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

Agreement Between
Michigan Department of Health & Human Services
And
CMHSP_____
For
Managed Mental Health Supports and Services

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 managed mental health supports and services is identified in the annual Legislative Appropriation for community mental health services programs. Payment to the CMHSP will be paid based on the funding amount specified in Part II, Section 7.0 of this contract. The 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: Contractual Services Terms and Conditions; (b) Part II: Statement of Work; and (c) all Attachments as specified in Parts I and II 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 & Human Services

_____ _____
Kim Stephen, Director Date
Bureau of Budget and Purchasing

For the CONTRACTOR:

_____ _____
Name (print) Title (print)

_____ _____
Signature Date

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DEFINITIONS/EXPLANATION OF TERMS

1.0 DEFINITION 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. Any reference to Medicaid, CMS or medical necessity is limited in application to the Children's Waiver and SED Waiver programs administered by the CMHSP as part of this contract.

Appropriations Act: The annual Appropriations Act adopted by the State Legislature that governs Michigan Department of Health & Human Services (MDHHS) funding.

Categorical Funding: Funding or funds as applicable that are (1) designated by the state legislature in the Appropriations Act for a specific purpose, project, and/or target population or so designated by the MDHHS; and (2) identified as Categorical Funds in the contract.

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.

Cultural Competency: 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 towards better meeting the needs of minority populations.

Customer: In this contract, customer includes all people located in the defined service area who are or may potentially receive services.

Developmental Disability: Means either of the following:

1. If applied to an individual older than five years, a severe, chronic condition that meets all of the following requirements:
    A. Is attributable to a mental or physical impairment or a combination of mental and physical impairments
    B. Is manifested before the individual is 22 years old.
    C. Is likely to continue indefinitely.
    D. Results in substantial functional limitations in three or more of the following areas of major life activities:
        1.self-care;
        2.receptive and expressive language;
        3.learning, mobility;
        4.self-direction;
        5.capacity for independent living;
        6.economic self-sufficiency.
    E. Reflects the individual's need for a combination and sequence of special, inter-

disciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

2. 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 developmental disability as defined in item 1 if services are not provided.

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 health care information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper based, and mandates "best effort" compliance.

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. Park 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 Acts 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 Eligible: An individual who has been determined to be eligible for Medicaid and who has been issued a Medicaid card.

Mental Health Crisis Situation: A situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following apply:

1. The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.
2. The individual is unable to provide himself or herself with food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
3. The individual's judgment is so impaired that he or she is unable to understand the need for treatment and, in the opinion of the mental health professional, his or her continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

Persons with Limited English Proficiency (LEP): Individuals, who cannot speak, write, read or understand the English language at a level that could restrict access to services.

Policy Manuals of the Medical Assistance Program: The Michigan Department of Health & 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 policy manual of the Medical Assistance Program. The Medicaid manual is referenced in this contract when a particular policy is intended to be followed for non-Medicaid individuals served in the Children's Waiver, and MI Child.

Practice Guideline: MDHHS-developed guidelines for 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. MDHHS guidelines issued prior to June 2000 were called “Best Practice Guidelines.” All guidelines are now referred to as Practice Guidelines.

Serious Emotional Disturbance: 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: 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. The following disorders are included only if they occur in conjunction with another diagnosable serious mental illness:

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

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

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

Urgent Situation: A situation in which an individual is determined to be at risk of experiencing a mental health crisis situation in the near future if he or she does not receive care, treatment, or support services.

PART I: CONTRACTUAL SERVICES TERMS AND CONDITIONS

1.0 PURPOSE

The Michigan Department of Health & Human Services (MDHHS), hereby enters into a contract with the CMHSP identified on the signature page of this contract. The purpose of this contract is to obtain the services of the CMHSP to manage and provide a comprehensive array of mental health services and supports as indicated in this contract.

2.0 ISSUING OFFICE

This contract is issued by the Michigan Department of Health & 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 CMHSP to the attention of the Director of MDHHS's Bureau of Community Mental Health 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 & 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 J. Renwick, Director
Bureau of Community Based Services
Department of Health & Human Services
5th Floor – Lewis Cass Building
320 South Walnut
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 C 7.0.1 and other changes agreed upon by the parties for no more than three (3) one-year extensions after September 30, 2016. 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 7.0 "Contract Financing", and authorized payments are described in Attachment C 7.0.1 to this contract.

6.0 LIABILITY

6.1 Cost Liability

The MDHHS assumes no responsibility or liability for costs under this contract incurred by the CMHSP prior to October 1, 2015. Total liability of the MDHHS is limited to the terms and conditions of this contract.

6.2 Contract Liability

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 CMHSP under this contract shall be the responsibility of the CMHSP, 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 CMHSP, its employees, officers or agent. Nothing herein shall be construed as a waiver of any governmental immunity for the County(ies), the CMHSP, 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 CMHSP 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 CMHSP 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 CMHSP's ability to continue service delivery at the current level. This includes actions filed in courts or governmental regulatory agencies.

7.0 CMHSP RESPONSIBILITIES

The CMHSP shall be 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. The CMHSP is responsible for complying with all reporting requirements as specified in this contract. Data reporting requirements are specified in Part II, Section 6.5 of the contract. Finance reporting requirements are specified in Part II, Section 7.8. Additional requirements are identified in Attachment C 7.0.2 (Performance Objectives).

7.1 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 CMHSPs 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 CMHSP shall implement a written policy that requires the CMHSP and its provider network to use, accept, and honor the standard release form that was created by MDHHS under Public Act 129 of 2014.

8.0 ACKNOWLEDGMENT OF MDHHS FINANCIAL SUPPORT

The CMHSP shall reference the MDHHS as providing financial support in publications including annual reports and informational brochures.

9.0 DISCLOSURE

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

10.0 CONTRACT INVOICING AND PAYMENT

MDHHS funding obligated through this contract includes both state and federal funds, which the state is responsible to manage. Detail regarding the MDHHS financing obligation is specified in Part II, Section 7.0 of this contract and in Attachment C 7.0.1 to this contract. Invoicing for PASARR is addressed in Attachment C 4.5.1, the PASARR Agreement.

11.0 LITIGATION

The state, its departments, and its agents shall not be responsible for representing or defending the CMHSP, the CMHSP's personnel, or any other employee, agent or sub-contractor of the CMHSP, named as a defendant in any lawsuit or in connection with any tort claim. The MDHHS and the CMHSP 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 CMHSP shall submit annual litigation reports to MDHHS, providing the following detail for all civil litigation that the CMHSP, sub-contractor, or the CMHSP's insurers or insurance agents are parties to:

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.

12.0 CANCELLATION

Material Default

The MDHHS may cancel this contract for material default of the CMHSP. Material default is defined as the substantial failure of the CMHSP to meet CMHSP certification requirements as stated in the Michigan Mental Health Code (Section 232a) or other Mental Health Code mandated provisions. In case of material default by the CMHSP, the MDHHS may cancel this contract without further liability to the state, its departments, agencies, or employees and

procure services from other CMHSPs or other providers of mental health services that the department has determined can operate in compliance with applicable standards and are capable of maintaining the delivery of services within the county or counties.

In canceling this contract for material default, the MDHHS shall provide written notification at least ninety (90) days prior to the cancellation date of the MDHHS intent to cancel this contract to the CMHSP and the relevant County(ies) Board of Commissioners. The CMHSP may correct the problem during the ninety (90) day interval, in which case cancellation shall not occur. In the event that this contract is canceled, the CMHSP 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 CMHSP responsible for providing the required local match funding. The transition plan shall set forth the process and time frame for the transition. The CMHSP 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 the MDHHS. The CMHSP will cooperate with the 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 CMHSP's responsibility to the new contractor.

13.0 CLOSEOUT

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

A. Within 45 days (interim), and 90 days (final), following the end date imposed by Part I, Section 12.0, the CMHSP shall provide to the MDHHS, all financial, performance and other reports required by this contract.

B. Payment for any and all valid claims for services rendered to covered recipients prior to the effective end date shall be the CMHSP's responsibility, and not the responsibility of the MDHHS.

C. The portion of all reserve accounts maintained by the CMHSP that were funded with MDHHS funds and related interest are owed to the MDHHS within 90 days, less amounts needed to cover outstanding claims or liabilities unless otherwise directed in writing by the MDHHS.

D. Reconciliation of equipment with a value exceeding $5,000, purchased by the CMHSP within the last two fiscal years, will occur as part of settlement of this contract. The CMHSP 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 GF funds used to purchase each item, and also whether or not the equipment is required by the CMHSP as part of continued service provision to the continuing service population. The MDHHS will provide written notice within 90 days or less of any needed settlements concerning the portion of funds ending. If the CMHSP disposes of the equipment, the appropriate portion of the value must be returned to the MDHHS (or used to offset costs in the final financial report).

E. All earned carry-forward funds and savings from prior fiscal years that remain unspent as of the end date, must be returned to the MDHHS within 90 days. No carry-forward funds or savings as provided in Part II, Section 7.7.1 and 7.7.1.1, can be earned during the year this contract ends, unless specifically authorized in writing by the MDHHS.

F. All financial, administrative and clinical records under the CMHSP'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 directed otherwise in writing by the MDHHS.

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

14.0 CONFIDENTIALITY

Both the MDHHS and the CMHSP shall assure that services and supports to and information contained in the records of people served under this agreement, or other such recorded information required to be held confidential by federal or state law, rule or regulation, in connection with the provision of services or other activity under this agreement shall be privileged communication, shall be held confidential, and shall not be divulged without the written consent of either the recipient or a person responsible for the recipient, except as may be otherwise required by applicable law or regulation. Such information may be disclosed in summary, statistical, or other form, which does not directly or indirectly identify particular individuals.

15.0 ASSURANCES

The following assurances are hereby given to the MDHHS:

15.1 Compliance with Applicable Laws

The CMHSP will comply with applicable federal and state laws, guidelines, rules and regulations in carrying out the terms of this agreement.

15.2 Anti-Lobbying Act

With regard to any federal funds received or utilized under this agreement, the CMHSP 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 104-208). Further, the CMHSP shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including sub-contracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

15.3 Non-Discrimination

In the performance of any contract or purchase order resulting here from, the CMHSP 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 CMHSP further agrees that every sub-contract 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 sub-contractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 P.A. 453, as amended, MCL 37.2201 et seq, and the Persons with Disabilities Civil Rights Act, 1976 P.A. 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 CMHSP shall incorporate language in all contracts awarded: (1) prohibiting discrimination against minority-owned, women-owned, and handicapper-owned businesses in sub-contracting; and (2) making discrimination a material breach of contract.

15.4 Debarment and Suspension

With regard to any federal funds received or utilized under this agreement, assurance is hereby given to the MDHHS that the CMHSP 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 sub-contractors:

A. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or CMHSP;

B. 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;

C. 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 B, and;

D. 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.

15.5 Federal Requirement: Pro-Children Act

Assurance is hereby given to the MDHHS that the CMHSP 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 CMHSP also assures that this language will be included in any sub-awards, which contain provisions for children's services.

15.6 Hatch Political Activity Act and Inter-governmental Personnel Act

The CMHSP will comply with the Hatch Political Activity Act, 5 USC 1501-1508, 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. 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.

15.7 Limited English Proficiency

The CMHSP 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.

15.8 Health Insurance Portability and Accountability Act

To the extent that this act is pertinent to the services that the CMHSP provides to the MDHHS, the CMHSP assures that it is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements currently in effect and will be in compliance by the time frames specified in the HIPAA regulations for portions not yet in effect.

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

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

16.0 MODIFICATIONS, CONSENTS AND APPROVALS

This contract will not be modified, amended, extended, or augmented, except by a writing 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.

17.0 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. Michigan Mental Health Code and Administrative Rules
C. Michigan Public Health Code and Administrative Rules
D. MDHHS Appropriations Act in effect during the contract period
E. Approved Children's Waiver, corresponding CMS conditions, Medicaid Policy Manuals and subsequent publications
F. All other pertinent federal and state statutes, rules and regulations
G. All final MDHHS guidelines, final technical requirements as referenced in the contract - Additional guidelines and technical requirements may be added as provided for in Part I, Section 16.0 of this contract.

In the event of any conflict over the interpretation of the specifications, terms, and conditions indicated by the MDHHS and those indicated by the CMHSP, the dispute resolution process in included in Part I, Section 18.0 of this contract will be utilized.

This contract supersedes all proposals or prior agreements, oral or written, and all other communications pertaining to the purchase of mental health supports and services for the non-Medicaid population between the parties.

18.0 DISPUTE RESOLUTION

Disputes by the CMHSP 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 CMHSP desires to pursue the dispute, the CMHSP shall request that the dispute be resolved through the dispute resolution process. This process shall involve a meeting between agents of the CMHSP and the MDHHS. The MDHHS Deputy Director of Behavioral Health and Developmental Disabilities Administration will identify the appropriate Deputy Director(s) or other department representatives to participate in the process for resolution. The Deputy Director may handle disputes involving financial matters unless the MDHHS Director has delegated these duties to the Administrative Tribunal.

The CMHSP shall provide written notification requesting the engagement of the dispute resolution process. In this written request, the CMHSP 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 CMHSP request. The Deputy Director shall provide the CMHSP 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 CMHSP regarding the action being disputed by the CMHSP 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.

19.0 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.

20.0 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.

21.0 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. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this contract.

22.0 RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR)

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

23.0 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 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.

24.0 UNFAIR LABOR PRACTICES

Pursuant to 1980 P.A. 278, as amended, MCL 423.321 et seq., the state shall not award a contract or sub-contract to an employer or any sub-contractor, manufacturer or supplier of the employer, whose name appears in the current register compiled by the Michigan Department of Consumer

and Industry Services. The state may void any contract if, subsequent to award of the contract, the name of the CMHSP as an employer, or the name of the sub-contractor, manufacturer of supplier of the CMHSP appears in the register.

25.0 SURVIVOR

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

26.0 GOVERNING LAW

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

PART II: STATEMENT OF WORK

1.0 SPECIFICATIONS

The following sections provide an explanation of the specifications and expectations that the CMHSP must meet and the services that must be provided under the contract. The CMHSP is not, however, constrained from supplementing this with additional services or elements deemed necessary to fulfill the intent of the contract and Mental Health Code.

1.1 Targeted Geographical Area for Implementation

The CMHSP shall provide mental health and developmental disability supports and services to individuals described in Section 1.2 below who are located in or whose county of residence is determined to be in the County(ies) of the CMHSP MH/DD service area.

1.2 Target Population

The CMHSP shall direct and prioritize services to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208. The CMHSP shall also provide medically necessary defined mental health benefits to children certified in the Children's Waiver program. The CMHSP may use GF formula funds authorized through this contract to provide services - not covered under the 1915(b)/1915(c) concurrent waiver - to Medicaid beneficiaries who are individuals with serious mental illness, serious emotional disturbances or developmental disabilities. With MDHHS approval the CMHSP may use GF funds or underwrite a portion of the cost of covered services to these beneficiaries if Medicaid payments for services to these beneficiaries are exhausted.

The CMHSP may use GF formula funds authorized through this contract:

1. to provide services that are not covered under the 1915(b) and 1915(c) Medicaid Habilitation Supports waiver to Medicaid beneficiaries who are individuals with serious mental illness, serious emotional disturbances or developmental disabilities; or

2. to underwrite a portion of the cost of covered services to these beneficiaries if Medicaid payment for services to the PIHP is exhausted; and
3. for CMHSPs that are under subcontract with the PIHP, when the contract with the PIHP stipulates conditions regarding such use of General Funds. MDHHS reserves the right to disallow such use of General funds if it believes that the PIHP-CMHSP contract conditions were not met

1.3 Responsibility for Payment of Authorized Services

The CMHSP shall be responsible for the payment of services that the CMHSP authorizes. This provision presumes the CMHSP and its agents are fulfilling their responsibility to customers 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 CMHSPs. In the event there is an unresolved dispute between CMHSPs, either party may request MDHHS involvement to resolve the dispute, and the MDHHS will make such determination. Likewise, services shall not be delayed or denied as a result of a dispute of payment responsibility between the CMHSP and another agency. The COFR Agreement included as Attachment C1.3.1 shall be followed by the CMHSP to resolve county of financial responsibility disputes.

2.0 SUPPORTS AND SERVICES

The CMHSP shall make available the array of supports and services designated in MCL 330.1206(1) and (for enrolled individuals) those supports and services available under the Children's Waiver. Relevant service and support descriptions are contained in the current MDHHS Medical Services Administration Policy for Prepaid Health Plans and these definitions are incorporated by reference into this agreement, to the extent they are consistent with the Board's service obligations under MCL 330.1206(1), and the Children's Waiver. Attachment C 6.5.1.1 of this contract. The CMHSP must limit services to those that are medically necessary and appropriate, and that conform to professionally accepted standards of care. Discussion of the array of services shall occur during the person-centered planning process, which is used to develop the individual plan of service

2.1 Availability of Services

The CMHSP agrees to meet priority needs as reflected in Section 208 of the Mental Health Code to the full extent that available resources allow. The CMHSP service obligations under this contract are guided by a recognition that these services do not represent an individual entitlement. The Mental Health Code does not establish an individual entitlement to mental health services in the way the Federal Medicaid program does for health insurance, but rather it indicates that persons with certain qualifying conditions and impairments must have the first priority for available resources and services within the public mental health system.

3.0 ACCESS ASSURANCE

3.1 Access Standards

The CMHSP shall ensure timely access to supports and services in accordance with the following standards, shall report its performance on the standards in accordance with Attachment C 6.5.1.1, and shall locally monitor its performance and take action necessary to improve access for recipients.

A. Mental Health

1. At least 95% of all people receive a pre-admission screening for psychiatric inpatient care for whom the disposition was completed in three hours.
2. At least 95% of all people receive a face-to-face meeting with a professional for an assessment within 14 calendar days of a non-emergency request for service (by sub-population).
3. At least 95% of all people start at least one ongoing service within 14 calendar days of a non-emergent assessment with a professional.

B. The CMHSP shall ensure geographic access to supports and services in accordance with the following standards, and shall make documentation of performance available to MDHHS site reviewers.

For office or site-based mental health services, the individual's primary service providers (e.g., case manager, psychiatrist, primary therapist, etc.) should be within 30 miles or 30 minutes of the individual's residence in urban areas, and within 60 miles or 60 minutes in rural areas. ("Primary provide" excludes community inpatient, state inpatient, partial hospitalization, extended observation beds and any still existing day programs.)

C. The CMHSP shall be responsible for outreach and ensuring adequate access to services to the priority populations.

D. In addition, the CMHSP shall assure access according to the following standard, and shall report its performance on the standard in accordance with Attachment C 6.5.1.1.

100% of people who meet the OBRA Level II Assessment criteria for specialized mental health services for people residing in nursing homes, as determined by the MDHHS, shall receive CMHSP managed mental health services.

3.2 Medical Necessity

The CMHSP may implement the medical necessity criteria specified by the MDHHS. Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet the person's mental health needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical industry standards of care. In addition, the CMHSP must also consider social services and community supports that are crucial for full participation in community life, must apply person-centered

planning for individuals with mental health needs, and must consider environmental factors and other available resources that might address the situation. The criteria are intended to ensure appropriate access to care, to protect the rights of recipients and to facilitate an appropriate matching of supports and services to individual needs for the priority populations, consistent with the resources (general fund allocation) available to the CMHSP to serve these individuals. The level and scope of such services are contingent on available funding, and services provided through the use of general funds are not an entitlement to any individual recipient.

3.3 Other Access Requirements

3.3.1 Person-Centered Planning

The Michigan Mental Health Code establishes the right for all recipients to have an Individual Plan of Service (IPS) developed through a person-centered planning process (Section 712, added 1996). The CMHSP shall implement person-centered planning in accordance with the MDHHS Person-Centered Planning Practice Guideline, Attachment C 3.3.1.

3.3.2 Limited English Proficiency

The CMHSP shall assure equal access for people with limited English proficiency, as outlined by the Office of Civil Rights Policy Guidance in the Title VI Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency. This guideline clarifies responsibilities for providing language assistance under Title VI of the Civil Rights Act of 1964.

3.3.3 Cultural Competence

The supports and services provided by the CMHSP (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 CMHSP has five components in place: (1) a method of community assessment; (2) sufficient policy and procedure to reflect the CMHSP'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; (5) the provision of supports and services within the cultural context of the recipient is also necessary to demonstrate this commitment.

3.3.4 Self-Determination Policy and Practice Guideline

It is the expectation that CMHSPs will assure compliance among their network of service providers with the elements of. Self-Determination Policy and Practice Guideline contract attachment C 3.3.4. This will mean that the CMHSP will assure, access to arrangements that support self-determination as described in the SD Policy by adults receiving services. Arrangements that support self-determination are available to adults receiving services; no adult is mandated to use self-determination approaches.

The implementation expectations for this policy are aimed at fostering continual learning and improvement in the implementation of the elements of self-determination.

Reviews of CMHSP performance, in the area of Self Determination, will emphasize continuous quality improvement approaches applying teaching, coaching, mutual learning, and exploring best practice rather than a static compliance approach. The CMHSP must offer a range of financial management service options (as described in Section III of the SD Policy), with all options supporting the principles, concepts and key elements of self determination. Technical Assistance on the implementation of arrangements that support self-determination is available in the Self-Determination Implementation Technical Advisory (formerly Choice Voucher System Technical Advisory).

3.3.5 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 C3.3.5.1 to this contract.

4.0 SPECIAL COVERAGE PROVISIONS

If funds are appropriated the following sub-sections describe special considerations, services, and/or funding arrangements required by this contract. The parties recognize that some persons served under these special considerations, services or arrangements may be Medicaid beneficiaries, and that the CMHSP may discharge its obligations and service provision responsibilities specified below to such individuals using both general funds dollars and available Medicaid specialty service benefits and coverages.

4.1 Nursing Home Placements

All designated state funds that the MDHHS has authorized to the CMHSP for the placement of people with mental health and/or developmental disability-related needs out of nursing homes, shall continue to be used for this purpose until such time that the CMHSP is notified in writing by the MDHHS that the MDHHS's data indicates there are no people who have been screened by the OBRA program in need of placement. These funds may also be used to divert people from nursing home placements.

4.2 Nursing Home Mental Health Services

All designated state funds that the MDHHS has authorized to the CMHSP for nursing home mental health and/or developmental disability-related services shall continue to be used for

this purpose until such time that MDHHS approves an alternative. Residents of nursing homes with mental health needs shall be given the same opportunity for access to CMHSP services as other individuals covered by this contract.

4.3 Prevention Services

Funds categorically defined for prevention efforts shall be used for the specified purpose only.

4.4 Categorical Funding

Funds categorically defined shall be used for the specified purpose only.

1. The appropriations act for mental health services for special populations requires the following:
    A. From the funds appropriated in part 1 for mental health services for special populations, the department shall ensure that CMHSPs meet with multicultural service providers to develop a workable framework for contracting, service delivery, and reimbursement.
    B. Funds appropriated in part 1 for mental health services for special populations shall not be utilized for services provided to illegal immigrants, fugitive felons, and individuals who are not residents of this state. The department shall maintain contracts with recipients of multicultural services grants that mandate grantees establish that recipients of services are legally residing in the United States. An exception to the contractual provision shall be allowed to address individuals presenting with emergent mental health conditions.
    ~~C.~~ The annual report shall not be required for any CMHSP receiving less than $1000.00 in special population funding in a fiscal year. The department shall require an annual report from the contractors that receive multicultural integration funding. The annual report, due 60 days following the end of the contract period, shall include specific information on services and programs provided, the client base to which the services and programs were provided, information on any wraparound services provided and the expenditures for those services. The department shall provide the annual reports to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, and the state budget office.
2. The annual report shall include the following:
    A. Describe the population served. Include the number of unduplicated individuals served during this fiscal year. Include relevant demographic or diagnostic data.
    B. Briefly summarize specific mental health services that were provided and corresponding activities that occurred for special populations throughout the fiscal year.

4.5 OBRA Pre-Admission Screening and Annual Resident Review

The CMHSP shall be responsible for the completion of Pre-Admission Screenings and Annual Resident Reviews (PASARR) for individuals who are located in the CMHSP service area presenting for nursing home admission, or who are currently a resident of a nursing

home located in the CMHSP service area. A copy of the MDHHS/CMHSP PASARR Agreement is attached (Attachment C 4.5.1).

4.6 Long Term Care

The CMHSP shall assume responsibility for people who are verified to meet the Michigan Mental Health Code eligibility criteria and who are determined by the MDHHS through the PASARR assessment process to be ineligible for nursing home admission due to mental illness or developmental disability.

Service shall not be denied or delayed as a result of a dispute of financial responsibility between the CMHSP and long-term care agent. The MDHHS shall be notified in the event of a local dispute and the MDHHS shall determine the responsibility of the CMHSP and the long-term care agent in these disputes.

4.7 SED Waiver

The intent of this program is to provide 1915 (c) Home and Community Based Waiver Services, as approved by Centers for Medicare and Medicaid Services (CMS) for children with Serious Emotional Disturbances, along with state plan services in accordance with the Medicaid Provider Manual. (See attachment C 4.7.1 1915 (c) Home and Community Based Waiver Services and State Plan Services to Children with Serious Emotional Disturbance (SEDW)).

Within the SEDW, there are two funding streams that constitute the match to the federal Medicaid funding. The Community Mental Health Services Program (CMHSP) provides the match to the federal Medicaid funding for children not funded by the Michigan Department of Health & Human Services (MDHHS). For the (MDHHS) SEDW Project, the match to the federal Medicaid funding is provided by MDHHS. Attachment C 4.7.2 1915 (c) Home and Community Based Waiver for Children with Serious Emotional Disturbance (SEDW) outlines CMHSP responsibilities related to the two distinct funding streams.

A. The CMHSP shall assess eligibility for the SEDW and submit applications to the MDHHS for those children the CMHSP determines are eligible. For children determined ineligible for the SEDW, the CMHSP, on behalf of MDHHS, informs the family of its right to request a fair hearing by providing written adequate notice of denial of the SEDW to the family.

B. The CMHSP shall carry out administrative and operational functions delegated by MDHHS to the CMHSPs as specified in the CMS approved (c) waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.

C. The CMHSP shall assure that services are provided in amount, scope and duration as specified in the approved plan of service. Wraparound is a required service for all participants in the SEDW and CMHSPs must assure sufficient service capacity to meet the needs of SEDW recipients.

D. The CMHSP shall comply with credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by the CMHSPs, as it pertains to the rendering of services within the SEDW. CMHSPs are responsible for ensuring that each provider, directly or contractually employed, credentialed or non-credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and requirements.

E. The CMHSP shall bill Medicaid in a timely manner on a fee-for-service basis for covered services delivered in accordance with the most recent Medicaid Provider Manual. Billings must represent the actual direct cost of providing the services. The actual direct cost of providing the services includes amounts paid to contractors for providing services, and the costs incurred by the CMHSP in providing the services as determined in accordance with2 CFR 200 Subpart E Cost Principles. Benefit plan administrative costs are not to be included in the billings. Benefit plan administrative costs related to providing the 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.

F. The CMHSP Office of Recipient Rights shall assure that the semi-annual and annual recipient rights data reports required by MCL 330.1755(5)(j) and MCL 330.1755(6) are submitted to the PIHP Quality Assessment and Performance Improvement Program (QAPIP) in addition to other entities and individuals specified in law. The CMHSPs shall ensure that there is a signed agreement between the CMHSP Office of Recipient Rights, the MDHHS Bureau of Child and Adult Licensing (BCAL) and MDHHS Children's Protective Services (CPS) regarding reporting and investigation of suspected abuse, neglect, and exploitation in programs operated or contracted with the CMHSP.

G. Medicaid fee for service funds paid to the CMHSP under the SEDW may be utilized for the implementation of, or continuing participation in, locally established multi-agency shared funding arrangements developed to address the needs of beneficiaries served through multiple public systems. Local interagency agreements and/or memoranda of understanding will stipulate the amount and source of local funding. Medicaid is to be billed on a fee-for-service basis for services to children enrolled in the SEDW when the service is: 1) a covered service for the SEDW; 2) determined to be medically necessary; 3) not covered or paid by from other sources. Monitoring safeguards and relevant documents must be in place to ensure compliance.

H. As allowed under the MDHHS/CMHSP master contract, a CMHSP may use State General Funds to cover those costs (indirect administrative costs, direct program costs, and/or direct service cost which exceed the Medicaid fee-for-service reimbursement rate.)

I. The CMHSP and its partner agencies may elect to use excess local contributions to fund the 1915(c) Waiver for Children with Serious Emotional Disturbance (SED) to pay for the cost of products or services that do not qualify as allowable under this waiver. The CMHSP shall separately report this use of excess local contributions as specified in the FSR.

J. Through the Event Reporting System (ERS), the CMHSP will report the following

incidents for children on the SEDW**:** Suicide; Non suicide Death; Arrest of Consumer; Emergency Medical Treatment Due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions; Hospitalization due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions.

4.8 – Disaster Behavioral Health CMHSP Responsibilities

In the event of a disaster or community emergency, more people are affected by the psychological impact of the disaster than those that are physically impacted. In order to promote community resilience and recovery it is imperative that a solid community disaster behavioral health plan is established. A Community Mental Health Service Program (CMHSP) is responsible, in partnership with other local response agencies/organizations, for assessing the psychological impact of the disaster on victims and response personnel and coordination of Disaster Behavioral Health in collaboration with local emergency management. In order to meet this mission, CMHSPs shall to the extent that GF funds are available,:

1. Designate a primary and alternate emergency preparedness coordinator (EPC).
    a. Participate in local emergency management disaster planning and exercises in collaboration with local health department, regional healthcare coalitions, and jurisdictionally appropriate emergency manager(s).
    b. Attend/host trainings geared toward disaster mental/behavioral health planning, response, and recovery.
2. Provide emergency response support, including memoranda of agreement (MOA) both formal and informal, in collaboration with private sector or mental/behavioral health service providers and Non-governmental organizations (NGOs) such as the American Red Cross, Regional Health Care Coalitions and/or Michigan Crisis Response Association.
    a. Coordinate local community assessments of disaster behavioral health to determine the psychological impact of a disaster on survivors and disaster response personnel.
    b. Provide psychological triage of individuals as appropriate (example, PsySTART triage).
    c. According to the time frames recommended for the application of each intervention, provide appropriate disaster behavioral health services, including, but not limited to:
        i. Psychological First Aid
        ii. Crisis intervention/stabilization
        iii. Grief/bereavement counseling
        iv. Critical Incident Stress Management (CISM)
        v. Post-Traumatic Stress Disorder Counseling
        vi. Substance use disorder counseling
        vii. Provide community outreach activities as needed

viii. Advise local Public Information Officer (PIO) of appropriate disaster behavioral health messaging

ix. Request additional disaster behavioral health resources according to pre-established emergency management channels

3. Develop and maintain formal and informal mutual aid agreements (MUA) with other agencies outside of their jurisdiction. The number and type should be individualized by need but at least one (1) MUA should be developed.

4.9 Mental Health Court Pilot Projects

The mental health court pilot projects are specialized court dockets that use a problem solving approach to reduce contacts with the criminal justice system and to facilitate a participation in mental health and substance use treatment services for those identified as mentally ill. Cross system collaboration between the criminal justice system and the mental health community is critical to successful programs. CMHSPs where a mental health court exists will be required to provide detail on mental health court participants. The following reporting requirements apply: (1) CMHSPs must be able to identify MH Court participants and all associated encounters; (2) CMHSPS must provide a HIPAA compliant list of consumer unique IDs to MDHHS upon request so that mental health court participant data can be drawn from the state data warehouse; (3) CMHSPs may be requested to provide detail or summary information about services provided to MH Court participants. Additionally, the Department or its designee is permitted to visit and, or to make an evaluation of the project. CMHSPs will be required to participate in MDHHS funded evaluation activities. (See attachment C4.9.1 Mental Health Court Pilot Projects)

4.10 Pooled Funding Arrangements

Funding for the purpose of implementing or continuing 1915(a) capitated projects or other MDHHS approved funding arrangements shall be placed into a pooled funding arrangement limited to that purpose.

5.0 OBSERVANCE OF FEDERAL, STATE AND LOCAL LAWS

The CMHSP agrees that it will comply with all state and federal statutes, accompanying regulations, and administrative procedures that are in effect, or that become effective during the term of this contract. The state must implement any changes in state or federal statutes, rules, or administrative procedures that become effective during the term of this contract. Federal statutes and regulations pertaining to the Medicaid program are applicable to the operation of the Children's Waiver. This includes laws and regulations regarding human subjects research and data projections set forth in 45 CFR and HIPAA.

5.1 Fiscal Soundness of the CMHSP

The state is responsible to assure that the contractor maintain a fiscally solvent operation. In this regard, the MDHHS may evaluate the ability of the CMHSP to perform services based on determinations of payable amounts under the contract.

5.2 Suspended Providers

Federal regulations and state law preclude reimbursement for any services ordered,

prescribed, or rendered by a provider who is currently suspended or terminated from direct and indirect participation in the Michigan Medicaid program or federal Medicare program. A recipient may purchase services provided, ordered, or prescribed by a suspended or terminated provider, but no state funds may be used. The MDHHS publishes a list of providers who are terminated, suspended or otherwise excluded from participation in the program. The CMHSP must ensure that its provider networks do not include these providers.

Similarly, a CMHSP may not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's equity who is currently debarred or suspended by any federal agency. CMHSPs are also prohibited from having an employment, consulting, or any other agreement with a debarred or suspended person for the provision of items or services that are significant and material to the CMHSP's contractual obligation with the state.

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: www.arnet.gov/epls.

5.3 Public Health Reporting

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

6.0 CMHSP ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE SERVICES

6.1 Organizational Structure

The CMHSP shall maintain an administrative and organizational structure that supports a ~~high~~ quality, comprehensive managed mental health program. The CMHSP'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.

6.2 Administrative Personnel

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

The CMHSP 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
- Recipient Rights Officer

6.3 Customer Services

6.3.1 Customer Services: General

Customer Services is an identifiable function that operates to enhance the relationship between the recipient and the CMHSP. This includes orienting new recipients to the services and benefits available including how to access them, helping recipients with all problems and questions regarding benefits, handling customer/recipient 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 customer/recipient has a need for help, and is able to help on the first contact in most situations.

6.3.2 Recipient Rights and Grievance/Appeals

The CMHSP shall establish an Office of Recipient Rights in accordance with all of the provisions of Section 755 of the Michigan Mental Health Code and corresponding administrative rules and for substance abuse, Section 6321 of P.A. 365 of 1978, and corresponding administrative rules. The Community Mental Health Service Program (CMHSP) shall assure that, within the first **90** days of employment, the Recipient Rights Office Director, and all Rights Office staff shall attend, and successfully complete, the Basic Skills Training programs offered by the Department's Office of Recipient Rights. In addition, all Rights Office staff must comply with the requirements delineated in Attachment C.6.3.2.3.A. None of the requirements in this paragraph shall apply to Rights Office clerical staff unless they are involved in processing complaints.

The Community Mental Health Service Program (CMHSP) shall assure that, within the first 180 days of employment Executive Directors hired by a CMHSP shall be required to attend a Recipient Rights training focused on the role of the Executive Director relative to the Recipient Rights protection and investigation system.

The Community Mental Health Services Program shall require that all contractual agreements with LPH/U service providers include Attachment C.6.3.2.3.A as an amendment to the contract.

The CMHSP shall make reasonable efforts to obtain a signed agreement between the CMHSP Office of Recipient Rights, the LARA Adult Foster Care and Homes for the Aged Licensing Division (formerly BCAL), and MDHHS Adult Protective Services (APS) regarding reporting and investigation of suspected abuse, neglect, and exploitation in programs operated or contracted with the CMHSP.

The CMHSP Office of Recipient Rights shall assure that the semi-annual and annual recipient rights data reports required by MCL 330.1755(5)(j) and MCL 330.1755(6) are submitted to the PIHP Quality Assessment and Performance Improvement Program (QAPIP) in addition to other entities and individuals specified in law.

The Community Mental Health Services Program shall assure that it has policies and procedures that address residents' property and funds as required by MCL 330.1752. The policies and procedures should address the proper handling of consumer funds by the agency, if applicable, and any applicable service provider~~;~~ and require Community Mental Health Services Program monitoring of resident funds and valuables for compliance with the Licensing Rules for Adult Foster Care Small Group Homes (R 400.14315).

6.3.2.1 CMHSP Local Dispute Resolution Process
The CMHSP shall conduct CMHSP local dispute resolution processes in accordance with Attachment C 6.3.2.1.

6.3.2.2 Family Support Subsidy Appeals
The CMHSP shall conduct Family Support Subsidy Appeals in accordance with Attachment C 6.3.2.2.

6.3.2.3 Continuing Education Requirements for Recipient Rights Staff
The CMHSP shall conduct continuing education activities in accordance with Attachment C 6.3.2.3.A.

6.3.2.3B Recipient Rights Training Standards for CMHSP Staff
The CMHSP shall conduct training standards in accordance with Attachment C 6.3.2.3.B.

6.3.2.4 Recipient Rights Appeal Process
The CMHSP shall conduct recipient rights appeals processes in accordance with Attachment C 6.3.2.4.

6.3.3 Marketing
Marketing materials are materials intended to be distributed through written or other media to the community that describe the availability of services and supports and how to access those supports and services. Such materials shall meet the following standards:

A. All such materials shall be written at the 4th grade reading level to the extent possible (i.e., sometimes necessary to include medications, diagnoses, and conditions that do not meet the 4th grade criteria).
B. All materials shall be available in the languages appropriate to the people served within the CMHSP's area. 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 Volume 65, August 16, 2002).
C. All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA).
D. Material shall not contain false and/or misleading information.

Marketing materials shall be available to the MDHHS for review of consistency with these standards.

6.4 Provider Network Services

The CMHSP is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract.

In this regard, the CMHSP agrees to:

A. 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.
B. Have clear written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.
C. Provide a copy of the CMHSP's prior authorization policies to the provider when the provider joins the CMHSP's provider network. The CMHSP must notify providers of any changes to prior authorization policies as changes are made.
D. Provide to the MDHHS in the format specified by the MDHHS, provider agency information profiles that contain a complete listing and description of the provider network available to recipients in the service area.
E. Notify MDHHS within seven (7) days of any changes to the composition of the provider network organizations that negatively affect access to care. CMHSPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network organization and/or composition that the MDHHS determines to negatively affect the CMHSP's ability to meet its service obligations under MCL 330.1206(1) to priority populations (MCL 330.1208) may be grounds for sanctions.
F. Assure that network providers do not segregate the CMHSP's recipients in any way from other people receiving their services.
G. The CMHSP shall assure HIPAA compliant access to information about persons receiving services in their contractual residential settings by individuals who have completed training and are working under the auspices of the Dignified Lifestyles Community Connections program.

6.4.1 Provider Contracts

The CMHSP 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.

The CMHSP may sub-contract for the provision of any of the services specified in this contract including contracts for administrative, financial management and data processing. The CMHSP shall be held solely and fully responsible to execute all provisions of this contract, whether or not said provisions are directly pursued by the CMHSP or pursued by the CMHSP through a sub-contract vendor. The CMHSP shall ensure that all sub-contract arrangements clearly specify the type of services being purchased. Sub-contracts shall ensure that the MDHHS is not a party to the contract

and therefore not a party to any employer/employee relationship with the sub-contractor of the CMHSP.

Sub-contracts entered into by the CMHSP shall address the following:

A. Duty to treat and accept referrals
B. Prior authorization requirements
C. Access standards and treatment time lines
D. Relationship with other providers
E. Reporting requirements and time frames
F. QA/QI systems
G. Payment arrangements (including coordination of benefits, ability to pay determination, etc.) and solvency requirements
H. Financing conditions consistent with this contract
I. Anti-delegation clause
J. Compliance with Office of Civil Right Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency"

In addition, sub-contracts shall:

K. Require the provider to cooperate with the CMHSP's quality improvement and utilization review activities.
L. Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
M. Require providers to meet accessibility standards as established in this contract.

All sub-contracts must be in compliance with State of Michigan statutes and will be subject to the provisions thereof. All sub-contracts must fulfill the requirements of this contract that are appropriate to the services or activities delegated under the sub-contract.

All employment agreements, provider contracts, or other arrangements, by which the CMHSP intends to deliver services required under this contract, whether or not characterized as a sub-contract, shall be subject to review by the MDHHS.

Sub-contracts that contain provisions for a financial incentive, bonus, withhold, or sanctions must include provisions that protect recipients from practices that result in the inappropriate limitation or withholding of required (MCL 330.1206-1) services that would otherwise be provided to eligible individuals (MCL 330.1208).

CMHSPs and their provider networks shall accept staff training provided by other CMHSPs and their provider networks to meet their training requirements when: 1) that staff training is substantially similar to their own training; and 2) staff member completion of such training can be verified.

This is applicable to any staff training area. This includes the required staff training in the areas of abuse and neglect (recipient rights), person-centered planning: HIPAA

security, and certificates earned from specific clinical training in evidence-based, best and promising practices such as ACT, DBT, PMTO, FPE, and motivational interviewing.

6.4.2 Provider Credentialing

The CMHSP 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 CMHSP must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state. The CMHSP also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the CMHSPs standards.

6.4.3 Collaboration with Community Agencies

CMHSPs 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. Such agencies and organizations include local health departments, local MDHHS human service offices, regional PIHP entity for substance abuse services, community and migrant health centers, nursing homes, Area Agency and Commissions on Aging, Medicaid Waiver agents for the 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 CMHSP's recipients. CMHSPs are encouraged to coordinate with these entities through participation in multipurpose human services collaborative bodies, and other similar community groups. The CMHSP 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 when the other party is willing. To ensure that the services provided by these agencies are available to all CMHSPs, an individual contractor shall not require an exclusive contract as a condition of participation with the CMHSP.

The CMHSP shall have a documented policy and set of procedures to assure that coordination regarding mutual recipients is occurring between the CMHSP and/or its provider network, and primary care physicians. This policy shall minimally address all recipients of CMHSP 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.

6.5 Management Information Systems

The CMHSP shall ensure a Management Information System and related practices that reflect sufficient capacity to fulfill the obligations of this contract.

Management information systems capabilities are necessary for at least the following areas:

- Recipient registration and demographic information
- Provider enrollment

- Third party liability activity
- Claims payment system and tracking
- Grievance and complaint tracking
- Tracking and analyzing services and costs by population group, and special needs categories as specified by MDHHS
- Encounter and demographic data reporting
- Quality indicator reporting
- HIPAA compliance
- UBP compliance
- Recipient access and satisfaction

6.5.1 Uniform Data and Information

To measure the CMHSP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures, the CMHSP must provide the MDHHS with uniform data and information as specified in this contract, and other such additional or different reporting requirements or data elements as the parties may agree upon from time to time. Any changes in the reporting requirements required by state or federal law will be communicated to the CMHSP at least 90 days before they are effective unless state or federal law requires otherwise. Other changes beyond routine modifications to the data reporting requirements must be agreed to by both parties.

The CMHSP's timeliness in submitting required reports and their accuracy will be monitored by the MDHHS and will be considered by the MDHHS in measuring the performance of the CMHSP. The CMHSP CEO or designee must certify the accuracy of the data.

The CMHSP must cooperate with the MDHHS in carrying out validation of data provided by the CMHSP by making available recipient records and a sample of its data and data collection protocols.

The CMHSP shall submit the information below to the MDHHS consistent with the time frames and formats specified in Attachment C 6.5.1.1. This information shall include:

A. Recipient Level Information
    1. Demographic Characteristics - this information shall be updated at least annually for recipients receiving continuing supports or services.
    2. Functional Capacities for Children with Severe Emotional Disturbance - this information shall be updated at least annually for recipients receiving continuing supports or services.
    3. Service Utilization/Encounter Data

B. CMHSP Level Information
    1. Sub-Element Cost Report
    2. Quality Management Data
    3. Office of Recipient Rights

C. The CMHSP shall submit a written review of death for every recipient whose death occurred within six (6) months of the recipient's discharge from a state-operated service. The review shall include:
    1. Recipient's name
    2. Gender
    3. Date of birth
    4. Date, time, place of death
    5. Diagnoses (mental and physical)
    6. Cause of death
    7. Recent changes in medical or psychiatric status, including notation of most recent hospitalization
    8. Summary of condition and treatment (programs and services being provided to the recipient) preceding death
    9. Any other relevant history
    10. Autopsy findings if one was performed and available
    11. Any action taken as a result of the death

D. Should additional statistical or management information from data currently collected by the CMHSP be required by the MDHHS, at least 45 days written notice shall be provided. The written request shall identify who is making the request and the purpose of the request. The MDHHS shall make earnest efforts not to request additional information (above and/or beyond what is required in this contract and/or any modification of the contract informational requirements). Particular exceptions include additional informational requirements issued by funding and regulatory sources and/or resulting from legislative action.

Reporting Requirements for the period October 1, 2016 to September 30, 2017 are included in Attachment C 6.5.1.1

6.5.2 Encounter Data Reporting

In order to assess quality of care, determine utilization patterns and access to care for various health care services, the CMHSP shall submit encounter data containing detail for each recipient encounter reflecting all services provided by the CMHSP. Encounter records shall be submitted monthly via electronic media in the format specified by the MDHHS. Encounter level records must have a common identifier that will allow linkage between the MDHHS's and the CMHSPs management information systems. Encounter data requirements are detailed in the Reporting Requirements attached to this contract. The CMHSP agrees to participate in the reporting of encounter data quality improvement data, Medicaid performance indicator data and sub element cost data consistent with PIHP Medicaid requirements.

6.5.3 Level of Care Utilization System (LOCUS)

In order to ensure the MDHHS has the ability to use the LOCUS assessment for all individuals served by CMHSP the LOCUS is required to be included in the assessment of all non-Medicaid individuals.

The CMHSP will:

1. Ensure that the LOCUS is incorporated into the initial assessment process for all Non-Medicaid eligible 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, through Deerfield Behavioral Health, with cost covered by BHDDA through Mental Health and Wellness Commission funding; or
    c. Use of software purchased through Deerfield Behavioral Health with costs covered by BHDDA through Mental Health and Wellness Commission funding.
2. Ensure that each Non-Medicaid eligible individual 18 years and older with a severe mental illness, who is receiving services as of October 1, 2016, has a LOCUS completed as part of any re-assessment process during the current fiscal year.
3. Collaborate with BHDDA for ongoing fidelity monitoring on the use of the tool.
4. Provide the composite score for each LOCUS that is completed in accord with the established reporting guidelines.

6.6 Financial Management System

6.6.1 General

The CMHSP 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 CMHSP will comply with generally accepted accounting principles (GAAP) for governmental units when preparing financial statements. The CMHSP will use the principles and standards of 2 CFR 200 Subpart E Cost Principles for determining all costs reported on the financial status report, except for a) local funds, not obligated to meet local match requirements nor required as reserve against possible obligations or liabilities; b) selected items of allowable cost – agreed upon by the CMHSP and MDHHS – where state law or county regulations differ from federal policy as outlined in 2 CFR 200 Subpart E Cost Principles and requires adherence to different principles or a different methodology for cost allocation, distribution or estimation, c) earned revenue not encumbered to satisfy local match obligations, nor required as an adjustment or credit or distribution to offset or reduce expense items allocated to a federal award or to state general fund allocation; d) other grants or awards where the grantor requires principles and standards other than those described in2 CFR

200 Subpart E Cost Principles. Expenditures of General Fund Formula Funds reported on the financial status report must comply with Sections 240 241 and 242 of the Mental Health Code. Cost settlement of the General Fund Formula Funding to the CMHSP will be based upon costs reported on the financial status report. If a conflict exists between 2 CFR 200 Subpart E Cost Principles and Section 242 of the Mental Health Code regarding expenditures the more restrictive sections of Section 242 of Mental Health Code will prevail.

The accounting and financial systems established by the CMHSP shall be a double entry system having the capability to identify application of funds to specific funding streams participating in service costs for recipients. Such funding streams consist of, but are not limited to: Medicaid payments, State General Funds, Children's Waiver, and other party reimbursements. Additionally, the system shall be capable of identifying the funding source participation in such a way as to determine whether the expenditure qualifies for exemption from Section 308 (90% match) of the Mental Health Code. The accounting system must be capable of reporting the use of these specific fund sources by major population groups (MIA, MIC, DD and Other Populations). In addition, cost accounting must follow the same methods for Medicaid and GF funds~~.~~

The CMHSP 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.

6.6.3 Claims Management System

The CMHSP shall make timely payments to all providers for clean claims. This includes payment at 90% or higher of all clean claims from affiliates and network sub-contractors within 30 days of receipt, and at least 99% of all clean claims within 90 days of receipt, except services rendered under a sub-contract in which other timeliness standards have been specified and agreed to by both parties.

A clean claim is a valid claim completed in the format and time frames specified by the CMHSP and that can be processed without obtaining additional information from the provider of 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 (Children's Waiver and SEDW only). A valid claim is a claim for supports and services that the CMHSP is responsible for under this contract.

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

6.6.3.1 Post-payment Review

The CMHSP may utilize a post-payment review methodology to assure claims have been paid appropriately.

6.6.3.2 Total Payment

The CMHSP 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. The CMHSP's providers may not bill recipients for the difference between the provider's charge and the CMHSP's payment for services. The providers shall not seek nor accept additional supplemental payment from the recipient, his/her family, or representative, for services authorized by the CMHSP.

6.6.3.3 Electronic Billing Capacity

The CMHSP must be capable of accepting electronic billing for services billed to the CMHSP, or the CMHSP claims management agent. The CMHSP may require its providers to meet the same standard as a condition for payment. CMHSPs are expected to make progress in reducing duplicate data entry requirements across CMHSP and provider systems.

6.6.3.4 Third Party Resource Requirements

CMHSPs are payers of last resort and will be 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., Medicaid, Medicare) that has liability for all or part of a recipient's covered benefit. The CMHSP shall collect all payments available from other parties for services provided to its recipients. The CMHSP 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.

6.6.3.5 Vouchers

Vouchers issued to recipients for the purchase of services provided by professionals may be utilized in non-contract agencies that have a written referral network agreement with the CMHSP that specifies credentialing and utilization review requirements. Voucher rates for such services shall be predetermined by the CMHSP using actual cost history for each service category and average local provider rates for like services.

Voucher arrangements for purchase of recipient-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 Part II, Section 6.4.1 (Provider Contracts). However, the CMHSP remains responsible for ensuring the appropriate use of funds allocated to the recipient through a voucher, for establishing and verifying relevant qualifications of service providers, and for maintaining and reporting required fiscal, demographic and service data.

6.6.3.6 Payment of State-Delivered Services

A. The CMHSP shall authorize payment, within forty-five (45) days of receiving the bill, for the actual number of authorized days of care provided to its recipients in state facilities.
B. Payment for state-operated services shall be made at the net state-billing rate in effect on October 1 of each fiscal year. The net state-billing rate is based on the cost of providing appropriate care to patients less all other sources of reimbursement. The state net billing rate and the state operated service (purchase of services) rate provided to the CMHSP will be the same amount.
C. The CMHSP shall authorize payment of the county match portion of the net cost of services provided to people who are residents as defined by Section 306 and Section 307 of the Michigan Mental Health Code.
D. Authorization of undisputed bills shall be made within forty-five (45) days of receipt of the billing.
E. The CMHSP shall identify to the MDHHS disputes concerning bills on a case-by-case basis within 30 days of the bill and shall work with the MDHHS in resolving these disputes on a timely basis.
F. The MDHHS may refer to the Michigan Department of Treasury (MDT) for collection of all bills that are both undisputed and overdue.
G. Billing disputes must include details that clarify and justify the dispute, and should be submitted to the MDHHS Accounting Section, if not resolved with the hospital/center reimbursement office.

6.7 State Lease Expiration

The MDHHS shall notify the CMHSP, in writing, of the expiration of the state lease for each residential facility at least one year prior to the expiration date of each residential facility. The CMHSP shall be responsible for any lease costs it causes the MDHHS or any state agency subsequent to the expiration of the lease.

6.8 Quality Assessment and Performance Improvement Program Standards

6.8.1 General

The CMHSP 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.

Note that if a CMHSP is a PIHP or is part of a PIHP's provider network, the CMHSP's involvement in implementing two PIHP QAPIP quality improvement projects satisfies the QAPIP requirement for two performance improvement projects under this contract.

6.8.2 Annual Effectiveness Review

The CMHSP 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 CMHSP. 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 CMHSP's QAPIP must be provided annually to network providers and to recipients upon request. Information on the effectiveness of the CMHSP's QAPIP must be provided to the MDHHS upon request.

6.8.3 Behavior Treatment Plan Review Committee

The CMHSP shall use 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 C 6.8.3.1 Technical Requirement for Behavior Treatment Plans.

6.9 Service and Utilization Management

The CMHSP shall assure that customers located in the service area have clear and identifiable access to needed supports and services when they are needed, and that supports and services are of high quality and delivered according to established regulations, standards, and best practice guidelines. The CMHSP shall also perform utilization management functions sufficient to control costs and minimize risk while assuring quality care and in compliance with Section 208 of the Mental Health Code. Additional requirements are described in the following sub-sections.

6.9.1 State Managed Services

A. The CMHSP shall authorize inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. The CMHSP shall review treatment at intervals determined jointly between the authorizing CMHSP and the State Facility and authorize continued stay. The application of this provision to NGRI and IST cases requires additional clarification stemming from the conditions specified in Chapter 10 of the Michigan Mental Health Code. The clarification and requirements are specified in the NGRI Protocol, Attachment C 6.9.1.1. The provisions of Chapter 10 shall apply to all authorizations.

B. The MDHHS and CMHSP agree that admissions must meet the criteria specified in the Michigan Mental Health Code for adults and children with mental illness, or that the criteria for judicial or administrative admission of a person with developmental disabilities must be met, and that inpatient care in a state hospital/center must be the most appropriate level of care available. The parties further agree that continued stay will be authorized, as long as the criteria for continued stays is met.

C. The CMHSP's authorization of admission and of continued treatment shall be the basis on which the CMHSP will reimburse the MDHHS for the state cost of inpatient services provided in a state-managed hospital/center. The CMHSP's obligation for the local match cost of such services shall not be affected by this section. Service authorizations shall be conveyed in writing to the hospital/center. The MDHHS contract manager shall be notified by the CMHSP within seven (7) days of the decision when the CMHSP determines that continued inpatient care is no longer warranted based on the criteria stated in the above item B, but the hospital/center did not discharge the recipient according to the recognized placement plan developed according to Sections 209(a) and 209(b) of the Michigan Mental Health Code. The CMHSP shall not be liable for any inpatient services that have not been authorized by the CMHSP in this circumstance. Likewise, the MDHHS contract manager shall be notified by the hospital/center whenever an authorization of continued stay by the CMHSP is clinically unwarranted in the judgment of the hospital/center. Such notification shall initiate a process for resolution of the differences.

D. The CMHSP shall comply with the requirements of attachment C 6.9.1.2 of this contract.

6.9.2 Individual Service Records

The CMHSP shall establish and maintain a comprehensive individual service record system consistent with the provisions MCL 330.1746(1), other requirements stipulated in statute and rule, applicable standards contained in MSA Policy Bulletin Chapter I as it relates to the Children's Waiver, and – if the CMHSP has obtained accreditation consistent with MCL 330.1232a (3) - the standards set by the national accrediting organization. The CMHSP shall maintain in a legible manner, via hard copy or electronic storage/imaging, individual service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided. The records shall be retained for a period of seven (7) years from the date of service or termination of service for any reason. This requirement must be extended to all of the CMHSP's provider agencies.

6.9.3 Other Service Requirements

The CMHSP shall assure that in addition to those provisions specified in Part II, Section 3.0 “Access Assurance,” services are planned and delivered in a manner that reflects the values and expectations contained in the following guidelines:

A. Housing Practice Guideline (Attachment C 6.9.3.1)
B. Inclusion Practice Guideline (Attachment C 6.9.3.2)
C. Consumerism Practice Guideline (Attachment C 6.9.3.3)

6.9.4 Coordination

The CMHSP shall assure that services to each individual are coordinated with primary health care providers and other service agencies in the community that are serving the recipient. In this regard, the CMHSP will implement practices and agreements

described in Part II, Section 6.4.3 of this contract.

6.9.5 Jail Diversion

The CMHSP shall provide services designed to divert people that qualify for BH/DD services from a possible jail incarceration, when appropriate. Such services should be consistent with the Jail Diversion Practice Guideline. The CMHSP will collect data reflective of jail diversion activities and outcomes as indicated in the Practice Guideline, Attachment C 6.9.5.1 to this contract.

6.9.6 School-to Community Transition

The CMHSP shall 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 6.9.6.1 to this contract.

6.9.7 Children's Waiver

A. The CMHSP shall identify children who meet the eligibility criteria for the Children's Waiver Program and submit to MDHHS prescreens for those children.
B. The CMHSP shall carry out administrative and operational functions delegated by MDHHS to the CMHSPs as specified in the CMS approved (c) waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.
C. The CMHSP shall determine the appropriate Category of Care/Intensity of Care and the amount of publicly funded hourly care for each Children's Waiver Program recipient per the Medicaid Provider Manual.
D. The CMHSP shall assure that services are provided in amount, scope, and duration as specified in the approved plan.
E. The CMHSP shall comply with policy covering credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by the CMHSPs, as it pertains to the rendering of services within the Children's Waiver Program. CMHSPs are responsible for ensuring that each provider, directly or contractually employed, credentialed or non–credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and 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.
F. The CMHSP shall bill Medicaid in a timely manner on a fee-for-service basis for all covered services delivered, in accordance with the most recent Medicaid manual. Billings must represent the actual direct cost of providing the services. 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 with2 CFR 200 Subpart E Cost Principles. Benefit plan administrative costs are not to be included in the billings. Benefit plan administrative costs related to providing the 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.

G. The CMHSP Office of Recipient Rights shall assure that the semi-annual and annual recipient rights data reports required by MCL 330.1755(5)(j) and MCL 330.1755(6) are submitted to the PIHP Quality Assessment and Performance Improvement Program (QAPIP) in addition to other entities and individuals specified in law. The CMHSPs shall ensure that there is a signed agreement between the CMHSP Office of Recipient Rights, the MDHHS Bureau of Child and Adult Licensing (BCAL) and MDHHS Children's Protective Services (CPS) regarding reporting and investigation of suspected abuse, neglect, and exploitation in programs operated or contracted with the CMHSP.

H. Through the Critical Incident Reporting System, the CMHSP will report the following incidents for children on the CWP: Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions; Hospitalization due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions.

6.9.9 CMHSP Trauma Policy

The CMHSPs, through their direct service operations and their network providers, shall develop a trauma-informed system for all ages and across the services spectrum in accordance with attachment C6.9.9.1 Trauma Policy.

7.0 CONTRACT FINANCING

The provisions provided in the following subsections describe the financing arrangements in support of this contract. The authorized funding to be provided by the MDHHS to the CMHSP is included as Attachment C 7.0.1 to this contract.

MDHHS may revise the funding authorization contained in Attachment C 7.0.1 during the contract year without formal amendment. Such revisions in authorizations shall be incorporated in a final authorization that is transmitted to the CMHSP and shall be utilized for cost settlement purposes. These revisions may include residential lease close outs and categorical authorization changes when these have been authorized by MDHHS. Additionally, with the mutual written concurrence of each of the involved CMHSPs and MDHHS, these authorization revisions may include transfers pursuant to section 236 and section 307 of the Mental Health Code.

7.1 Local Obligation

The CMHSP shall provide the local financial obligation for services requiring local match, as stipulated by the Mental Health Code. In the event a CMHSP is unable to provide the required local obligation, the CMHSP shall notify the MDHHS immediately. This may result in MDHHS reducing the state portion of total financing available through this contract. The

state obligation shall continue to be at the reduced level in the subsequent year unless the CMHSP provides the MDHHS with a plan and assurances that the local obligation shortfall has been rectified.

7.2 Revenue Sources for Local Obligation

The following sub-sections describe potential revenue sources for the CMHSP's local obligation:

7.2.1 County Appropriations

Appropriations of general county funds to the CMHSP by the County Board of Commissioners.

7.2.2 Other Appropriations and Service Revenues

Appropriations of funds to the CMHSP 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 CMHSP, as reflected in this contract.

7.2.3 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.

Local funds exclude grants or gifts received by the County, the CMHSP, or agencies contracting with the CMHSP, from an individual or agency contracting to provide services to the CMHSP.

An exception may be made, where the CMHSP 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 CMHSP payments to the contract agency that are claimed as matchable expenses for the purpose of state financing.

7.2.4 Special Fund Account

CMHSPs may establish and maintain the Community Mental Health Special Fund Account that comports with Section 226a of the Michigan Mental Health Code.

CMHSPs may enter into subcontract agreements with Medicaid Health Plan (MHP) managed care organizations to provide the MHP's beneficiaries with outpatient mental health services.

So long as the reimbursement the CMHSPs' receive from the MHPs fully covers the CMHSPs' underlying cost of providing their individuals with health plan services, the payments received from the MHP qualify as third party reimbursements under Section 226a of the Mental Health Code. Such funds may only be used as local match for State general fund/general purpose funding.

MHP funds held in a special fund account can never be used as matching funds for any federal program that requires match or used to provide matching funding to MDHHS under contract section 7.4.5 implementation of P. A. 131 of 2009, Section 428. The CMHSP shall account for and report all MHP third party reimbursements separately from all other local fund revenue sources.

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.

The Social Security Administration (SSA) benefit received by a CMHSP on behalf of a consumer does not qualify as a recipient fee or third-party reimbursement for purposes of Section 226a of the Mental Health Code.

7.2.5 Investment Interest

Interest earned on funds deposited or invested by or on behalf of the CMHSP, except as otherwise restricted by GAAP or2 CFR 200 Subpart E Cost Principles. Also, interest earned on MDHHS funds by contract agencies and/or network providers as specified in its contracts with the CMHSP.

7.2.6 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 childcare funds) and from public or private school districts for CMHSP mental health services.

7.3 Local Obligations - Requirement Exceptions

The following services shall not require the CMHSP to provide a local obligation:

A. Residential programs as defined in Section 309 of the Michigan Mental Health Code. Specialized residential services, as defined in Section 100d (6) of the Michigan Mental Health Code, includes mental health services that are expressly designed to provide rehabilitation and therapy to a recipient, that are provided in the residency of the recipient, and that are part of a comprehensive individual plan of services.
B. Services provided to people whose residency is transferred according to the provisions in Section 307 of the Michigan Mental Health Code.
C. Programs for which responsibility is transferred to the CMHSP and the state is responsible for 100% of the cost of the program, consistent with the Michigan Constitution.
D. Services provided to an individual under criminal sentence to a state prison.

7.4 MDHHS Funding

MDHHS funding includes both state and federal funds (Children's Waiver and federal block grants), which the state is responsible to manage. MDHHS financial

responsibility is specified in Chapter 3 of the Michigan Mental Health Code (P.A. 258 of the Public Acts of 1974, as amended) and the level of funding contained in the current year state legislative Appropriations Act. The financing in this contract is always contingent on the annual Appropriations Act.

7.4.1 State Mental Health General Fund Formula Funding

The MDHHS shall provide the CMHSP full year state mental health General Fund Formula Funding (GF formula funds) for recipients who meet the population and service requirements described in this contract. These funds shall be distributed based upon a formula.

The MDHHS contract obligation is the aggregate of the GF Formula Funds and the as identified in Attachment C 7.0.1. Final authorization will be based on the actual payments, with the GF Formula funds being the residual authorization.

Beginning with the first month of this contract, the MDHHS shall provide to the CMHSP an amount equal to one-month payment of the funding authorized in Attachment C 7.01 as Operations Base, State facility and Categorical. This pre-payment will be issued on the first Wednesday of each month. Prior to the issuance of the September GF payment, MDHHS will reconcile the year-to-date GF payments and the actual payments for to determine the final GF obligation.

The full year GF formula funds authorized for this contract year is reflected in Attachment C 7.0.1.

7.4.1.1 GF Formula Funds Calculation

The General Funds appropriated to CMH that are non-categorical and not needed to support Medicaid payments, together with the General Funds authorized to CMH under the Purchase of Service line within the state budget, make up the GF formula funds provided to CMHSPs.

This funding is based upon the prior year full-year authorizations, together with adjustments for executive orders, transfers and other program/policy requirements, plus any current year appropriation changes. The MDHHS has redistributed some of these formula funds across CMHSPs in prior years, and may do so again to further reduce identified financing inequities. Prior notice will be given to the CMHSP in the event of a redistribution.

7.4.2 Special and/or Designated Funds: Exclusions

Special and/or Designated Funds (including categorical and earned revenue funds) are those funds that are earmarked by the MDHHS for a specific purpose, project, and/or target population and are not included in the GF formula funding.

These funds and programs may be authorized through separate contractual arrangements between the CMHSP and the MDHHS. These agreements typically include performance and outcome expectations, reporting requirements, and finance-

related specifications. The CMHSP shall identify the revenues and expenditures associated with these projects as part of financial reporting required by this contract.

The full year Special and/or Designated Funds identified as categorical funding are state General Funds earmarked by the appropriation and the MDHHS for a specific purpose, project, and/or target population. The categorical funding authorized through this contract is specified in Attachment C 7.0.1. Funding for any Special and/or Designated Funds shall not be redirected by the CMHSP without prior written approval of the MDHHS.

7.4.3 Fee-for-Service

The Children's Waiver is a fee-for-service Medicaid program. The MDHHS shall reimburse the CMHSP, in accordance with MDHHS-approved budgets and Medicaid reimbursement policies, for billings submitted by the CMHSP for each beneficiary with a MDHHS approved Children's Waiver. The CMHSP will be reimbursed based on the billings submitted, as this program shall not be pre-paid.

7.4.5 Implementation of Current Year Appropriation Act

The CMHSP will participate in the implementation of the current year appropriation act which requires each PIHP shall provide, 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 rates for the PIHPs.

The CMHSP agrees to provide local funds to the MDHHS through the PIHP. The CMHSP agrees to provide local funds, in the amount stipulated in Attachment C 7.0.1, to the MDHHS through the PIHP. 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. In the event that a CMHSP fails to meet this obligation and the PIHP has not made available other bona fide local funds to offset this obligation, MDHHS will reduce the CMHSP State Mental Health General Fund authorization/payment to the CMHSP by an equivalent amount.

7.5 Operating Practices

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

A. Generally Accepted Accounting Principles for Governmental Units.
B. Audits of State and Local Governmental Units, issued by the American Institute of Certified Public Accountants (current edition).
C. 2 CFR 200 Subpart E Cost Principles except for the conditions described in 6.6.1.

7.6 Audits

The CMHSP shall ensure the completion of a fiscal year end Financial Statement Audit

conducted in accordance with Generally Accepted Auditing Standards (GAAS); and a fiscal year end 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 CMH Compliance Examination Guidelines in Attachment C 7.6.1.)

The CMHSP shall submit to the MDHHS the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDHHS-funded programs, and management letter (if issued) with a response within 30 days after receipt of the practitioner's report, but no later than June 30th following the contract year end. The CMHSP must submit the reporting package by e-mail to MDCH 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.

If the CMHSP does not submit the required Financial Statement Audit Report, Compliance Examination Report, management letter (if issued) with a response, and Corrective Action Plan 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 CMHSP is more than 120 days delinquent in meeting the filing requirements and an extension has not been approved by MDHHS.

MDHHS shall issue a management decision on findings, comments, and questioned costs contained in the CMHSP Compliance Examination Report within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the Compliance Examination finding or comment is sustained; the reasons for the decision; the expected CMHSP action to repay disallowed costs, make financial adjustments, or take other action; and a description of the appeal process available to the CMHSP. Prior to issuing the management decision, MDHHS may request additional information or documentation from the CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs.

The appeal process available to the CMHSP relating to MDHHS management decisions on Compliance Examination findings, comments and disallowed costs is included in Attachment C 7.6.2.

7.7 Financial Planning

In developing an overall financial plan, the CMHSP shall consider, the reinvestment of carry-forward savings, and the strategic approach in the management of risk, as described in the following sub-sections.

7.7.1 Savings Carry Forward

Provisions regarding the carry forward of state mental health General Funds – authorized under MCL 330.1226(2)(c) - are included in the following sub-sections. Note that these provisions may be limited or canceled by the closeout provision in Part I, Section 13.0, Closeout, and may be modified by actions stemming from Part II, Section 8.0, Contract Remedies and Sanctions.

7.7.1.1 General Fund Carry Forward

At the conclusion of the fiscal year, the CMHSP may carry forward up to 5% of state mental health General Funds (formula funding) authorized through this contract. These funds shall be treated as state funds and shall be budgeted as a CMHSP planned expenditure in the subsequent year. All carry-forward funds unexpended in the subsequent year shall be returned to the MDHHS.

7.7.2 Expenditures to Retire Unfunded Pension Liabilities

The CMHSP may include expenditures to retire unfunded pension and other post employment liabilities on the Financial Status Report if the liability is supported by an actuarial report, and the retirement of the unfunded pension and other post employment liabilities complies with generally accepted accounting principles (GAAP). The CMHSP shall not, however, include expenditures to retire unfunded pension and other post employment liabilities on the Financial Status Report if such expenditures would cause the CMHSP to exceed the contractual budget authorization from MDHHS.

7.8 Finance Planning, Reporting and Settlement

The CMHSP shall provide financial reports to the MDHHS as specified in attachment C 6.5.1.1. Forms and instructions are posted to the MDHHS website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html

7.8.1 Executive Expenditures Survey for Sec. 904 (2)(k)

The CMHSP shall report expenditures that includes a breakout of the salary, benefits, and pension of each executive level staff and shall include the director, chief executive, and chief operating officers and other members identified as executive staff.

The CMHSP shall provide this report to the MDHHS as specified in attachment C 6.5.1.1. The form with instructions are posted to the MDHHS website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html.

7.9 Legal Expenses

The following legal expenses are ALLOWABLE:

1) Legal expenses required in the administration of the program on behalf of the State of Michigan or Federal Government.
2) 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.
3) Legal expenses incurred in the course of providing consumer care.

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

8.0 CONTRACT REMEDIES AND SANCTIONS

The state will utilize a variety of means to assure compliance with contract requirements. 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. The MDHHS may utilize actions in the following order:

A. Notice of the contract violation and conditions will be issued to the CMHSP with copies to the board.
B. Require a plan of correction and specified status reports that become a contract performance objective (Attachment C 7.0.2).
C. If previous items above have not worked, impose a direct dollar penalty and make it a non-matchable CMHSP administrative expense and reduce earned savings by the same dollar amount.
D. For sanctions related to reporting compliance issues, the MDHHS may delay 10% of scheduled payment amount to the CMHSP until after compliance is achieved. The MDHHS may add time to the delay on subsequent uses of this provision. (Note: The MDHHS may apply this sanction in a subsequent payment cycle and will give prior written notice to the CMHSP).
E. Initiate contract termination.

The implementation of any of these actions does not require a contract amendment to implement. The sanction notice to the CMHSP 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 CMHSP 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. Failure to complete or achieve contractual performance objectives.
E. Substantial inappropriate service denial of services required by this contract or substantial services not corresponding to condition. Substantial can be a pattern or large volume or small volume, but severe impact.
F. Repeated failure to honor appeals/grievance assurances. Substantial or repeated health and/or safety violations.

9.0 RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES

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

9.1 General Provisions

A. Notify the CMHSP of changes in contractual services or conditions of providing contractual services.
B. Protect against fraud and abuse involving MDHHS funds and recipients in cooperation with appropriate state and federal authorities.
C. Administer an alternative dispute resolution process for recipients not Medicaid eligible to consider issues regarding suspension, termination or reduction of services and supports defined in the Grievance and Appeal Technical Requirement.
D. Collaborate with the CMHSP on quality improvement activities, fraud and abuse issues, and other activities that impact on the services provided to recipients.
E. Conduct a recipient quality of life survey and publish the results.
F. Review CMHSP marketing materials.
G. Apply contract remedies necessary to assure compliance with contract requirements.
H. Monitor the operation of the CMHSP to ensure access to quality care for all individuals in need of and qualifying for services.
I. Monitor quality of care provided to recipients of CMHSP services and supports.
J. Refer local issues back to the CMHSP.
K. Coordinate efforts with other state departments involved in services to these populations.
L. Administer the Children's Waiver Program.
M. Administer the PASARR Program.
N. When repeated health and welfare issues/emergencies are raised or concerns regarding timely implementation of medically necessary (Children's Waiver and SEDW only) services the MDHHS authority to take action is acknowledged by the CMHSP.

9.2 Contract Financing

The MDHHS shall pay to the CMHSP, state general funds and PASARR funds, as agreed to in the contract.

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

A. Action by the Michigan state legislature that removes any MDHHS funding for, or authority to provide for, specified services.
B. 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.

C. 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.

9.3 State Facilities

The MDHHS agrees:

A. To supply to the CMHSP, at the time of completion, copies of the State Facilities' ability-to-pay determination on each county resident admitted to a state facility, to inform the CMHSP of any claims on the financial assets of recipients and their families, and of any appeals by recipients or their families.
B. To pursue all possible first- and third-party reimbursements.
C. To provide the CMHSP with rates for state-managed services no later than October 1 of each fiscal year. Rates shall be issued that include the net state rate paid by the CMHSP and the gross rate on which the local share of facility billings is based.
D. The protection and investigation of the rights of recipients while on inpatient status at the state hospital or center shall be the responsibility of the MDHHS Office of Recipient Rights. When requested, the MDHHS Office of Recipient Rights shall share appropriate information on investigations related to the CMHSP's residents in accordance with the confidentiality provisions of the Michigan Mental Health Code (P.A. 258 of 1974 as amended, Section 748).
E. To comply with the NGRI Protocol C 6.9.1.1.
F. To comply with attachment C 6.9.1.2.

9.4 Reviews and Audits

The MDHHS may conduct reviews and audits of the CMHSP regarding performance under this contract. The MDHHS shall make good faith efforts to coordinate reviews and audits to minimize duplication of effort by the CMHSP and independent auditors conducting audits and Compliance Examinations.

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

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.

9.4.1 MDHHS Reviews

Some parts of the Review and Audit procedures outlined in this section do not apply to MDHHS site visits, in that those site visits combine the review of the CMHSP and the PIHP.

A. 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.
B. The MDHHS will schedule 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.
C. Except as precluded in Section 9.4.1 (B) above, the guideline, protocol and/or instrument to be used to review the CMHSP, or a detailed agenda if no protocol exists, shall be provided to the CMHSP at least 30 days prior to the review.
D. At the conclusion of the review, the MDHHS shall conduct an exit interview with the CMHSP. The purpose of the exit interview is to allow the MDHHS to present the preliminary findings and recommendations.
E. Following the exit review, the MDHHS shall generate a report within 45 days identifying the findings and recommendations that require a response by the CMHSP.
    1. The CMHSP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The CMHSP may also present new information to the MDHHS that demonstrates they were in compliance with 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 CMHSP 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 (D) above.
    2. The MDHHS will review the POC, seek clarifying or additional information from the CMHSP as needed, and issue an approval of the POC within 30 days of having required information from the CMHSP. The MDHHS will take steps to monitor the CMHSPs implementation of the POC as part of performance monitoring.
    3. 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.
F. The CMHSP can appeal findings reflected in review reports through the dispute resolution process identified in this contract.

9.4.2 MDHHS Audits

Some parts of the Review and Audit procedures outlined in this section do not apply to MDHHS site visits, in that those site visits combine the review of the CMHSP and the PIHP.

A. As used in this section, an audit is an examination of the CMHSP and its contract service providers' financial records, policies, contracts, and financial management practices, conducted by the MDHHS Office of Audit or its agent, to verify the CMHSP's compliance with legal and contractual requirements.
B. The MDHHS will schedule audits at mutually acceptable start dates to the extent possible. The MDHHS will provide the CMHSP 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 CMHSP to review the nature and scope of the audit.
C. The MDHHS audits of CMHSPs will generally supplement the independent auditor's Compliance Examination and may include one or more of the following objectives:
    1. To assess the CMHSP's effectiveness and efficiency in complying with the contract, and establishing and implementing specific policies and procedures as required by the contract;
    2. To assess the CMHSP'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 (Children's Waiver and SEDW Only); and applicable accounting standards; and
    3. To determine the MDHHS's share of costs in accordance with applicable MDHHS requirements and agreements, and any balance due to/from the CMHSP.

    To accomplish the above listed audit objectives, MDHHS auditors will review CMHSP documentation, interview CMHSP staff members, and perform other audit procedures as deemed necessary.
D. The audit report and appeal process is identified in Attachment C 9.3.2.1 and is a part of this contract.

10.0 RESPONSIBILITIES OF THE DEPARTMENT OF ATTORNEY GENERAL

The MDHHS has responsibility and authority to make all fraud and/or abuse referrals to the Department 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 (855) MI-FRAUD (643-7283) or by sending a memo to:

Office of Inspector General
Michigan Department of Health & Human Services

P. O. Box 30062
Lansing, MI 48909

When reporting suspected fraud and/or abuse, the contractor should provide, if possible, the following information to the 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 if applicable 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 Department of the Attorney General, and with any subsequent legal action that may arise from such investigation.

In addition, the CMHSP must report the following to the MDHHS on an annual basis:

- Number of complaints of fraud and abuse made to the state that warrants preliminary investigation.
- For each which warrants investigation, supply the
    1. Name
    2. ID number
    3. Source of complaint
    4. Type of provider
    5. Nature of complaint
    6. Approximate dollars involved, and
    7. Legal & administrative disposition of the case.

The annual report on fraud and abuse complaints is due to MDCH on January 31st, and should cover complaints filed with the state during the fiscal year. It should be filed electronically at MDHHS-BHDDA-Contracts-MGMT@michigan.gov.

COUNTY OF FINANCIAL RESPONSIBILITY
Technical Requirement for CMHSPs

I. INTRODUCTION

Lack of statutory clarity with respect to establishing County of Financial Responsibility (COFR) has, in some cases, resulted in delays of appropriate services to consumers, protracted disputes and inconsistency of resolution across the state. This is particularly true for consumers who have never received services from a state operated facility and for whom financial responsibility is thus not addressed directly by Chapter 3 of the Mental Health Code. CMHSPs are statutorily responsible for serving persons 'located' in their jurisdiction even when responsibility for payment is in question. This technical requirement provides a contractual basis for determining County of Financial Responsibility and a process for resolving disputes, regardless of funding source.

This technical requirement is based on the following principles:

- Consumers have a right to choose where they live, unless restricted by court order.
- Consumer requests for particular providers, regardless of location, must be considered within the person centered planning process.
- Capitation payments are intended to be a means of funding PIHPs to provide defined benefits to eligible beneficiaries within a system of services. As such, they are not intended as payment for services to any identified individual consumer. Therefore, this Requirement assumes that the receipt of a PEPM payment should not be considered in determining the COFR, nor is specific consideration of the amount of a PEPM a factor in determining the obligation to pay of the COFR.
- Funding for persons served through the Habilitation Services (1915-C) Waiver is intended to support services to named individuals. Thus, such funding should be considered when determining the payment obligation of a COFR when the consumer is served outside the COFR.
- Consumers served according to the terms of this contract must be provided appropriate service without delay resulting from issues of financial responsibility. Community Mental Health Services Programs/Prepaid inpatient Health Plans will act ethically to provide service to consumers meeting eligibility requirements when the COFR is disputed.

II. ESTABLISHING COUNTY OF RESPONSIBILITY

A. General Rule. For persons served under the terms of this contract, the financially responsible CMHSP is the one that served them in the county where they last lived independently.

B. Children. The COFR will be the county where the child and parents have their primary residence, unless the child (including individuals through age 19) is a temporary or permanent ward of the court. For temporary and permanent wards of the court (including tribal), the COFR is the county served by the 'court of record', which is where the child was made a ward of the court, or where

jurisdiction of the court was transferred upon movement of the child. This court is the 'court of record', which is the 'court of jurisdiction'. For adopted children, once adoption proceedings are completed, the COFR is the county where the adoptive parents have their primary residence.

In the case of divorced parents, the COFR is the county in which the parent with legal and physical custody resides. If the parents have joint legal and physical custody, the COFR is the county of residence of the parent with whom the child lives while attending school.

In the case of a child placed by parents into the custody of a legal guardian with authority to consent, the COFR is the county in which the guardian resides, for the period of the placement. If the parent(s) place the child into the custody of another adult without guardianship, the COFR remains the county where the parent with legal and physical custody resides.

In the case of a voluntary placement of a child by parents into a 24-hour dependent care facility funded by a CMHSP, the COFR is the residence of the parent with legal and physical custody at the time of placement. If the parent(s) move during the placement, upon the children's discharge, the COFR is the county in which the parent with legal and physical custody resides.

A child who is legally emancipated, or reaches age 18, and establishes an independent residence shall be considered a resident of the county where he or she resides. A child who is discharged from a dependent care setting upon reaching age 18, and who is not a ward of the court, and establishes an independent residence shall be considered a resident of the county of that residence. The General Rule (A above) shall apply to a child who attains adult status by reaching the age of 18 or through legal emancipation when discharged into a new dependent setting, or when that adult chooses to remain in the same dependent setting, so long as that individual is no longer a ward of the court.

C. Adults. Consumers have the right to choose where they live, unless restricted by a court order.

- The choice shall be considered to be the consumer's/guardian's choice when it is not instigated or facilitated by a service manager or provider. Assistance by service managers or providers in a County to notify another County of the consumer's decision to move shall not be determined to be facilitation of the choice.

When a consumer, who is living dependently, chooses to relocate from County A to County B into a dependent living situation, the COFR shall remain the county in which he/she last lived independently.

When a consumer relocates to a dependent setting in County B from an independent setting in County A, County A shall remain the COFR, under any of the following circumstances:

- There is an existing agreement between County A and County B; or
- County A has continued to provide and pay for Mental Health Services; or
- The consumer requests services from County B within 120 days of relocation

When the CMH (including direct or contracted service providers), or MDHHS office initiates and facilitates the relocation of an adult consumer from County A to County B, County A shall remain the COFR.

When the consumer and/or his/her family wishes to obtain services in county B because services in County A have been determined to be unavailable through a Person-Centered Planning process, County A remains the COFR, with responsibility to authorize and pay for the service, if that service meets eligibility guidelines utilized by County A.

D. Persons Living in Unlicensed Settings.

Unlicensed settings are generally considered to be independent living. The COFR is the CMHSP serving the county where the residence is located. If the consumer's Level of Care and Intensity of Service required is equivalent to a dependent living setting, the consumer shall be considered to be in dependent care for the purposes of COFR. Equivalency to dependent care shall be established when the individual's Person Centered Plan provides for provision of eight or more hours of specialized services and/or supports in the residence each day.

E. Provision of Specialized Mental Health Treatment Services to Persons in Nursing Homes.

For provision of OBRA Specialized Services, the COFR is the county in which the nursing home is located. For mental health services which are not specialized, financial responsibility shall be assigned as in A. above.

F. Jail.

CMHSPs are responsible to provide mental health services to their local county correctional facilities (jails) on the same basis as they provide services to other persons located in their geographical jurisdiction. CMHSPs shall work with Jail personnel to ensure that all reimbursements for health services are pursued, including the county's (not the CMHSP's) responsibility to pay for the costs of health care. If a jailed individual requires State provided inpatient care, the COFR shall be the COFR prior to the individual entering jail. When an individual is released from jail and establishes an independent residence in the county of the jail, the COFR shall be the county in which the residence is located. If the person is released into a dependent setting, the COFR shall be assigned according to the General Rule (A. above).

G. State Correctional Facility.

When an individual is released, at the end of his/her sentence or on Parole, the COFR shall be the County in which the individual last lived independently prior to entering the correction facility, under the following circumstances:

- The individual has been receiving *specialized* mental health services in Prison, and is determined to have a continued and immediate need for services; or
- The individual requests specialized services, or is involuntarily committed for specialized services within 30 days of release AND
- Meets the eligibility standards for Medicaid or access standards of the CMHSP for GFfunded services.

H. Extent of Financial Liability.
The County which is financially responsible shall pay the full cost of authorized services provided beginning on the date the consumer enters the service system.

It is the responsibility of the serving CMHSP to notify the CMHSP which is, or may be determined under this requirement to be, the COFR that a consumer has initiated a request for service or has been served in a crisis situation. Should the consumer's clinical condition prohibit gathering of information to determine COFR, the COFR's liability shall be limited to 30 days prior to notification by the serving board.

I. Standard for Response by COFR.
Upon notification that a consumer has requested services outside its jurisdiction, the COFR shall respond to a request by the servicing Program/PHP within the Access Standard timelines for all consumers, as specified in this contract.

J. PEPM Payments/Medicaid Residency Status.
Serving CMHSPs shall work to change Medicaid Residency Status, and the corresponding PEPM payment, where appropriate. However, Medicaid Residency status, and the PIHP receiving the capitated payment are not determining factors in establishing COFR.

K. Contractual Arrangements.
Nothing in this Requirement precludes a contractual arrangement between CMHSPs/PIHPs which specifies conditions, standards, or protocols other than those contained in this document, so long as those provisions are consistent with statute and regulation and do not violate provisions found elsewhere in this contract. When such arrangements provide for the permanent transfer of responsibility, the following conditions must be met.

1. It is optional; all parties agree to the arrangement
2. It applies to adult consumers only
3. The contract applies to consumers who are in stable, long-term living arrangements outside their 'home' CMHSP, without plans to move
4. The principles underlying the COFR agreement remain intact, including the consumer's right to choose

5. The consumer's service array, based on needs assessment and consumer choice will not be altered as a function of this contract
6. For HSW enrollees, the HSW certificate will be transferred upon MDHHS receipt of documentation from both the 'home' and the 'serving' PIHPs with an effective date of transfer
7. The end date of the contract is the beginning of the fiscal year when the capitation rate of the 'serving' county includes the costs reported

III. DISPUTE RESOLUTION

Good faith efforts to resolve disputes, utilizing principles of ethical conduct, and the standards contained in this document must be made prior to initiating this Dispute Resolution process. In order to facilitate informal dispute resolution, each CMHSP/PHP shall provide the name of a responsible contact person to the manager of this contract and to the MACMHB for publication on its website. This good faith effort shall include documented notification of the Executive Director of each CMHSP regarding the known facts and areas of disagreement within two business days of identification of the disagreement.

When formal Dispute Resolution is required, the following process shall be used:

A. Dispute Resolution Committee.

A COFR Dispute Resolution Committee, consisting of three persons, shall be constituted annually, at the beginning of the fiscal year. One person shall be appointed by MDHHS and two shall be appointed by the MACMHB. Vacancies on the committee shall be filled within ten days. The Committee shall appoint its chair by consensus. The MACMHB shall appoint a third person who will serve as an alternate representative in cases which would present a conflict of interest for one of the regular representatives.

B. Initiation of Dispute Resolution.

Either party may initiate dispute resolution by notifying the
MACMHB and the MDHHS Contract Manager identified in this contract in writing.

C. Fact Finding.

The MACMHB shall notify each Board/PIHP, and all members of the Dispute Resolution Committee, within three business days of receiving notification, that a formal dispute has been received. Each CMHSP shall respond to MDHHS and the MACMHB, with a copy to the other CMHSP/PIHP, within three business days with a written response, including

- The facts as each entity sees them;
- The rationale for their position, including documents to support their position. In cases involving a child who is a ward of the court, documents must include a court order which establishes the 'court of record/jurisdiction'. Additional documents may be presented at the hearing.

D. Dispute Resolution Meeting.

The Dispute Resolution Committee will designate a time and place for a resolution meeting, which will be held no later than 30 days following submission of the facts identified in B. above. At this time

- Each CMHSP's (or PIHP's in cases involving Medicaid) designated responsible representative will attend. Each representative will be provided an opportunity to make a verbal presentation regarding the case. Each CMHSP (PIHP) representative must be empowered by its CMHSP (PIHP) to negotiate a settlement of the dispute.
- Should a negotiated settlement not be reached at this meeting, the committee will meet, without others present, to arrive at a decision reached by majority vote of the Resolution Committee.
- The decision shall be reached, and conveyed to the disputing parties, on the day of the meeting.
- A record of each proceeding, including documentation of the facts and the decision, shall be kept by the MDHHS and by the MACMHB for public review.

IV. DEFINITIONS

"Living Independently". The following factors will be used to determine whether a person is 'living independently':

- The location in which the person is residing is not transient. For example, residing in a motel or hotel which is rented by the day or week, without intent to remain in the community is not considered 'living independently.' Likewise, placement in a half-way house upon release from jail or prison is not considered 'living independently'. Living in a vehicle is also not considered 'living independently.'
- Migrant workers shall be considered the responsibility of the CMHSP in which they are housed.
- The intent of the individual to be part of the community shall be considered. For example, persons who are homeless, living on the street or in a shelter shall be considered part of the community, when the intent of the person is to remain in the community.
- The location in which the person resided prior to moving into a county was not a boarding school, a facility, or a dependent living setting as defined in the Mental Health Code and utilized in Section 306 thereof.

Provider. As used in Part II, C above, means a provider of specialized behavioral health services or a dependent living site regardless of whether such services are delivered under contract with a CMHSP/PIHP.

PREPAID INPATIENT HEALTH PLANS AND COMMUNITY MENTAL HEALTH SERVICES PROGRAMS

ACCESS SYSTEM STANDARDS

Revised: February, 2014

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 mental 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 mental illness 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 or, for those who do not have any of these benefits as a person whose presenting needs for mental 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 mental 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, 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. For individuals with substance use disorders, the Access Management Standards for Substance Use Disorder Services shall apply for access to substance use disorder treatment. Access Management Standards for Substance Use Disorder Services can be found at:
http://www.michigan.gov/documents/MDHHS/Policy_Tx_07_AMS_183337_7.pdf

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.
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.
    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.
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[1], 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
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[2].
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.

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

[1] For definition of emergent and urgent situations, see MHC §330.1100a and 1100d
[2] 42 CFR §438.114

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[3]. 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[4].
c. The access system shall inquire as to the existence of any established medical or psychiatric advance directives relevant to the provision of services[5].
d. The organization shall assure coverage and provision of post stabilization services for Medicaid beneficiaries once their crises are stabilized[6]. 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. 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 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[7]. 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

[3] MDHHS Administrative Rule 330.2006
[4] MHC § 330.1206 and 1409
[5] 42 CFR §438.6; MCL 700.5501 et seq
[6] 42 CFR §438.114.
[7] MHC §330.1208

Manual of Mental Health Disorders (DSM)[8], 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 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[9].
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.
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.
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. Legal eligibility and priority criteria (where applicable).
    iv. Documentation of any emergent or urgent needs and how they were immediately linked for crisis service.
    v. Identification of screening disposition.
    vi. 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[10].
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[11].

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[8] 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

[9] Public Health Code P.A. 368 of 1978 §333.6100 and 6200 and MDHHS Administrative Rule 325.14101

[10] MHC §330.1208

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.

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[12].

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[13]. 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.
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.

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 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 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.

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[11] MHC §330.1226
[12] 42 CFR §438.208
[13] Choice of providers: 42 CFR §438.52.

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.

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.

b. **Rights**

i. The access system shall provide Medicaid and MIChild beneficiaries information about the local dispute resolution process and the state Medicaid Fair Hearing process[14]. When an individual is determined ineligible for Medicaid specialty service and supports 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)[15]. The access system shall provide individuals with substance use disorders, or persons with co-occurring substance use/mental illness with information regarding the local substance abuse coordinating Office of Recipient Rights[16].

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[17].

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.

v. The access system shall ensure the person and any referral source (with the person's consent) are informed of the reasons for denial,

[14] 42 CFR § 438.10.
[15] MHC §330.1706
[16] MDHHS Administrative Rule 325.14302
[17] MHC §330.1706

and shall recommend alternative services and supports or disposition[18].

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[19].
   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[20].

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.
   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[21].

[18] 42 CFR § 438.10
[19] 42 CFR § 438.10
[20] 42 CFR § 438.10
[21] 42 CFR §438.214. MDHHS/PIHP Contract, Part II, Attachment 6.7.1.1

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[22].
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[23].
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.

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[24]. The policies and procedures shall minimally assure:
   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[25]. 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.

[22] 42 CFR §438.10
[23] Michigan Medicaid Provider Manual, General Information Chapter
[24] MHC §330.1124
[25] MHC §330.1208

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.

Michigan Department of Health and Human Services
Mental Health and Substance Abuse 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 Recovery Council
Recovery Policy and Practice Advisory
Version: 6/13/11

Purpose and Application

It is the policy of Michigan Department of Health and Human Services (MDHHS) that services and supports provided to individuals with mental illness including co-occurring conditions are based in recovery. 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 of the Michigan Recovery Council (to give voice), establishment of the Michigan Recovery Center of Excellence (to share resources) and the development of a peer workforce (to share the journey).

In order to move toward a recovery-based system of services, the beliefs and knowledge about recovery must be strengthened. MDHHS asked the Recovery Council to develop and has adopted the following recovery statement, guiding principles and expectations for systems change:

Recovery Statement

Recovery is choosing and reclaiming a life full of meaning, purpose and one's sense of self. It is an ongoing personal and unique journey of hope, growth, resilience and wellness. In that journey, recovery builds relationships supporting a person's use of their strengths, talents and passions. Recovery is within each and every individual.

Guiding Principles of Recovery

The following principles outline essential features of recovery for the individual:

1. *Recovery is a Personal Journey* and each person can attain and regain their hopes and dreams in their own way. Each journey is grounded in hope, and a sense of boundless possibilities. The strength, talent and abilities of each individual provide an opportunity to reach his or her own life goals. Everyone can attain and maintain recovery and move to a place of independence beyond the public mental health system.

2. *Recovery includes all Aspects of Life* and is driven through the services and supports selected and controlled by the individual. Partnerships are formed based on trust and respect. Recovery will be attained and maintained with the support of friends, family, peers, advocates and providers.

3. *Recovery is Life Long* and requires ongoing learning. Each individual has the courage to plan for and achieve wellness. Increased personal knowledge builds experience in advocating for services and supports.

4. *Recovery iSupports Health and Wellness* and is the responsibility of each individual with support from others who provide physical and mental health services. Integrating physical and mental health is essential to wellness. Through self advocacy and support, the highest attainable quality of life will be achieved. With the integration of mental health and physical health, increased length of life is possible.

Expectations for Implementation of Recovery Practices

Based on the above principles, the Recovery Council established the following expectations to guide organizations at all levels in creating an environment and system of supports that foster recovery:

1. Promote changes in state law and policies at all levels to establish effective communication between peers, within systems and among service providers.

   Requirements:
   - Provide ongoing education to stakeholders on recovery principles and practices in conjunction with state level policies including recovery, trauma informed care, person-centered planning, and self-determination.

   - Develop and maintain a plan to educate and increase communication within the broader community using guidance and leadership from local recovery committees and councils.

   - Provide knowledge and education in partnership with the Michigan Recovery Council 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:
   - Provide a person-centered and peer-oriented access and welcoming process for individuals assessed for eligibility that addresses the reduction and elimination of redundant/duplicative paperwork.

   - Assure pathways are in place for expedited reentry into services for individuals who have been discharged, but once again need services and supports from the public mental health system.

   - Provide guidance during discharge planning with verbal and written information on how to access mental health and other community services.

3. Align policies, procedures and practices to foster and protect individual choice, control and self-determination, from the person-centered planning process through the arrangement of supports and services.

   Requirements:
   - Develop a proactive plan using baseline data to increase the number of self-determination arrangements as a direct result of choice during the person-centered planning process.

   - Provide an estimate of the cost of services annually, when significant changes occur to the individual plan of service and as requested by the individual following the person-centered planning process.

   - 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 peer support including the choice of working with Certified Peer Support Specialists (CPSS) as a choice and option for individuals throughout the service array and within the person-centered planning process.

   Requirements:
   - Develop and implement an educational approach with written materials to provide information to stakeholders on peer services.

   - Provide information on the choices and options of working with peers in a journey of recovery including CPSS as part of the person-centered planning process.

   - Collect baseline data on the number of individuals who receive peer services with a proactive plan on increasing the number of individuals served.

5. Address the concerns raised by the National Association of State Mental Health Program Directors (NASMHPD) report *Morbidity and Mortality in People with Serious Mental Illness* by aligning services and supports to promote and ensure access to quality health care and the integration of mental and physical health care. Specific 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 morbidity, mortality and co-morbid conditions with a strategic planning process to address and decrease risk factors associated with early death.

- Provide referrals and outreach to assist individuals with meeting their basic needs, including finding affordable housing and having enough income to address risk factors associated with poverty.

- Identify, develop and strengthen community partnerships to promote models and access for the integration of physical and mental 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 service array.

   Requirements:

   - Complete a strategic planning process that builds on the actions and outcomes of the Michigan Recovery Council, including results from the Recovery Enhancing Environment (REE) and implementation of the statewide recovery curriculum.

   - Provide ongoing education of recovery and environments that promote recovery with all staff, including executive management, psychiatrists, case managers, clinicians, support staff, leadership and board members.

   - Include a list of competencies in recovery principles and practices in employee job descriptions and performance evaluations.

   - Work in partnership with individuals receiving services, including CPSS, in all aspects of the development and delivery of recovery-oriented trainings and activities.

How Michigan's Efforts Align with Federal Policy

MDHHS recognizes that recovery is highly individualized. 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, as well as state and national policies. Recovery emphasizes the strong voice and advocacy of people with lived experience. By drawing on their personal experiences and powerful passion, they have been and remain the primary force in promoting systems transformation.

In 2006, the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) published a National Consensus Statement that defined recovery as "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 full potential." Additionally, the Consensus Statement lists the following "Ten Fundamental Components of Recovery" that are reflected in the Council's recommendations above:

Self-Direction	Individualized and Person-Centered
Empowerment	Holistic
Non-Linear	Strengths-Based
Peer Support	Respect
Responsibility	Hope

SAMHSA ten fundamental components and the MDHHS recovery policy and practices are just beginning to achieve their desired results. True change will require a series of legislative actions, state and federal policies and Mental Health Code changes intentionally designed to promote choice, voice and control for individuals who receive supports and services. Few states, Michigan included, have developed a policy and practice guideline on recovery, thus, MDHHS relied on the work, ideas and heart of the Recovery Council to craft this document.

Successful implementation of these guiding principles and recommendations for systems change will demand an active response from people in recovery across the state. The policy must be treated like recovery itself, with meaning, purpose, and dedication to support individual and system actions toward making it an "ongoing personal and unique journey of hope, growth, resilience and wellness." Hard work will be required to ensure that this policy is embraced and implemented. The Recovery Council and MDHHS look forward to assessing progress toward these principles every year.

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MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities
SELF-DETERMINATION POLICY & PRACTICE GUIDELINE[i]
October 1, 2013

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

[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.

individual choice and control of personalized provider relationships within an 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 Health & Human Services (MDHHS)). 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

Mental Health Services for Special Populations
Metrics and Reporting Template

Metrics for all Special Population Providers

- Number of persons served **(unduplicated count)**
- Number of psychiatric evaluations provided **(unduplicated count)**
- Number of mental health therapy sessions provided **(unduplicated count)**
- Number of Wraparound services provided **(unduplicated count)**

Report Narrative to describe:

- Client base served (including confirmation that special population funds were not used for services provided to illegal immigrants, fugitive felons and individuals who are not residents of the state-unless provided to individuals with emergent mental health conditions)
- Wraparound services provided
- Services and programs provided (outside of wraparound)
- Whether funds are tracked to the individual person receiving services. If funds are not tracked in this manner, please describe plans in place to be able to do so at the beginning of the next quarter.

	Unduplicated Number Provided During the Reporting Period	**Total Cost of Services**	**Amount funded through State Special Populations Funding**	**Amount Funded through other State funding sources (including Medicaid)**	**Amount funded through local funds**
Psychiatric Evaluations					
Mental Health Therapy Sessions					
Wrap Around Services					
Total Unduplicated Number of Persons Served During the Reporting Period					

PASARR AGREEMENT

I. PURPOSE

The CMHSP will complete PRE-ADMISSION SCREENINGS and ANNUAL RESIDENT REVIEWS (hereinafter referred to as PASARR) for individuals who are located in the CMHSP's MH/DD service area presenting for nursing facility admission, or who are currently a resident of a nursing facility located in said service area, as required by the Omnibus Budget Reconciliation Act (hereinafter referred to as OBRA) of 1987. The method of costing, billing and payment for these services is described below. This Agreement replaces any previous contract or amendment related to pre-admission screenings and annual resident review.

II. REQUIREMENTS

A. Evaluations and assessments as described herein shall be prepared and submitted in accordance with the following documents:

1. Medicaid Provider Manual Nursing Section only if the individual is a Medicaid beneficiary.

2. Federal Register/Vol 57, No. 230/Monday, November 30, 1992/Rules and Regulations/Subpart C -- Pre-admission Screening and Annual Resident Review of Mentally Ill and Mentally Retarded Individuals. These are operationalized in the OBRA Manual (5-04).

3. The CMHSP must ensure that all new employees, who administer PASARR, are trained on the policies and procedures with respect to the OBRA/PASARR process through Improving MI Practices website at: www.improvingmipractices.org.

The DEPARTMENT will notify the CMHSP of any changes in these documents due to federal rules and state requirements. The CMHSP will have implemented such changes within sixty (60) days of the DEPARTMENT's notification to the CMHSP unless otherwise provided by federal regulations.

PRE-ADMISSION SCREENING

B. The CMHSP will provide evaluations and assessments for all individuals located in the CMHSP's service area who are presented for admission to a nursing facility regardless of the location of the admitting facility and for whom a Level I Pre-admission Screening procedure (DCH Form 3877) has identified the possible presence of a mental illness or a developmental disability. This evaluation and assessment will be completed and an appropriate determination made prior to admission of the individual to a nursing facility. This evaluation and assessment will be completed utilizing criteria specified in

Paragraph A. above by OBRA electronic application or paper system requirements.

C. The CMHSP agrees that Pre-admission Screenings will be completed and required documentation submitted to the DEPARTMENT within four (4) working days of referral of the individual to the CMHSP by whatever agent performing the Level I identifies.

ANNUAL RESIDENT REVIEW

D. The CMHSP will provide Annual Resident Reviews to all nursing facility residents who are located in the CMHSP's service area and who have been identified through the Pre-admission Screening or Annual Resident Review process as having either a mental illness or developmental disability or who have otherwise been identified to the CMHSP by submission of DCH Form 3877. This evaluation and assessment must be completed utilizing criteria specified in Paragraph A. above.

E. The CMHSP agrees that Annual Resident Reviews will be completed and required documentation submitted to the DEPARTMENT within fourteen (14) calendar days of receipt by the CMHSP of an appropriately completed DCH Form 3877 from the nursing facility(ies). In the case of Annual Resident Reviews of persons who have been admitted to a nursing facility without a Pre-admission screening as an exempted hospital discharge, the CMHSP will complete a review and submit required documentation to the DEPARTMENT within fourteen (14) calendar days of referral. In either situation, if a CMHSP is unable to comply with this requirement in a particular case, the CMHSP will notify the DEPARTMENT.

III. RECORDS, BILLINGS, AND REIMBURSEMENT

A. The CMHSP will maintain all documentation and records concerning services provided, client treatment recommendations and treatment plans, and verification of compliance with standards for subsequent audit, and actual cost documentation for a period of seven (7) years and assure that all such documentations will be accessible for audit by appropriate DEPARTMENT staff and other authorized agencies.

B. The CMHSP will submit monthly billings to the DEPARTMENT for services provided based on an actual cost basis as defined in "Revised Billing Procedures for OBRA Pre-Admission Screening, and Annual Resident Review for Nursing Facility Clients" DCH memorandum, William J. Allen, October 2, 1996, which is included to this agreement. Only one (1) bill will be considered for payment per month, and should be submitted for payment to the DEPARTMENT within forty-five (45) days after the end of the month in which the service was provided, except for the September bill which shall be submitted within fifteen (15) days after the end of the month. In the event that the CMHSP realizes costs incurred after a billing has been submitted, the CMHSP may submit a revised billing. In any event, all

bills for services provided under this Agreement must be received by the DEPARTMENT within fifteen (15) days following the end of the fiscal year. Submitted bills will also include the number of evaluations completed during the month being billed by completing the "Detail of Services Billed" form. The PASARR forms located in the MDHHS OBRA Operations Manual must be utilized by the CMHSP for reporting and billing.

The CMHSP will submit a "Certificate of Indirect Costs" for indicating the indirect rate being used for indirect costs billed to the department. The form, attached, should be filled out annually.

C. Payments earned by the CMHSP for these services will be included as earned revenue from the DEPARTMENT on the revenue and expenditure reports required by this contract. PASARR expenditures will be specifically identified as part of the "Other Services" section of the final FSR. Separation by MI and DD is not required. All payments made under this Agreement are subject to the requirements under the Single Audit Act of 1984. The CFDA number for the federally funded portion of payments made to the CMHSP under this Agreement is 93.778.

IV. DEPARTMENT RESPONSIBILITIES

A. The DEPARTMENT agrees that for bills received pertaining to this Agreement and which are correctly and completely submitted on a timely basis as specified in Paragraph III.B. above, payments will be made within forty-five (45) days of receipt of bills for approved services. All payments will be made at 100% of the CMHSP's charge as submitted.

B. Preparing claims for federal financial participation and submitting these claims to the Medical Services Administration will be the responsibility of the DEPARTMENT. The CMHSP will provide the DEPARTMENT with such documentation as may be required to support claims for federal financial participation.

C. The DEPARTMENT will hold the CMHSP financially harmless where the CMHSP has followed procedures as outlined in Federal Office of Management and Budget 2 CFR Part 200, Subpart E – Cost Principles, and has documentation as to the services performed. The Federal Office of Management and Budget, 2 CFR Part 200, Subpart E – Cost Principles, is included in the MDHHS Technical Manual. The CMHSP will be responsible where procedures related to these identified evaluations are not followed or where documentation is lacking.

V. TERMINATION

The Agreement may be terminated by either party within sixty (60) days notice. Said notice shall be made in writing and sent by certified mail. Termination will take effect sixty (60)

days from receipt of said notice.

DETAIL OF SERVICES BILLED

Nursing Facility Evaluations

CMH Board Name:_____ Month/Year:_____

Name of Resident	Date of Birth	*Type of Screening	MI or DD	Date of Service
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

***Indicate PAS or ARR**

SUMMARY BILLING FOR PRE-ADMISSION SCREENING and ANNUAL RESIDENT REVIEWS (PASARR)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CMH BOARD_____TELEPHONE NUMBER:_____
PERSON COMPLETING FORM:_____
MONTH ENDING:_____ DATE SUBMITTED:_____
NUMBER of Reviews: DD_____ MI_____ TOTAL_____

I. DIRECT COSTS

TOTAL

A. Direct labor(excluding overtime, shift or holiday premiums and fringe benefits) $_____

B. Other Labor(overtimes, shift or holiday premiums and fringe benefits). $_____

C. Other Direct Costs(contractual services, supplies/materials, travel, equipment, telephone, office space, etc.) $_____

D. Subtotal Direct Costs: $_____

II. INDIRECT COSTS

Computation Method:
1. Approved Cost Allocation Plan: (Plan must be reviewed and approved by MDHHS before using indirect rate based on actual costs)
Direct Costs(I.D) above _____x Indirect Rate_____ $_____

III. TOTAL COSTS

(Direct and Indirect Costs) $_____

IV. FEDERAL REIMBURSEMENT

(Total Costs ..III Above) Total Costs_____ x .75 = $_____

CMHSP CERTIFICATION

The CMHSP has reported all costs at actual and in conformance with Federal OMB 2 CFR Part 200, Subpart E – Cost Principles. The CMHSP acknowledges that all costs are subject to audit for federal reimbursement purposes and assumes full responsibility and proper documentation.

_____ _____

COMMUNITY MENTAL HEALTH SERVICES PROGRAMS DIRECTOR **DATE**

I authorize the Total Costs (III above) to be paid to the Community Mental Health Services Board or Authority.

_____ _____

MDHHS Authorized Staff **DATE**

CERTIFICATE OF INDIRECT COSTS

This is to certify that the indirect cost rate proposal has been reviewed and is submitted herewith the knowledge and belief:

1. All costs included in this proposal, dated_____, to establish billing or final indirect costs rates for fiscal year_____, are allowable in accordance with the requirements of the Federal Award to which they apply and OMB 2 CFR Part 200, Subpart E – Cost Principles. Unallowable costs have been adjusted for in allocating costs as indicated in the cost allocation plan.

2. All costs included in this proposal are properly allocable to Federal awards on the basis of a beneficial or casual relationship between the expenses incurred and the agreements to which they are allocated in accordance with applicable requirements. Further, the same costs that have been treated as indirect costs have not been claimed as direct costs. Similar types of costs have been accounted for consistently and the Federal Government will be notified of any accounting changes that would affect the predetermined rate. If the department finds that the indirect rate was not determined correctly, the CMH agrees to pay the department any difference of all payments made.

I declare that the foregoing is true and correct.

Community Mental Health Agency:

Name:_____

Signature:_____

Title:_____

Date:_____

STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF COMMUNITY HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48913
JAMES K. HAVEMAN, JR., Director

October 2, 1996

TO: Executive Directors
Community Mental Health Services Programs

FROM: William J. Allen, Chief Executive Officer
Behavioral Health

SUBJECT: Revised Billing Procedures for OBRA Pre-Admission Screening, Initial and Annual Resident Reviews for Nursing Home Clients

Billings for PASARR screenings are governed by the federal A-87 circular. This document defines direct and indirect costs. In the past A-87 has allowed indirect cost to be based on 10% of direct labor costs or on a percentage approved by the federal government through the submission of a cost allocation plan. Recent changes to the A-87 process allow the state agency to approve a percentage based on a cost allocation model. The Department is in the process of developing a methodology for such cost allocation which is expected to be completed this fall. In the interim, CMHSPs may use one of the following three methodologies for calculating indirect costs under the PASARR contract:

1. An accepted and approved AIS/MR cost report.

2. The indirect rate from a cost allocation plan developed by Griffiths & Associates that has been approved by the department.

3. The past policy of using 10 percent of the direct salaries and wages as an indirect rate.

When the standardized model for cost allocation has been adopted, the method using the 10 percent and AIS will no longer be acceptable.

Reasonable compliance with procurement procedures is also required for securing contracted services, including documentation of any sole service contracts in accordance with federal requirements. Attachments include the following items:

1. OBRA procedure for billing
2. OMB Circular A-87
3. 45 CFR 74, subpart P
4. Appendix G - Attachment O of OMB Circular A-102
5. Instructions and billing form for completing billings

Any questions concerning these cost accounting requirements should be addressed by the Department of Community Health, Revenue Enhancement Division, Richard Miles or Richard Foster.

WJA:SOH:eed
Attachments

c. David Verseput
David Viele
Richard Miles

STATEMENT OF WORK

1915(c) Home and Community Based Waiver for Children with a Serious Emotional Disturbance (SEDW) Traditional Population

Responsibility of CMHSP

A. The CMHSP shall provide the local financial obligation for the federal funds paid under the SEDW for services to recipients enrolled in the SEDW as long as the recipient continues to be eligible for the waiver and has service needs as determined through a wraparound process. This may include state or local general fund /general purpose dollars and must constitute 'clean match' to the federal funds.

The CMHSP and partner agencies are responsible to provide local match for the federal dollars. In the event that partner agencies are unable to provide the required local obligation, or provide funds that do not qualify as match for Federal Medicaid funds, the CMHSP is responsible for providing the match obligation. MDHHS will reimburse the CMHSP the federal share of SEDW services billed fee-for-service at the lesser of charge or Medicaid fee screen. MDHHS will reduce the state portion of the general fund formulae dollars of the total financing available to the CMHSP to meet the match obligation. I. As part of periodic audits, if there is a retroactive disallowance of one of the fund sources for the match, the CMHSP is responsible for that portion that is reimbursed to the federal government.

B. When a child and his/her family move to a county within Michigan that has an enrolled CMHSP provider for the SEDW, the child remains eligible for the waiver. When the original county becomes aware the family will be moving, the CMHSP will assist the family by coordinating the transfer with the receiving county and will notify MDHHS with the expected date of transfer. When the family moves, the receiving county will identify the Child and Family Team. The Team will determine if the current IPOS will be adopted as written, revised, or a new planning meeting will be scheduled. The receiving county will submit a new Waiver Certification form. However, if the child and his/her family move to a county where the CMHSP is not a participating CMHSP for the SEDW, the child's waiver must be terminated.

1915(c) Home and Community Based Waiver Services and State Plan Services to Children with Serious Emotional Disturbance (SEDW) enrolled in the Michigan Department of Human Services (MDHHS) SEDW Project

The MDHHS Project includes children in foster care and children adopted from Michigan's child welfare system. The MDHHS will transfer funds to the Michigan Department of Health and Human Services (MDHHS) to match Medicaid for those services provided to MDHHS children enrolled on the SEDW. MDHHS will reimburse the CMHSPs participating in the MDHHS SEDW Project the state and federal match for services billed on a fee for service basis, at the lesser of charge or Medicaid fee screen.

Responsibilities

The MDHHS in accordance with the general purposes and objectives of this agreement will provide reimbursement on a fee-for-service basis in accordance with the terms and conditions of this agreement contingent upon appropriate reports, records, and documentation being maintained by the CMHSP.

MDHHS SEDW Project Procedural Requirements

A. Develop local agreements with County MDHHS offices outlining roles and responsibilities regarding the MDHHS SEDW Project.

B. MDHHS workers and CMHSP Wraparound Supervisors identify a specific referral process for children identified by MDHHS as potentially eligible for the SEDW.

C. Participate in required SEDW Project State/Local technical assistance meetings.

D. Collect and report to MDHHS all data as requested by MDHHS and as specified in the local agreement with DHS for children and youth enrolled in the MDHHS SEDW Project.

E. Children in the SEDW, may reside in foster care in a non-participating county pursuant to placement by MDHHS or the court of a participating county, with SEDW oversight by a participating county's CMHSP. Further, as described in the MDHHS/CMHSP Managed Mental Health Supports and Services Contract, the County of Financial Responsibility will be the county where the child and parents have their primary residence, unless the child (including individuals through age 19) is a temporary or permanent ward of the court. For temporary and permanent wards of the court (including tribal courts), the COFR is the county served by the 'court of record', which is where the child was made a ward of the court, or where jurisdiction of the court was transferred upon movement of the child. This court is the 'court of record', which is the 'court of jurisdiction'.

TECHNICAL REQUIREMENT FOR SED CHILDREN
REVISED May 2, 2016

REGARDING: 1) MEDICAID ELIGIBILITY CRITERIA FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE; AND 2) ESTABLISHING GENERAL FUND PRIORITY FOR MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

General Considerations:

This requirement provides a framework to be used by Community Mental Health Services Programs (CMHSPs) for establishing general fund priority for mental health services to children with SED according to the requirements of the Michigan Mental Health Code (Section 330.1208). The criteria framework for general fund priority for non-Medicaid 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 general fund priority framework in the Technical Requirement is that diagnosis alone is not sufficient to determine eligibility for general fund priority for services. This means that the practice of using a defined or limited set of diagnoses to determine general fund priority 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 general fund priority framework delineated in this document is intended to: (1) assist Community Mental Health Services Programs (CMHSPs) in determining severity, complexity and duration that would indicate a need for specialty mental health services and supports for non-Medicaid children to establish priority for service under the Michigan Mental Health Code, 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.

Selection of Services

For Non-Medicaid children, once an eligibility determination has been made based on the criteria delineated in this document, selection of services is determined based on priority of general funds and person-centered planning and family-centered practice.

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. CMHSPs typically use "unspecified" diagnosis codes found in the ICD-10 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 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

> 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.

[1] The recommendations for the CAFAS scores as detailed under the functioning dimension described in this document is estimated to capture about 84.2% of the children currently being served by CMHSPs.

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:

Area I:

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:

<u>Area I</u>:

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 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.

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. 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.		

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**

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 G47.50 Parasomnia, unspecified G47.9 Sleep disorder, unspecified F51.4 Sleep terrors (night terrors)
510 Sleep onset disorder		
520 Night waking disorder		
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-10 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

MENTAL HEALTH COURT
PARTICIPANT DATA REPORT INSTRUCTIONS
Revised: July, 2012

Instructions:

The Participant Data Report form is to be completed each quarter and is due 30 days following the end of the quarter. Due dates are January 30 for the first quarter, April 30 for the second quarter, July 30 for the third quarter and October 30 for the fourth quarter. Please email the completed form to Jackie Wood at woodj10@michigan.gov Questions regarding this request should be directed to Jackie Wood by phone at 517.373.4316 or e mail.

Section A. Mental Health Court Participants

This section of the spreadsheet is intended to identify, in rows A-1 through A-4 the number of mental health court participants by quarter. The areas highlighted in yellow are for entry.

Column Descriptions

C-A This column represents the number of participants in the 1st quarter.
C-B This column represents the number of participants in the 2nd quarter
C-C This column represents the number of participants in the 3rd quarter
C-D This column represents the number of participants in the 4th quarter

Row Descriptions

The first four rows are intended to identify the number of participants as of the last day of the previous quarter – the end of period participants is the beginning count for the next quarter. The subsequent rows are intended to identify new participants during that quarter and the number leaving during the time period. Row B-4 should represent the number of participants as of the end date of the reporting period.

A-1 Beginning of the Time Period. (Last day of previous quarter, automatically entered from previous quarter - except for Q1 when you have to manually enter "ending" from Q4 of previous fiscal year)
A-2 New Participants During the Time Period
A-3 Participants Leaving Program During the Time Period (Automatically enters from the sum rows of A-5 through A-7)
A-4 End of the Time Period Participants (Automatically enters into next quarter Beginning Time Period)

The next set of rows is intended to describe, in further detail, the participants entered in row B-3. That is, if 14 participants left the program during the reporting period, the sum of rows B-5 through B-8 should equal the number reported in B-3.

Disposition of Persons Exiting the Program
A-5 Terminated by Program-Compliance
A-6 Dropped Out/Participant Choice
A-7 Completed
A-8 Other (describe) For this row, provide additional information that describes the disposition of the participant.

MENTAL HEALTH COURT
CONSUMER UNIQUE ID REPORTING INSTRUCTIONS

GENERAL INFORMATION:

Each CMHSP where a mental court project exists is required to submit information annually that will permit the Department to identify QI and encounter information for mental health court participants from the state warehouse.

The instructions below provide guidance for the transmittal of the necessary information for each mental health court participant. A standardized Excel spreadsheet format has been developed for this purpose.

REPORTING PERIOD AND DUE DATE:

Each project must submit information for each consumer participating in the mental health court projects during the report period. The report period requested covers the period of 10/1/2012 through 9/30/2013 and is due 10/31/2013.

REPORTING FORMAT (EXCEL SPREADSHEET):

The attached spreadsheet requires the following format and information requirements:

- Include the CMHSP name, the name of the contact person submitting the spreadsheet, and the contact email and phone number.

Column A. This column represents the PIHP ID

Column B. This column represents the CMHSP ID

Column C. This column represents the Consumer Unique ID

Column D. This column represents the Medicaid ID if the consumer has a Medicaid ID.

Column E. This column represents the SCCM Case ID number. The SCAO SCCM number can be obtained by contacting the individual assigned by the court to enter participant data into the SCCM web-based database. Note-this is not the docket number but a unique number assigned by the SCCM database for each participant.

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MENTAL HEALTH COURT
PARTICIPANT DATA REPORT INSTRUCTIONS
Revised: July, 2012

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Mental Health Court Participant Report

CMHSP: CMHSP Name

CMH Contact (name, e-mail and phone) for questions: Contact Name / Email / Phone Number

Reporting Time Period: Reporting Time Period

Revised May 2011

A	Mental Health Court Partipants By Time Period	Actual				Comments
		Qtr 1: 10/1-12/31	Qtr 2: 1/1-3/31	Qtr 3: 4/1-6/30	Qtr 4: 7/9-9/30	
		C-A	C-B	C-C	C-D	
1	Beginning of the Period		0	0	0	
2	New Participants During the Period					
3	Participants Leaving Program	0	0	0	0	
4	End of the Period Participants	0	0	0	0	
	Disposition of Persons Exiting Program	0	0	0	0	
5	Terminated by Program-Compliance					
6	Dropped Out/Participant Choice					
7	Completed					
8	Other (describe)					

MENTAL HEALTH COURT
CONSUMER UNIQUE ID REPORTING INSTRUCTIONS

GENERAL INFORMATION:

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If you have any questions, please contact Jackie Wood at woodj10@michigan.gov or at (517) 373-4316.

Mental Health Court Participant Consumer ID Numbers

For The Period 10/1/16 - 9/30/17

Due 10/31/17

CMHSP Name:	Type CMHSP Name Here
Contact Person:	Type Contact Name Here
Contact Telephone:	Type Contact Phone Number Here
Contact Email:	Type Contact Email Address Here

PIHP ID	CMHSP ID	Unique ID	Medicaid ID	SCAO SCCM Case #

Mental Health Court Participant Consumer ID Numbers

For The Period 10/1/16 - 9/30/17

Due 10/31/17

CMHSP Name:	Type CMHSP Name Here
Contact Person:	Type Contact Name Here
Contact Telephone:	Type Contact Phone Number Here
Contact Email:	Type Contact Email Address Here

PIHP ID	CMHSP ID	Unique ID	Medicaid ID	SCAO SCCM Case #

CMHSP LOCAL DISPUTE RESOLUTION PROCESS

I. SUMMARY BACKGROUND

All consumers have the right to a fair and efficient process for resolving complaints regarding their services and supports managed and/or delivered by Community Mental Health Services Programs (CMHSPs) and their provider networks. A recipient of or applicant for public mental health services may access several options to pursue the resolution of complaints. These options are defined through the Recipient Rights requirements referenced in the Michigan Mental Health Code (hereafter referred to as the Code) for all recipients of public mental health services, and the MDHHS/CMHSP contract. Additional options for Medicaid beneficiaries are explained in the Appeal and Grievance Technical Requirement located in Attachment P.6.3.2.1 of the MDHHS contracts with the Pre-paid Inpatient Health Plans (PIHPs). It is important to note that an individual receiving mental health services and supports may pursue their complaint within multiple options simultaneously.

Chapters 7, 7a, 4 and 4a of the Code describe the broad set of rights and protections for recipients of public mental health services as well as the procedures for the investigation and resolution of recipient rights complaints. For the purposes of this requirement, the focus will be on those complaints related to the denial, reduction, suspension or termination of services and supports. Specifically, the purpose of this document is to provide operational guidance to CMHSPs to meet the requirements of the MDHHS/CMHSP contract regarding grievance and appeal systems for recipients who are not Medicaid eligible, contained in Section 6.3.2 - Recipient Rights and Grievance/Appeals.

This requirement is based upon the premise that all recipients of, or applicants for, public mental health services will receive notice of their rights and an explanation of the grievance and appeal processes. This requirement in no way requires the exhaustion of grievance or alternative dispute resolution processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7a of the Code.

II. UNDERLYING VALUES AND PRINCIPLES

Properly structured grievance and appeal processes for consumers should promote the resolution of consumer concerns, as well as support and enhance the overall goal of improving the quality of care. The internal and external grievance and appeal processes should be:

- Timely
- Fair to all parties
- Administratively simple
- Objective and credible
- Accessible and understandable to consumers
- Cost and resource efficient
- Subject to quality review

In addition, the process should:

- Not interfere with communication between consumers and their CMHSP service providers.
- Assure that service providers who participate in a grievance and appeal process on behalf of enrollees should be free from discrimination or retaliation.
- Assure that consumers who file a grievance should be free from discrimination or retaliation.

(Adapted from the Consumer Bill of Rights and Responsibilities, A report to the President of the United States, prepared by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, November 1997.)

III. RECIPIENT RIGHTS REQUIREMENTS REGARDING THE DENIAL OF SERVICES

A. Denial of Hospitalization

1. If a pre-admission screening unit or children's diagnostic and treatment service of the CMHSP denies hospitalization, the individual, his/her guardian or his/her parent in the case of a minor child, may request a second opinion from the executive director of the CMHSP.

The request for the second opinion shall be processed in compliance with Sections 409(4), 498e(4) and 498h(5) of the Code. If the conclusion of the second opinion is different from the conclusion of the children's diagnostic and treatment service or the pre-admission screening unit, the executive director, in conjunction with the medical director, shall make a decision based upon all clinical information available within one business day.

2. If the request for a second opinion is denied, the individual or someone on his/her behalf may file a recipient rights complaint with the CMHSP Office of Recipient Rights.

3. If the initial request for inpatient admission is denied, and the individual is a current recipient of other CMHSP services, the individual or someone on his/her behalf may file a Chapter 7 complaint alleging a violation of his/her right to treatment suited to condition.

4. If the second opinion determines the individual is not clinically suitable for hospitalization and the individual is a current recipient of other CMHSP services, and a recipient rights complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the CMHSP Rights Office for processing under Chapter 7A.

B. Denial of Access to Community Mental Health Service Program Services

1. If an initial applicant for CMHSP services is denied such services, the applicant or his/her guardian, or the applicant's parent in the case of a minor must be informed of their right to request a second opinion of the executive director. The request shall be processed in compliance with Section 705 of the Code and must be resolved within five business days.

2. The applicant may not file a recipient rights complaint for denial of services suited to condition as he/she does not have standing as a recipient of mental health services. He or she may, however, file a rights complaint if the request for a second opinion is denied.

C. Denial of Family Support Subsidy

1. Pursuant to Section 159(3) of the Code, "if an application for a family support subsidy is denied or a family support subsidy is terminated by a community mental health services program, the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by the community mental health services program. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, being Sections 24.271 to 24.287 of the Michigan Compiled Laws."

2. Pursuant to the Administrative Rules: Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from the community mental health services program. (R330.1616 Availability of forms) (Note: It is acceptable to ask families to write a letter to the CMHSP requesting an appeals hearing, in lieu of a standardized form.)

3. A community mental health services program shall review an application and promptly approve or deny the application and shall provide written notice to the applicant of its action and of the opportunity to administratively appeal the decision if the decision is to deny the application. If the denial is due to the insufficiency of the information on the application form or the required attachments, the CMHSP shall identify the insufficiency. (Rule R330.1641 Application review)

4. If an application is denied or the subsidy terminated, a parent or legal guardian may file an appeal. The appeal shall be in writing and be presented to the community mental health service program within two months of the notice of denial or termination. (R330.1643 Appeal)

5. If an appeals hearing is held at the CMHSP and the presiding officer upholds the family's appeal in violation of Mental Health Code

language, MDHHS shall require that the CMHSP reimburse MDHHS the disputed amount.

6. Families wishing to appeal the decision of the CMHSP hearings officer may do so through circuit court in their county of residence.

7. If a CMHSP approves an application in violation of Mental Health Code language or without full documentation proving eligibility, MDHHS shall require that the CMHSP reimburse MDHHS the disputed amount.

IV. REQUIRED LOCAL DISPUTE RESOLUTION PROCESS

A. The CMHSP must have a local dispute resolution process, to address decisions by the CMHSP and/or their provider networks that impact the consumer's access to, or satisfaction with, services and supports.

Each CMHSP must have a written description of its local dispute resolution process available for review by MDHHS. The description must reflect all of the requirements below and indicate if the CMHSP ORR system is to be used, and if so, any modifications or additions to the CMHSP ORR system to be implemented. CMHSPs are encouraged to utilize their local ORR system for this purpose rather than establishing another process that would be duplicative. The CMHSP shall not assign a Rights Officer as Hearings Officer due to the inherent conflict of roles and responsibilities.

B. The local dispute resolution process at a minimum must possess the following characteristics:

1. It provides for prompt resolution. The Code provides for up to 90 days for a recipient rights complaint to be resolved (Section 778).

2. It assures the participation of individuals with the authority to require corrective action. Someone with the authority to act upon the recommendations of the dispute resolution process must be involved. This would include the executive director or designee.

3. It assures that the person reviewing the grievance, complaint or dispute will not be the same person(s) who made the initial decision that is subject to the dispute, complaint or grievance.

4. It has a mechanism for expedited review of a grievance, complaint or dispute involving emergency situations as defined by the Code and further operationalized below.

Sections 409(4), 498e(4) and 498h(5) of the Code provide an opportunity for an individual denied hospitalization to request a second opinion from the CMHSP executive director. The executive director shall arrange for an

additional evaluation to be performed within three days, excluding Sundays and legal holidays, after he/she receives the request. If the conclusion of the second opinion is different from the conclusion of the children's diagnostic and treatment service or the pre-admission screening unit, the executive director, in conjunction with the medical director, shall make a decision within one business day based upon all clinical information available.

5. It provides the individual with written notification of the local dispute resolution process decision and subsequent avenues available to the individual if he or she is not satisfied with the result, including the right of individuals without Medicaid coverage to access the MDHHS Alternative Dispute Resolution process after exhausting local procedures.

6. It provides reports of disputes, complaints and grievances periodically to the CMHSP governing body.

7. Reports of disputes, complaints and grievances will be reviewed by the CMHSP Quality Improvement Program to identify opportunities for improvement.

8. Records of disputes, grievances, and complaints must be made available to the MDHHS for review upon request.

V. DISPUTES, GRIEVANCES AND COMPLAINTS PROCESS FOR NON-MEDICAID RECIPIENTS

A. Background

A principle reflected throughout the MDHHS/CMHSP contract is that all recipients of mental health services and supports shall be treated in the same manner, wherever possible. With respect to appeals and grievances, there is a fundamental difference between Medicaid-funded services and those funded through state funds.

Public formula funded mental health services are not an entitlement programs. The Code describes broad groups of individuals with certain qualifying conditions to whom public mental health services shall or may be directed, with priority always given to individuals with severe conditions and impairments. The Code does not establish an individual entitlement to mental health services in the way that the Federal Medicaid program does for health insurance, but rather it indicates that persons with certain qualifying conditions and impairments must have the first priority for available resources and services within the public mental health system.

The Code provides protections, second opinions and dispute resolution mechanisms for all individuals receiving public mental health services, with the expectation that all disputes will be resolved locally, with the ability to appeal to

the MDHHS in only those instances where it is alleged that the investigative findings of the local office of recipient rights are not consistent with the facts or with law, rules, policies or guidelines (Section 786). To implement the principle that all consumers are to be treated in the same manner whenever possible, this requirement expands the non-Medicaid individual's ability to appeal to the MDHHS.

B. Expedited Processes for Service Denials:

2. Whenever initial access to CMHSP services or supports are denied, the CMHSP must inform the individual, his or her guardian, or in the case of a minor, his/her parent, of their right to a second opinion consistent with Section 705 of the Code. The second opinion must be performed within five business days.

3. If access to psychiatric inpatient service is denied, the individual or, if a minor, his/ her parent or guardian, must be informed of his/her right to a second opinion consistent with Sections 409(4), 498e(4) and 498h(5) of the Code and the CMHSP Local Dispute Resolution Process as described in Section III.A above.

4. In the event that a physician or licensed psychologist external to the CMHSP attests in writing that the individual (applicant or current recipient) meets the definition of an emergency situation as defined in Section 100a (23)(a) or (c) of the Code, the CMHSP must assess the individual to determine if the individual meets the inpatient admission certification criteria, as defined in the MDHHS Service Selection Guidelines. If psychiatric inpatient services are denied, the individual, his/her guardian, or his/her parent in the case of a minor child, must be informed of their right to a second opinion consistent with Section III.A above and their right to further contest an unfavorable second opinion through the Local Dispute Resolution Process, with the decision from that process to be reached within three business days.

5. If the CMHSP does not recommend hospitalization and an alternative service requested by the individual, his/her guardian, or his/her parent is denied, the CMHSP must inform the individual, his/her guardian, or in the case of a minor, his/her parent, of his/her ability to access the Local Dispute Resolution Process. The decision from that process for these persons must be reached within three business days.

6. The CMHSP must communicate the decision of the Local Dispute Resolution Process and inform the individual, his/her guardian, or his/her parent of a minor child of their right to access the MDHHS Alternative Dispute Resolution Process.

C. Processes for Suspension, Reduction or Termination of Existing Services:

2. Whenever an existing service or support or existing services are to be suspended, terminated, or reduced by an agency or unit performing a utilization review (UR) function, or when the action is taken outside of the person-centered planning process when the CMHSP does not have an identifiable UR unit, the CMHSP must inform the individual with written notification of the change at least 10 business days prior to the effective date of the action. The notice shall include:
    a. A statement of what action the CMHSP intends to take;
    b. The reasons for the intended action;
    c. The specific justification for the intended action;
    d. An explanation of the Local Dispute Resolution Process

    Actions taken as a result of the person-centered planning process or those ordered by a physician are not considered an adverse action.

2. In the event that the individual utilizes the Local Dispute Resolution Process or the second opinion processes as described above, the CMHSP must communicate in writing the outcome of that process to the individual. That communication must include notification to the individual of their ability to request access to the MDHHS Alternative Dispute Resolution Process by sending such request to:

    Department of Health and Human Services
    Division of Program Development, Consultation and Contracts
    Bureau of Community Mental Health Services
    ATTN: Request for MDHHS Level Dispute Resolution
    Lewis Cass Building - 5th Floor
    Lansing, MI 48913

    Access to the MDHHS process does not require agreement by both parties, but may be initiated solely by the consumer.

    The individual has 10 days from the written notice of the Local Dispute Resolution Process outcome to request access to the MDHHS Alternative Dispute Resolution Process.

3. A Model Local Dispute Resolution Process for Persons without Medicaid is presented in Exhibit 1.

D. MDHHS responsibilities regarding the Alternative Dispute Resolution Process for persons not receiving Medicaid.

1. MDHHS shall review all requests within two business days of receipt.

2. If the MDHHS representative, using a “reasonable person” standard believes that the denial, suspension, termination or reduction of services

and/or supports will pose an immediate and adverse impact upon the individual's health and safety, the issue is referred within one business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the MDHHS/CMHSP contract.

3. In all other cases, the MDHHS representative shall attempt to resolve the issue with the individual and the CMHSP within 15 business days. The recommendations of the MDHHS representative are non-binding in those cases where the decision poses no immediate impact to the health and safety of the individual.

VI. DEFINITIONS

Resolution notice - notice to the consumer that is required within established time frames relative to the disposition of disputes, complaints and grievances, and resolution of the disputes, complaints and grievances.

Rights complaint - a written or verbal statement by a recipient or anyone acting on behalf of a recipient alleging a violation of a Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.
Utilization Review - A process in which established criteria are used to recommend or evaluate services provided in terms of cost-effectiveness, necessity, and effective use of resources.

VII. REFERENCES

PA 516 of 1996
PA 258 of 1974, as amended
S.353-Health Insurance Bill of Rights of 1997
42 CFR Chapter IV, Subpart E, Sections 431.200 et seq
Exhibit 1
Model CMHSP Local Dispute Resolution Process

FAMILY SUPPORT SUBSIDY PROGRAM
FSS GUIDELINES FOR DETERMINING ELIGIBILITY OF APPLICANTS

February 2010

I. SUMMARY/BACKGROUND

The Michigan Department of Health and Human Services Family Support Subsidy (FSS) program is a program that provides financial support to families who care for their child with severe disabilities in the family home. This financial support may help prevent or delay out-of-home placement. In other situations, the program may provide the funds necessary to allow the child to return home from an out-of-home placement.

Michigan's Mental Health Code and Administrative Rules establish the parameters and process for determining eligibility of applicants to the FSS program.

II. VALUES AND PRINCIPLES

Supporting families is a high priority of Michigan's public mental health system, as evidenced by the FSS program. Michigan's public policy is that children with developmental disabilities, like all children, need loving and enduring family relationships. For over two decades, the Michigan Department of Health and Human Services's policy has been that children should be supported to live with their families and if out-of-home placement becomes necessary, it should be temporary and time limited with a goal of family reunification or, for some children, adoption.

Providing financial support to families that include a child with severe disabilities may enable families to stay together, allows them flexibility in purchasing special services at the local level, and saves taxpayer money by avoiding or reducing the need for more costly out-of-home placements. With this subsidy, families are empowered to make decisions and purchases based upon the special needs of their child.

III. FAMILY SUPPORT SUBSIDY GUIDELINES

Pursuant to Section 157(2) of the Mental Health Code, "The department shall create application forms and shall make the forms available to community mental health services programs for determining the eligibility of applicants..."

A. Determining the eligibility of applicants includes:

1) Helping families understand the requirements of the program

2) Providing assistance in completing the application

3) Application processing to determine eligibility

4) Requesting technical assistance from MDHHS as appropriate

5) Liaison between families and MDHHS

6) Outreach to schools, medical offices, clinics, hospitals, etc.

7) Participating in the FSS program annual survey

8) Arranging a hearing, at the family's written request, if the community mental health agency denies or terminates a family support subsidy

9) Participating in efforts to recapture monies received by families after the child/family's change in eligibility.

B. Applicants to this program must complete MDHHS-1181, FSS application. The community mental health services program (CMHSP) FSS coordinator may assist the applicant and provide direction.

C. The child's date of birth must be verified. A copy of the child's legal birth certificate is preferable.

D. The name(s) and address as written on the application is the way it will appear on the subsidy warrant (check). Please make sure that all information is legible and accurate. If two names are listed on the application, both names will be used as dual payees on the warrant.

E. The educational eligibility category must be documented annually by certification from the Michigan local public or intermediate school district the child attends (or would attend if he/she were in the public school system). Certification can be in the form of the child's Multidisciplinary Evaluation Team

(MET) report, Individual Educational Program Team (IEPT) report or by a letter or memorandum on school letterhead. Suggested checklist language has been developed for this purpose and schools wishing to utilize it may contact the local CMHSP.

1) If the child's educational eligibility category is cognitive impairment, eligibility can be determined by the school psychologist or other qualified school representative who can verify, in writing, that the child's latest intellectual assessment shows development at a rate of 4.5 or more standard deviations below the mean.

2) If the child's educational eligibility category is autism spectrum disorder, the school must verify the child's special education programming. Eligible programming for children with autism spectrum disorder is limited to the following: program for students with severe cognitive impairment (R340.1738), program for students with severe multiple impairments (R340.1748), or programs for students with autism spectrum disorder (R340.1758).

   a) Please note that special education rule number 340.1758 describes two alternatives for educating children with ASD. Rule number 340.1758(1)(a) describes the traditional classroom for children with ASD, taught by a teacher of students with ASD. Rule number 340.1758(1)(b) describes a special education <u>program</u>, tailored to an individual student's needs, that assures the provision of educational programming for students with ASD. A 340.1758(1)(b) program can be carried out in many different school settings including the general education classroom or resource room. If a child's IEP states the special education rule number associated with a particular classroom setting and the programming includes components of 340.1758(1)(b), FSS educational eligibility could be determined if school authorities are able to assert, in writing, that the child's educational program <u>also</u> meets the requirements of 340.1758(1)(b).

F. A copy of the family's most recently filed Michigan income tax form documents the family's taxable income. To be eligible for this program, the taxable income must be $60,000 or less.

1) Other documentation is acceptable only if the family did not file a Michigan income tax form - having recently moved here from another state or country or having too little income to require filing. Other documentation that is acceptable if a state form is not filed includes (in descending order): a family's most recently filed federal income tax form, Supplemental Security Income statement, Michigan Department

of Human Services statement, W-2 form, recent check stub or a hand-written, signed note attesting to no taxable income. **A Medicaid card is not an acceptable proof of income.**

G. **For new applicants only:** If the family's most recently filed Michigan income tax form shows a taxable income of more than $60,000, but the family's financial worth has decreased since filing (layoff, death, divorce, etc.), documentation of projected income can be used to determine eligibility. When projected income is used to determine eligibility, the following year's tax form must reflect a taxable income of $60,000 or less. If it is above $60,000, the family must pay back the total amount of subsidy dollars received.

H. The parent or legal guardian completing the application must verify that the child is living with him/her or temporarily with a relative.

I. A parent or legal guardian must sign the form attesting to the truth of all information provided.

J. The CMHSP FSS coordinator's signature on the bottom of the application confirms that all back up documentation proving eligibility is on file at the CMHSP and that the CMHSP is verifying that the family is entitled to receive FSS payments.

K. The completed MDHHS-1181 application form is sent to:

Family Support Subsidy Program
Michigan Department of Health and Human Services
320 S. Walnut Street
5th Floor, Lewis Cass Building
Lansing, MI 48913

L. The FSS statewide coordinator reviews the applications, verifies that eligibility is appropriately determined and enters the data into the program's check processing system. This data is transmitted to the Michigan Department of Treasury on a monthly basis. Near the 20th of each month, the Michigan Department of Treasury processes, prints and releases payments to eligible families.

IV. LEGAL REFERENCES

Mental Health Code Act, 258 MI. 330.1156-330.1161

Continuing Education Requirements for Recipient Rights Staff
Technical Advisory

Background/Regulatory Overview

The purpose of this Technical Advisory is to establish processes for meeting the educational mandates for Recipient Rights Officers/Advisors set forth in the following sections of the Michigan Mental Health Code and MDHHS/CMHSP Managed Mental Health Supports and Services Contract.

330.1754 State office of recipient rights; establishment by department; selection of director; powers and authority of state office of recipient rights.
(2) The department shall ensure all of the following: (f) Technical assistance and training in recipient rights protection are available to all community mental health services programs and other mental health service providers subject to this act.

330.1755 Office of recipient rights; establishment by community mental health services program and hospital.
(2) Each community mental health services program and each licensed hospital shall ensure all of the following: (e) Staff of the office of recipient rights receive training each year in recipient rights protection.

MDHHS/CMHSP Managed Mental Health Supports and Services Contract:
The Community Mental Health Services Program (CMHSP) shall assure that, within the first three months (90 days) of employment, the Recipient Rights Office Director, and all Rights Office staff (excluding clerical staff) shall attend and successfully complete the Basic Skills Training programs offered by the Department's Office of Recipient Rights. In addition, within every three (3) year period subsequent to their completion of Basic Skills, the Recipient Rights Office Director and all Rights Office staff (excluding clerical staff) must comply with the requirements specified in Attachment C6.3.2.3A "Continuing Education Requirements for Recipient Rights Staff".

Definitions

1. Continuing Education Unit:
   One Continuing Education Unit (CEU) is defined as one clock hour (60 minutes) of participation in an organized continuing education experience under responsible sponsorship, capable direction, and qualified instruction. The primary purpose of the CEU is to provide a permanent record of the educational accomplishments of an individual who has completed one or more significant educational experiences.

2. Category I Credits: Operations
   This category includes programs that support and enhance the fundamental scope of responsibilities and effective work of recipient rights staff. These may be directly related to prevention, complaint resolution, and monitoring and education that support the fundamental scope of a Rights Office's operations. Examples include:
   - Rights Office Operations Techniques
   - Enhancing Investigative Skills

Inpatient Rights
Out-of-catchment rights protection
Writing effective rights-related contract language
Conducting effective site visits
How to protect rights in a dual rights protection system

3. Category II Credits: Legal Foundations
   This category includes programs that enhance the understanding and application of the Mental Health Code, Administrative Rules, Disability and Human Rights Laws, Federal Laws and regulations and any other laws addressing the legal rights of a mental health recipient.

4. Category III Credits: Leadership
   This category includes programs that support and enhance the leadership abilities of rights staff. Examples include:
   Community Mental Health Services Program (CMHSP) issues
   How to establish a rights presence in an organization
   Understanding rights data and how to use it to trigger systemic organizational changes
   What goes on in a Failure Mode Event Analysis (FMEA)/Adverse Event Review
   Working with key individuals in your organization—Customer Services, Contracts Unit, and how it can enhance rights

5. Category IV Credits: Augmented Training
   This category includes training sessions that contains information that would help rights staff have a better understand the people they serve, their disabilities, their families, or training indirectly related to rights but affecting rights. These may include trainings in mental health conditions and disabilities, treatment and support modalities, recovery, and self-determination as long as these topics can be ascertained to have a component that relates to assisting the attendee in the protection of rights. Examples include:
   Understanding MI/SUD Co-occurring disorders
   How to communicate with people with disabilities
   Ethics
   HIPAA and the MHC
   Consumers from different cultures (including deaf, deafblind and hard of hearing community)
   Diversity Issues

6. CMHSP: Community Mental Health Services Program

7. Continuing Education Committee: A committee appointed by the Director of the MDHHS Office of Recipient Rights upon recommendation from the Director of the Education and Training Unit of the Office of Recipient Rights. This committee shall consist of rights staff and management from MDHHS-ORR, CMHSP's, and LPH/U's and shall have at least one representative who is a Licensed Master's Social Worker (LMSW). This committee shall review applications and assign an appropriate category to each approved application. Committee members shall be appointed for a three-year term and may be re-appointed at the discretion of the Director of ORR.

8. Department: Michigan Department of Health and Human Services (MDHHS)

9. LPH/U: Licensed Private Hospital/Unit

Standards

A. Basic Requirements

1. All staff of the Department, a community mental health services program (CMHSP), or a licensed private
Hospital (LPH/U), employed for the purpose of providing recipient rights services shall, within the first 90 days of employment, attend, and successfully complete, the Basic Skills Training curriculum as determined by the Michigan Department of Health and Human Services Office of Recipient Rights. The Basic Skills curriculum shall consist of the following classes:
Basic Skills – Part 1
Basic Skills – Part 2
NOTE: THIS IS CLARIFICATION NOT A CHANGE

B. Continuing Education Requirements

1. All staff employed or contracted to provide recipient rights services shall receive education and training oriented toward maintenance, improvement or enhancement of the skills required to effectively perform the functions as rights staff.
2. A minimum of 36 contact hours of education or training shall be required over a three (3) year period subsequent to the completion of the Basic Skills requirements, and in every three (3) year period thereafter.
3. The 36 contact hours obtained must be in rights-related activities and must fall within one or more of the categories identified in the definitions above.
4. A minimum of 12 contact hours must be obtained in programs classified as Category I or II.
5. No more than 12 credits in a 3 year period may be earned through the use of online learning resources.
6. CEU's may be received by attending programs or conferences developed by the Department, other rights-related organizations, organizations that have applied to the Office of Recipient Rights Training Division for approval of their programs or through online training.
7. Rights staff may request approval for other educational programs by utilizing the established approval process.
8. Recipient rights staff should retain documentation of meeting the CEU requirements for a period of four (4) years from the date of attendance. It is suggested that the following information be kept on file:
    a. The title of the course or program and any identification number assigned to it by the education provider. The number of CEU hours completed.
    b. The provider's name and identifying number.
    c. Verification of your attendance by the provider.
    d. The date and location of the course.
9. Reviews will be conducted by the MDHHS Office of Recipient Rights Assessment Unit staff at each assessment of a recipient rights program to determine if all rights staff have met both the basic and continuing education requirements.
10. CMHSPs who contract with Licensed Private Hospitals/Units shall mandate compliance with the

standards in this Technical Advisory by the Recipient Rights Office staff of those entities.

C. Procedures for Training approval

1. Training that is automatically approved for CEU credits:

   a) MDHHS ORR training *excluding Basic Skills*
   b) Sessions at the MDCH ORR Annual Conference, including the Pre-Conference session
   c) Training provided by, or sponsored by, MDHHS Office of Recipient Rights

2. Training that may be approved for CEU credits, if meeting the criteria above and with the submission of the necessary documents by the applicant:

   a) RROAM sponsored training
   b) CMH/LPH/U sponsored training
   c) Training provided by other agencies, entities, or professionals—law enforcement, mental health or physical health professionals, accreditation bodies, risk management, corporation counsel/lawyer, etc.
   d) Training provided to the Rights Officer/Advisor for their own profession's licensure.
   e) Other training in the community at large, including on-line training, if requirements as detailed above are met.

3. CEU Documentation and Notification

   a) Application

      To apply for CEU credits for a training, complete the MDHHS ORR Continuing Education Course Summary (Exhibit A) form and send by email, mail or FAX, at least 30 calendar days prior to the date of the event, to:

      MDHHS ORR Education and Training Unit
      18471 Haggerty Road
      Northville, MI 48168
      FAX: 248-348-9963
      Email: MDHHS-ORR-Training@michigan.gov

   b) Verification of attendance.

      Attendance can be verified through provision of a Certificate of Attendance, copies of a training record, copy of an attendance/sign in sheet, a copy of the training agenda or outline with a self-attestation statement that the applicant did attend the training. Verification of attendance shall be kept on file with the applicant and be readily available for review by MDHHS ORR if requested.

   c) Notification
      Applicants will receive notification of approval determination for CEU credits no later than 30 business days following receipt of the required documents. Approved courses, credit and category information will be posted on the ORR website.
      d) Application Review, Approval and Appeal

Applications from organizations outside the Department, or applications from individuals who have attended, or plan to attend training programs shall be reviewed and approved or rejected by the Continuing Education Committee. If an application is rejected by the Continuing Education Committee it may be appealed to the director of the office of recipient rights. The decision of the Director of ORR is the final MDHHS position on the application.

Exhibit A: APPLICATION FOR RECIPIENT RIGHTS CEU CREDIT

OFFICE OF RECIPIENT RIGHTS
APPLICATION FOR RECIPIENT RIGHTS CEU CREDIT

APPLICANT (ORGANIZATION OR INDIVIDUAL)			
APPLICANT'S CONTACT INFORMATION	EMAIL: PHONE: ADDRESS: CITY/ZIP:		
COURSE DATE COURSE TITLE LOCATION			
COURSE PRESENTER			
COURSE DESCRIPTION			
COURSE OBJECTIVES		Description of Learning Objectives	Class Time
	1		
	2		
	3		
	4		
	5		

Requested Category	Category I Operations	Category II Legal Foundations	Category III Leadership	Category IV Augmented
Describe how the content relates to Rights?				

Please attach a detailed agenda.

Recipient Rights Training Standards for CMH and Provider Staff
Technical Requirement NEW

Rationale

The purpose of this Technical Requirement is to establish standardized concepts for the training of new staff in the CMHSPs and their provider agencies. Establishment of these criteria is required in order to provide a standardized knowledge base to all staff that assures the rights of recipients are applied in a consistent manner across the state. This consistency should enable various CMH agencies to accept the training of similar agencies and, thus, decrease cost of training by eliminating the need for redundant retraining.

Authority

330.1753 Recipient rights system; review by department.

The department shall review the recipient rights system of each community mental health services program in accordance with standards established under section 232a, to ensure a uniformly high standard of recipient rights protection throughout the state. For purposes of certification review, the department shall have access to all information pertaining to the rights protections system of the community mental health services program.

330.1754 State office of recipient rights; establishment by department; selection of director; powers and authority of state office of recipient rights.

(2) The department shall ensure all of the following: (f) Technical assistance and training in recipient rights protection are available to all community mental health services programs and other mental health service providers subject to this act.

330.1755 Office of recipient rights; establishment by community mental health services program and hospitals.

(5) Each office of recipient rights established under this section shall do all of the following: (f) Ensure that all individuals employed by the community mental health services program, contract agency, or licensed hospital receive training related to recipient rights protection before or within 30 days after being employed.

Definitions

Core Competencies:

The Core Competencies are a consensus set of skills necessary for an understanding of the rights of mental health recipients. The Core Competencies reflect foundational knowledge that professionals and paraprofessionals engaging in the provision of services to public mental health recipients must have in order to provide services in accordance with Chapter 7 of the Michigan Mental Health Code. These competencies are organized into thirteen domains, reflecting skill areas identified by Chapter 7.

Recipient: means an individual who receives mental health services from the department, a community mental health services program, or a facility or from a provider that is under contract with the department or a community mental health services program.

Resident: an individual who receives services in either a state operated facility, a licensed psychiatric hospital or unit or an adult foster care facility.

STANDARDS:

1. Training for newly hired agency and provider staff shall encompass the entirety of the core competencies identified in Exhibit A.
2. Annual rights training may focus on any or all of the competencies.

Exhibit A – Areas to be covered in Training

	Board of Directors	Administration	Clinical Staff - Non-Residential	Clinical Staff - Specialized Residential	Direct Care Staff - Specialized Residential	Direct Care Staff - Non Residential	Outpatient Clinic - All Staff	Volunteers	Recipients (not required)	Advisory Committee	Appeals Committee
Abuse and Neglect	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳
Advisory Committee	✳	✳							✳	✳	
Appeals Process	✳	✳							✳	✳	✳
Confidentiality	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳
Dignity & Respect	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳	
Employee Rights		✳	✳	✳	✳	✳	✳				
Family Rights	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳	
ORR Investigative Process	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳
Overview of the Rights System	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳
Reporting Requirements	✳	✳	✳	✳	✳	✳	✳	✳	✳	✳	
Responsibilities of the Board of Directors	✳	✳								✳	✳
Responsibilities of the Agency Director	✳	✳								✳	✳
RESIDENTIAL RIGHTS (inpatient, group home)											
Civil Rights		✳	✳	✳	✳	✳	✳	✳	✳		
Communications and Visits		✳		✳	✳				✳		
Financial Issues		✳		✳	✳				✳		
Freedom of Movement		✳		✳	✳				✳		
Linitations/Restrictions		✳	✳	✳	✳	✳	✳	✳	✳		
Medication Rights		✳		✳	✳				✳		
Person Centered Planning		✳	✳	✳	✳	✳	✳	✳	✳		
Personal Property		✳		✳	✳				✳		
Photographs, Fingerprints, Taping		✳		✳	✳				✳		
Safe, Sanitary, Humane Environment		✳	✳	✳	✳	✳	✳	✳	✳		
Seclusion/Restraint		✳		✳	✳				✳		

Exhibit B – Core Competencies

Code Citation and Title
MHC 330.1722 ABUSE AND NEGLECT

Code Language

A recipient of mental health services shall not be subjected to abuse or neglect.

COMPETENCIES:

- We have a zero-tolerance stance regarding abuse and neglect
- Abuse is defined as:
  - An act (or provocation of another to act) by an employee, volunteer or agent of the provider that causes or contributes to a recipient's death, sexual abuse, serious or non-serious physical harm or emotional harm.
  - The use of unreasonable force on a recipient with or without apparent harm;
  - An action taken on behalf of a recipient by a provider, who assumes the recipient is incompetent, which results in substantial economic, material, or emotional harm to the recipient;
  - An action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient
  - The use of language or other means of communication by an employee, volunteer, or agent of a provider to degrade, threaten, or sexually harass a recipient.
- Agents of the Provider: people who work for agencies that contract with the Department, a CMHSP or PIHP, or a LPH/U
- Neglect is defined as:
  - Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service:
    1. that caused or contributed to the death, sexual abuse of, serious, or non- serious physical harm or emotional harm to a recipient, or
    2. that placed, or could have placed, a recipient at risk of physical harm or sexual abuse.
  - The failure to report apparent or suspected abuse or neglect of a recipient.
- "Bodily function" means the usual action of any region or organ of the body.
- "Emotional harm" means impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.
- "Non-serious physical harm" means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.
- “Physical management" means a technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself, or others.
- "Serious physical harm" means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
- "Sexual abuse" means any of the following:
  - Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.

    - Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
    - Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.
- "Sexual contact" means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following:
    - Revenge.
    - To inflict humiliation.
    - Out of anger.

- "Sexual harassment" means sexual advances to a recipient, requests for sexual favors from a recipient, or other conduct or communication of a sexual nature toward a recipient.
- “Sexual penetration” means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person’s body or of any object into the genital or anal openings of another person’s body, but emission of semen is not required.
- "Time out" means a voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.
- "Unreasonable force" means physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances:
    - There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.
    - The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
    - The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service.
    - The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force

Code Citation and Title
MHC 330.1704 CIVIL RIGHTS
AR 330.7009 CIVIL RIGHTS

Code Language

In addition to the rights, benefits, and privileges guaranteed by other provisions of law, the state constitution of 1963, and the constitution of the United States, a recipient of mental health services shall have the rights guaranteed by this chapter unless otherwise restricted by law.

The rights enumerated in this chapter shall not be construed to replace or limit any other rights, benefits, or privileges of a recipient of services including the right to treatment by spiritual means if requested by the recipient, parent, or guardian.

A provider shall establish measures to prevent and correct a possible violation of civil rights related to the service provision. A violation of civil rights shall be regarded as a violation of recipient rights and shall be subject to remedies established for recipient rights violations.

A recipient shall be permitted, to the maximum extent feasible and in any legal manner, to conduct personal and business affairs and otherwise exercise all rights, benefits, and privileges not divested or limited.

COMPETENCIES:

- A recipient shall be permitted, to the maximum extent feasible and in any legal manner, to conduct personal and business affairs and otherwise exercise all rights, benefits, and privileges not divested or limited.
- A violation of civil rights shall be regarded as a violation of recipient rights
- A recipient shall be asked if they wish to participate in an official election and, if desired, shall be assisted in doing so.
- A recipient shall be permitted to exercise the right to practice their religion
- A recipient shall have the right to NOT have a religion prescribed for them
- A Recipient is presumed competent unless a guardian has been appointed
- A recipient shall not be subject to illegal search or seizure.

Code Citation and Title
MHC 330.1748 CONFIDENTIALITY

Code Language

- *Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and shall not be open to public inspection.*
- *If information made confidential by this section is disclosed, the identity of the individual to whom it pertains shall be protected and shall not be disclosed unless it is germane to the authorized purpose for which disclosure was sought; and, when practicable, no other information shall be disclosed unless it is germane to the authorized purpose for which disclosure was sought.*
- *Individuals receiving information made confidential by this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.*
- *For case record entries made subsequent to March 28, 1996, information made confidential by this section shall be disclosed to an adult recipient, upon the recipient's request, if the recipient does not have a guardian and has not been adjudicated legally incompetent*

COMPETENCIES:

- Recipients who are adults and do not have a guardian are entitled to review their record without exception; discuss agency protocol for assuring this.
- For recipients with a guardian and those under 18 information can be withheld if determined by a physician to be detrimental.
- Explain the difference between mandatory disclosure, discretionary with consent and discretionary
- Discuss agency policy on Correction of Record (statement by recipient)
- Preferred method for answering the phone so as not to disclose information
- Agency protocol for inquiries by law enforcement (what happens when the police show up at the door)
- Under circumstances allowed in the Code language this right may be limited.
- MPAS can access a recipient's record if it has received a complaint on behalf of the recipient or has probable cause to believe based on monitoring or other evidence that the recipient has been subject to abuse or neglect.
- Discuss privileged communications 33.1750 (psychiatrists and psychologists only)

Code Citation and Title
MHC 330.1708 DIGNITY AND RESPECT

Code Language

A recipient has the right to be treated with dignity and respect.

COMPETENCIES:
Showing respect for recipients shall include:

- Calling a person by his or her preferred name
- Knocking on a closed door before entering
- Using positive language
- Encouraging the person to make choices instead of making assumptions about what he or she wants
- Taking the person's opinion seriously, including the person in conversations; allowing the person to do things independently or to try new things.
- Provide definitions of dignity and respect (Use agency's definition if different)

  Dignity: To be treated with esteem, honor, politeness; to be addressed in a manner that is not patronizing, condescending or demeaning; to be treated as an equal; to be treated the way any individual would like to be treated.

  Respect: To show deferential regard for; to be treated with esteem, concern, consideration or appreciation; to protect the individual's privacy; to be sensitive to cultural differences; to allow an individual to make choices.

Code Citation and Title
MHC 330.1711 RIGHTS OF FAMILY MEMBERS

Code Language
Family members of recipients shall be treated with dignity and respect. They shall be given an opportunity to provide information to the treating professionals. They shall also be provided an opportunity to request and receive educational information about the nature of disorders, medications and their side effects, available support services, advocacy and support groups, financial assistance and coping strategies.

COMPETENCIES:

- Providing family members an opportunity to request and receive educational information about the nature of disorders, medications and their side effects, available support services, advocacy and support groups, financial assistance and coping strategies.
- Receive information from or provide information to family members within the confidentiality constraints of Section 748 of the Mental Health Code.
- Discuss agency protocols regarding family members who want to provide information
- Be aware of the location of these materials
- Assure that family members are treated with dignity and respect

Code Citation and Title
MCL 330.1724 FINGERPLRINTS, PHOTOGRAPHS, AUDIORECORDINGS, VIDEORECORDINGS AND USE OF ONE-WAY GLASS

Code Language
A recipient shall not be fingerprinted, photographed, audiotaped or viewed through one-way glass for purposes of identification, in order to provide services (including research) or for educational or training purposes without prior written consent.

COMPETENCIES:

- Prior written consent from the recipient, the recipient's guardian or a parent with legal and physical custody of a minor recipient must be obtained before fingerprinting, photographing, audio-recording, or viewing through one-way glass.
- The procedures above shall only be utilized in order to provide services (including research) to identify, s recipient, or for education and training purposes.
- Photographs include still pictures, motion pictures and videotapes.
- Photographs may to be taken for purely personal or social purposes and must be treated as the recipient's personal property. Photographs must not be taken for this purpose if the recipient has objected.
- Fingerprints, photographs and audio-recordings and any copies of these are to be made part of the recipient record and are to be destroyed or returned to the recipient when no longer essential or upon discharge, whichever occurs first.
- If fingerprints, photographs or audio-recordings are done and sent out to others to help determine the name of the recipient, the individual receiving the items must be informed that return is required for inclusion in the recipient record.
- Restrictions may be put in place if the recipient is receiving services pursuant to the criminal provisions of Chapter 10 of the Mental Health Code – Incompetent to Stand Trial, Not Guilty by Reason of Insanity, recipient of the Department of Corrections Mental Health Services Program
- Video surveillance may be conducted in a psychiatric hospital for purposes of safety, security, and quality improvement.
- Video surveillance may only be conducted in common areas such as hallways, nursing station areas, and social activity areas within the psychiatric unit. Video surveillance recordings taken in common areas shall not be used for treatment or therapeutic purposes. Before implementation of video surveillance, the psychiatric hospital shall establish written policies and procedures that address, at a minimum, all of the following:
    - Identification of locations where video surveillance images will be recorded and saved.
    - Mechanisms by which recipients and visitors will be advised of the video surveillance.
    - Security provisions that assure that only authorized staff members have access to view recorded surveillance video. The security provisions shall include all of the following:
        - Who may authorize viewing of recorded surveillance video?
        - Circumstances under which recorded surveillance video may be viewed.
        - Who may view recorded surveillance video with proper authorization.
        - Safeguards to prevent and detect unauthorized viewing of recorded surveillance video.
        - Circumstances under which recorded surveillance video may be duplicated and what steps will be taken to prevent unauthorized distribution of the duplicate.
    - Documentation required to be maintained for each instance of authorized access, viewing duplication, or distribution of any recorded surveillance videos.
    - Process to assure retrieval of distributed recorded surveillance video when the purpose for which the video was distributed no longer exists.
    - Archived footage of video surveillance recordings for up to 30 days unless notice is received that an incident requires investigation by the department's office of recipient rights, the licensing division of the bureau of health systems, law enforcement, licensed psychiatric hospital or unit office of recipient rights, and the United States department of health and human services centers for Medicaid and Medicare services. In that case, archived footage of video surveillance recordings may be retained for the duration of the investigation.
    - Recorded video surveillance images shall not be maintained as part of a recipient's clinical record

Code Citation and Title	
MCL 330.1744	**FREEDOM OF MOVEMENT**
MCL 330.1708	**LEAST RESTRICTIVE SETTING**

Code Language
Mental health services shall be offered in the least restrictive setting that is appropriate and available.
Every recipient has the right to move about his or her residence, environment and community.

COMPETENCIES:

- Mental health services shall be offered in the least restrictive setting that is appropriate and available.
- The freedom of movement of a recipient shall not be restricted more than necessary to provide mental health services, to prevent injury to himself, herself or others, or to prevent substantial property damage
- House rules may restrict freedom of movement only by general restrictions:
  - From areas that could cause health or safety or problems
  - Temporary restrictions from areas for reasonable unforeseeable activities including repair or maintenance
  - For emergencies in case of fire, tornadoes, floods, etc.
- Seclusion and restraint are prohibited except in a MDHHS operated or licensed hospital. Every patient in one of those settings has the right not to be secluded or restrained unless it is essential to prevent the patient from physically harming himself, herself or others.
- Time out, defined as a VOLUNTARY response to a therapeutic suggestion to a recipient to remove himself or herself from a stressful situation to another area to regain control. (AR 330.7001[x])
- Physical management, defined as a techniques used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself or others. (AR 330.7001[m])
- Physical management may only be used when a recipient is presenting an imminent risk of serious or non-serious physical harm to himself, herself or others and lesser restrictive interventions have been unsuccessful in reducing or eliminating an imminent risk of serious or non-serious physical harm.
- Physical management must not be included as a component of a behavior treatment plan
- Prone immobilization of a recipient for the purpose of behavioral control is prohibited (by agency policy) or (implementation of physical management techniques other than prone immobilization is medically contraindicated and documented in the recipient's record) (AR 330. 7243 [11][i][ii])
- This right can be limited but only as allowed in the individual plan of service (IPOS) following review and approval by the Behavior Treatment Plan Review Committee (CMH only) and the special consent of the 47

Code Citation and Title
MHC 330.1712 INDIVIDUALIZED WRITTEN PLAN OF SERVICES
AR 330.7199
MDHHS PRACTICE GUIDELINE
TECHNICAL REQUIREMENT FOR BEHAVIOR TREATMENT REVIEW COMMITTEES

Code Language

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.

COMPETENCIES:

- 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.
- If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.
- An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

Code Citation and Title
MCL 330. 1708 (1) (2) AR 330.7171 SAFE, SANITARY, HUMANE,TREATMENT ENVIRONMENT

Code Language
Every resident is entitled to mental health services in a safe, sanitary and humane treatment environment.

COMPETENCIES:

- Mental Health Code requires safe, sanitary, humane treatment environment
- Does not define what this means so we use Adult Foster Care Licensing Rules (400.14401 – 14403) to determine if the residential setting was safe, sanitary or humane.
    - Assure pressurized hot and cold water
    - Hot water temp no more than 105 degrees to 120 degrees at the faucet
    - Assure all sewage is disposed of in a public sewer system or as approved by the health department
    - Maintain an insect, rodent or pest control program
    - Store and safeguard poisons, caustics and other dangerous materials in non-resident and non-food reparation storage areas
    - Assure adequate preparation and storage of food items.
    - Assure premises are constructed, arranged and maintained to adequately provide for the health, safety and well-being of occupants

- Provide for resident health, hygiene and personal grooming including assistance and training in personal grooming practices, including bathing, tooth brushing, shampooing, hair grooming, shaving and care of nails. Provider must supply toilet articles, toothbrush and dentifrice, opportunity to shower or bathe at least once every 2 days, regular services of a barber or beautician and the opportunity to shave daily (males) [AR 7171]

Code Citation and Title
VARIOUS

Code Language

330.1706 Notice of rights.

Except as provided in section 707, applicants for and recipients of mental health services and in the case of minors, the applicant's or recipient's parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available for review by applicants and recipients.

330.1776 Rights complaint; filing; contents; recording; acknowledgment; notice; assistance; conduct of investigation. (1) A recipient, or another individual on behalf of a recipient, may file a rights complaint with the office alleging a violation of this act or rules promulgated under this act.

330.1778 Investigation; initiation; recording; standard of proof; written status report; written investigative report; new evidence.

330.1784 Summary report; appeal. (1) Not later than 45 days after receipt of the summary report under section 782, the complainant may file a written appeal with the appeals committee with jurisdiction over the office of recipient rights that issued the summary report.

COMPETENCIES:

- What is the Rights Office, Who is in it?
- What are the various roles: Prevention, Monitoring, Education, Complaints
- What is your (staff) role in complaints (1776)?
- What happens when there is a complaint? The complaint process
- Employee Rights (retaliation/harassment (1755 3),Whistleblowers (Civil Action), Bullard-Plawecki (by HR or waived): emphasis on non-retaliation & disciplinary action)
- Basics of rights appeals - What do staff need to know and be able to explain about appeals? (1784)
- Other Key Points: Access by ORR, Preponderance of Evidence standard

Code Citation and Title
SUITABLE SERVICES – INFORMED CONSENT

Code Language

330.1100a Definitions; A to E. (19) "Consent" means a written agreement executed by a recipient, a minor recipient's parent, or a recipient's legal representative with authority to execute a consent, or a verbal agreement of a recipient that is witnessed and documented by an individual other than the individual providing treatment.

R 330.7003 Informed consent.

COMPETENCIES:

(1) All of the following are elements of informed consent:
(a) Legal competency. An individual shall be presumed to be legally competent. This presumption may be rebutted only by a court appointment of a guardian or exercise by a court of guardianship powers and only to the extent of the scope and duration of the guardianship. An individual shall be presumed legally competent regarding matters that are not within the scope and authority of the guardianship.
(b) Knowledge. To consent, a recipient or legal representative must have basic information about the procedure, risks, other related consequences, and other relevant information. The standard governing required disclosure by a doctor is what a reasonable patient needs to know in order to make an informed decision. Other relevant information includes all of the following:

(i) The purpose of the procedures.
(ii) A description of the attendant discomforts, risks, and benefits that can reasonably be expected.
(iii) A disclosure of appropriate alternatives advantageous to the recipient.
(iv) An offer to answer further inquiries.

(c) Comprehension. An individual must be able to understand what the personal implications of providing consent will be based upon the information provided under subdivision (b)
(d) Voluntariness. There shall be free power of choice without the intervention of an element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion, including promises or assurances of privileges or freedom. There shall be an instruction that an individual is free to withdraw consent and to discontinue participation or activity at any time without prejudice to the recipient.

Code Citation and Title
SUITABLE SERVICES – FAMILY PLANNING

R 330.7029 Family planning and health information.
The individual in charge of the recipient's written plan of service shall provide recipients, their guardians, and parents of minor recipients with notice of the availability of family planning, and health information services and, upon request, provide referral assistance to providers of such services. The notice shall include a statement that receiving mental health services does not depend in any way on requesting or not requesting family planning or health information services.

Code Citation and Title
SUITABLE SERVICES – TREATMENT BY SPIRITUAL MEANS

R 330.7135 Treatment by spiritual means.
A provider shall permit a recipient to have access to treatment by spiritual means upon the request of the recipient, a guardian, if any, or a parent of a minor recipient.

Code Citation and Title
SUITABLE SERVICES – MENTAL HEALTH SERVICES SUITED TO CONDITION

330.1708 Suitable services; treatment environment; setting; rights.
A recipient shall receive mental health services suited to his or her condition.

Code Citation and Title
SUITABLE SERVICES – CHOICE OF PHYSICIAN/MHP

330.1713 Choice of physician or mental health professional.
A recipient shall be given a choice of physician or other mental health professional in accordance with the policies of the community mental health services program, licensed hospital, or service provider under contract with the

community mental health services program, or licensed hospital providing services and within the limits of available staff in the community mental health services program, licensed hospital, or service provider under contract with the community mental health services program, or licensed hospital

Code Citation and Title
SUITABLE SERVICES – NOTICE OF CLINICAL STATUS

330.1714 Informing resident of clinical status and progress.
A recipient shall be informed orally and in writing of his or her clinical status and progress at reasonable intervals established in the individual plan of services in a manner appropriate to his or her clinical condition.

ADDITIONAL RIGHTS GRANTED TO RESIDENTS OF SPECIALIZED RESIDENTIAL FACILITIES

Code Citation and Title
MHC 330.1726 COMMUNICATIONS

Code Language
Every resident is entitled to unimpeded, private and uncensored communication with others by mail, telephone and to visit with person of his/her choice.

COMPETENCIES:
- Residents are allowed to use mail and telephone services. These communications must not be censored; staff should not open mail for residents without authorization. If necessary, funds must be provided (in reasonable amounts) for postage, stationary, telephone.
- Residents must be allowed access to computers to use in communication.
- If house rules are to be established regarding telephone calls, mail and visits, these must be reasonable and support the right as indicated above.
- House rules (limitations) must be posted in conspicuous areas for residents, guardians, visitors and others to see.
- Restrictions can be made on these rights for individuals but only as allowed in the individual plan of service (IPOS) following review and approval by the Behavior Treatment Plan Review Committee and the special consent of the resident or his/her legal representative.
- Communication by mail, telephone and to have visitors shall not be limited if:
  The communications are between a resident and his/her attorney or a court, or between a resident and <u>any other individuals</u> when the communication involves legal matters or may be the subject of legal inquiry.

Code Citation and Title
AR 330.7139 ENTERTAINMENT MATERIALS, INFORMATION AND NEWS

Code Language
Every resident has the right to acquire entertainment materials, information and news at his or her own expense, to read written or printed materials and to view or listen to television, radio, recordings or movies made available at a facility.

COMPETENCIES:
- Provider must never prevent a resident from exercising this right for reasons of, or similar to, censorship.
- Provider must establish written policies and procedures that provide for all of the following:

  - Any general program restrictions on access to material for reading, listening or viewing
  - Determining a resident's interest in, and provide for, a daily newspaper
  - Assure material not prohibited by law may be read or viewed by a minor unless there is an objection by the minor's parent or guardian
  - Permit attempts by the staff person in charge of the minor's IPOS to persuade a parent or guardian of a minor to withdraw objections to material desired by the minor.
- Provider may require that materials acquired by the resident that are of a sexual or violent nature be read or viewed in the privacy of the resident's room

Code Citation and Title
MHC 330.1726 VISITS

Code Language
Every resident is entitled to unimpeded, private and uncensored communication with others by mail, telephone and to visit with person of his/her choice.

TRAINING POINTS:

- Residents must be allowed the ability to visit with persons of their choice
- If house rules are to be established regarding visits, these must be reasonable and support the right as indicated above.
- House rules (limitations) must be posted in conspicuous areas for residents, guardians, visitors and others to see.
- Restrictions can be made on these rights for individuals but only as allowed in the individual plan of service (IPOS) following review and approval by the Behavior Treatment Plan Review Committee and the special consent of the resident or his/her legal representative.
- The ability to have visitors at any time shall not be limited if the communications are between a resident and his/her attorney or a court, or between a resident and <u>any other individuals</u> when the communication involves <u>legal matters</u> or may be the subject of legal inquiry.

Code Citation and Title
SUITABLE SERVICES – SERIVCES OF MENTAL HEALTH PROFESSIONAL

330.1715 Services of mental health professional.
If a resident is able to secure the services of a mental health professional, he or she shall be allowed to see the professional at any reasonable time.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
RECIPIENT RIGHTS APPEAL PROCESS

Chapter 7A of the Michigan Mental Health Code, PA 258 of 1974 as amended, establishes the right of public mental health service recipients or someone on their behalf to file complaints alleging a violation of rights guaranteed by Chapter 7 of the Code. Chapter 7A also assures that an appeal can be taken regarding the findings, remedial action, or timeliness of the complaint investigation. The purpose of this is to establish a process for handling these appeals to assure all recipients and those acting on their behalf receive due process including its essential elements of notice and an opportunity to be heard by a fair and impartial decision-making entity.

I. Definitions

A. Appeals Committee: A committee appointed by the MDHHS Director or by the board of a community mental health services program (CMHSP). The governing board of a licensed private psychiatric hospital/unit (LPH/U) shall designate the appeals committee of the CMHSP to hear appeals brought by or on behalf of a recipient of that CMHSP. For non-CMHSP recipients, the LPH/U, may appoint its own Appeals Committee in compliance with section 774(4)(a) of the Code or, by agreement with MDHHS, designate the MDHHS Appeals Committee to hear appeals against the LPH/U under section 774(4)(b) of the Code.

B. Appellant: The complainant or, if different than the complainant, the recipient or his/her legal guardian, if any, who seeks review by an appeals committee or the MDHHS pursuant to sections 784 and 786 of the Code.

C. Complainant: The individual who files a recipient rights complaint.

D. Legal Guardian: A judicially appointed guardian or parent with legal custody of a minor recipient.

E. Office: Any of the following:

1. With respect to a rights complaint involving services provided directly by the MDHHS, the state Office of Recipient Rights created under section 754 of the Code.

2. With respect to a rights complaint involving services provided directly or under contract to a community mental health services program, the office of recipient rights created by the community mental health services program under section 755 of the Code.

3. With respect to a rights complaint involving services provided directly or under contract to a licensed private psychiatric hospital/unit, the office of recipient rights created by the licensed hospital under section 755 of the Code.

F. Respondent: The service provider that had responsibility at the time of an alleged rights violation for the services with respect to which a rights complaint has been filed.

G. Responsible Mental Health Agency (RMHA): A MDHHS hospital or center; a community mental health services program; a licensed private psychiatric hospital or unit.

II. Procedure – Appeals Committee

A. The office of recipient rights with the MDHHS, a CMHSP, or an LPH/U shall assure that training is provided to the Appeals Committee, as required by Section 755(2)(a) of the Code.

B. Every complainant, recipient if different than the complainant, and the recipient's legal guardian, if any, shall be informed in the Summary Report issued by the MDHHS facility director, executive director of a CMHSP or the director of an LPH/U of the right to appeal to the designated Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 784(2), the time frame for submission of the appeal, advocacy organizations that may assist with filing the written appeal, and an offer of assistance by the office of recipient rights in the absence of assistance from an advocacy organization.

C. Not later than 45 calendar days after receipt of the Summary Report under section 782 of the Code, the appellant may file a written appeal with the Appeals Committee having jurisdiction to act upon it.

D. If the Summary report contains a plan of action, the office of recipient rights is provided written notice and evidence of the completion of the plan.
If the Summary report contains a plan of action, and the completed action is different than that proposed, the MDHHS facility director, CMHSP executive director or director of the LPH/U shall assure that the office of recipient rights, the complainant, recipient if different than the complainant, his/her legal guardian, if any, shall be provided written notice including specific information as to the action that was taken and the date that it occurred. The complainant, recipient, if different that the complainant, and his/her legal guardian, if any, shall be afforded 45 days after receipt of the notice to appeal the appropriate Appeals Committee on the grounds of inadequate action taken to remedy a rights violations.

E. Grounds for appeal to the Appeals Committee shall be as follows:

1. The investigative findings of the office are not consistent with the facts or with law, rules, policies or guidelines
2. The action taken or plan of action proposed by the respondent does not provide an adequate remedy
3. An investigation was not initiated or completed on a timely basis

F. Within 5 business days of receipt of the appeal, members of the appeals committee shall review the appeal to determine if it meets the criteria stated above. This review may be conducted by the full Committee or by an individual member or subcommittee designated by the full Committee to fulfill this responsibility. The Committee shall maintain a log of all appeals received and the disposition of each.

G. Within 5 business days of receipt of the appeal, written notice that the appeal has been accepted shall be provided to the appellant and a copy of the appeal shall be provided to the respondent and RMHA. The appellant shall also be informed within the same time frame if the appeal has not been accepted as it did not meet the criteria set forth in E. above.

H. Within 30 calendar days after receipt of a written appeal that is found to state one or more of the grounds cited in E. above, the Appeals Committee shall meet in closed session and review the facts as stated in all complaint investigation documents. Any member of the Appeals Committee who has a personal or professional relationship with an individual involved in the appeal shall abstain from participating in that appeal. The Committee shall not consider additional allegations that were not part of the original complaint at issue on appeal but shall inform appellant of his/her right to file the complaint with the office.

I. At the meeting in H. preceding, the Appeals Committee shall do one of the following:

1. Uphold the investigative findings of the office and the action taken or plan of action proposed by the respondent;

2. Return the investigation to the office and direct that it be reopened or reinvestigated;

3. Uphold the investigative findings of the office but direct that the respondent take additional or different action to remedy the violation;

4. If the Committee confirms that the investigation was not initiated or completed in a timely manner, recommend that the MDHHS-ORR director, executive director of the CMHSP or director of the LPH/U take appropriate supervisory action with the investigating rights officer/advisor;

5. If the RMHA is a CMHSP or an LPH/U, recommend that the board or governing body request an external investigation by MDHHS-Office of Recipient Rights.

J. The Appeals Committee shall document its decision in writing within 10 working days following the decision and shall provide copies of such to the respondent, appellant, recipient if different than appellant, the recipient's legal guardian, if any, the RMHA and the office. Documentation shall include justification for the decision made by the Committee.

K. If the Appeals Committee directs that the office reopen or reinvestigate the complaint, the office shall submit another investigative report in compliance with section 778(5) within 45 calendar days of receipt of the written decision of the Committee to the MDHHS facility directors, CMHSP executive director or the director of the LPH/U. The 45 calendar day time frame may be extended at the discretion of the Appeals Committee upon a showing of good cause by the office. At no time shall the time frame exceed 90 days.

1. Within 10 business days of receipt of the reinvestigate report, the MDHHS facility director, executive director of the CMHSP or the director of the LPH/U shall issue another Summary Report in compliance with section 782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the office and the Appeals Committee.

2. If the findings of the office remain unsubstantiated upon reinvestigation, the appellant may file a further appeal to the MDHHS-APPEALS - Level 2 Appeal, if the appellant continues to assert that the investigative findings of the office are not consistent with the facts or with law, rules, policies or guidelines. The Summary Report shall contain information regarding the appellant's right to further appeal, the time frame for the appeal and the ground for appeal. The report shall also inform the appellant of advocacy organizations that may assist in filing the written appeal or offer the assistance of the office in the absence from an advocacy organization.

3. If the investigative findings result in the substantiation of a previously unsubstantiated rights violation but the appellant disagrees with the adequacy of the action or plan of action proposed by the respondent, the appellant may file an appeal on such grounds to the Appeals Committee. The Summary Report shall inform the appellant of this right as well as further information as stated in II B above.

L. If the Appeals Committee upholds the findings of the office and directs that the respondent take additional or different action, that direction shall be based on the fact that appropriate remedial action has not been taken in compliance with section 780 of the Code.

1. The Appeals Committee shall base its determination upon any or all of the following:
    a. Action taken or proposed did not correct or remedy the rights violation.
    b. Action taken or proposed was/will not be taken in a timely manner.
    c. Action taken or proposed did not/will not prevent a future recurrence of the violation.

2. Written notice of this direction for additional or different action to be taken by the respondent shall also be provided to the RMHA if different than the respondent and the office.

3. Within 30 calendar days of receipt of the determination from the Appeals Committee, respondent shall provide written notice to the Appeals

Committee that the action has been taken or justification as to why it was not taken. The written notice shall also be sent to the appellant, recipient if different than appellant, the recipient's legal guardian, if any, the RMHA if different than the respondent, and the office.

4. If the action taken by the respondent is determined by the Appeals Committee and/or the appellant still to be inadequate to remedy the violation, the appellant shall be informed by the Appeals Committee of his/her right to file a recipient rights complaint against the RMHA, i.e., MDHHS facility director, executive director of a CMHSP or the director of an LPH/U for violation of section 754(3)(c) or 755(3)(b) of the Code.

M. If the Appeals Committee recommends that the board or governing body of the RMHA (a CMHSP or a LPH/U), request an external investigation by MDHHS-Office of Recipient Rights, the Board of Directors may make the request to MDHHS-ORR, in writing, within 5 business days of receipt of the request from the Appeals Committee.

1. Within 10 business days of receipt of the investigative report from MDHHS-ORR, the executive director of the CMHSP or the director of the LPH/U shall issue a Summary Report in compliance with section 782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the office and the Appeals Committee.

2. The complainant, recipient if different than the complainant, and the recipient's legal guardian, if any, shall be informed in the Summary Report issued by the executive director of a CMHSP or the director of an LPH/U of the right to appeal to the MDHHS Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 784(2), the time frame for submission of the appeal, advocacy organizations that may assist with filing the written appeal, and an offer of assistance by the office of recipient rights in the absence of assistance from an advocacy organization.

3. Not later than 45 calendar days after receipt of the Summary Report, the appellant may file a written appeal with the MDHHS Appeals Committee.

4. If the Summary report contains a plan of action, the office of recipient rights is provided written notice and evidence of the completion of the plan. If the Summary report contains a plan of action, and the completed action is different than that proposed, the CMHSP executive director or director of the LPH/U shall assure that the office of recipient rights, the complainant, recipient if different than the complainant, his/her legal guardian, if any, shall be provided written notice including specific information as to the action that was taken and the date that it occurred. The complainant, recipient if different that the complainant and his/her legal guardian, if any, shall be afforded 45 calendar days after receipt of the notice to appeal the appropriate Appeals Committee on the grounds of inadequate action taken to remedy a rights violations.

III. MDHHS Appeals

A. An appeal to MDHHS Appeals may be taken only upon the ground that the investigative finding of the office were inconsistent with the facts or with law, rules, policies or guidelines; and only after a decision on an appeal has been made by the appropriate Appeals Committee to uphold the findings of an investigation, or, upon reinvestigation, the findings of the office remain unsubstantiated.

B. Within 45 calendar days after receiving written notice of the decision of the Appeals Committee under section II. I. 1. or the Summary Report in II. K. 2., the appellant may file a written appeal with MDHHS appeals. The written appeal shall be mailed to:

MDHHS-APPEALS
Level 2 Appeal
Lewis Cass Building, 1st floor
P.O. Box 30807
Lansing, MI 48909

FAX: (517) 241-7973

C. Upon receipt of the appeal, MDHHS-APPEALS shall give written notice of the receipt to the respondent, local office of recipient rights holding the record of the complaint and the RMHA. If the appeal involves the findings of a rights advisor with the MDHHS Office of Recipient Rights, the Director of that office shall also receive written notice of receipt of the appeal. The respondent, local office holding the record of the complaint, MDHHS-ORR Director, and the RMHA shall ensure that MDHHS has access to all necessary documentation and other evidence cited in the complaint and local appeal.

D. MDHHS-APPEALS shall review the record generated by the local appeal. It shall not consider additional evidence or information that was not available during the local appeal.

E. Within 30 calendar days after receiving the appeal, MDHHS-APPEALS shall review the appeal and do one of the following:

1. Uphold the findings of the office.
2. Affirm the decision of the Appeals Committee.
3. Return the matter to the director of the department's Office of Recipient Rights, the executive director of the CMHSP or the director of the LPH/U with instruction for additional investigation or consideration.

F. MDHHS-APPEALS shall provide copies of its action to the respondent, the appellant, recipient if different than appellant, the recipient's legal guardian, if any, the board of a CMHSP, the governing body of the LPH/U and the local office of recipient rights holding the record. If the appeal involves the findings of a MDHHS-ORR rights advisor, the MDHHS-ORR director shall also be provided copies of the action. If MDHHS-APPEALS upholds the findings of the office, notice shall be provided to the appellant of his/her legal right to seek redress through the circuit court.

G. If MDHHS-APPEALS instructs that additional investigation be conducted, the director of MDHHS-ORR, the executive director of the CMHSP or the director of the LPH/U shall assure that such investigation is completed in a fair and impartial manner within 45 calendar days of his/her receipt of the written notice from MDHHS-APPEALS. The 45 calendar day time frame may be extended at the department's discretion upon a showing of good cause by the MDHHS-ORR director, CMHSP executive director or LPH/U director. At no time shall the time frame exceed 90 calendar days. In cases of re-investigation by MDHHS-ORR, the director of that office shall be responsible for the submission of the investigative report to the appropriate MDHHS facility director.

H. Within 10 business days of the receipt of the investigative report, the facility director, executive director of the CMHSP, or the director of the LPH/U shall issue a Summary Report in compliance with section 782 of the Code to the department, appellant, recipient if different than appellant and the recipient's legal representative, if any.

1. If the findings of the additional investigation remain the same as those appealed, the department shall inform appellant, recipient if different than appellant and the recipient's legal guardian, if any, in writing of the right to seek redress through the circuit court.
Copies of this notice will be provided to the deputy director of the MDHHS Mental Health/Substance Abuse Services (if the investigation was conducted by staff of the MDHHS-ORR) the director of MDHHS Quality Management and Service Innovation (if the investigation was conducted by a CMHSP) or the Licensing Officer with the Psychiatric Licensure Unit of the MDHHS Division of Health Facility Licensing and Certification (if the investigation was conducted by an LPH/U).

2. If the additional investigation results in the substantiation of previously unsubstantiated violation but the appellant, recipient if different than the appellant and/or the recipient's legal guardian, if any, disagrees with the adequacy of the action taken or plan of action proposed to remedy the violation, the department shall inform the individual(s) of the right to appeal this to the local Appeals Committee.

MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
FY17 REPORTING REQUIREMENTS
Effective 10/1/16

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1 = Normal – Swallows all types of foods 12
2 = Modified independent – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown 12
3 = Requires diet modification to swallow solid food – e.g., mechanical diet (e.g., purée, minced) or only able to ingest specific foods 12
4 = Requires modification to swallow liquids – e.g., thickened liquids 12
5 = Can swallow only puréed solids AND thickened liquids 12
6 = Combined oral and parenteral or tube feeding 12
7 = Enteral feeding into stomach – e.g., G-tube or PEG tube 12
8 = Enteral feeding into jejunem – e.g., J–tube or PEG-J tube 12
9 = Parenteral feeding only—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN) 12
Blank = Missing 12
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*11. Monetary Amount (effective 10/1/13): 19
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) 19
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MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
FY17 REPORTING REQUIREMENTS
Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2016 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. 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 and Quality Improvement Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter and quality improvement (demographic) data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- Mental Health 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.
- Cost per code instructions that contain 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, Version 6.0" is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators

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:

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management

- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- 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 members 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 CMHSP 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**
1/31/2017	1Q Special Fund Account – Section 226a, PA of the MHC	October 1 to December 31
4/30/2017	2Q Special Fund Account – Section 226a, PA of the MHC	October 1 to March 31
5/31/2017	Mid-Year Status Report	October 1 to March 31
6/30/2017	Semi-annual Recipient Rights Data Report	October 1 to March 31. Section I only. See section "Recipient Rights Data Report" for additional information in this attachment.
8/15/2017	3Q Special Fund Account – Section 226a, PA of the MHC	October 1 to June 30
8/15/2017	Projection Financial Status Report – All Non-Medicaid,	October 1 to September 30
8/15/2017	Projection State Services Utilization, Reconciliation & Cash Analysis	October 1 to September 30
8/15/2017	Projection General Fund Contract Settlement Worksheet	October 1 to September 30
8/15/2017	Projection General Fund Reconciliation and Cash Settlement	October 1 to September 30
10/1/2017	General Fund – Year End Accrual Schedule	October 1 to September 30
FY17 Monthly	PASARR Agreement Monthly Billing	Only one (1) bill will be considered for payment per month, and should be submitted for payment to the DEPARTMENT within forty-five (45) days after the end of the month in

		which the service was provided, except for the September bill which shall be submitted within fifteen (15) days after the end of the month.
11/10/2017	Interim Financial Status Report – All Non-Medicaid,	October 1 to September 30
11/10/2017	Interim State Services Utilization, Reconciliation & Cash Analysis	October 1 to September 30
11/10/2017	Interim Special Fund Account – Section 226a, PA of the MHC	October 1 to September 30
11/10/2017	Interim General Fund Contract Settlement Worksheet	October 1 to September 30
11/10/2017	Interim General Fund Reconciliation and Cash Settlement	October 1 to September 30
11/10/2017	Categorical Funding – Multi-cultural Annual Report	October 1 to September 30
12/30/2017	Annual Recipient Rights Data Report	October 1 to September 30. Sections I, II, III & IV. See section "Recipient Rights Data Report" for additional information in this attachment.
1/31/2018	Annual Report on Fraud and Abuse Complaints	October 1 to September 30
2/28/2018	Final Financial Status Report – All Non-Medicaid	October 1 to September 30
2/28/2018	Final State Services Utilization, Reconciliation & Cash Analysis	October 1 to September 30
2/28/2018	Final Special Fund Account – Section 226a, PA of the MHC	October 1 to September 30
2/28/2018	Final General Fund Reconciliation and Cash Settlement	October 1 to September 30
2/28/2018	Final General Fund Contract Settlement Worksheet	October 1 to September 30
2/28/2018	Sub-Element Cost Report	See Attachment 6.5.1.1 Submit report to: QMPMeasures@michigan.gov
2/28/2018	Annual Submission Requirement Form – Estimated FTE Equivalents	For the fiscal year ending October 1 to September 30, 2016
2/28/2018	Annual Submission Requirement Form – Requests for Services and Disposition of Requests	For the fiscal year ending October 1 to September 30,2016
2/28/2018	Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 1	For the fiscal year ending October 1 to September 30, 2016
2/28/2018	Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 2	For the fiscal year ending October 1 to September 30, 2016
2/28/2018	Annual Submission Requirement Form – Waiting List	For the fiscal year ending October 1 to September 30, 2016
2/28/2018	Annual Submission Requirement Form – Specialized Residential	For the fiscal year ending October 1 to September 30, 2016
2/28/2018	Annual Submission Requirement Form – Community Needs Assessment	For the fiscal year ending October 1 to September 30, 2016
2/28/2018	CMHSP Administrative Cost Report	For the fiscal year ending October 1 to September 30, 2016

2/28/2018	Executive Administrative Expenditures Survey for Sec. 904(2)(k)	October 1 to September 30, 2017
30 days after receipt, but no later than June 30, 2017	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter. Compliance exam and plan of correction	October 1 to September 30th Submit reports to: MDHHS-AuditReports@michigan.gov

FY 2017 DATA REPORT DUE DATES

	Nov14	Dec	Jan15	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec15	Jan16
1. Consumer level** Demographic BHTEDS (monthly)[1] b. Encounter (monthly)[1]	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2.PIHP level a. Medicaid Utilization and Net Cost Report: annually)[2]				√											
b. Performance indicators (quarterly)[2]					√			√			√			√	
c. Consumer Satisfaction (annually) [2]										√					
d. CAFAS [3]													√		
e. Critical incidents (monthly)[3]															

NOTES:

1. Send data to MDHHS MIS via DEG
2. Send data to MDHHS, Behavioral Health & Developmental Disabilities Administration, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDHHS web site at: www.michigan.gov/dhhs Click on "Reporting Requirements"

**Consumer level data must be submitted immediately 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.

PIHP level reports are due at 5 p.m. on the last day of the month checked

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.

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. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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 DEVELOPMENTAL DISABILITIES

For FY16, the CMHSPs 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.

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.

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* ***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.

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* ***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

***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**

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 psychotropic 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

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: http://www.michigan.gov/mdhhs/0,4612,7-132-2941_38765---,00.html 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	YYYYMMDD	36	43	Yes	Yes	

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE ABUSE 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 CMHSP 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 as appropriate.
- 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 837includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
- 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 MDHHS Quality 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-10 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.

****10.*** ***Procedure Modifier Code***
Enter modifiers 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 10/1/13):
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)

FY'16 SUB-ELEMENT COST REPORT

This report provides the total service data necessary for MDHHS management of CMHSP contracts and reporting to the Legislature. The data set reflects and describes the support activity provided to or on behalf of all consumers receiving services from the CMHSP **regardless of funding stream** (Medicaid, general fund, grant funds, private pay, third party pay, autism iSPA, contracts). The format is presented by procedure code, beginning with facility services reported by revenue code. Most of the activity reported here will also have been reported in the encounter data system. Refer to the PIHP/CMHSP Encounter Reporting Costing per Code and Code Chart on the MDHHS web site for a crosswalk between services and the appropriate codes.

Instructions and reporting templates can be found at:

http://www.michigan.gov/MDHHS/0,4612,7-132-2941_38765---,00.html

FY17 CMHSP GENERAL FUND COST REPORT

This report provides the general fund cost and service data necessary for MDHHS management of CMHSP contracts. The data set of cases, units and costs reflects and describes the support activity provided to or on behalf of all uninsured and underinsured consumers receiving services from the CMHSP paid with general funds. This report also includes information on consumers who are enrolled in a benefit plan (i.e., Medicaid, or Children's Waiver) but who are also receiving a general fund-covered service like family friend respite or state inpatient, or are on spend-down and receiving some of their services funded by general fund. The format is presented by procedure code, beginning with facility services reported by revenue code. Most of the activity reported here will also have been reported in the encounter data system. Refer to the PIHP/CMHSP Encounter Reporting Costing per Code and Code Chart on the MDHHS web site for a crosswalk between services and the appropriate codes.

Instructions and reporting templates can be found at:

http://www.michigan.gov/MDHHS/0,4612,7-132-2941_38765---,00.html

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM
VERSION 6.0
FOR CMHSPS

The Michigan Mission Based Performance Indicator System (version 1.0) was first implemented in FY'97. That original set of indicators reflected nine months of work by more than 90 consumers, advocates, CMHSP staff, MDHHS staff and others. The original purposes for the development of the system remain. Those purposes include:

- 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 CMHSP 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 CMHSP performance. Therefore, performance indicators should be reported by the CMHSP 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.

CMHSP PERFORMANCE INDICATOR SYSTEM

NOTE: Consumers covered by the Medicaid autism benefits are to be excluded from the calculations.

ACCESS

1. The percent of all adults and children receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.
    a. Standard = 95% in three hours
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers

2. The percent of new persons 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, and DD children).
    a. Standard = 95% in 14 days
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, DD adults, DD children, and Medicaid SA

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 and DD children)
    a. Standard = 95% in 14 days
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, DD adults, DD children, and Medicaid SA

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).
    a. Standard = 95%
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers

    Scope: All children and all adults (MI, DD) - Do not include dual eligibles (Medicare/Medicaid) in these counts.

5. The percent of face-to-face assessments with professionals that result in decisions to deny CMHSP services. (MI and DD) (Old Indicator #6)
    a. Quarterly report
    b. CMHSP
    c. Scope: all MI/DD consumers

6. The percent of Section 705 second opinions that result in services. (MI and DD) (Old Indicator #7)

a. Quarterly report
b. CMHSP
c. Scope: all MI/DD consumers

EFFICIENCY

*7. The percent of total expenditures spent on administrative functions for CMHSPs. (Old Indicator #9)

a. Annual report (MDHHS calculates from cost reports)
b. PIHP for Medicaid administrative expenditures
c. CMHSP for all administrative expenditures

OUTCOMES

*8. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by CMHSP who are in competitive employment. (Old Indicator #10)

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

*9. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop). (Old Indicator #11)

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge**.** (Old Indicator #12)

a. Standard = 15% or less within 30 days
b. Quarterly report
c. PIHP for all Medicaid beneficiaries
c. CMHSP
d. Scope: All MI and DD children and adults - Do not include dual eligibles (Medicare/Medicaid) in these counts.

11. The annual number of substantiated recipient rights complaints per thousand persons served with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II. (Old Indicator #13)

*13. The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

*14. The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

CMHSP PERFORMANCE INDICATOR REPORTING DUE DATES

FY 2017 Due Dates

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screening	10/01 to 12/31	3/31/17	1/01 to 3/31	6/30/17	4/01 to 6/30	9/30/17	7/01 to 9/30	12/31/17	CMHSPs
2. 1st request	10/01 to 12/31	3/31/17	1/01 to 3/31	6/30/17	4/01 to 6/30	9/30/17	7/01 to 9/30	12/31/17	CMHSPs
3. 1st service	10/01 to 12/31	3/31/17	1/01 to 3/31	6/30/17	4/01 to 6/30	9/30/17	7/01 to 9/30	12/31/17	CMHSPs
4. Follow-up	10/01 to 12/31	3/31/17	1/01 to 3/31	6/30/17	4/01 to 6/30	9/30/17	7/01 to 9/30	12/31/17	CMHSPs
5. Denials	10/01 to 12/31	3/31/17	1/01 to 3/31	6/30/17	4/01 to 6/30	9/30/17	7/01 to 9/30	12/31/17	CMHSPs
6. 2nd Opinions	10/01 to 12/31	3/31/17	1/01to 3/31	6/30/17	4/01 to 6/30	9/30/17	7/01 to 9/30	12/31/17	CMHSPs
7. Admin Costs*	10/01 to 9/30	2/27/18							CMHSPs
8. Competitive employment*	10/01 to 9/30	N/A							MDHHS
9. Minimum wage*	10/01 to 9/30	N/A							MDHHS
10. Readmissions	10/01 to 12/31	3/31/17	1/01 to 3/31	6/30/17	4-01 to 6-30	9/30/17	7/01 to 9/30	12/31/17	CMHSPs
11. RR complaints	10/01 to 9/30	12/31/17							CMHSPs
13. Residence (DD)*	10/01 to 9/30	N/A							MDHHS
14. Residence (MI)*	10/01 to 9/30	N/A							MDHHS

*Indicators with *: MDHHS collects data from encounters, quality improvement or cost reports and calculates performance indicators

STATE LEVEL DATA COLLECTION

CAFAS

Child and Adolescent Functional Assessment Scale (CAFAS) shall be performed for each child with serious emotional disturbance at intake, quarterly thereafter, and at exit. Scale scores shall be exported using the FAS Outcomes application in xml format. In order that the scores along with de-identified data are automatically sent to the Eastern Michigan University Level of Functioning (LOF) Project, the CMHSP must assure the research box remains checked. MDHHS uses aggregate reports from the LOF Project for internal planning and decision-making. In FY'11 MDHHS will cover 50% of the FAS Outcomes annual licensing fee of $400 per CMHSP, and 50% of the per usage fee of $2.95.

Annually each CMHSP shall submit an aggregate CAFAS report to MDHHS. The report is automatically generated by the FAS Outcomes program. **Methodology and instructions for submitting the reports are posted on the MDHHS web site at www.michigan.gov/MDHHS. Click on Mental Health and Substance Abuse, then "Reporting Requirements."**

Preschool and Early Childhood Functional Assessment Scale (PECFAS) shall be performed for each child, four through six year olds, with serious emotional disturbance at intake, quarterly thereafter, and at intake.

DECA

The Devereux Early Childhood Assessment (DECA) for Infants (1 to 18 months), Toddler (18-36 months) or Clinical (24-47 months) shall be completed by a trained rater for each young child with serious emotional disturbance or for each young child served, age 1 to 47 months, when open under the parent with mental illness or intellectual/developmental disability, at intake, quarterly thereafter, and at exit. All DECAs are to be entered into the electronic DECA (eDECA) system**.** DECA (Infant, Toddler and Clinical) raters are to have attended an in-person MDCH sponsored training, a MDCH sponsored webinar or have received training by a certified Devereux Early Childhood Trainer.

Annually, MDCH will aggregate the DECA scores and use this information for internal planning and decision-making.

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 substance use disorder, 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 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 receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- **Arrest of Consumer** for individuals 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 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"

RECIPIENT RIGHTS DATA REPORT

INSTRUCTIONS FOR COMPLETING THE RECIPIENT RIGHTS DATA REPORT

Use the CURRENT (DCH 0046 REV01/2014) excel form and email the report. The annual report letter can be sent by USPS or a signed PDF copy can be sent via email. The semi annual report memo can be sent by email

Demographic Data

CMHSPs: Insert the number of consumers served (unduplicated count) in cell E6.
LPH/Us: Insert the number of patient days in cellE11. Insert the population type served (MI, SED, Both)

Annual Demographic Data for:		
CMH INFORMATION		
Number of Consumers Served (unduplicated count):		(CMH)
LPH/U INFORMATION		
Number of Patient Days:		(LPH/U)
Populations Served:		(LPH/U)

Service Site Information

CMHSPs only:

Insert the type and number of sites in your catchment area, and the number of sites out of catchment area. In the third column insert **only** the number of service sites that **must** be visited. In the fourth column, insert the number of site visits conducted. If a site is visited more than once, **only** note the first visit on this report.

If the site requires a visit, please list in column E

Type of Site	In Catchment Area	Out of Catchment Area	Total Sites Requiring Visits	Site Visit Conducted
Out Patient				
Residential MI				
Residential DD				
Residential MI & DD				
Inpatient				
Day Program MI				
Day Program DD				
Workshop (prevocational)				
Supported Employment				
ACT				
Case Management				
Psychosocial Rehab				
Partial Hospitalization				
SIP				
Crisis Center				
Children's Foster Care				
Total Number of Service Sites that Require Site Visits:			0	
Total Number of Site Visits Conducted:			0	

Staffing Information:

CMHSPs: FTE's are defined as hours paid for recipient rights functions. List the full time equivalents for your office.

Explain the breakdown of staff (if there is one); investigators/administrators, clerical/support, trainers. If there is only 1 person for all functions, fill in only cellC38

36	RIGHTS FTE INFORMATION - CMH	
37	Do not fill in row 39-41 if 1 person has all roles	
38	Total Number of Rights FTEs*:	
39	Number of Investigators/administrators (FTE)	
40	Number of Trainers (FTE)	
41	Number of Clerical Support (FTE)	

LPH/Us: List the hours per week paid for recipient rights functions

43	RIGHTS FTE INFORMATION - LPH/U	
44		
45	Number of Rights Hours (*total per week*):	
46		

Appeal Information

CMHSPs and LPH/Us **without** an agreement with MDHHS:

Insert the number of appeals submitted (to the committee), the number accepted and the disposition of the appeals heard.

49	APPEALS INFORMATION (if agency has local appeals committee)	
50		
51	Number of Appeals Submitted	
52	Number of Appeals Accepted	
53	Number Number of Appeals Upheld	
54	Number of Appeals Sent Back for Reinvestigation	
55	Number of Appeals Requesting External Investigation by DHC	
56	Number of Appeals Sent Back for Further Action	
57	Total Number of Appeals Received by Appeals Committee	0

Complaint Data:

Section 1: Complaint Data Summary

⇒ *THIS SECTION IS REQUIRED TO BE COMPLETED) FOR THE ANNUAL REPORT AND SEMI-ANNUAL REPORT*

Part A: Totals

Insert the name of the Rights Office Director in cell C2
The number of **Allegations** will populate from the Aggregate Summary.
Complaint Source: Enter the category of the complainant: Recipient; Staff; ORR; Guardian/ Family; Anonymous; Community/General Public; Total. The total of "Complaint Sources" must be the same as the "Complaints Received".

20	COMPLAINT SOURCE	
21		
22	Recipient	
23	Staff	
24	ORR	
25	Guardian/Family	
26	Anonymous	
27	Community/General Public	
28	*Total Complaints Received*	0
29		

Timeframes of Completed Investigations: The total in this section will auto-fill the number of abuse and neglect I & II investigations as well as the number of all other investigations (NOT interventions). Fill in the number of cases under each timeframe manually (not including any time following submission to the director).

Category	Total	≤30	≤60	≤90	>90
Abuse/Neglect I & II	0				
All others	0				

Part B: Aggregate Summary of Allegations by Category
For each sub-category, insert the following:

-
- Number of allegations involved
- Number of these in which some **intervention **** was conducted
- Number of allegations substantiated by investigation.
- Number of these **investigated ***
- Number of allegations substantiated by intervention.

In each subcategory: If "0", enter 0 in ALL appropriate boxes of the row where an allegation is received

- The recipient population for targeted allegations; adult MI (MI), Developmental Disability (DD), Seriously Emotionally Disturbed (SED), (number of persons involved)

* Investigation: A detailed inquiry into, and systematic examination of, an allegation raised in a rights complaint and reported in accordance with Chapter 7A, Report of Investigative Findings.

**Intervention: To act on behalf of a recipient to resolve a complaint alleging a violation of a code protected right when the facts are clear and the remedy, if applicable, is clear, easily obtainable and does not involve statutorily required disciplinary action.

**Interventions are not allowed in allegations of abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation or retaliation/harassment.*

Part C: Remediation of Substantiated Rights Violations:

For each allegation, which, through investigation **or intervention,** it was established that a recipient's right was violated indicate (from the drop down):

- The category name
- The Specific Provider type (see table)
- The Specific remedial action taken (be sure to list 1 action per column)
- The number of the type of population

Provider	**Remedial Action**	**Population**
Outpatient	Verbal Counseling	MI
Residential Ml	Written Counseling	DD
Residential DD	Written Reprimand	SED
Mixed Residential (MI/DD)	Suspension	SEDW
Inpatient	Demotion	DD-CWP
Day Program MI	Staff Transfer	HSW
Day Program DD	Training	HMIABW
Workshop (Prevocational)	Employment Termination	
Supported Employment	Employee left the agency, but substantiated	
ACT	Contract Action	
Case Management	Policy Revision/Development	
Psychosocial Rehabilitation	Environmental Repair/Enhancement	
Partial Hospitalization	Plan of Service Revision	
SIP	Recipient Transfer to Another Provider/Site	
Other	Other	

**Employee left the agency, but substantiated; a letter was placed in the employee's personnel file indicating that the allegation of a rights violation requiring disciplinary action was substantiated.

SEDW

This is a 1915(c) waiver (Home and Community-Based Services Waiver) for children with serious emotional disturbance. This waiver is administered through Community Mental Health Services Programs (CMHSPs) in partnership with other community agencies and is available in a limited number of counties. Eligible consumers must meet current MDHHS contract criteria for the state psychiatric hospital for children and demonstrate serious functional limitations that impair the child's ability to function in the community.

DD- CWP

This is a 1915(c) waiver (Home and Community-Based Services Waiver) for children with developmental disabilities who have challenging behaviors and/or complex medical needs. This waiver is administered through Community Mental Health Services Programs (CMHSPs) and is available statewide. Eligible consumers must be eligible for, and at risk of, placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

HSW

The Habilitation Supports Waiver is a 1915(c) waiver (Home and Community-Based Services Waiver) for people who have developmental disabilities and who meet the eligibility requirements: have active Medicaid, live in the community, and otherwise need the level of services provided by an intermediate care facility for mental retardation (ICF/MR) if not for the HSW. There are no age limitations for enrollment in the HSW. This waiver is administered through Prepaid Inpatient Health Plans (PIHPs) and affiliate Community Mental Health Services Programs (CMHSPs). The HSW is available statewide. **RECIPIENT RIGHTS DATA REPORT**

THE FOLLOWING SECTION IS REQUIRED FOR THE ANNUAL REPORT ONLY

Section II: Training Activity

Part A: Training Received by Rights Office Staff

First, enter the name of each staff who receive training in column A. Fill in each staff in column C using the drop-down box. Indicate, for each rights staff, name of the rights related training received during the period, the CEU Category and the number of hours for each (Operations, Legal/Foundations, Leadership, Augmented)

8	**STAFF NAMES** *(List Names)*		Staff Name	Topic of Training Received	CEU Type	# Hours
9						
10						
11						
12						
13						
14						

Part B: Training Provided by Rights Office

Indicate if update training is required. If it is required, indicate how often.

Indicate the name of the training provided during the period, the length of the session, the number of

CMH or Hospital Staff involved, the number of contractual staff involved, the number of other staff involved, type of "others" and the number of consumers trained.

Method of Training
Face-to-Face
Video
Computer
Paper
Video & Face-to-Face
Computer & Face-to-Face Paper & Face-to-Face Other (please describe)

	Topic of Training Provided	How long is the training? # Hours	# Agency Staff	# Contractual Staff	# of Consumers	# Other	Type of Other Staff	Method of Training Provided	Description (If Needed)
10									
11									
12									

If the training is conducted by someone else, indicate, in the description column, who conducted the training and the date the training was reviewed by the rights office.

Section III: Desired Outcomes for the Office

List the outcomes establish for the office from the last fiscal year (from last year's report). From the drop-down box, select whether the goal is "ongoing" or "accomplished". Ongoing goals will automatically populate into the current year. List any new outcomes for the office during the next fiscal year.

Section IV: Recommendations to the CMHSP Board or LPH Governing Board

List any recommendations made to the governing Board regarding the rights office or recipient rights activity as part of the annual report. Be sure to include issues identified by the Advisory Committee throughout the year or discussed as part of the annual and semi-annual report review. Do not leave this blank.

General Information:

LPH/Us are to include ALL data regarding complaints on the Annual & Semi-Annual Reports.
LPH/Us must fill out one Annual report for each facility.
CMHSPs are NOT to include LPH/U data on the Annual & Semi-Annual Reports

REPORT DATES:

Semi-Annual
October 1 through March 31
Section I

Cover letter from Rights Office
Hospital

Annual
October 1 through September 30
Section, I, II, III, IV

Cover Letter from Executive Director or Director

To “the department” & Advisory Committee	To “the department” & Board of CMHSP or governing board of licensed hospital
Due at MDHHS: June 30	Due at MDHHS: December 30

QUALITY IMPROVEMENT PROGRAMS FOR CMHSPs
TECHNICAL REQUIREMENT

The State will implement the standards for internal quality assurance mechanisms as specified below. They are based upon the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993 and HCFA's draft Standards and Guidelines for Review of Medicare and Medicaid Managed Care Organizations (December 22, 1997). These documents have been modified to reflect: concepts and standards more appropriate to the population of persons served under the current waiver request; Michigan state law; and existing requirements, processes and procedures implemented in Michigan.

Michigan Standards

STANDARD I: Quality Improvement Program - The organization shall have a Quality Improvement Program (QIP) that achieves, through ongoing measurement and intervention, improvement in aspects of clinical care and non-clinical services that can be expected to affect consumer health status, quality of life, and satisfaction.

A. The organization has a written description of its QIP. The written description contains a detailed description of the structure of the QI system and a set of QI objectives that are developed annually and include a timetable for implementation and accomplishment. The plan must evaluate the QI program at least annually.

B. Scope - The written QIP plan includes a description for how the organization shall assure that all demographic groups, care settings, and types of services are included in the scope of the QIP.

C. The written plan must reflect the specific activities of the QIP, including:

1. The process for the identification and selection of aspects of clinical care and non-clinical services to be monitored and considered for process improvement projects;
2. The methods used to gather, analyze, report, and utilize customer satisfaction;
3. The mechanisms that will be used to evaluate and annually revise the QIP written plan.
4. The responsibilities of the governing body, executive director, medical director, managers, direct staff and subcontracting agencies in the QI process.
5. The structure responsible for performing QI functions and assuring that program improvements are occurring within the CMHSP. This committee or other structure must:

    a. Demonstrate that it meets or occurs with a frequency that is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions.

b. Established parameters for the role, structure and function of the structure/committee.

c. Maintain records documenting the structure's/committee's activities, findings, recommendations and actions.

D. Continuous Activity - The written description provides for continuous performance of the activities, including tracking of issues over time.

E. Follow Through - The plan must delineate the mechanisms or procedures to be used for adopting and communicating process and outcome improvements.

F. Focus on Health Outcomes - The plan must address the role for mental health outcomes, of value to purchasers and individuals, to the extent possible within existing technology.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT - The QIP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality assessment and performance improvement projects, and related activities, and pursues opportunities for improvement on an ongoing basis.

The QIP has written guidelines for its quality-related activities, which include:

A. Specification of clinical or health services delivery areas to be monitored

1. The monitoring and evaluation of care reflects the population served by the CMHSP in terms of age groups, disease categories, and special risk status.

2. At its discretion and/or as required by the State Medicaid agency, the organization's QIP also monitors and evaluates other important aspects of care and service.

B. Use of quality indicators

1. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.

2. Indicators shall include, but not be limited to, those selected by the state agency.

3. Methods and frequency of data collection are appropriate and sufficient to detect need for program change.

C. Use of clinical care standards/practice guidelines

1. When there are nationally accepted or mutually agreed upon clinical standards/practice guidelines, QI activities monitor quality of care against those standards/guidelines.

2. When guidelines exist, a mechanism is in place for continually updating the standards/guidelines.

D. Implementation of remedial action plans

1. The QIP requires that appropriate remedial action be taken whenever inappropriate or substandard services are furnished as determined by substantiated recipient rights complaints, clinical indicators, or clinical care standards or practice guidelines where they exist.

2. Follow-up remedial actions are documented.

E. Assessment of effectiveness of corrective actions

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

2. The CMHSP assures follow-up on identified issues to ensure that actions for improvement have been effective.

F. The Quality Improvement Program describes the process of the review and follow-up of sentinel events for persons enrolled in the Children's Waiver (CW), the Children with Serious Emotional Disturbance Waiver (SEDW), and who receive services funded by these programs from CMHSPs. CMHSPs that are service providers of PIHPs, should reach agreement on how sentinel events will be handled for individuals receiving 1915(b) services or Habilitation Supports Waiver services managed by the PIHP.

1. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate, with root cause analyses to commence within two business days of the sentinel event.

2. Staff involved in reviewing and analyzing the sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involved death or serious medical conditions, must involve a physician or nurse.

3. All unexpected* deaths of Children's Waiver, and SED Waiver beneficiaries, who at the time of their deaths were receiving specialty supports and services from CMHSPs, must be reviewed and must include:

    a. Screens of individual deaths with standard information (e.g. coroner's report, death certificate).
    b. Involvement of medical personnel in the mortality reviews.
    c. Documentation of the mortality review process, findings, and recommendations.
    d. Use of mortality information to address quality of care.
    e. 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.

STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY - Responsibilities of the Governing body for monitoring, evaluating, and making improvements to care include:

A. Oversight of QIP - There is documentation that the Governing Body has approved the overall QIP and an annual QI plan.

B. QIP progress reports - The Governing Body routinely receives written reports from the QIP describing actions taken, progress in meeting QI objectives, and improvements made.

C. Annual QIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QIP that includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered to assess the QIP's continuity, effectiveness and current acceptability.

D. Program modification - Upon receipt of regular written reports from the QIP delineating actions taken and improvements made, the Governing Body assures that the Executive Director takes action when appropriate and directs that the operational QIP be modified on an ongoing basis to accommodate review findings and issues of concern within the Community Mental Health Service Program (CMHSP).

STANDARD IV: QIP SUPERVISION - There is a designated senior executive who is responsible for the QI program implementation. The organization's Medical Director has an identifiable role in the QIP.

STANDARD V: Provider Qualification and Selection - The QIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the State and who are employees of the CMHSP or under contract to the

CMHSP, are qualified to perform their services. The QIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs.

The CMHSP must have written policies and procedures for the credentialing process that 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 QIP are incorporated into this re-credentialing process.

The CMHSP must also insure:

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.

STANDARD VI: ENROLLEE RIGHTS AND RESPONSIBILITIES - The organization demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

A. The CMHSP monitors and assures that each individual has all of the rights established in Federal and State law.

B. The CMHSP shall have a local recipient rights office found to be in substantial compliance with the requirements of Chapter 7 of the Michigan Mental Health Code, as evidenced by a site review conducted by the state agency.

C. The CMHSP shall submit an annual report of the CMHSP's Office of Recipient Rights to the state office as required by Chapter 7 of the Michigan Mental Health Code.

D. The organization conducts 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.

1. The assessments must address the issues of the quality, availability, and accessibility of care.
2. As a result of the assessments, the organization:

a. Takes specific action on individual cases as appropriate;
b. Identifies and investigates sources of dissatisfaction;
c. Outlines systemic action steps to follow-up on the findings; and
d. Informs practitioners, providers, recipients of service, and the governing body of assessment results.

3. The organization evaluates the effects of the above activities.

4. 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.

STANDARD VIII: UTILIZATION MANAGEMENT

A. Written Program Description - The organization has a 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 and overutilization.

C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:

1. Review decisions are supervised by qualified medical professionals.

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 patients. 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.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)
MENTAL HEALTH AND SUBSTANCE ABUSE 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 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 Health and Human Services Administrative Rule 330.7199(2)(g)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROTOCOL FOR COMMUNITY MENTAL HEALTH SERVICES PROGRAMS

STATE MANAGED SERVICES AND FINANCIAL LIABILITY FOR PERSONS ACQUITTED OF A CRIMINAL CHARGE BY REASON OF INSANITY

Purpose of Protocol

Section 6.9.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract requires Community Mental Health Services Programs (CMHSPs) to authorize medically necessary inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. It further requires CMHSPs to review treatment at intervals (at least annually) and authorize medically necessary continued stay. Section 6.9.1 also notes that the application of these provisions to forensic situations requires additional considerations and references this attachment. Regardless of where the person is served, if they have been acquitted of the criminal charges and subsequently, civilly committed under a probate court order, their inpatient care must be authorized by the responsible CMHSP. Section 302 of the Mental Health Code states that "...a county is financially liable for l0% of the net cost of any service that is provided by the department, directly or by contract, to a resident of that county." This Section does not apply to (1) an individual under a criminal sentence to a state prison; (2) a criminal defendant determined incompetent to stand trial under Section 1031 of the Mental Health Code; or (3) an individual acquitted of a criminal charge by reason of insanity, *during the initial 60-day period of evaluation* [italics added] provided for in Section 1050 of the Mental Health Code. However, CMHSPs are financially liable for 10% of the net cost of any service that is provided by the department, directly or by contract to a resident of that county who the criminal courts have acquitted or found not guilty by reason of insanity (NGRI), and committed under a civil (probate) court order to the custody of the Center for Forensic Psychiatry (hereinafter referred to as the Forensic Center) *after the initial 60-day period of evaluation* [italics added].[1] The purpose of this revised protocol is to provide clarification and additional guidance in applying the *State Managed Services* provisions described in Section 6.9.1 of the Contract for persons on NGRI status during and after the initial 60-day criminally ordered period of evaluation at the Forensic Center, and to establish a procedure for waiving financial liability in those instances when a court order or decision of the NGRI committee, the hospital or department limits the legal or contractual authority of CMHSPs.

[1] This refers to criminal acquittees or those who committed crimes but were found not guilty by reason of insanity (NGRI). Included are those who a criminal court has ordered under Section 1050 to be examined for up to 60 days at the Center for Forensic Psychiatry to determine whether they meet criteria as persons requiring mental health treatment under Section 401 or 515 of the Mental Health Code.

By being provided with advanced notice for planning during the criminal evaluation period, CMHSPs will be afforded more time to review patient evaluations, prepare for probate court testimony and complete an initial plan of service.

PROTOCOL

CMHSP Authorization for Medically Necessary Inpatient State Managed Services For Persons Acquitted of a Criminal Charge by Reason of Insanity (NGRI)

Initial Commitment or Judicial Admission Orders from a Probate Court

In instances where a defendant is acquitted of a criminal charge because they were found to be not guilty by reason of insanity (NGRI), the court will take steps to involuntarily commit the acquittee under a criminal order to the Forensic Center for a diagnostic period of 60-days. Upon receipt of the order but no later than 30 days before it expires, the Forensic Center shall:

E-mail or fax a copy of the order to the responsible CMHSP of a court ordered admission. The order will provide the CMHSP basic legal information such as person's name, date the order was issued, and identifying court information. It is expected that the CMHSP will be able to use this advanced information for planning and scheduling purposes.

Examine the acquittee's mental condition in order to form an opinion as to whether the acquittee meets the civil involuntary treatment criteria set forth in Section 401 or 515 of the Mental Health Code.

Complete their examination and submit a report with the court, and a copy to the CMHSP, setting forth its opinion as to whether the acquittee meets the criteria of a person requiring treatment or judicial admission as defined by Section 401 or 515 of the Mental Health Code. If in their opinion, the acquittee meets criteria, it shall make recommendation to the court for admission of the person to the Forensic Center or other state-operated hospital or center. A number of factors will be considered in this order, including the security risks posed by the person.

- If the criminal court agrees with the recommendation of the Forensic Center, it may direct the prosecutor to petition the probate court for a civil commitment or judicial admission.

- It is at that point in the process that CMHSP should be formally notified by the probate court of its intent to hold an initial hearing to determine whether the person requires involuntary treatment at the Forensic Center or one of the other state hospitals or center.

(Note: Whether the probate court promptly notifies the responsible CMHSP or not usually depends upon the working relationship the Court has with the CMHSP)

- At the hearing, the CMHSP will have an opportunity to either concur with the recommendation to hospitalize or admit the person to the Forensic Center, state hospital or center, or present arguments that it has a comprehensive plan of services and supports which it is prepared to implement as an alternative to involuntary admission.

- If the community-based alternative presented by the CMHSP is determined to be appropriate to meet the needs of the person, the Court may issue an alternative or combined alternative treatment order. It this occurs, the court will discharge the person and he or she will no longer have a NGRI status with the state. Otherwise, the Court will proceed to commit the person to the Forensic Center or one of the other state operated hospitals or the state D.D. Center. It is at that point that the CMHSP becomes financially liable for the provision of state operated services.

- Usually it will be the Forensic Center that will be requesting an authorization from the responsible CMHSP to provide medically necessary inpatient care in accordance with provisions described in Section 6.9.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract.[2] To better identify and track individuals who have been admitted in this matter, the department clerically and clinically identifies such patients or residents as recipients on NGRI status with the Department. Public Safety and minimum level of required custody are factors used in determining which state operated program is capable of complying with the terms and conditions of the court orders.

- If the person is admitted to the Forensic Center, the CMHSP shall be financially liable for <u>only</u> the 10% share of the net cost of services provided by the Center. If the person is later transferred from the Forensic Center and admitted to another state-operated hospital or center, the CMHSP shall be financially liable for the full net cost of state-provided services.

[2] Section 6.9.1 of the MDHHS/CMHSP Mental Health Supports and Services Contract states that the CMHSP shall authorize medically necessary inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. The MDHHS and CMHSP agree that admissions must be medically necessary; that criteria specified in the Michigan Mental Health Code must be met for adults and children with mental illness or that the criteria for judicial or administrative admissions of a person with developmental disabilities must be met; and that inpatient care in a state hospital/center must be the most appropriate level of care available. The parties further agree that continued stay will be authorized so long as the requirements for medical necessity are met and the CMHSP cannot offer an alternative at the appropriate level of care.

<u>Second and One Year Continuing Treatment Orders</u>

- At any point after issuance of the initial probate court commitment order, the CMHSP may either:

    1. Authorize hospitalization or judicial admission to the Forensic Center, or another state-operated hospital or center.

2. Deny authorization for hospitalization or judicial admission to the Forensic Center, or another state-operated hospital or center, on the basis that it has a community alternative and is fully prepared to implement a pre-release plan for community placement and aftercare services, which addresses the person's treatment and placement needs, and security risks;

3. Approve authorization of admission for hospitalization to the Forensic Center, but deny authorization of a subsequent transfer from the Forensic Center to another state operated hospital or center for hospitalization or judicial admission, on the basis that it has a community alternative and is fully prepared to implement a pre-release plan for community placement and aftercare services which addresses the person's treatment and placement needs, and security risks;

If the CMHSP does not authorize admission for hospitalization to the Forensic Center or transfer of a person on NGRI status from the Forensic Center to another state-operated hospital or center, the CMHSP shall submit a copy of its pre-release plan for community placement and aftercare services to the Forensic Center's NGRI Committee and MDHHS Division of Mental Health Community Services for review. (See attached submission requirements)

If the NGRI Committee is in agreement that the CMHSPs comprehensive service and placement plan addresses treatment needs and security risks, and the CMHSP is prepared to make a clinically appropriate community placement, the probate court will be notified and the person on NGRI status will be discharged to the CMSHP.

Upon discharge, the CMHSP shall not incur financial liability for state-provided services.

Note: The only exception to these conditions is if the person was found not guilty by reason of insanity for the crime of murder or criminal sexual conduct. Under such circumstances, the Director of the Department of Health and Human Services may exercise discretionary judgment to overrule the decisions of all parties and admit and maintain the person on NGRI status to a state-operated hospital or center in keeping with DCH Administrative Directive 10-C-1050AD dated March 19, 2003. If this decision is made, the CMHSP will be held liable for <u>only</u> the 10% share of the net cost of any service provided by the Department.[3]

3 The Department of Health and Human Services Administrative Directive 10-C-1050-AD states that, Any person found NGRI for the crime of murder, recommended by the NGRI Committee for release must be reviewed by the Director/designee of the Department of Health and Human Services for final authorization.

If the NGRI Committee makes a determination that a person on NGRI status should remain at the Forensic Center or transfer to another state-operated hospital or center, because in their opinion the CMHSP plan does not comprehensively address placement and treatment needs, and security risks, or that the CMHSP is not prepared to fully implement a pre-release plan for community placement and aftercare services, the CMHSP will be held financially liable for the state services provided. Under such circumstances, the CMHSP can appeal the hospital decision to Department's Division of Mental Health Community Services in keeping with the terms of its contract.

If the CMHSP fails to submit copies of its pre-release plan for community placement and aftercare services, or the Forensic Center's NGRI Committee and the MDHHS Division of Mental Health Community Services both determine the CMHSP's plan falls short of addressing the needs of the person on NGRI status, the person shall not be discharged, and the CMHSP will continue to be held financially liable for only the 10% share of the net cost of services provided to the person at the Forensic Center following its initial 60-day evaluation period, and the full net cost of the services provided by another state-operated hospital or center. The CMHSP may appeal this determination in keeping with the terms of its contact with the department.
Occasionally, the Forensic Center may be unable to provide the responsible CMHSP with the full 10-day notice of transfer. When this occurs, it is usually because the Forensic Center is experiencing a bed capacity emergency that necessitates expedited patient transfers. If this occurs, the CMHSP will only be held financially responsible for the 10% county share for each day that notice was delayed up to a max of 10 days.

CMHSP Continued Stay Reviews, Pre-Release and Community Placement Planning

The CMHSP may present a pre-release plan for community placement and aftercare services at any time following the admission of a person under a probate court order on NGRI status to the Forensic Center or another state-operated hospital and center. (A description of the submission requirements is attached to this protocol.) When the CMHSP determines it can serve the person in a community setting, the CMHSP will develop and submit a pre-release plan for community placement and aftercare services to the Forensic Center or another state-operated hospital or center, and the Forensic Center's NGRI Committee for review and approval. The plan must address the person's placement and service needs, and security risks. It should also include a proposed placement date and a description of the specific placement options considered for the person.

- If the treating state-operated hospital or center, and the Forensic Center's NGRI Committee approve the CMHSP's pre-release plan for community placement and aftercare services, the person will be discharged. For purposes of determining financial liability, the CMHSP shall not be financially liable for state-provided services when the person is on authorized leave status (conditional release), or upon discharge.

Note: There may be circumstances when a person on NGRI status will be determined clinically suitable for discharge, but the probate court may order that the person not be discharged but be placed under the clinical supervision of the Forensic Center or another state-operated hospital or center. In addition to implementing an approved pre-release plan for community placement and aftercare services, the CMHSP shall comply with provisions of the court order and reporting requirements of the Forensic Center's NGRI Committee, and the treating state-operated hospital and center. Similar to the standard discharge provisions, the CMHSP shall not be financially liable for state-provided services after a person on NGRI status is released on Authorized Leave status.

- If the treating state-operated hospital or center, and the Forensic Center's NGRI Committee do not approve the CMHSP's pre-release plan for community placement and aftercare services, the reason/s for that decision will be communicated to the CMHSP in writing. Under such circumstances, the CMHSP may appeal the decision in keeping with the terms of its contact with the department.

- If the CMHSP's pre-release plan for community placement and aftercare services is not approved by the treating state-operated hospital or center, and the Forensic Center's NGRI Committee within 30 days of initial submission, the CMHSP may submit a copy of its plans to the MDHHS Division of Program Development, Consultation and Contracts as evidence that it has demonstrated "a good faith effort" to implement a pre-release plan for community placement and aftercare services.

- If the MDHHS Division of Program Development, Consultation and Contracts does not believe that the CMHSP has demonstrated a "a good faith effort" to implement a pre-release plan for community placement and aftercare services address the person's placement and treatment needs, and security risks, the reason/s for that decision will be communicated to the CMHSP in writing and the CMHSP shall remain financially liable for the 10% share of the net cost of state-provided services if the person is maintained at the Forensic Center, and the full net cost of state-provided services, if those services are provided at another state-operated hospital or center.

- However, if the MDHHS Division of Program Development, Consultation and Contracts determines that the CMHSP has demonstrated an "a good faith effort" to implement a comprehensive placement and service plan, the person on NGRI status will remain in the hospital or center, but the CMHSP will be financially liable for <u>only</u> the 10% share of the net cost of state-provided services.

- The Director of the Department of Health and Human Services retains final authority over all discharge decisions involving persons on NGRI status for the crime of murder or criminal sexual conduct and is being considered for discharge.

In those instances where the Director overrules the decision of the treating hospital and center, the Forensic Center's NGRI Committee, or the MDHHS Division of Program Development, Consultation and Contracts, to approve the CMHSP pre-release plan for community placement and aftercare services, the CMHSP shall be financially liable for only the 10% share of the net cost of state-provided services.

- All CMHSP community placement and service plans that have been determined by the MDHHS Division of Program Development, Consultation and Contracts to not meet the A good faith effort standard may be appealed in accordance with the provisions described in Section 18.0 of the MDHHS/CMHSP Mental Health Managed Supports and Services Contract.

- When the Department waives the CMHSP financial liability based on the "a good faith effort" principle described above, the CMH should continue to periodically monitor and update their placement plans. This means that the CMHSP needs to engage in pre-release planning for community placement and aftercare services at least every 12 months in order to keep the waiver active. An exception to this waiver period requirement involves decisions made by the Director of Health and Human Services to maintain a person on NGRI status for the crime of murder on active inpatient status.[4]

[4] The Department of Health and Human Services Administrative Directive 10-C-1050-AD states that, A...Any person found NGRI for the crime of murder, recommended by the NGRI Committee for release must be reviewed by the Director/designee of the Department of Health and Human Services for final authorization.

Appendix #1

STATUTORY REQUIREMENTS
Michigan Mental Health Code (1996)
Chapter 10, §330.2050
Disposition of Persons Found Not Guilty by Reason of Insanity

The court shall immediately commit any person who is acquitted of a criminal charge by reason of insanity to the custody of the center for forensic psychiatry, for a period not to exceed 60 days. The court shall forward to the center a full report, in the form of a settled record, of the fact concerning the crime, which the patient was found to have committed, but which he was acquitted by reason of insanity. The center shall thoroughly examine and evaluate the present mental condition of the person in order to reach an opinion on whether the person meets the criteria of a person requiring treatment or for judicial admission set forth in section 401 or 515.

Within the 60-day period, the center shall file a report with the court, prosecuting attorney, and defense counsel. The report shall contain a summary of the crime, which the patient committed but of which he was acquitted by reason of insanity and an opinion as to whether the person meets the criteria of a person requiring treatment or for judicial admission as defined by Section 401 or 515, and the facts upon which the opinion is based. If the opinion stated is that the person is a person requiring treatment, the report shall be accompanied by certificates from two physicians, at least one of whom shall be a psychiatrist, which conform to the requirements of section 400(j).

After receipt of the report, the court may direct the prosecuting attorney to file a petition pursuant to Section 434 or 516 for an order of hospitalization or an order of admission to a facility with the probate court of the person's county of residence or of the county in which the criminal trial was held. Any certificates that accompanied the report of the center may be filed with the petition, and shall be sufficient to cause a hearing to be held pursuant to section 451 even if they were not executed within 72 hours of the filing of the petition. The report from the court containing the facts concerning the crime for which he was acquitted by reason of insanity shall be admissible in the hearings.

If the report states the opinion that the person meets the criteria of a person requiring treatment or for judicial admission, and if a petition is to be filed pursuant to subsection (3), the center may retain the person pending a hearing on the petition. If a petition is not to be filed, the prosecutor shall notify the center in writing. The center, upon receipt of the notification, shall cause the person to be discharged.

The release provisions of sections 476 to 479 of this act shall apply to a person found to have committed a crime by a court or jury, but who is acquitted by reason of insanity, except that a person shall not be discharged or placed on leave without first being evaluated and recommended for discharge or leave by the department's program for forensic psychiatry, and authorized leave or absence from the hospital may be extended for a period of 5 years.

Appendix #2

DIRECTOR'S OFFICE
MAR 27 2003
FORENSIC CENTER

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

~~JOHN ENGLER~~
~~Governor~~
Jennifer M. Granholm
Governor

~~JAMES K. HAVEMAN, JR.~~
~~Director~~
Janet Olszewski
Director

Administrative Directive
10-C-1050/AD

IMMEDIATE EFFECT

Replaces Patients Committed Under The Legal Status of Not Guilty By Reason of Insanity, 10-C-1050/AD; rescinded March 24, 2003

March 19, 2003

TO: **Hospital and Center Directors**

FROM: **Janet Olszewski**

SUBJECT:
PATIENTS COMMITTED UNDER THE LEGAL STATUS OF NOT GUILTY BY REASON OF INSANITY

It is the policy of the Department of Community Health that all patients/residents under the legal status of "not guilty by reason of insanity" who have improved to the point, that release from hospitalization or transfer between facilities is being considered, shall have their treatment plan and recommendations reviewed by the "NGRI" Committee at the Center for Forensic Psychiatry.

All recommendations to the court for release from hospitalization, transfer between facilities, or alternative treatment shall be reviewed by the NGRI Committee prior to filing and/or appearance. The written recommendations of the NGRI Committee shall be entered into the patient record and disclosed during testimony, if requested. Referrals to the NGRI Committee for review shall be made by the hospital/center director/designee. Any delay in referring or filing necessary papers in a timely manner that would result in not renewing the order, will be considered a violation of this policy.

Any person found NGRI for the crime of murder or for a crime that involves sexual conduct, recommended by the NGRI Committee for release, must be reviewed by the Director/designee of the Department of Community Health for final authorization.

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DCH-0357 (03/02)

Appendix #3

CMHSP REQUIREMENTS FOR A "GOOD FAITH EFFORT" SUBMISSION

The submission shall include:

- The individual's name and basic identifying information.
- A description of both the individual's strengths and his or her placement, and service needs in major life domains (health, legal and safety, finances, housing, daily activities, work/school, social relationships, family relationships, etc.)
- A description of the security risks posed by the individual if placed in the community.
- A summary of the CMHSP response and reasons for disagreement with the decision of the Center for Forensic Center NGRI committee regarding placement.
- A copy of the CMHSP's pre-release plan for the individual that includes a detailed description of:
- The specific placement option that has been arranged for the individual and the scheduled date for placement,
- The specific services and supports that CMHSP has arranged to address the individual's treatment needs, and
- The measures that the CMHSP has taken to address the particular security risks the individual can be expected to pose to himself and the community upon release.

DEPARTMENT OF COMMUNITY HEALTH
STATE FACILITY ATTACHMENT
October 1, 2013

Purpose of Attachment
Section 6.9.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract requires Community Mental Health Services Programs (CMHSPs) to authorize medically necessary inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. It further requires CMHSPs to participate in treatment planning, treatment monitoring and other related activities at agreed upon intervals and authorize medically necessary continued stay. This attachment outlines the responsibilities of the Department of Health and Human Services and the Community Mental Health Services Program with respect to State Facility use.

I. Responsibility of the State Facility

A. The Department's State Facilities shall provide appropriate services to Consumers served by the State Facility in all its inpatient service settings.

B. The Department's State Facilities shall inform the individual designated by the CMHSP Executive Director of any significant change in the mental or physical condition or mental health service requirements of a Consumer at the State Facility, including any unusual incidents, i.e. elopement, serious self-harm, injury and death, according to the procedures specified in this attachment.

C. The Department's State Facilities shall provide access to all essential information, including clinical and service records and billing records and billing source data, to authorized representatives of the CMHSP for the purpose of participating in treatment planning, monitoring and reviewing the provision of services by the State Facility to Consumers, under the terms of this attachment.

II. Responsibilities of the CMHSP

A. The CMHSP shall serve as the single point of entry to and exit from the State Facility for all of consumers of the CMHSP.

B. The CMHSP shall advise all Consumers applying for admission to the State Facility that joint treatment planning will occur between the State Facility and the CMHSP staff.

C. The CMHSP shall evaluate and screen all requests for admittance of its consumers to the State Facility. The CMHSP shall provide the State Facility with:
1. evaluations and recommendations for admission to the State Facility;
2. A report of all known medical issues related to the consumer;
3. The consumer's most recent individual plan of service as applicable; and

4. A list of the consumer's medications, as well as information on any medication tapering plans or history of failed trials of monotherapy.

D. The CMHSP shall participate in the development of the Individual Plan of Service (IPOS) for consumers by the State Facility under this attachment, utilizing the Person-Centered Planning (PCP) process.

D. The CMHSP shall lead in planning for and arranging appropriate community placement services and facilitating the discharge planning of its consumers from the State Facility.

E The CMHSP shall be responsible for making determinations on its authorizations, in advance, for consumers as to all admissions of and continued stay at the State Facility, according to the procedures specified in this attachment. The CMHSP shall be responsible for the preparation of an alternative treatment plan and report(s) pertaining to consumers.

F. The CMHSP may enter into subcontracts and have a contract provider carry out the CMHSP duties designated in this Agreement. However, the duties remain the responsibility of the CMHSP, and the CMHSP is responsible for providing and keeping the State Facility updated with a list of authorized subcontractors.

III. Liaisons

The CMHSP Executive Director and the Department's State Facilities Directors shall designate specific members of their staff who shall serve as liaisons between the parties. The primary objective of these staff shall be to facilitate the ongoing working relationship between the parties hereto and their staff, and the implementation and monitoring of the terms and conditions of this attachment. The CMHSP Executive Director and the State Facility Directors shall provide each other with an updated list of staff members having liaison responsibilities, a written description of their liaison responsibilities, duties and functions, the programs for which they work, and the phone numbers and office hours for the staff and programs.

IV. Services and Coordination

Under this attachment is the intent of the CMHSP and the State Facility to promote cooperation, collaboration and coordination among their respective representatives for the benefit of the mutual mental health provisions for consumers and residents.

A. PRE-ADMISSION SCREENING

The CMHSP shall evaluate and screen consumers who present themselves or are presented in the community or at the State Facility for potential admission to the State Facility. Any determination to hospitalize a CMHSP consumer at the State Facility shall be based on evaluation and screening conducted in accordance with Chapter 4 ("Civil Admission and Discharge Procedures: Mental Illness"), Chapter 4A ("Civil Admission

and Discharge Procedures for Emotionally Disturbed Minors"), or Chapter 5 ("Civil Admission and Discharge Procedures: Developmentally Disabilities") of the Michigan Mental Health Code.

B. SERVICE UTILIZATION

1. The CMHSP authorization of admission and continued stay at the State Facility constitutes the basis on which the CMHSP shall reimburse the MDHHS for the fixed net state cost of inpatient services provided at the State Facility. The CMHSP authorizations shall be conveyed in written form to the State Facility, and shall accompany the consumer upon admission to the State Facility.

   Any CMHSP authorization of continued stay of a CMHSP consumer at the State Facility shall be based upon the continued need of the individual for inpatient services at the State Facility and established after reviewing the clinical status of the individual and consultation with the State Facility staff. The CMHSP and the State Facility agree that continued stay will be authorized so long as the requirements for medical necessity are met and the CMHSP cannot implement an alternative that provides the Consumer with the appropriate level of care.

   If a Consumer is involuntarily court-ordered for admission to the State Facility, the CMHSP shall be considered as having authorized the admission for purposes of billing. If the admission is not accompanied by a CMHSP authorization, the Facility will notify the CMHSP of the admission, within three (3) business days of the admission, with a request for an authorization of continued treatment or plan for discharge. The facility may bill the CMHSP for the period from admission through the first business day of service without specific authorization and for the services provided from the date of notification until discharge as specified in the CMHSP plan.

2. The MDHHS shall bill the CMHSP only for daily units of services actually rendered by the State Facility for the CMHSP consumers. The CMHSP and the State Facility agree that the actual total number of days of service provided by the State Facility, pursuant to the MDHHS/CMHSP Contract and this attachment, are subject to verification from billings and statistical data from the MDHHS and from State Facility service documentation accessible for review by the CMHSP staff.

   The State Facility shall provide information to the MDHHS Accounting Division that specifies the type, amount, and the days of each contractual service provided, to enable the MDHHS to bill the CMHSP for billable services provided by the State Facility to consumers and to enable the CMHSP to continuously monitor State Facility utilization and to continuously track services and all incurred costs of the services. All such information shall be provided to the CMHSP by the State Facility within ten (10) business

days following the completion of each service month that this attachment remains in effect.

C. COORDINATION OF TREATMENT PLANNING AND SERVICES

The CMHSP and the State Facility shall exchange clinical information and cooperate mutually in treatment planning and services, including as follows:

1. The CMHSP shall provide the State Facility with relevant mental, physical, education, social histories, and testing data, etc. for consumers who have had treatment in CMHSP programs and services. As soon as possible, but not later than five (5) business days after the admission of a CMHSP consumer to the State Facility, the State Facility shall be provided with the CMHSP's determination of the presenting problem and/or behavior that led to hospitalization, projected length of stay, objectives to be accomplished during hospitalization, possible community placements, and community treatment alternatives upon discharge from the State Facility.

2. The CMHSP shall be provided access to the State Facility treatment staff for consultation about the status of CMHSP consumers who are patients or residents of the State Facility, and shall be provided access to the CMHSP consumers at the State Facility, upon reasonable notice.

3. The CMHSP is responsible for all guardianship matters concerning its consumers, including hearings. The State Facility will support the CMHSP as necessary with regard to documents and issues.

4. If an individual is admitted to the State Facility on an Incompetent to Stand Trial (IST) order, the State Facility shall actively pursue a release of information at the time of admission to ensure early involvement of the CMHSP.

5. The State Facility shall involve the CMHSP in ongoing joint treatment team meetings for consumers who are CMHSP consumers. The State Facility will also provide reasonable notice of treatment team meetings for all CMHSP consumers, including new consumers.

6. The CMHSP, in concert with the State Facility, shall assess the discharge potential of each CMHSP consumer currently hospitalized at the State Facility at each treatment team meeting. For consumers on Not Guilty by Reason of Insanity (NGRI) status, the State Facility agrees to abide by the terms and conditions of the NGRI Agreement, which is Attachment C.6.9.1.1 of the MDHHS/CMHSP contract.

7. If a CMHSP consumer's planned discharge is delayed, the State Facility staff designated to coordinate the discharge shall inform the CMHSP as

to the cause and anticipated duration of the delay, so that placement can still be facilitated by the CMHSP.

D. DISCHARGE PLANNING AND COMMUNITY PLACEMENT

The State Facility hereby assures the CMHSP that all requests for consumer discharge will be processed and coordinated through its responsible treatment teams and, if applicable, the designated placement review committee, with the involvement of CMHSP staff, as applicable, for all CMHSP consumers who no longer meet the criteria for admission as established in Chapter 4, Chapter 4A, or Chapter 5, respectively, of the Michigan Mental Health Code. It shall be the responsibility of the CMHSP to plan and implement community placement for each of its consumers discharged from the State Facility.

1. The process involving all requests for discharge and placement of CMHSP consumers shall include the following:

    - To facilitate an orderly transition from the State Facility to community settings, the appropriate representatives of the CMHSP and the State Facility shall participate in the consumer's discharge planning process.
    - The CMHSP shall coordinate discharge planning with the State Facility.
    - The CMHSP shall submit a discharge plan that will address specific services appropriate to the needs of the Consumer upon discharge from the State Facility.
    - The State Facility will include all discharge planning information contained in the Person-Centered Planning (PCP) process documents.
    - It is expected that if the State Facility agrees with the CMHSP discharge plans, it will support the CMHSP in coordinating the discharge.

2. In those instances when the CMHSP has determined a consumer is ready for discharge from the State Facility, but the State Facility disagrees, the consumer shall be discharged AMA (against medical advice).

3. In the case of a disagreement on the suitability for discharge from the State Facility of a CMHSP consumer who is judicially admitted, the CMHSP may seek relief through a re-determination by the Probate Court.

4. The State Facility shall consult with the CMHSP prior to any decision to place a CMHSP consumer on convalescent status with the State Facility.

5. The State Facility shall provide the CMHSP with discharge information for a CMHSP consumer and with discharge summaries, including medical information, immediately upon discharge.

6. When medically appropriate, the State Facility will provide a one-week (7 days) supply of medication and, in addition, a prescription for a two-week (14 days) supply of medication. The CMHSP may request a prescription for an additional two (2) weeks. If medication will not be provided, the CMHSP will be informed prior to discharge. The CMHSP psychiatrist is responsible to write prescriptions within the first two (2) weeks following discharge. The CMHSP may request the assistance of a prescription from the State Facility.

7. When a CMHSP consumer, under the age of twenty-six (26), is being discharged from the State Facility, the State Facility shall notify the respective Intermediate School District (ISD) of the consumer's discharge from the State Facility. Upon discharge of the consumer from the State Facility, the CMHSP shall assume responsibility for the coordination of services between the local ISD and the CMHSP.

E. TRANSFER OF CMHSP CONSUMERS FROM A STATE FACILITY TO ANOTHER STATE FACILITY

1. In the case of a court-ordered transfer of a CMHSP consumer from the State Facility to another State Facility for inpatient care, the State Facility will provide the CMHSP with an informational notice of any court-ordered transfers. This notice will be provided within five (5) business days following issuance of the court's transfer order.

2. If a CMHSP consumer makes an election of placement permitted by the Mental Health Code or Administrative Rules, the State Facility will provide notice to the CMHSP of the request for a transfer.

3. A CMHSP consumer may be discharged from the State Facility for subsequent transfer to an inpatient or residential care unit of a non-state hospital/center upon written request and approval of the CMHSP.

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 Community Health (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

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.

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.

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.

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.

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 Policy

Statement of Purpose

The purpose of this policy is to underscore the BHDDA/MDHHS's expectation of CMHSPs to support schools with students with disabilities to transition to full community inclusion. Such services are required by the Michigan Mental Health Code Section 330.1227, School-to-Community Transition Services.

> *"Each community mental health services program shall participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional 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."*

In other words, this does not usurp the primary responsibility of DOE for school to community transition.

Furthermore; Section 330.1100d(11) of the Michigan 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 postsecondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living, or community participation."*

Although this policy 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.*
> *(2) 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/Homeless youth
- Children with emotional disturbance at risk of expulsion from school
- Youth who "age out" of:
    1. The DSM diagnosis for which they are receiving mental health services; who do not qualify for adult service or criteria for SMI/ID/DD;
    2. Children's Waiver;
    3. Children's Special Health Care Services plan;
    4. Foster care placement, making them at risk for being homeless.
- Children/Youth involved in multiple systems – Child Welfare/Juvenile Justice/Substance Use Disorder, etc.

Summary:
The effectiveness of primary and secondary school programming for students with disabilities; inclusive of behavioral health challenges or needs, directly affects services and financial planning of CMHSPs. Schools that best prepare students with disabilities to live, learn, and work in the community and to access generic community services such as transportation and recreation create fewer demands on the adult services system including CMHSPs and foster better community participation and integration for individuals with disabilities. CMHSPs have a responsibility to grow community partnerships and provide information about eligibility requirements, types of services, and person-centered planning in the public mental health system to school systems initially and update as needed and to student, parents or legal guardians when requested..
Recognizing limited resources and funding for such transition efforts, it is imperative that CMHSPs begin this process as the school identifies those students reaching 16 years of age. The intent of this policy is to:

1. Ensure students and their families are fully informed about CMHSP services and supports in partnership with the school.
2. Maximize young adult outcomes, including participation in employment, access to natural supports, and access to needed adult support services.
3. With the school, identify the number of likely students to be eligible for CMHSP services after the student reaches 18 years of age to allow CMHSPs to anticipate future service needs and ideally lower long-term support costs by assisting the student to smoothly transition into community with as many natural supports as possible.
4. Ensure collaboration between CMHSPs, schools, and other local partners.

CMHSPs should actively participate with schools and other community services providers to effectively braid resources that best assure the student transitions to the community as independently as possible.

> *NOTE: It is allowable to braid resources from community partners to support individuals seeking to obtain, return to competitive employment, or increase their employment objectives. This service can be used concurrently to supplement/complement services to help individuals achieve their desired employment outcomes **as long as there is no duplication of resources for the same service element(s) at the same time.** Documentation is maintained that same service is not presently available under a program funded under WIOA, Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

It remains imperative that CMHSPs jointly promote:

- Implementing the values of Individuals with Disabilities Education Act (IDEA) with particular focus on community inclusion in the least restrictive environment, keenly focused on vocational exploration, work experiences, and ideally paid work.
- Becoming more knowledgeable of school practices better preparing youth for adult life.

CMHSPs need to ensure that schools, students, families, caregivers, and community partners have basic knowledge of what CMHSPs can provide to youth/adults with disabilities, and eligibility criteria for these services through a family-centered/youth guided process and plan. This information should be distributed to applicable schools and also available on-line.

CMHSPs shall make available the following information through the CMHSP customer services efforts:

1. Values governing public mental health services including:
    a. Recovery
    b. Self-determination

   c. Full community inclusion
   d. Person-centered planning
2. Eligibility criteria:
   a. Michigan Mental Health Code priority populations
   b. Specialty behavioral health (including the boundary with the Qualified Health Plans)

   c. Local service selection guidelines/protocols/etc.
3. Local service array for child, youth, and adult service providers, including contact information at the CMHSP to the school for systemic service related issues.

Additionally, CMHSPs have the responsibility to provide information to appropriate local school administrators about specific conditions which would indicate the likelihood that a student would need assessment and/or service from the CMHSP upon turning 18 years of age including:

- Students classified under the school system as Severe Multiple Impairments (SXI), Severe Cognitive Impairment (SCI), Moderate Cognitive Impairment (MoCI), and/or Mild Cognitive Impairment (MiCI) 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 Autism Spectrum Disorder (ASD) covers students with a very broad range of skills and abilities often necessitating further assessment to determine eligibility for CMHSP services.
- Students classified as Emotional Impairment (EI) would have to be assessed for eligibility for adult services from the CMHSP. In the public mental health system, Serious Emotional Disturbance (SED), by definition, ends at the age of 18. Students classified as SED as well as Specific Learning Disabled (SLD) and Physical Impairment (PI) or Otherwise Health Impaired (OHI) would need to be assessed with consent for an appropriate developmental disability or mental illness diagnosis.
- When the legal guardian is considering CMHSP services, the CMHSP will provide a screening and possibly an assessment. CMHSPs will look at factors that include: risk for expulsion from school, need for assistance in multiple life domains, or absence of a stable natural support network.

Essential elements with required tracking, and activities, and measurement criteria are outlined in the following table:

Essential elements:	Tracking:	Activities:	Measurement Criteria:
Coordinated planning and development with student's local school district or Intermediate School District (ISD) at least by 16th year to shape least restrictive community opportunities for independence, employment and post school education.	-Documentation of a local agreement noting responsibilities of each party - A work plan that details specific action plans for outreach to and communication with schools, young adults and families	-Track number of youth likely to be CMHSP eligible at age 18 and beyond - Establish or participate in a local transition planning or coordination council - Development of local transition guides that address supports and resources	- Annual documentation of number of youth likely to be eligible for services -Documentation of local participation
Outreach and communication to young adults and families	- Participation in Individualized Education	-At least annual group presentations about potential eligibility to	-Documentation of at least annual presentation

	Program (IEP) meetings that address transition	youth, parents/guardians, and school staff - Participation in local transition fairs -Upon determination of likely eligibility, participate in at least 1 annual student IEP meeting for each likely eligible student	-Documentation of participation in IEPs for likely eligible youth at the youth's invitation
Increased focus on integrated residential/community-based living	Track: -Number of pre age 18 students with integrated living as a goal in transition plan -Integrated -Non-integrated -Number of post age 18 students with integrated residential living as a goal in transition plan	-Track growth in integrated living	- Number of post-age 18 students seeking integrated residential living
Increase focus on integrated employment	Track: -Number of pre age 18 students with work as a goal in transition plan -Integrated -Non-integrated -Number of post age 18 students with competitive, integrated work as a goal in transition plan	-Track growth in competitive, integrated work goals	Number of post-age 18 students seeking competitive integrated employment

Data tracked during the fiscal year is to be submitted on an annual basis by December 1st following the end of the fiscal year and will be outlined in a corresponding attachment. The attachment will be developed by a workgroup of MDHHS and CMHSP representatives, with the goal to complete the attachment during FY 17.

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: Thomas J. Renwick, Director, Bureau of Community Based Services

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 Attachment C.6.9.6.1) 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 C 3.4.1.1 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.

Michigan Department of Health & Human Services
Behavioral Health and Developmental Disabilities Administration

TRAUMA POLICY

The purpose of the policy is to address the trauma in the lives of the people served by the public behavioral health system. The policy is promulgated to promote the understanding of trauma and its impact, ensure the development of a trauma informed system and the availability of trauma specific services for all populations served. Trauma is defined as:

> *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.*[1]

Policy

It is the policy of Michigan Department of Health and Human Services – Behavioral Health and Developmental Disabilities Administration (MDHHS - BHDDA) that Community Mental Health Service Programs (CMHSPs), through their direct service operations and their network providers, shall develop a trauma-informed system for all ages and across the services spectrum and shall ensure that the following essential elements are provided:

I. Adoption of trauma informed culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization.
II. Engagement in organizational self-assessment of trauma informed care
III. Adoption of approaches that prevent and address secondary trauma of staff (See Exhibit A)
IV. Screening for trauma exposure and related symptoms for each population
V. Trauma-specific assessment for each population
VI. Trauma-specific services for each population using evidence based practice(s) (EBPs); or evidence informed practice(s) are provided in addition to EBPs
VII. CMHSPs through their direct service operations and their network providers shall join with other community organizations to support the development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders[2] [3]

Standards

To ensure a trauma informed behavioral health system, the following standards are required to meet the stated policy.

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[1] Substance Abuse Mental Health Services Administration (SAMHSA), http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx
[2] Substance Abuse and Mental Health Services Administration, Leading Change: SAMHSA's Role and Actions 2011-2012.
[3] SAMHSA's Initiatives, Preventing Substance Abuse and Mental Illness, 2010.

	Policy	Standards - Requirements
I.	**Adoption of trauma informed Culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization.**	(a.) The CMHSP shall, through its direct service operations and its network providers, develop and support a Quality Improvement committee with representatives from children, adult, SUD, I/DD services and consumers. The committee's primary focus is to ensure the building and maintaining of trauma informed care within the CMHSP's direct service operations and its network providers. (b.) The CMHSP, through its direct services operations and its network providers, shall ensure that all staff, including direct care staff, are trained/has ongoing training in trauma informed care (online module, *Creating Cultures of Trauma Informed Care* with Roger Fallot, Ph.D. of Community Connections, Washington, DC is available at http://improvingmipractice.org). Training needs to be updated on a regular basis due to changes in the research and/or evidence based approaches. Staff trained in trauma informed care should (1.) understand what trauma is and the principles of trauma informed care; (2.) know the impact of trauma on a child's and/or adult's life; (3.) know strategies to mitigate the impact of the trauma(s); and (4) understand re-traumatization and its impact. (c.) Policies and procedures shall ensure a trauma informed system of care is supported and that the policies address trauma issues, re-traumatization and secondary trauma of staff.
II.	**Engagement in organizational self-assessment of trauma informed care**	(a.) The CMHSP Quality Improvement committee conducts an organizational self-assessment to evaluate the extent to which current agency's policies are trauma-informed, identify organizational strengths and barriers, including an environmental scan to ensure that the environment/building(s) do(es) not re-traumatize (online module available to assist the committee in their orientation to self-assessment. The module, *Creating Cultures of Trauma-Informed Care: Assessing your Agency* with Roger Fallot, Ph.D. & Lori L. Beyer, LICSW, Community Connections, Washington, DC is available at http://improvingmipractice.org). The self-assessment is updated every three (3) years.

	Policy	Standards - Requirements
III.	**Adoption of approaches that prevent and address Secondary Trauma of staff**	(a.) The CMHSP, through direct services operations and its network providers, adopt approaches that prevent and address secondary traumatic stress of all staff, including, but not limited to: • Opportunity for supervision • Trauma-specific incident debriefing • Training • Self-care • Other organizational support (e.g., employee assistance program).
IV.	**Screening for trauma exposure and related symptoms for each population**	(a.) CMHSP, through direct service operations and provider network, shall use a culturally competent, standardized and validated screening tool appropriate for each population during the intake process and other points as clinically appropriate. Examples of standardized, validated screening tools are provided in the trauma section of the website, www.improvingMIpractices.org.
V.	**Trauma –specific assessment for each population**	(a.) CMHSP shall, through direct service operations and provider network, use a culturally competent, standardized and validated assessment instrument appropriate for each population. Trauma assessment is administered based on the outcome of the trauma screening. Examples of assessment tools are provided in the trauma section of the website, www.improvingMIpractices.org.
VI.	**Trauma-specific services for each population using EBP(s) or evidence informed practices are provided in addition to EBPs**	(a.) The CMHSP, through its direct service operations and network providers, shall use evidence based trauma-specific services for each population in sufficient capacity to meet the need. The services are delivered within a trauma informed environment. Examples of trauma-specific services are provided in the trauma section of the website, www.improvingMIpractices.org.
VII.	**CMHSP through its direct service operations and its network providers, shall join with other community**	(a.) CMHSP and its network providers shall join with community organizations, agencies, community collaboratives (i.e., MPCBs) and community coalitions (i.e., Substance Abuse Coalitions, Child Abuse and Neglect Councils, Great Start Collaboratives, neighborhood coalitions, etc.) to support the development of a trauma

	Policy	Standards - Requirements
	organizations to support the development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders.	informed community that promotes healthy environments for children, adults and their families. (b.) Education on recovery and the reduction of stigma are approaches supported in a trauma informed community. (c.) Substance abuse prevention programming is provided using a SAMHSA approved, evidence based and trauma informed approach.

Exhibit A. Source is the National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary Traumatic Stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms captures elements of this definition but are not all interchangeable with it.

Compassion fatigue, a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with the term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material.

Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

MDHHS CONTRACT FINANCING

1. **Insert GF allocation.**

2. **Special Population Funding (as applicable)**

3. **Insert 428 Schedule**

MDHHS Performance Objectives

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Community Mental Health

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Health and Human Services

Fiscal Year End September 30, 2017

V2017-1

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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, 2016 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, 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, 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 indicated.

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; the expected PIHP or CMHSP action to repay disallowed costs, make financial adjustments, or take other action; and a description of the appeal process available to the PIHP or CMHSP. 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 in2 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 (located at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).

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 with2 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 $187500 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 Sub-recipient 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 $187,500 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 2015/2016 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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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 PIHP Master Contract and Section 7.6 of the CMHSP 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 CMHSP and holds an exit conference with CMHSP 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 CMHSP	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 CMHSP 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 CMHSP	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 CMHSP, 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 CMHSP	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 CMHSP's 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 CMHSP and other relevant parties. The letter bound with the final audit report describes the audited CMHSP'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 CMHSP 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 CMHSP resolves all findings in a satisfactory manner. Works with the audited CMHSP 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.