to the contents of this information is strictly prohibited. If you have received this fax in error, please telephone us immediately so that we can correct the error and arrange for destruction or return of the faxed document."

EXHIBIT B

DIRECTIONS FOR COMPLETING MDHHS/OROSC DELIVERY TO A CLIENT BY A THIRD PARTY FORM

Date: Fill in date methadone dispensed.

Client#: Fill in client's number.

Program Treatment Name: Fill in Treatment Programs Name

Program ID: Fill in Program's I-SATS Number

Program Telephone: Fill in Program's Phone Number

Fax: Fill in Program's Fax Number

E-Mail: Fill in Program's E-Mail Address

Name of Dispensing Nurse: Fill in Name of Dispensing Nurse

Licensing Number of Dispensing Nurse: Fill in Licensing Number

Signature of Dispensing Nurse: Dispensing Nurse's Signature

Justification for why client is unable to pick up the methadone at the clinic: Explain the reason, such as a disability; specify. A note from the client's physician or similar documentation from the OTP physician must be placed in the client's chart.

Methadone is being transported to: Fill in client at residence, relative's residence, not the specific address.

Medication provided from _____to _____: List dates

Number of Doses Dispensed at One Time_____: List number of doses dispensed. Not to exceed 7 doses without MDHHS/OROSC written permission.

Person Delivering the Methadone: List person's name that is delivering the methadone.

Relationship to Client: Indicate relationship to client, such as spouse, roommate, etc.

Liability Statement: Person delivering methadone should read and sign on the signature line.

Signature of Person Delivering Methadone: Deliverer signs.

Witness: Witness to the Deliverer's signature.

Signature of Person Receiving Medication: Signature of client who receives the methadone.

THE FORM, SIGNED BY THE CLIENT, IS TO BE RETURNED TO THE CLINIC WITH THE EMPTY AND UNUSED BOTTLES.

Both the delivery person and the client agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDHHS/OROSC liable for any unauthorized use of the methadone.

Distribution
Original Copy to OTP: The original of the form is retained at the OTP.
Copy to Client: A copy of the form is to be made and given to the client.

MDHHS/OROSC DELIVERY TO A CLIENT BY A THIRD PARTY FORM

DATE:_____ Client #:_____

Program Treatment Name:_____ Program ID:_____

Program Telephone:_____Fax:_____E-Mail:_____

Name Of Dispensing Nurse:_____License#:_____

Signature of Dispensing Nurse:_____

Justification for why client is unable to pick up the methadone at the clinic:

_____

_____

(Documentation from the client's physician or OTP physician must be included in the client's chart)

Methadone is being Delivered to: _____

Methadone provided from: _____to _____ Number of Doses Dispensed at One Time:_____
(Date) (Date) (Not to exceed 7 doses)

Person Delivering Methadone :_____Relationship to Client:_____

Due to the above named client's temporary inability to pick-up his/her methadone, the above named Opioid Treatment Program has permission from MDHHS/OROSC to allow delivery of the methadone to the client. I understand that this arrangement is for a specific period of time only, and that when this time ends, I will either no longer be picking up the medication, or will have to complete another MDHHS/OROSC DELIVERY TO CLIENT BY A THIRD PARTY FORM. I further understand that methadone is a narcotic, to be ingested by the client only, and that harm, including death could come to anyone else ingesting it. When I pick-up this medication, I must present current government issued pictured identification (Driver's License, State Identification Card, Military Identification Card). I must also present any necessary documentation from the treating physician, so that the clinic is kept up-to-date on the current status of the client's medical condition. I am aware that the methadone must be transported in a locked box and kept in this manner. Empty and unused bottles must be returned in the locked box. I have been made aware that loitering within a one-block

radius of the clinic is prohibited. Both the delivery person and the client agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDHHS/OROSC liable for any unauthorized use of the methadone.

_____ _____

Signature of Person Delivering the Methadone Signature of Person Receiving Methadone

_____

Witness

THE FORM, SIGNED BY THE BOTH THE PERSON DELIVERING AND THE PERSON RECEIVING THE METHADONE, IS TO BE RETURNED TO THE CLINIC WITH THE USED BOTTLES.

DISTRIBUTION: Original to OTP
Copy to Client

EXHIBIT C

DIRECTIONS FOR COMPLETING MDHHS/OROSC DELIVERY OF METHADONE TO ANOTHER FACILITY FORM

Date: Fill in date methadone dispensed.

Client#: Fill in client's number.

Program Treatment Name: Fill in Treatment Programs Name

Program ID: Fill in Program's I-SATS Number

Program Telephone: Fill in Program's Phone Number

Fax: Fill in Program's Fax Number

E-Mail: Fill in Program's E-Mail Address

Methadone Delivered to: Facility Name, Phone Number: Fill in name of facility and phone number.

Name of Dispensing Nurse: Fill in Name of Dispensing Nurse

Licensing Number of Dispensing Nurse: Fill in Licensing Number

Signature of Dispensing Nurse: Dispensing Nurse's Signature

Justification for why client is unable to pick up the methadone at the clinic: Explain the reason such as incarceration, etc.

Methadone is being transported to: Facility's Name and Phone Number.

Medication provided from _____to _____: List dates

Number of Doses Dispensed at One Time_____: List number of doses dispensed. Not to exceed 14 doses without MDHHS/OROSC written permission.

Liability Statement: Person delivering the methadone should read and then sign.

Person Delivering the Methadone: Print the facility staff person's name.

Witness: Witness to the transporters signature. Print name and Sign.

Name of Person Receiving the Methadone at the Facility: Printed Name and Signature of facility staff who accepts delivery of the methadone.

Both the delivery person and the facility agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDHHS/OROSC liable for any unauthorized use of the methadone.

Distribution: Original Copy to OTP: The original of the form is retained at the OTP.
Copy to Facility: A copy of the form is made and given to the facility.

MDHHS/OROSC DELIVERY OF METHADONE TO ANOTHER FACILITY FORM

DATE:_____ Client # _____

Program Treatment Name:_____ Program ID:_____

Program Telephone:_____Fax:_____E-Mail:_____

Methadone Delivered to: Facility Name_____Phone _____

Name Of Dispensing Nurse:_____License#:_____

Signature of Dispensing Nurse:_____

Justification for why client is unable to pick up the methadone at the clinic:

_____

_____

_____

Methadone provided from: _____to _____ Number of Doses Dispensed at One Time:_____
(Date)(Date) (Not to exceed 14 doses)

Due to the above named client's temporary inability to pick-up his/her methadone, the above named Opioid Treatment Program has permission from MDHHS/OROSC to allow transportation of the methadone to the above named facility. I understand that this arrangement is for a specific period of time only, and that when this time ends, I will either no longer be picking up the methadone, or will have to complete another "MDHHS/OROSC Delivery of Methadone to another Facility Form". I further understand that methadone is a narcotic, to be ingested by the client only, and that harm, including death could come to anyone else ingesting it. When I pick-up the methadone I must present current government issued pictured identification (Driver's License, State Identification Card, Military Identification Card). I must also present any necessary documentation from the treating physician, so that the clinic is kept up-to-date on the current status of the client's medical condition. I have been made aware that loitering within a one-block radius of the

clinic is prohibited. I am aware that the methadone is a controlled substance and my institution's protocols will be observed. Both the delivery person and the client agree to all terms stated on this form as well as to additional requirements the OTP may have pertaining to off-site dosing. By signing this form, both parties will not hold the OTP or MDHHS/OROSC liable for any unauthorized use of the methadone.

Person Transporting Methadone _____ Title_____
Print Print

_____
Signature

Facility Staff Receiving the Methadone_____
Print

_____
Signature Date

Witness_____ _____

Print Signature

DISTRIBUTION: Original to OTP
Copy to Client

EXHIBIT D

INSTRUCTIONS FOR

EXCEPTION REQUEST AND RECORD OF JUSTIFICATION UNDER 42 CFR ' 8.11(h)

(FORM SMA-168)

Purpose of Form: The SMA-168 form was created to facilitate the submission and review of patient exceptions under 42 CFR ' 8.11(h). SAMHSA will use the information provided to review patient exception requests@ and determine whether they should be approved or denied. A patient exception request@ is a request signed by the physician for approval to change the patient care regimen from the requirements specified in Federal regulation (42 CFR, Part 8). The physician makes this request when he/she seeks SAMHSA approval to make a patient treatment decision that differs from regulatory requirements.

This is a flexible, multi-purpose form on which various patient exception requests may be documented and approved or denied, along with an explanation for the action taken. It is most frequently used to request exceptions to the regulation on the number of take-home doses permitted for unsupervised use, such as during a family or health emergency. The form is also frequently used to request a change in patient protocol or for an exception to the detoxification standards outlined in the regulation.

GENERAL INSTRUCTIONS

Please complete **ALL** items on the form. As appropriate, there is space to indicate if an item does not apply.

The instructions below show the item from the form in **bold text**. In the column next to the bold text is a description of the information requested.

ITEM	INSTRUCTION
BACKGROUND INFORMATION ON PROGRAM AND PATIENT	
Program OTP No	Opioid Treatment Program (OTP) identification numberCsame as the old FDA number. Begins with 2 letters of your State abbreviation, followed by 5 numbers, then a letter. This number should fit into the format on the form.
Patient ID No	Confidential number you use to identify the patient. Please do not use the patient=s name or other identifying information. Number of digits does **NOT** have to match number of boxes on the form.
Program Name	Name of opioid treatment program, clinic or hospital in which patient enrolled.
Telephone	Voice telephone number. **PLEASE INCLUDE YOUR AREA CODE.**

ITEM	INSTRUCTION
Fax	Facsimile (FAX) number. **PLEASE INCLUDE YOUR AREA CODE.**
Email	Indicate electronic mail (e-mail) address of the CONTACT person.
Name & Title of Requestor	Name and title of physician or staff member authorized to submit this request.
Patient=s Admission Date	Date patient enrolled at this facility.
Patient=s current dosage level	Dosage patient receives **NOW.** Please indicate the dosage in milligrams (mg).
Methadone/LAAM/Other	Place an AX@ on the line next to the medication the patient takes. If you check AOther,@ write in the name of the medication in the space provided.
Patient=s program attendance schedule per week	Place an AX@ on the line to the left of each day per week the patient **NOW** reports to the clinic for medication.
***If current attendance is less than once per week, please enter the schedule**	If patient **NOW** reports to the clinic **LESS** that once a week, please indicate how often he/she reports.
Patient status	Place an AX@ on the line to the left of the item that best describes the patient=s **CURRENT** status. If the patient=s status does not appear on the list on the form, please place an AX@ on the line next to AOther@ and write in the patient=s **CURRENT** status.

REQUEST FOR CHANGE

Nature of request	Please place an AX@ on the line to the left of the description that **BEST** describes this request. If your request is not listed in this item on the form, place an AX@ on the line to the left of AOther@ and describe your request.
Decrease regular attendance to	Place an AX@ on the line to the left of each day per week that the patient is to report for medication.
Beginning date	Enter the date that the exception is scheduled to begin.
***If new attendance is less than once per week, please enter the schedule**	If you are asking to reduce the patient=s attendance schedule to **LESS THAN** once per week, please indicate the schedule on the line provided.
Dates of Exception	Please indicate the dates that the exception will be effective.
# of doses needed	Indicate how many doses will be dispensed during the exception period.
Justification	Please place an AX@ on the line to the left of the best description of the reason for this request. If the reason is not listed in this item, place an AX@ on the line next to AOther@ and write in the justification.

REQUIREMENTS

Regulation Requirements	There are certain guidelines that programs must follow regarding take-home medication and detoxification admissions. Next to each of the 3 statements listed in this item, please indicate whether the OTP followed the stipulated requirements. For each statement that does not apply, place an AX@ on the line to the left of AN/A@ (not applicable).
Submitted by:	
Printed Name of Physician	Please **PRINT** the name of the physician making the request.
Signature of Physician	Once ALL the items above have been completed, the physician should SIGN here.

ITEM	INSTRUCTION
Date	Date the form is signed.

APPROVALCThis section will be completed by the appropriate authorities.

State response to request	If this form must be reviewed or approved by your State, be sure that you forward this form to the proper authority, who will indicate approval or denial of your request in the space provided.
Federal response to request	This is the place on the form where CSAT will indicate whether the request is accurate and approved. The form will be faxed or e-mailed back to you.
Please submit to CSAT/OPATC Fax: (301) 443-3994 or Email: otp@samhsa.gov	When you have completed the form, either fax or email it to CSAT at the numbers provided here.

Effect: This form was created to facilitate the submission and review of patient exceptions under 42 CFR ' 8.11(h). This does not preclude other forms of notification.

Paperwork Reduction Act Statement

Public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-xxxx); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-xxxx).

1. BACKGROUND INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION CENTER FOR SUBSTANCE ABUSE TREATMENT	Form Approved: OMB Number 0930-0206 Expiration Date: 09/30/2003 See OMB Statement on Reverse
Exception Request and Record of Justification **Under 42 CFR ' 8.11 (h)**	DATE OF SUBMISSION Date you submit form to CSAT.

Note: This form was created to assist in the interagency review of patient exceptions in opioid treatment programs (OTPs) under 42 CFR ' 8.11 (h).

Detailed INSTRUCTIONS are on the cover page of this form. PLEASE complete **ALL** applicable items on this form. Your cooperation will result in a speedy reply. Thank you.

BACKGROUND INFORMATION ON PROGRAM AND PATIENT

Program OTP No: (Same as FDA No.) B ' B **Patient ID No:**

Program identification numberCold FDA number. Begins with 2 letters of your State abbreviation, followed by 5 numbers, then a letter. Should fit into the format above.

Number you use to identify patient. Number of digits does **NOT** have to match number of boxes above. **DO NOT USE PATIENT=S NAME.**

Program Name: Name used to identify opioid treatment program, clinic, or hospital in which patient enrolled.

Telephone: Phone #, **including area code**. **Fax:** Fax #, **including area code**. **E-mail:** . . . of contact person.

Name & Title of Requestor: Name and title of physician or staff member authorized to submit request.

Patient=s Admission Date: Date patient enrolled in this facility.

Patient=s current dosage level: mg Methadone LAAM Other:

Dosage patient receives **NOW**.

Place an AX@ on the line next to the medication the patient takes. If you check AOther,@ write in the name of the medication.

Patient=s program attendance schedule per week (Place an AX@ next to all days that the patient attends*): S M T W T F S

Place an AX@ on the line to the left of each day per week the patient **NOW** reports to the clinic for medication.

*If **current** attendance is less than once per week, please enter the schedule:

If patient **NOW** reports to the clinic **LESS** that once weekly, please indicate how often he/she reports.

Patient status: Employed ____ Unemployed ____ Homemaker ____ Student ____ Disabled ____ Other:

Place an AX@ on the line next to the item that best describes the patient=s **CURRENT** status. If that status does not appear on this list, please place an AX@ on the line next to AOther@ and write in the patient=s **CURRENT** status.

REQUEST FOR CHANGE

REQUEST FOR CHANGE REGARDING PATIENT TREATMENT

Nature of request:

___ Temporary take-home medication ___ Temporary change in protocol ___ Detoxification exception ___ Other : _____

Please place an AX@ on the line next to the item above that **BEST** describes what this request is about. If your request is not listed above, place an AX@ on the line next to AOther@ and describe your request.

Decrease regular attendance to

(Place an AX@ next to appropriate days*):

S	M	T	W	T	F	S

Beginning date: _____

Place an AX@ on the line to the left of each day per week you want the patient to report for medication.

Date you want new attendance schedule to begin.

*If **new** attendance is less than once per week, please enter the schedule: _____

If you are asking to reduce the number of days per week the patient reports to the program to **LESS THAN** once per week, please indicate the schedule on the line above.

Dates of Exception: **From** _____ **to** _____ **# of doses needed:** _____

Please indicate the dates that the exception you are requesting will be effective.

Indicate how many doses will be dispensed during the exception period.

Justification: ___ Family Emergency ___ Incarceration ___ Funeral ___ Vacation ___ Transportation Hardship

___ Step/Level Change ___ Employment ___ Medical ___ Long Term Care Facility ___ Other Residential Treatment

___ Homebound ___ Split Dose ___ Other : _____

Please place an AX@ on the line to the left of the item above that best describes the reason for this request. If the reason is not listed above, place an AX@ on the line next to AOther@ and write in the justification.

REQUIREMENTS

REQUIREMENTS (GUIDELINES AND SIGNATURE)

Regulation Requirements:

2. **For take-home medication:** Has the patient been informed of the dangers of children ingesting methadone or LAAM? Yes No N/A
3. **For take-home medication:** Has the program physician determined that the patient meets the 8-point evaluation criteria to determine whether the patient is responsible enough to handle methadone as outlined in 42 CFR '8.12(i)(2)(i)-(viii)? Yes No N/A
4. **For multiple detoxification admissions:** Did the physician justify more than 2 detoxification episodes per year and assess the patient for other forms of treatment (include dates of detoxification episodes) as required by 42 CFR '8.12(e)(4)? Yes No N/A

There are certain guidelines that programs must follow regarding take-home medication and detoxification admissions. Next to each item above, please indicate whether you followed the stipulated requirements. For each statement that does not apply to you, place an AX@ on the line to the left of AN/A@ (not applicable).

Submitted by:

Printed Name of Physician	Signature of Physician	Date
Please PRINT the name of the physician making the request.	Once ALL the items above have been completed, the physician should SIGN here.	Date form is signed.

APPROVAL OF AUTHORITIES

APPROVAL

State response to request:

___ Approved ___ Denied _____

State Methadone Authority **Date**

Explanation: _____

If this form must be reviewed or approved by your State, be sure that you forward this form to the proper authority, who will indicate approval or denial of your request in the space above.

Federal response to request:

___ Approved ___ Denied _____

Public Health Advisor, Center for Substance Abuse Treatment **Date**

Explanation: _____

CSAT will indicate whether the request is accurateand approved or denied in this space. The form will be faxed or emailed back to you.

Please submit to CSAT/OPATCFax: (301) 443-3994; Email: otp@samhsa.gov

This exception is contingent upon approval by your State Methadone Authority (as applicable) and may not be implemented until you receive such approval.

FORM SMA-168 (FRONT)

Purpose of Form: This form was created to facilitate the submission and review of patient exceptions under 42 CFR ' 8.11(h). This does not preclude other forms of notification.

Paperwork Reduction Act Statement

Public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0206); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0206.

FORM SMA-168 (BACK)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

CENTER FOR SUBSTANCE ABUSE TREATMENT

FORM SMA-168

Exception Request and Record of Justification

Under 42 CFR ' 8.11 (h)

Form Approved: OMB Number 0930-0206

Expiration Date: 09/30/2006

See OMB Statement on Reverse

DATE OF SUBMISSION

Note: This form was created to assist in the interagency review of patient exceptions in opioid treatment programs (OTPs) under 42-CFR ' 8.11 (h).

Detailed INSTRUCTIONS are on the cover page of this form. PLEASE complete **ALL** applicable items on this form. Your cooperation will result in a speedy reply. Thank you.

Program OTP No: (Same as FDA ID) B ' B **Patient ID No:**

Program Name:

Telephone: **Fax:** **E-mail:**

Name & Title of Requestor:

Patient=s Admission Date: **Patient=s current dosage level:** mg Methadone LAAM Other:

Patient=s program attendance schedule per week (Place an AX@ next to all days that the patient attends*): **S M T W T F S**

*If **current** attendance is less than once per week, please enter the schedule:

Patient status: Employed ___ Unemployed ___ Homemaker ___ Student ___ Disabled ___ Other:

Nature of request: Request Change

___ Temporary take-home medication ___ Temporary change in protocol ___ Detoxification exception ___ Other:

Decrease regular attendance to (Place an AX@ next to appropriate days*): **S M T W T F S** **Beginning date:**

*If **new** attendance is less than once per week, please enter the schedule:

Dates of Exception: **From** **to** **# of doses needed:**

Justification ___ Family Emergency ___ Incarceration ___ Funeral ___ Vacation ___ Transportation Hardship

___ Step/Level Change ___ Employment ___ Medical ___ Long Term Care Facility ___ Other Residential Treatment

___ Homebound ___ Split Dose ___ Other _____

Regulation Requirements:

5. **For take-home medication:** Has the patient been informed of the dangers of children ingesting methadone or LAAM? Yes No N/A
6. **For take-home medication:** Has the program physician determined that the patient meets the 8-point evaluation criteria to determine whether the patient is responsible enough to handle methadone as outlined in 42 CFR ' 8.12(i)(2)(i)-(viii)? Yes No N/A

3. For multiple detoxification admissions: Did the physician justify more than 2 detoxification episodes per year and assess the patient for other forms of treatment (include dates of detoxification episodes) as required by 42 CFR ' 8.12(e)(4)? Yes No N/A

Submitted by:

Printed Name of Physician **Signature of Physician** **Date**

State response to request:

___ Approved ___ Denied _____

State Methadone Authority **Date**

Explanation: _____

Federal response to request:

___ Approved ___ Denied _____

C. Todd Rosendale, Public Health Advisor **Date**

Center for Substance Abuse Treatment

Explanation: _____

This exception is contingent upon approval by your State Methadone Authority (as applicable) and may not be implemented until you receive such approval.

FORM SMA-168

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

JAMES K. HAVEMAN
DIRECTOR

MEMORANDUM

DATE: October 15, 2012

TO: Regional Substance Abuse Coordinating Agency Directors

FROM: Deborah J Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Final Treatment Policy #5, Criteria for Using Methadone for Medication-Assisted Treatment and Recovery

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On July 23, 2012, the Bureau of Substance Abuse and Addiction Services (BSAAS) sent a draft of the revised *Treatment Policy #5, Criteria for Using Methadone for Medication-Assisted Treatment and Recovery*, to all coordinating agencies for review and comment. Comments were due to BSAAS by August 23, 2012. No comments were received; therefore, this policy went into effect October 1, 2012 as revised.

As noted in the memo that accompanied the draft, changes were required to the portions of the policy and the consent form that addressed medication-assisted treatment for pregnant and non-pregnant adolescents. These revisions were on page six of the policy and page one of the consent form, and were made to clarify the previous policy as detailed in our April 20 memo (attached).

If you have any questions, please contact Lisa Miller at millerL12@michigan.gov or 517-241-1216.

Thank you.

Attachments

c: Felix Sharpe

TREATMENT POLICY #05

SUBJECT: Criteria for Using Methadone for Medication-Assisted Treatment and Recovery

ISSUED: September 1, 2003, revised August 5, 2005, October 3, 2007, July 31, 2011, October 1, 2011, and August 24, 2012

EFFECTIVE: October 1, 2012

PURPOSE:

The purpose of this policy is to clarify the process for the use of methadone in medication-assisted treatment and recovery for opioid dependence.

SCOPE:

This policy applies to all regional substance abuse PIHPs and their provider network of opioid treatment programs (OTPs). Medicaid-specific services are also identified in this document. The state administrative rules and federal regulations are not replaced or reduced by these criteria.

BACKGROUND:

Methadone Use in Medication-Assisted Treatment and Recovery

Methadone is an opioid medication used in the treatment and recovery of opioid dependence to prevent withdrawal symptoms and opioid cravings, while blocking the euphoric effects of opioid drugs. In doing so, methadone stabilizes the individual so that other components of the treatment and recovery experience, such as counseling and case management, are maximized in order to enable the individual to reacquire life skills and recovery. Methadone is not a medication for the treatment and recovery from non-opioid drugs.

The Medicaid Provider Manual lists the medical necessity requirements that shall be used to determine the need for methadone as an adjunct treatment and recovery service. The Medicaid-covered substance use disorder benefit for methadone services includes the provision and administration of methadone, nursing services, physician encounters, physical examinations, lab tests (including initial blood work, toxicology screening, and pregnancy tests) and physician-ordered tuberculosis (TB) skin tests. The medical necessity requirements and services also apply to all non-Medicaid covered individuals.

Consistent with good public health efforts among high-risk populations, and after consultation with the local health department, an OTP may offer Hepatitis A and B, as well as other adult immunizations recommended

by the health department, or they should refer the individual to an appropriate health care provider. Smoking cessation classes or referrals to local community resources may also be made available.
The American Society of Addiction Medicine (ASAM) level of care (LOC) indicated for individuals receiving methadone is usually outpatient. The severity of the opioid dependency and the medical need for methadone should not be diminished because medication-assisted treatment has been classified as outpatient. Counseling services should be conducted by the OTP that is providing the methadone whenever possible and appropriate. When the ASAM LOC is not outpatient or when a specialized service is needed, separate service locations for methadone dosing and other substance use disorder services are acceptable, as long as coordinated care is present and documented in the individual's record.

If methadone is to be self-administered off-site of the OTP, off-site dosing must be in compliance with the current Michigan Department of Health & Human Services (MDHHS) *Treatment Policy #4: Off-Site Dosing Requirements for Medication-Assisted Treatment*. This includes Sunday and holiday doses for those individuals not deemed to be responsible for managing take-home doses.

All six dimensions of the ASAM patient placement criteria must be addressed:

1. Acute intoxication and/or withdrawal potential.
2. Biomedical conditions and complications.
3. Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications).
4. Treatment acceptance/resistance.
5. Relapse/continued use potential.
6. Recovery/living environment.

In using these dimensions, the strengths and supports, or recovery capital, of the individual will be a major factor in assisting with the design of the individualized treatment and recovery plan.

In many situations, case management or care coordination services may be needed by individuals to further support the recovery process. These services can link the individual to other recovery supports within the community such as medical care, mental health services, educational or vocational assistance, housing, food, parenting, legal assistance, and self-help groups. Documentation of such referrals and follow up must be in the treatment plan(s) and progress notes within the individual's chart. If it is determined that case management or care coordination is not appropriate for the individual, the rationale must be documented in the individual's chart. The acupuncture detoxification five-point protocol is suggested as a means of assisting the individual with symptom management of anxiety and restorative sleep.

Clarification of Substance-Dependence Treatment and Recovery with Methadone in Individuals with Prior or Existing Pain Issues

All persons assessed for a substance use disorder must be assessed using the ASAM patient placement criteria and the current Diagnostic and Statistical Manual of Mental Disorders (DSM). In the case of opioid addiction, pseudo-addiction must also be ruled out. Tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction. In some cases, primary care and other doctors may misunderstand the scope of the OTP and refer individuals to the OTP for pain control. The "Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain," should be consulted to assist in determining when substance use disorder treatment is appropriate, as well as the publication, *Responsible Opioid Prescribing: A Michigan Physician's Guide* by Scott M. Fishman, MD. This publication was distributed to all controlled substance prescribers in Michigan by the Michigan Department of Health &

Human Services, Bureau of Health Professions, in September of 2009. OTPs are not pain clinics, and cannot address the underlying medical condition causing the pain. The OTP and CA are encouraged to work with the local medical community to minimize inappropriate referrals to OTPs for pain.

Individuals receiving methadone as treatment for an opioid addiction may need pain medication in conjunction with this adjunct therapy. The use of non-opioid analgesics and other non-medication therapy is recommended whenever possible. Opioid analgesics as prescribed for pain by the individual's primary care physician (or dentist, podiatrist) can be used; they are not a reason to initiate detoxification to a drug-free state, nor does their use make the individual ineligible for using methadone for the treatment of opioid addiction. The methadone used in treating opioid addiction does not replace the need for pain medication. It is recommended that individuals inform their prescribing practitioners that they are on methadone, as well as any other medications. On-going coordination (or documentation of efforts if prescribing practitioners do not respond) between the OTP physician and the prescribing practitioner is required for continued services at the OTP and for any off-site dosing including Sunday and holidays.

REQUIREMENTS:

These codes, regulations, and manuals must be followed:

- *Methadone Treatment and Other Chemotherapy*, Michigan Administrative Code, Rule 325.14401-325.14423
- *Certification of Opioid Treatment Programs*, U.S. Code of Federal Regulations, 42 CFR Part 8
- *Michigan Medicaid Provider Manual*

An OTP using methadone for the treatment and recovery of opioid dependency must be:

1. Licensed by the state as a methadone provider.
2. Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or The Joint Commission (TJC), formerly JCAHO.
3. Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an OTP.
4. Registered by the Drug Enforcement Administration (DEA).

PROCEDURE:

Admission Criteria

Decisions to admit an individual for methadone maintenance must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Patient Placement Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria. It is important to note that each individual, as a whole, must be considered when determining LOC, as methadone maintenance therapy may not be the best answer for every individual. For exceptions, see "Special Circumstances for Pregnant Women and Adolescents" on page six (6). Consistent with the LOC determination, individuals requesting methadone must be presented with all appropriate options for substance use disorder treatment, such as:

- Medical Detoxification.
- Sub-acute Detoxification.
- Residential Care.
- Buprenorphine/Naloxone.
- Non-Medication-Assisted Outpatient.

In addition to these levels of care, each CA is expected to have providers available that can also offer case management services, treatment for co-occurring disorders, early intervention, and peer recovery and recovery support services. Acupuncture detoxification may be used in all levels of care. These additional service options can be provided to opioid dependent individuals who do not meet the criteria for adjunct methadone treatment. Individuals should be encouraged to participate in treatment early in their addiction before methadone is necessary.

Admission procedures require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process. The physician may refer the individual for further medical assessment as indicated.

Individuals must be informed that all of the following are required:

1. Daily attendance at the clinic is necessary for dosing, including Sundays and holidays if criteria for take home medication are not met.
2. Compliance with the individualized treatment and recovery plan, which includes referrals and follow-up as needed.
3. Monthly random toxicology testing.
4. Coordination of care with all prescribing practitioners (physicians, dentists, and any other health care provider) over the past year.

It is the responsibility of the OTP, as part of the informed consent process, to ensure that individuals are aware of the benefits and hazards of methadone treatment. It is also the OTP's responsibility to obtain consent to contact other OTPs within 200 miles to monitor for enrollments in other programs (42 CFR §2.34).

OTPs must request that individuals provide a complete list of all prescribed medications. Legally prescribed medication, including controlled substances, must not be considered as illicit substances when the OTP has documentation that it was prescribed for the individual. Copies of the prescription label, pharmacy receipt, pharmacy print out, or a Michigan Automated Prescription System (MAPS) report must be included in the individual's chart or kept in a "prescribed medication log" that must be easily accessible for review.

Michigan law allows for individuals with the appropriate physician approval and documentation to use medical marijuana. Although there are no prescribers of medical marijuana in Michigan, individuals are authorized by a physician to use marijuana per Michigan law. For enrolled individuals, there must be a copy of the MDHHS registration card for medical marijuana issued in the individual's name in the chart or the "prescribed medication log." Following these steps will help to ensure that an individual who is using medical marijuana per Michigan law will not be discriminated against in regards to program admission and exceptions for dosing.

If an individual is unwilling to provide prescription or medical marijuana information, the OTP must include a statement to this effect, signed by the individual, in the chart. These individuals will not be eligible for off-site dosing, including Sunday and holiday doses. OTPs must advise individuals to include methadone when providing a list of medications to their healthcare providers. The OTP physician may elect not to admit the individual for methadone treatment if the coordination of care with health care providers and/or prescribing physicians is not agreed to by the client.

Off-site dosing, including Sundays and holidays, is not allowed without coordination of care (or documentation of efforts made by the OTP for coordination) by the OTP physician, the prescriber of the identified controlled substance (opioids, benzodiazepines, muscle relaxants), and the physician who approved the use of medical marijuana. This coordination must be documented in either the nurse's or the doctor's notes. The documentation must be individualized, identifying the individual, the diagnosis, and the length of time the individual is expected to be on the medication. A MAPS report must be completed at admission. A MAPS report should be completed before off-site doses, including Sundays and holidays, are allowed and must be completed when coordination of care with other physicians could not be accomplished.

If respiratory depressants are prescribed for any medical condition, including a dental or podiatry condition, the prescribing practitioners should be encouraged to prescribe a medication which is the least likely to cause danger to the individual when used with methadone. Individuals who have coordinated care with prescribing practitioners, and are receiving medical care or mental health services, will be allowed dosing off site, if all other criteria are met. If the OTP is closed for dosing on Sundays or holidays, arrangements shall be made to dose the individual at another OTP if the individual is not deemed responsible for off-site dosing.

Special Circumstance for Pregnant Women and Adolescents

Pregnant women

Pregnant women requesting treatment are considered a priority for admission and must be screened and referred for services within 24 hours. Pregnant individuals who have a documented history of opioid addiction, regardless of age or length of opioid dependency, may be admitted to an OTP provided the pregnancy is certified by the OTP physician, and treatment is found to be justified. For pregnant individuals, evidence of current physiological dependence is not necessary. Pregnant opioid dependent individuals must be referred for prenatal care and other pregnancy-related services and supports, as necessary.

OTPs must obtain informed consent from pregnant women and all women admitted to methadone treatment that may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice. Because methadone and opiate withdrawal are not recommended during pregnancy, due to the increased risk to the fetus, the OTP shall not discharge pregnant women without making documented attempts to facilitate a referral for continued treatment with another provider.

Pregnant adolescents

For an individual under 18 years-of-age, a parent, legal guardian, or responsible adult designated by the relevant state authority, must provide consent for treatment in writing (Attachment A). In Michigan, the "relevant state authority" to provide consent is children's protective services (CPS) through the Department of Human Services [Public Act 238 722.621]. A copy of this signed, informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone, and must be filed in the medical record.

Non-Pregnant adolescents

An individual under 18 years-of-age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment. No individual under 18 years-of-age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority/CPS consents, in writing, to such treatment (Attachment A). This is sufficient consent to allow for persons 16 and 17 years-of-age to enter methadone treatment [*Administrative Rules for Substance Abuse Services, Rule 325.14409(5)*]. However, persons 15 years-of-age and under must also have permission for admission by the state opioid treatment authority (SOTA), as well as the Drug Enforcement Administration (DEA). A copy of this signed informed consent statement must be placed in the individual's medical record. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone, and must be filed in their medical record [42CFR Subpart 8.12 (e) (2)].

Treatment and Continued Recovery Using Methadone

Individual needs and rate of progress vary from person-to-person and, as such, treatment and recovery must be individualized and treatment and recovery plans must be based on the needs and goals of the individual (*Treatment Policy #06: Individualized Treatment Planning*). Referrals for medical care, mental health issues, vocational and educational needs, spiritual guidance, and housing are required, as needed, based on the information gathered as part of the assessment and other documentation completed by the individual. The use of case managers, care coordinators, and recovery coaches is recommended for individuals whenever possible (*Treatment Policy #8: Substance Abuse Case Management Requirements*). Increasing the individual's recovery capital through these supports, will assist the recovery process and help the individual to become stable and more productive within the community.

Compliance with dosing requirements or attendance at counseling sessions alone is not sufficient to continue enrollment. Reviews to determine continued eligibility for methadone dosing and counseling services must occur at least every four months by the OTP physician during the first two years of service. An assessment of the ability to pay for services and a determination for Medicaid coverage must be conducted at that time, as well. If it is determined by the OTP physician that the individual requires methadone treatment beyond the first two years, the justification of the medical necessity for methadone only needs to occur annually. However, financial review and eligibility for Medicaid is required to continue at a minimum of every six months.

An individual may continue with services if all of the following criteria are present:

a. Applicable ASAM criteria are met.
b. The individual provides evidence of willingness to participate in treatment.
c. There is evidence of progress.
d. There is documentation of medical necessity.
e. The need for continuation of services is documented in writing by the OTP physician.

Individuals, who continue to have a medical need for methadone, as documented in their medical record by the OTP physician, are not considered discharged from services; nor are individuals who have been tapered from methadone, but still need counseling services.

All substances of abuse, including alcohol, must be addressed in the treatment and recovery plan. Treatment and recovery plans and progress notes are expected to reflect the clinical status of the individual along with progress, or lack of progress in treatment. In addition, items such as the initiation of compliance contracts, extra counseling sessions, or specialized groups provided, and off-site dosing privileges that have been initiated, rescinded, or reduced should also be reflected in progress notes. Referrals and follow-up to those referrals must be documented. The funding authority may, at its discretion, require its approval of initial and/or continuing treatment and recovery plans.

For individuals who are struggling to meet the objectives in his/her individual treatment and recovery plans, OTP medical and clinical staff must review, with the individual, the course of treatment and recovery and make adjustments to the services being provided**.** Examples of such adjustments may be changing the methadone dosage (including split dosing), increasing the length or number of counseling sessions,

incorporating specialized group sessions, using compliance contracts, initiating case management services, providing adjunctive acupuncture treatment, and referring the individual for screening to another LOC.

Medical Maintenance Phase of Treatment

As individuals progress through recovery, there may be a time when the maximum therapeutic benefit of counseling has been achieved. At this point, it may be appropriate for the individual to enter the medical maintenance (methadone only) phase of treatment and recovery if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. To assist the OTP in making this decision, *TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* offers the following criteria to consider when making the decision to move to medical maintenance:

- Two years of continuous treatment.
- Abstinence from illicit drugs and from abuse of prescription drugs for the period indicated by federal and state regulations (at least two years for a full 30-day maintenance dosage).
- No alcohol use problem.
- Stable living conditions in an environment free of substance use.
- Stable and legal source of income.
- Involvement in productive activities (e.g., employment, school, volunteer work).
- No criminal or legal involvement for at least three years and no current parole or probation status.
- Adequate social support system and absence of significant un-stabilized co-occurring disorders.

Discontinuation of Services

Individuals must discontinue treatment with methadone when treatment is completed with respect to both the medical necessity for the medication and for counseling services. In addition, individuals may be terminated from services if there is clinical and/or behavioral non-compliance. If an individual is terminated, the OTP must attempt to make a referral for another LOC assessment or for placing the individual at another OTP, and must make an effort to ensure that the individual follows through with the referral. These efforts must be documented in the medical record. The OTP must follow the procedures of the funding authority in coordinating these referrals.

Any action to terminate treatment of a Medicaid recipient requires a notice of action be given to the individual. The individual has a right to appeal this decision; services must continue and dosage levels maintained while the appeal is in process.

The following are reasons for discontinuation/termination:

1. Completion of Treatment – The decision to discharge an individual must be made by the OTP's physician with input from clinical staff and the individual. Completion of treatment is determined when the individual has fully or substantially achieved the goals listed in his/her individualized treatment and recovery plan and when the individual no longer needs methadone as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.

2. Administrative Discontinuation – The OTP must work with the individual to explore and implement methods to facilitate compliance. Administrative discontinuation relates to non-compliance with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment.

The repeated or continued use of illicit opioids and non-opioid drugs, including alcohol, would be considered non-compliance. OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (*Administrative Rules of Substance Abuse Services Programs in Michigan*, R 325.14406). Individuals whose toxicology results do not indicate the presence of methadone metabolites must be considered noncompliant, with the same actions taken as if illicit drugs (including non-prescribed medication) were detected.

OTPs must test for alcohol use if: 1) prohibited under their individualized treatment and recovery plan; or 2) the individual appears to be using alcohol to a degree that would make dosing unsafe. The following actions are also considered to be non-compliant:

- Repeated failure[1] to submit to toxicology sampling as requested.
- Repeated failure[1] to attend scheduled individual and/or group counseling sessions, or other clinical activities such as psychiatric or psychological appointments.
- Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.
- Repeated failure[1] to follow through on other treatment and recovery plan related referrals.

[1] *Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist individuals to comply with activities.*

The commission of acts by the individual that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to the following:

- Possession of a weapon on OTP property.
- Assaultive behavior against staff and/or other individuals.
- Threats (verbal or physical) against staff and/or other individuals.
- Diversion of controlled substances, including methadone.
- Diversion and/or adulteration of toxicology samples.
- Possession of a controlled substance with intent to use and/or sell on agency property or within a one block radius of the clinic.
- Sexual harassment of staff and/or other individuals.
- Loitering on the clinic property or within a one-block radius of the clinic.

Administrative discontinuation of services can be carried out by two methods:

1. Immediate Termination – This involves the discontinuation of services at the time of one of the above safety-related incidents or at the time an incident is brought to the attention of the OTP.

2. Enhanced Tapering Discontinuation – This involves an accelerated decrease of the methadone dose (usually by 10 mg or 10% a day). The manner in which methadone is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the individual.

It may be necessary for the OTP to refer individuals who are being administratively discharged to the local access management system for evaluation for another level of care. Justification for noncompliance termination must be documented in the individual's chart.

REFERENCES:

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U.S. Code of Federal Regulations, Public Health Service, 42 CFR Part 8 § C. (2001). *Certification of Opioid Treatment Programs.* Retrieved from http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl.

APPROVED BY: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

An electronic version of the *Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment* form (Attachment A) can be found on our website at www.michigan.gov/mdhhs-orosc, choose 'Treatment' and then 'OROSC Policy and Technical Advisory Manual'.

TREATMENT POLICY #05 October 1, 2012 ATTACHMENT A

Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment

Name of Patient_____ Date_____

Date of Birth (MM/DD/YY)_____ Patient's Age_____ Pregnant: Yes___ No___

Name of Parent or Legal Guardian_____

Name of Practitioner Explaining Procedures_____

Name of Program Medical Director_____

An individual under 18 years of age, who is not pregnant, is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment.

No individual 16 or 17 years-of-age may be admitted to maintenance treatment unless a parent or legal guardian consents, in writing, to such treatment. For persons 15 years-of-age and under, a parent or legal guardian consent is required, as well as permission for admission by the state opioid treatment authority (SOTA). A copy of the program's signed informed consent statement must be placed in the individual's clinical chart. This signed consent is in addition to the general consent that is signed by all individuals receiving methadone and shall be filed in their clinical charts.

The parent or legal guardian must sign a release of information for the Opioid Treatment Program (OTP) staff to verify the individual's admission and discharge dates and any other specific information requested by the OTP.

Verification of Detoxification/Drug-Free Treatment Attempts

(DOES NOT APPLY TO PREGNANT ADOLESCENTS)

Facility/Counselor Name_____

Street Address_____

City, State, Zip_____

Phone Number _____

Fax Number _____

Dates of Service: From (MM/DD/YY)_____

To (MM/DD/YY)_____

Verified by:

*OTP Staff Person Name*_____

*Title*_____ *OTP*

*Staff Signature*_____

*Date*_____

Facility/Counselor Name_____

Street Address_____

City, State, Zip_____

Phone Number_____

Fax Number _____

Dates of Service: From (MM/DD/YY)_____

To (MM/DD/YY)_____

Verified by:

*OTP Staff Person Name*_____

*Title*_____ *OTP*

*Staff Signature*_____

*Date*_____

Consent for an Adolescent to Participate in Opioid Pharmacotherapy Treatment

INFORMED CONSENT STATEMENT

FOR PARENT/GUARDIAN

I hereby authorize and give voluntary consent to_____Medication-Assisted Treatment Program and its medical personnel to dispense and administer opioid pharmacotherapy (includes methadone or buprenorphine) as part of the treatment of my child's addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve taking the prescribed opioid drug on the schedule determined by the program physician in accordance with federal and state regulations.

I further authorize provision of the following: diagnostic assessment, individual and group counseling, medication review and monitoring. My child's participation is voluntary. I understand that this program follows person-centered planning guidelines and that my child's treatment plan will be individualized to meet my child's needs and goals, and I will participate in the development of my child's treatment plan.

I understand that it is important for me to inform any medical provider, who may treat my child for any medical problem, that my child is enrolled in an opioid treatment program so that the provider is aware of all the medications my child is taking, can provide the best possible care, and can avoid prescribing medications that might affect the opioid pharmacotherapy or the chances of successful recovery from opioid addiction. If pregnant, my child will receive prenatal care and I will sign releases for coordination of care with that provider.

I understand that I may withdraw my child, from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand my child will be offered a medically supervised tapering process for discontinuation. Withdrawal is not recommended when the individual is pregnant.

Parent/Guardian:

Name_____Signature_____Date_____

Witness:

Name_____Signature_____Date_____

OTP Physician:

Name_____Signature_____Date_____

State Opioid Treatment Authority (Required for minors 15 years-of-age and younger.)**:**

Name___Signature_____Date___

III. PREVENTION REQUIREMENTS

Prevention Policy #01, Synar— Effective July 21, 2015
Amendment #2

Prevention Policy #02 Addressing Communicable Disease Issues in the Substance Abuse Service Network—

Effective January 1, 2012

PREVENTION POLICY # 01

SUBJECT: Synar
RE-ISSUED: July 21, 2015
EFFECTIVE: July 21, 2015

PURPOSE:

The purpose of this policy is to specify Prepaid Inpatient Health Plans (PIHP) requirements with regard to federal Substance Abuse Prevention and Treatment (SAPT) Block Grant Synar compliance.

SCOPE:

This policy applies to Prepaid Inpatient Health Plans (PIHPs) and their Synar-related provider network, including Designated Youth Tobacco Use Representatives (DYTUR), which are part of substance abuse services administered through the Michigan Department of Health and Human Services, Office of Recovery oriented Systems of Care (MDHHS/OROSC).

BACKGROUND:

States must show compliance with federal requirements to be considered eligible for the SAPT Block Grant. States are also required to submit an annual report and an implementation plan with regard to Synar related activities. These requirements are incorporated in the annual SAPT Block Grant application. The state may be penalized up to 40 percent of the State's federal (SAPT) Block Grant award for non-compliance.

The Synar Requirements are summarized as follows:

1) States must enact a youth access to tobacco law restricting the sale and distribution of tobacco products to minors. The Michigan Youth Tobacco Act (YTA) satisfies this requirement by restricting the sale and distribution of tobacco products to minors.

2) States must actively enforce their youth access to tobacco laws.

3) The State must conduct a formal Synar survey annually, to determine retailer compliance with the tobacco youth access law and to measure the effectiveness of the enforcement of the law.

4) The State must achieve and maintain a youth tobacco non-sales rate of 80 percent or better to underage youth during the formal Synar survey.

In addition, the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention (SAMHSA/CSAP) requires that an accurate listing of tobacco retail outlets be maintained, including periodic tobacco retail outlet coverage studies intended to confirm the accuracy of the list and establishes Synar sampling requirements.

REQUIREMENTS:

It is the responsibility of the PIHP to implement tobacco access prevention measures to achieve and maintain a youth tobacco non-sales rate of 80 percent or better within their region. In doing so, it is required that the PIHP will:

1) Use best practices relative to reducing access to tobacco products by underage youth;

2) Incorporate use of data specific to the PIHP region including youth sales data, analysis of the effectiveness of Synar related activities; and

3) Collaborate with local partners including law enforcement.

Activities associated with Synar best practices and other evidenced based prevention such as conducting inspections, and providing merchant or vendor education are defined as prevention services and must be carried out by a licensed substance abuse prevention program.
Specific responsibilities include the following:

1) Develop and implement a regional plan of Synar/tobacco prevention activity that will restrict youth access to tobacco and surpass the 80 percent non-sales rate.

2) Conduct activities necessary to ensure the Tobacco Retailer Master List is correct and participate in the clarification and improvement initiative, as well as the CSAP Mandated Coverage Study. Submit to OROSC all information as required by the OROSC/PIHP contract agreement.

3) Annually conduct and complete the Formal Synar Survey to all outlets in the sample draw listing during the designated time period and utilize the official OROSC protocol. Additionally, edit the survey compliance check report (CCR) forms and submit all required information to OROSC as required by the OROSC/PIHP contract agreement.

4) Contribute to enforcement of the Michigan YTA at tobacco outlets within the PIHP region by conducting non-Synar enforcement checks with law enforcement participation. If law enforcement involvement is not feasible, conduct non-Synar enforcement activity through civilian checks.

It is recommended that non-Synar checks be carried out in no less than 25 percent of the outlets in the PIHP region with priority to vendor categories that have historically had a higher sell rate to minors, e.g., Gas Stations, Bar/Lounges, and Restaurants.

For PIHPs with a 20 percent “sell rate” or Retailer Violation Rate (RVR) higher than 20 percent for two consecutive Synar surveys, the requirement is that no less than 50 percent of the outlets within the region will have at least one enforcement check activity during the subsequent third year

Note: SAPT Block Grant funds cannot be used for law enforcement; this includes Formal Synar and non-Synar activities.

5) Conduct Vendor Education activities, utilizing the OROSC approved vendor education protocol, with not less than 25 percent of the total outlets within the PIHP region.

6) Seek to change community norms and conditions by forming relationships with stakeholders for the purposes of developing joint initiatives and/or for collaboration to impact sales trends to youth.

7) Identify a DYTUR agency to implement Synar-related activities. The agency or individual identified as the DYTUR, must have knowledge in the area of youth tobacco access reduction and related Synar prevention initiatives.

8) Provide information to satisfy federal reporting requirements including information about law enforcement activities relevant to violations of the YTA. Correspondingly, it is the responsibility of the

PIHP to comply with Synar protocol, and demonstrate a good faith effort to, obtain and report this information. Documentation of good faith effort may be required if the PIHP cannot provide the required information.

REPORTING REQUIREMENTS:

See the MDHHS/PIHP agreement for PIHP reporting requirements.

PROCEDURE:

Identification and implementation of activities, and local data collection and evaluation procedures, are left to the discretion of the PIHP with the exception of the Formal Synar Survey Protocol (to be used for all enforcement checks), the Vendor Education Protocol, the Synar Tobacco Retailer Master List Clarification, and Improvement/Coverage Study Procedures complete with methodology and practices requirements. All associated protocols are placed on the OROSC website, and updated as needed.

Technical assistance to PIHPs in development of local procedures is available through OROSC.

REFERENCES:

Youth Tobacco Act 31 of 1915, MCL1915 PA31, Michigan Legislature, 1915-1916 Legislative Session, Lansing, MI. (Amended September 1, 2006). Can be found on website: http://www.legislature.mi.gov/(c32puon1tgtsa355dn3zqljp)/mileg.aspx?page=MCLPASearch

APPROVED BY: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

PREVENTION POLICY # 02

SUBJECT: Addressing Communicable Disease Issues in the Substance Abuse Service Network

ISSUED: October 1, 2006; Revised: April 1, 2011, and September 14, 2011

EFFECTIVE: January 1, 2012

PURPOSE:

This policy revises regional substance abuse coordinating agency (CA) requirements with regard to addressing communicable disease. The primary charge of communicable disease efforts is to prevent the further spread of infection in the substance using population. The original policy, effective October 1, 2006, converted guidelines issued in the 2004 Action Plan Guidelines document, to a policy requirement. The policy was revised in April 2011 to re-affirm many of the original policy requirements, and implemented new requirements for targeting resources.

This revision eliminates most of the prior requirements that were put in place even though, for the past several years, Michigan has not been a designated state required to expend block grant funding on communicable disease (CD) services. When the results of CD services, such as outreach, counseling and testing services, performed over the years were examined, very low prevalence rates of new HIV infection and other CDs were found. Therefore, on the basis of a low prevalence rate of CDs, primarily new HIV infection rates, and reduced availability of funding for core substance use disorder (SUD) services, the requirement for designated communicable disease funding is repealed beginning in fiscal year 2012. However, in recognition of the linkage between CDs and SUD treatment, minimal requirements have been retained to assure needs are met for persons with, or at-risk for, HIV/AIDS or other communicable diseases, and are in treatment for substance abuse.

SCOPE:

This policy applies to CAs and their provider network, which are a part of substance abuse services administered through the Michigan Department of Health & Human Services (MDHHS), Office of Recovery Oriented Systems of Care (OROSC).

BACKGROUND:

Given the causal relationship between HIV/AIDS, hepatitis, other CDs, substance abuse, and the importance of recognizing the role of CD assessment in the development of substance abuse treatment plans for clients, a comprehensive approach is the most effective strategy for preventing infections in the drug using population and their communities.

The CA must assure persons with SUDs who are at-risk for and/or living with HIV/AIDS, sexually transmitted diseases/infections (STD/Is), tuberculosis (TB), hepatitis C, and other CDs, have access to culturally sensitive and appropriate substance abuse prevention and treatment to address their multiple needs in a respectful and dignified manner.

REQUIREMENTS:

Staffing

Each CA must assure staff knowledge and skills in the provider network are adequate and appropriate for addressing communicable disease related issues in the client population, as appropriate for each position within each provider, in accordance with the "Minimum Knowledge Standards" that follow:

Minimum Knowledge Standards for Substance Abuse Professionals - Communicable Disease Related

BSAAS mandates that all staff with client contact at a licensed treatment provider have at least a basic knowledge of HIV/AIDS, TB, Hepatitis, and STD, and the relationship to substance abuse. BSAAS provides a web-based training that will cover minimal knowledge standards necessary to meet this **Level 1** requirement. However, if a CA region desires to provide this training through other mechanisms, the following information must be included:

- HIV/AIDS, TB, Hepatitis (especially A, B, and C) and STD/Is, as they relate to the agency target population.
- Modes of transmission (risk factors, myths and facts, etc.).
- Linkage between substance abuse and these CDs.
- Overview of treatment possibilities.
- Local resources available for further information/screening.

CA regions are required to maintain a tracking mechanism to assure SUD provider staff completes Level 1 training.

Services

1. All persons receiving SUD services who are infected by mycobacterium tuberculosis must be referred for appropriate medical evaluation and treatment. The CA's responsibility extends to ensuring that the agency, to which the client is referred to, has the capacity to provide these medical services, or to make these services available, based on the client's ability to pay. If no such agency can be identified locally (within reasonable distance), the CA must notify MDHHS/OROSC.
2. All clients entering residential treatment and residential detoxification must be tested for TB upon admission. With respect to clients who exhibit symptoms of active TB, policies and procedures must be in place to avoid a potential spread of the disease. These policies and procedures must be consistent with the Centers for Disease Control (CDC) guidelines and/or communicable disease best practice.
3. All pregnant women presenting for treatment must have access to STD/Is and HIV testing.
4. Each CA is required to assure that all SUD clients entering treatment have been appropriately

screened for risk of HIV/AIDS, STD/Is, TB, and hepatitis, and that they are provided basic information about risk.

5. For those clients entering SUD treatment identified with high-risk behaviors, additional information about the resources available, and referral to testing and treatment must be made available.

Financial and Reporting Requirements

For the required services set forth in this policy, there are no separate financial or reporting requirements.

If a CA chooses to utilize state funds to provide communicable disease services beyond the scope of this policy:

1. The CA must ensure that recipients are persons with SUDs.
2. The Communicable Disease Provider Information Plan must be completed at the beginning of each fiscal year in conjunction with the CA Action Plan submission (Attachment A).
3. The Communicable Disease Provider Information Report must be completed within 60 days following the end of a fiscal year and submitted to MDHHS-OROSC@michigan.gov (Attachment A).
4. The CA must submit data to the HIV Event System [HES] for Health Education/Risk Reduction Informational Sessions and Single-Session Skills Building Workgroups, as well as HIV Counseling, Testing and Referral Services (CTRS), consistent with MDHHSHIV/AIDS Prevention and Intervention Section (HAPIS) data collections methods.

PROCEDURE:

Procedures to meet these requirements are at the discretion of the PIHP.

REFERENCES:

Center for Substance Abuse Treatment. (Reprinted 2000). *Substance Abuse Treatment for Persons with HIV/AIDS*, Treatment Improvement Protocol (TIP) Series 37. U.S. Department of Health and Human Services, Substance Abuse, and Mental Health Services Administration. Rockville, MD.

Center for Substance Abuse Treatment. (Reprinted 1995). *Screening for Infectious Disease Among Substance Abusers*, Treatment Improvement Protocol (TIP) Series 6. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Rockville, MD.

Approved by:

Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

COMMUNICABLE DISEASE PROVIDER INFORMATION PLAN / REPORT				
PIHP:	**Fiscal Year:**		**Date Submitted/ Revised:**	
Name(s) of CD Providers under Contract with the PIHP:				
PIHP Contact Person and E-mail Address:				
For each intervention listed below and provided in the PIHP's region, complete the following information:				
INTERVENTION	**PLAN** Original	**PLAN** Revised	**REPORT** (Actual #'s) Due Date: 60 days following the end of the fiscal year.	
*NOTE: Those items identified with an * are required to be reported in the* HIV Event System (*HES).*	**Estimated Number of Individuals to Receive Services**	**Estimated Number of Sessions to be Provided**	**Number of Individuals who Received Services**	**Number of Sessions that were Provided**
Column A	*Column B*	*Column C*	*Column D*	*Column E*
*** HE/RR HIV/AIDS Information Session**				
*** HE/RR Skills Building Workshops** (singl e session)				
*** HIV CTRS at SUD Treatment Provider** (include site type/site number on separate attachment)				
*** HIV CTRS at Other Locations** (include site type/site number on separate attachment)				
*** Other/Non-HIV CTRS Outreach Contacts** (include schedule of locations and times on separate attachment)				
TOTALS				

Site Type/Site Numbers for locations where HIV CTRS will be provided:

Locations and Times where non-HIV CTRS Outreach will be provided:

COMMUNICABLE DISEASE PROVIDER INFORMATION PLAN/REPORT INSTRUCTIONS

If a PIHP chooses to continue to fund CD services, the information on this form must be completed. The form lists various communicable disease (CD) interventions/services that are eligible, although not required, to be funded through community grant dollars based on PIHP need and priority.

I. Completing the Plan

Columns B and C (Estimated Number of Individuals to Receive Services and Estimated Number of Sessions to be Provided) must be completed each fiscal year and is due to the Office of Recovery Oriented Systems of Care with the PIHP's Action Plan submission.

Please use the check box provided to identify the CD Provider Information Plan as "Original" at the initial submission of the plan. If the CD Provider Information Plan data does change, please use the check box provided to identify that the plan was "Revised" as appropriate through the course of the fiscal year.

II. Completing the Report

For those services/events that an identified CD provider conducted for the PIHP, post the number of individuals who received the services and the number of sessions provided in Columns D and E.

Report Due Date: An annual report is required to be completed within sixty (60) days following the end of the fiscal year and submitted to mdhhs-orosc@michigan.gov.

III. Questions

For questions or assistance regarding this form, contact the OROSC Communicable Disease Specialist, at mdhhs-orosc@michigan.gov or 517-373-4700.

IV. CREDENTIALING AND STAFF QUALIFICATION REQUIREMENTS

Michigan Department of Health & Human Services

Behavioral Health and Developmental Disabilities Administration

Bureau of Community Mental Health Services

Credentialing and Staff Qualification Requirements for the Prepaid Inpatient Health Plan Provider Network

This contract attachment outlines requirements for credentialing and staff qualifications throughout the substance abuse PIHP provider network**.** This document is organized as follows:

I. PIHP Credentialing Requirements
II. Provider Staff Certification Requirements
III. Staff Qualifications for Substance Use Disorder Prevention Services
IV. Staff Qualifications for Substance Use Disorder Treatment Services
V. Other Staff-Related Definitions

I. PIHP CREDENTIALING REQUIREMENTS

In implementing staff qualifications requirements, the PIHP must:

1) Adopt and disseminate policy with respect to required professional qualifications for prevention and treatment direct service personnel in the PIHP network, applicable both to salaried and contractual personnel. In general, the requirements contained herein are expected to represent the minimum standards for substance use disorder (SUD) prevention and treatment services. However, it is recognized that specialized services may require enhanced staff qualifications.

   When establishing requirements for qualifications or training, for staff that do not require certification, PIHPs are expected to:

   a) Recognize and utilize training and education that is specific or related to the needed knowledge and skills necessary to perform the required tasks.

   b) Recognize in-service and provider new staff orientation.

   c) Recognize and provide reciprocity for training provided through PIHPs that address relevant topic and content areas.

2) Assure that staff qualifications are met throughout the provider panel through PIHP policy and procedures.

PIHPs must consider the use of deemed status, reciprocity and delegation provisions when permissible, in order to establish a single credentialing and associated monitoring requirements for the provider, and reduce administrative burden on both the provider and the PIHP. Whenever possible, it is preferable that PIHPs permit deemed status or reciprocity, and that a single responsible PIHP be identified when multiple PIHPs contract with a single provider.

3) Assure that criminal background checks are conducted as a condition of employment for its own potential employees and for network provider employees. Although criminal background checks are required, it is not intended to imply that a criminal record should necessarily bar employment. The verification of these checks and a justification for the decisions that are made should be documented in the employee personnel or interview file. The decisions must be consistent with state and federal rules and regulations regarding individuals with a criminal history. PIHPs may also establish criteria for the frequency of criminal background checks for individuals during employment episodes. At a minimum, checks should take place every other year from when the initial check was made.

   Criminal background checks must be completed by an organization, service, or agency that specializes in gathering the appropriate information to review the complete history of an individual. Use of the state of Michigan Offender Tracking Information System (OTIS) or a county level service that provides information on individuals involved with the court system are not appropriate resources to use for criminal background checks.

4) Recognize and comply with state health care licensing professional scope of practice and supervision requirements.

Credentialing Responsibilities

Primary responsibility for assurance that staff qualification requirements are met rests with the individual and the provider agency that directly employs or contracts with the individual to provide prevention or treatment services.

Responsibilities of the individual, provider agency and the PIHP are generally as follows:

1) The individual is responsible for achieving and maintaining his or her certification.
2) The provider agency that directly employs or contracts with the individual to provide prevention or treatment services is responsible for verifying the ongoing certification status of the employee. This includes verification of the credential(s), monitoring staff, development plans, and compliance with continuing education requirements.
3) The PIHP is responsible for establishing certification-related contractual obligations with their provider network consistent with these requirements. With the intended locus of responsibility resting with the individual and the provider agency, the PIHP has responsibility for provider agency performance monitoring to assure these

obligations have been met.

Although it is not intended that PIHPs maintain primary source verification functions or individual certification or credentialing files on behalf of their provider network, it is recognized that this may represent a prudent or necessary business practice of the PIHP. PIHPs maintaining primary source verification files may be asked to provide their justification for doing so.

Compatibility with PIHP Requirements

PIHP policy and procedures with regard to credentialing should be compatible with PIHP credentialing and re-credentialing business processes. MDHHS has issued a PIHP Credentialing policy entitled *Credentialing and Re-Credentialing Processes* (Attachment of the MDHHS PIHP contract). This policy defines organizational providers as entities that directly employ and/or contract with individuals to provide health care services. These services include treatment of substance use disorders. In this regard, PIHPs are considered to be organizational providers.

The PIHP credentialing policy outlines two requirements associated with credentialing of organizational providers:

1) Each PIHP must validate, and re-validate at least every 2 years that the organizational provider is licensed or certified as necessary to operate in the state and has not been excluded from Medicaid or Medicare participation.
2) The PIHP must ensure that the contract between the PIHP and any organizational provider requires that the organizational provider credential and re-credential their directly employed and subcontracted direct service providers in accordance with the PIHP's policies and procedures (which must conform to MDHHS's credentialing process).

Added clarification for CAs that are not PIHPs: The intention of this policy is to assure that credentialing responsibilities are carried out, and associated records are maintained at the provider organization level. If a PIHP employs individual practitioners for the purposes of providing treatment or prevention services, the CA is an organizational provider. The PIHP is not required by the MDHHS with providers that meet the organizational provider definition, then the PIHP must:

1) Ensure that the contract between the PIHP and their organizational provider requires that the provider credential and re-credential their directly employed and subcontracted providers in accordance with the policy.
2) Ensure that the provider has not been excluded from Medicaid or Medicare participation.

II. PROVIDER STAFF CERTIFICATION REQUIREMENTS

The following provides detailed information regarding the certification requirements for the PIHP provider network.

General

These certification requirements represent the standards for individual PIHP provider network requirements. Special consideration can be made for both special population needs (such as those of adolescents) and for specialty services (such as provision of methadone to women that are pregnant).

Also, it is expected that reimbursement rates reasonably acknowledge the cost implications of certification requirements and recognize workforce development obligations already incorporated in provider accreditation requirements. PIHPs may consider rate incentives for enhanced staffing requirements for specialty services.

Application

Certification requirements apply to the entire PIHP provider network for services directed to the prevention and treatment of substance use disorders. This includes staff working for or within local governmental units such as intermediate school districts, local health departments, or community mental health service board programs when these are under contract to the PIHP as a provider and/or funded through the MDHHS/PIHP master agreement, depending on the scope of their work, as described in this document.

Certification requirements do not apply to staff solely engaged in:

1) Synar tobacco compliance checks or vender education.
2) Provision of communicable disease prevention and education services.

Refer to revised Prevention Policy #02-*Addressing Communicable Disease Issues in the Substance Abuse Service Network* for information about communicable disease staff training requirements.

Certification requirements apply on the basis of staff role and responsibility regardless of employment status or type. Examples of employment status include: direct employee, contractual, or volunteer. Examples of type include: full-time, part-time, intermittent, or seasonal.

An individual's certification requirements are determined on the basis of each of their job responsibilities. That is, situations in which an individual's responsibilities cross roles and responsibilities as outlined below, and each role category independently determines the associated certification requirement. For example, an individual functioning as a case manager (certification not required) and as a treatment clinician would be required to be certified even though their responsibilities include functions for which certification is not required. Unless an exception is specified below under the various staff types, individuals who are timely in the process of completing their registered development plan for the specified credential are considered to meet certification requirements. For example, a recent MSW graduate working in a position providing treatment to persons with substance use disorders with an approved development plan would be considered to meet certification requirements.

Development plans are required to include time frames, milestones, be date-specific and appropriate to the experience requirements associated with the certification credential. For example, a development plan must recognize hours of experience requirements in the context of the employee's status (full, part time). However, development plans must contain prompt and reasonable timeframes for completion. In general, a clinical staff person employed full-time will have up to a three-year development plan, and those working part-time will have up to a six-year plan. It is the responsibility of the individual to make the necessary changes to their plan, through MCBAP, if there is a change in work status. A six-year plan for an individual working full-time would not be considered to have reasonable timeframes for completion.

Timely completion of a development plan refers to the completion of the plan in the established timeframe based on work status. Timely in the process of completion refers to the yearly progress being made with the goals of the plan. At minimum, this should reflect an appropriate proportion of the work being completed in each year of the plan.
An individual who does no work on a three-year plan during years one and two and then seeks to complete everything during year three would not be seen as being timely in the process of completion and would not meet the credentialing requirements that have been established.

Since June 2007, the accepted equivalent credentials to the Michigan Certification Board for Addiction Professionals (MCBAP) certification are as follows:

- For prevention: Certified Health Education Specialist (CHES) through the *National Commission for Health Education Credentialing*
- For treatment: Certification through the *Upper Midwest Indian Council on Addiction Disorders (UMICAD)*
- For medical doctors: *American Society of Addiction Medicine (ASAM)* (Some physicians, depending on the scope of their work performed at the agency, will function in the category of "Specifically Focused Staff, " as described in this

document)

- For psychologists: *American Psychological Association (APA) specialty in addiction*

This listing will be updated, and PIHPs notified in writing, should additional equivalent credentials be identified.

Should a situation arise with an established provider where there are no longer employees available that meet the credentialing requirements, the provider and the PIHP are responsible for developing a "time-limited exception plan" appropriate to the situation to ensure that the established clients with the provider continue to receive services. An example of such a situation would be a provider that has one or more credentialed clinicians leave resulting in the remaining staff not being able to provide services to the clients. The PIHP and provider could then enter into an exception plan agreement where a qualified but non-credentialed person can provide services to those clients until credentialed staff are hired, return from leave, etc.

The length of the plan should be adequate to serve the immediate need of the affected clients but should not exceed 120 days in an initial agreement. For administrative efficiency, when providers participate in multiple PIHP provider panels, the affected PIHPs should jointly determine an appropriate exception plan. Once a plan is initiated, the PIHP must notify the department in writing specifying the situation and the action being taken to resolve it.

MCBAP Staff Certification Requirements – By Staff Function

Since October 1, 2008, all individuals performing staff functions outlined below must:

1) Be certified appropriate to their job responsibilities under one of the credentialing categories or an approved alternative credential; or
2) Have a registered development plan and be timely in its implementation; or
3) Be functioning under a time-limited exception plan approved by the PIHPas described earlier in this document.

Individuals under any of these three categories will be considered to meet MCBAP certification requirements. Note that a development plan is timely when there is evidence that steps or activities included in the development plan are being implemented and can be expected to be completed within a reasonable period of time. The supervisor of the individual is responsible for regularly monitoring the status of the development plan. MCBAP maintains a list of individuals who have active development plans and this can be accessed through their website at mcbap.com. All individuals who have an

active development plan and are working toward completion are considered to meet the staff certification requirements for providing substance use disorder services in Michigan.

Staff functions for which these requirements apply are Prevention Professionals, Prevention Supervisors, Treatment Specialists, Treatment Practitioners, and Treatment Supervisors. The following chart outlines certification, supervision, and licensure requirements. It is intended to assist in the determination of MCBAP certification requirements in the provider network, licensing requirements may still apply depending on the nature of the work duties and scope of practice.

Job Function and Description	MCBAP Certification Required for the Job Function	Supervision Required for the Job Function
Treatment Supervisors Commonly described as Supervisors, Managers, or Clinical Supervisors. This represents individuals directly supervising staff, including all levels (first, second line, etc) of clinical services.	• Certified Clinical Supervisor – Michigan (CCS-M) • Certified Clinical Supervisor – IC&RC (CCS) • Development Plan – Supervisor (DP-S) – approved development plan in place	Professional licensure requirements may apply, depending on the nature of the work duties and scope of practice.

Job Function and Description	MCBAP Certification Required for the Job Function	Supervision Required for the Job Function

Treatment Specialists Commonly described as clinicians, therapists, or counselors. This represents direct clinical treatment service provider staff not identified as specifically focused.	• Certified Alcohol and Drug Counselor – Michigan (CADC-M) • Certified Alcohol and Drug Counselor (CADC) • Certified Advanced Alcohol and Drug Counselor (CAADC) • Development Plan – Counselor (DP-C) – approved development plan in place • Certified Criminal Justice Professional – IC&RC – (CCJP) • Certified Co-Occurring Disorders Professional – IC&RC – (CCDP) – Bachelors level only • Certified Co-Occurring Disorders Professional Diplomat – IC&RC – (CCDP-D) – Masters level only	MCBAP supervisory credential – CCS-M or CCS, an approved alternative certification or a registered development plan to obtain the MCBAP credential.
Treatment Practitioners Commonly described as treatment staff providing direct service to clients like education and support; or they may be new to the field.	• A registered development plan that is timely in its implementation • Development Plan – Counselor (DP-C) – approved development plan in place	MCBAP supervisory credential – CCS-M or CCS, an approved alternative certification or a registered development plan to obtain the MCBAP credential.
Prevention Supervisors Commonly described as prevention program supervisors and represent individuals responsible for overseeing prevention staff and/or prevention services.	• Certified Prevention Consultant – Michigan (CPC-M) • Certified Prevention Consultant – IC&RC (CPC-R) • Certified Prevention Specialist – Michigan (CPS-M) • Certified Prevention Specialist – IC&RC (CPS) – only if credential effective for three (3) years	No state requirements specified.
Prevention Professionals Commonly described as Program or Prevention Coordinator, Prevention Specialist or Consultant, or Community Organizer and have responsibility for implementing a range of prevention plans, programs, and services.	• Certified Prevention Specialist – Michigan (CPS-M) • Certified Prevention Consultant – Michigan (CPC-M) • Certified Prevention Specialist – IC&RC (CPS) • Certified Prevention Consultant – IC&RC (CPC-R) • Development Plan – Prevention (DP-P) – approved development plan in place	Supervision by MCBAP prevention credentialed staff or an approved alternative certification.

Supervision Requirements for Non-Certified Staff

Individuals with staff functions outlined below are not required to be MCBAP certified, but are required to be supervised by MCBAP certified staff. Individuals with a development plan for counseling (DP-C) or prevention (DP-P) cannot function in the role of supervisor for non-certified staff.

Specifically Focused Treatment Staff This category includes Case Managers, Recovery Support Staff, as well as staff who provide ancillary health care services such as nurses, occupational therapists, psychiatrists, and children's services staff in women's specialty programs. Licensing requirements may apply depending on the nature of the work duties and scope of practice.
Specifically Focused Prevention Staff Staff that consistently provide a specific type of prevention service. They do not have responsibilities for implementing a range of prevention plans, programs, or services.
Treatment Adjunct Staff Commonly described as: Resident Aide, Pharmacy Techs or Child Care Aides or program aides/techs. Adjunct staff are involved with the client but not at a clinical treatment services level. It is recognized that some treatment adjunct staff provide didactic or skill development services. Licensing requirements may apply to adjunct staff depending on the nature of the work duties and scope of practice; they may also work under the direction of appropriately licensed and/or credentialed staff.
Interns for the Provision of Services Interns are individuals who, as part of an educational curriculum while in the process of obtaining a degree related to the substance use disorder field, provide prevention or treatment services to clients. These services must be provided under the supervision of a MCBAP treatment credentialed staff (or an approved alternative certification) and any specific licensing requirements for the degree being sought. All services provided by interns may be allowable and billable as long as the intern is being appropriately supervised.

The MCBAP certification requirements *do not replace or supersede state licensure scope of practice and supervision requirements* for health care professionals such as social workers, counselors, or psychologists.

Supervision Requirements for Clinical Staff

Individual/Clinical Supervision – Refers to the intervention that is provided by a s e n i o r member of a profession to a junior member, or members, of the same profession.

This service is focused on enhancing the professional functioning of the junior member(s) and monitoring the quality of the professional services offered to clients by the junior member(s).

Supervision can be provided by a variety of methods like individual, group, live and recorded observation, and should include a review of documentation. Supervision activities are recorded outside of client records and are generally reflected in a log. Supervision activities that are recorded in client records involve the review and co- signing of progress notes, assessments, and treatment plans, only of those individuals who are providing clinical services as part of an internship placement through an institution of higher learning.

In Michigan, to provide supervision in the substance use disorder prevention and treatment fields, an individual must have one of the following MCBAP credentials or an established development plan leading to certification in one of the credentials:

- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Consultant – IC&RC (CPC-R)
- Certified Prevention Specialist – Michigan (CPS-M)
- Certified Prevention Specialist – IC&RC (CPS) – only if credential effective for three (3) years
- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)
- Certified Clinical Supervisor – Michigan (CCS-M)
- Certified Clinical Supervisor – IC&RC (CCS)
- Development Plan – Supervisor (DP-S) – approved development plan in place
- For medical doctors: *American Society of Addiction Medicine (ASAM)*
- For psychologists: *American Psychological Association (APA)*

Due to the variety of professional services that are provided within the substance use disorder treatment field, a clinical supervisor may in fact, not have what is viewed as a "clinical background" in terms of education and training. This could result in a situation where a CCS, with no formal education in clinical work, is supervising the work of clinical staff (Master's prepared) providing psychotherapy. It is recommended that the supervisor have the appropriate education in the area where clinical supervision is being provided. In situations where this is not possible, due to staffing levels or the general staffing make up of an organization, the CA needs to approve the supervision process of the provider or enter into a plan with the provider that is outlined in the "Considerations Due To Availability of Certified Supervisory Staff" section below.

<u>Certification Requirements for Temporary or Supervisory Assignments</u>

Cross-over work assignments occur in those situations when an individual staff's roles and responsibilities have different MCBAP certification requirements on a temporary, time-limited basis (less than 120 days). Temporary work assignments include, for example, working out of class, temporary assignments to a higher or different position during the time required to fill a vacancy, providing coverage for a staff person on leave status, or similar situations. Examples of temporary work assignments are: assignment of a treatment clinician to clinical supervisory responsibilities, or a prevention professional assigned to supervisory prevention activities due to a vacant position or employee leave of absence.

During the temporary work assignment period, the individual performing the duties of the absent/vacant staff position will not be required to meet the MCBAP certification requirement for that temporary position. However, the individual with the temporary work assignment must have the certification or development plan appropriate to their current roles and responsibilities. For example, an individual temporarily assigned to clinical supervision would be required to be treatment-certified and an individual assigned to prevention supervisory responsibilities would be expected to be prevention- certified.

When the provider does not have any suitable employee available, or does not have the capacity to meet these requirements, the provider and the PIHP are responsible for developing and implementing a "time-limited exception plan." The PIHP and provider should enter into an exception plan agreement where a qualified but non-credentialed person can provide adequate and appropriate supervision services to those credentialed staff currently providing services to clients. The length of the plan should be adequate to serve the immediate need of the provider and clients but should not exceed 120 days in an initial agreement.

Supervisory exception plans may include purchase of supervisory services on a short- term basis, cross-PIHP or provider staff support or other actions appropriate to the situation and health care professional licensure requirements. For administrative efficiency, when providers participate in multiple PIHP provider panels, the affected PIHP s should jointly determine an appropriate plan. Once a plan is initiated, the PIHP must notify the department in writing specifying the situation in detail and the action being taken to resolve it.

Considerations Due To Availability of Certified Supervisory Staff

It is expected that certified supervisory staff may not be available during the implementation period, or the size/scope of some providers (i.e. single provider in a rural setting) result in shared supervision of either prevention and treatment programs or other unique arrangements. In these situations, the responsible PIHP and provider must develop a plan that recognizes that general supervisory responsibilities (such as approval of time off, etc) are at the discretion of the provider. However, a plan addressing how "content specialty" and clinical supervision will be provided must be developed and implemented. The plan as feasible and appropriate to the

situation may consider hiring qualifications for new staff, supervised practical training, use of mentors or consultants, use of regional/other resources, development of a regional cadre for the content area or continuing education. Once a plan is initiated, the PIHP must notify the department in writing specifying the situation in detail and the action being taken to resolve it.

Diversity and Workforce Development

The development of a diverse pool of candidates and a workforce that is representative of the community and service population is valued and encouraged as is the development of career ladders that assist individuals in gaining the knowledge and skills that enable career advancement. The development of opportunities for peers as mentors and recovery specialists is also encouraged.

III. STAFF QUALIFICATIONS FOR SUD PREVENTION SERVICES

The staff qualifications that follow reflect changes that went into effect October 1, 2008.

Definitions

Prevention Professional:

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Prevention Specialist – Michigan (CPS-M)
- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Specialist – IC&RC (CPS)
- Certified Prevention Consultant – IC&RC (CPC-R)

OR – An individual who has an approved alternative certification:

- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)

OR – An individual who has a registered development plan for a prevention credential, and is timely in its implementation leading to certification. Individuals with a prevention development plan will utilize the following to identify their credential status:

- Development Plan – Prevention (DP-P)

Prevention Supervisor:

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Prevention Consultant – Michigan (CPC-M)
- Certified Prevention Consultant – IC&RC (CPC-R)
- Certified Prevention Specialist – Michigan (CPS-M)
- Certified Prevention Specialist – IC&RC (CPS) – only if credential effective for three (3) years

OR – An individual who has an approved alternative certification:

- Certified Health Education Specialist (CHES) through the National Commission for Health Education Credentialing (NCHEC)

Individuals must utilize the appropriate credential acronym designated in this document when applying signatures for any required billable services.

IV. STAFF QUALIFICATIONS FOR SUD TREATMENT SERVICES

The staff qualifications that follow reflect changes that went into effect October 1, 2008.

Definitions

Substance Abuse Treatment Specialist (SATS):

An individual who has licensure in one of the following areas, AND is working within his or her licensure-specified scope of practice:

Physician (MD/DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Psychologist (LP), Limited Licensed Psychologist (LLP), Temporary Limited Licensed Psychologist (TLLP), Licensed Professional Counselor (LPC), Limited Licensed Counselor (LLC), Licensed Marriage and Family Therapist (LMFT), Limited Licensed Marriage and Family Therapist (LLMFT), Licensed Masters Social Worker (LMSW), Limited Licensed Masters Social Worker (LLMSW), Licensed Bachelor's Social Worker (LBSW), or Limited Licensed Bachelor's Social Worker (LLBSW);

AND they have a registered development plan and are timely in its implementation leading

to certification. Individuals with a counselor development plan will utilize the following to identify their credential status:

- Development Plan – Counselor (DP-C)

OR – they are functioning under a time limited exception plan approved by the PIHP, as detailed in this document.

OR – An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Alcohol and Drug Counselor – Michigan (CADC-M)
- Certified Alcohol and Drug Counselor – IC&RC (CADC)
- Certified Advanced Alcohol and Drug Counselor – IC&RC (CAADC)
- Certified Criminal Justice Professional – IC&RC (CCJP)
- Certified Co-Occurring Disorders Professional – IC&RC (CCDP) – Bachelors level only
- Certified Co-Occurring Disorders Professional Diplomat – IC&RC (CCDP-D) – Masters level only

OR – An individual who has an approved alternative certification:

- For medical doctors: *American Society of Addiction Medicine (ASAM)*
- For psychologists: *American Psychological Association (APA)*
- Certification through the *Upper Midwest Indian Council on Addiction Disorders (UMICAD)*

A Physician (MD/DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN) or Licensed Practical Nurse (LPN) who is not providing treatment services to clients beyond the scope of practice of their licensure are considered to be Specifically Focused Treatment Staff and are not required to obtain the MCBAP credentials. If one of these individuals wants to provide substance use disorder treatment services to clients, outside the scope of their licensure, then the MCBAP certification requirements apply.

Substance Abuse Treatment Practitioner (SATP):

An individual who has a registered MCBAP certification development plan that is timely in its implementation AND is supervised by an individual with a CCS-M, CCS, or a DP-S. Individuals with a counselor development plan will utilize the following to identify their credential status:

- Development Plan – Counselor (DP-C)

Treatment Supervisor:

An individual who has one of the following Michigan specific (MCBAP) or International Certification & Reciprocity Consortium (IC&RC) credentials:

- Certified Clinical Supervisor – Michigan (CCS-M)
- Certified Clinical Supervisor – IC&RC (CCS)

OR – An individual who has an approved alternative certification:

- For medical doctors: American Society of Addiction Medicine (ASAM)
- For psychologists: American Psychological Association (APA)

OR – An individual who has a registered development plan, for the supervisory credential and is timely in its implementation leading to certification. Individuals with a supervisor development plan will utilize the following to identify their credential status:

- Development Plan – Supervisor (DP-S)

Individuals must utilize the appropriate credentials acronym designated in this document when applying signatures for any required billable services.

V. Other Staff-Related Definitions

Individual Licensure Requirements – Refers to the requirements set forth in the public health code for each category of licensed professions. The licensed individual is responsible for ensuring that he/she is functioning within the designated scopes of service and is involved in the appropriate supervision as designated by the licensing rules of his/her profession.

Clinical Addiction Services – The services in substance use disorder treatment that involve individual or group interventions, that focus on providing education, assisting with developing insight into behaviors and teaching skills to understanding and change those behaviors.

Individual Therapy – The actions involved in assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio- psychosocial problems; and may include the involvement of the intra-psychic, intra- personal, or psychosocial dynamics of individuals. This requires specially trained and educated clinicians to perform these functions.

Other Services – Those services in substance use disorder treatment that involve directing, assisting, and teaching client skills necessary for recovery from substance use disorders. Specially focused staff or recovery coaches generally provide these services.

Program Supervision – An administrative function that ensures agency compliance with laws, rules, regulations, policies, and procedures that have been established for the provision of substance use disorder prevention and treatment services.

Treatment Billing Codes Based on Qualifications

All services provided by a SATS or SATP must be performed under appropriate supervision for billing to occur. Prevention billing is maintained by a statewide agreement and data system.

Billing Code	Code Description	Substance Abuse Treatment Specialist (SATS)	Substance Abuse Treatment Practitioner (SATP)
H0001	Alcohol and/or drug assessment face-to-face service for the purpose of identifying functional and treatment needs and to formulate the basis for the Individualized Treatment Plan	**X**	**X**
H0004	Behavioral health counseling and therapy, per 15 minutes	**X**	**X**

Billing Code	Code Description	Substance Abuse Treatment Specialist (SATS)	Substance Abuse Treatment Practitioner (SATP)
H0005	Alcohol and/or drug services; group counseling by a clinician	**X**	**X**
H0010	Alcohol and/or drug services; sub-acute detoxification; medically monitored residential detox (ASAM Level III.7-D)	**X**	**X**
H0012	Alcohol and/or drug services; sub-acute detoxification; clinically monitored residential detox; non-medical or social detox setting (ASAM Level III.2-D)	**X**	**X**
H0014	Alcohol and/or drug services; ambulatory detoxification without extended on-site monitoring (ASAM Level I-D)	**X**	**X**

H0015	Alcohol and/or drug services; intensive outpatient (from 9 to 19 hours of structured programming per week based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education	**X**	**X**
H0018	Alcohol and/or drug services; short term residential (non-hospital residential treatment program)	**X**	**X**
H0019	Alcohol and/or drug services; long-term residential (non-medical, non-acute care in residential treatment program where stay is typically longer than 30 days)	**X**	**X**
H0022	Early Intervention	**X**	**X**
H2035	Substance abuse treatment services, per hour	**X**	**X**
H2036	Substance abuse treatment services, per diem	**X**	**X**
T1012	Peer recovery and recovery support *	**X**	**X**
90804 - 90815	Psychotherapy (individual) **	**X**	
90826	Interactive individual psychotherapy **	**X**	
90847	Family psychotherapy **	**X**	
90853	Group psychotherapy **	**X**	
90857	Interactive group psychotherapy **	**X**	
0906	Intensive Outpatient Services – Chemical dependency	**X**	**X**

***** *Specially focused treatment staff may also provide and bill for this service.*
****** *Appropriate licensure may still apply.*

V. TECHNICAL ADVISORIES

Contract Technical Advisory #01 Local Advisory Council Guidelines—
Issued August 9, 1990; Reissued September 18, 2006

Treatment Technical Advisory #01 Suboxone® Use in an Opioid Treatment Program—
Issued December 1, 2005

Treatment Technical Advisory #05 Welcoming—
Issued October 1, 2006

Treatment Technical Advisory #06
Counseling Requirements for Clients Receiving Methadone Treatment— Issued August 10, 2007

Treatment Technical Advisory #07 Peer Recovery/Recovery Support— Issued March 17, 2008

Treatment Technical Advisory #08
Enhanced Women's Services— Issued January 31, 2012

Treatment Technical Advisory #09 Early Intervention—
Issued November 30, 2011

Treatment Technical Advisory #11 Recovery Housing
Amendment #1

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

MEMORANDUM

Date: September 18, 2006

To: Regional Coordinating Agencies

From: Donald L. Allen, Jr., Director
Office of Drug Control Policy

Subject: Technical Advisory (TA)

Attached is the finalized document: *Contract Technical Advisory #01 – Local Advisory Council Guidelines*. This is an update to the 1990 document currently required by contract and will go into effect on October 1, 2006.

This advisory was distributed to the field for comments on 7/13/06. Comments from Northern and Pathways were received during the review period, ending 9/11/06, and were considered in this final document.

If you have any questions or need further clarification on any issue in this advisory, please contact Mark Steinberg at (517) 335-0180 or SteinbergM@michigan.gov.

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MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF DRUG CONTROL POLICY

CONTRACT TECHNICAL ADVISORY # 01

SUBJECT: Local Advisory Council Guidelines
ISSUED: August 9, 1990, revised October 1, 2006

PURPOSE:

To provide guidelines regarding the structure and membership of the Local Advisory Council.

SCOPE:

This advisory applies to Substance Abuse Regional Coordinating Agencies (CAs).

BACKGROUND:

Section 6226 (3) of Public Act 368 of 1978 states that a "coordinating agency shall have a local advisory council consisting of representatives of public and private treatment and prevention programs and private citizens in accordance with the guidelines established by the Administrator".

RECOMMENDATIONS:

Purpose of the Council

Each local advisory council should:

a. Seek to ensure the quality of services;

b. Seek to ensure that the services made available through the CA are accessible and responsive to their community's needs, that services are available to all segments of the community, and that the services are comprehensive and delivered in a culturally competent manner;

c. Provide a mechanism for efforts to expand and coordinate resources and activities with other agencies, community organizations and individuals to support the mission of the CA;

d. Provide opportunity for public comment on matters relevant to substance abuse prevention and treatment within the community; and

e. Provide their community a forum to discuss substance abuse services and problems throughout the service area.

Each local advisory council may:

a. Comment on the application and issuance and renewal of substance abuse services licenses, opportunities for comment may include web based means; and

b. Review and comment not less than biannually on the progress and effectiveness of services in the region and resource development partnerships.

Structure of the Council

The Advisory Council membership should include representation from the following sectors (not in any priority order):

a. Public and private substance abuse prevention, treatment or recovery providers including representation from the CA provider panel;

b. Individuals who are or have been directly served by substance abuse prevention, treatment, and recovery programs;

c. Local agencies or other stakeholders such as law enforcement, education, related services agencies such as housing, employment assistance or other health and social services agencies including local foundations, United Way as well as advocacy-oriented agencies and organizations; and

d. The general public, including civic organizations and the business community representing an interest in and willingness to advocate for prevention and treatment services for persons with, or at risk of substance use disorders.

Administration of the Council

Membership is required to be representative of the diversity of the CA catchment area. CAs must seek to include representation from underserved populations.

Note: the CA governing board may also function as the Advisory Council so long as the duties and membership guidelines are met.

Information regarding the Advisory Council must initially be submitted with the CA's designation material to the Michigan Department of Community Health, Office of Drug Control Policy (MDCH/ODCP) and must be resubmitted as changes occur. The information submitted must include:

a. Exact title of the council;

b. Membership roster including expiration dates of terms, place of residence, professional position and/or other pertinent information to reflect the groups represented;

c. Method of selecting membership, including opportunities for new council members and average term duration not to exceed six years, unless an exception is approved by the state substance abuse authority (ODCP); and

d. Council by-laws or charter.

The council by-laws or charter is expected to be approved by the Governing Board of the CA, and provide a process by which to reconcile differences between council and governing board in a manner reflective of the best interests of the community being served.

Alternative Method. In recognition that some CAs may satisfy the recommendations contained in this advisory through an alternative arrangement, the CA may request a waiver. A waiver request must provide sufficient information to demonstrate that the purpose of the Advisory Council will be met, that representation through alternative means satisfies the content of this guideline and that their governing board has approved the alternative method. Waiver approval of the alternative method by the state substance abuse authority (ODCP) is required.

Advisory Council Costs

Reasonable costs associated with the Advisory Council, or an approved alternative method that meets the intent and purpose of this advisory, will be considered eligible for MDCH/ODCP funding as contained in the annual allocation consistent with applicable Federal Office of Management and Budget (OMB) Circulars and general contract requirements. Members may be reimbursed for reasonable costs associated with meeting participation such as for example, mileage or meals when these are consistent with the policies of the CA with regard to reimbursement standards. State administered funds may not be used to reimburse employees of governmental or other agencies to the extent they receive reimbursement for the same expenses from their employers. State administered funds may not be used for payment of per diems for Advisory Council members. For these purposes, a per diem means a payment for meeting attendance.

REFERENCES:

Public Health Code, MCL 1978 PA368, Article 6, Part 62, Section 333.6226, Michigan Legislature, 1977-1978 Legislative Session, Lansing, MI. (September 30, 1978)

APPROVED BY: Donald Allen

Donald L. Allen, Jr., Director
Office of Drug Control Policy

JENNIFER M. GRANHOLM
GOVERNOR
One Michigan

STATE OF MICHIGAN
OFFICE OF DRUG CONTROL POLICY
Department of Community Health

JANET OLSZEWSKI
DIRECTOR
Department of Community Health

DATE: November 21, 2005

TO: Opioid Treatment Programs
Regional Coordinating Agencies

FROM: Doris Gellert, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Suboxone® Use in an Opioid Treatment Program

Attached is "Treatment Advisory 1: Suboxone® Use in an Opioid Treatment Program." This advisory addresses questions from Opioid Treatment Programs (OTPs) and regional coordinating agencies (CAs) regarding limits for prescribing or dispensing Suboxone®.

Contact Marilyn Miller, Treatment Specialist at 517-241-2608, 517-335-2121 fax, or email millermar@michigan.gov if you have any questions or concerns.

cc: Irene Kazieczko

320 South Walnut Street, Second Floor, Lansing, Michigan 48913 517.373.4700 FAX 517.335.2121

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

Substance Abuse Technical Advisory 1: Suboxone® Use in an Opioid Treatment Program

Issue Date: December 1, 2005

Purpose

This advisory is to clarify the issue of the maximum number of patients for prescribing or dispensing Suboxone® at an Opioid Treatment Program (OTP).

Scope

Suboxone® may be obtained by clients in two ways through an OTP.

1) The OTP physician can write a prescription for the client to fill at a pharmacy, or
2) the medication may be dispensed from an OTP, like methadone.

OTP physicians and programs must consider the best interest of the client and safety to the public when determining by which method a client should receive Suboxone®

Counseling requirements are the same for clients receiving physician prescribed Suboxone® as they are for those receiving Suboxone® from an OTP. Administrative Rules of Substance Abuse Service Programs in Michigan state:

> R325.14419(2): "A client record shall contain, at a minimum, all of the following information . . . (g) twice monthly progress reports by the counselor, signed and dated . . ."

<u>Prescribing for External Fill at a Pharmacy-30 Patient Maximum Per Physician</u>

Prescribing Suboxone® is limited to physicians who have obtained the waiver from the Substance Abuse and Mental Health Services Administration (SAMHSA) for prescribing buprenorphine-containing products and who have a Drug Enforcement Administration (DEA) registration. When prescribing Suboxone® to be filled at a pharmacy, the physician is limited to a maximum of 30 active clients at a time. The 30 maximum number of clients includes the total number of clients from all locations in which the physician works (OTP, private office, clinic, etc.). Requirements for prescribing buprenorphine-containing products are listed in the Drug Addiction Treatment Act of 2000 (PL 106-310), Section 3502. Clients are automatically approved for off-site dosing. Physicians should select clients for Suboxone® for external fill at a pharmacy based on stability of the client for off-site dosing rather than the chronological order in which the clients were admitted to treatment.

Dispensing from an OTP

When a client will be obtaining Suboxone® through an OTP, a physician's order for dispensing the medication at the OTP will be necessary. There is no limit to the number of clients that can be dispensed Suboxone® through an OTP, however the regulations regarding how the client receives this medication are more stringent than those who have obtained a prescription for external fill at a pharmacy. Suboxone® dispensed from an OTP must adhere to 42 CFR, Part 8.12 of the federal regulations as well as MDCH "Treatment Policy #4-Revised: Off-Site Dosing of Opioid Treatment Medication-Methadone." However, because Suboxone® is a Class III Controlled Substance and methadone is a Class II Controlled Substance, an accelerated reduced attendance schedule can be requested using the SAMHSA Exception Request and Record of Justification Form (SMA 168). Weekly attendance after one week in treatment would be considered reasonable. Suboxone® should be specified in the "Other" category on the exception request. This request needs both MDCH and CSAT/DPT approval.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

DATE: September 20, 2006

TO: Regional Coordinating Agencies

FROM: Donald L. Allen, Jr., Director
Office of Drug Control Policy

SUBJECT: **Welcoming Technical Advisory**

Attached is Technical Advisory #5 – Welcoming that will go into effect October 1, 2006.

This technical advisory (TA) was submitted to coordinating agencies for comment and none were presented by the due date. The attached is the final version of this TA.

Should you have any questions or need further clarification of this advisory, please contact Joyce Washburn at (517) 335-5247 or by email at washburnjoy@michigan.gov.

Attachment

TREATMENT TECHNICAL ADVISORY # 05

SUBJECT: Welcoming

ISSUED: October 1, 2006

PURPOSE:

The purpose of this technical advisory is to establish expectations for the implementation of a welcoming philosophy.

SCOPE:

This technical advisory applies to the Regional Substance Abuse PIHPs and their provider network, as administered through the Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (MDHHS0OROSC).

It is expected that all CA and provider network staff involved in the provision of substance abuse services understand and take action to operate within these welcoming principles. These actions consist of reviewing business practices, identifying areas in need of improvement, and implementing identified changes.

BACKGROUND:

A welcoming philosophy is based on the core belief of dignity and respect for all people, while, in turn, following good business practice. The concept of welcoming became popular in the 1990s, when there was an increased emphasis on co-occurring disorder treatment. In this context welcoming was determined to be an important factor in contributing to successful client outcomes.

The goal of addiction treatment is to move individuals along the path of recovery. There are two main features of the recovery perspective. It acknowledges that recovery is a long-term process of internal change and it recognizes that these internal changes proceed through various stages. As addiction is a chronic disease, it is characterized by acute episodes or events that precipitate a heightened need for an individual to change their behavior. It is important for the system to understand and support the treatment-seeking client by providing an environment including actions/behavior that foster entry and engagement throughout the treatment process and supports recovery.

The Network for the Improvement of Addiction Treatment (NIATx) has expanded the application of welcoming principles to include all customers of an agency (agency staff, referral sources, client families). This technical advisory concurs with this expanded perspective. The NIATx “Key Paths to Recovery” goals of reduced waiting, reduced no shows, increased admissions, and increased continuation in treatment, incorporate an expectation for a welcoming philosophy.

RECOMMENDATIONS:

Welcoming is conceptualized as an accepting attitude and understanding of how people 'present' for treatment. It also reflects a capacity on the part of the provider to address the client's needs in a manner that accepts and fosters a service and treatment relationship. Welcoming is also considered a best practice for programs that serve persons with co-occurring mental health and substance use disorders.

The following principles list the characteristics/attitudes/beliefs that can be found at a program or agency that is fostering a welcoming environment:

General Principles Associated with Welcoming

- Welcoming is a continuous process throughout the agency/program and involves access, entry, and on-going services.
- Welcoming applies to all "clients" of an agency. Beside the individual seeking services and their family, a client also includes the public seeking services; other providers seeking access for their clients; agency staff; and the community in which the service is located and/or the community resides.
- Welcoming is comprehensive and evidenced throughout all levels of care, all systems and service authorities.
- A welcoming system is 'seamless'. It enables service regardless of original entry point, provider and current services.
- In a welcoming system, when resources are limited or eligibility requirements are not met, the provider ensures a connection is made to community supports.
- A welcoming system is culturally competent and able to provide access and services to all individuals seeking treatment.

Welcoming – Service Recipient

- There is openness, acceptance, and understanding of the presenting behaviors and characteristics of persons with substance use disorders.
- For persons with co-occurring mental health problems, there is openness, acceptance, and understanding of their presenting behaviors and characteristics.
- Welcoming is recipient-based and incorporates meaningful client participation and 'client satisfaction' that includes consideration to the family members/significant others.
- Services are provided in a timely manner to meet the needs of individuals and/or their families.
- Clients must be involved in the development of their treatment plans and goals.

Welcoming – Organization

- The organization demonstrates an understanding and responsiveness to the variety of help-seeking behaviors related to various cultures and ages.

- All staff within the agency integrates and participates in the welcoming philosophy.
- The program is efficient in sharing and gathering authorized information between involved agencies rather than having the client repeat it at each provider.
- The organization has an understanding of the local community, including community differences, local community involvement and opportunities for recovery support and inclusion by the service recipient.
- Consideration is given to administrative details such as sharing paperwork across providers, ongoing review to streamline paperwork to essential and necessary information.
- A welcoming system is capable of providing follow-up and assistance to an individual as they navigate the provider and the community network(s).
- Welcoming is incorporated into continuous quality improvement initiatives.
- Hours of operation meet the needs of the population(s) being served.
- Personnel that provide the initial contact with a client receive training and develop skills that improve engagement in the treatment process.
- All paperwork has purpose and represent added value. Ingredients to managing paperwork are the elimination of duplication, quality forms design and efficient processing, transmission, and storage.

Welcoming – Environmental and Other Considerations

- The physical environment provides seating, space, and consideration to privacy, a drinking fountain and/or other 'amenities' to foster an accepting, comfortable environment.
- The service location is considered with regard to public transportation and accessibility.
- Waiting areas include consideration for family members or others accompanying the individual seeking services.

Staff Competency Principles

- Skills and knowledge appropriate to staff and their roles throughout the system (reception, clinical, treatment support, administrative).
- Staff should have the knowledge and skill to be able to differentiate between the person and their behaviors.
- Staff should be respectful of client boundaries in regards to personal questions and personal space.
- Staff uses attentive behavior, listening with empathy not sympathy.

Performance Indicators

PIHPs are expected to include a provision in their provider network contracts requiring welcoming principles be implemented and maintained.

Client satisfaction surveys are expected to incorporate questions that address the 'welcoming' nature of the agency and its services.

PIHPs include consideration to welcoming principles in their provider network site visit protocols. MDHHS/OROSC may review these provider network protocols during their visits to the PIHP.

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5 Promising Practices Improving Timeliness. Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

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5 Promising Practices Increasing Continuation. Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

5 Promising Practices Reducing No Shows. Retrieved July 6, 2006, from Network for the Improvement of Addiction Treatment website: www.NIATx.net

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Mee-Lee, David. (2004). *Tips and Topics*, Volume 2, No.7. Retrieved July 6, 2006, from David Mee-Lee, M.D. Training & Consulting website: http://www.dmlmd.com/2004.11.ezine.html

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White, W.L., Kurtz, E., Sanders, M. (2006). *Recovery Management*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, William. (2005). *Recovery Management: What If We Really Believed That Addiction Was A Chronic Disorder?* Retrieved from Great Lakes Addiction Technology Transfer Center website: http://www.glattc.org

APPROVED BY: __*SIGNED*_____

Donald L. Allen, Jr., Director
Office of Drug Control Policy

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

DATE: August 10, 2007

TO: Regional Coordinating Agencies
Opioid Treatment Programs

FROM: Donald L. Allen, Jr., Director
Office of Drug Control Policy

SUBJECT: Technical Advisory – 06, Counseling Requirement for Clients Receiving Methadone Treatment

Attached is Technical Advisory #6 – Counseling Requirements for Clients Receiving Methadone Treatment that becomes effective August 10, 2007. The draft policy was submitted to coordinating agencies and opioid treatment programs on March 6, 2007, with a 60-day comment period. Comments from the Michigan Association of Substance Abuse Coordinating Agencies, Clinton-Eaton-Ingham Substance Abuse Services Program and Project Rehab-Life Guidance Services were received and taken into consideration for the final document.

If you have any questions, please contact Marilyn Miller, State Methadone Authority, at millermar@michigan.gov or by phone at 517-241-2608.

Attachment

cc: Division of Licensing and Certification

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www.michigan.gov/odcp • (517) 373-4700

TREATMENT TECHNICAL ADVISORY # 06

SUBJECT: Counseling Requirement for Clients Receiving Methadone Treatment

ISSUED: August 10, 2007

PURPOSE:

The purpose of this technical advisory is to clarify the substance abuse administrative rule specific to the counseling requirements for clients receiving methadone as part of their substance abuse treatment.

SCOPE:

This technical advisory provides direction to all Opioid Treatment Programs (OTPs) in Michigan that receive public funds and can be utilized by non-funded programs for guidance, as well.

BACKGROUND:

Effective July 5, 2006, The Michigan Department of Health & Human Services Administrative Rules for Substance Abuse Service Programs was revised in several areas for the first time since their inception in 1981. One of the rule changes involved the requirements for counseling services for clients receiving treatment through a methadone program. The new language for counseling requirements is as follows:

> Per R325.14419 (2) (g), if the client's treatment plan identifies a need for counseling services and includes the provision of these services, then signed and dated progress reports by the counselor must be included in the clinical record.

The previous rule language for this section read as follows:

> "Twice monthly progress reports by the counselor, signed and dated."

The change in this rule was meant to emphasize the importance of individualized care for clients receiving medication-assisted treatment in an OTP and that duration and frequency of counseling must be based on medical necessity. The previous language established universal counseling criteria for all clients without consideration of individual needs. As a result, clients could receive counseling services that were not needed or could have been inadequate to meet the needs of the clients based on the interpretation of this rule.

RECOMMENDATIONS:

The following recommendations are being made to assist programs in making the adjustment to this rule change and offer direction on how to provide needed services to clients. These recommendations seek to emphasize individualized treatment and the need for counseling services to be based on medical necessity. Further, these recommendations will also provide guidance for programs on how client recovery can be supported in ways other than individual counseling. The justification for the counseling services must be in the treatment plan with specific goals and objectives indicating why the services are being provided and what is going to be accomplished. The recommendations and guidance are as follows:

1. The amount and duration of counseling for the client should be determined based on medical necessity as well as the individual needs of the client and not on arbitrary criteria such as predetermined time, funding source, philosophy of the program staff, or payment limits. Decisions on counseling should be determined in collaboration with the client, the program physician, the client's primary counselor and the clinical supervisor. This decision-making process should be documented in the clinical record and the treatment plan should reflect the decisions that are made.

2. Counseling services must be included in the treatment plan. The treatment plan and the treatment plan reviews not only serve as tools in guiding treatment, they help in the administrative function of service authorizations. Decisions concerning the duration of stay, intensity of counseling, transfer, discharge, referrals, and authorizations are based on individualized determination of need and on progress toward treatment goals and objectives. The client's need for counseling, in terms of quantity and duration, must be reflected in the treatment plan and the need that is being addressed in the counseling must be identified by a comprehensive biopsychosocial assessment. The Michigan Department of Health & Human Services/Office of Recovery Oriented Systems of Care Treatment Policy #6-Individualized Treatment Planning can be used as a guide to assist with this process.

3. As client needs change throughout treatment, adding counseling services or increasing the frequency of contacts is not always the right answer. Many times support services can be added or modified as necessary to assist the client in meeting his/her goals without having to immediately depend on individual counseling services. These modifications may be the addition of specialized treatment groups or community support services. Attendance at community support groups should be incorporated into the client's treatment plan. This will enhance the formal counseling, if it is being provided, and help the client develop on-going support as they complete counseling. Peer recovery support should also be included when necessary and available. Case management and referrals for medical and dental care, housing, vocational education and employment, resolutions of legal issues, parenting classes, family reunification, etc. should be incorporated into the treatment plan when the client is at an appropriate stage of change and is ready to address these needs. Special needs of clients can be coordinated with another licensed substance abuse treatment provider. These services may include residential care and

specialized prenatal care or specialized women's services, depending on the need of the client. Assisting the client in maintaining recovery goes beyond counseling services and ensuring that all other needs are appropriately met is an important component of success.

4. As a client progresses through treatment, there may be a time when the maximum therapeutic benefit of counseling has been achieved. At this point, the client may be appropriate to enter the methadone only (medical maintenance) phase of treatment if it has been determined that ongoing use of the medication is medically necessary and appropriate for the client. To assist the OTP in making this decision, TIP 43 "Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs" offers the following criteria to consider when making the decision to move to medical maintenance:

    a. Absence of a significant, unstable co-occurring disorder.
    b. Abstinence from all illicit drugs and from abuse of prescription drugs for a period of at least six months prior to entry into methadone only status.
    c. No alcohol use problem.
    d. Ability to maintain stability in their current living environment.
    e. Stable and legal source of income.
    f. Involvement in productive activities as defined in their individual plan of service; e.g., employment, school, volunteering.
    g. No new criminal or legal involvement for one year prior to the methadone only phase.
    h. Adequate social support system, including but not limited to, self-help groups and sponsorship.

    These guidelines are not inclusive of all of the areas to be considered when making this decision. It is important to review each client on an individual basis when making this decision and document in the medical record how the decision was made to move to medical maintenance.

5. If a client has received counseling and successfully completed it, the client may receive counseling again as long as it is based on the needs of the client and it is determined to be medically necessary. Being involved in medical maintenance does not preclude the client from again receiving or starting counseling services.

REFERENCES:

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APPROVED BY:

Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

JAMES K. HAVEMAN
DIRECTOR

MEMORANDUM

DATE: October 11, 2012

TO: Regional Substance Abuse Coordinating Agency Directors

FROM: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Technical Advisory on Peer Recovery Support Services

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Enclosed is Technical Advisory #07 *Peer Recovery Support Services.* Developed by a multi-disciplinary group of individuals from the substance use disorder service field as part of the ROSC transformation process, this document was distributed for review and comment on April 16, 2012. Comments were received from one coordinating agency and a peer from the same region; they focused on various components of language and descriptors used in the document. These comments were used to ensure that descriptors for affiliation support included faith-based recovery, that peer recovery associates could provide emotional support as part of their role, and that supervision for peers did not include any reference to it being "clinical" in nature.

Technical Advisory #07 *Peer Recovery Support Services* is now complete and has an effective date of September 1, 2012. It replaces the previous technical advisory of the same number, titled *Peer Recovery/Recovery Support Services*, which was released in March of 2008. This updated advisory addresses the development and use of peer delivered support services and does not address the general concept of recovery support services like the first version. This advisory provides direction for the training and establishment of two levels of peer delivered support services, the recovery coach and the recovery associate.

It should be noted that, although this advisory provides guidelines to the field with current information relative to the delivery of peer support services, changes in many areas may be required as behavioral health integration moves forward.

If you have any questions with regard to Technical Advisory #07, please contact Lisa Miller at MillerL12@michigan.gov or 517.241.1216.

TREATMENT TECHNICAL ADVISORY #07

SUBJECT: Peer Recovery Support Services

ISSUED: March 17, 2008, revised July 16, 2012

EFFECTIVE: September 1, 2012

PURPOSE:

The purpose of this technical advisory (TA) is to provide guidelines to the substance use disorder (SUD) field pertaining to the nature and structure of peer recovery support services and peer recovery support persons. The TA includes the type of position and perspective on potential kinds of responsibilities; and the identification of training and key elements to be within the training.

This TA will provide information on the nature of peer recovery support services (PRSS) for the state of Michigan's publically funded SUD service system. It further establishes the differences between the two types of peers who would function within the SUD service system, and potentially within other collaborative partner organizations. The TA presents information that will clarify the types of support services provided by trained peer recovery support personnel, as well as the level and nature of training needed to attain the skills and capacity to function effectively when providing PRSS. Additionally, this TA is intended to create a level of continuity within the state with regard to PRSS and the peers who provide these services.

This TA should be viewed as an initial step in formalizing PRSS for the SUD service system. It should be expected that, as integration moves forward within the behavioral health system, required training and education, the delivery of services, and even the titles of those providing services may change to be consistent with the needs of integration.

SCOPE:

This TA impacts PIHPs and the publically funded provider network.

BACKGROUND:

Peer recovery and recovery support services were added to the administrative rules for substance use disorders when the rules were revised in 2006. This revision recognized peer recovery and recovery supports as an expansion of the existing licensing categories that cover treatment and prevention services in Michigan. The Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (formerly the Office of Drug Control Policy) formed a workgroup in January 2007 for the

purpose of developing standards and implementation guidelines for the new licensing category: Peer Recovery/Recovery Supports.

This program category was intended to recognize and thereby permit the implementation of peer recovery support programs for persons with substance use disorders in Michigan. This licensing category was developed to allow programs to provide services to assist individuals in the process of recovery through program models such as using peers and other professionals in a community setting and providing a location and other supports for activities of the recovery community. Peer recovery and recovery support services are designed to include prevention strategies and support services to attain and maintain recovery and prevent relapse.

As a result of the recovery oriented system of care (ROSC) transformation in Michigan, as well as the evolution of peer support services and what they are perceived to be, BSAAS convened a second workgroup in late 2010 to review and amend the guidelines for Peer Recovery/Recovery Support Services. The content of this document was developed by the ROSC Transformation Steering Committee Peer-Based Recovery Support Workgroup, a group of individuals who work to assist people with their recovery process by utilizing a broad array of SUD services and supports. These individuals work in various capacities and within the numerous factions found in a ROSC. Throughout the development process, the group utilized sources of information from some of the best known experts, individuals, and organizations operating within federal and state domains, who are engaged in the development and implementation of a ROSC, specifically with regard to the provision of PRSS. Considerable thought, energy, and commitment contributed to this process, leading to the end goal of creating a sustainable tool to further the establishment by regulating and utilizing PRSS within a ROSC.

Terms and Definitions

The following terms and definitions are provided for understanding their application within the content of this document:

Peer - A person in a journey of recovery who identifies with an individual based on a shared background and life experience.

Peer Recovery Associate - The name given to individuals who assist the peer recovery coach by engaging in designated peer support activities. These persons have been provided an orientation and brief training in the functional aspect of their role by the entity that will utilize them to provide supports. These individuals are not trained to the same degree as the peer recovery coach.

Peer Recovery Coach - The name given to peers who have been specifically trained to provide advanced peer recovery support services in Michigan. A peer recovery coach works with individuals during their recovery journey by linking them to the community and its resources. They serve as a personal guide or mentor, helping the individual overcome personal and environmental obstacles.

Recovery Community - Persons having a history of alcohol and drug problems who are in or seeking recovery, including those currently in treatment; as well as family members, significant others, and other supporters and allies (SAMHSA, 2009b).

Recovery Support Services - Non-clinical services that assist individuals and families to recover from alcohol or drug problems. They include social support, linkage to, and coordination among, allied service providers, and a full-range of human services that facilitate recovery and wellness contributing to an improved quality of life. These services can be flexibly staged and may be provided prior to, during, and after treatment. RSS may be provided in conjunction with treatment, or as separate and distinct services, to individuals and families who desire and need them. Professionals, faith-based and community-based groups, and other RSS providers are key components of ROSC (SAMHSA, 2009b).

RECOMMENDATIONS:

Peer Recovery Support Services – Core Values

Within PRSS it is recognized that individuals in recovery, their families, and their community allies are critical resources that can effectively extend, enhance, and improve formal treatment services. PRSS are designed to assist individuals in achieving personally identified goals for their recovery by selecting and focusing on specific services, resources, and supports. These services are available within most communities employing a peer-driven, strength-based, and wellness-oriented approach that is grounded in the culture(s) of recovery and utilizes existing community resources.

PRSS emphasize strength, wellness, community-based delivery, and the provision of services by peers rather than SUD service professionals. As such, these services can be viewed as promoting self-efficacy, community connectedness, and quality of life, which are important factors to sustained recovery.

This TA recognizes five core values developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT), and adds a sixth value:

- **Keeping recovery first** – Placing recovery at the center of the effort, grounding peer services in the strengths and inherent resiliency of recovery rather than in the pathology of substance use disorders.

- **Cultural diversity and inclusion** – Developing a recovery community peer support services program that honors different routes to recovery and has leaders and members from many groups at all levels within the organization.

- **Participatory process** – Making sure the recovery community directs, or is actively involved in, project design and implementation, so that recovery community members can identify their own strengths and needs, and design and deliver peer services that address them.

- **Authenticity of peers helping peers** – Drawing on the power of example, as well as the hope and motivation, that one person in recovery can offer to another; providing opportunities to give back to the community, and embracing the notion that both people in a relationship based on mutuality can be helped and empowered in the process.

- **Leadership development –** Building leadership abilities among members of the recovery community so that they are able to guide and direct the service program and deliver support services to their peers. (SAMHSA, 2009b)

- **Supporting integrated mental health and SUD services –** Assuring that individuals with co-occurring substance use and mental health disorders receive integrated healthcare.

Types of Peer Recovery Support Services

The CSAT Recovery Community Support Program's PRSS Projects have developed and piloted a variety of peer services. These pilots have concluded that not all programs can provide all services, and that some peer leaders can provide one or more services. The placement of peers varies from recovery centers, stand-alone peer programs, traditional treatment and prevention programs, and other sites that may include: hospitals, correctional programs/institutions, mental health programs/facilities, doctors' offices, veterans' services, and counseling services (for profit and non-profit). The location where peers provide services can also vary from community-based to office-based. Activities are targeted to individuals and families at all places along the path to recovery. This would include outreach to individuals who are still active in their disorder and or addiction, up to and including individuals who have been in recovery for several years.

PRSS can consist of a limitless array of services depending on the agency providing the services, the funding source for the services, the training of the peers within the agency, and the individual, family, or community being served. The different kinds of activities have been divided into four service categories: emotional support, informational support, instrumental support, and affiliational support (SAMHSA, 2009a). Table 1 identifies and describes the types of support and provides a brief number of examples for each support type.

Table 1-Type of Social Support and Associated Peer Recovery Support Services

Type of Support	Description	Peer Support Service Examples
Emotional	Demonstrate empathy, caring, or concern to bolster a person's self-esteem and confidence.	• Peer mentoring • Peer-led support groups
Informational	Share knowledge and information and/or provide life or vocational skills training.	• Parenting class • Job readiness training • Wellness seminar
Instrumental	Provide concrete assistance to help others accomplish tasks.	• Child care • Transportation • Help accessing community health and social services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	• Recovery centers • Sports league participation • Alcohol- and drug-free socialization opportunities • Faith-based

(SAMHSA, 2009b)

Using the four SAMHSA types of support as a basis, an enhanced list of broad-ranging activities that peers could provide has been compiled. Although this list is meant to be as thorough as possible, other activities may be identified. As long as these activities fit the definition of PRSS, as stated earlier in this document, they would be appropriate to add to this compilation. Table 2 provides the expanded compilation of activities by the earlier identified types of support.

Table 2 - Activities by Service Categories and Types of Support

type of Support	Service Category
Emotional	Listening to problems (identify resources to meet the need) Leading/mentoring/coaching Leading support groups Relating stories Offering hope Validating client experience Supporting self-assessment (identify where an individual is and where they want to go) Walking with the individual (find out the comfort level to complete a task or attend an event) Advocating Empowering

type of Support	Service Category
Informational	Peer-led resource connector programs Health and wellness classes and workshops Education and career planning classes and workshops Leadership development classes and workshops System navigation (assisting someone to work through the layers/regulations of a system to obtain services that are needed) One-on-one teaching Recovery plan development Personal (individual) development Problem-solving Pursuing education Life-skills classes, workshops, and trainings including: ➢ Dental ➢ Mental health ➢ Physical health ➢ Nutrition ➢ Legal Keep recovery first (the importance of working one's own recovery path needs to be of paramount importance) Various groups for instruction: ➢ Parenting ➢ 12-Step Literacy ➢ Navigating the 12-Steps ➢ Stress management ➢ Conflict resolution ➢ Trauma ➢ Job skills ➢ Social skills in recovery ➢ Others as needed

type of Support	Service Category
Instrumental	Direct instrumental services (connections to get a person's most basic needs met, i.e., food banks, clothing banks, housing/shelter) Make warm connections to services and referrals (making an in-person introduction or on-sight delivery to a site for needed services/support) Open doors for an individual (making face-to-face contact with a person or organization on behalf of the individual seeking assistance) Hands-on advocating (taking responsibility to take another's banner and push for them so that systems can bend or change to meet that person's needs) Navigate community resources (teaching individuals about the who, what, where, and why of community services, so that they understand where to turn, where to go and who to talk with) Follow up on referrals Outreach – recovery checkups Arrange regular (weekly, etc.) meetings with individuals
Affiliational	Alcohol- and other drug-free social/recreational activities Recovery centers Engagement centers Drop-in centers Recovery community connections Social/recreational activities Cultural activities – music, arts, theatre and poetry, picnics, networking, etc. Faith-based recovery supports

(SAMHSA, 2009b)

Michigan's Two Types of Peer Support Roles

Michigan will utilize two types of peer roles in the provision of PRSS. They are:

1) Peer Recovery Coach:

- Receives a specialized level of training around a specific variety of skill sets designed to support an enhanced level of interaction with the individuals with whom they work.
- Receives training most often outside of the given work environment.
- Operates and works effectively within any of the four types of support activities – emotional, informational, instrumental, and affiliational.

2) Peer Recovery Associate:
   - Receives a more generalized training typically provided by the entity in which they will ultimately work.
   - Provides the types of interactions designed to meet more immediate needs and facilitate access to generalized community services.
   - Operates typically within affiliational and instrumental types of activities, may include limited emotional support.

   As a recovery associate gains comfort working with peers, and strengthens their skill level regarding effective interaction and boundary identification, this individual may consider training to become a recovery coach.

Peers can be employed full- or part-time with an agency or volunteer to provide support services. All peer recovery associates, whether they are paid employees or volunteers, should have some basic training in order to assure the provision of quality services, and to assure that their activities "do no harm" to either themselves or the individuals being served. All peer recovery coaches will be required to participate in a designated peer recovery coach training.

Training Peer Recovery Coaches and Peer Recovery Associates

In order to provide services, a peer recovery coach or a peer recovery associate must meet certain qualifications based on experience and education. In Michigan, peer recovery associates must receive training appropriate to the tasks in which they will engage. Associates will be selected by the agencies in which they will provide support services. The nature of the services to be provided will directly influence the selection of the peers and the content of training that the peers will receive. The actual training and its content will be at the discretion of the hiring agency. However, there are minimum criteria that should be included in the training, such as:

- Gaining knowledge of community resources.
- Listening skills.
- Taking a non-judgmental stance (the ability to respond positively and provide assistance to an individual regardless of personal opinions, experiences, and choices).
- Understanding of confidentiality.
- Establishing boundaries.

- Possessing an attitude that there are many paths to recovery – none any better than another.

In order to be a peer recovery coach, individuals will need to complete a designated training. To accomplish the goal of training and preparing peer recovery coaches, a model curriculum, the Connecticut Community for Addiction Recovery (CCAR) Peer Recovery Coach Training course, has been identified. The CCAR training will provide individuals with the desired standard of preparedness to become a peer recovery coach and provide the tools necessary to perform the job. The CCAR training has a sound curriculum, good outcomes and high acclaim from the state of New York, Iowa, and Georgia, who all have been using the CCAR training and curriculum. Upon conclusion of this training, participants will receive a certificate indicating that they have successfully and satisfactorily completed the designated training and are qualified as a peer recovery coach to provide PRSS in Michigan. If the CCAR training is not utilized, the certifying program that is used must minimally include the same key focal elements found in the CCAR training.

To complete the entire scope of these elements, an average training would encompass 40 hours. The following elements from the CCAR training are to be incorporated into all peer recovery coach trainings:

- Comprehensive overview of the purpose and tasks of a recovery coach.
- Tools and resources useful in providing recovery support services.
- Skills needed to link people to needed supports within the community that promote recovery.
- Basic understanding of substance use and mental health disorders, crisis intervention, and how to respond in a crisis situation.
- Skills and tools for effective communication, motivational enhancement strategies, recovery action planning, cultural competency, and recovery ethics.
- Clarity regarding the fact that recovery coaches do not provide clinical services. They do, however, work with people experiencing difficult emotions and physical states.

The training must help the individual:

- Describe the roles and functions of a recovery coach.
- List the components of a recovery coach.
- Build skills to enhance relationships.
- Discuss co-occurring disorders and medication-assisted recovery.
- Describe stages of changes and their applications.
- Address ethical issues.
- Experience wellness planning.
- Practice newly acquired skills.

Training modules must include:

- How to create a safe environment.
- What recovery is (components of recovery, recovery core values, and guiding principles of recovery).
- Skills to enhance relationships.
- Listening and communication skills.
- Values and differences.
- Skills to address transference/countertransference.

- Skills to manage sexual harassment.
- Crisis intervention.
- Stigma and labels.
- How to tell your own stories.
- Issues of self-disclosure.
- Referral skills.
- Pathways to recovery.
- Stages of change.
- Motivational interviewing.
- Cultural competence.
- Privilege and power.
- Spirituality and religion.
- Resources and programs.
- Self-care.
- Boundary issues and respect.
- Recovery wellness planning.

Differences between a Peer Recovery Coach and a Peer Recovery Associate

There are significant differences within many facets of the training, preparation, and work provided by a peer recovery coach versus a peer recovery associate. The table below highlights some of the variants:

Peer Recovery Coaches	Peer Recovery Associates
Training	
Coaches are expected to complete 40 hours of CCAR training, or another like course as previously defined in this TA.	Associates are to receive a shorter training provided by the organization that will utilize their assistance on more basic elements of service and interaction (see page 9 for list of potential training elements).
Length of Time in Recovery	
An individual who is a peer coach should have two to four years of stable recovery.	An associate position could be offered to someone with a minimum of six months in recovery. Due to being in early recovery, the individual should be actively working their own recovery process and have an established support system outside of this role.
Level of Autonomy	
A coach may engage in solo outreach efforts and client interaction.	An associate will receive oversight by a recovery coach or supervisor.

Peer Recovery Coaches	Peer Recovery Associates
Breadth of Experience/Skill Level	
A coach is expected to have a much wider variety of skills and knowledge base.	The associate may be very specific to a particular task within the agency – example: follow-up calls.
Long Term Expectations	
Coaches may view their position as a paraprofessional with or without aspirations of continuing on with a degree(s).	Associate may or may not have further expectations. It may be their desire to "give back" to the recovery community.
Supervision Needs	
A recovery coach will have weekly (or more) supervision.	An associate may not need the same extent of "supervision" due to their limited role/responsibility.

Additional similarities/overlaps which may exist between a peer recovery coach and peer recovery associate include:

- Knowledge of community resources (resource broker).
- Position may be paid or unpaid.
- Expectation of recovery background.
- Leadership of peer-run groups.
- Engagement in tasks: referring, linking, educating.
- Importance of honoring that there are many pathways to recovery.

Unique Challenges to Peer Recovery Coaches and Associates

Peers, because they are in recovery, may face a unique challenge that many in the SUD service workforce do not. Due to the nature of this work, peers may be placed into situations, while they are providing services, where they might encounter others from their past who were their "using friends" or "dealers." Hence, it is important to understand how to act in situations when these negative encounters occur. Therefore, support for a peer who has a need because of these encounters should be available. Support can come from the supervisor, another more experienced peer, or other agency staff with whom the peer feels comfortable enough to discuss the issues.

The same is to be said for peer recovery coaches and associates with regard to the issue of relapse. It is well-known that addiction is a relapsing, chronic brain disease. Agencies that utilize peers, whether they are paid or unpaid, are therefore urged to recognize the nature of addiction and develop a non-punitive

policy in response to peer relapse. As a part of this advisory, the agency is further encouraged to work with the peer to develop a recovery re-engagement plan to facilitate the peer's return to recovery.

Supervision of Peer Recovery Staff

The employment of peers as recovery coaches and recovery associates will place additional responsibilities on agencies and their staff. There are several factors that must be considered to allow and support peers to function in their jobs. Supervision is as important for peers as it is for clinicians. Peers need the support and expertise a supervisor gives to be effective as a coach or an associate.

Peer recovery staff needs to be respected as equal members of an agency's staff. They are as much a part of an agency/organization as are support, clinical, and executive staff. Intentional and purposeful acknowledgement, role delineation, and supervision are critical to the blending of roles, rules, and regulations among staff. Peers come with a unique amount of knowledge and personal experience in addictions and other co-occurring disorders. This experience makes them a valuable part of the organization. It is important for management to orient existing staff to the roles that peers will have within the agency. This will prevent or reduce misunderstandings for all staff. A resource that is helpful in this regard is a document entitled, *Manual for Recovery Coaching and Personal Recovery Plan Developme*nt by David Loveland, Ph.D. and Michael Boyle, MA (2005).

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APPROVED BY:

Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

MEMORANDUM

DATE: January 20, 2012

TO: Regional Substance Abuse Coordinating Agency Directors
Michigan Association of Substance Abuse Coordinating Agencies President
Association of Licensed Substance Abuse Organizations President
Salvation Army Harbor Light Director

FROM: Deborah Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Technical Advisory for Enhanced Women's Services Expectations

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Attached is the final version of Technical Advisory #08 – Enhanced Women's Services, which will go into effect on January 31, 2012.

A draft of this technical advisory (TA) was submitted to the coordinating agencies, Michigan Association for Substance Abuse Coordinating Agencies, Association of Licensed Substance Abuse Organizations, and Salvation Army Harbor Light on October 11, 2011, for a 30-day response period. Comments were received from network180, Lakeshore Coordinating Council and Kalamazoo Community Mental Health and Substance Abuse Services, and incorporated into the final document.

This TA focuses on establishing guidelines for enhanced women's services, as an adjunct to designated women's programs. Also attached are the reporting requirements for Enhanced Women's Services programming and instructions for the report. The report is in addition to current reporting requirements for designated women's programs. Because this is a new service opportunity, special care was taken to ensure that enhanced women's services operate the same across the state.

Should you have any questions or need further clarification on any issues in this advisory, please contact Angie Smith-Butterwick at smitha8@michigan.gov, or (517) 373-7898.

Attachments

DJH:ssb

c: Felix Sharpe

TREATMENT TECHNICAL ADVISORY #08

SUBJECT: Enhanced Women's Services

ISSUED: January 31, 2012

PURPOSE:

The purpose of this advisory is to provide guidance to the field on developing an intensive case management program for PIHPs and their designated women's programs. It is designed to incorporate long-term case management and advocacy programming for pregnant, and up to twelve months post-partum, women with dependent children who retain parental rights to their children.

SCOPE:

This advisory impacts the PIHP and its designated women's programs provider network.

BACKGROUND:

In 2008, the Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (OROSC) was awarded a four-year grant from the Center for Substance Abuse Prevention (CSAP) to implement the Parent-Child Assistance Program (PCAP), an evidence-based program developed at the University of Washington. PCAP is a three year case management/advocacy program targeted at high-risk mothers, who abuse alcohol and drugs during pregnancy, and their children. The eligiblity criteria for PCAP participation is women who are pregnant or up to six-months postpartum, have abused alcohol and/or drugs during the pregnancy, and are ineffectively engaged with community service providers.

Traditional case management services offered through designated women's programs tend to be for the duration of the woman's treatment episode and only office-based interventions. These interventions are frequently performed by the assigned clinician, and involve linking and referring the client to the next level of care or other supportive services that are needed. Enhanced Women's Services are designed to encourage providers to take case management to the next level for designated women's providers. This is a long-term case management and advocacy program, and outcomes such as increased retention, decreased use, increased family planning, and a decrease in unplanned pregnancies have shown that the extended support time and commitment to keeping women involved serves this population well.

The PCAP model shares the same theoretical basis, relational theory, as women's specialty services. Relational theory emphasizes the importance of positive interpersonal relationships in women's growth, development and definition of self, and in their addiction, treatment and recovery. It is the relationship between the woman and the advocate that is the most important

aspect of PCAP. The PCAP model uses both the Stages of Change model and motivational interviewing when working with individuals. The stage of change that the woman is at for each of the identified problem areas of her life is taken into consideration when developing the plan of service. The case manager/advocate uses motivational interviewing techniques to help the woman move along the path toward meeting her goals.

In September 2009, BSAAS embarked on a recovery oriented system of care (ROSC) transformational change initiative. This initiative changes the values and philosophy of the existing service delivery system from an acute crisis orientation to a long term stable recovery orientation. As part of this work, a set of guiding principles has been developed to describe the values and elements that Michigan wants this new system to have. The PCAP model, with its peer focus and strategies that include treatment, prevention, and recovery services delivered in a community-based setting, demonstrates the critical components of a ROSC. The long-term support gives clients a stable basis for a future healthy lifestyle without the need to use or abuse alcohol and drugs. PCAP also fits into identified practices in the ROSC transformation process, including peer-based recovery support services, strengthening the relationship with community, promoting health and wellness, expanding focus of services and support, using appropriate dose/duration of services, and increasing post-treatment checkups and support.

As part of sustaining evidence-based practices and core components of the PCAP model, and in response to interest in the program by current non-PCAP funded PIHPs, this technical advisory has been developed to provide guidance on implementing enhanced women's services in the state. This technical advisory identifies core components of PCAP needed for implementation of enhanced women's services, and should be considered as a supplement to the OROSC Women's Treatment Policy (OROSC Treatment Policy #12). In addition, implementation of these services can also serve as evidence of ROSC transformation.

Definitions

Case Management – a substance use disorder program that coordinates, plans, provides, evaluates, and monitors services of recovery, from a variety of sources, on behalf of, and in collaboration with, a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

Community Based – the provision of services outside of an office setting. Typically these services are provided in a client's home or in other venues, including while providing transportation to and from other appointments.

Core Components – those elements of an evidence-based program that are integral and essential to assure fidelity to a project, and that must be provided.

Crisis Intervention – a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher level of care if intervention is not provided.

Face-to-Face – this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and providers, as long as this service is provided within the established confidentiality standards for substance use disorder services.

Fetal Alcohol Spectrum Disorders (FASD) – an umbrella term describing the range of effects that can occur in an individual whose mother drank during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis. It refers to conditions such as fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neurodevelopment disorder (ARND), and alcohol-related birth defects (ARBD).

Individual Assessment – a face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Treatment Planning – direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current level of care, to ensure true and realistic needs are being addressed and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Peer – an individual who has shared similar experiences of parenthood, addiction, or recovery.

Peer Advocate (for Enhanced Women's Services) – an individual with similar life experience who provides support to a client in accessing services in a community.

Peer Support – individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another.

Recovery – a highly individualized journey of healing and transformation where the person gains control over his/her life. It involves the development of new meaning and purpose, growing beyond the impact of addiction or a diagnosis. This journey may include the pursuit of spiritual, emotional, mental, and physical well-being.

Recovery Planning – process that highlight's and organizes a person's goals, strengths and capacities to determine the barriers to be removed or problems to be resolved in order to help people achieve their goals. This should include an asset and strength-based assessment of the client.

Substance Use Disorder – a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

RECOMMENDATIONS:

Components Required for Enhanced Women's Services Programming

1. Any Designated Women's Program is eligible to offer Enhanced Women's Services to the target population. Programs choosing to develop an Enhanced Women's Services program will be required to follow the guidelines of the Women's Treatment Policy (OROSC Treatment Policy #12), as well as those outlined in this technical advisory.

2. The Enhanced Women's Services model will use a three-pronged approach to target the areas where women have problems that directly impact the likelihood of future alcohol or drug-exposed births:
   - The first is to eliminate or reduce the use of alcohol or drugs. Individuals who are involved with Enhanced Women's Services are connected with the full continuum of substance use disorder services to help the woman and her children with substance use and abuse.
   - The second is to promote the effective use of contraceptive methods. If a woman is in control of when she becomes pregnant, there is a higher likelihood that the birth will be alcohol and drug-free. Referrals for family planning, connecting with a primary care physician, and appropriate use of family planning methods are all considered interventions for this aspect of programming.
   - The third is to teach the woman how to effectively use community-based service providers, including accessing primary and behavioral health care. The peer advocate teaches women how to look for resources and get through the formalities of agencies in order to access needed services, and how to effectively use the services.

3. Peer advocates in Enhanced Women's Services must be peers, to the extent that they are also mothers and may have experienced similar circumstances as their potential clients. They do not need to have a substance use disorder (SUD), or be in recovery from a SUD. Agencies should also follow their cultural competency plan for hiring peer advocates. The peer advocate must meet current state training or certification requirements applicable to their position. An additional list of training requirements is provided later in this document.

4. One of the core components of Enhanced Women's Services is transportation. The program requires that peer advocates be community-based and provide reasonable transportation services for their enrolled clients to relevant appointments and services. Beyond the transportation assistance that this provides to the woman, this has proven to be an excellent time to exchange information.

5. A second core component is the persistence with which the peer advocates stay in touch with their clients. A woman is not discharged from Enhanced Women's Services because she has not been in contact with her peer advocate for a month or more. It is expected that the peer

advocate will actively look for clients when they have unexpectedly moved, and will utilize emergency contacts provided by the client to re-engage her in services.

Enrollment Criteria

Any woman who is pregnant, or up to twelve months post-partum with dependent children, is eligible for participation in Enhanced Women's Services. This includes women who are involved with child welfare services and are attempting to regain custody of their children. If a woman enrolled in Enhanced Women's Services permanently loses custody of her children, and is not currently pregnant, she must be transferred to other support services, as she is no longer eligible for women's specialty services.

As identified in the Individualized Treatment Policy (OROSC Treatment Policy #06), treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include, but are not limited to age, gender, culture, and development. As a client's needs change, the frequency, and/or duration of services may be increased or decreased as medically necessary. Client participation in referral and continuing care planning must occur prior to a move to another level of care for continued treatment.

Service Requirements

In addition to the services provided through Women's Specialty Services, the following are requirements of Enhanced Women's Services:

1. Maintain engaged and consistent contact for at least 18 to 24 months in a home visitation/community based services model, expandable up to three years.
2. Provide supervision twice monthly.
3. Require maximum case load of 15 per peer advocate.
4. Continue services despite relapse or setbacks, with consideration to increasing services during this time.
5. Initiate active efforts to engage clients who are "lost" or drop out of the program, and efforts made to re-engage the client in services.
6. Coordinate service plan with extended family and other providers in the client's life.
7. Coordinate primary and behavioral health.
8. Utilize motivational interviewing and stages of change model tools and techniques to help clients define and evaluate personal goals every three months.
9. Provide services from a strength-based, relational theory perspective.
10. Link and refer clients to appropriate community services for clients and dependent children as needed, including schools.
11. Continue to offer services to a woman and her children no matter the custody situation, as long as mother is attempting to regain custody.
12. Provide community-based services; these are services that do not take place in an office setting.
13. Provide transportation assistance through peer advocates, including empowering clients to access local transportation and finding permanent solutions to transportation challenges.

Peer advocates' billable time for transporting clients to and from relevant appointments is allowable and encouraged.

14. Develop referral agreement with community agency to provide family planning options and instruction.
15. Screen children of appropriate age using the Fetal Alcohol Syndrome (FAS) Pre-screen form attached to the Fetal Alcohol Spectrum Disorders Policy (OROSC Treatment Policy #11).
16. Identify clients in Enhanced Women's Services programming with the "HD" modifier.

Education/Training of Peer Advocates:

Individuals working and providing direct services for Enhanced Women's Services must complete training on the following topics within three months of hire:

- Fundamentals of Addiction and Recovery*
- Ethics (6 hours)
- Motivational Interviewing (6 hours)
- Individualized Treatment and Recovery Planning (6 hours)
- Personal Safety, including home visitor training (4 hours)
- Client Safety, including domestic violence (2 hours)
- Advocacy, including working effectively with the legal system (2 hours)
- Maintaining Appropriate Relationships (2 hours)
- Confidentiality (2 hours)
- Recipient Rights (2 hours, available online)
  *Could be accomplished by successful completion of the MAFE if no other opportunity is available.

In addition, the following training must also be completed within the first year of employment:

- Relational Treatment Model (6 hours)
- Cultural Competence (2 hours)
- Women and Addiction (3 hours)
- FASD (including adult FASD) (6 hours)
- Trauma and Trauma Informed Services (6 hours)
- Gender Specific Services (3 hours)
- Child Development (3 hours)
- Parenting (3 hours)
- Communicable Disease (2 hours, available online)

Peer advocates must complete the above trainings as indicated. Any training provided by domestic violence agencies, the Michigan Department of Health & Human Services, or child abuse prevention agencies would be appropriate. If these trainings are not completed within the one-year time frame, the peer advocate would not be eligible to continue in the position until the requirements are met. Until training is completed, peer advocates must be supervised by another

individual who meets the training requirements and is working within the program. Documentation is required and must be kept in personnel files. Other arrangements can be approved by the OROSC Women's Treatment Coordinator. These hours are an approximation only, and based on P-CAP requirements and consideration of the needs of Michigan's population.

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APPROVED BY:

Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

MEMORANDUM

DATE: November 23, 2011

TO: Regional Substance Abuse Coordinating Agency Directors
Michigan Association of Substance Abuse Coordinating Agencies President
Association of Licensed Substance Abuse Organizations President
Salvation Army Harbor Light Director

FROM: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Technical Advisory for Early Intervention Expectations

Attached is the final version of Technical Advisory #09 – *Early Intervention*, which will go into effect on November 30, 2011.

The draft technical advisory (TA) #09 was submitted to the coordinating agencies (CAs), Michigan Association for Substance Abuse Coordinating Agencies, Association of Licensed Substance Abuse Organizations, residential providers, and the Salvation Army Harbor Light on April 13, 2011, for a 90-day response period. Comments were received from Macomb County Community Mental Health, and Oakland Substance Abuse Services, and incorporated into the final document.

This TA focuses on establishing minimal guidelines for early intervention treatment services, while keeping traditional prevention services intact. Because this is a new service category, special care was taken to allow enough variability so that CAs could tailor their early intervention programming to best meet the needs of their region.

Should you have any questions or need further clarification on any issues in this advisory, please contact Angie Smith-Butterwick at smitha8@michigan.gov, or (517) 373-7898.

Attachment

DJH:ssb

c: Felix Sharpe

TREATMENT TECHNICAL ADVISORY #09

SUBJECT: Early Intervention

ISSUED: November 30, 2011

PURPOSE:

The purpose of this advisory is to establish the process and expectations for Level 0.5 of the *American Society of Addiction Medicine's Patient Placement Criteria, 2nd Edition-Revised (ASAM PPC-2R)* in substance use disorder treatment.

SCOPE:

This advisory impacts all substance abuse PIHPs and their providers who offer substance use disorder (SUD) services.

BACKGROUND:

Substance abuse treatment early intervention programs are effective with clients who are considered risky users, those experiencing mild or moderate problems, as well as those who are experiencing some of the symptoms of abuse or dependence (DHHS CSAP, 2002). Early intervention services would also be appropriate for those individuals who are considered to be in the pre-contemplative stage of change.

Treatment and prevention service providers may offer early intervention services to clients who, for a known reason, are at risk for developing alcohol or other drug abuse or dependence, but for whom there is not yet sufficient information to document alcohol or other drug abuse or dependence. Those staff providing early intervention services must be supervised by appropriately credentialed staff. The goals of early intervention include:

- Increasing protective factors that promote a reduction in substance use.
- Improving a client's readiness to change.
- Preparing clients for the next level of treatment.
- Integrating new skills into clients' lives on a daily basis.

The Center for Substance Abuse Treatment's (CSAT) *Treatment Improvement Protocol (TIP) 35* (DHHS CSAT, 1999b), indicates providers can be helpful at any time in the change process by accurately assessing the client's readiness to change by utilizing the appropriate motivational strategies to assist their move to the next level. Clients already engaged in more intensive services (outpatient [OP], intensive outpatient [IOP], residential) should not receive early intervention services. However, clients who are at the level of contemplation that makes them appropriate for treatment may receive early intervention services as an interim service.

A workgroup was convened to determine standards for early intervention treatment. The workgroup was comprised of representatives from PIHPs, providers and the Office of Recovery Oriented Systems of Care.

Revisions to the *Substance Abuse Administrative Rules* have designated early intervention as a "substance abuse treatment service category." The Michigan Administrative Code, R325.14102(a)(1), defines early intervention as a specifically focused treatment program, including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process, and individuals who may not meet the threshold of abuse or dependence.

ASAM PPC-2R defines early intervention as "services that explore and address any problems or risk factors that appear to be related to the use of alcohol and other drugs and that help the individual to recognize the harmful consequences of inappropriate use. Such individuals may not appear to meet the diagnostic criteria for a substance use disorder, but require early intervention for education and further assessment," (Mee-Lee et. al., 2001). Ideally, early intervention services in Michigan will follow *ASAM PPC-2R* criteria while staying within the guidelines of the administrative rules.

It is important to note that, while this is a new service category for the treatment field, the prevention field has been providing this type of service for some time. "Prevention" refers to this level of service as Problem Identification and Referral (PIR), and defines it as "helping a person with an acute personal problem involving, or related to SUDs, to reduce the risk that the person might be required to enter the SUDs treatment system" (U.S. CFR, 1996). Individuals eligible for PIR services are identified as having indulged in illegal or age inappropriate use of tobacco, alcohol and/or illicit drugs. These individuals are screened to determine if their behavior can be reversed through education. Designed to increase and enhance protective factors that reduce and prevent SUDs, the assessment for, and the implementation of PIR services, may be population-based or focused on the individual. These potential participants of PIR services do not meet the threshold for substance abuse or dependence, and no diagnosis is made. PIR services include, but are not limited to, interventions such as, employee assistance programs, and student assistance and education programs targeting persons charged with driving under the influence (DUI), or driving while intoxicated. The Institute of Medicine's "Continuum of Care" model (Institutes of Medicine, 1994), classifies prevention interventions based on their target populations. For example, PIR interventions targeting individuals using substances, but not diagnosed with a substance use disorder, would be classified as "case identification" services, also described as "early intervention."

Early intervention as a treatment service provides an intervention that is appropriate for the individual and their stage of change, as well as access to clinical services. Clients are screened on an individual level only, and a diagnosis is required, at least on a provisional basis. Intervention plans, or at minimum a participation goal, are developed for this level of service. Participants are not required to meet abuse or dependence thresholds for early intervention services.

DEFINITIONS:

- **Community Group Activist/Recovery or Other Volunteer:** Not recognized as a credential category; responsibilities determine credentialing requirement.
- **Intervention Plan:** A minimal plan that sets forth the goals, expectations, and implementation procedures for an intervention. Specific activities that intend to change the knowledge, attitudes, beliefs, behaviors, or practices of individuals.
- **Prevention Professional:** An individual who has licensure as identified in the *Credentialing and Staff Qualifications* portion of the Michigan Department of Health & Human Services (MDHHS) CA contract, **AND** is working within his or her licensure-specified scope of practice, or an individual who

has an approved certification. These individuals have responsibility for implementing a range of prevention plans, programs and services.

- **Specially Focused Staff:** Individuals responsible for carrying out specific activities relative to treatment programs and are not responsible for clinical activities. May include case managers or AMS staff. Staff works under the direction of specialists or supervisors. Certification is not required, although appropriate licensure may be required depending on the scope of practice.
- **Stages of Change:**
  - **Pre-contemplation:** clients are not considering change at this stage, and do not intend to change behaviors in the foreseeable future.
  - **Contemplation:** clients have become aware that a problem exists, may recognize that they should be concerned about their behavior, but are typically ambivalent about their use, and changing their behavior.
  - **Preparation:** clients understand that the negative consequences of continued substance use outweigh any perceived benefits and begin specific planning for change. They may begin to set goals for themselves, and make a commitment to stop using.
  - **Action:** clients choose a strategy for change and actively pursue it. This may involve drastic lifestyle changes and significant challenges for the client.
  - **Maintenance:** clients work to sustain sobriety and prevent relapse. They become aware of situations that will trigger their use of substances and actively avoid those when possible.
- **Substance Abuse Treatment Specialist (SATS):** An individual who has licensure as identified in the *Credentialing and Staff Qualifications* portion of the MDHHS PIHP contract, **AND** is working within his or her licensure-specified scope of practice, **OR** an individual who has an approved certification. These are clinical staff providing substance use disorder treatment and counseling, and are responsible for the provision of treatment programs and services.*****
- **Substance Abuse Treatment Practitioner (SATP):** An individual who has a registered Michigan Certification Board for Addiction Professionals (MCBAP) certification development plan, that is timely in its implementation, **AND** is supervised by an individual with a Certified Clinical Supervisor credential through MCBAP or a registered development plan to obtain the supervisory credential, while completing the requirements of the plan (6000 hours).*****

**** The above definitions can be found in the SUD Services Policy Manual included in the MDHHS PIHP contract agreement. Please refer to the contract agreement for a full description of the credentialing requirements.***

RECOMMENDATIONS:

Clients who are appropriate for this level of treatment, at the very least, shall meet the criteria in the current edition of the *ASAM PPC-2R*, for level 0.5 or its equivalent. The criteria are as follows:

- The individual who is appropriate for level 0.5 services shows evidence of problems and risk factors that appear to be related to substance use, but do not meet the diagnostic criteria for a Substance-Related Disorder, as defined in the current Diagnostic and Statistical Manual (DSM).
- Dimensions 1, 2, and 3: concerns are stable or being addressed through appropriate services.

- Dimensions 4, 5, and 6: one of the following specifications in these dimensions must be met.
  - Dimension 4: the individual expresses a willingness to gain an understanding of how his/her current alcohol or drug use may be harmful or impair the ability to meet responsibilities and achieve goals.
  - Dimension 5: the individual does not understand the need to alter his/her current pattern of use, *or* the individual needs to acquire the specific skills needed to change his/her current pattern of use.
  - Dimension 6: the individual's social support system consists of others whose substance use patterns prevent them from meeting responsibilities or achieving goals, or the individual's family members are abusing substances which increases the individual's risk for a substance use disorder, or the individual's significant other holds values regarding substance use that create a conflict for the individual, or the individual's significant other condones or encourages inappropriate use of substances.

Services should be focused on meeting the client where they are within the stages of change. Some clients may be appropriate for a higher level of care, but uncomfortable engaging in formal treatment, or at a stage of change that may not significantly benefit from formal treatment services. In this instance, early intervention services would be allowable. Clients may be screened through the local Access Management System (AMS) and, if appropriate, referred for early intervention services at the provider of their choice. However, clients may also be screened through the early intervention program, as determined by the appropriate coordinating agency. Treatment providers will perform, at minimum, a screening to determine appropriate services for the client, as well as to measure future progress. The treatment provider and the client will then establish goals to achieve during the course of treatment/intervention. Clients may then be offered an appropriate intervention, based on their established goals. Some clients will require referral for further assessment or to another level of treatment due to emerging concerns.

Early intervention services should be time-limited and short-term, and may be used as a stepping-stone to the next level for those clients who need it. Early intervention may also be used as an interim service, while an individual waits for their assessed level of care to become available.

<u>Allowable Services in Early Intervention</u>

- **Group:** Prevention and/or treatment occurring in a setting of multiple persons with similar concerns/situations gathered together with an appropriately credentialed staff that is intended to produce prevention of, healing or recovery from, substance abuse and misuse. Group models used in early intervention prevention and treatment are not intended to be psychotherapeutic or limited, and may include:
  - **Educational groups**, which educate clients about substance abuse.
  - **Skill development groups**, which teach skills needed to attain and sustain recovery, for example: relapse triggers and tools to sustain recovery.
  - **Support groups**, which support members and provide a forum to share information about engaging in treatment, maintaining abstinence and managing recovery. These may be managed by peers or credentialed staff.
  - **Interpersonal process groups**, which look at major developmental issues that contribute to addiction or interfere with recovery.

- **Individual:** One-on-one education and/or counseling between a provider and the client.

- **Alcohol and Drug Education:** May occur in a group setting as outlined above (educational groups), or may be used as independent study, with the provider giving "assignments" to be discussed at the next session.

- **Referral/Linking/Coordination of Services:** Office-based service activity performed by the primary service provider to address needs identified, and/or to ensure follow-through with outside services/community resources, and/or to establish the client with other substance use disorder services.

Please note that the above services are offered in many treatment settings, and may be utilized for those clients seeking early intervention services. However, in order to be billed as an early intervention service, a program must have a license for early intervention.

Clients may engage in more than one of the above interventions at a time, based upon individual need. If it becomes evident that a client is in need of a higher level of care, arrangements should be made to transfer that client into the appropriate level of service. Also to be taken into consideration at that point, is the client's readiness to change and willingness to engage in treatment.

The transferring of clients between treatment providers and counselors often results in client dropout. Thus, what is frequently termed a "warm hand-off," connecting the client with the new provider/therapist directly by way of a three-way call or other appropriate communication, is preferred when transitioning clients.

Eligibility

Prevention: Persons identified and assessed as having indulged in illegal or age inappropriate use of tobacco, alcohol and/or illicit drugs that do not meet the threshold for substance abuse or dependence, and for whom no diagnosis is made; i.e., college or military substance abuse; alcohol, tobacco, and illicit drug–impaired driving; children of alcoholics; children of substance abusing parents; Fetal Alcohol Spectrum Disorder; and HIV/AIDs.

Treatment: As previously noted, clients seeking this level of care, must meet, at a minimum, Level 0.5 of the *ASAM PPC-2R*, and be experiencing some problems and/or consequences associated with their substance use. For example, those who are seeking services related to a first time DUI charge would not be eligible without also meeting ASAM criteria. Clients already engaged in more intensive services, or at a level of contemplation that makes them appropriate for treatment, should not receive early intervention services. However, those clients waiting for treatment services may access early intervention as an interim service.

Funding

Funding for early intervention services comes from treatment and prevention. However, early intervention services performed or provided within a prevention program shall not be funded with Community Grant dollars. The Healthcare Common Procedure Coding System for early intervention services provided with treatment funding is *H0022*, which encompasses many of the allowable services. The Medicaid Provider Manual lists early intervention as an allowable service (12.1.B, 2011).

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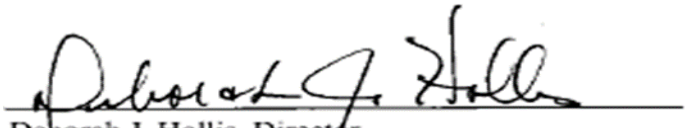
APPROVED BY:



Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

TREATMENT TECHNICAL ADVISORY #11

SUBJECT: Recovery Housing

ISSUED: July 31, 2015

EFFECTIVE: October 1, 2015

PURPOSE:

The purpose of this advisory is to provide guidance to the field on developing and supporting recovery housing for *Prepaid Inpatient Health Plans (PIHPs)* and interested programs.

SCOPE:

This advisory impacts *PIHPs* and their provider network.

BACKGROUND:

The Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care (OROSC) began researching opportunities for recovery housing in late 2011. A request was sent to all states and several of the former coordinating agencies, for information regarding their recovery housing standards and structures. In addition, the *National Association of Recovery Residences' (NARR)* standards were reviewed. Many states endorsed the *Oxford House* model, while others had a combination of housing options available for their recovery population. States that have been awarded *Access to Recovery Grants* had developed extensive standards to monitor recovery housing and funding that went along with it.

Clarification regarding using *Substance Abuse Block Grant (SABG)* funds for recovery housing was sought from the *Center for Substance Abuse Treatment*. *SABG* funds may not be used to fund an individual's lodging in recovery housing. However, *SABG* funding can be used in conjunction with a treatment service category to provide room and board for any individual, to the extent that it is integral to the treatment process. In addition, the *SABG* set aside for pregnant and parenting women does allow payment to provide housing eligible women. Recovery Housing for the pregnant and parenting population will ideally be offered through a designated program to ensure that all of their needs are met.

Definitions

OROSC has defined "recovery housing" as follows:

> *Recovery housing provides a location where individuals in early recovery from a behavioral health disorder are given the time needed to rebuild their lives, while developing the necessary skills to embark on a life of recovery. This temporary arrangement will provide the individual with a safe and secure environment to begin the process of reintegration into society, and to build the necessary recovery capital to*

return to a more independent and functional life in the community. These residences provide varying degrees of support and structure. Participation is based on individual need and the ability to follow the requirements of the program. (Excerpt from the proposed *Substance Use Disorder Benefit Package* for the state of Michigan).

RECOMMENDATIONS:

From the review of standards available nationally, OROSC determined that there were certain aspects of the establishment and maintenance of recovery housing that was necessary for success. They are as follows:

- Maintain an alcohol-and illicit-drug-free environment.
- Maintain a safe, structured, and supportive environment.
- Set clear rules, policies, and procedures for the house and participating residents.
- Establish an application and screening process for potential residents.
- Endeavor to be good neighbors and get residents involved in their community.

Recovery Housing Standards

After careful consideration of the options available, OROSC has come to the determination that the levels of recovery housing and standards identified by *NARR* most closely fit the vision of recovery housing for Michigan. The levels are as follows:

- **Level I - Peer Run –** staff positions within the residence are not paid; setting is generally single family residences; services include drug screenings and house meetings; and residence is democratically run with policies and procedures.
- **Level II - Monitored** – staff consists of at least one compensated position within the house; setting is primarily single family residences, potentially apartments or other types of dwellings; services include house rules, peer run groups, drug screens, and house meetings; and residence is administered by house manager with policies and procedures.
- **Level III - Supervised** – staff includes a facility manger, certified staff or case manager(s); setting is all types of residential; services include clinical services accessed in the community, service hours within the house, and in-house life skill development; and residence has administrative oversight with policies and procedures.
- **Level IV - Service Provider** – staff are credentialed; setting is all types of residential, often a step down phase within care continuum of a treatment center; services include in-house clinical services and life skill development; and residence has clinical and administrative supervision with policies and procedures.

The following are samples of the standards identified by *NARR*; they are representative of the interests and activities that OROSC supports. Recovery residences must:

- Identify clearly the responsible person(s) in charge of the recovery residence to all residents.
- Collect and report an accurate process and outcome data for continuous quality improvement.
- Maintain an accounting system that fully documents all resident's financial transactions, such as, fees, payments, and deposits.

- Use an applicant screening process that helps maintain a safe and supportive environment for a specific group of persons in recovery.
- Foster mutually supportive and recovery-oriented relationships between residents and staff through peer-based interactions, house meetings, community gatherings, recreational events, and other social activities.
- Encourage each resident to develop and participate in his/her own personalized recovery plan.
- Provide non-clinical, recovery support and related services.
- Encourage residents to attend mutually supportive, self-help groups, and/or outside professional services.
- Maintain the interior and exterior of the property in a functional, safe, and clean manor that is compatible with the neighborhood.
- Provide rules regarding noise, smoking, loitering, and parking that are responsive to a neighbor's reasonable complaints.

The full *NARR* standards can be found at http://narronline.org/wp-content/uploads/2013/09/NARR-Standards-20110920.pdf

In addition to the standards developed by *NARR*, recovery residences should maintain a prevention license through the Michigan Department of Licensing and Regulatory Affairs. This will help ensure a minimum level of housing standards throughout the state.

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APPROVED BY:

Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

VI. TREATMENT REQUIREMENTS

Treatment
Policy #02
Acupuncture
—
Effective May 1, 1994; Reissued March 2007

Treatment
Policy #06

Individualized Treatment and Recovery Planning—
Effective April 2, 2012

Treatment Policy
#07 Access Management
System— Effective
November 1, 2006 has
been replaced by
contract attachment
P4.1.1 Access
Management System
Amendment #1

Treatment Policy #08

Substance Abuse Case Management Program
Requirements— Effective January 1, 2008

Treatment Policy #09

Outpatient Treatment Continuum of Services
Effective June 20, 2008

Treatment
Policy #10

Residential Treatment Continuum of
Services— Effective October 1,
2010

Treatment Policy #12
Women's Treatment
Services—

Effective October 1, 2010

MEMORANDUM

DATE: October 19, 2012

TO: Regional Substance Abuse Coordinating Agency Directors

FROM: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Revised Treatment Policy #02: *Acupuncture*

Attached is the final version of Treatment Policy #02: *Acupuncture*. This policy will become effective November 1, 2012.

A draft of this policy was sent to all substance abuse coordinating agencies for review on August 24, 2012. Comments and feedback were received from Macomb County Community Mental Health, which were utilized to finalize this policy. The feedback expressed the desire for clarification regarding the ability of an acupuncture detoxification specialist to bill for services, and at what point they were eligible to bill. Clarification is provided within the policy.

If you have any questions or need further clarification, please contact Angie Smith-Butterwick, at smitha8@michigan.gov or 517-373-7898.

DJH/asb

Attachment

TREATMENT POLICY #02

SUBJECT: Acupuncture

ISSUED: May 1, 1994, revised June 2001, March 2007, and July 2012

EFFECTIVE: November 1, 2012

PURPOSE:

To establish standards for the use of acupuncture when used as an adjunct therapy in substance use disorder treatment.

SCOPE:

The Office of Recovery Oriented Systems of Care will allow community grant expenditures for acupuncture as an adjunct therapy in any substance use disorder treatment setting. Acupuncture may be used to support drug-free or medication-assisted treatment (MAT).

BACKGROUND:

In 1972, the use of auricular acupuncture for acute drug withdrawal was developed in Hong Kong. Shortly thereafter, Michael Smith, M.D., a psychiatrist at Lincoln Hospital in the South Bronx, New York City, started using it extensively. Dr. Smith developed a five-point auricular protocol, which has been adopted by the National Acupuncture Detoxification Association (NADA). The following ear points are used in the protocol: liver, kidney, lung, sympathetic nervous system, and shen men (spirit gate). Stimulation of these ear points reduces stress and anxiety, which allows the patient to be more receptive to counseling. It also lessens depression and insomnia, and alleviates the craving for substances, thus aiding in recovery. It should be noted that the term "detoxification" is used as an eastern or Traditional Chinese Medicine (TCM) concept and is based on the principle that illnesses can be caused by the accumulation of toxic substances (toxins) in the body. Eliminating existing toxins and avoiding new toxins are essential parts of the healing process. Used in this manner, detoxification principles should be implemented throughout the treatment continuum and to prevent relapse rather than only in the initial stage of treatment.

Auricular acupuncture offers a low-cost way to enhance outcomes and lower the total cost of substance abuse treatment. It has been shown to be effective in relieving the symptoms of withdrawal from alcohol, heroin, and crack cocaine; making patients more receptive to treatment; reducing or eliminating the need for MAT; and lessening the chances of relapse. Some clients experience a decrease in depression and anxiety symptoms as a result of acupuncture, which can contribute to their success in recovery. Studies have also shown success in decreasing the

symptoms of post-traumatic stress disorder in veterans in the United States and refugees abroad. Auricular acupuncture has been used successfully in treating pregnant substance abusing women and drug-exposed infants who are experiencing withdrawal.

Non-auricular acupuncture points can also be used as part of an individualized acupuncture treatment plan when performed by a registered acupuncturist.

Acupuncture may be performed as an adjunct therapy to any treatment modality in any setting. Counseling, 12-step programs, relapse prevention, referral for supportive services, and life skills training are all components of a comprehensive program that can include acupuncture. Auricular acupuncture for substance use disorder treatment appears to work best in a group setting. In keeping with the philosophy of TCM, the patient is encouraged to be actively involved in his/her own treatment and to see substance abuse holistically, as part of total emotional, physical, and spiritual health, and to recognize the relationship his/her disorder has to other people and the environment.

REQUIREMENTS:

Michigan Law

Acupuncture may be performed by the following individuals: a) Medical Doctor, b) Doctor of Osteopathy, and c) Registered Acupuncturist. An individual who holds a Certificate of Training in Detoxification Acupuncture as an Acupuncture Detoxification Specialist (ADS) issued by NADA and is under the supervision of a person licensed to practice medicine in the state may use the NADA protocol for substance use disorder treatment. The supervising physician needs not be trained in acupuncture nor be present when the procedure is performed.

Disposable sterile needles must be used for all acupuncture treatments.

The following Michigan Compiled Laws, from the Public Health Code, pertain to acupuncture:

333.16215 Supervision of Acupuncture
333.16501 Definition of Acupuncturist
333.16511 Exemption from Registration

PROCEDURE:

The recommended procedure for the use of acupuncture as a substance use disorder treatment support is the protocol developed by NADA. This five point auricular protocol, which includes the liver, kidney, lung, sympathetic nervous system and shen men points, is the only procedure allowed to be performed by a NADA trained and certified ADS. Registered Acupuncturists and physicians may use their professional judgment and expertise in determining the acupuncture points to be used.

Clinicians who wish to become proficient in the NADA protocols must study under a NADA Registered Trainer, usually by participating in a 30-hour classroom/didactic training course followed by 40 hours of hands-on work in a clinic. Upon completion of training, the trainee's documentation is submitted to NADA for final approval and issuance of a certificate of training completion as an ADS. Once certified and insured, the ADS is able to bill for services.

More information about the NADA Protocol, how to become an ADS, and training resources may be found at www.acudetox.com.

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APPROVED BY:

Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

MEMORANDUM

DATE: April 26, 2012

TO: Substance Abuse Coordinating Agency Directors

FROM: Deborah J. Hollis, Director
Bureau of Substance Abuse and Addiction Services

SUBJECT: Treatment Policy #6: *Individualized Treatment and Recovery Planning*

Attached is the final version of Treatment Policy #6: *Individualized Treatment and Recovery Planning*. This policy became effective April 2, 2012.

A draft of this policy was sent to all substance abuse coordinating agencies for review in December 2011. Comments and feedback were received from the Detroit Bureau of Substance Abuse Prevention, Treatment and Recovery, Mid-South Substance Abuse Commission, and Genesee County Community Mental Health, which were utilized to finalize this policy. Some of the feedback received indicated that there was a preference for separate treatment and recovery planning. BSAAS believes that it is important that these activities take place simultaneously to ensure client input and the viability of recovery planning. Concerns were expressed that treatment goals and objectives that completely reflect the client's words are not always measurable. Adjustments were made to the policy to correct this issue. The policy also provides clarification regarding required signatures on treatment plans and updates.

If you have any questions or need further clarification, please contact Angie Smith-Butterwick, at smitha8@michigan.gov or 517-373-7898.

DJH:ssb

Attachment

c: Felix Sharpe
Jeff Wieferich

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TREATMENT POLICY # 06

SUBJECT: Individualized Treatment and Recovery Planning

ISSUED: September 22, 2006, revised February 29, 2012

EFFECTIVE: April 2, 2012

PURPOSE

The purpose of this policy is to establish the requirements for individualized treatment and recovery planning. Treatment and recovery plans must be a product of the client's active involvement and informed agreement. Direct client involvement in establishing the goals and expectations for treatment is required to ensure appropriate level of care determination, identify true and realistic needs, and increase the client's motivation to participate in treatment. By participating in the development of their recovery plan, clients can identify resources they may already be familiar with in their community and begin to learn about additional available services. Treatment and recovery planning requires an understanding that each client is unique and each plan must be developed based on the individual needs, goals, desires and strengths of each client.

The planning process can be limited by the information that is gathered in the assessment or by actual planning forms. All planning forms should be reviewed on at least an annual basis to ensure that the information being gathered, or the manner in which it is recorded, continues to support the individualized treatment and recovery planning process.

SCOPE

This policy impacts the PIHP and its provider network of substance use disorder services.

BACKGROUND

Expectations for individualized treatment planning had been advisory requirements in the contract with the CAs from 2004 through 2006. This policy formalizes those expectations and introduces the need for recovery planning as an essential part of this process.

REQUIREMENTS

The Administrative Rules for Substance Abuse Programs in Michigan promulgated under PA 368 of 1978, as amended, state, "A recipient shall participate in the development of his or her treatment plan." [Recipient Rights Rules, Section 305(1)].

All PIHP providers must also be accredited by one of the approved national accreditation bodies. Accreditation standards also require evidence of client participation in the treatment planning

process. Evidence of client participation includes goals and objectives in the client's own words, goals and objectives based on needs the client identified in the assessment, and evidence the client was in attendance when the plan was developed.

PROCEDURE

Treatment and recovery planning begins at the time the client enters treatment – either directly or based on a referral from an access system – and ends when the client completes or leaves formal treatment services. Planning is a dynamic process that evolves beyond the first or second session when required documentation has been completed. Throughout the treatment process, as the client's needs change, the plan must be revised to meet the new needs of the client.

Recovery planning is undertaken as a component of the treatment plan and should progress as the client moves through the treatment process. It is important that the recovery plan be a viable and workable plan for the client and, upon the end of formal treatment services, he/she is able to continue along his/her recovery path with guidance from his/her plan. It is not acceptable that the recovery plan be developed the day before a client's planned completion of treatment services.

The treatment and recovery plans are not limited to just the client and the counselor. The client may request any family members, friends or significant others be involved in the process. Once each plan is developed, the client, counselor, and other involved individuals, such as significant others, family and mental health providers, must sign the form indicating understanding of the plan and the expectations.

Establishing Goals and Objectives

The initial step in developing an individualized treatment and recovery plan involves the completion of a biopsychosocial assessment. This is a comprehensive assessment that includes current and historical information about the client. From this assessment, the needs and strengths of the client are identified and it is this information that assists the counselor and client in establishing the goals and objectives that will be focused on in treatment. The identified strengths can be used to help meet treatment goals based on the client's individual needs. Examples of strengths might be a healthy support network, stable employment, stable housing, a willingness to participate in counseling, etc. After strengths are identified, the counselor assists the client in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the client can provide motivation to participate in treatment, assist in identifying the most appropriate modality of treatment (individual, group, etc.), and may take the focus off any negative situations that surround the client getting involved in treatment, i.e., legal problems, work problems, relationship problems, etc.

Writing the Plan

Once the goals and objectives are jointly decided on, they are recorded in the planning document utilized by the provider. Goals must be stated in the client's words or based on the client's reported concerns. Each goal that is written down should be directly tied to a need that was identified in the assessment. Once a goal has been identified, then the objectives – the activities the client needs to perform to achieve the goal – are recorded. The objectives must be developed with the client but do not have to be recorded in the client's exact words. The objectives need to be written in a manner in which they can be measured for progress toward completion along with a targeted completion date. The completion dates must be realistic to the client or the chances of compliance with treatment are greatly reduced.

Establishing Treatment Interventions

The next component of the plan is to determine the intervention(s) that will be used to assist the client in being able to accomplish the objectives. In other words – what action will the client take to achieve a goal, and what action will the counselor take to assist the client in achieving the goal. This should be specific, not just generalized statements of individual or group therapy. Again, these actions must be mutually agreed upon to provide the best chance of success for the client.

Framework for Treatment

The individualized treatment and recovery plan provides the framework by which services should be provided. Any individual or group sessions that the client participates in must address or be related to the goals and objectives in the plan. When progress notes are written, they reflect what goal(s)/objective(s) were addressed during a treatment session. The progress notes recorded by the clinician, should document progress or lack of progress and any adjustments/changes to the treatment and recovery plan. Once a change is decided on, it should then be added to the plan in the format described above and initialed by the client or with documentation of client approval.

Treatment and Recovery Plan Progress Reviews

Plans must be reviewed and documentation of such must be placed in the client record. The frequency of the reviews can be based on the time frame in treatment (60, 90, 120 days) or on the number of treatment episodes that have taken place since admission or since the last review (8, 10, 12 episodes). The reviews must include input from all clinicians/treatment/recovery providers involved in the care of the client, as well as any other individuals the client has involved in his/her plan. This review should reflect on the progress the client has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them, and the need to add any additional goals/objectives due to new needs of the client. As with the initial plan, the client, clinician, and other relevant individuals should sign this review. If individual signatures are unable to be obtained, documentation explaining why must be provided.

The plan and plan reviews not only serve as tools to provide care to the client, they help in the administrative function of service authorization. Decisions concerning, but not limited to, length of stay, transfer, discharge, continuing care, and authorizations by CAs must be based on individualized determinations of need and on progress toward treatment and recovery goals and objectives. Such decisions must not be based on arbitrary criteria, such as pre-determined time or payment limits.

Policy Monitoring and Review

The PIHP will monitor compliance with individualized treatment and recovery planning and these reviews will be made available to the Office of Recovery Oriented Systems of Care (OROSC) during site visits. OROSC will also review for individualized treatment and recovery planning during provider site visits. Reviews of plans will occur in the following manner:

- A review of the biopsychosocial assessment to determine where and how the needs and strengths were identified.

- A review of the plan to check for:

    1. Matching goals to needs – Needs from the assessment are reflected in the goals on the plan.
    2. Goals are in the client's words and are unique to the client – No standard or routine goals that are used by all clients.
    3. Measurable objectives – The ability to determine if and when an objective will be completed.
    4. Target dates for completion – The dates identified for completion of the goals and objectives are unique to the client and not just routine dates put in for completion of the plan.
    5. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.
    6. Signatures – client, counselor, and involved individuals, or documentation as to why no signature.
    7. Recovery planning activities are taking place during the treatment episode.

- A review of progress notes to ensure documentation relates to goals and objectives, including client progress or lack of progress, changes, etc.

- An audit of the treatment and recovery plan progress review to check for:

    1. Progress note information matching what is in review.
    2. Rationale for continuation/discontinuation of goals/objectives.
    3. New goals and objectives developed with client input.
    4. Client participation/feedback present in the review.
    5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature.

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APPROVED BY:

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Bureau of Substance Abuse and Addiction Services

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

DATE: December 12, 2007

TO: Coordinating Agency Executive Directors

FROM: Donald L. Allen, Director
Office of Drug Control Policy

SUBJECT: Treatment Policy #08: *Substance Abuse Case Management Program Requirements*

Attached is the final version of the Michigan Department of Community Health (MDCH), Office of Drug Control Policy (ODCP) Treatment Policy #08: *Substance Abuse Case Management Program Requirements*. This policy was sent to all coordinating agencies on September 7, 2007 with a review period of 30 days. Macomb County Community Mental Health submitted comments that were utilized in the finalization of the policy.

Attachment

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TREATMENT POLICY # 08

SUBJECT: SUBSTANCE ABUSE CASE MANAGEMENT PROGRAM REQUIREMENTS

ISSUED: January 1, 2008

EFFECTIVE DATE: January 1, 2008

PURPOSE:

The purpose of this policy is to establish requirements for Case Management (CSM) programs.

SCOPE:

PIHP substance abuse provider network.

BACKGROUND:

The substance abuse administrative rules were changed July 5, 2006. These changes resulted in case management becoming a licensable program category. In October 2006, Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care (MDHHS/OROSC) provided the field with a technical advisory on the different types of case management models to assist programs in making a decision on the type of CSM programs that can be utilized based on the needs of the population within their region.

REQUIREMENTS:

The definition of case management contained in Administrative Rule 325.14101(g) is as follows:

> Case Management means a substance use disorder case management program that coordinates, plans, provides, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

The action plan guideline (APG) has established the requirement of having a CSM program available in each PIHP region by September 30, 2009. To ensure that each PIHP and their providers develop an identifiable case management program and satisfy APG requirements, the following must be incorporated in the development of CSM services process:

1. The program must be identifiable and distinct within the agency's service configuration.

2. The agency must offer or purport to offer the case management services as a separate and distinct program among any other program services that may be offered.

Eligibility

In addition to the client agreeing to participate in CSM services, at least one of following criteria must be present in order for the client to be eligible for CSM services:

1. Client has a documented need in at least one domain involving community living skills, health care, housing, employment/financial, education or another functional area in that person's life.
2. Client has a demonstrated history of recovery failure with or without recovery support services.
3. Client has a substance use disorder involving a primary drug of choice that will require longer-term involvement in treatment services to support recovery (such as methamphetamine, heroin/opiates, inhalants).
4. The chronicity and severity of the client's disorder is such that ongoing support is needed to increase the probability of recovery (such as years of use and first involvement with treatment, or a co-occurring mental health disorder is present with substance use disorder).

A client who is receiving CSM services from another CSM service or program (mental health, child welfare, justice system etc.) is not eligible for substance use disorder CSM services regardless of the criteria met above. Also, a client who has needs that could be met through another CSM service, for which the client qualifies, is not eligible for substance use disorder CSM services. In situations where it is determined that the client's needs cannot be met, authorization for concurrent enrollment can be provided by the PIHP on a case-by-case basis. In these situations, there must be coordination with the other program to ensure that specific services are not duplicated.

Clients can receive CSM services when they are involved in other levels of care if it is determined to be a necessary adjunct to the current services. CSM services can also be provided as a step-down from a more intensive level of treatment and can be provided as a stand-alone service if eligibility requirements are met. CSM services are designed to provide the client with support to maintain recovery during the transition from formal treatment services to self-sustained recovery, but are also designed to assist in providing additional support while the client is receiving services in the initial period of treatment.

Minimum Service Expectations

There are many functions and/or activities that a case management program can be engaged in to provide services to clients. Although many of the functions of case management programs will be established at the local level, the following functions for a case management program are being established as the minimum expectations:

1. The ability to link and/or refer clients to support services depending on the needs and functioning level of clients.
2. The provider must be able to serve as an advocate to assist and/or represent the client and his/her needs with other agencies or service providers. This may include but is not limited to serving as the "voice" of the client in situations where the client is unable to effectively represent himself/herself, accompanying clients to appointments, assisting with completion of forms or meeting other requirements the client may have to secure support/services, making appointments for clients, or ensuring follow-through of appointments. The level and intensity of involvement should be dependent on the individual client.
3. Ability to see clients in their community or the capability for face-to-face client interaction outside of the office setting.
4. The CSM provider must be able to monitor and continually assess the changing functional and social needs of clients as they progress through recovery and document this information as required.
5. The CSM programs must be able to work with a treatment team if needed.
6. Case management services must be based on an individualized treatment or recovery plan and have the ability to provide, or refer for, crisis intervention.

It is not permissible for CSM providers to incorporate both service provision and service authorization/re-authorization responsibility for their own clients. Authorizations must be distinct from CSM functions and should be completed through a separate process that is independent of providing case management services to the client.

CSM Program Categories

Treatment Technical Advisory (TA) #03: *Implementing Case Management Services* identified four types of case management models that have been shown to be effective in helping clients with recovery from substance use disorders. In the TA, licensing requirements were not established for each model. To further clarify the requirements and expectations for PIHPs and providers developing a case management program funded through the MDHHS PIHP contract agreement, the models are reviewed below and licensing requirements for the PIHP provider network CSM programs have been established for each model:

1. **The Broker/Generalist**: This model identifies clients' needs and assists clients to access resources. Service planning or areas of needed assistance may be limited to contacts with the case manager and would not require development of an intensive long-term relationship. Clients who receive this type of CSM service typically do not have multiple needs and are able to access and utilize other resources more independently than clients who receive case management services under the other models. The case manager advocacy role is less intensive than other CSM service models. Essentially, the case manager provides the client with the information and

provides assistance with access to other services and supports, and the client is responsible for follow through. The case manager assesses and monitors follow-through, but less intensive support is needed by the client.

The ability for the case manager to be able to work with the client outside the office and in the client's environment is required but interventions within the office are appropriate given the higher functioning level of the clients. Therapeutic services, beyond resource acquisition, are not provided under this model and, if needed, the client is referred to an appropriate source for the service or referred back to the primary treatment provider if these services are being provided as an adjunct to another level of care. Crisis intervention services are limited to providing assistance with acquiring resources. Any clinical or mental health crisis interventions are provided by previously identified providers in the community. The development of social support networks for the client, a function of the other models of CSM, is not a part of this model.

- Possession of a Screening, Assessment, Referral and Follow-up (SARF) only license is permitted for programs that will be strictly providing this model only. A treatment license is not required as long as services meet the CSM Administrative Rule definitions. A service category license for case management programs for persons with substance use disorders is required.

2. **Strengths-Based Perspective**: The two principles of this model are 1) providing clients support for asserting direct control over the search for resources; and 2) assisting clients in examining their own strengths and assets as the vehicle for resource acquisition. This model encourages the use of informal helping networks, promotes the importance of the client-case manager relationship, and provides an active, aggressive form of outreach. This model has been used with the substance abuse population because of 1) the usefulness of helping the client access resources for recovery; 2) the strong advocacy component; and 3) the emphasis on helping clients identify their strengths, assets, and abilities.

   Services in this model include therapeutic interventions like therapy or skills teaching for clients and/or their significant others, when these are needed to assist with the recovery process. Crisis intervention services are provided as a part of this model as well. In keeping with the concept of building the client-case manager relationship, services in this model generally take place in the community or the client's environment in contrast to an office based setting.

   - A treatment license is required in addition to the case management service category license to provide this type of program.

3. **Assertive Community Treatment**: Utilizes a team model to provide services to clients. This model also provides services in the community and clients are sought

out by the team for contact. The chronic nature of substance abuse is acknowledged with the purpose of modifying the course of the condition and alleviating suffering. Abstinence is not an expectation of participation. Typically, this model is set up for relatively long-term involvement with clients due to the chronic nature of the population served and maintains ongoing contact with the client to assist with recovery. This model is fundamentally similar to the mental health Assertive Community Treatment (ACT) program and services design except for the composition of the team and the type of credentialed staff providing the service. The team composition is at local discretion.

- A treatment license is required in addition to the case management service category license to provide this type of program.

4. **Clinical/Rehabilitation**: This model involves combining therapy and case management services. In this way, all of the client needs are addressed through a single program. This can be described as having a single clinician serve as a therapist and as the case manager. This model serves clients that have been identified as having many needs and functional impairments but are not so severe that an ACT program is required. These clients have the ability to make many decisions for themselves in regards to treatment issues as well as the level of CSM intervention and advocacy needed.

   Whereas in the previous models, getting the clients involved in services and programs to meet identified needs is the main focus, there is equal focus on the therapeutic interventions and activities that are provided in this model. Services are provided in the community in the client's environment and this is the distinguishing factor between this service and standard outpatient care that takes place in an office setting.

   The following conditions must be in place in order for this type of program to meet the established CSM requirements:
   1. The program must have a distinct component of integrated CSM and clinical services
   2. Distinct eligibility criteria must be in place regarding client qualifications for the program
   3. The program must meet the minimum service expectations of a CSM program
   4. Clients are able to continue in the program even after the therapeutic needs are addressed but functional needs remain.

   - A treatment license is required in addition to the case management service category license to provide this type of program.

<u>Care Management/Care Coordination</u>

This service is designed to support CA resource allocation as well as service utilization. Agencies engaged in care coordination monitor and/or assist with referrals and assess associated barriers to service utilization by the client. Care Management/Care Coordination is considered to represent treatment episode management. Care management or care coordination, an allowable administrative expenditure service under Medicaid, is an administrative function performed at the CA or through the access system. Care management recognizes that some clients represent such service or financial risk to the organization that closer monitoring of the individual case is warranted. Involvement in care management services does not preclude the client from being involved in CSM services as the two programs have separate and distinct functions. However, services must be coordinated, collaborative and unduplicated.

The PIHP or access system provider may implement care management at any time.

Women's Specialty Services

Women's specialty services, required as part of the Federal Substance Abuse Prevention and Treatment block grant, are commonly referred to as "case management" services. However, the requirements of 1) providing or arranging primary medical care for women, including prenatal care, and child care while women are receiving such services; 2) providing or arranging primary pediatric care and immunizations for the children of women in treatment; and 3) providing sufficient transportation to ensure that women and their dependent children have access to the previously mentioned services, do not meet the expectations that ODCP has established for case management services as defined in the administrative rules. The services under the women's specialty requirements are considered care coordination but can be provided as part of a case management program.

REQUIRED REPORTS:

None unless otherwise specified in the MDHHS-PIHP agreement.

PROCEDURE:

None specified for establishing a CSM program.

REFERENCES:

Center for Substance Abuse Treatment, *Comprehensive Case Management for Substance Abuse Treatment*, Treatment Improvement Protocol (TIP) Series, Number 27, DHHS Publication No. (SMA) 98-322, Rockville, MD; Substance Abuse and Mental Health Services Administration 1998. http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.49769

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State of Michigan, State Office of Administrative Hearings and Rules, Michigan Administrative Code, Substance Abuse Service Programs, http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=32514101&Dpt=CH&RngHigh=

Treatment Policy #3: Buprenorphine. Michigan Department of Health & Human Services, Office of Recovery Oriented Systems of Care, 2006. http://www.michigan.gov/documents/Treatment_Policy_03_Buprenorphine_145923_7.pdf

APPROVED BY: __*SIGNED*_____
Donald L. Allen, Jr., Director
Office of Drug Control Policy

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

DATE: June 20, 2008

TO: Regional Coordinating Agencies
Outpatient Treatment Continuum of Services Workgroup

FROM: Donald L. Allen, Jr., Director
Office of Drug Control Policy

SUBJECT: Treatment Policy #09: *Outpatient Treatment Continuum of Services*

Attached is the final version of the Michigan Department of Community Health (MDCH), Office of Drug Control Policy (ODCP) Treatment Policy #09: *Outpatient Treatment Continuum of Services*. This policy was sent to all coordinating agencies and the Outpatient Treatment Continuum of Services Workgroup on February 28, 2008 with a review period of 60 days. St. Clair County Community Mental Health, Mid-South Substance Abuse Commission, Riverhaven Coordinating Agency, Southeast Michigan Community Alliance (SEMCA) and Lakeshore Coordinating Council submitted comments that were utilized in the finalization of the policy.

This policy is effective immediately and full cooperation is expected.

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TREATMENT POLICY #09

SUBJECT: Outpatient Treatment Continuum of Services

ISSUED: February 20, 2008

EFFECTIVE: June 20, 2008

PURPOSE

The purpose of this policy is to establish the requirements for outpatient services that endorse use of American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria and to ensure that services are individualized and culturally, age and gender appropriate.

SCOPE

This policy impacts the PIHP and its outpatient LOC service provider network.

BACKGROUND

Outpatient treatment includes a wide variety of covered services with the expectation that authorizations for these services are individualized to the needs of the client. Throughout the outpatient LOC, assessment, treatment plan and recovery support preparations are required as they must be included in the authorized treatment services. As a client's needs change, the frequency and/or duration of services may be increased or decreased as medically necessary. The ASAM levels correspond with planned hours of services, in a group and/or individual setting during a week and as scheduled with the client.

Historically, services have been described as follows:

- Outpatient – treatment that may be offered in a variety of settings, but often takes place in an office-type setting. Can include group and/or individual therapy services.
- Intensive Outpatient – treatment that often takes place in an office-type setting, but can be offered in other settings, and consists of a minimum of nine hours, maximum of 19 hours of services per week. Services include individual, group and interactive education-(didactic) type services.
- Enhanced Outpatient – similar to intensive outpatient service because it also offers expanded hours per week, but with a greater emphasis on individualized treatment to meet the client's needs.
- Ambulatory Detoxification – detoxification that does not take place in a continuously monitored program/setting.

The frequency and duration of outpatient treatment services are expected to be guided by the ASAM LOC and are referred to as follows:

ASAM Level 0.5 Early Intervention – These services are not differentiated by the number of hours received during a week. The amount and type of services provided are based on individual needs including consideration of both the client's motivation to change and other risk factors that may be present.

ASAM Level I.0 Outpatient – Services are less than nine hours during a week.

ASAM Level I-D Ambulatory Detoxification Without Extended On-Site Monitoring – Services are not established by hours but are set up to effectively monitor/educate an individual going through the detoxification process. Medical monitoring is at a minimum.

ASAM Level II.1 Intensive Outpatient – Services 9-19 hours in a week. The services are provided at least three days a week to fulfill the minimum nine-hour commitment.

ASAM Level II-D Ambulatory Detoxification With Extended On-Site Monitoring – Services are not established by hours but must be sufficient to effectively monitor/educate an individual going through the detoxification process. Medical monitoring is more routine to determine impact of withdrawal.

ASAM Level II.5 Partial Hospitalization – Services that are provided 20 or more hours in a week. (Hospitalization is used as a descriptor by ASAM. It is not meant to indicate that the service must take place in a hospital setting.)

ASAM levels of care describe the need for treatment from the perspective of weekly service intensity based on the needs of the client. The identification of these needs is intended to drive service selection and authorization for care. The determination of service intensity, within outpatient services, is based on the client's ASAM LOC determination; not the designation of the provider program as being early intervention, outpatient, intensive outpatient, or partial hospitalization. For purposes of treatment episode data set (TEDS) admission reporting, LOC may be established on the basis of the authorization for service rather than service participation.

Definitions

Bundled Services – Are an approach to treatment that ties multiple covered services together and provides them in a single treatment setting. Specific activities are not differentiated in billing or reimbursement.

Counseling – An interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Interactive Education (didactic) – Refers to services that are designed or intended to teach information about addiction and/or recovery skills.

Medical Necessity – Treatment that is reasonable, necessary and appropriate based on individualized treatment planning and evidence-based clinical standards.

Psychotherapy (therapy) – The assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (from Social Work Administrative Rules).

Recovery – A voluntarily maintained lifestyle comprised of sobriety, personal health and socially responsible living.

Substance Use Disorder – A term inclusive of substance abuse and dependence that also encompasses problematic use of substances that does not meet the criteria for substance abuse or dependence.

Unbundled Services – An approach to treatment that seeks to provide the appropriate service or combination of specific services to match the needs of a client. Billing and reimbursement is specific to the service provided.

REQUIREMENTS

PIHPs must have the capacity to provide an outpatient continuum that will meet the needs of clients at all ASAM levels of intensity. Outpatient care is defined as treatment services that are provided in a setting that does not require the client to have an overnight stay at a facility as part of the treatment service but involves regularly scheduled sessions. Outpatient treatment is an organized, non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week, but when medically necessary can total over 20 hours in a week. The combination of days and hours and nature of services is based on the client's needs. A program director is responsible for the overall management of the clinical program and appropriate, credentialed and certified staff members provide treatment.

Treatment must be individualized based on a biopsychosocial assessment, diagnostic impression and client characteristics that include age, gender, culture and development. Authorization decisions regarding length of stay (including continued stay), change in LOC and discharge, must be based on the ASAM patient placement criteria. Client participation in referral and continuing care planning must occur prior to transfer or discharge.

Outpatient care may be provided only when the service meets all of the following criteria:

- Medical necessity;
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders is used to determine an initial diagnostic impression of a substance use disorder, abuse or dependence (also known as provisional diagnosis) – the diagnostic impression must include all five axes;
- Is based on individualized determination of need; and,
- ASAM Patient Placement Criteria are used to determine substance use disorder treatment placement/admission and/or continued stay needs and are based on a LOC determination using the six assessment dimensions of the current ASAM Patient Placement Criteria below:

    1) Withdrawal potential.
    2) Medical conditions and complications.
    3) Emotional, behavioral or cognitive conditions and complications.
    4) Readiness to change.
    5) Relapse, continued use or continued problem potential.
    6) Recovery/living environment.

Outpatient treatment services are appropriate for those clients with minimal or manageable medical conditions; minimal or manageable withdrawal risks; emotional, behavioral and cognitive conditions that will not prevent the client from benefiting from this level of care; services must address treatment readiness; minimal or manageable relapse potential; and, a minimally to fully supportive recovery environment. Clients who continue to demonstrate a lack of benefit from outpatient services, whether they are actively or sporadically involved in their treatment, may be referred to the Access Management System (AMS) for another level of care determination and discharged if the client is unwilling to accept other services appropriate to their level of care determination. Relapse alone is not sufficient justification to discharge a client from treatment but it does indicate that a change in treatment services may be needed.

Covered Services

The following services can be provided in the outpatient setting:

Individual Assessment – A face-to-face service for the purpose of identifying functional and treatment needs; and, to formulate the basis for the Individualized Treatment Plan to be implemented by the provider. *Note: By September 30, 2008, assessment will no longer be a covered service if it takes place at a centralized CA Access Management setting or one that does not also provide licensed treatment services. Time limited waivers to this requirement may be requested of the Office of Recovery Oriented Systems of Care (OROSC).*

Individual Treatment Planning – Refers to the direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed and to increase the client's

motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each client and be specific to the diagnostic impression and assessment.

Individual Therapy – Face-to-face interventions with the client.

Group Therapy – Face-to-face interventions with three or more clients, which includes therapeutic interventions/counseling.

Counseling – Face-to-face intervention (by non-professional staff) with a client, for the purpose of goal setting and achievement and skill building.

Interactive Education (didactic) Groups – Activities that center on teaching skills to clients and are necessary to support recovery. These groups can be lead by non-masters prepared staff.

Family Therapy – Face-to-face interventions with the client and significant other and/or traditional or non-traditional family members. *Note: In these situations, the identified client need not be present for the intervention.*

Crisis Intervention – A service for the purpose of addressing problems/issues that may arise during treatment, which could result in the client requiring a higher LOC if intervention is not provided.

Referral/Linking/Coordinating of Services – Office-based service activity performed by the primary clinician to address needs identified through the assessment, and/or ensuring follow through with access to outside services, and/or to establish the client with another substance use disorder provider.

Recovery Support and Preparation – Services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Compliance Monitoring – For the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program (i.e., onsite testing such as pbt's or non-laboratory urinalysis).

Early Intervention – Treatment services for individuals with substance use disorders and/or individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use. Services may be initiated at any stage of change but are expected to be stage-based.

Detoxification/Withdrawal Monitoring – For the purpose of preventing/alleviating medical complications related to no longer using or decreasing the use of a substance.

Substance Abuse Outpatient Program – Programs that are individualized and include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation and treatment based on medical necessity. These may include individual, group and family treatment. These services are billed under the "H" code sequence.

Note: The Substance Abuse Outpatient Program is the 'bundled' outpatient category while the above are various optional services within outpatient programs.

PROCEDURE

Admission Criteria

Outpatient services must be authorized based on the number of hours and/or types of services that are medically necessary. Re-authorization or continued treatment must take place when it has been demonstrated that the client is benefiting from treatment but additional covered services are needed for the client to be able to sustain recovery independently.

Re-authorization of services can be denied in situations where the client has not been actively involved in their treatment or engaging in behavior that is deemed to violate the rules and regulations of the program providing services. This is evidenced as repeatedly missing appointments, not participating/refusing to participate in treatment activities, patients present a risk of harm to self or others, or a demonstrated lack of benefit from treatment. Progress notes must support lack of benefit and that other, appropriate services have been offered.

The services provided in the outpatient setting can be provided through a bundled substance abuse outpatient program or in an unbundled manner. The CA may decide if services in their region will be bundled or unbundled. Regardless of how services are purchased by the CA, services must be based on the individual needs of the client and services must be individually tailored to the client's needs.

Additional Programs With in the Outpatient Category

The 2006 Administrative Rule Revisions add new program categories of Early Intervention, Peer Recovery/Recovery Support Services, and Case Management for persons with substance use disorders and Integrated Treatment for persons with substance use disorders and mental health disorders. Services provided in this program setting must be licensed under the appropriate treatment setting for the specific category and when the following conditions are met:

- Must meet the threshold of a 'program.'
- Must be identifiable and distinct within the agency's service configuration.

- The agency must offer or purport to offer the service (program) category as a distinct service. That is, a client may be admitted only to the program category without additional outpatient services in place (i.e., case management, peer recovery).

Outpatient programs may incorporate services such as recovery support, early intervention, information and referral/linking/coordinating if these are offered in the context of the program and do not meet the three conditions outlined above.

In the outpatient LOC, clients may benefit from additional supportive services and may participate in case management, integrated treatment or recovery support services concurrently. However, concurrent participation in early intervention services is not allowed.

Caseload requirements and staffing ratios must be within the established licensing criteria [Part 7, R 325.14701, 701(1)]; however, these decisions must also be made with consideration to the needs and characteristics of the clients being served.

Medication Assisted Treatment

Covered services for methadone and pharmacological supports and laboratory services, as required by Office of Pharmacological Alternative Treatment/Center for Substance Abuse Treatment (OPAT/CSAT) regulations and the Administrative Rules for Substance Abuse Service Programs in Michigan, include:

- Methadone medication.
- Suboxone.
- Nursing services.
- Physical examination.
- Physician encounters.
- Laboratory tests.
- TB skin test (as ordered by physician).

Opiate-dependent patients may be provided chemotherapy using medication as an adjunct to therapy. This service takes place in an outpatient capacity and provisions of such services must meet the following criteria:

- Services must be provided under the supervision of a physician licensed to practice medicine in the state of Michigan.
- The physician must be licensed to prescribe controlled substances, as well as licensed to work at a methadone program.
- The methadone component of the substance abuse treatment program must be licensed as such by the state and be certified by the OPAT/CSAT and licensed by the Drug Enforcement Administration.
- An MD/DO, physician's assistant, nurse practitioner, registered nurse, licensed practical nurse, or pharmacist must administer methadone.

- Michigan Department of Health & Human Services (MDHHS)/Office of Recovery Oriented Systems of Care (OROSC) Treatment Policy #05 - *Enrollment Criteria for Methadone Maintenance and Detoxification Program* (attached to the MDHHS/prepaid inpatient health plan (PIHP) contract) must be followed.

Early Intervention

A specifically focused treatment program including stage-based intervention for individuals with substance use disorders or, problems related to substance use, as identified through a screening or assessment process. These individuals may or may not meet the threshold of a diagnosis of abuse or dependence of a substance.

To meet medical necessity criteria, an early intervention program must:

1) Screen and assess for the presence of a substance use disorder.
2) Be required to identify or evaluate a substance use disorder.
3) Be intended to treat, diminish or stabilize the symptoms of a substance use disorder.
4) Be expected to arrest or delay the progression of a substance use disorder.
5) Be designed to assist the client to attain or maintain a sufficient level of functioning in order to achieve the goal of recovery.

Early intervention treatment must be based on individualized treatment planning, provided by an appropriately credentialed substance abuse professional, and sufficient to assist the client in their recovery. This does not prohibit or restrict prevention programs from providing services within the Problem Identification and Referral strategy and/or through the allocation for prevention services.

To distinguish between problem identification and referral offered by prevention programs and early intervention treatment programs, see below:

Prevention–Problem Identification and Referral	**Treatment- Early Intervention**
Screening for substance use disorders may be **population based or individual.**	Screening for substance use disorders at **individual level.**
No diagnosis is made.	**Assessment required**; diagnosis may be provisional.
Program may include substance use interventions in additional to or in context of other services.	Individual treatment plan; a goal for recipient program participation is minimal requirement.
Participants not **determined** to meet substance abuse or dependence thresholds.	Participants not **required** to meet substance abuse or dependence thresholds.

Purpose of service may be larger and/or **designed to increase protective and/or decrease risk factors.**	Purpose of program is to provide **clinical intervention** appropriate to the individual and their stage of change.

Peer Recovery/Recovery Support Services

Recovery support programs that are designed to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery and offer social emotional and/or educational supportive services to help prevent relapse and promote recovery. These services are provided on an individual basis (through recovery coaches) or through a centralized location where services can be accessed by clients (through recovery centers):

Recovery coach – The position title given to a peer that provides recovery support services to individuals in formal treatment or during the post-treatment period.

Recovery center – Location in which recovery programming is designed and delivered, primarily by individuals in recovery, and house services that offer social, emotional and/or educational support to help prevent relapse and promote recovery.

Minimum Requirements for Peer Recovery and Recovery Support Programs are:

- Programs must promote and support the recovery of the participant
- Services must be included in the individual's recovery plan
- Ethics and confidentiality training for program leadership is required
- The PIHP must assure appropriate training of staff and peer leaders, and must assure program oversight based on guidelines established for developing this service (Treatment Technical Advisory #07)
- Community grant agreement funds cannot be used for services and costs that are not otherwise allowable under federal and state guidelines
- Community grant agreement funds cannot be used for recreational events

Case Management Services

A substance use disorder case management program coordinates, plans, provides, evaluates and monitors services or recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. It offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

Integrated Treatment Services

These services are accommodated by a program design that offers and provides both substance use disorder and mental health treatment in an integrated manner as evidenced by staffing, services and program content. The program is designed for individuals determined through an assessment process to have both distinct substance use and mental health disorders. Services must be provided through one service setting and through a single treatment plan and represent appropriate clinical standards including stage-based interventions.

Programs that focus primarily on one disorder but are able to address the interaction between the disorders and/or coordinate services with other providers do not require a service category license as an integrated treatment program and are not viewed as providing integrated treatment services.

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APPROVED BY: __*Signed*_____
Donald L. Allen, Director
Office of Drug Control Policy

TREATMENT POLICY #10

SUBJECT: Residential Treatment Continuum of Services

ISSUED: May 3, 2013

EFFECTIVE: May 3, 2013

PURPOSE:

The purpose of this policy is to establish the requirements for residential services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to support individualized services that maintain cultural, age, and gender appropriateness.

SCOPE:

This policy impacts the PIHP and its adult residential LOC service provider network.

BACKGROUND:

Residential treatment includes a wide variety of covered services with the provision of these services expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited in indicating what activities or services must be provided to clients in a residential program. They do indicate, however, that ten hours of scheduled activities, with two of those hours being formalized counseling, must take place each week.

At the time of their creation, these standards adequately met the needs of clients being served. In the time since the rules were promulgated, there have been many changes in the treatment field. The emergence of evidence-based best practices, the ASAM Patient Placement Criteria Second Edition – Revised (ASAM PPC-2R), and the stages-of-change models that have been developed. These changes have essentially left the administrative rules obsolete in the area of recommended services. This policy seeks to establish residential treatment criteria that will result in services that are provided in accordance with those outlined by ASAM, and are more reflective of services that have been shown to be effective in providing care to individuals receiving residential care.

Throughout the current residential level of services assessment, treatment planning, and recovery support preparations are required, and must be included in the authorized treatment services. Historically, residential services have been defined by length-of-stay, not by the needs of the client. This has resulted in essentially two descriptors for residential services:

- Short-term residential: less than 30 days in a program
- Long-term residential: 30 days or more in a program

This view of residential treatment has contributed to the expectation that all clients will equally benefit from the services being offered and resulted in clients with varying needs being admitted into the same program. This makes it more difficult to assure and provide services that are focused on addressing the individual needs of each client.

Definitions

Toxicology Screening - screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non-laboratory urinalysis).

Core Services - are defined as Treatment Basics, Therapeutic Interventions, and Interactive Education/Counseling. See the chart in the "Covered Services" section for further information.

Counseling - an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Crisis Intervention - a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher LOC if intervention is not provided.

Detoxification/Withdrawal Monitoring - monitoring for the purpose of preventing/alleviating medical complications related to no longer using, or decreasing the use of, a substance.

Face-to-Face - this interaction not only includes in-person contact, it may also include real-time video and audio linkage between a client and provider, as long as this service is provided within the established confidentiality standards for substance use disorder services.

Facilitates Transportation - assist the client, potential client, or referral source in arranging transportation to and from treatment.

Family Counseling - face-to-face intervention with the client and their significant other and/or traditional or non-traditional family members for the purpose of goal setting and achievement, as well as skill building. Note: in these situations, the identified client need not be present for the intervention.

Family Psychotherapy - face-to-face, insight-oriented interventions with the client and their significant other and/or traditional or non-traditional family members. Note: in these situations, the identified client need not be present for the intervention.

Group Counseling - face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

Group Psychotherapy - face-to-face, insight-oriented interventions with three or more clients.

Individual Assessment - face-to-face service for the purpose of identifying functional and treatment needs, and to formulate the basis for the Individualized Treatment Plan to be implemented by the provider.

Individual Counseling - face-to-face intervention for the purpose of goal setting and achievement, and skill building.

Individual Psychotherapy - face-to-face, insight-oriented interventions with the client.

Individual Treatment Planning - direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education - services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as a "didactic" education.

Interactive Education Groups - activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

Medical Necessity - treatment that is reasonable, necessary, and appropriate based on individualized treatment planning and evidence-based clinical standards.

Peer Support - individuals who have shared experiences of addiction and recovery, and offer support and guidance to one another in a treatment setting.

Psychotherapy - an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (MDLARA, Michigan Administrative Code, Social Work General Rules).

Recovery - a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (White, 2007).

Recovery Planning - purpose is to highlight and organize a person's goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

Recovery Support and Preparation - services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Referral/Linking/Coordination of Services - office-based service activity performed by a primary clinician, or other assigned staff, to address needs identified through the assessment, and/or to ensure follow through with access to outside services, and/or to establish the client with another substance use disorder service provider.

Substance Use Disorder - a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

REQUIREMENTS:

The residential levels of care from ASAM are established based on the needs of the client. As part of the purpose of this document, the short and long-term descriptors will no longer be used to describe residential services. PIHPs will need to have the capacity to provide a residential continuum that will meet the needs of clients at ASAM levels III.1, III.3, and III.5.–The frequency and duration of residential treatment services are expected to be guided by the ASAM levels of care, and are described as follows:

ASAM Level III.1 – Clinically Managed Low-Intensity Residential Services

These services are directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual in the worlds of work, education, and family life. Treatment services are similar to low-intensity outpatient services focused on improving the individual's functioning and coping skills in Dimension 5 and 6.

The functional deficits found in this population may include problems in applying recovery skills to their everyday lives, lack of personal responsibility, or lack of connection to employment, education, or family life. This setting allows clients the opportunity to develop and practice skills while reintegrating into the community.

ASAM Level III.3 – Clinically Managed Medium-Intensity Residential Services

These programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery. Services may be provided in a deliberately repetitive fashion to address the special needs of individuals who are often elderly, cognitively impaired, or developmentally delayed. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning.

The deficits for clients at this level are primarily cognitive, either temporary or permanent. The clients in this LOC have needs that are more intensive and therefore, to benefit effectively from services, they must be provided at a slower pace and over a longer period of time. The client's level of impairment is more severe at this level, requiring services be provided differently in order for maximum benefit to be received.

ASAM Level III.5 – Clinically Managed High-Intensity Residential Services

These programs are designed to treat clients who have significant social and psychological problems. Treatment is directed toward diminishing client deficits through targeted interventions. Effective treatment approaches are primarily habilitative in focus; addressing the client's educational and vocational deficits, as well as his or her socially dysfunctional behavior. Clients at this level may have extensive treatment or criminal justice histories, limited work and educational experiences, and antisocial value systems.

The length of treatment depends on an individual's progress. However, as impairment is considered to be significant at this level, services should be of a duration that will adequately address the many habilitation needs of this population. Very often, the level of impairment will limit the services that can actually be provided to the client resulting in the primary focus of treatment at this level being focused on habilitation and development, or re-development, of life skills. Due to the increased need for habilitation in this client population, the program will have to provide the right mix of services to promote life skill mastery for each individual.

ASAM LOC describe the need for treatment from the perspective of the level of impairment of the client; with the higher the level of impairment requiring the longer duration, slower more repetitive services. The identification of these needs is intended to assist with service selection and authorization for care. The placement of the client is based on the ASAM LOC determination. Due to the unique and complex nature of each client, it is recognized that not every client will "fit" cleanly into one level over another by just looking at the level of impairment. There may be situations where a case could be made for a client to receive services in each of these levels and each would be appropriate. In these situations, documentation should be made as to the rationale for the decision. In addition, variations in treatment that do not follow these guidelines should also be documented in the client record.

The cost of the service should not be the driving force behind the decision; the decision should be made based on what is most likely to help the client be successful in treatment and achieve recovery.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by a client:

Level of Care	Level III.1	Level III.3	Level III.5
Dimension 1 Withdrawal Potential	No withdrawal risk, or minimal/stable withdrawal; concurrently receiving Level I-D or Level II-D	Not at risk of severe withdrawal, or moderate withdrawal is manageable at Level III.2-D	At minimal risk of severe withdrawal at Levels III.3 or III.5. If withdrawal is present, it meets Level III.2-D criteria
Dimension 2 Medical conditions and complications	None or very stable; or receiving concurrent medical monitoring	None or stable; or receiving concurrent medical monitoring	None or stable; or receiving concurrent medical monitoring
Dimension 3 Emotional, behavioral, or cognitive conditions and complications	None or minimal; not distracting to recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required	Mild to moderate severity; needs structure to focus on recovery. If stable, a dual diagnosis capable program is appropriate. If not, a dual diagnosis-enhanced program is required. Treatment should be designed to respond to any cognitive deficits	Demonstrates repeated inability to control impulses, or a personality disorder that requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A dual diagnosis enhanced setting is required for the seriously mentally ill client
Dimension 4 Readiness to change	Open to recovery but needs a structured environment to maintain therapeutic gains	Has little awareness and needs interventions available only at Level III.3 to engage and stay in treatment; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)	Has marked difficulty engaging in treatment, with dangerous consequences; or there is high severity in this dimension but not in others. The client needs a Level I motivational enhancement program (Early Intervention)
Dimension 5 Relapse, continued use, or continued problem potential	Understands relapse but needs structure to maintain therapeutic gains	Has little awareness and needs intervention only available at Level III.3 to prevent continued use, with imminent dangerous consequences because of cognitive deficits or comparable dysfunction	Has no recognition of skills needed to prevent continued use, with imminently dangerous consequences
Dimension 6 Recovery/living environment	Environment is dangerous, but recovery achievable if Level III.1 24-hour structure is available	Environment is dangerous and client needs 24-hour structure to cope	Environment is dangerous and client lacks skills to cope outside of a highly structured 24-hour setting

PROCEDURE:

Admission Criteria

Admission to residential treatment is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis) – the diagnostic impression must include all five axes. The diagnosis will be confirmed by the provider's assessment process.
- Individualized determination of need.
- ASAM PPC-2R is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the current ASAM PPC-2R below:

  7) Withdrawal potential.
  8) Medical conditions and complications.
  9) Emotional, behavioral, or cognitive conditions and complications.
  10) Readiness to change – as determined by the Stages of Change Model.
  11) Relapse, continued use or continued problem potential.
  12) Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development.

Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM PPC-2R. As a client's needs change, the frequency, and/or duration, of services may be increased or decreased as medically necessary. Client participation in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

Service Requirements

The following chart details the required amount of services that have been established for residential treatment in the three levels of care. Documentation of all core services, and the response to them by the client, must be found in the client's chart. In situations where the required services cannot be provided to a client in the appropriate frequency or quantity, a justification must also be documented in the client record.

Level of Care	Minimum Weekly Core Services	Minimum Weekly Life Skills/Self Care
ASAM III.1 Clients with lower impairment or lower complexity of needs	At least 5 hours of clinical services per week	At least 5 hours per week
ASAM III.3 Clients with moderate to high impairment or moderate to high complexity of needs	Not less than 13 hours per week	Not less than 13 hours per week
ASAM III.5 Clients with a significant level of impairment or very complex needs	Not less than 20 hours per week	Not less than 20 hours per week

Covered Services

The following services must be available in a residential setting regardless of the LOC and based on individual client need:

Type	Residential Services Description
Basic Care	Room, board, supervision, self-administration of medications monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery-oriented.
Treatment Basics **Core Service**	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services; preparation for 'next step'.
Therapeutic Interventions **Core Service**	Individual, group, and family psychotherapy services appropriate for the individual's needs, and crisis intervention. Services provided by an appropriately licensed, credentialed, and supervised professional working within their scope of practice.
Interactive Education /Counseling **Core Service**	Interaction and teaching with client(s) and staff to process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Examples: disease of addiction, mental health, and substance use disorder.
Life Skills/Self-Care (building recovery capital)	Social activities that promote healthy community integration/ reintegration; development of community supports, parenting, employment, job readiness, how to use public transportation, hygiene, nutrition, laundry, education.
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; family visits; treatment coordination; support groups; drug/alcohol free campus.

Treatment Planning/Recovery Planning

Clients entering any level of residential care will have recovery and functional needs that will continue to require intervention once residential services are no longer appropriate. Therefore, residential care should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the client. Residential care should not be presented to clients as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once the residential stay is over.

To make the transition to the next LOC, the residential care provider may assist the client in choosing an appropriate service based on needs and location scheduling appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the residential provider arrange for any needed assistance to ensure a seamless transfer to the next LOC.

Continuing Stay Criteria

Re-authorization or continued treatment should be based on ASAM PPC-2R Continued Service Criteria, medical necessity, and a reasonable expectation of benefit from continued care.

Continuing stay can be denied in situations where the client has decided not to participate in his/her treatment. This is evidenced by continued non-compliance with treatment activities, other behavior that is deemed to violate the rules and regulations of the program providing the services, or a demonstrated lack of benefit from treatment received, after documented attempts to meet the needs of the client, by adjusting the services, were made. Progress notes must support lack of benefit, and that other appropriate services have been offered, before a client can be terminated from a treatment episode.

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STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

DATE: August 25, 2009

TO: All Regional Substance Abuse Coordinating Agencies

FROM: Deborah J. Hollis, Acting Director
Office of Drug Control Policy (ODCP)

SUBJECT: Treatment Policy #11: *Fetal Alcohol Spectrum Disorders*

Attached is a final copy of Treatment Policy #11: *Fetal Alcohol Spectrum Disorders* (FASD). The purpose of this treatment policy is to provide guidance to the publicly funded substance abuse system regarding the requirement for FASD prevention and the pre-screening of children for FASD. This policy establishes the standards and expectations that were identified in Treatment Technical Advisory #4: *Fetal Alcohol Spectrum Disorder*, as contract requirements for Fiscal Year 2010.

ODCP received two comments from the field in response to the draft policy. The only change made was a revision to add a recommendation for programs serving men with children, that they be given consideration to include FASD prevention education within the treatment setting. Otherwise, there have been no other changes to the content of this document; it just seeks to move it from advisory status to policy status.

Comments and/or questions can be directed to Joyce Washburn at washburnjoy@michigan.gov or by phone at (517) 335-5247.

DJH:ssb

Attachment

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TREATMENT POLICY # 12

SUBJECT: **Women's Treatment Services**

ISSUED: **September 30, 2010**

EFFECTIVE: **October 1, 2010**

PURPOSE:

The purpose of this policy is to establish the philosophy and requirements for women's treatment services (designated women's programs and gender competent programs).

SCOPE

This policy impacts the PIHP, its designated women's programs, and gender competent service provider network.

BACKGROUND

The Substance Abuse Prevention and Treatment (SAPT) Block Grant requires states to spend a set minimum amount each year for treatment and ancillary services for eligible women. Eligible women have been defined as, "pregnant women and women with dependent children, including women who are attempting to regain custody of their children." (42 U.S.C. 96.124 [e])

Pregnant women are identified as a priority population under the SAPT Block Grant regulations. Michigan Public Act 368 of 1978, part 62, section 333.6232, identifies "a parent whose child has been removed from the home under the child protection laws of this state or is in danger of being removed from the home under the child protection laws of this state because of the parent's substance abuse," as a priority population for substance use disorder services above others with substantially similar clinical conditions.

Michigan law extends priority population status to men whose children have been removed from the home or are at danger of being removed under the child protection laws. To support their entrance into and success in treatment, men who are shown to be the primary caregivers for their children are also eligible to access ancillary services such as child care, transportation, case management, therapeutic interventions for children, and primary medical and pediatric care, as defined by 45 CFR Part 96.

In August 2008, the National Association of State Alcohol and Drug Abuse Directors and the Women's Services Network (WSN), comprised of representatives from all 50 states, produced a document for the field entitled, *Guidance to States: Treatment Standards for Women with Substance Use Disorders*. This document is based on the knowledge and experience of the WSN

members. Its purpose is to improve substance use disorder treatment services to women through the establishment of standards that build on the capabilities, strengths and creativity of state systems and provider networks.

To be able to offer services that are gender and culturally competent, it is important to understand the client and their environment, and embrace values that promote the best services possible to the population. Successful recovery for women requires that the service delivery system integrates substance use disorder treatment, mental health services, recovery supports and, frequently, treatment for past traumatic events. When it is left to the woman seeking treatment to integrate these services, an unnecessary burden is placed on her and her potential for recovery.

To meet the specific needs of women, successful programs begin with an understanding of the emotional growth of women. Current thinking describes a woman's development in terms of the range of relationships in which a woman can engage. This is very different from the theories of emotional growth, which have been the basis of substance use disorder treatment, and which apply to the psychological growth of men. The relationship theories for women suggest that the best context for stimulating emotional growth comes from an immersion in empathic, mutual relationships.

The strongest impetus for women seeking treatment is problems in their relationships, especially with their children. A woman's self-esteem is often based on her ability to nurture relationships. Her motivation and willingness to continue treatment is likely to be fueled by her desire to become a better mother, partner, daughter, etc. Programs that meet the needs of women acknowledge this desire to preserve relationships as strength to be built upon, rather than as resistance to treatment. When a program operates from this theoretical point of view, the characteristics of the clinical treatment program, and its objectives and measures of success are defined very differently from those of traditional treatment programs.

Vision

To implement a change in the practice of women's substance use disorder treatment providers and system transformation in Michigan. This will be accomplished by having a strength-based coordinated system of care, driven by a shared set of core values that is reflected and measured in the way we interact with, and deliver supports and services for families who require substance abuse, mental health, and child welfare services.

Core Values

- Family-Centered: A family centered approach means that the focus is on the family, as defined by the client themselves. Families are responsible for their children and are respected and listened to as we support them in working toward meeting their needs, reducing system barriers, and promoting changes that can be sustained over time. The goal of a family-centered team and system is to move away from the focus of a single client

represented in a system, to a focus on the functioning, safety and wellbeing of the family as a whole.

♦ Family Involvement: The family's involvement in the process is empowering and increases the likelihood of cooperation, ownership and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives, including decisions made about their service plans. It is important to recognize that a woman defines her own family and that this definition may not be traditional.

♦ Build on Natural and Community Supports: Recognize and utilize all resources in our communities creatively and flexibly, including formal and informal supports and service systems. Every attempt should be made to include the family's relatives, neighbors, friends, faith community, co-workers or anyone the family would like to include in the team process. Ultimately families will be empowered and have developed a network of informal, natural, and community supports so that formal system involvement is reduced or not needed at all.

♦ Strength-Based: Strength-based planning builds on the family's unique qualities and identified strengths that can then be used to support strategies to meet the family's needs. Strengths should also be found in the family's environment through their informal support networks, as well as in attitudes, values, skills, abilities, preferences and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs emerge, with strategies discussed and implemented.

♦ Unconditional Care: Means that we care for the family, not that we will care "if." It means that it is the responsibility of the service team to adapt to the needs of the family – not of the family to adapt to the needs of a program. If difficulties arise, the individualized services and supports change to meet the family's needs.

♦ Collaboration Across Systems: An interactive process in which people with diverse expertise, along with families, generate solutions to mutually defined needs and goals building on identified strengths. All systems working with the family have an understanding of each other's programs and a commitment and willingness to work together to assist the family in obtaining their goals. The substance use disorder, mental health, child welfare and other identified systems collaborate and coordinate a single system of care for families involved within their services.

♦ Team Approach Across Agencies: Planning, decision-making and strategies rely on the strengths, skills, mutual respect, and creative and flexible resources of a diversified, committed team. Team member strengths, skills, experience and resources are utilized to select strategies that will support the family in meeting their needs. Team members may include representatives from the multiple agencies a family is involved in, as well as any who offer support and resources to families. All family, formal and informal team

members share responsibility, accountability, and authority; while understanding and respecting each other's strengths, roles and limitations.

♦ Ensuring Safety: When Children's Protective Services, foster care agencies, or domestic violence shelters are involved, the team will maintain a focus on family and child safety. Consideration will be given to whether the identified threats to safety are still in effect, whether the child is being kept safe by the least intrusive means possible and whether the safety services in place are effectively controlling those threats. In situations involving domestic violence, the team will need to work with the family to develop and maintain a viable safety plan.

♦ Gender/Age/Culturally Responsive Treatment: Services reflect an understanding of the issues specific to gender, age, disability, race, ethnicity and sexual orientation, and also reflect support, acceptance, and understanding of cultural and lifestyle diversity.

♦ Self-sufficiency: Families will be supported, resources shared and team members held responsible for achieving self-sufficiency in essential life domains (including, but not limited to safety, housing, employment, financial, educational, psychological, emotional and spiritual).

♦ Education and Work Focus: Dedication to positive, immediate and consistent education, employment and or employment-related activities that result in resiliency and self-sufficiency, improved quality of life for self, family and the community.

♦ Belief in Growth, Learning and Recovery: Family improvement begins by integrating formal and informal supports that instill hope and are dedicated to interacting with individuals with compassion, dignity and respect. Team members operate from a belief that every family desires change and can take steps toward attaining a productive and self-sufficient life.

♦ Outcome Oriented: From the onset of family team meetings, levels of personal responsibility and accountability for all team members, both formal and informal supports, are discussed, agreed upon and maintained. Identified outcomes are understood and shared by all team members. Legal, education, employment, child-safety and other applicable mandates are considered in developing outcomes. Progress is monitored and each team member participates in defining success. Selected outcomes are standardized, measurable and based on the life of the family and its individual members.

DEFINITIONS

Care Management/Care Coordination: An administrative function performed at the PIHP or through the access system, allowable under Medicaid, which manages an episode of care.

Case Management: A substance use disorder program that coordinates, plans, provides, evaluates and monitors services or recovery, from a variety of resources, on behalf of, and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process.

Eligible: Pregnant women and women with dependent children, including women who are attempting to regain custody of their children.

Gender Competent: Capacity to identify where difference on the basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population.

Gender-Responsiveness (Designated Women's Program): Creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of the lives of women and girls, and that addresses and responds to their strengths and challenges. (Bloom and Covington, 2000)

REQUIREMENTS AND PROCEDURE

The Michigan Department of Health & Human Services (MDHHS) is dedicated to the following fundamental principles as the foundation for integrating women-specific substance use disorder treatment services and non-gender specific services, while focusing on effective and comprehensive treatment of women and their families.

Developing a Philosophy of Working with Women who have Substance Use Disorders

Program Structure:

1. Treatment revolves around the role women have in society, therefore treatment services must be gender specific.
   - Gender-responsive programs are not simply "female only" programs that were designed for males.
   - A woman's sense of self develops differently in women-specific groups as opposed to co-ed groups.
   - Because women place so much value on their role in society and relationships, to not take this into consideration in the recovery process is to miss a large component of a woman's identity.
   - Equality does not mean sameness; in other words, equality of service delivery is not simply about allowing women access to services traditionally reserved for men. Equality must be defined in terms of providing opportunities that are relevant to each gender so that treatment services may appear very different depending on to whom the service is being delivered.

- The unique needs and issues (e.g., physical/sexual/emotional victimization, trauma, pregnancy and parenting) of women should be addressed in a safe, trusting and supportive environment.
- Treatment and services should build on women's strengths/competencies and promote independence and self-reliance.

2. A relational model, based on the psychological growth of women shall be the foundation for recovery (e.g., the Self-in-Relation model). The recognition that, for women, the primary experience of self is relational; that is, the self is organized and developed in the context of important relationships. (Surrey, 1985)
   - A model that emphasizes the importance of relationships in a woman's life, and attempts to address the strengths as well as the problems arising for women from a relational orientation.

3. A collaborative philosophy, driven by the woman and her family, shall be used.
   - Utilizing cross-systems collaboration and the involvement of informal supports to promote a woman's recovery.
   - A client-centered, goal-oriented approach to accessing and coordinating services across multiple systems by:
     1. assessing needs, resources and priorities,
     2. planning for how the needs can be met,
     3. establishing linkages to enhance a woman's access to services to meet those identified needs,
     4. coordinating and monitoring service provision through active cross-system communication and coordinated treatment/service plans, and
     5. removing barriers to treatment and advocating for services.
   - A woman's needs determine the connections with agencies and systems that impact her life or her family's life, despite the number of agencies or systems involved.
   - Ideally, each woman will have a single, collaborative treatment plan or service plan used across systems. When this is not possible, coordination of as many systems as possible will lessen the confusion and stress this creates in a woman's life.
   - Care coordination and case management are the key to a woman's progress in recovery.

4. A model of empowerment is utilized in treatment and recovery planning.
   - The client is shown and taught how to access services, advocate for herself and her family, and request services that are of benefit to her and her family.
   - This process is woven into recovery, and could be taught by a recovery coach or case manager.
   - The ultimate goal for the service system is to weave the woman so well into the informal support systems that the role of formal services is very small or not needed at all.

5. Employment is recommended as an important component in recovery and serves as an important therapeutic tool.

- The structure of work is a benefit to recovery, and treatment providers need to be aware of the work requirements of Temporary Assistance for Needy Families/Work First. Historically, treatment providers have been reluctant to encourage clients to return to work or engage in work related activities during the early stages of recovery. However, waiting to address employment concerns may create further challenges for the client facing Work First requirements.

6. A multi-system approach that is culturally aware shall be employed in the recovery process.
   - Gender specificity and cultural competence go hand-in-hand. There are a number of gender and cultural competencies that allow people to assist others more effectively. This requires a willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable people of and from the community.

Education/Training of Staff:

In addition to current credentialing standards, individuals working and providing direct service within a designated women's program (gender responsive) must have completed a minimum of 12 semester hours, or the equivalent, of gender specific substance use disorder training or 2080 hours of supervised gender specific substance use disorder training/work experience within a designated women's program. Those not meeting the requirements must be supervised by another individual working within the program, and be working towards meeting the requirements. Documentation is required to be kept in personnel files.

Those working and providing direct service within a gender competent program must have completed a minimum of 8 semester hours, or the equivalent, of gender specific substance use disorder training or 1040 hours of supervised gender specific substance use disorder training. Those not meeting the requirements must be supervised by another individual working within the program, and be working towards meeting the requirements. Documentation is required to be kept in personnel files. Other arrangements can be approved by the Office of Recovery Oriented Systems of Care (OROSC) Women's Treatment Coordinator.

Appropriate topics for gender specific substance use disorder training include, but are not limited to:

- Women's studies
- Trauma
- Grief
- Relationships
- Parenting
- Child Development
- Self-esteem/empowerment
- Relational treatment model
- Women in the criminal justice system
- Women and addiction

Admissions:

PIHPs and treatment providers must follow the priority population guidelines identified in the MDHHS/OROSC contract with PIHPs, listed below, for admitting women to treatment:

Population	Admission Requirement	Interim Service Requirement
Pregnant Injecting Drug User	1) Screened and referred within 24 hours. 2) Detoxification, methadone or residential – offer admission within 24 business hours. Other Levels of Care – offer admission within 48 business hours.	**Begin within 48 hours:** 1. Counseling and education on: a. HIV and TB. b. Risks of needle sharing. c. Risks of transmission to sexual partners and infants. d. Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early Intervention Clinical Services.
Pregnant with Substance Use Disorder	1) Screened and referred within 24 hours. 2) Detoxification, methadone or residential – offer admission within 24 business hours. Other Levels of Care – offer admission within 48 business hours.	**Begin within 48 hours:** 1. Counseling and education on: a. HIV and TB. b. Risks of transmission to sexual partners and infants. c. Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early Intervention Clinical Services.
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	**Begin within 48 hours – maximum waiting time 120 days:** 1. Counseling and education on: a. HIV and TB. b. Risks of needle sharing. c. Risks of transmission to sexual partners and infants. 2. Early Intervention Clinical Services.
Parent at Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	**Begin within 48 business hours:** Early Intervention Clinical Services.
All Others	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	**Not Required.**

* The full table can be found in the MDHHS/OROSC contract with PIHPs.

The admission standards listed above should be considered minimum standards. Those CAs and programs interested in providing the best possible treatment to families should be meeting a higher standard for admission and interim service provision.

Treatment:

Programs that are designed to meet women's needs tend to be more successful in retaining women clients. For a provider to be able to offer women-specific treatment, its programs shall include the following criteria:

1. Accessibility

CAs and providers must demonstrate a process to reduce barriers to treatment by ensuring that priority population requirements are met, as well as providing ancillary services or ensuring that appropriate referrals to other community agencies are made.

- There are many barriers that may critically inhibit attendance and follow-through for women with children. They may include child care, transportation, hours of operation and mental health concerns.

2. Assessment

Assessment shall be a continuous process that evaluates the client's psychosocial needs and strengths within the family context, and through which progress is measured in terms of increased stabilization/functionality of the individual/family. In addition, all assessments shall be strength-based.

- Women with children need to be assessed and treated as a unit. Women often both enter and leave treatment because of their children's needs. By assessing the family and addressing areas that need strengthening, providers give women a better chance at becoming stable in their recovery.

3. Psychological Development

Providers shall demonstrate an understanding of the specific stages of psychological development and modify therapeutic techniques according to client needs, especially to promote autonomy.

- Many of the traditional therapeutic techniques reinforce women's guilt, powerlessness and "learned helplessness," particularly as they operate in relationships with their children and significant others.

4. Abuse/Violence/Trauma

Providers must develop a process to identify and address abuse/violence/trauma issues. Services will be delivered in a trauma-informed setting and provide safety from abuse, stalking by partners, family, other participants, visitors and staff.

- A history of abuse, violence and trauma often contributes to the behavior of substance abusing and dependent women. A provider who does not take this history into consideration when treating the woman is not fully addressing the addiction or resulting behaviors.

5. Family Orientation

Providers must identify and address the needs of family members through direct service, referral or other processes. Families are a family of choice defined by the clients themselves.

Agencies will include informal supports in the treatment process when it is in the best interest of the client.

- Many women present in a family context with major family ties and responsibilities that will continue to define their sense of self. Drug and alcohol use in a family puts children at risk for physical and emotional growth and developmental problems. Early identification and intervention for the children's problems is essential.

6. Mental Health Issues

Providers must demonstrate the ability to identify concurrent mental health disorders, and develop a process to have the treatment for these disorders take place, in an integrated fashion, with substance use disorder treatment and other health care. It is important to note that treatment for both mental health issues and substance use disorders may lead to the use of medication as an adjunct to treatment.

- Women with substance abuse problems often present with concurrent mood disorders and other mental health problems.

7. Physical Health Issues

Providers shall:

- inquire about health care needs of the client and her children, including completing the Fetal Alcohol Syndrome Disorder screening as appropriate (MDHHS/OROSC Treatment Policy #11, 2009),
- make appropriate referrals, and
- document client and family health needs, referrals, and outcomes.
    - Women with a substance use disorder and their children are at high risk for significant health problems. They are at a greater risk for communicable diseases such as HIV, TB, hepatitis and sexually transmitted diseases. Prenatal care for women using/abusing substances is especially important, as their babies are at risk for serious physical, neurological and behavioral problems. Early identification and intervention for children's physical and emotional growth and development, and for other health issues in a family is essential.

8. Legal Issues

Providers shall document each client's compliance and facilitate required communication to appropriate authorities within the guidelines of federal confidentiality laws. Additionally, programs will individualize treatment in such a way as to help a client manage compliance with legal authorities.

- Women entering treatment may be experiencing legal problems including custody issues, civil actions, criminal charges, probation and parole. This adds another facet to the treatment and recovery planning process and reinforces the need for case management associated with women's services. By helping a woman identify her legal issues, steps that need to be taken, and how to incorporate this information into goals for her individualized treatment plan, a provider can greatly reduce stress on the client and make this type of challenge seem more manageable.

9. Sexuality/Intimacy/Exploitation

Providers shall:

- conduct an assessment that is sensitive to sexual abuse issues,
- demonstrate competence to address these issues,
- make appropriate referrals,
- acknowledge and incorporate these issues in the recovery plan, and
- assure that the client will not be exposed to exploitive situations that continue abuse patterns within the treatment process (co-ed groups are not recommended early in treatment, physical separation of sexes is recommended in residential treatment settings).
    - A high rate of treatment non-compliance among females with substance use disorders, with a history of sexual abuse, has been documented. The frequent incidence of sexual abuse among women with substance use disorders necessitates the inclusion of questions specifically related to the topic during the initial evaluation (assessment) process. Lack of recognition of a sexual abuse history or improper management of disclosure can contribute to a high rate of non-compliance in this population.

10. Survival Skills

Providers must identify and address the client's needs in the following areas, including but not limited to:

- Education and literacy.
- Job readiness and job search.
- Parenting skills.
- Family planning.
- Housing.
- Language and cultural concerns.
- Basic living skills/selfcare.

The provider shall refer the client to appropriate services and document both the referrals and outcomes.

- Women's treatment is often complicated by a variety of problems that must be addressed and integrated into the therapeutic process. Many of these problems may be addressed in the community, utilizing community resources, which will in turn help the client build a supportive relationship with the community.

11. Continuing Care/Recovery Support

Providers shall:

- develop a recovery/continuing care plan with the client to address and plan for the client's continuing care needs,
- make and document appropriate referrals as part of the continuing care/recovery plan, and
- remain available to the client as a resource for support and encouragement for at least one year following discharge.
    - In order for a woman to maintain recovery after treatment, she needs to be able to retain a connection to treatment staff or case managers, and receive support from appropriate services in the community.

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