

Executive Summary
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Mental Health & Substance Abuse Administration
Changes to the FY 11 contract between MDCH and the PIHPs

Additions and changes to the contract between the Michigan Prepaid Inpatient Health Plans for Medicaid Specialty Services and MDCH

- I. Contract effective date: October 1, 2010 through September 30, 2011
- II. Approval of the following new sections to the contract boilerplate is requested:

No new contract sections for FY11.
- III. Approval of changes to the following contract sections is requested. Additions are included in “**bold**” and deletion in “~~strikeout~~.”

Revise Part I, Section I, Purpose as follows:

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

Under approval granted by the Centers for Medicare and Medicaid Services (CMS), MDCH operates a Section 1915(b) Medicaid Managed Specialty Services and Support Program Waiver. Under this waiver, selected Medicaid state plan specialty services related to mental health and developmental disability services, as well as certain covered substance abuse services, have been “carved out” (removed) from Medicaid primary physical health care plans and arrangements. The 1915(b) Specialty Services Waiver Program operates in conjunction with Michigan's existing 1915(c) Habilitation Supports Waiver for persons with developmental disabilities. Such arrangements have been designated as “Concurrent 1915(b)/(c)” Programs by CMS. In Michigan, the Concurrent 1915(b)/(c) Programs are managed on a shared risk basis by specialty Prepaid Inpatient Health Plans (PIHPs), selected through the Application for Participation (AFP) process.

The purpose of this contract is to obtain the services of the selected PIHP to manage the Concurrent 1915(b)/(c) Programs in a designated services area and to provide a comprehensive array of specialty mental health and substance abuse services and supports as indicated in this contract.

This contract is a cost reimbursement contract under OMB Circular A-87. It is therefore subject to compliance with the principles and standards of OMB Circular A-87 for determining costs for Federal awards carried out through cost reimbursement contracts, and other agreements with State and local governments and federally recognized Indian tribal governments (governmental units).

Revise Section 6.1.1 Event Notification as follows:

In addition to other reporting requirements outlined in this contract, the PIHP shall immediately notify MDCH of the following events:

1. Any consumer death that occurs within ~~six~~ twelve months of the individual's discharge from a state facility; and/or a death that occurs as a result of suspected staff member action or inaction. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, to QMPMeasures@michigan.gov and include the following information:

- a. **Name of beneficiary**
- b. **Beneficiary ID number (Medicaid, ABW, MiChild)**
- c. **Consumer I (CONID) if there is no beneficiary ID number**
- d. **Date, time and place of death (if a licensed foster care facility, include the license #)**
- e. **Preliminary cause of death**
- f. **Contact person's name and E-mail address**

2. Relocation of a consumer's placement due to licensing issues.

3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours

4. The conviction of a PIHP/CMHSP or provider panel staff members for any offense related to the performance of their job duties or responsibilities.

Except as otherwise instructed above, Notification of these events shall be made telephonically or other forms of communication within **five (5) business days** to contract management staff members in MDCH's Mental Health and Substance Abuse Administration.

Revise Section 6.3.3 Information Requirements as follows:

B. Additional Information Requirements

1. The PIHP must notify beneficiaries that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. The PIHP must also notify beneficiaries how to access alternative formats.

2. The PIHP must provide the following information to all beneficiaries:

- a. ~~Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the~~

~~beneficiary's service area.~~ **A listing of contracted providers that identifies provider name, locations, telephone numbers, any non-English languages spoken, and whether they are accepting new patients.** This includes, at a minimum, information about primary service providers (e.g. case manager, psychiatrist, primary therapist, etc.) and any restrictions on the beneficiary's freedom of choice among network providers. **A written copy of this listing must be provided to each beneficiary annually, unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer service line is acceptable.**

- b. Their rights and protections, as specified in "Appeal and Grievance Resolution Processes Technical Requirement."
 - c. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled
 - d. Procedures for obtaining benefits, including authorization requirements.
 - e. The extent to which, and how, beneficiaries may obtain benefits and the extent to which, and how, after-hours crisis services are provided.
 - f: Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost to the PIHP of each covered support and service he/she is receiving.**
 - g. MDCH will assemble a workgroup to develop a program integrity process which verifies claimed services were provided. This will include Explanation of Benefits reports for beneficiaries that will satisfy CMS audit requirements. Anticipated target date of April, 2011.**
5. The PIHP will ~~inform beneficiaries of additional information that is available upon request, including the following:~~ **provide information to beneficiaries about managed care and care coordination responsibilities of the PIHP, including:**
- a. Information on the structure and operation of the MCO or PIHP;
 - b. Physician incentive plans in use by the PIHP or network providers as set forth in 42 CFR 438.6(h).

Revise Section 6.4 Provider Network Services as follows:

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

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

And sub-section 6.4.J as follows:

- J. ~~Annually evaluate providers who perform delegated functions.~~
Annually monitor affiliates, as applicable, and provider networks who perform delegated functions to assure quality and performance in accordance with the standards in the Quality Assessment and Performance Improvement Technical Requirement (Attachment 6.7.1.1.)

Revise Section 6.4.5 as follows:

Many Medicaid beneficiaries receiving services from the PIHP will be enrolled in a MHP for their health care services. The MHP is responsible for non-specialty level mental health services. It is therefore essential that the PIHP have a written, functioning coordination agreement with each MHP serving any part of the PIHP's service area. **At a minimum these arrangements must address integration of physical and mental health plans. Agreement by MDCH and CFI to develop language and have something in place by October, 2011.** A model coordination agreement is herein included as Attachment P 6.4.5.1 A and B.

Remove Section 6.6.2 Financial Reporting as follows:

~~6.6.2 Financial Reporting~~

~~The PIHP shall provide financial reports to MDCH as specified in Section 7.8 and at times and in formats specified. Forms and instructions are posted to the DCH website at: http://www.michigan.gov/mdch/0,1607,7_132_2941_38765_00.html (See attachment P7.8.1, Finance Planning, Reporting and Settlement)~~

Revise Section 6.7.4 Evidence-based, Promising and Best Practices as follows:

As part of the Quality Assessment and Performance Improvement Program, the PIHP is required to develop and implement a process for adopting and using nationally accepted or mutually-agreed upon clinical standards for the practices employed with the people it serves. In 2004 MDCH began an initiative to encourage and support the PIHPs' use of evidence-based, promising and best practices in Michigan. Financial support was provided through the Mental Health Block Grant to PIHPs to implement the federal Substance Abuse and Mental Health Services Administration (SAMHSA) recognized models of either Family Psycho-Education or Integrated Treatment for Co-occurring Disorders. The PIHP will implement and make available the SAMHSA

models of Family Psycho-Education model and Integrated Treatment for Co-occurring Disorders one of several evidence based practices (EBPs) and ACT promising practices for adults with serious mental illness. The PIHP must have a co-occurring capable system of care for people who have mental health and substance use disorders. (See attachments P6.7.4.1 Integrated Dual Disorders Treatment (IDDT) Services **and P6.7.4.2 Family Psychoeducation (FPE) Services**)

Add paragraph to Section 7.0 Contract Financing as follows:

The rates included in attachment P7.0.1 are in effect with the initial contract. Rates may be revised without formal amendment of the contract when these revisions are actuarially certified, approved by CMS are necessary to comply with the requirements of an Executive Order or MDCH appropriations and are incorporated by reference in this contract when transmitted in writing to the PIHP.

Revise Section 7.8 Finance Planning, Reporting and Settlement as follows:

The PIHP shall provide financial reports to the MDCH as specified in this contract, and on forms and formats specified by the MDCH. Forms and instructions are posted to the DCH website at: <http://www.michigan.gov/mdch/0,1607,7-132-294138765---,00.html> (See attachment P7.8.1, Finance Planning, Reporting and Settlement)

For FY 11, two Financial Status Reports (FSR) reporting requirements will be changed:

1) A Mid-Year Status Report will be due May 31 and the FSR submission requirement is eliminated. A workgroup will provide consultation on the Mid-Year Status report format and instructions.

2) The third quarter financial status reports (FSRs) noted in attachment 7.8.1 covering October 1st through June 30th (actual accrued revenues and expenses) and the full year projection FSR are due August 15th. These reports are intended to represent actual expenditures through June 30, 2011. The CMHSP or PIHP has the option of using May 31st YTD accrued expenditures for both the nine month report and full year projection if it is not feasible to use expenditures through June.

~~Financial reporting will require that the PIHP utilize accounting principles specified in Section 6.6.1 in reporting revenues and expenditures (except that P.A. 423 funds must be reported on a cash basis of accounting). The full year spending plan is to be updated by the PIHP on a quarterly basis to reflect full year impacts of year-to-date experiences. PIHPs that maintain an ISF Risk Reserve Account, and any form of reserve account are required to report on the status of these accounts on a~~

~~quarterly basis, as well as year end reports. The MDCH will use information from the financial reports in making determinations and judgments regarding the PIHP's performance, including implications for the risk corridors.~~

~~While reporting of funds authorized for Direct Care Wage Increase is no longer required, the parties agree to continue to utilize those funds for that purpose.~~

~~Required reports and time frames are listed below. Reports are due at the MDCH 30 days following the end of the reporting period, except the interim and final reports. The final report is due 90 days from the end of the state fiscal year. The interim final report is due November 10, unless the State of Michigan requires an earlier close-out schedule in which case notice will be provided to the PIHP as soon as possible.~~

Technical Corrections to the following sections:

Section 7.4.1 Medicaid

Section 7.4.1.1 Medicaid Rate Calculation

Section 7.4.1.3 Medicaid State Plan and (b)(3) Payments

Section 7.4.1.4 1915(c) Habilitation Supports Waiver Payments

IV. Add the following new attachments to the Contract:

Attachment P6.7.4.2 Family Psychoeducation (FPE) Services

V. The following attachments to the Contract are updated or revised:

Attachment 6.3.1.1 Customer Service Standards

Attachment 6.5.1.1 PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries

Attachment P6.7.1.1 Quality Assessment and Performance Improvement Programs For Specialty Pre-Paid Inpatient Health Plans

Attachment P7.6.1 Compliance Examination Guidelines

Attachment P7.8.1 Finance Planning, Reporting and Settlement

Contract Manager and Location Building:
Mark Kielhorn – Lewis Cass Building, 320 S. Walnut
Contract Number# _____

**Agreement Between
Michigan Department of Community Health
And
PIHP
For
The Medicaid Managed Specialty Supports and Services
Concurrent 1915(b)/(c) Waiver Program**

Period of Agreement:

This contract shall commence on October 1, 2010 and continue through September 30, 2011. This agreement is in full force and effect for the period specified.

Program Budget and Agreement Amount:

Total funding available for specialty supports and services is identified in the annual Legislative Appropriation for community mental health services programs. Payment to the PIHP will be paid based on the funding amount specified in Part II, Section 7.0 of this contract. The estimated value of this contract is contingent upon and subject to enactment of legislative appropriations and availability of funds.

The terms and conditions of this contract are those included in: (a) Part I: 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 Community Health

Mary Jane Russell, Deputy Director
Operations Administration

Date

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.

Application for Participation (AFP): The document issued on January 3, 2002 that specifies the standards and requirements for specialty Prepaid Inpatient Health Plans (PIHPs), the PIHP's plans of correction, and any stated conditions as reflected in the MDCH approval of the application.

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

Beneficiary: An individual who is eligible for Medicaid and who is receiving or may qualify to receive services through the PIHP under this contract.

Capitation Rate: The fixed per person monthly rate payable to the PIHP by the MDCH for each Medicaid eligible person covered by the Concurrent 1915(b)/1915(c) Waiver Program, regardless of whether or not the individual who is eligible for Medicaid receives covered specialty services and supports during the month. The capitated rate does not include funding for beneficiaries enrolled in the Medicaid 1915(c) Children's Waiver, beneficiaries residing in State-operated Developmental Disability Centers (ICF/MR facility services, over 16 beds), children enrolled in Michigan's separate health insurance program (MiChild) under Title XXI of the Social Security Act, and other individuals eligible for a separate set of services under Michigan's pending Health Insurance Flexibility and Accountability (HIFA) Waiver.

Capitated Payments: Monthly payments based on the Capitation Rate that are payable to the PIHP by the MDCH for the provision of Medicaid services and supports pursuant to Section 7.0 of this 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.

Comprehensive Specialty Services Network: CMHSPs in an affiliation eligible for a special provider designation that affords them special consideration in the provider network and permits them to receive a sub-capitation of Medicaid funds from the PIHP.

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: is an acceptance and respect for difference, a continuing self-

assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of minority populations.

Customer: In this contract, customer includes all Medicaid eligible individuals located in the defined service area who are receiving or may potentially receive covered services and supports.

Developmental Disability: As described in Section 330, 1100a of the Michigan Mental Health Code, a 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, interdisciplinary, 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.

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

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA):

Public Law 104-191, 1996 to improve the Medicare program under Title XVIII of the Social Security Act, the Medicaid program under Title XIX of the Social Security Act, and the

efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper-based, and mandates “best effort” compliance.

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

Medicaid Eligible: Individual who has been determined to be eligible for Medicaid and who has been issued a Medicaid card. Medicaid eligibility is linked to certain coverages, services and benefits defined in the state plan for medical assistance. Because of the link between eligibility and benefits, Medicaid eligible individuals are also referred to in this agreement as "beneficiaries."

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

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

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

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

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

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

Prepaid Inpatient Health Plan (PIHP): 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 401 et al June 14, 2002, regarding Medicaid managed care. (In Medicaid regulations, Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" (Prepaid Inpatient Health Plan).

Serious Emotional Disturbance: As described in Section 330, 1100c of the Michigan Mental Health Code, a serious emotional disturbance is a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDCH, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

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

Serious Mental Illness: As described in Section 330, 1100c of the Michigan Mental Health Code, a serious mental illness is a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDCH 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: MDCH-developed document with recommended parameters for PIHPs regarding administrative practice and derived from public policy and legal requirements.

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

PART I: CONTRACTUAL SERVICES TERMS AND CONDITIONS

1.0 PURPOSE

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

Under approval granted by the Centers for Medicare and Medicaid Services (CMS), MDCH operates a Section 1915(b) Medicaid Managed Specialty Services and Support Program Waiver. Under this waiver, selected Medicaid state plan specialty services related to mental health and developmental disability services, as well as certain covered substance abuse services, have been “carved out” (removed) from Medicaid primary physical health care plans and arrangements. The 1915(b) Specialty Services Waiver Program operates in conjunction with Michigan's existing 1915(c) Habilitation Supports Waiver for persons with developmental disabilities. Such arrangements have been designated as “Concurrent 1915(b)/(c)” Programs by CMS. In Michigan, the Concurrent 1915(b)/(c) Programs are managed on a shared risk basis by specialty Prepaid Inpatient Health Plans (PIHPs), selected through the Application for Participation (AFP) process.

The purpose of this contract is to obtain the services of the selected PIHP to manage the Concurrent 1915(b)/(c) Programs in a designated services area and to provide a comprehensive array of specialty mental health and substance abuse services and supports as indicated in this contract.

This contract is a cost reimbursement contract under OMB Circular A-87. It is therefore subject to compliance with the principles and standards of OMB Circular A-87 for determining costs for Federal awards carried out through cost reimbursement contracts, and other agreements with State and local governments and federally recognized Indian tribal governments (governmental units).

2.0 ISSUING OFFICE

This contract is issued by the Michigan Department of Community Health (MDCH). The MDCH is the sole point of contact regarding all procurement and contractual matters relating to the services described herein. MDCH is the only entity authorized to change, modify, amend, clarify, or otherwise alter the specifications, terms, and conditions of this contract. Inquiries and requests concerning the terms and conditions of this contract, including requests for amendment, shall be directed by the PIHP to the attention of the Director of MDCH's Bureau of Mental Health and Substance Abuse Services and by the MDCH 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 Community Health, 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:

Irene Kazieczko
Bureau of Community Mental Health Services
Department of Community Health
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, 2010 through September 30, 2011. The contract may be extended in increments no longer than 12 months, contingent upon mutual agreement to an amendment to the financial obligations reflected in Attachment P 7.0.1, and other changes required by the department. No more than three (3) one-year extensions after September 30, 2011 shall occur. Fiscal year payments are contingent upon and subject to enactment of legislative appropriations.

5.0 PAYMENT METHODOLOGY

The financing specifications are provided in Part II, Section 7.0 "Contract Financing" and estimated payments are described in Attachment P 7.0.1 to this contract.

6.0 LIABILITY

6.1 Cost Liability

The MDCH assumes no responsibility or liability for costs under this contract incurred by the PIHP prior to October 1, 2010. Total liability of the MDCH 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 PIHP under this contract shall be the responsibility of the PIHP, and not the responsibility of the MDCH, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the part of the PIHP, its employees,

officers or agent. Nothing herein shall be construed as a waiver of any governmental immunity for the county(ies), the PIHP, its agencies or employees as provided by statute or modified by court decisions.

- B. All liability, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out pursuant to the obligations of the MDCH under this contract shall be the responsibility of the MDCH and not the responsibility of the PIHP if the liability, loss, or damage is caused by, or arises out of, the action or failure to act on the part of MDCH, its employees, or officers. Nothing herein shall be construed as a waiver of any governmental immunity for the State, the MDCH, its agencies or employees or as provided by statute or modified by court decisions.
- C. The PIHP and MDCH agree that written notification shall take place immediately of pending legal action that may result in an action naming the other or that may result in a judgment that would limit the PIHP's ability to continue service delivery at the current level. This includes actions filed in courts or by governmental regulatory agencies.

7.0 PIHP RESPONSIBILITIES

The PIHP shall be responsible for the operation of the Concurrent 1915(b)/(c) Program within its designated service area. Operation of the Concurrent 1915(b)/(c) Program must conform to regulations applicable to the concurrent program and to each (i.e., 1915(b) and 1915 (c)) Waiver. The PIHP shall also be responsible for development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract. If the PIHP elects to subcontract, the PIHP shall comply with applicable provisions of federal procurement requirements, as specified in Attachment P 6.4.1.1, except as waived for CSSNs in the 1915(b) Waiver. The PIHP is responsible for complying with all reporting requirements as specified in Part II, Section 6.5.1 of the contract and the finance reporting requirements specified in Part II, Section 7.8. Additional requirements are identified in Attachment P 7.0.2 (Performance Objectives).

8.0 ACKNOWLEDGMENT OF MDCH FINANCIAL SUPPORT

The PIHP shall reference the MDCH 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 PA 442, as amended, MCL 15.231, et seq.

10.0 CONTRACT INVOICING AND PAYMENT

MDCH funding obligated through this contract is Medicaid capitation payments. Detail regarding the MDCH financing obligation is specified in Part II, Section 7.0 of this contract and in Attachment P 7.0.1 to this contract.

11.0 LITIGATION

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

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

The PIHP shall submit annual litigation reports providing the following detail for all civil litigation that the PIHP, subcontractor, or the PIHP's insurers or insurance agents are parties to. Reports must include the following details:

- Case name and docket number
- Name of plaintiff(s) and defendant(s)
- Names and addresses of all counsel appearing
- Nature of the claim
- Status of the case

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

12.0 CANCELLATION

The MDCH may cancel this contract for material default of the PIHP. Material default is defined as the substantial failure of the PIHP to fulfill the obligations of this contract, the standards promulgated by the department pursuant to P.A. 597 of the Public Acts of 2002 (MCL 330.1232b) or CMHSP Certification requirements as stated in the Michigan Mental Health Code (Section 232a). In case of material default by the PIHP, the MDCH may cancel this contract without further liability to the State, its departments, agencies, and employees, and procure services from other PIHPs.

In canceling this contract for material default, the MDCH shall provide written notification at least thirty (30) days prior to the cancellation date of the MDCH intent to cancel this contract to the PIHP and the relevant county(ies) Board of Commissioners. The PIHP may correct the problem during the thirty (30) day interval, in which case cancellation shall not occur. In the event that this contract is canceled, the PIHP shall cooperate with the MDCH to implement a transition plan for recipients. The MDCH shall have the sole authority for approving the adequacy of the transition plan, including providing for the financing of said plan, with the PIHP

responsible for providing the required local match funding. The transition plan shall set forth the process and time frame for the transition. The PIHP will assure continuity of care for all people being served under this contract until all service recipients are being served under the jurisdiction of another contractor selected by MDCH. The PIHP will cooperate with MDCH in developing a transition plan for the provision of services during the transition period following the end of this contract, including the systematic transfer of each recipient and clinical records from the PIHP's responsibility to the new contractor.

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

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 under Section 12.0, the PIHP shall provide to MDCH, all financial, performance, and other reports required by this contract.
- B.
- B. Payment for any and all valid claims for services rendered to covered recipients prior to the effective end date shall be the PIHP's responsibility, and not the responsibility of the MDCH.
- C. The portion of all reserve accounts accumulated by the PIHP that were funded with MDCH funds and related interest are owed to MDCH within 90 days, less amounts needed to cover outstanding claims or liabilities, unless otherwise directed in writing by MDCH.
- D. Reconciliation of equipment with a value exceeding \$5,000, purchased by the PIHP or its affiliates with funds provided under this contract, since October 1, 2002 will occur as part of settlement of this contract. The PIHP will submit to the MDCH an inventory of equipment meeting the above specifications within 45 days of the end date. The inventory listing must identify the current value and proportion of Medicaid funds used to purchase each item, and also whether or not the equipment is required by the PIHP as part of continued service provision to the continuing service population. MDCH will provide written notice within 90 days or less of any needed settlements concerning the portion of funds ending. If the PIHP disposes of the equipment, the appropriate portion of the value must be returned to MDCH (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 MDCH within 90 days. No carry-forward funds or savings as provided in section 7.7.2, can be earned during the year this contract ends, unless specifically authorized in writing by the MDCH.

- F. All financial, administrative, and clinical records under the PIHP's responsibility must be retained for a period of seven years, unless these records are transferred to a successor organization or the PIHP is directed otherwise in writing by MDCH.

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

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

14.0 CONFIDENTIALITY

Both the MDCH and the PIHP shall assure that services and supports to, and information contained in the records of beneficiaries served under this agreement, or other such recorded information required to be held confidential by 45 CFR 160 and 164 and/or PA 258 of 1974 and PA 368 as amended, in connection with the provision of services or other activity under this agreement shall be privileged communication. 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 MDCH:

15.1 Compliance with Applicable Laws

PIHPs will comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1973, and the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

15.2 Anti-Lobbying Act

The PIHP will comply with the Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq, and Section 503 of the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act (Public Law 104-208). Further, the PIHP shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

15.3 Non-Discrimination

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

Additionally, assurance is given to the MDCH that pro-active efforts will be made to identify and encourage the participation of minority-owned, women-owned, and handicapper-owned businesses in contract solicitations. The PIHP shall incorporate language in all contracts awarded: (1) prohibiting discrimination against minority-owned, women-owned, and handicapper-owned businesses in subcontracting; and (2) making discrimination a material breach of contract.

15.4 Debarment and Suspension

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

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

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

15.6 Hatch Political Activity Act and Intergovernmental Personnel Act

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

15.8 Health Insurance Portability and Accountability Act

To the extent that this act is pertinent to the services that the PIHP provides to the MDCH, the PIHP 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 PIHP from unauthorized disclosure as required by state and federal regulations. The PIHP must provide safeguards that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the contract.

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

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

15.9 Byrd Anti-Lobbying Amendment

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

15.10 Davis-Bacon Act

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

15.11 Contract Work Hours and Safety Standards

(All contracts in excess of \$2,000 for construction and \$2,500 employing mechanics or laborers). (40 U.S.C. 327 - 333) -- Where applicable, all contracts awarded by recipients in excess of \$2,000 for construction contracts and in excess of \$2,500 for other contracts that involve the employment of mechanics or laborers shall include a provision for compliance with Section 102 and 107 of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327 - 333), as supplemented by Department of Labor regulations (29 CFR part 5). Under Section 102 of the Act, each contractor shall be required to compute the wages of every mechanic and laborer on the basis of a standard workweek of 40 hours. Work in excess of the standard workweek is permissible provided that the worker is compensated at a rate of not less than 1 and 1/2 times the basic rate of pay for all hours worked in excess of 40 hours in the workweek. Section 107 of the Act is applicable to construction work and provides that no laborer or mechanic shall be required to work in surroundings or under working conditions that are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

15.12 Rights to Inventions Made Under a Contract or Agreement

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

15.13 Clean Air Act and Federal Water Pollution Control Act

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

16.0 MODIFICATIONS, CONSENTS AND APPROVALS

This contract cannot be modified, amended, extended, or augmented, except in writing and only when 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 SUCCESSOR

Changes in CMHSP affiliates to this PIHP may be proposed to MDCH during the second year of this contract. All changes in CMHSP affiliate members must be prior approved by the MDCH. Such changes are at the sole discretion of the MDCH in consultation with the Community Health Specialty Services Panel.

18.0 ENTIRE AGREEMENT

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

- A. This contract including attachments and appendices
- B. The standards as contained in the Application for Participation (AFP) as they pertain to the provision of specialty services to Medicaid beneficiaries and the plans of correction and subsequent plans of correction submitted and approved by MDCH and any stated conditions, as reflected in the MDCH approval of the application unless prohibited by federal or state law
- C. Michigan Mental Health Code and Administrative Rules
- D. Michigan Public Health Code and Administrative Rules
- E. Approved Medicaid Waivers and corresponding CMS conditions, including 1915(b) and (c) Waivers
- F. MDCH Appropriations Acts in effect during the contract period
- G. Balanced Budget Act of 1997 (BBA) final rule effective 42 CFR 400, et al June 14, 2002
- H. All other pertinent Federal and State Statutes, Rules and Regulations
- I. All final MDCH guidelines, and final technical requirements, as referenced in the contract. Additional guidelines and technical requirements must be added as provided for in Part 1, Section 16.0 of this contract
- J. Michigan Medicaid Provider Manual: Mental Health -Substance Abuse section

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

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

19.0 DISPUTE RESOLUTION

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

In the event of the unsatisfactory resolution of a non-emergent contractual dispute or compliance/performance dispute, and if the PIHP desires to pursue the dispute, the PIHP shall

request that the dispute be resolved through the dispute resolution process. This process shall involve a meeting between agents of the PIHP and the MDCH. The MDCH Deputy Director for Mental Health and Substance Abuse Services will identify the appropriate Deputy Director(s) or other department representatives to participate in the process for resolution, unless the MDCH Director has delegated these duties to the Administrative Tribunal.

The PIHP shall provide written notification requesting the engagement of the dispute resolution process. In this written request, the PIHP shall identify the nature of the dispute, submit any documentation regarding the dispute, and state a proposed resolution to the dispute. The MDCH shall convene a dispute resolution meeting within twenty (20) calendar days of receipt of the PIHP request. The Deputy Director shall provide the PIHP and MDCH 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 MDCH position regarding the dispute.

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

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

20.0 NO WAIVER OF DEFAULT

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

21.0 SEVERABILITY

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

22.0 DISCLAIMER

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

Captions and headings used in this contract are for information and organization purposes.

23.0 RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR)

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

24.0 NOTICES

Any notice given to a party under this contract must be written and shall be deemed effective, if addressed to such party at the address indicated on the signature page and Section 3.0 of this contract upon (a) delivery, if hand delivered; (b) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (c) the third (3rd) business day after being sent by U.S. mail, postage prepaid, return receipt requested; or (d) the next business day after being sent by a nationally recognized overnight express courier with a reliable tracking system. Either party may change its address where notices are to be sent by giving written notice in accordance with this section.

25.0 UNFAIR LABOR PRACTICES

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

26.0 SURVIVOR

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

27.0 GOVERNING LAW

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

29.0 ETHICAL CONDUCT

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

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

PART II: STATEMENT OF WORK

1.0 SPECIFICATIONS

The following sections provide an explanation of the specifications and expectations that the PIHP must meet and the services that must be provided under the contract. The PIHP is not, however, constrained from supplementing this with additional services or elements deemed necessary to fulfill the intent of the Managed Specialty Services and Supports Program. All provisions of this contract apply to the management of the substance abuse benefit as well as mental health benefits, unless explicitly exempted.

1.1 Targeted Geographical Area for Implementation

The PIHP shall manage the Concurrent 1915(b)/(c) Program under the terms of this agreement in the County(ies) of your geographic service area hereafter referred to as “service area” or exclusively as “Medicaid specialty service area.”

1.2 Target Population

The PIHP shall serve Medicaid beneficiaries in the service area described in 1.1 above who require the Medicaid services included under the 1915(b) Specialty Services Waiver, or who are enrolled in the 1915(c) Habilitation Supports Waiver.

1.3 Responsibility for Payment of Authorized Services

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

Services shall not be delayed or denied as a result of a dispute of payment responsibility between two or more PIHPs. In the event there is an unresolved dispute between PIHPs, either party may request MDCH involvement to resolve the dispute, and MDCH will make such determination. Likewise, services shall not be delayed or denied as a result of a dispute of payment responsibility between the PIHP and another agency.

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

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

- a) The PIHP does not respond to a request for pre-approval within 1 hour;
- b) The PIHP cannot be contacted; or

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

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

1.4 Behavior Treatment Plan Review Committee

The 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 P 1.4.1. Technical Requirement for Behavior Treatment Plans

2.0 SUPPORTS AND SERVICES

2.1 Concurrent 1915(b)/(c) Program:

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

2.1.1 1915(b) Services

State Plan Services: Under the 1915(b) Waiver component of the 1915(b)/(c) program, the PIHP is responsible for providing the following state plan services to beneficiaries in the service area who meet applicable coverage or service eligibility criteria:

- ICF/MR services (under 16 beds)
- Inpatient psychiatric hospital services (adults)
- Inpatient psychiatric hospital services for individuals under age 22
- Psychiatric partial hospitalization services (outpatient hospital service)
- Certain physician services related to inpatient or partial hospitalization services
- Mental Health Clinic Services

- Mental Health Community Rehabilitation Services
- Mental Health Crisis Residential and Crisis Stabilization Services
- Mental Health Psychosocial Rehabilitation Program
- Substance Abuse Rehabilitative Services
- Targeted Case Management for Adults and Children with mental illness or serious emotional disturbance and for Individuals with a developmental disability
- Personal Care for Persons in CMHSP Specialized Residential Settings
- Specialty Medicaid state plan services covered under this agreement and required to treat, correct, or ameliorate an illness or condition identified through an EPSDT screening

Specific service and support definitions included under and associated with these state plan coverage responsibilities are provided in the Michigan Medicaid Provider Manual: Mental Health -Substance Abuse section.

2.1.1 1915(b)(3) Services

As specified in the CMS waiver approval, beginning on January 1, 2004 the services aimed at providing a wider, more flexible, and mutually negotiated set of supports and services; that will enable individuals to exercise and experience greater choice and control will be offered under Michigan's approved 1915(b) Waiver Renewal, using the authority of Section 1915(b)(3) of Title XIX of the Social Security Act. The PIHP use Medicaid capitation payments to offer and provide more individualized, cost-effective supports and services, according to the beneficiary's needs and requests, in addition to provision of the state plan coverage(s) for which the beneficiary qualifies. The listing of these services, their definitions, medical necessity criteria, and amount scope and duration requirements for the 1915(b)(3) services is included in the Michigan Medicaid Provider Manual.

2.1.2 1915(c) Services

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

- Chore Service
- Community Living Supports
- Enhanced Dental
- Enhanced Medical Equipment and Supplies
- Enhanced Pharmacy
- Environmental Modifications
- Family Training

- Out of home Non-Vocational Habilitation
- Personal Emergency Response System
- Pre-Vocational Habilitation
- Private Duty Nursing
- Respite Care
- Supports Coordination
- Supported Employment

2.2 Service Requirements

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

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

3.0 ACCESS ASSURANCE

3.1 Access Standards

The PIHP shall ensure timely access to supports and services in accordance with the Access Standards in Attachment 3.1.1 and the following timeliness standards, and report its performance on the standards in accordance with Attachment P 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 who receive a pre-admission screening for psychiatric inpatient care have a disposition completed in three (3) hours.
2. At least 95% of all people receive a face-to-face meeting with a professional 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-crisis (emergency) assessment with a professional.

B. Substance Abuse

1. 95% of people receive an assessment within 24 hours of referral or presentation for urgent situations. (Standard: 95%)
2. 95% of people are admitted for treatment within 24 hours of assessment in urgent situations.
3. 95% of people receive an assessment for non-urgent situations within five days of referral or presentation.
4. 95% of people are admitted to treatment within seven (7) days following a non-urgent assessment.

C. The PIHP shall ensure geographic access to covered, alternative, and allowable supports and services in accordance with the following standards, and shall make documentation of performance available to MDCH site reviewers.

1. For office or site-based mental health services, the individual's primary service providers (e.g., case manager, psychiatrist, primary therapist, etc.) must be within 30 miles or 30 minutes of the recipient's residence in urban areas, and within 60 miles or 60 minutes in rural areas.
2. For office or site-based substance abuse services, the individual's primary service provider (e.g., therapist) must be within 30 miles or 30 minutes of the recipient's residence in urban areas and within 60 miles or 60 minutes in rural areas.

D. The PIHP shall be responsible for outreach and ensuring adequate access to covered services for beneficiaries. The PIHP shall assure that substance abuse screening/referral is available 24 hours, 7 days a week.

E. In addition, the PIHP shall assure access according to this standard: 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 MDCH, shall receive PIHP managed mental health services. The PIHP shall report its performance on the standard in accordance with Attachment P 6.5.1.1.

F. The FY 2011 Medicaid capitation payment for children birth through 17 has been adjusted to support increased access for children to Medicaid specialty mental health and substance abuse services and supports. MDCH has included, as an attachment to this contract, projected the amount of additional Medicaid funds provided specifically to this PIHP for children birth through age 17, in FY 2011. Each Pre-Paid Inpatient Health Plan (PIHP) is expected to increase the overall number of children served and increase expenditures for children's services in

FY 2011 over the base year of FY 2006. MDCH will issue a FY 2006 baseline on each dimension by PIHP. Increased penetration, utilization and expenditures are expected on each dimension, as applicable. The following measures will be used to monitor each PIHP. The PIHPs' performance will be evaluated quarterly in each of the following age ranges: birth through 3 years, 4 through 7 years and 7 through 17 years. Expenditures will be evaluated annually. All of the performance measures are based on reporting elements currently in Attachment P.6.5.1.1. of this contract.

Each PIHP will negotiate its individual performance targets. A baseline for FY 2006 will be established. For FY'08 no sanctions will be imposed for failure to reach target. In future years, pay for performance will be imposed, with the details of the pay for performance arrangement negotiated between MDCH and the PIHP and included in subsequent contract amendments.

Measure 1. An increased number of Medicaid children per 1000 Medicaid eligible children in the PIHP service area who are provided Medicaid mental health specialty services and supports.

Data elements to be used for measurement:

- Medicaid ID
- Date of birth = <18 years
- Have an encounter in the data warehouse for the fiscal year

Measure 2. For children with: a) serious emotional disturbance (SED) and b) DD/SED co-occurring conditions, an increased number of Medicaid children per 1000 Medicaid eligible children in the PIHP service area who are provided Medicaid mental health specialty services and supports.

Data elements to be used for measurement:

- Medicaid ID
- Date of birth = <18 years
- QI data: for a) #17.02 (Disability designation is MI) = 1 (yes) [Note: 17.01 and 17.03 should each = 2 (no) or 3 (not evaluated)]; for b) 17.01 (Disability designation is DD) + 17.02 = 1 (yes) [Note: 17.03 should = 2 (no) or 3 (not evaluated)]
- Have an encounter in the data warehouse for the fiscal year

Measure 3. For children with developmental disabilities, an increased number of Medicaid children per 1000 Medicaid eligible children in the PIHP service area who receive mental health specialty services and supports.

Data elements to be used for measurement:

- Medicaid ID
- Date of birth = <18 years
- QI data: #17.01 (Disability designation is DD) = 1 (yes) [Note: 17.02 and 17.03 should each = 2 (no) or 3 (not evaluated)]
- Have an encounter in the data warehouse for the fiscal year

Measure 4. An increased number of Medicaid children per 1000 Medicaid eligible children, of Michigan's most vulnerable children, who receive specialty mental health services and supports as measured by the following:
An increased number of Medicaid children, per 1000 Medicaid eligible children, who receive mental health specialty services and supports who are also served by the Department of Human Services (DHS) for abuse or neglect (reporting element 28.01) and/or who reside in a DHS foster family home (reporting element 8).

Data elements to be used for measurement:

- Medicaid ID
- Date of birth = <18 years
- QI data: #28.01 (Child served by DHS for abuse and neglect) = 1 (yes) + #8 (Residential living arrangement) = 5 (Foster family home)
- Have an encounter in the data warehouse for the fiscal year

Measure 5: An increase in FY 2011 Medicaid expenditures for services for children over the base year of FY2006 Medicaid expenditures for children with: a) developmental disabilities, b) serious emotional disturbance, c) DD/SED co-occurring conditions, and d) children also served by DHS for abuse or neglect, and/or reside in a DHS foster family home.

Data elements to be used for measurement:

- Medicaid ID
- Date of birth = <18 years
- QI data: a) #17.01 (Disability designation is DD) = 1 (yes) [Note: 17.02 and 17.03 should each = 2 (no) or 3 (not evaluated)]; b)#17.01 (Disability designation is MI) = 1 (yes) [Note: 17.01 and 17.03 should each = 2 (no) or 3 (not evaluated)]; c) #17.01 + #17.02 = 1 (yes) [Note: 17.03 should = 2 (no) or 3 (not evaluated)]; d) #28.01 =1 (yes) + # 8 = 8 (Foster family home)
- X number of units of services in the warehouse for FY
- X cost per unit of each service (from the PIHP's Medicaid Utilization and Net Cost Report for the FY)

G. The FY 2011 Medicaid capitation payment for persons with substance use disorders (SUD) has been adjusted to support increased access for adults and children to Medicaid specialty substance abuse services and supports. Each Pre-Paid Inpatient Health Plan (PIHP) are expected to increase the overall number of people with SUD served and increase expenditures for Medicaid substance abuse services in FY 2011 over the base year of FY 2006. MDCH will issue a FY 2006 baseline on each dimension by PIHP. Increased penetration, utilization and expenditures are expected on each dimension, as applicable. The following measures will be used to monitor each PIHP. The PIHPs' performance will be evaluated quarterly in each of the following age ranges: birth through 17 years and 18 years and older. Expenditures will be evaluated annually. All of the performance measures are based on reporting elements currently in Attachment 6.5.1.1. of the Medicaid contract.

Measure 1. An increased number of Medicaid children (birth through age 17 years) with SUD per 1000 in the PIHP service area who are provided Medicaid substance abuse specialty services and supports.

Data elements to be used for measurement:

- Medicaid ID
- Date of birth = <18 years
- QI data: #17.03 (Disability designation is SUD) = 1 (yes) [Note: 17.01 and 17.02 should each = 2 (no) or 3 (not evaluated)]
- Have a substance abuse services encounter in the data warehouse for the fiscal year

Measure 2. An increased number of Medicaid adults (age 18 and older) with SUD per 1000 in the PIHP service area who are provided Medicaid substance abuse specialty services and supports.

Data elements to be used for measurement:

- Medicaid ID
- Date of birth = 18 years and over
- QI data: #17.03 (Disability designation is SUD) = 1 (yes) [Note: 17.01 and 17.02 should each = 2 (no) or 3 (not evaluated)]
- Have a substance abuse services encounter in the data warehouse for the fiscal year

Measure 3. An increased percentage in FY 2011 Medicaid expenditures over the base year of FY 2006 Medicaid expenditures for children and adults with SUD.

Data elements to be used for measurement:

- Medicaid ID
- QI data: #17.03 (Disability designation is SUD) = 1 (yes) [Note: 17.01 and 17.02 should each = 2 (no) or 3 (not evaluated)]
- **X** number of units of substance abuse services in the warehouse for FY
- **X** cost per unit of each service (from the PIHP's Medicaid Utilization and Net Cost Report for the FY)

3.2 Medical Necessity

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

3.3 Service Selection Guidelines

The criteria for service selection is included in the in the Michigan Medicaid Provider Manual: Mental Health -Substance Abuse section.

3.4 Other Access Requirements

3.4.1 Person-Centered Planning

The Michigan Mental Health Code establishes the right for all individuals to have an Individual Plan of Service (IPS) developed through a person-centered planning process (Section 712, added 1996). The PIHP shall implement person-centered planning in accordance with the MDCH Person-Centered Planning Practice Guideline (Attachment P 3.3.1.1). This provision is not currently a requirement for services provided through the Medicaid Substance Abuse capitation portion of this contract.

3.4.2 Cultural Competence

The supports and services provided by the PIHP (both directly and through contracted providers) shall demonstrate an ongoing commitment to linguistic and cultural competence that ensures access and meaningful participation for all people in the service area. Such commitment includes acceptance and respect for the cultural values, beliefs and practices of the community, as well as the ability to apply an understanding of the relationships of language and culture to the delivery of supports and services.

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

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

3.4.3 Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Under Michigan's specialty service waiver and this agreement, the PIHP is responsible for the provision of specialty services Medicaid benefits, and must make these benefits available to beneficiaries referred by a primary EPSDT screener, to correct or ameliorate a qualifying condition discovered through the screening process.

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

3.4.4 Self-Determination

It is the expectation that PIHPs will assure compliance among their network of service providers with the elements of this policy. This will mean that the PIHP will assure, when arrangements that support the pursuit of self-determination are sought by adult

consumers (self determination is an option for adult consumers); no consumer is mandated to use self determination approaches), developed and offered, by the PIHP, that they conform to the elements of the policy and practice guideline.

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

Reviews of PIHP 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. It is the mutual understanding of the parties that the requirement for implementation of arrangements that entail use of a fiscal intermediary to support direct employment or contracting by consumers of preferred, qualified providers, may be delayed until 90 days following the issuance of revised technical advisory on the use of the Choice Voucher System, and best practice standards for PIHP/Provider fiscal intermediary arrangements. This revised technical advisory and best practice standards will be developed by MDCH, in concert with consumers, consumer advocates, and members of the Michigan Association of Community Mental Health Boards (chosen by the Association). The PIHP must offer a range of financial management service options, including the fiscal intermediary, when these options support the principles, concepts and key elements of self determination

3.4.5 Choice

In accordance with 42 CFR 438.6(m), the PIHP must assure that the beneficiary is allowed to choose his or her health care professional, i.e., physician, therapist, etc. to the extent possible and appropriate.

3.4.6 Second Opinion

If the beneficiary requests, the PIHP must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the beneficiary to obtain one outside the network, at no cost to the beneficiary.

3.4.7 Out-of-Network Responsibility

If the PIHP is unable to provide necessary medical services covered under the contract to a particular beneficiary the PIHP must adequately and timely cover these services out of network for the beneficiary, for as long as the entity is unable to provide them within the network.

3.4.8 Denials By Qualified Professional

The PIHP must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must

be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition.

3.4.9 Utilization Management Incentives

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

4.0 SPECIAL COVERAGE PROVISIONS

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

4.1 Nursing Home Placements

The PIHP agrees to provide medically necessary Medicaid specialty services to facilitate placement from or to divert admissions to a nursing home, for eligible beneficiaries determined by the OBRA screening assessment to have a mental illness and/or developmental disability and in need of placement and/or services.

Funding allocated for OBRA placement and for treatment services shall continue to be directed to this population.

4.2 Nursing Home Mental Health Services

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

4.3 Multicultural Services

The PIHP agrees to provide medically necessary covered Medicaid services and supports to eligible beneficiaries served through programs receiving categorical state funding for multicultural services.

4.4 Capitated Payments and Other Pooled Funding Arrangements

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

supplant or replace the service or funding obligation of other public programs.

5.0 OBSERVANCE OF FEDERAL, STATE AND LOCAL LAWS

The PIHP agrees that it will comply with all state and federal statutes, 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. This includes laws and regulations regarding human subjects research and data projections set forth in 45 CFR and HIPAA.

5.1 Special Waiver Provisions for MSSSP

Michigan's Specialty Services and Supports Waiver Program authorized under 1915(b)(1), (3) and (4) of the Social Security Act is approved until September 30, 2011.

This five-year waiver 1915(c) waiver, referred to as the Home and Community-Based Waiver, serving people with a developmental disability, is approved until September 30, 2012. Under these waivers, beneficiaries are entitled to specified medically necessary specialty supports and services from the PIHP.

5.2 Fiscal Soundness of the Risk-Based PIHP

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

5.3 Program Integrity

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

(a) PIHP Ownership and Control Interests

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

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

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

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

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

(b) PIHP Responsibilities for Monitoring Ownership and Control Interests Within Their Provider Networks

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

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

(c) PIHP Responsibility for Disclosing Criminal Convictions

PIHPs are required to promptly notify the Division of Program Development,

Consultation and Contracts, Mental Health and Substance Abuse Administration in MDCH if:

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

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

(d) PIHP Responsibility for Notifying MDCH of Administrative Actions that Could Lead to Formal Exclusion

The PIHP must promptly notify the Division of Program Development, Consultation and Contracts, Mental Health and Substance Abuse Administration in MDCH if they have taken any administrative action that limits a provider's participation in the Medicaid program, including any provider entity conduct that results in suspension or termination from the PIHP's provider network.

The United States General Services Administration (GSA) maintains a list of parties excluded from federal programs. The "excluded parties lists" (EPLS) and any rules and/or restrictions pertaining to the use of EPLS data can be found on GSA's web page at the following internet address: <http://exclusions.oig.hhs.gov>. The state sanctioned list is at: www.michigan.gov/mdch, click on providers, click on Information for Medicaid Providers, click on List of Sanctioned Providers. Both lists must be regularly checked.

5.4 Public Health Reporting

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

5.5 Medicaid Policy

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

6.0 PIHP ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE SERVICES

6.1 Organizational Structure

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

6.1.1 Event Notification

In addition to other reporting requirements outlined in this contract, the PIHP shall immediately notify MDCH of the following events:

1. Any consumer death that occurs within twelve months of the individual's discharge from a state facility; or a death that occurs as a result of suspected staff member action or inaction. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, to QMPMeasures@michigan.gov and include the following information:

- a. Name of beneficiary
- b. Beneficiary ID number (Medicaid, ABW, MiChild)
- c. Consumer I (CONID) if there is no beneficiary ID number
- d. Date, time and place of death (if a licensed foster care facility, include the license #)
- e. Preliminary cause of death
- f. Contact person's name and E-mail address

2. Relocation of a consumer's placement due to licensing issues.

3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours

4. The conviction of a PIHP/CMHSP or provider panel staff members for any offense related to the performance of their job duties or responsibilities.

Except as otherwise instructed above, Notification of these events shall be made telephonically or other forms of communication within five (5) business days to contract management staff members in MDCH's Mental Health and Substance Abuse Administration.

6.2 Administrative Personnel

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

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

- Administrator (Chief Executive Officer)
- Chief Operating Officer
- Medical Director and Clinical/Program Director(s)
- Chief Financial Officer
- Management Information System Director
- Customer Services 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 individual and the Prepaid Inpatient Health Plan (PIHP). This includes orienting new individuals to the services and benefits available including how to access them, helping individuals with all problems and questions regarding benefits, handling individual complaints and grievances in an effective and efficient manner, and tracking and reporting patterns of problem areas for the organization. This requires a system that will be available to assist at the time the individual has a need for help, and being able to help on the first contact in most situations. Key aspects of the customer service system are included in Section 3/6 of the Application for Participation. Standards for customer services are in Attachment P.6.3.1.1.

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

6.3.2 Recipient Rights and Grievance/Appeals

The PIHP shall adhere to the requirements stated in the MDCH Grievance and Appeal Technical Requirement, which is an attachment to this contract (Attachment P 6.3.2.1) in addition to provisions specified in 42 CFR 438.100.

Individuals enrolled in Medicaid must be informed of their right to an administrative hearing if dissatisfaction is expressed at any point during the rendering of state plan services. While PIHPs may attempt to resolve the dispute through their local processes, the local process must not supplant or replace the individual's right to file a hearing request with MDCH. The PIHP's grievance or complaint process may, and

should, occur simultaneously with MDCH's administrative hearing process, as well as with the recipient rights process. The PIHP shall follow fair hearing guidelines and protocols issued by the MDCH.

The PIHP and all affiliated CMHSPs must maintain an Office of Recipient Rights in accordance with all of the provisions of Section 755 of the Michigan Mental Health Code and for substance abuse, Section 6321 of P.A. 365 of 1978, and corresponding administrative rules.

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

The PIHPs must maintain records of grievances and appeals.

6.3.3 Information Requirements

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

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

B. Additional Information Requirements

1. The PIHP must notify beneficiaries that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. The PIHP must also notify beneficiaries how to access alternative formats.
2. The PIHP must provide the following information to all beneficiaries:

- a. A listing of contracted providers that identifies provider name, locations, telephone numbers, any non-English languages spoken, and whether they are accepting new patients. This includes, at a minimum, information about primary service providers (e.g. case manager, psychiatrist, primary therapist, etc.) and any restrictions on the beneficiary's freedom of choice among network providers. A written copy of this listing must be provided to each beneficiary annually, unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer service line is acceptable.
 - b. Their rights and protections, as specified in "Appeal and Grievance Resolution Processes Technical Requirement."
 - c. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled
 - d. Procedures for obtaining benefits, including authorization requirements.
 - e. The extent to which, and how, beneficiaries may obtain benefits and the extent to which, and how, after-hours crisis services are provided.
 - f. Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost to the PIHP of each covered support and service he/she is receiving.
 - g. MDCH will assemble a workgroup to develop a program integrity process which verifies claimed services were provided. This will include Explanation of Benefits for beneficiaries that will satisfy CMS audit requirements. Anticipated target date of April, 2011.
3. The PIHP must give each beneficiary written notice of a significant change in its provider network including the addition of new providers and planned termination of existing providers.
 4. The PIHP will make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.
 5. The PIHP will provide information to beneficiaries about managed care and care coordination responsibilities of the PIHP, including:
 - a. Information on the structure and operation of the MCO or PIHP;
 - b. Physician incentive plans in use by the PIHP or network providers as set forth in 42 CFR 438.6(h).

6.4 Provider Network Services

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

accountable party for the Medicaid beneficiaries in its service area, regardless of the functions it has delegated to its CSSNs and its provider networks.

In this regard, the PIHP 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 clearly written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.
- C. Provide a copy of the PIHP's prior authorization policies to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to prior authorization policies as changes are made.
- D. Provide a copy of the PIHP's grievance, appeal and fair hearing procedures and timeframes to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to those procedures or timeframes.
- E. Provide to MDCH in the format specified by MDCH, provider agency information profiles that contain a complete listing and description of the provider network available to recipients in the service area.
- F. Notify MDCH within seven (7) days of any changes to the composition of the provider network organizations. PIHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDCH determines to negatively affect recipient access to covered services may be grounds for sanctions.
- G. Assure that the provider network responds to the cultural, racial, and linguistic needs (including interpretive services as necessary) of the service area, and make oral interpretation services available free of charge to each potential beneficiary. This applies to all non-English languages not just those that the State identifies as prevalent. Each entity must notify its beneficiaries how to access oral interpretation services.
- H. Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility.

- I. Assure that network providers do not segregate PIHP individuals in any way from other people receiving their services.
- J. ~~Annually evaluate providers who perform delegated functions.~~
Annually monitor affiliates, as applicable, and provider networks who perform delegated functions to assure quality and performance in accordance with the standards in the Quality Assessment and Performance Improvement Technical Requirement (Attachment 6.7.1.1.)
- K. The PIHP 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 Procurement

The PIHP is responsible for the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract. Where the PIHP and affiliated CMHSPs fulfill these responsibilities through subcontracts, they shall adhere to applicable provisions of federal procurement requirements as specified in Attachment P 6.4.1.1.

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

- a. May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification;
- b. Must give those providers not selected for inclusion in the network written notice of the reason for its decision;

Is not required to contract with providers beyond the number necessary to meet the needs of its beneficiaries, and is not precluded from using different practitioners in the same specialty. Nor is the PIHP prohibited from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to its beneficiaries. In addition, the PIHP's selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. Also, the PIHP must ensure that it does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

6.4.2 Subcontracting

The PIHP may subcontract for the provision of any of the services specified in this contract including contracts for administrative and financial management, and data processing. The PIHP shall be held solely and fully responsible to execute all provisions of this contract, whether or not said provisions are directly pursued by the PIHP, pursued by affiliated CMHSPs, or pursued by the PIHP through a subcontract vendor. The PIHP shall ensure that all subcontract arrangements clearly specify the type of services being purchased. Subcontracts shall ensure that the MDCH is not a party to the contract and therefore not a party to any employer/employee relationship with the subcontractor of the PIHP.

Subcontracts entered into by the PIHP shall address 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) and solvency requirements
- H. Financing conditions consistent with this contract
- I. Anti-delegation clause
- J. Compliance with Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency"
- K. EPSDT requirements
- L. In all contracts with health care professionals, the PIHP must comply with the requirements specified in the "Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans", Attachment P 6.7.1.1.: and require the provider to cooperate with the PIHP's quality improvement and utilization review activities
- M. Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.
- N. Not prohibit a provider from discussing treatment options with a recipient that may not reflect the PIHP's position or may not be covered by the PIHP.
- O. Not prohibit a provider from advocating on behalf of the recipient in any grievance or utilization review process, or individual authorization process to obtain necessary health care services.
- P. Require providers to meet Medicaid accessibility standards as established in Medicaid policy and this contract.

In accordance with 42 CFR 434.6(b), all subcontracts entered into by the PIHP must

be in writing and fulfill the requirements of 42 CFR 434.6(a) and 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract. All subcontracts must be in compliance with all State of Michigan statutes and will be subject to the provisions thereof. All subcontracts must fulfill the requirements of this contract that are appropriate to the services or activities delegated under the subcontract.

All employment agreements, provider contracts, or other arrangements, by which the PIHP intends to deliver services required under this contract, whether or not characterized as a subcontract, shall be subject to review by the MDCH at its discretion.

Subcontracts that contain provisions for a financial incentive, bonus, withhold, or sanctions, (including sub-capitations) must include provisions that protect individuals from practices that result in the withholding of services that would otherwise be provided according to medical necessity criteria and best practice standards, consistent with 42 CFR 422.208 and 422.210. The PIHP shall provide a copy of each contract that contains incentive, bonus, withhold, or sanction provisions (including sub-capitations) to the MDCH at the time the contract is issued to the provider. MDCH reserves the right to disallow such contracts if the provisions appear to increase the risk to MDCH, or to jeopardize individuals' access to services. The PIHP must provide information on its Provider Incentive Plan (PIP) to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a PIP).

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

6.4.2.1 Contracts with CSSNs

The approved 1915(b) waiver includes establishment of CSSNs which are formed by PIHPs and their affiliates. Contracts between CSSNs and PIHPs must include:

- a. Descriptions of the payment method of Medicaid funds to be used by the PIHP and assumptions used that such payments are at a level that will meet the needs of beneficiaries residing in that county(ies).
- b. Define the model and methods of risk between the PIHP and the CMHSP affiliate.
- c. Describe the PIHP oversight to assure that the CMHSP is managing the services and risk within the funding assumptions.
- d. Provide for requirements by which the CMHSP affiliate can use its state General Funds for Medicaid purposes.

- e. Provide for payments of the local match obligation of the CMHSP to the PIHP.
- f. Describe the funding assumptions regarding the delegation of PIHP administrative activities and functions, and reporting of such activities and expenses to the PIHP.
- g. Requirement and process for monitoring and tracking expenditures on 1915(b) state plan services, (b)(3) services, and 1915(c) services and assure that aggregate expenditures for (b)(3) services do not grow or rise faster than the respective aggregate expenditures for 1915(b) state plan and 1915(c) services.

6.4.2.2 Agreements with Substance Abuse Coordinating Agencies (CA) for Substance Abuse Services

Medicaid funds appropriated for substance abuse services are intended to be used for such purpose, within the contractual conditions between the PIHP and MDCH regarding risk corridors and savings stipulated elsewhere. The PIHP must have a contract with the Coordinating Agency(ies) that cover their PIHP region. This contract must cover the conditions noted in 6.4.2. The contract must include the amount of funding to be paid to the Coordinating Agency. In general it is expected that the amount will be 100% of the payment received through the Substance Abuse rate structure for the Medicaid eligible beneficiaries in that county(ies) at the PIHP Substance Abuse geographic factor, less an amount for PIHP administration consistent with the PIHP non-delegated administration methodology. In addition, the PIHP, in conjunction with the agreement of the CA, can deduct an amount to support use of Medicaid SA services through a specified provider, with particular reference to services for persons with co-occurring disorders. The PIHP shall make a payment of Medicaid funds for substance abuse services to the Coordinating Agency within five (5) business days of receipt of Medicaid funds from the MDCH.

When the PIHP is one of several PIHPs funding the CA, the contract(s) between the PIHP and the CA(s), shall also stipulate that the CA is able to use the funding from all of the PIHPs to maximize how it meets the needs of all beneficiaries within the CA region, to manage risk and savings across the CA region.

6.4.3 Provider Credentialing

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

6.4.4 Collaboration with Community Agencies

PIHPs 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, Medicaid Health Plans (MHPs), local DHS offices, Substance Abuse Coordinating Agencies, 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 PIHP individuals. PIHPs are encouraged to coordinate with these entities through participation in multi-purpose human services collaborative bodies, and other similar community groups.

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

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

6.4.5 Medicaid Health Plan (MHP) Agreements

Many Medicaid beneficiaries receiving services from the PIHP will be enrolled in a MHP for their health care services. The MHP is responsible for non-specialty level mental health services. It is therefore essential that the PIHP have a written, functioning coordination agreement with each MHP serving any part of the PIHP's service area. At a minimum these arrangements must address integration of physical and mental health plans. Agreement by MDCH and CFI to develop language and have something in place by October, 2011. A model coordination agreement is herein included as Attachment P 6.4.5.1 A and B.

6.4.6 Health Care Practitioner Discretions

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

- A. For the beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

- B. For any information the beneficiary needs in order to decide among all relevant treatment options
- C. For the risks, benefits, and consequences of treatment or non-treatment
- D. For the beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.5 Management Information Systems

The PIHP 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:

- Monthly downloads of Medicaid eligible information
- Individual 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 MDCH
- Encounter and demographic data reporting
- Quality indicator reporting
- HIPAA compliance
- UBP compliance
- Individual access and satisfaction

6.5.1 Uniform Data and Information

To measure the PIHP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates, the PIHP must provide the MDCH with uniform data and information as specified by MDCH as previously agreed, and such additional or different reporting requirements (with the exemption of those changes required by federal or state law and/or regulations) as the parties may agree upon from time to time. Any changes in the reporting requirements, required by state and federal law, will be communicated to the PIHP at least 90 days before they are effective unless state or federal law requires otherwise. Both parties must agree to other changes, beyond routine modifications, to the data reporting requirements. The PIHP is not responsible for collecting and reporting Medicaid substance abuse data at this time.

The PIHP's timeliness in submitting required reports and their accuracy will be monitored by MDCH and will be considered by MDCH in measuring the

performance of the PIHP. Regulations promulgated pursuant to the Balance Budget Act of 1997 (BBA) require that the CEO or designee certify the accuracy of the data.

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

MDCH and the PIHPs agree to use the Encounter Data Integrity Group (EDIT) for the development of instructions with costing related to procedure codes, and the assignment of Medicaid and non-Medicaid costs. The recommendations from the EDIT group have been incorporated into the Attachment P 6.5.1.1..

The PIHP shall submit the information below to the MDCH consistent with the time frames and formats specified in Attachment P 6.5.1.1

Should additional statistical or management information from data currently collected by the PIHP be required by the MDCH, 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 MDCH 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.

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, affirm capitation rate calculations and estimates, the PIHP shall submit encounter data containing detail for each recipient encounter reflecting all services provided by the PIHP. Encounter records shall be submitted monthly via electronic media in the HIPAA-compliant format specified by MDCH. Encounter level records must have a common identifier that will allow linkage between MDCH's and the PIHP's management information systems. Encounter data requirements are detailed in the PIHP Reporting Requirements Attachment P.6.5.1.1 to this contract.

The following ASC X12N 837 Coordination of Benefits loops and segments are required by MDCH for reporting services provided by and/or paid for by the PIHP and/or CMHSP.

- Loop 2320 – Other Subscriber Information
 - SBR – Other Subscriber Information
 - DMG – Subscriber Demographic Information
 - OI – Other Insurance Coverage Information

Loop 2330A – Other Subscriber Name
 NM1 – Other Subscriber Name
Loop 2330B – Other Payer Name
 NM1 – Other Payer Name
 REF – Other Payer Secondary Identifier

Submission of data for any other payer other than the PIHP and/or CMHSP is optional. Reporting monetary amounts in the ASC X12N 837 version 4010 is optional.

6.6 Financial Management System

6.6.1 General

The PIHP shall maintain all pertinent financial and accounting records and evidence pertaining to this contract based on financial and statistical records that can be verified by qualified auditors. The PIHP will comply with generally accepted accounting principles (GAAP) for government units when preparing financial statements. The PIHP will use the principles and standards of OMB Circular A-87 for determining all costs related to the management and provision of Medicaid covered specialty services under the Concurrent 1915(b)/(c) Waiver Programs reported on the financial status report. The accounting and financial systems established by the PIHP shall be a double entry system having the capability to identify application of funds to specific funding streams participating in service costs for individuals. The accounting system must be capable of reporting the use of these specific fund sources by major population groups (MIA, MIC, DD and SA). In addition, cost accounting methodology used by the PIHP must ensure consistent treatment of costs across different funding sources and assure proper allocation to costs to the appropriate source.

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

6.6.1.1 Rental Costs

The following limitations regarding rental costs¹ shall apply to all PIHPs and affiliate CMHSPs regardless if they are organized as an official county agency, a community mental health organization, or a community mental health authority. All rental costs that exceed the limits in this section are not allowable and shall not be charged as a cost to Medicaid.

- a. Subject to the limitations in subsection b through e of this section, rental costs are allowable to the extent that the rates are reasonable in

¹ Rental costs are NOT the same as the capital cost of a building or facility. Capital costs are costs for construction, purchase, remodeling or similar costs for a building or facility **owned** by the entity (not rented), and limitations for such capital costs are established in Section 242 of the Mental Health Code and OMB Circular A-87.

light of such factors as: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased. Rental arrangements should be reviewed periodically to determine if circumstances have changed and other options are available.

- b. Rental costs under “sale and lease back” arrangements are allowable only up to the amount that would be allowed had the PIHP or CMHSP continued to own the property. This amount would include expenses such as depreciation or use allowance, maintenance, taxes and insurance.
- c. Rental costs for a County building (owned by a County or owned by an Authority established by a County as a separate legal entity) are allowable only up to the amount that would be allowed had title to the property vested in the PIHP/CMHSP. This amount would include expenses such as depreciation or use allowance, maintenance, interest, taxes and insurance. These expenses are allowable to the extent that they meet the criteria in OMB Circular A-87.
- d. Rental costs under “less-than-arm’s-length” leases are allowable only up to the amount that would be allowed had title to the property vested in the PIHP or CMHSP. This amount would include expenses such as depreciation or use allowance, maintenance, interest, taxes and insurance. For this purpose, a less-than-arm’s-length lease is one under which one party to the lease agreement is able to control or substantially influence the actions of the other². Such leases include, but are not limited to those between divisions of a governmental unit; governmental units under common control through common officers, directors, or members; and a governmental unit and a director, trustee, officer, or key employee of the governmental unit or his immediate family, either directly or through corporations, trusts, or similar arrangements in which they hold a controlling interest. For example, a governmental unit may establish a separate corporation for the sole purpose of owning property and leasing it back to the governmental unit.
- e. Rental costs under leases which are required to be treated as capital leases under GAAP are allowable only up to the amount (depreciation or use allowance, maintenance, interest, taxes and insurance) that would be allowed had the PIHP or CMHSP purchased the property on the date the lease was executed. Financial Accounting Standards Board Statement 13, Accounting for Leases,

² By definition all CMHSPs have a less than arms-length relationship with the counties that appoint members to the mental health board.

shall be used to determine whether a lease is a capital lease. Interest expenses related to the capital leases are allowable to the extent that they meet the criteria in OMB Circular A-87. Unallowable costs include amounts paid for profit, management fees, and taxes that would not have been incurred had the PIHP or CMHSP purchased the facility.

6.6.2 Intentionally Left Blank

6.6.3 Claims Management System

The PIHP 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 subcontractors within 30 days of receipt, and at least 99% of all clean claims within 90 days of receipt, except services rendered under a subcontract in which other timeliness standards have been specified and agreed to by both parties.

A clean claim is a valid claim completed in the format and time frames specified by the PIHP and that can be processed without obtaining additional information from the provider 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. A valid claim is a claim for supports and services that the PIHP is responsible for under this contract. It includes services authorized by the PIHP, and those like Medicare co-pays and deductibles that the PIHP may be responsible for regardless of their authorization.

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

6.6.3.1 Post-payment Review

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

6.6.3.2 Total Payment

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

of the amount that the beneficiary would owe if the PIHP provided the services directly.

6.6.3.3 Electronic Billing Capacity

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

6.6.3.4 Third Party Resource Requirements

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

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

6.6.3.5 Vouchers

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

Voucher arrangements for purchase of individual-directed supports delivered by non-professional practitioners may be through a fee-for-service arrangement.

The use of vouchers is not subject to the provisions of Section 6.4.1 (Provider Contracts and Procurement) and Section 6.4.2 (Subcontracting) of this contract.

6.6.3.6 Programs with Community Inpatient Hospitals

Upon request from DCH, the PIHP must develop programs for improving access, quality, and performance with providers. Such programs must include DCH in the design methodology, data collection, and evaluation. The PIHP must make all payments to both network and out-of-network providers dictated by the methodology jointly developed by the DCH in collaboration with the PIHP workgroup.

6.7 Quality Assessment and Performance Improvement Program Standards

6.7.1 Quality Assessment and Performance Improvement Program

The PIHP shall have a fully operational Quality Assessment and Performance Improvement Program in place that meets the conditions specified in the Quality Assessment and Performance Improvement Program Technical Requirement," Attachment P 6.7.1.1.

6.7.2 External Quality Review

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

6.7.3 Annual Effectiveness Review

The PIHP shall annually conduct an effectiveness review of its QAPIP. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for recipients as a result of quality assessment and improvement activities and interventions carried out by the PIHP. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and

objectives. Information on the effectiveness of the PIHP's QAPIP must be provided annually to network providers and to recipients upon request. Information on the effectiveness of the PIHP's QAPIP must be provided to the MDCH upon request.

6.7.4 Evidence-based, Promising and Best Practices:

As part of the Quality Assessment and Performance Improvement Program, the PIHP is required to develop and implement a process for adopting and using nationally accepted or mutually-agreed upon clinical standards for the practices employed with the people it serves. In 2004 MDCH began an initiative to encourage and support the PIHPs' use of evidence-based, promising and best practices in Michigan. Financial support was provided through the Mental Health Block Grant to PIHPs to implement the federal Substance Abuse and Mental Health Services Administration (SAMHSA) recognized models of either Family Psycho-Education or Integrated Treatment for Co-occurring Disorders. The PIHP will implement and make available the SAMHSA models of Family Psycho-Education model and Integrated Treatment for Co-occurring Disorders one of several evidence based practices (EBPs) and ACT promising practices for adults with serious mental illness. The PIHP must have a co-occurring capable system of care for people who have mental health and substance use disorders. (See attachments P6.7.4.1 Integrated Dual Disorders Treatment (IDDT) Services and P6.7.4.2 Family Psychoeducation (FPE) Services)

In addition, the PIHPs must adopt and make available other evidence-based, promising and best practices for adults with serious mental illness, and children and adolescents with serious emotional disturbance, and persons with developmental disabilities. For adults with serious mental illness these may include but are not limited to the Family Psycho-Education model; the Co-occurring Disorders program; the SAMHSA model of supported employment; medication algorithms, best practices in consumer-operated services; innovative collaborative efforts between the mental health service delivery system and other providers and sectors of the community, including: homeless services providers, Department of Human Services (DHS), judiciary and the criminal justice system, substance abuse providers, primary health care providers, and refugee services groups. or other evidence-based or promising practices. For children and adolescents these may include the Parent Management program; best practice home-based and wraparound approaches; innovative collaborative efforts between the mental health service delivery system and other providers and sectors of the community, including: child welfare organizations, DHS, judiciary and the criminal justice system and substance abuse providers. or other evidence-based or promising practices. For persons with developmental disabilities best practices may include, but are not limited to, supports for competitive employment, independent living, and community participation. (MI Standards are contained in Attachment 6.7.1.1)

6.7.5 ARR Quality Improvement Goals

In FY 10, MDCH will review jointly with each PIHP, their responses to the ARR for development of quality improvement goals to be included in the FY 11 contract.

6.8 Service and Utilization Management

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

6.8.1 Beneficiary Service Records

The PIHP shall establish and maintain a comprehensive individual service record system consistent with the provisions of MSA Policy Bulletins, and appropriate state and federal statutes. The PIHP shall maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided. The records shall be retained for a minimum 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 PIHP's provider agencies.

6.8.2 Other Service Requirements

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

- A. Inclusion Practice Guideline (Attachment P 6.8.2.1)
- B. Housing Practice Guideline (Attachment P 6.8.2.2)
- C. Consumerism Practice Guideline (Attachment P 6.8.2.3)
- D. Personal Care in Non-Specialized Home Guideline (Attachment P 6.8.2.4)

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

6.8.3 Coordination

The PIHP shall assure that services to each recipient are coordinated with primary health care providers', including Medicaid Health Plans, and other service agencies in the community that are serving the individual. In this regard, the PIHP will implement practices and agreements described in Section 6.4.4 of this contract.

6.8.4 Jail Diversion

The PIHP shall provide services designed to divert beneficiaries that qualify for MH/DD specialty services from a possible jail incarceration, when appropriate. Such

services should be consistent with the Jail Diversion Practice Guideline. The PIHP will collect data reflective of jail diversion activities and outcomes as indicated in the Practice Guideline (Attachment P 6.8.4.1).

6.8.5 School-to Community Transition

The PIHP 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 MDCH School-to-Community Transition Guideline (Attachment P 6.8.5.1).

6.8.6 Advance Directives

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

6.9 Regulatory Management

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

7.0 CONTRACT FINANCING

The provisions provided in the following subsections describe the financing arrangements in support of this contract. An estimate of the funding to be provided by the MDCH to the PIHP is included as Attachment P 7.0.1 to this contract.

The PIHP agrees to provide to the MDCH, for deposit into a separate contingency account, local funds as authorized in the State Appropriations Act. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients

or the state matching portion of the Medicaid capitation payments made to a CMHSP or an affiliation of CMHSPs. The amount of such funds and payment schedule is provided in Attachment P 7.0.1.

The rates included in attachment P7.0.1 are in effect with the initial contract. Rates may be revised without formal amendment of the contract when these revisions are actuarially certified, approved by CMS are necessary to comply with the requirements of an Executive Order or MDCH appropriations and are incorporated by reference in this contract when transmitted in writing to the PIHP.

The Department of Health and Human Services (HHS), United States Comptroller General or their representatives must have access to books, documents, etc., of the PIHP.

7.1 Local Obligation

The PIHP shall provide the local financial obligation for those Medicaid funds and covered specialty services determined to require local match, as required by the Mental Health Code. In the event a PIHP is unable to provide the required local obligation, the PIHP shall notify the MDCH immediately.

7.1.A. If a state appropriations Act permits the contribution from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation payments, the PIHP shall provide on a quarterly basis the PIHP obligation for local funds as a bona fide source of match for Medicaid. The payment dates and amounts are shown in a schedule in Attachment P 7.0.1.

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

7.2 Revenue Sources for Local Obligation

The following are potential revenue sources for the PIHP's local obligation for Medicaid funds/services (if any):

A. County Appropriations

Appropriations of general county funds to the PIHP by the County Board of Commissioners

B. Other Appropriations and Service Revenues

Appropriations of funds to the PIHP or its contract agencies by cities or townships; funds raised by fee-for-service contract agencies and/or network providers as part of the agencies' contractual obligation, the intent of which is to satisfy and meet the local match obligation of the PIHP, as reflected in this contract

C. 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

D. Special Fund Account

Funds of participating PIHPs from the Community Mental Health Special Fund Account consistent with Section 226a of the Michigan Mental Health Code. The Supplemental Security Income (SSI) benefit received by some residents in adult foster care homes is a Federal income supplement program designed to help aged, blind, and disabled people, who have little or no income. It provides cash to meet basic needs for food, clothing, and shelter. SSI income shall not be collected or recorded as a recipient fee or third-party reimbursement for purposes of Section 226a of the Mental Health Code. This includes the state supplement to SSI.

E. Investment Interest

Interest earned on funds deposited or invested by or on behalf of the PIHP, except as otherwise restricted by GAAP or OMB circular A-87. Also, interest earned on MDCH funds by contract agencies and/or network providers as specified in its contracts with the PIHP.

F. Other Revenues for Mental Health Services

As long as the source of revenue is not federal or state funds, revenues from other county departments/funds (such as child care funds) or revenues from public or private school districts for PIHP mental health services.

G. Grants or Gifts Exclusions

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

An exception may be made, where the PIHP can demonstrate that such funds constitute a transfer of grants or gifts made for the purposes of financing mental health services, and are not made possible by PIHP payments to the contract agency that are claimed as matchable expenses for the purpose of state financing.

7.3 Local Obligations - Requirement Exceptions

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

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

7.4 MDCH Funding

MDCH funding includes both Medicaid funds related to the 1915(b) Waiver and funds connected to the 1915(c) Habilitation Supports Waiver. The financing in this contract is always contingent on the annual Appropriation Act. The PIHP may use GF formula funds to provide services not covered under the 1915(b) and 1915(c) Medicaid Habilitation Supports waivers for Medicaid beneficiaries who are individuals with serious mental illness, serious emotional disturbances or developmental disabilities, or underwrite a portion of the cost of covered services to these beneficiaries if Medicaid payments for services to the CMHSP is exhausted. PIHP affiliate members (CPSSNs) that are under subcontract with the PIHP may use GF formula funds to provide services not covered under the 1915(b) and 1915(c) Medicaid Habilitation Supports waivers for Medicaid beneficiaries who are individuals with serious mental illness, serious emotional disturbances or developmental disabilities, or underwrite a portion of the cost of covered services to these beneficiaries that when the contract with the PIHP stipulates conditions regarding such use of General Funds. MDCH reserves the right to disallow such use of General Funds if it believes that the PIHP-CMHSP contract conditions were not met, or if it believes that the CMHSP was not appropriately assigning costs to Medicaid and to General Funds in order to maximize the savings allowed within the risk corridors.

CMS approved the actuarial soundness of the capitation rates as specified in the rules contained in the Balanced Budget Act for Managed Care via an approval letter on December 22, 2003. CMS has required that BBA compliant, actuarially sound rates, and capitation payments be made since January 1, 2004.

Since FY 2011, the MDCH has provided the PIHP two managed care payments each month for the Medicaid covered specialty services. One payment is based on all Medicaid eligibles within the PIHP region. This payment covers payments for MH/DD and SA state plan and alternative (B3) services. The second payment is based on a subset of Medicaid eligibles that are also enrolled in the Habilitation Supports C-waiver.

Specific financial detail regarding the MDCH funding is provided as Attachment P 7.0.1.

7.4.1 Medicaid

The MDCH shall provide to the PIHP both the state and federal share of Medicaid funds as a capitated payment based upon a per eligible per month (PEPM) methodology. The MDCH will provide access to an electronic copy of the names of

the Medicaid eligible people for whom a capitation payment is made. A PEPM is determined for each of the populations covered by this contract, which includes services for people with a developmental disability, a mental illness or emotional disturbance, and people with a substance use disorder as reflected in this contract.

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

Beginning with the first month of this contract, the PIHP shall receive a pre-payment equal to one month.

The MDCH shall not reduce the PEPM to the PIHP to offset a statewide increase in the number of Medicaid eligibles.

The Medicaid per eligible per month (PEPM) rates, effective October 1, 2010 are attached to this contract, Attachment 7.0.1. The actual number of Medicaid eligibles shall be determined monthly and the PIHP shall be notified of the eligibles in their service area via the pre-payment process.

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

7.4.1.1 Medicaid Rate Calculation

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

The Medicaid Rate Calculation is based on the actuarial documentation letter from Milliman USA. Two sets of rate calculations are required: 1) one set of factors for the 1915(b) state plan and 1915(b)(3) services and 2) one set of factors for 1915 (c) Habilitation Supports Waiver services. The capitation rates for FY 2011 are based on recipients with scope/coverage codes 1D/2D/1F/2F/1K/2K/1P/1T/2T, The Milliman USA letter documents the calculation rate methodology and provides the required certification regarding actuarial soundness as required by the Balanced Budget Act Rules effective August 13, 2002. The chart of rates and factors contained in the actuarial documentation is included as Attachment P.7.0.1.

Several groups of Medicaid eligibles are excluded from the capitation methodology/payments. The groups are identified in sections 7.4.1.3 and

7.4.1.4. In addition, the rate calculations and payments excluded eligibility months associated with periods of retro-eligibility. The PIHP is responsible for service to these individuals and may use their Medicaid funding for such services, except for that period of time each month prior to when the individual is spent-down.

The MDCH shall not reduce the 1915(b), 1915(b)(3) PEPM or the C-waiver rates to the PIHP to offset a statewide increase in the number of Medicaid eligibles.

7.4.1.2 Medicaid Payments

MDCH will provide the Prepaid Inpatient Health Plan (PIHP) two managed care payments each month for the Medicaid covered specialty services.

7.4.1.3 Medicaid State Plan and (b)(3) Payments

The capitation payment for the state plan and (b)(3) Mental Health, Developmental Disability and Substance Abuse services is based on all Medicaid eligibles within the PIHP region, excluding Children's Waiver enrollees and persons residing in a ICF/MR-DD (MPC/CARO) or individuals enrolled in a Program for All Inclusive Care (PACE) organization. SED waiver enrollees, individuals incarcerated and individuals on Spend-down. The capitation payment will be adjusted each for recovery of payments for Medicaid eligibles who DCH has subsequently been notified of their date of death. The primary PIHP payments will be scheduled based on the second Thursday following the first Wednesday of the month. . When applicable, additional payments may be scheduled (i.e. retro-rate implementation). HIPAA compliant 834 and 820 transactions will provide eligibility and remittance information.

7.4.1.4 1915(c) Habilitation Supports Waiver Payments

The 1915(c) Habilitation Supports Waiver capitation payment will be made to PIHPs based on all Medicaid eligibles within the PIHP region, excluding Children's Waiver enrollees, persons residing in a ICF/MR-DD (MPC/CARO) individuals enrolled in a Program for All Inclusive Care (PACE) organization. SED Waiver enrollees, and individuals incarcerated who are also enrolled in the 1915(c) HSW, The HSW payment will include payment for months associated with periods of retro-eligibility including persons who met the spend-down requirements for a prior month. Additionally, the capitation payment will be adjusted each month for 1) recovery of payments for Medicaid eligibles who DCH has subsequently been notified of their date of death and 2) recovery of payments previously made on behalf of Medicaid eligibles enrolled in the HSW who, upon a retrospective review did not meet all the HSW enrollment criteria e. g. did not receive a 1915 (c) service within the payment month. This HSW payment will be scheduled the third Thursday following the

first Wednesday of the month. When applicable, additional payments may be scheduled (i.e. retro-rate implementation). - HIPAA compliant 834 and 820 transactions will provide eligibility and remittance information. Encounters submitted on a HIPAA compliant 837 will be used to verify receipt of service.

Continued HSW enrollment and monthly 1915(c) capitation payment will be made only for individuals who meet all of the following criteria:

- (a) Are full-coverage Medicaid beneficiaries (Scope/Coverage codes 1/F or 2/F) during the month for which the capitation payment is to be made. Note: the system has been coded to make retroactive capitation payments for past months on behalf of HSW enrollees who become full coverage after Medicaid “card cut off,” e.g., spend-downs or retro-eligible per DHS.
- (b) Are enrolled in the 1915(c) waiver program, with waiver certificates and all supporting documentation up-to-date for the month in which the capitation payment is made.
- (c) Receive at least one 1915(c) HSW service in the month for which the capitation payment is to be made.
- (d) Live in a community setting and receive an HSW service at least one day during the month, e.g., cannot live in a nursing facility or Mt. Pleasant Center during an entire month.

The 1915(c) waiver payment process will permit payments based on county of financial responsibility (COFR) for persons who are enrolled with the PIHP but reside outside of the PIHP area. The HSW cap payments made will be to the COFR at the county of residence PIHP’s rate, i.e., computed using that PIHP’s geographical factor.

The requirement to verify receipt of a HSW service each month will be done using the encounter data reported on the 837 encounter transaction file. In order to assure timely HSW service verification, PIHPs must report the service within 90 days of provision regardless of claim adjudication status.

MDCH personnel reviews PIHP enrollment information and approves (within the constraint of the total yearly number of available waiver certificates and targeted populations) those that are in compliance with waiver enrollment qualifications and requirements.

MDCH personnel reviews all disenrollments from the HSW prior to the effective date of the action.

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

- 1) the PIHP has presented no suitable candidate for enrollment in the HSW within 60 days of the certificate being vacated; and,

- 2) there is a high priority candidate (person exiting the ICF/MR or graduating from the Children's Waiver Program) in another PIHP where no certificate is available. The MDCH has submitted an "attrition replacement" amendment request in an attempt to offset the potential for the 7,900 enrollee cap to cause under-spending due to attrition. If approved, that amendment will increase the c-value above the current 7,900 and allow the PIHPs, consistent with the MDCH's enrolled month and cost caps for each PIHP, to "fill in behind" attrition with new beneficiaries.

The MDCH will work with PIHPs that request to redirect a portion of their current state general funds allocation to support, i.e., provide the state match share, additional waiver certificates. Such requests would include the Purchase of Services general funds freed up by the PIHP's net reduction of utilized DD Center days. Addition of waiver certificates is dependent on CMS approval of an amendment to the 1915(c) waiver to increase the c-value which will allow additional waiver enrollments.

PIHPs that receive payments in excess of their identified dollar expenditure cap for the fiscal year will incur reductions in general fund allocation to cover costs for the state share of payments received.

7.4.1.5 Expenditures for Medicaid 1915 state plan, 1915(b)(3) and 1915(c) services

On a month-to-month basis, the PIHP can flexibly and interchangeably expend capitation payments received through the three sources or "buckets." Once capitation payments are received, the PIHP may spend any funds received on 1915(b) state plan services, (b)(3) services, or 1915(c) waiver services. All funds must be spent on Medicaid beneficiaries for Medicaid services.

While there is flexibility in month-to-month expenditures and service utilization related to the three "buckets," the PIHP must :

- a. Submit encounter data on service utilization - with transaction code modifiers that identify the service as 1915(b) state plan, (b)(3) services, or 1915(c) services – and this encounter data (including cost information) will serve as the basis for future 1915(b) state plan, (b)(3) services, and 1915(c) waiver capitation rate development.
- b. The PIHP has certain coverage obligations to Medicaid beneficiaries under the 1915(b) waiver (both state plan and (b)(3) services), and to enrollees under the 1915(c) waiver. It must use capitation payments to address these obligations.
- c. The PIHP must monitor and track expenditures on 1915(b) state plan services, (b)(3) services, and 1915(c) services and assure that aggregate expenditures for (b)(3) services do not grow or rise faster

than the respective aggregate expenditures for 1915(b) state plan and 1915(c) services.

7.4.2 Special and/or Designated Funds: Inclusions

The Medicaid PEPM financing as well as state GF formula funds, which are included in a separate contract, may include funds that were previously earmarked as special and/or designated funds. These funds shall continue to be expended for the purpose that they were earmarked and may not be re-directed for any other use without prior written approval from the MDCH.

7.5 Operating Practices

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

- 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. OMB Circular A-87

7.6 Audits

The PIHP shall ensure the completion of an annual independent financial audit for each fiscal year that will clearly indicate the operating results for the reporting period and the financial position of the PIHP at the end of the fiscal year. A copy of this audit report, along with the management letter and the PIHP's response to the management letter, shall be submitted to MDCH within 30 days of receipt of the audit report by the PIHP board of directors.

The PIHP shall ensure the completion of a fiscal year end Financial Statement Audit conducted in accordance with Generally Accepted Auditing Standards (GAAS); and a **contract end date of September 30**. Compliance Examination conducted in accordance with the American Institute of CPA's (AICPA's) Statements on Standards for Attestation Engagements (SSAE) 10 - Compliance Attestation, and the CMH Compliance Examination Guidelines in Attachment P.7.6.1.

The PIHP shall submit to the MDCH the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDCH-funded programs, and management letter (if issued) with a response within nine months after the end of the PIHP's fiscal year end to:

Michigan Department of Community Health

Office of Audit
Quality Assurance and Review Section
P.O. Box 30479*
Lansing, Michigan 48909-7979

*** For Express Delivery:**
Capital Commons Center
400 S. Pine Street
Lansing, Michigan 48933

Alternatives to paper filing may be viewed at www.michigan.gov/mdch by selecting Inside Community Health – Office of Audit.

If the PIHP does not submit the required Financial Statement Audit Report, Compliance Examination Report, management letter (if issued) with a response, and Corrective Action Plan within nine months after the end of the PIHP's fiscal year and an extension has not been approved by MDCH, MDCH 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 MDCH. MDCH may retain the amount withheld if the PIHP is more than 120 days delinquent in meeting the filing requirements and an extension has not been approved by MDCH.

MDCH shall issue a management decision on findings and questioned costs contained in the PIHP 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 is sustained; the reasons for the decision; the expected PIHP action to repay disallowed costs, make financial adjustments, or take other action; and a description of the appeal process available to the PIHP. Prior to issuing the management decision, MDCH may request additional information or documentation from the PIHP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs.

The appeal process available to the PIHP relating to MDCH management decisions on Compliance Examination findings and disallowed costs is included in Attachment P.7.6.2.

7.7 Financial Planning

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

7.7.1 Risk Corridor

Funding from other sources or arrangements identified as funding formula, categorical, all fee-for-service, PECPM MICHild and Adults Benefits Waiver payments are completely excluded from the shared-risk arrangement, as the PIHP assumes full risk of operating within the boundaries of the approved expenditure and

revenue budgets of each of these funding arrangements. The shared risk arrangements shall cover all Medicaid 1915, 1915(b)(3) capitation and 1915(c) Habilitation Supports Waiver payments. The risk corridor is administered across all services, with no separation for mental health and substance abuse funding

- A. The PIHP shall retain unexpended risk-corridor-related funds between 95% and 100% of said funds. The PIHP shall retain 50% of unexpended risk-corridor related funds between 90% and 95% of said funds. The PIHP shall return unexpended risk-corridor-related funds to the MDCH between 0% and 90% of said funds and 50% of the amount between 90% and 95%.
- B. The PIHP may retain funds noted in 7.7.1.A, except as specified in Part 1, section 13.0 “Closeout”
- C. The PIHP shall be financially responsible for liabilities incurred above the risk corridor-related operating budget between 100% and 105% of said funds contracted.
- D. The PIHP shall be responsible for 50% of the financial liabilities above the risk corridor-related operating budget between 105% and 110% of said funds contracted.
- E. The PIHP shall not be financially responsible for liabilities incurred above the risk corridor-related operating budget over 110% of said funds contracted.

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

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

“The PIHP financial responsibility for liabilities for costs between 100% and 110% must be paid from the following sources: first, if the PIHP has an ISF for risk funding or insurance for cost over-runs, that must be used before any other funds.

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

7.7.2 Savings and Reinvestment

Provisions regarding the Medicaid savings and the PIHP reinvestment strategy are included in the following subsections. It should be noted that only a PIHP may earn and retain Medicaid savings. CA’s and affiliate CMHSPs may not earn or retain Medicaid savings. 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 Remedies and Sanctions.

7.7.2.1 Medicaid Savings

The PIHP may retain unexpected Medicaid Capitation funds up to 7.5% of the Medicaid pre-payment authorization. These funds shall be included in the PIHP reinvestment strategy as described below. All Medicaid savings funds must be expended within one fiscal year following CMS approval of the reinvestment plan. In the event that a final MDCH audit report creates new Medicaid savings, the PIHP will have one year following the date of the final audit report to expend those funds according to Section 7.7.2.2. Unexpended Medicaid savings shall be returned to the MDCH as part of the year-end settlement process. MDCH will return the federal share of the unexpended savings to CMS.

7.7.2.2 Reinvestment Strategy - Medicaid Savings

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

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

7.7.2.3 Community Reinvestment Strategy

Services and supports must be directed to the Medicaid population. Community reinvestment plans to provide services contained in the State Medicaid Manual do not require prior approval. Prior approval by MDCH and CMS is required for all other expenditures in the community reinvestment plan. Community reinvestment funds are to be invested in accordance with the following criteria:

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

- A. Expansion or continuation of existing state plan or 1915(b)(3) approved treatment, support and/or service models to address projected demand increases.
- B. Community education, prevention and/or early intervention initiatives.
- C. Treatment, support and/or service model research and evaluation.

D. The PIHP may use up to 15% of Medicaid savings for administrative capacity and infrastructure extensions, augmentations, conversions, and/or developments to: (1) assist the PIHP (as a PIHP) to meet new federal and/or state requirements related to Medicaid or Medicaid-related managed care activities and responsibilities; (2) implement consolidation or reorganization of specific administrative functions related to the Application for Participation and pursuant to a merger or legally constituted affiliation; or (3) initiate or enhance recipient involvement, participation, and/or oversight of service delivery activities, quality monitoring programs, or customer service functions.

E. Identified benefit stabilization purposes. Benefit stabilization is designed to enable maintenance of contracted benefits under conditions of changing economic conditions and payment modifications. This enables the PIHP to utilize savings to assure the availability of benefits in the following year.

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

7.7.3. Risk Management Strategy

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

7.7.4. PIHP Assurance of Financial Risk Protection

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

The PIHP may use one or a combination of measures to assure financial risk protection, including pledged assets, reinsurance, and creation of an ISF. The use of an ISF in this regard must adhere to Attachment P 7.7.4.1, and must be reported to the MDCH as required by the financial reporting requirements of this contract.

The PIHP will submit a specific written Risk Management Strategy to the Department within sixty days of signing this contract. The Risk Management strategy will identify the amount of reserves, insurance and other revenues to be used by the PIHP to assure that its risk commitment is met. Whenever General Funds are included as one of the listed revenue sources, MDCH may disapprove the list of revenue sources, in whole or in part, after review of the information provided and a meeting with the PIHP. Such a

meeting will be convened within 45 days after submission of the risk management strategy. If disapproval is not provided within 60 days following this meeting, the use of general funds will be considered to be allowed. Such disapproval will be provided in writing to the PIHP within 60 days of the first meeting between MDCH and the PIHP. Should circumstances change, the PIHP may submit a revision to its Risk Management Strategy at any time. MDCH will provide a response to this revision, when it changes the PIHPs intent to utilize General Funds to meet its risk commitment, within 30 days of submission.

7.8 Finance Planning, Reporting and Settlement

The PIHP shall provide financial reports to the MDCH as specified in this contract, and on forms and formats specified by the MDCH. Forms and instructions are posted to the DCH website at: http://www.michigan.gov/mdch/0,1607,7-132-2941_38765---,00.html (See attachment P7.8.1, Finance Planning, Reporting and Settlement)

For FY 11, two Financial Status Reports (FSR) reporting requirements will be changed:

- 1) A Mid-Year Status Report will be due May 31 and the FSR submission requirement is eliminated. A workgroup will provide consultation on the Mid-Year Status report format and instructions.
- 2) The third quarter financial status reports (FSRs) noted in attachment 7.8.1 covering October 1st through June 30th (actual accrued revenues and expenses) and the full year projection FSR are due August 15th. These reports are intended to represent actual expenditures through June 30, 2011. The CMHSP or PIHP has the option of using May 31st YTD accrued expenditures for both the nine month report and full year projection if it is not feasible to use expenditures through June.

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

The following legal expenses are UNALLOWABLE:

- 1) Where the Michigan Department of Community Health (MDCH) or the

Centers for Medicare & Medicaid Services (CMS) takes action against the provider by initiating an enforcement action or issuing an audit finding, then the legal costs of responding to the action are unallowable except as noted in the following circumstances.

a) The PIHP/CMHSP prevails and the action is reversed.

Example: The audit finding is not upheld and the audit adjustment is reversed.

b) The PIHP/CMHSP prevails as defined by reduction of the contested audit finding(s) by 50 percent or more.

Example: An audit finding for an adjustment of \$50,000 is reduced to \$25,000. Or, in the case of several audit findings, a total adjustment of \$100,000 is reduced to \$50,000.

c) The PIHP/CMHSP enters into a settlement agreement with MDCH or CMS prior to any Hearing.

2) Legal expenses for the prosecution of claims against the State of Michigan or the Federal Government.

3) Legal expenses contingent upon recovery of costs from the State of Michigan or the Federal Government.

7.10 Performance Objective

The performance objective for Sections 3.1F and 3.1G are included in Attachment P 7.0.2

8.0 CONTRACT REMEDIES AND SANCTIONS

The state will utilize a variety of means to assure compliance with contract requirements and with the provisions of Section 330, 1232(b) of Michigan's Mental Health Code, regarding Specialty Prepaid Inpatient Health Plans. The state will pursue remedial actions and possibly sanctions as needed to resolve outstanding contract violations and performance concerns. The application of remedies and sanctions shall be a matter of public record. If action is taken under the provisions of Section 330, 1232(b) of the Mental Health Code, an opportunity for a hearing will be afforded the PIHP, consistent with the provisions of Section 330, 1232(b)(6).

The MDCH will utilize actions in the following order:

- A. Notice of the contract violation and conditions will be issued to the PIHP with copies to the Board.
- B. Require a plan of correction and specified status reports that becomes a contract performance objective.
- C. If previous items above have not worked, impose a direct dollar penalty and make it a non-matchable PIHP administrative expense and reduce earned savings from that fiscal year by the same dollar amount.
- D. For sanctions related to reporting compliance issues, MDCH may delay up to 25% of scheduled payment amount to the PIHP until after compliance is achieved. MDCH

may add time to the delay on subsequent uses of this provision. (Note: MDCH may apply this sanction in a subsequent payment cycle and will give prior written notice to the PIHP)

- E. Initiate contract termination.

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

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

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

9.0 RESPONSIBILITIES OF THE DEPARTMENT OF COMMUNITY HEALTH

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

9.1 General Provisions

- A. Notify the PIHP of the name, address, and telephone number, if available, of all Medicaid eligibles in the service area. The PIHP will be notified of changes, as they are known to the MDCH.

- B. Provide the PIHP with information related to known third-party resources and any subsequent changes as the department becomes aware of said information. Notify the PIHP of changes in covered services or conditions of providing covered services.
- C. Protect against fraud and abuse involving MDCH funds and recipients in cooperation with appropriate state and federal authorities.
- D. Administer a Medicaid fair hearing process consistent with federal requirements.
- E. Collaborate with the PIHP on quality improvement activities, fraud and abuse issues, and other activities that impact on the services provided to individuals.
- F. Conduct an individual quality-of-life survey and publish the results.
- G. Review PIHP marketing materials.
- H. Apply contract remedies necessary to assure compliance with contract requirements.
- I. Monitor the operation of the PIHP to ensure access to quality care for all individuals in need of and qualifying for services.
- J. Monitor quality of care provided to individuals who receive PIHP services and supports.
- K. Refer local issues back to the PIHP.
- L. Monitor, in aggregate, the availability and use of alternative services.
- M. Coordinate efforts with other state departments involved in services to the population.
- N. When repeated health and welfare issues/emergencies are raised or concerns regarding timely implementation of medically necessary services the MDCH authority to take action is acknowledged by the PIHP. During FY 10 MDCH will issue a protocol that addresses what actions will be taken.

9.2 Contract Financing

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

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

- A. Action by the Michigan State Legislature or by the Center for Medicare and Medicaid Services that removes any MDCH funding for, or authority to provide for, specified services.
- B. Action by the Governor pursuant to Const. 1963, Art. 5, 320 that removes the MDCH's funding for specified services or that reduces the MDCH'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 MDCH shall issue an amendment to this contract reflective of the above condition.

9.3 Reviews and Audits

The MDCH will and federal agencies may conduct reviews and audits of the PIHP regarding performance under this contract. The MDCH shall make good faith efforts to coordinate reviews and audits to minimize duplication of effort by the PIHP.

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

MDCH 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.

The MDCH may inspect and audit any financial records of the PIHP or its subcontractors.

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

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

Reviews and audits shall be conducted according to the protocols in section P.9.3.1, except when conditions appear to be severe and warrant deviation or when state or federal laws supersede these protocols.

9.3.1 MDCH Reviews

- A. As used in this section, a review is an examination or inspection by the MDCH or its agent, of policies and practices, in an effort to verify compliance with requirements of this contract.
- B. The MDCH 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 9.3.1 (A) above, the guideline, protocol and/or instrument to be used to review the PIHP, or a detailed agenda if no protocol exists, shall be provided to the PIHP at least 30 days prior to the review.
- D. At the conclusion of the review, the MDCH shall conduct an exit interview with the PIHP. The purpose of the exit interview is to allow the MDCH to present the preliminary findings and recommendations.
- E. Following the exit review, the MDCH shall generate a report within 45 days identifying the findings and recommendations that require a response by the PIHP.
 - 1. The PIHP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The PIHP may also present new information to the MDCH that demonstrates it was in compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the exit interview and the POC). When access or care to individuals is a serious issue, the PIHP may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified in C above.
 - 2. The MDCH will review the POC, seek clarifying or additional information from the PIHP as needed, and issue an approval of the POC within 30 days of having required information from the PIHP. The MDCH will take steps to monitor the PIHP's implementation of the POC as part of performance monitoring.
 - 3. The MDCH 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 PIHP can appeal findings reflected in review reports through the dispute resolution process identified in this contract.

9.3.2 MDCH Audits

- A. The MDCH and/or federal agencies may inspect and audit any financial records of the entity or its subcontractors. As used in this section, an audit is an examination of the PIHP's, its affiliates', and its contract service providers' financial records, policies, contracts, and financial management practices, conducted by the MDCH Office of Audit or its agent, or by a federal agency or its agent, to verify the PIHP's compliance with legal and contractual requirements.
- B. The MDCH will schedule MDCH audits at mutually acceptable start dates to the extent possible. The MDCH will provide the PIHP with a list of documents to be audited at least 30 days prior to the date of the audit. An entrance meeting will be conducted with the PIHP to review the nature and scope of the audit.
- C. MDCH audits of PIHPs will generally include the following (3) objectives (The MDCH may, however, modify their audit objectives as deemed necessary):
 - 1. to assess the PIHP's effectiveness and efficiency in complying with the contract and establishing and implementing specific policies and procedures as required by the contract; and
 - 2. to assess the PIHP's effectiveness and efficiency in reporting their financial activity to the MDCH in accordance with contractual requirements; applicable federal, state, and local statutory requirements; Medicaid regulations; and applicable accounting standards; and
 - 3. to determine the MDCH's share of costs in accordance with applicable MDCH requirements and agreements, and any balance due to/from the PIHP.

To accomplish the above listed audit objectives, MDCH auditors will review PIHP documentation, interview PIHP staff members, and perform other audit procedures as deemed necessary.

- D. The audit report and appeal process is identified in Attachment 9.3.2.1 and is a part of this contract.

As used in this section, an audit is an examination of the PIHP and their contract service providers' financial records, policies, contracts, and financial management practices, conducted by the MDCH Office of Audit or its agent, to verify the PIHP's compliance with legal and contractual requirements.

- A. The MDCH will schedule audits at mutually acceptable start dates to the extent possible. The MDCH will provide the PIHP with a list of documents to be audited at least 30 days prior to the date of the audit. An entrance meeting will be conducted with the PIHP to review the nature and scope of the audit.

- B. The MDCH audits of PIHPs will generally supplement the independent auditor's Compliance Examination and may include one or more of the following objectives:
 - 1. To assess the PIHP's effectiveness and efficiency in complying with the contract, and establishing and implementing specific policies and procedures as required by the contract;
 - 2. To assess the PIHP's effectiveness and efficiency in reporting their financial activity to the MDCH in accordance with contractual requirements; applicable federal, state, and local statutory requirements; Medicaid regulations; and applicable accounting standards; and
 - 3. To determine the MDCH's share of costs in accordance with applicable MDCH requirements and agreements, and any balance due to/from the PIHP.

To accomplish the above listed audit objectives, MDCH auditors will review PIHP documentation, interview PIHP staff members, and perform other audit procedures as deemed necessary.

- C. The audit report and appeal process is identified in Attachment P 9.3.2.1 and is a part of this contract.

9.3.3 Imposition of Sanctions

As specified in Michigan Mental Health Code: 330.1232b Specialty Prepaid Health Plans, "the MDCH may invoke sanctions if it makes a determination that a specialty prepaid health plan is not in substantial compliance with promulgated standards and with established federal regulations, that the specialty prepaid health plan has misrepresented or falsified information reported to the state or to the federal government, or that the specialty prepaid health plan has failed substantially to provide necessary covered services to recipients under the terms of the contract. Sanctions may include intermediate actions including, but not limited to, a monetary penalty imposed on the administrative and management operation of the specialty prepaid health plan, imposition of temporary state management of a community mental health services program operating as a specialty prepaid health plan, or termination of the department's Medicaid managed care contract with the community mental health services program.

Before imposing a sanction on a community mental health services program that is operating as a specialty prepaid health plan, the department shall provide that specialty prepaid health plan with timely written notice that explains both of the following:

- a) The basis and nature of the sanction.
- b) The opportunity for a hearing to contest or dispute the department's findings and intended sanction, prior to the imposition of the sanction. A hearing under this section is subject to the provisions governing a contested case under the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.201 to 24.328, unless otherwise agreed to in the specialty prepaid health plan contract.”

10.0 RESPONSIBILITIES OF THE DEPARTMENT OF ATTORNEY GENERAL

The MDCH has responsibility and authority to make all fraud and/or abuse referrals to the Office of the Attorney General, Health Care Fraud Division. Contractors who have any suspicion or knowledge of fraud and/or abuse within any of the MDCH's programs must report directly to the MDCH by calling (866) 428-0005 or by sending a memo to:

Program Investigations Section
Capitol Commons Center Building
400 S. Pine, 6th Floor
Lansing, MI 48909

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

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

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

In addition, the PIHP must report the following to the MDCH 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.

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION**

**Technical Requirement
For Behavior Treatment Plan Review Committees
FY10 Revision**

Application:

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

Preamble:

It is the expectation of the Michigan Department of Community Health (MDCH) 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.

MDCH will not tolerate violence perpetrated on the recipients of public mental health services 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 a 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 and interventions nor other kinds of interventions were successful, proposes restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee.

MDCH 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 MDCH 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 consequence 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 consequence 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**.

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. Use of intrusive techniques as defined here requires the review and approval by the Committee.

Peer-reviewed literature: Scholarly works that typically represent the latest original research in the field, research that has been generally accepted by academic and professional peers for dissemination and discussion. Review panels are comprised of other researchers and scholars who use criteria such as “significance” and “methodology” to evaluate the research. Publication in peer-reviewed literature does not necessarily mean the research findings are *true*, but the findings are considered authoritative *evidence* for a claim whose validation typically comes as the research is further analyzed and its findings are applied and re-examined in different contexts or using varying theoretical frameworks.

Physical Management: A technique used by staff to restrict the movement of an individual by direct physical contact in order to prevent the individual 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. Physical management, as defined here, shall not be included as a component of a behavior treatment plan. 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. Physical management involving prone immobilization of an individual for behavioral control purposes is **prohibited under any circumstances**. Prone immobilization is extended physical management of a recipient in a prone (face down) position, usually on the floor, where force is applied to the recipient’s 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 *quality of life* and decrease problem behavior by 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 problem behaviors such as self-injury, aggression, property destruction, pica, defiance, and disruption.

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

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 recipient 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.

- 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 prohibiting communication with others to achieve therapeutic objectives; prohibiting ordinary access to meals; 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 recipient, 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 recipient, guardian or parent of a minor recipient may only occur when the recipient 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 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 experience in applied behavior analysis; 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. The Committee shall keep all its meeting minutes, and clearly delineate the actions of the Committee.

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

G. 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 more intrusive or restrictive the interventions, or the more frequently they are applied, the more often the entire behavior treatment plan should be reviewed by the Committee.

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 service recipients.

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])

- H. On a quarterly basis track and analyze the use of all physical management 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., group home, day program) where behaviors and interventions occurred
 3. Behaviors that initiated the techniques.
 4. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
 5. Attempts to use positive behavioral supports.
 6. Behaviors that resulted in termination of the interventions.
 7. Length of time of each intervention.
 8. Staff development and training and supervisory guidance to reduce the use of these interventions.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's Quality Assessment and Performance Improvement Program or the CMHSP's Quality Improvement Program, and be available for MDCH review. Physical management, permitted for intervention in emergencies only, is considered a critical incident 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.

- I. In addition, the Committee may:
 1. Advise and recommend to the agency the need for specific staff training in positive behavioral supports and other 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. In addition, the Committee might recommend a limit for the number of emergency interventions that can be used with an individual in a defined period before the mandatory initiation of a process that includes assessments and evaluations, and possible development of a behavior treatment plan, as described in this requirement.
 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 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 change 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.
- C. Behavior treatment plans that propose to use physical management 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.

- 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 problem behavior.
 2. A functional 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 attempted 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, and where the intervention has limited or no support in the literature, why the plan is the best option available.
 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
Department of Community Health Administrative Rule 330.7199(2)(g)

PREPAID INPATIENT HEALTH PLANS AND COMMUNITY MENTAL HEALTH SERVICES PROGRAMS

ACCESS SYSTEM STANDARDS

Revised: August 2009

Preamble

It is the expectation of the Michigan Department of Community Health (MDCH) 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 MDCH 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, Adult Benefit Waiver (ABW), 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, ABW 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/mdch/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 service¹.
- 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 available².
 - 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

¹ MDCH Specialty Pre-Paid Health Plan 2002 Application for Participation (AFP), Section 3.1

² 42 CFR § 438.10 and 438.206. Michigan Mental Health Code, P.A. 258 of 1974 (MHC) §330.1206. MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.2. MDCH AFP, Section 3.1.8

- 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 needs³, 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 challenges⁴
- 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 served⁵.
- 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 completed⁶.

³ For definition of emergent and urgent situations, see MHC §330.1100a and 1100d

⁴ 42 CFR § 438.10. MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.2. MDCH AFP, Section 3.1.8

⁵ 42 CFR §438.114

⁶ MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.1 and Attachment 3.4.1.1; MCL 330.1706

II. SCREENING FOR CRISES

- a. Access system staff shall first determine whether the presenting mental health need is urgent, emergent or routine and, if so, will address emergent and urgent need first. To assure understanding of the problem from the point of view of the person who is seeking help, methods for determining urgent or emergent situations must incorporate “caller or client-defined” crisis situations. Workers must be able to demonstrate empathy as a key customer service method.
- b. The organization shall have emergency intervention services with sufficient capacity to provide clinical evaluation of the problem; to provide appropriate intervention; and to make timely disposition to admit to inpatient care or refer to outpatient services⁷. 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 applicable⁸.
- c. The access system shall inquire as to the existence of any established medical or psychiatric advance directives relevant to the provision of services⁹.
- d. The organization shall assure coverage and provision of post stabilization services for Medicaid beneficiaries once their crises are stabilized¹⁰. 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 MDCH/PIHP and MDCH/CMHSP contracts¹¹ and:
 - i. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the individual is a Medicaid beneficiary.
 - ii. The Adult Benefits Waiver (ABW) Chapter of the Medicaid Provider Manual, if the individual is an ABW beneficiary.
 - iii. The MICHild Provider Manual if the individual is a MICHild beneficiary.
 - iv. The Michigan Mental Health Code and the MDCH Administrative Rules, if the individual is not eligible for Medicaid, ABW or MICHild¹². CMHSPs shall serve individuals with serious mental

⁷ MDCH Administrative Rule 330.2006

⁸ MHC § 330.1206 and 1409

⁹ 42 CFR §438.6; MCL 700.5501 et seq

¹⁰ 42 CFR §438.114. MDCH/PIHP Contract, Part I, Section 1

¹¹ MDCH/PIHP & CMHSP Contracts, Part II, Section 3

¹² MHC §330.1208

- 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, MDCH expects that individuals with other diagnoses of mental disorders with a diagnosis found in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM)¹³, 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 MDCH/PIHP and MDCH/Substance Abuse Coordinating Agency (CA) contracts¹⁴ and:
 - i. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the individual is a Medicaid beneficiary.
 - ii. The Adult Benefits Waiver Chapter of the Medicaid Provider Manual, if the individual is an ABW beneficiary.
 - iii. The MICHild Provider Manual if the individual is a MICHild beneficiary.
 - iv. The priorities established in the Michigan Public Health Code, if the individual is not eligible for Medicaid, ABW or MICHild¹⁵.
 - 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 administered¹⁶.
 - 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 MDCH/PIHP specialty services and supports contract¹⁷.
 - 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.

¹³ 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](#)

¹⁴ MDCH/CA contract, Attachment A, Statement of Work, and Attachment E, Methadone Enrollment Criteria and Access Management Policy

¹⁵ Public Health Code P.A. 368 of 1978 §333.6100 and 6200 and MDCH Administrative Rule 325.14101

¹⁶ MDCH AFP, Section 3.1.5

¹⁷ MDCH/PIHP Contract, Part II, Section 3.4.3. Michigan Medicaid Provider Manual, Practitioner Chapter

- 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 source¹⁸.
- 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, ABW or MICHild, is placed on a 'waiting list' and why¹⁹.

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 physicians²⁰.

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 MDCH/PIHP and CMHSP contract-required standard timeframes²¹. 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 process²².
- 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

¹⁸ MHC §330.1208

¹⁹ MHC §330.1226

²⁰ 42 CFR §438.208

²¹ Choice of providers: 42 CFR §438.52. MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.4. Timeframes for access: Section 3.1

²² MDCH AFP, Section 3.2. MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.1 and Attachment 3.4.1.1

- services, to their Medicaid Health Plans²³ 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, ABW, or MICHild mental health and substance abuse services, nor who meet the priority population to be served criteria in the Michigan Mental Health Code or the Michigan Public Health Code for substance abuse services, to alternative mental health or substance abuse treatment services available in the community.
 - c. The access system shall provide information about other non-mental health community resources or services that are not the responsibility of the public mental health system to individuals who request it²⁴.

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 appropriate²⁵.

b. Rights

- i. The access system shall provide Medicaid, ABW and MICHild beneficiaries information about the local dispute resolution process and the state Medicaid Fair Hearing process²⁶. When an individual is determined ineligible for Medicaid specialty service and supports, ABW 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)²⁷. 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 Rights²⁸.

²³ 42 CFR §438.10

²⁴ MDCH AFP, Section 2.9

²⁵ MDCH AFP, Section 2.9

²⁶ 42 CFR § 438.10. MDCH/PIHP Contract, Part II, Section 6.3.2 and Attachment 6.3.2.1

²⁷ MHC §330.1706

²⁸ MDCH Administrative Rule 325.14302

- 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 process²⁹.
- 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 requested³⁰.
- v. The access system shall ensure the person and any referral source (with the person's consent) are informed of the reasons for denial, and shall recommend alternative services and supports or disposition³¹.

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 them³².
- 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 LEP³³.

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.³⁴
 - 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

²⁹ MHC §330.1706, MDCH/CMHSP Contract, Part II, Attachment 6.3.2.1

³⁰ MDCH/PIHP & CMHSP Contract, Part II, Section 3.4.5

³¹ 42 CFR § 438.10

³² 42 CFR § 438.10, MDCH/PIHP Contract, Part II, Section 6.3.3. MDCH AFP, Section 3.1.1

³³ 42 CFR § 438.10, MDCH/PIHP Contract, Part II, Section 6.3.3

³⁴ MDCH AFP, Section 3.1.2

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 contract³⁵.
- 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 time³⁶.
- 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 standards³⁷.
- 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 transportation³⁸.

d. Waiting Lists

- i. The organization shall have policies and procedures for maintaining a waiting list for individuals not eligible for Medicaid, ABW or MICHild, and who request community mental health services but cannot be immediately served³⁹. The policies and procedures shall minimally assure:
 - 1. No Medicaid, ABW and MICHild beneficiaries are placed on waiting lists for any medically necessary Medicaid, ABW or MICHild service.

³⁵ 42 CFR §438.214. MDCH/PIHP Contract, Part II, Attachment 6.7.1.1

³⁶ 42 CFR §438.10

³⁷ Michigan Medicaid Provider Manual, General Information Chapter, Section 13.1

³⁸ MDCH AFP, Section 3.1.10

³⁹ MHC §330.1124

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, ABW, or MICHild⁴⁰. 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, ABW, or MICHild, who receive services on an interim basis that are other than those requested shall be retained on the waiting list for the specific requested program services. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
4. Use of a defined process, consistent with the Mental Health Code, to prioritize any service applicants and recipients on its waiting list.
5. Use of a defined process to contact and follow-up with any individual on a waiting list who is awaiting a mental health service.
6. Reporting, as applicable, of waiting list data to MDCH as part of its annual program plan submission report in accordance with the requirements of the Mental Health Code.

⁴⁰ MHC §330.1208

PERSON-CENTERED PLANNING

REVISED PRACTICE GUIDELINE

October 2002

I. SUMMARY/BACKGROUND

The Michigan Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a person-centered planning process regardless of age, disability or residential setting. In the past, Medicaid or other regulatory standards have governed the process of plan development. These standards drove the planning process through requirements on the types of assessments to be completed and the professionals to be involved. Person-centered planning departs from this approach in that the individual directs the planning process with a focus on what he/she wants and needs. Professionally trained staff plays a role in the planning and delivery of treatment, and may play a role in the planning and delivery of supports. However, the development of the Individual Plan of Service, including the identification of possible services and professionals, is based upon the expressed needs and desires of the individual. Health and safety needs are addressed in the Individual Plan of Service with supports listed to accommodate those needs.

The Michigan Department of Community Health (MDCH) has advocated and supported a family approach to service delivery for children and their families. This approach recognizes the importance of the family and the fact that supports and services impact the entire family. Therefore, in the case of minors, the child/family is the focus of service planning, and family members are integral to the planning process and its success. The wants and needs of the child/family are considered in the development of the Individual Plan of Service.

Managed care strategies play an important role in planning for, and delivery of, supports, services and/or treatment. Person-centered planning complements these strategies. Both strategies intend to ensure that individuals are provided with the most appropriate services necessary to achieve the desired outcomes. When an individual expresses a choice or preference for a support, service and/or treatment for which an appropriate alternative of lesser cost exists, and compromise fails, a process for dispute resolution and appeal may be needed. This document provides guidelines for addressing disputes.

The literature describes specific methods for person-centered planning, including, but not limited to, individual service design, Personal Futures Planning, MAPS, Essential Lifestyle Planning, Planning Alternative Tomorrows With Hope, etc. This practice guideline does not support one model over another. It does, however, define the values, principals and essential elements of the person-centered planning process.

II. VALUES AND PRINCIPLES UNDERLYING PERSON-CENTERED PLANNING

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

- A. Each individual has strengths, and the ability to express preferences and to make choices.
- B. The individual's choices and preferences shall always be honored and considered, if not always granted.
- C. Each individual has gifts and contributions to offer to the community, and has the ability to choose how supports, services and/or treatment may help them utilize their gifts and make contributions to community life.
- D. Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals and desires.
- E. A person's cultural background shall be recognized and valued in the decision-making process.

III. PCP PRACTICE GUIDELINES

- A. Essential Elements
 - 1. Person-centered planning is a process in which the individual is provided with opportunities to reconvene any or all of the planning processes whenever he/she wants or needs.
 - 2. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate in the planning meeting(s) to assist the individual with his/her dreams, goals and desires.
 - 3. The development of natural supports shall be viewed as an equal responsibility of the CMHSP and the individual. The CMHSP, in partnership with the person, is expected to develop, initiate, strengthen, and maintain community connections and friendships through the person-centered process.
 - 4. The individual is provided with the options of choosing external independent facilitation of his/her meeting(s), unless the individual is receiving short-term outpatient therapy only, medication only, or is incarcerated.
 - 5. Before a person-centered planning meeting is initiated, a pre-planning meeting occurs. In pre-planning the individual chooses:

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- a. dreams, goals, desires and any topics about which he/she would like to talk
 - b. topics he/she does not want discussed at the meeting
 - c. who to invite
 - d. where and when the meeting will be held
 - e. who will facilitate
 - f. who will record
6. All potential support and/or treatment options (array of mental health services including Medicaid-Covered Services and Alternative Services and Mental Health Code-required services) to meet the expressed needs and desires of the individual are identified and discussed with the individual.
- a. Health and safety needs are identified in partnership with the individual. The plan coordinates and integrates services with primary health care.
 - b. The individual is provided with the opportunity to develop a crisis plan.
 - c. Each Individual Plan of Service must contain the date the service is to begin, the specified scope, duration, intensity and who will provide each authorized service.
 - d. Alternative services are discussed.
7. The individual has ongoing opportunities to express his/her needs and desires, preferences, and to make choices. This includes:
- a. Accommodations for communication, with choices and options clearly explained, shall be made.
 - b. To the extent possible, the individual shall be given the opportunity for experiencing the options available prior to making a choice/decision. This is particularly critical for individuals who have limited life experiences in the community with respect to housing, work and other domains.
 - c. Individuals who have court-appointed legal guardians shall participate in person-centered planning and make decisions that are not delegated to the guardian in the Guardianship Letters of Authority.
 - d. Service delivery shall concentrate on the child as a member of a family, with the wants and needs of the child and family integral to the plan developed. Parents and family members of minors shall participate in the person-centered planning process unless:
 - (1) 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;
 - (2) The minor is emancipated; or
 - (3) 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 Mental Health Code. Justification of the exclusion of parents shall be documented in the clinical record.

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8. Individuals are provided with ongoing opportunities to provide feedback on how they feel about the service, support and/or treatment they are receiving, and their progress toward attaining valued outcomes. Information is collected and changes are made in response to the individual's feedback.
9. Each individual is provided with a copy of his/her Individual Plan of Service within 15 business days after their meeting.

B. Illustrations of Individual Needs

Person-centered planning processes begin when the individual makes a request to the Community Mental Health Services Program (CMHSP). The first step is to find out from the individual the reason for his/her request for assistance. During this process, individual needs and valued outcomes are identified rather than requests for a specific type of service. Since person-centered planning is an individualized process, how the CMHSP proceeds will depend upon what the individual requests.

This guideline includes a chart of elements/strategies that can be used by the person representing the CMHSP, depending upon what the individual wants and needs. Three possible situations are:

1. The individual expresses a need that would be considered urgent or emergent.

When an individual is in an urgent/emergent situation, the goal is to get the individual's crisis situation stabilized. Following stabilization, the individual and CMHSP will explore further needs for assistance and if required, proceed to a more in-depth planning process as outlined below. It is in this type of situation where an individual's opportunity to make choices may be limited.

2. The individual expresses a need or makes a request for a support, service and/or treatment in a single life domain and/or of a short duration.

A life domain could be any of the following:

- a. Daily activities
- b. Social relationships
- c. Finances
- d. Work
- e. School
- f. Legal and safety
- g. Health
- h. Family relationships, etc.

3. The individual expresses multiple needs that involve multiple life domains for support(s), service(s) or treatment of an extended duration.

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The following chart represents the elements/strategies that can be used depending on the kinds of needs expressed by the individual.

<i>ELEMENTS/STRATEGIES</i>	<i>URGENT/ EMERGENT</i>	<i>SHORT DURATION</i>	<i>EXTENDED DURATION</i>
The individual expresses his/her needs and/or desires. Accommodations for communication will be made to maximize his/her ability for expression.	X	X	X
The individual's preferences, choices and abilities are respected.	X	X	X
Potential issues of health and safety are explored and discussed. Supports to address health and safety needs are included in the Individual Plan of Service.	X	X	X
As a result of health or safety concerns or court-ordered treatment, limitations may exist for individual choice. However, opportunities for individuals to express their perceived needs can occur and opportunities to make choices among limited options can be given.	X	X	X
Person-centered planning includes pre-planning activities. These activities result in the determination of whether in-depth treatment or support planning is necessary, and if so, to determine and identify the persons and information that need to be assembled for successful planning to take place.		X	X

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<i>ELEMENTS/STRATEGIES</i>	<i>URGENT/ EMERGENT</i>	<i>SHORT DURATION</i>	<i>EXTENDED DURATION</i>
<p>In short-term/outpatient service areas, the individual is provided with information on person-centered planning, including pre-planning at or before the initial visit. Individuals are encouraged to invite persons to the session where the plan is developed.</p>		X	
<p>In collaboration with the CMHSP, the individual identifies strategies and supports, services and/or treatment needed to achieve desired outcomes.</p>		X	X
<p>Exploration of the potential resources for supports and services to be included in the individual's plan are to be considered in this order:</p> <ul style="list-style-type: none"> The individual. Family, friends, guardian, and significant others. Resources in the neighborhood and community. Publicly-funded supports and services available for all citizens. Publicly-funded supports and services provided under the auspices of the Department of Community Health and Community Mental Health Services Programs. 		X	X
<p>Regular opportunities for individuals to provide feedback are available. Information is collected and changes are made in response to the individual's feedback.</p>		X	X

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<i>ELEMENTS/STRATEGIES</i>	<i>URGENT/ EMERGENT</i>	<i>SHORT DURATION</i>	<i>EXTENDED DURATION</i>
<p>The individual's support network is explored with that person to determine who can best help him/her plan. The individual and the persons he/she selects together define the individual's desired future, and develop a plan for achieving desired outcomes. For any individual with dementia or other organic impairments, this should include the identification of spouses or other primary care givers who are likely to be involved in treatment or support plan implementation.</p>			X
<p>The process continues during the planning meeting(s) where the individual and others he/she has selected who know him/her well talk about the desired future and outcomes concentrating on the life domains previously identified as needing change.</p>			X

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IV. ASSURANCES AND INDICATORS OF PERSON-CENTERED PLANNING IMPLEMENTATION

It is the responsibility of the CMHSP to assure that the Individual Plan of Service is developed utilizing a person-centered planning process. Below are examples of systemic and individual level indicators that would demonstrate that person-centered planning has occurred. The methods of gathering information or evidence may vary, and include the review of administrative documents, clinical policy and guidelines, case record review and interviews/focus groups with individuals and their families.

A. Systemic indicators would include, but not be limited to:

1. The CMHSP has a policy or practice guideline that delineates how person-centered planning will be implemented.
2. Evidence that the CMHSP informs individuals of their right to person-centered planning and associated appeal mechanisms, investigates complaints in this area, and documents outcomes.
3. Evidence that the CMHSP's quality improvement system actively seeks feedback from individuals receiving services, support and/or treatment regarding their satisfaction, providing opportunities to express needs and preferences and the ability to make choices.
4. The CMHSP's staff development plan includes efforts to ensure that staff involved in managing, planning and delivering support and/or treatment services are trained in the philosophy and methods of person-centered planning.

B. Individual indicators could include, but not be limited to:

1. Evidence the individual was provided with information of his/her right to person-centered planning.
2. Evidence that the individual chose whether or not other persons should be involved, and those identified were involved in the planning process and in the implementation of the Individual Plan of Service.
3. Evidence that the individual chose the places and times to meet, convenient to the individual and to the persons he/she wanted present.
4. Evidence that the individual had choice in the selection of treatment or support services and staff.

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5. Evidence that the individual's preferences and choices were considered, or a description of the dispute/appeal process and the resulting outcome.
6. Evidence that the progress made toward the valued outcomes identified by the individual was reviewed and discussed for the purpose of modifying the strategies and techniques employed to achieve these outcomes.

V. DISPUTE RESOLUTION/APPEAL MECHANISMS

VI. DEFINITIONS

Case Manager/Supports Coordinator - The staff person who works with the individual to gain access to and coordinate the services, supports and/or treatment that the individual wants or needs.

Emancipated Minor - The termination of the rights of the parents to the custody, control, services and earnings of a minor, which occurs by operation of law or pursuant to a petition filed by a minor with the probate court.

Emergency Situation - A situation when the individual can reasonably be expected, in the near future, to physically injure himself, herself, or another person; is unable to attend to food, clothing, shelter or basic physical activities that may lead to future harm, or the individual's judgment is impaired leading to the inability to understand the need for treatment resulting in physical harm to self or others.

Family Member - A parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer, or an individual upon whom a primary consumer is dependent for at least 50 percent of his or her financial support.

Guardian - A person appointed by the court to exercise specific powers over an individual who is a minor, legally incapacitated, or has developmental disabilities.

Individual Plan of Service - A written Individualized Plan of Service directed by the individual as required by the Mental Health Code. This may be referred to as a treatment plan or a support plan.

Minor - An individual under the age of 18 years.

Person-Centered Planning - 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 honor the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

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

VII. LEGAL REFERENCES:

Mental Health Code Act, 258 MI. §§ 409-1-7 (1974 & Supp. 1996).

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- Refer to the Technical Requirement

July 18, 2003

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Mental Health and Substance Abuse Services
SELF-DETERMINATION POLICY & PRACTICE GUIDELINE¹

INTRODUCTION

Self-determination incorporates a set of concepts and values that emphasize participation and the achievement of personal control for individuals served through the public mental health system. These concepts and values stem from a core belief that people who require support through the public mental health system must have freedom not only to define the life they seek, but to be supported to direct the assistance they require in pursuit of that life. Persons who rely on the public mental health system for necessary supports and services must have access to meaningful options from which to make choices, and be supported to control the course of their lives. Arrangements that support self-determination must be sponsored by the public mental health system, 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.

The methods applicable to self-determination provide a route for the person to engage in activities that accompany a meaningful life. Activities that promote deep community connections, the opportunity for real work, ways to contribute to one's community, and participation in personally-valued experiences must be among the purposes of supports the person may need. 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 consumers of the public mental health system. In Michigan, the flexibility provided through the Medicaid 1915(b) Specialty Services waiver, together with the Mental Health Code requirements of PCP, have reoriented organizations to respond in new and more meaningful ways. Recognition has

¹Language in ***bold italics*** indicates items that require action on the part of the CMHSP

increased among providers and professionals that many consumers 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 consumer to choose, participate in, and accomplish a life with personal meaning. This has meant, for example, reconstitution of segregated programs into non-segregated intervention options that connect better with community life.

However, the move away from predefined programmatic approaches and professionally managed models has many barriers. Conflicts of interest abound among many who manage the current system. 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. Even when options are expanded, the choices currently available seldom dissolve the isolation of people with disabilities, reduce the segregation, nor necessarily promote participation in community life and the realization of full citizenship rights.

The Department of Community Health is supportive of the desire of people who use the services of the public mental health system to have a full and meaningful role in controlling and directing their specialty mental health services and supports arrangements. 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, and to the provision of support, direction and technical assistance so the system may make successful progress to resolve technical difficulties and apparent barriers, 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 in order to assure that arrangements which support self-determination are made available as a means for achieving consumer-designed plans of specialty mental health services and supports.

CORE ELEMENTS

- I. Consumers are to be provided with information about the principles of self-determination and the possibilities, models and arrangements involved. Consumers shall have access to the tools and mechanisms supportive of self-determination, upon request. Self-determination arrangements shall commence when the CMHSP and the consumer reach an agreement on a plan of specialty mental health services and supports, the amount of mental health and other public resources to be authorized to accomplish the plan, 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, CMHSPs shall ensure that their services planning and delivery processes are designed to encourage and support consumers to decide and control their own lives. The CMHSP shall offer and support easily-accessed methods for consumers 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 consumer.
- III. Consumers of services of 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 plan as developed through a person-centered planning process.
- IV. Fiscal responsibility and the wise use of public funds shall guide the consumer and the CMHSP in reaching an agreement on the allotment and use of funds comprising an individual budget. Accountability for the use of public funds must be a shared responsibility of the CMHSP and the consumer, consistent with the fiduciary obligations of the CMHSP.
- V. Realization of self-determination principles requires arrangements that are partnerships between the CMHSP and the consumer. They require the active commitment of the CMHSP to provide a range of options for consumer choice and control of personalized provider relationships within an overall environment of person-centered supports.
- VI. In the context of this partnership, CMHSPs must actively assist consumers with prudently selecting qualified providers and otherwise support the consumer with successfully using resources allotted in an individual budget.
- VII. Issues of health, safety and well-being are central to assuring successful accomplishment of a consumer's plan of specialty mental health services and supports. These issues must be addressed and resolved using the person-centered planning process, balancing consumer preferences and opportunities for self-direction with CMHSP obligations under federal and state law and applicable Medicaid Waiver regulations. Resolutions should be guided by the consumer's preferences and needs, implemented in ways that maintain the greatest opportunity for consumer control and direction.
- VIII. Self-determination requires recognition that there may be strong inherent conflicts of interest between the consumer's choices and current methods of planning, managing and delivering specialty mental health services and supports. The 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 consumer.

- IX. Arrangements that support self-determination, allowing a consumer to choose, control and direct providers of specialty mental health services and supports, are not themselves covered services under the Speciality Mental Health Plan. They are administrative mechanisms. Self-determination arrangements must be developed and operated within the requirements of the Prepaid Health Plan contract between the CMHSP and the State of Michigan and in accordance with federal and state law. Involvement in self-determination does not change a consumer's eligibility for particular specialty mental health services and supports.

POLICY

- I. ***Opportunity to pursue and obtain a plan incorporating arrangements that support self-determination shall be established in each Community Mental Health Services Program, for adults with developmental disabilities and adults with mental illness. Each CMHSP shall develop and make available a set of methods that provide opportunities for the consumer 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 the consumer.
- B. Consumers 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 plan of specialty mental health services and supports.
- C. ***A 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 each consumer.*** This shall include specific examples of alternative ways that a consumer 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 CMHSP to reduce its obligations to the consumer, or to avoid the provision of needed specialty mental health services and supports.
- E. ***A CMHSP shall actively support and facilitate a consumer's application of the principles of self-determination in the accomplishment of his/her plan of services.***
- II. ***Arrangements that support self-determination shall be made available to each consumer for whom an agreement on a plan of authorized specialty mental health services and supports, along with an acceptable individual budget, has***

been reached. A consumer initiates this process by requesting the opportunity to participate in self-determination. For the purposes of self-determination, reaching agreement on the plan must include delineation of the arrangements that will, or may, be applied by the consumer 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 a plan of specialty mental health services and supports, using a person-centered planning process.***
- B. As part of the planning process leading to an agreement about self-determination, ***the arrangements that will, or may, be applied by the consumer to pursue self-determination shall be delineated and agreed to by the consumer and the CMHSP.***
- C. The individual budget represents the expected or estimated costs of a concrete approach to accomplishing the consumer's plan.
- D. The amount of the individual budget shall be formally agreed to by both the consumer and the CMHSP before it may be authorized for use by the consumer. ***A copy of the individual budget must be provided to the consumer prior to the onset of a self-determination arrangement.***
- E. Proper use of an individual budget is of mutual concern to the CMHSP and the consumer.
 - 1. Mental Health funds included in an individual budget are the assets and responsibility of the CMHSP, and must be used consistent with statutory and regulatory requirements. ***Authority over their direction is delegated to the consumer***, for the purpose of achieving the goals and outcomes contained in the consumer's plan. ***The limitations associated with this delegation shall be delineated to the consumer*** as part of the process of developing the plan and authorizing the individual budget.
 - 2. ***An agreement shall be made in writing between the CMHSP and the consumer 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 include a copy of the consumer's plan and individual budget. The directions and assistance necessary*** for the consumer to properly apply the individual budget ***shall be provided to the consumer in writing when the agreement is finalized.***
 - 3. ***An individual budget, once authorized, shall be filed with the consumer's approved plan of service.*** An individual budget shall

be in effect for a specified period of time. Since the budget is based upon the consumer's plan of specialty mental health services and supports, when the plan needs to change, the budget may need to be reconsidered as well. In accordance with the Person-Centered Planning Practice Guidelines, the plan may be reopened and reconsidered whenever the consumer, or the agency, feels it needs to be reconsidered.

4. ***The individual budget is authorized by the CMHSP for the purpose of providing a defined amount of resources that may be directed by the consumer to pursue accomplishing their plan*** of specialty mental health services and supports. An individual budget shall be flexible in its use.
 - a. The consumer may adjust the specific application of CMHSP-authorized funds within the budget between budgetary line items and/or categories in order to adjust his/her specialty mental health services and supports arrangements as he or she deems necessary to accomplish his/her plan.
 - b. Unless the planned adjustment deviates from the goals and objectives in the consumer's plan, the consumer does not need to seek permission from the CMHSP nor be required to provide advance notification of an intended adjustment.
 - c. ***When a consumer makes adjustments in the application of funds in an individual budget, these shall occur within a framework*** that has been agreed to by the consumer and the CMHSP, and ***described in an attachment to the consumer's self-determination agreement***. When changes are made, these shall be promptly communicated to the CMHSP.
 - d. ***If an adjustment*** in the use of the budget is intended for a service/support that ***does not serve to accomplish the direction and intent of the person's plan, then the plan must be appropriately modified*** before the adjustment may be made. ***The CMHSP shall attempt to resolve such situations in an expedient manner***.
 - e. The funds aggregated and used to finance an individual budget may be controlled by more than one funding source. Flexibility in the use of these funds is therefore constrained by the specific limitations of funding sources (e.g., Home Help, Vocational Rehabilitation, etc.) ***Consumers must be informed when some of the resources associated with accomplishing their plan of services and supports involve commitments from***

funding sources other than the CMHSP, and assisted to work within constraints that accompany them.

- f. Funds allotted for specialty mental health services may not be used to purchase services which are not specialty mental health services, nor should contracts with providers of specialty mental health services be entered into if they are not fiscally prudent.
 5. ***Either party -- the CMHSP or the consumer -- may terminate a self-determination agreement***, and therefore, the self-determination arrangement. ***Prior to the CMHSP terminating an agreement, and unless it is not feasible, the CMHSP shall inform the consumer of the issues*** that have led to consideration of a discontinuation or alteration decision, ***in writing, and provide an opportunity for problem resolution***. Typically this 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 CMHSP discontinuation or alteration of a self-determination arrangement, the local processes for dispute resolution may be used to address and resolve the issues.
 6. Discontinuation of a self-determination agreement shall not, by itself, change the consumer's plan of services, nor eliminate the obligation of the CMHSP to assure specialty mental health services and supports required in the plan.
 7. ***In any instance of CMHSP discontinuation or alteration, the consumer must be provided an explanation of applicable appeal, grievance and dispute resolution processes and (where required) appropriate notice.***
- III. Assuring authority over an individual budget is a core element of self-determination. This means that the consumer may use, responsibly, an individual budget as the means to authorize and direct their providers of services and supports. ***A CMHSP shall design and implement alternative approaches that consumers electing to use an individual budget may use to obtain consumer-selected and -directed provider arrangements.***
- A. ***Within prudent purchaser constraints, a consumer shall be able to access any willing and qualified provider*** entity who 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 consumer-preferred providers through purchase of services agreements between the consumer and the***

provider. Options shall include, upon the consumer'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 CMHSP.
2. Services/supports to be provided by a qualified provider chosen by the consumer, with the CMHSP agreeing to enter into a contract with that provider.
3. Services/supports to be provided by a consumer-selected provider with whom the consumer executes a direct purchase-of-services agreement. ***The CMHSP shall provide guidance and assistance to assure that agreements to be executed with consumer-selected providers are consistent with applicable federal regulations governing provider contracting and payment arrangements.***
 - a. Consumers 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 CMHSP.***
 - b. Consumers 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 consumer, for review by authorized representatives of the CMHSP.
 - d. Consumers shall act as careful purchasers of specialty mental health services and supports necessary to accomplish their plan. Arrangements for purchasing services shall not be excessive in cost. Consumers should aim for securing a better value in terms of outcomes for the costs involved. Existing personal and community resources shall be pursued and utilized before using public mental health system resources.
 - e. Fees and rates paid to providers with a direct purchase-of-services agreement with the consumer shall be negotiated by the consumer, within the boundaries of the consumer's authorized individual budget. ***The CMHSP shall provide guidance as to the range of applicable rates, and may set maximum amounts that a consumer may spend to pay specific providers.***

4. A consumer shall be able to access 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 consumer.
 - c. CMHSP contractual language with provider entities that assures consumer selection of personnel, and removal or reassignment of personnel who fail to meet consumer preferences.
 - d. Use of CMHSP-employed direct support personnel, as selected and retained by the consumer.
5. ***A consumer participating in self-determination shall not be obligated to utilize CMHSP-employed direct support personnel or a CMHSP-operated or -contracted program/service.***
6. All individuals selected by the consumer, 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 consumer 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 CMHSP shall assist a consumer participating in 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 MDCH Technical Advisory instructions, their access to alternative methods for directing and managing support personnel.***

A. ***A 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, in order to assist the consumer in selecting, directing and controlling providers of specialty services and supports.

B. ***Fiscal intermediaries shall be under contract to the CMHSP or a designated sub-contracting entity.*** Contracted functions may include:

1. Payroll agent for direct support personnel employed by the consumer

(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 consumer-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 CMHSP and the consumer. Reports made to the consumer shall be in a format that is useful to the consumer in tracking and managing the funds making up the individual budget.
4. Provision of an accounting to the 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 CMHSP for specialty mental health services and supports provided by individuals and entities that have a direct agreement with the consumer.
6. Other supportive services, as denoted in the contract with the CMHSP, that strengthen the role of the consumer as an employer, or assist with the use of other agreements directly involving the consumer in the process of securing needed services.

C. ***A 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 consumer styles and characteristics. The CMHSP shall exercise due diligence in establishing the qualifications, characteristics and capabilities of the entity to be selected as a fiscal intermediary, and shall manage the use of fiscal intermediaries consistent with MDCH Technical Assistance Advisories addressing fiscal intermediary arrangements.***

D. An entity acting as a fiscal intermediary shall be free from other relationships involving the CMHSP or the consumer that would have the effect of creating a conflict of interest for the fiscal intermediary in relationship to its role of supporting consumer-determined services/supports transactions. These other relationships typically would include the provision of direct services to the consumer. ***The CMHSP shall identify and require remedy to any conflicts of interest of the entity that, in the judgement of the CMHSP, interfere with the performance of its role as a fiscal intermediary.***

E. ***A CMHSP shall collaborate with and guide the fiscal intermediary and***

each consumer involved in self-determination to assure compliance with various state and federal requirements, and to assist the consumer in meeting his/her obligations to follow applicable requirements. ***It is the obligation of the CMHSP to assure that the entities selected to perform intermediary functions are capable of meeting and maintaining compliance with the requirements associated with their stated functions, including those contained in relevant MDCH Technical Assistance Advisories.***

- F. Typically, funds comprising a consumer's individual budget would be lodged with the fiscal intermediary, pending appropriate direction by the consumer to pay consumer-selected and contracted providers. Where a consumer selected and directed provider of services has a direct contract with the CMHSP, the provider may be paid by the 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 CMHSP, as a matter of fiscal efficiency.

DEFINITIONS

Fiscal Intermediary

A fiscal Intermediary is an independent legal entity (organization or individual) that acts as a fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for the funds comprising a consumer's individual budget. A fiscal intermediary shall perform its duties as specified in a contract with a CMHSP or its designated sub-contractor. The purpose of the fiscal intermediary is to receive funds making up a consumer's individual budget, and make payments as authorized by the consumer to providers and other parties to whom a consumer using the individual budget may be obligated. A fiscal intermediary may also provide a variety of supportive services that assist the consumer 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; local ARC or other advocacy organizations; a subsidiary of a service provider entity if no conflict of interest exists.

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 Community Health and the 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 consumer's person-centered planning process, and should be specified in the consumer's plan, or result from a process developed locally to assure the health and well-being of consumers, conducted with the full input and involvement of local consumers and advocates.

Consumer

For the purposes of this policy, "Consumer" means the adult consumer of direct specialty

mental health services and supports, and/or his/her selected representative. That is, the consumer may select a representative to enter into the self-determination agreement and for other agreements that may be necessary for the consumer to participate in consumer-directed supports and services arrangements. Where the consumer has a legal guardian, the role of the guardian in self-determination shall be consistent with the guardianship arrangement established by the court. A person selected as the representative of the consumer shall not supplant the role of the consumer in the process of person-centered planning, in accordance with the Mental Health Code and the requirements of the contract between the CMHSP and the Department of Community Health. Where a consumer has been deemed to require a legal guardian, there is an extra obligation on the part of the CMHSP and those close to the consumer to assure that it is the consumer's preferences and dreams that drive the use of self-determination arrangements, and that the best interests of the consumer are primary. A CMHSP shall have the discretion to limit or restrict the use of self-determination arrangements by a guardian when the planned or actual use of those arrangements by that guardian are in conflict with the expressed goals and outcomes of the consumer.

Individual Budget

An individual budget is a fixed allocation of public mental health resources, and may also include other public resources whose access involves the assistance of the CMHSP, denoted in dollar terms. These resources are agreed upon as the necessary cost of specialty mental health services and supports needed to accomplish a consumer's plan of services/supports. The consumer served uses the funding authorized to acquire, purchase and pay for specialty mental health services and supports that support accomplishment of the consumer's plan.

Plan

A plan means the consumer's Individual Plan of Services and/or Supports, as developed using a person-centered planning process.

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.

Specialty Mental Health Services

This term includes any service/support that can legitimately be provided using funds authorized by the CMHSP in the individual budget. It includes alternative services and supports as well as Medicaid-covered services and supports.

Choice Voucher System

The Choice Voucher System is the designation for set of arrangements that facilitate and support accomplishing self-determination, through the use of an individual budget, a fiscal

intermediary, and direct consumer-provider contracting. Its use shall be guided by MDCH Technical Assistance Advisories which may be issued from time to time by the Department.

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. 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, they possess power to make meaningful choices in how they live their life.

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: FY 11 – Attachment P4.7.4
MDCH/CMHSP Managed Mental Health Supports and Services Contract: FY 11 – Attachment C4.7.4
March 18, 2008

TO: Executive Directors of Prepaid Inpatient Health Plans (PIHPs)
and Community Mental Health Services Programs (CMHSPs)

FROM: Irene Kazieczko, Director
Bureau of Community Mental Health Services

SUBJECT: Technical Advisory Regarding: 1) Medicaid Eligibility Criteria for Children with Serious Emotional Disturbance for Specialty Mental Health Services; and
2) Establishing General Fund Priority for Mental Health Services for Children with Serious Emotional Disturbance

Attached is the revised Technical Advisory Regarding: 1) Medicaid Eligibility Criteria for Children with Serious Emotional Disturbance for Specialty Mental Health Services; and 2) Establishing General Fund Priority for Mental Health Services for Children with Serious Emotional Disturbance. This advisory provides a framework to be used by PIHPs and CMHSPs for determining eligibility for Medicaid specialty mental health services for children with serious emotional disturbance (SED). The framework is also to be used for non-Medicaid children, for establishing general fund priority for services to children with SED according to the requirements of the Michigan Mental Health Code. The criteria for Medicaid eligibility for specialty mental health services and the framework for general fund priority for non-Medicaid children is based on the definition of serious emotional disturbance delineated in the Mental Health Code which includes the three dimensions of diagnosis, functional impairment and duration.

A key feature of the Medicaid eligibility criteria and general fund priority framework in the Technical Advisory is that diagnosis alone is not sufficient to determine eligibility for Medicaid specialty mental health services, nor general fund priority for services. This means that the practice of using a defined or limited set of diagnoses to determine Medicaid eligibility, or general fund priority for services should cease. As stated in the Mental Health Code, any diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (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.

Please remember, that PIHPs and CMHSPs are not to use eligibility determination documents that are no longer in effect. This includes attachment 3.3.2 in the PIHP and CMHSP contracts. This attachment has been removed from the contracts. Also, MSA Bulletins 95-03 and 00-10 are no longer in effect and should not be used to determine Medicaid eligibility for specialty mental health services.

On August 21, 2007, the Technical Advisory regarding Eligibility Criteria for Children with Serious Emotional Disturbance (SED) was issued for review and feedback. Feedback was received in writing from five CMHSPs, two PIHPs, one private provider, and the Michigan Association of Community Mental Health Boards (MACMHBs). In addition, we received verbal feedback from those CMHSPs participating in a conference call on September 10, 2007, and from the MACMHB Children’s Issues Committee.

Based on comments from the field, additions/corrections to the document were made. These include:

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program: FY 11 – Attachment P4.7.4

MDCH/CMHSP Managed Mental Health Supports and Services Contract: FY 11 – Attachment C4.7.4

- 1) Language was added to the criteria for 7-17 regarding the provision of services to a parent if the care-giving situation places the child at high risk for SED.
- 2) The exact language for the definition of SED was added from the Mental Health Code.
- 3) It was clarified that the Technical Advisory eligibility criteria does not apply to MIChild beneficiaries.
- 4) Language was added from the March 30, 2006 Patrick Barrie memorandum regarding eligibility and medical necessity criteria for B3 Direct Model Prevention Services.
- 5) The following changes were made to the crosswalk for 0-3:
 - Referencing sensitivity, shyness and social withdrawn disorder (313.2, .21 and .22) in relation to the Regulation of Disorders of Sensory Processing, Type A: Fearful/Cautious (411).
 - Conduct Disorder—child onset type (312.81 in ICD-9-CM and DSM IVR) now includes a notation that this diagnosis may be used with a child over 36 months of age.
 - Coordination Disorder (315.4 in ICD 9 CM and DSM IVR) has been dropped.

The department encourages the use of the Technical Advisory for Medicaid eligibility criteria and general fund priority framework over the next year, and additional feedback from the field will be accepted. The department does intend to incorporate the Technical Advisory into the Medicaid Provider Manual and into the contract negotiation process for FY09.

The department will also be providing training on the use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3®). Training was held November 1 and 2, 2007 in Traverse City in conjunction with the Michigan Association of Infant Mental Health (MAIMH), and another training is planned for April 10 and 11, 2008 at the Lansing Community College—West Campus. (A notice was sent out under separate cover.) We are also working with Kay Hodges to schedule training on the Pre-School and Early Childhood Functional Assessment Scale (PECFAS), the assessment tool recommended for measuring functional impairment for four through six year olds. We will send out this information when we finalize the dates and location. Lastly, for birth through three year olds, the department intends to field-test one or two tools with CMHSPs willing to participate, before making a recommendation for an assessment tool for functional impairment for that age group.

I wish to thank all of the CMHSPs and PIHPs, the MACMHB and its Children's Issues Committee for their time and effort in reviewing the Eligibility Criteria for Children with SED. I believe that the use of this document will provide a structure for bringing greater uniformity to eligibility decisions and improving access to public mental health system services for children with SED who are in need of our services.

Please contact Sheri Falvey at 517-241-5762, or at falvey@michigan.gov if you have questions.

Attachments

c: Sheri Falvey
Judy Webb
Mark Kielhorn

TECHNICAL REQUIREMENT FOR SEDW CHILDREN FINAL REVISED MARCH 18, 2008

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 Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) for determining eligibility for Medicaid specialty mental health services for children with serious emotional disturbance (SED). The framework is also to be used for non-Medicaid children, 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 for Medicaid eligibility for specialty mental health services and the 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 Medicaid eligibility criteria and general fund priority framework in the Technical Requirement is that diagnosis alone is not sufficient to determine eligibility for Medicaid specialty mental health services, nor general fund priority for services. This means that the practice of using a defined or limited set of diagnoses to determine Medicaid eligibility, or 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 Medicaid eligibility criteria and general fund priority framework delineated in this document are intended to: (1) assist Prepaid Inpatient Health Plans (PIHPs) and 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 Medicaid children and for non-Medicaid children 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. (Please note that the criteria contained in this document do not apply to MICHild beneficiaries. CMHSPs are the sole provider of the mental health benefit for MICHild beneficiaries who are to be provided medically necessary mental health services by CMHSPs regardless of functional impairment.)

Selection of Services

For Medicaid children, once an eligibility determination has been made based on the criteria delineated in this document, selection of services is determined based on person-centered planning and family-centered practice. Selection of services should also be made based on medical necessity criteria, and, where applicable, the service-specific criteria, coverage policy and decision parameters contained in the most recent version of the Medical Services Administration's Medicaid Policy Manual. However, decisions regarding access/eligibility should not be based on medical necessity criteria or service-specific criteria since these decisions are a separate and subsequent process to eligibility determinations.

Special Note: For Direct Prevention Services Models (CCEP, School Success Program, Infant Mental Health, Parent Education) with a family or child care provider regarding an individual child, the service should be noted in the child's plan of services as "medically necessary" and should be reported using the child's beneficiary identification number. PIHPs typically use "unspecified" diagnosis codes found in the ICD-9 for infants, young children and individuals who receive one-time crisis intervention.

Definition of Child with Serious Emotional Disturbance 7 through 17 Years

The definition of SED for children 7 through 17 years delineated below is based on the Mental Health Code, Section 330.1100d. In addition, extensive reviews and examinations of Child and Adolescent Functional Assessment Scale (CAFAS) data submitted by CMHSPs for the children currently served were undertaken to establish functioning criteria consistent with the Michigan Mental Health Code definition of serious emotional disturbance.¹ The parameters delineated below do not preclude the diagnosis of and the provision of services to an adult beneficiary who is a parent and who has diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance.

The following is the criteria for determining when a child 7 through 17 years is considered to have a serious emotional disturbance. All of the dimensions must be considered when determining whether a child is eligible for mental health services and supports as a child with serious emotional disturbance. The child shall meet each of the following:

Diagnosis

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

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

(For Children 7 through 17 Years Continued)

American Psychiatric Association and approved by the department and that has resulted in functional impairment as indicated below. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Degree of Disability/Functional Impairment

Functional impairment that substantially interferes with or limits the minor's role or results in impaired functioning in family, school, or community activities. This is defined as:

- A total score of 50 (using the eight subscale scores on the Child and Adolescent Functional Assessment Scale (CAFAS), or
- Two 20s on any of the first eight subscales of the CAFAS, or
- One 30 on any subscale of the CAFAS, except for substance abuse only.

Duration/History

Evidence that the disorder exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

Definition of Child with Serious Emotional Disturbance, 4 through 6 Years (48 through 71 months)

For children 4 through 6 years of age, decisions should utilize similar dimensions to older children to determine whether a child has a serious emotional disturbance and is in need of mental health services and supports. The dimensions include:

- (1) a diagnosable behavioral or emotional disorder;
- (2) functional impairment/limitation of major life activities; and
- (3) duration of condition.

However, as with infants and toddlers (birth through age three years), assessment must be sensitive to the critical indicators of development and functional impairment for the age group. Impairments in functioning are revealed across life domains in the young child's regulation of emotion and behavior, social development (generalization of relationships beyond parents, capacity for peer relationships and play, etc.), physical and cognitive development, and the emergence of a sense of self. All of the dimensions must be considered when determining whether a young child is eligible for mental health services and supports as a child with serious emotional disturbance.

The parameters delineated below do not preclude the provision of services to an adult beneficiary of a young child who is a parent and who has a diagnosis within the current

(For Children 4 through 6 Years Continued)

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

(For Children 4 through 6 Years Continued)

- 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

(For Children 4 through 6 Years Continued)

- 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

(For Children Birth through 3 Years Continued)

another diagnosable serious emotional disturbance: (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Degree of Disability/Functional Impairment

Interference with, or limitation of, an infant or toddler's proficiency in performing developmentally appropriate skills as demonstrated by at least one indicator drawn from two of the following three functional impairment areas:

Area I:

General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems. Indicators are:

- uncontrollable crying or screaming
- sleeping and eating disturbances
- disturbance (over or under expression) of affect, such as pleasure, displeasure, joy, anger, fear, curiosity, apathy toward environment and caregiver
- toddler has difficulty with impulsivity and/or sustaining attention
- developmentally inappropriate aggressiveness toward others and/or toward self
- reckless behavior(s)
- regression as a consequence of a trauma
- sexualized behaviors inappropriate for developmental age

Area II:

Behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibit the infant or toddler's daily adaptation and relationships. Behavioral indicators are:

- a restricted range of exploration and assertiveness
- severe reaction to changes in routines
- tendency to be frightened and clinging in new situations
- lack of interest in interacting with objects, activities in their environment, or relating to others and infant or toddler appears to have one of the following reactions to sensory stimulation:
 - hyper-sensitivity
 - hypo-sensitive/under-responsive
 - sensory stimulating-seeking/impulsive

Area III:

Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of infant/toddler,

(For Children Birth through 3 Years Continued)

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.

An assessment tool specifically targeting social-emotional functioning for infants and toddlers and assessment of the relationship between primary caregiver(s) will be determined based on field testing of recommended assessment tools.

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.

**Access Eligibility Criteria for Infants and Toddlers Who Require Specialty Services and Supports
(birth through 3 years [47 months] of age)**

Crosswalk between Diagnostic Classifications 0-3, ICD 9 CM and DSM IVR+

March 18, 2008

DC 0-3 R Diagnosis	ICD 9 CM Diagnosis <i>** Note: Refer to ICD 9 Coding Manual for Exclusions to this Diagnosis</i>	DSM IVR Diagnosis
100 Post traumatic Stress Disorder	<p>308 Acute reaction to stress** (requires 4th digit subclassification listed below). Includes:</p> <ul style="list-style-type: none"> • Catastrophic stress • Gross stress reaction (acute) • Transient disorders in response to exceptional physical or mental stress which usually subside within hours or days <p>308.0 Predominant disturbance of emotions</p> <ul style="list-style-type: none"> • Anxiety as acute reaction to exceptional (gross) stress <p>308.1 Predominant disturbance of consciousness Fugues as acute reaction to exceptional (gross) stress</p> <p>308.2 Predominant psychomotor disturbance</p> <ul style="list-style-type: none"> • Agitation states as acute reaction to exceptional (gross) stress • Stupor as acute reaction to exceptional (gross) stress <p>308.3 Other acute reactions to stress**</p> <ul style="list-style-type: none"> • Acute situational disturbance • Brief or acute posttraumatic stress disorder <p>308.4 Mixed disorders as reaction to stress</p> <p>308.9 Unspecified acute reaction to stress</p> <p>309.81 Prolonged posttraumatic stress disorder**</p> <ul style="list-style-type: none"> • Chronic posttraumatic stress disorder 	<p>Acute Stress Disorder</p> <p>308.3</p> <p>Post traumatic Stress Disorder</p> <p>309.81</p>
150 Deprivation/Maltreatment Disorder	<p>313.89 Emotional Disturbance of Childhood NEC**</p> <p>313.9 Unspecified emotional Disturbance of Childhood or adolescence</p>	<p>313.89 Reactive Attachment Disorder of Infancy or Early Childhood</p>

**Access Eligibility Criteria for Infants and Toddlers Who Require Specialty Services and Supports
(birth through 3 years [47 months] of age)**

Crosswalk between Diagnostic Classifications 0-3, ICD 9 CM and DSM IVR+

March 18, 2008

DC 0-3 R Diagnosis		ICD 9 CM Diagnosis <i>** Note: Refer to ICD 9 Coding Manual for Exclusions to this Diagnosis</i>		DSM IVR Diagnosis	
200	Disorder of Affect				
210	Prolonged Bereavement/Grief Reaction	309.00	Adjustment disorder with depressed mood • Grief reaction	309.0	Adjustment Disorder with Depressed Mood
		309.1	Prolonged depressive reaction**		
220	Anxiety Disorder of Infancy & Early Children	300.00	Anxiety state, unspecified** • Anxiety: neurosis, reaction, state (neurotic) • Atypical anxiety disorder	300.00	Anxiety Disorder NOS
		300.01	Panic disorder. Panic: attack, state	300.01	Panic disorder without
		300.02	Generalized anxiety disorder	300.02	Generalized Anxiety Disorder
		309.21	Separation anxiety disorder	309.21	Separation Anxiety Disorder
		313.0	Overanxious disorder** • Anxiety and fearfulness of childhood and adolescence • Overanxious disorder of childhood and adolescence		
221	Separation Anxiety	309.21	Separation anxiety disorder	309.21	Separation Anxiety Disorder
222	Specific Phobia	300.29	Other isolated or specific phobias	300.29	Specific Phobia
223	Social Anxiety Disorder	300.23	Social Phobia	300.02	Social Phobia
		313.2	Sensitivity, shyness and social withdrawn disorder (requires 5 th digit subclassification—listed below)		
		313.21	Shyness disorder of childhood		
		313.22	Sensitivity reaction of childhood or adolescence Introverted disorder of childhood --Social withdrawal of childhood or adolescence --Withdrawal reaction of childhood or adolescence		
224	Generalized Anxiety Disorder			300.02	Generalized Anxiety Disorder
225	Anxiety Disorder NOS			300.0	Anxiety Disorder NOS

**Access Eligibility Criteria for Infants and Toddlers Who Require Specialty Services and Supports
(birth through 3 years [47 months] of age)**

Crosswalk between Diagnostic Classifications 0-3, ICD 9 CM and DSM IVR+

March 18, 2008

DC 0-3 R Diagnosis	ICD 9 CM Diagnosis <i>** Note: Refer to ICD 9 Coding Manual for Exclusions to this Diagnosis</i>		DSM IVR Diagnosis
300 Adjustment Disorder	309 309.0	Adjustment Reaction (309.0—309.9) Brief depressive reaction --Adjustment disorder with depressed mood --Grief reaction	309.9 Adjustment Disorder: Unspecified
	309.24	Adjustment reaction with anxious mood	309.24 Adjustment Disorder with Anxiety
	309.28	Adjustment reaction with mixed emotional features	309.28 Adjustment Disorder with Mixed Anxiety and Depressed Mood
	309.3	With predominant disturbance of conduct --conduct disturbance as adjustment reaction --destructiveness as adjustment reaction	309.3 Adjustment Disorder with Disturbance of Conduct
	309.4	With mixed disturbances of emotions and conduct	309.4 Adjustment Disorder with Mixed Disturbance of Emotions and Conduct
	309.29	Other --culture shock	309.9 Adjustment Disorder NOS
	309.82	Adjustment reaction with physical symptoms	309.9 Adjustment Disorder NOS
	309.83	Adjustment reaction with withdrawal --Elective mutism as adjustment reaction	313.23 Selective Mutism
	309.9	--Hospitalism (in children) NOS Unspecified adjustment reaction --Adaptation reaction NOS --Adjustment reaction NOS	309.9 Adjustment Disorder NOS 309.9 Adjustment Disorder NOS
400* – Regulation Disorders of Sensory Processing Sensory Processing when coupled with parent/child interaction	312.9 313.0	Unspecified disturbance of conduct Overanxious disorder** --Anxiety and fearfulness of childhood and adolescence --Overanxious disorder of childhood and adolescence	312.9 300.02 Disruptive Behavior Disorder NOS Generalized Anxiety Disorder
410* Hypersensitive			
411* Type A: Fearful/Cautious			

+ To be used as a guide in Clinical Assessment/Diagnosis

**Access Eligibility Criteria for Infants and Toddlers Who Require Specialty Services and Supports
(birth through 3 years [47 months] of age)**

Crosswalk between Diagnostic Classifications 0-3, ICD 9 CM and DSM IVR+

March 18, 2008

DC 0-3 R Diagnosis	ICD 9 CM Diagnosis <i>** Note: Refer to ICD 9 Coding Manual for Exclusions to this Diagnosis</i>	DSM IVR Diagnosis
412*	Type B: Negative/Defiant 312.81 (Note: Also see 313.2, 313.21 or 313.22 for Sensitivity, shyness and social withdrawn disorder) Conduct Disorder—Child onset type (Note: for young child over 36 months of age)	Conduct Disorder—Child onset (Note: for young child over 36 months of age)
420*	Hypo/Underresponsive 312.9 Unspecified disturbance of conduct 313.81 Oppositional Defiant Disorder 314.00 Attention deficit disorder Without mention of hyperactivity --Predominantly inattentive type	Disruptive Behavior Disorder NOS Oppositional Defiant Disorder Attention Deficit Disorder—Predominately inattentive type
430*	Sensory Stimulation – Seeking/Impulsive 314.0 Attention Deficit Disorder --Requires 5 th digit subclassification--listed below 314.01 With hyperactivity—combined type --Overactivity NOS --Predominantly hyperactive/impulsive	Impulse Control Disorder NOS ADHD-Hyperactive impulsive disorder
500*	Sleep Disorder	Attention Deficit/Hyperactivity Disorder NOS
510*	Sleep Onset Disorder 307.40 Nonorganic sleep disorder, unspecified 307.41 Transient disorder of initiating or maintaining sleep <ul style="list-style-type: none"> • Hyposomnia associated with acute or intermittent emotional reactions or conflicts • Insomnia associated with acute or intermittent emotional reactions or conflicts • Sleeplessness associated with 	Dyssomnia NOS or Parasomnia NOS Insomnia Related to....

**Access Eligibility Criteria for Infants and Toddlers Who Require Specialty Services and Supports
(birth through 3 years [47 months] of age)**

Crosswalk between Diagnostic Classifications 0-3, ICD 9 CM and DSM IVR+

March 18, 2008

DC 0-3 R Diagnosis	ICD 9 CM Diagnosis <i>** Note: Refer to ICD 9 Coding Manual for Exclusions to this Diagnosis</i>	DSM IVR Diagnosis
	307.42 Persistent disorder of initiating or maintaining wakefulness • Hyposomnia, insomnia, or sleeplessness associated with: anxiety, conditioned arousal, depression (major) (minor), psychosis	307.42 or 327.02 Primary Insomnia Or Insomnia Related to...
	307.43 Transient disorder of initiating or maintaining wakefulness • Hypersomnia associated with acute or intermittent emotional reactions or conflicts	307.15 Hypersomnia Related to....
	307.44 Persistent disorder of initiating or maintaining wakefulness • Hypersomnia associated with depression (major) (minor)	307.44 or 327.15 Primary Hpersomnia or Hypersomnia Related to....
520*	307.45 Circadian Rhythm Sleep Disorder of nonorganic origin	307.30 or 327.31 Circadian Rhythm Sleep Disorder, Unspecified type or Delayed Sleep Phase Type
	307.46 Somnambulism or night terrors	307.46 Sleep Terror Disorder or Sleepwalking Disorder
	307.47 Other dysfunctions of sleep stages or arousal from sleep Nightmares: NOS, REM-sleep type, sleep drunkenness	307.47 Dyssomnia NOS, Nightmare Disorder, or Parasomnia NOS
	307.48 Repetitive intrusions of sleep Repetitive intrusions of sleep with: atypical polysomnographic features, environmental disturbances, repeated REM-sleep interruptions	307.47 Parasomnia NOS
	307.49 Other "Short sleeper," subjective insomnia complaint	307.42 Primary Insomnia
600	Feeding Behavior Disorders	
601	Feeding Behavior Disorders Other • Infantile feeding disturbances of	307.59 Feeding Disorder of Infancy or Early Childhood

Access Eligibility Criteria for Infants and Toddlers Who Require Specialty Services and Supports
(birth through 3 years [47 months] of age)

Crosswalk between Diagnostic Classifications 0-3, ICD 9 CM and DSM IVR+

March 18, 2008

DC 0-3 R Diagnosis	ICD 9 CM Diagnosis ** Note: Refer to ICD 9 Coding Manual for Exclusions to this Diagnosis	DSM IVR Diagnosis
	nonorganic origin • Loss of appetite—of nonorganic origin Other	
602	Feeding Disorders of Caregivers Caregiver/Infant Reciprocity 307.59 • Infantile feeding disturbances of nonorganic origin • Loss of appetite—of nonorganic origin	307.59 Feeding Disorder of Infancy or Early Childhood
603	Infantile Anorexia 307.59 • Infantile feeding disturbances of nonorganic origin • Loss of appetite—of nonorganic origin	307.59 Feeding Disorder of Infancy or Early Childhood
800	Other Disorders	

* Not Axis I Diagnoses

References

American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) Fourth Edition (Text Revision), 2000.

National Center for Health Statistics, International Classification of Diseases, Ninth Revision, Clinical Modification, 2004.

Zero to Three, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3 R), Washington, DC, 2005.

Maine DC 0-3 Committee, Crosswalk for DC 0-3 to ICD-9 Diagnosis Coding. 2004.

Perez, L. and Newman, M., "Crosswalk" for San Mateo, California, Developmental Approach to Infant Mental Health Diagnosis.

In addition, the Crosswalk developed by Florida was used as a reference.

+ To be used as a guide in Clinical Assessment/Diagnosis

PIHP CUSTOMER SERVICES STANDARDS Revised: October, 2010

Preamble

It is the function of the customer services unit to be the front door of the pre-paid inpatient health plan (PIHP), and to convey an atmosphere that is welcoming, helpful and informative. These standards apply to the PIHP and to any entity to which the PIHP has delegated the customer services function, including affiliate CMHSP(s), substance abuse coordinating agency (CA), or provider network.

Functions

- A. Welcome and orient individuals to services and benefits available, and the provider network.
- B. Provide information about how to access mental health, primary health, and other community services.
- C. Provide information about how to access the various rights processes.
- D. Help individuals with problems and inquiries regarding benefits.
- E. Assist people with and oversee local complaint and grievance processes.
- F. Track and report patterns of problem areas for the organization.

Standards

1. There shall be a designated unit called "Customer Services."
2. There shall be at the PIHP a minimum of one FTE (full time equivalent) performing the customer services functions whether within the customer service unit or elsewhere within the PIHP. If the function is delegated, affiliate CMHSPs, substance abuse coordinating agencies and network providers, as applicable, shall have additional FTEs (or fractions thereof) as appropriate to sufficiently meet the needs of the people in the service area.
3. There shall be a designated toll-free customer services telephone line and access to a TTY number. The numbers shall be displayed in agency brochures and public information material.
4. Telephone calls to the customer services unit shall be answered by a live voice during business hours. Telephone menus are not acceptable. A variety of alternatives may be employed to triage high volumes of calls as long as there is response to each call within one business day.
5. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized. **It is expected that the customer services/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.**
6. The customer handbook shall contain the state-required topics (See P.6.3.1.1.A)
7. The Medicaid coverage name and the state's description of each service shall be printed in the customer handbook.
8. The customer handbook shall contain a date of publication and revision(s).
9. Affiliate CMHSP, substance abuse coordinating agency, or network provider names, addresses, phone numbers, TTYs, E-mails, and web addresses, as well as whether the provider speaks any non-English language and if they are accepting new patients, shall be contained in the customer handbook.

10. Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area, including plan or program name, locations, and telephone numbers, shall be provided in the handbook.
11. Customer services unit shall maintain current listings of all providers, both organizations and practitioners, with whom the PIHP has contracts, the services they provide, any non-English languages they speak, any specialty for which they are known, and whether they are accepting new patients. This list must include independent PCP facilitators. Beneficiaries shall be given this list annually unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer services line is acceptable.
12. Customer services unit shall have access to information about the PIHP including CMHSP affiliate annual report, current organizational chart, CMHSP board member list, meeting schedule and minutes that are available to be provided in a timely manner to an individual upon request.
13. Upon request, the customer services unit shall assist beneficiaries with the grievance and appeals, and local dispute resolution processes, and coordinate as appropriate with Fair Hearing Officers and the local Office of Recipient Rights.
14. Customer services staff shall be trained to welcome people to the public mental health system and to possess current working knowledge, or know where in the organization detailed information can be obtained in at least the following:
 - a. *The populations served (serious mental illness, serious emotional disturbance, developmental disability and substance use disorder) and eligibility criteria for various benefits plans (e.g., Medicaid, Adult Benefit Waiver, MICHild)
 - b. *Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services
 - c. Person-centered planning
 - d. Self-determination
 - e. Recovery & Resiliency
 - f. Peer Specialists
 - g. *Grievance and appeals, Fair Hearings, local dispute resolution processes, and Recipient Rights
 - h. Limited English Proficiency and cultural competency
 - i. *Information and referral about Medicaid-covered services within the PIHP as well as outside to Medicaid Health Plans, Fee-for-Services practitioners, and Department of Human Services
 - j. The organization of the Public Mental Health System
 - k. Balanced Budget Act relative to the customer services functions and beneficiary rights and protections
 - l. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies)
 - m. Public Health Code (for substance abuse treatment recipients if not delegated to the substance abuse coordinating agency)

*Must have a working knowledge of these areas, as required by the Balanced Budget Act

**PIHP CUSTOMER SERVICES HANDBOOK
REQUIRED STANDARD TOPICS
Final: September 2006**

Each pre-paid inpatient health plan (PIHP) must have a customer services handbook that is provided to Medicaid beneficiaries when they first come to service and periodically thereafter through their tenure as service recipients. It is suggested that they be provided the handbook annually at the time of person-centered planning. The list below contains the topics that shall be in each PIHP's customer services handbook. The PIHP may determine the order of the topics as they appear in the handbook and may add more topics. In order that beneficiaries receive the same information no matter where they go in Michigan, the topics with asterisks below must use the standard language templates contained in this requirement. PIHPs should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates. Information in the handbook should be easily understood, and accommodations available for helping beneficiaries understand the information. The information must be available in the prevalent non-English language(s) spoken in the PIHP's service area.

Note: It is understood that PIHPs may have quantities of handbooks in stock that do not contain all of the language herein and are reluctant to discard them. It is suggested that PIHPs review such existing handbooks to assure that all the information required by the federal Balanced Budget Act is included and if not, produce supplemental material to distribute with the old handbooks. PIHPs should draft new handbooks with the information and language contained in this document, have them available for review in the Spring of 2007, and have them ready to be printed when the old stock is exhausted, but no later than October 1, 2007.

*Must use boilerplate language in templates (attached)

Topics Requiring Template Language (not necessarily in this order)

- *Confidentiality and family access to information
- *Coordination of care
- *Emergency and after-hours access to services
- *Glossary
- *Grievance and appeal
- *Language accessibility/accommodation
- *Payment for services
- *Person-centered planning
- *Recipient rights
- *Recovery
- *Service array, eligibility, medical necessity, & choice of providers in network
- *Service authorization

Other Required Topics (not necessarily in this order)

- Access process
- Access to out-of-network services
- Affiliate [for Detroit-Wayne, the MCPNs] addresses and phone numbers:
 - Executive director

- Medical director
- Recipient rights officer
- Customer services
- Emergency

Community resource list (and advocacy organizations)

Index

Right to information about PIHP operations (e.g., organizational chart, annual report)

Services not covered under contract

Welcome to PIHP

What is customer services and what it can do for the individual; hours of operation and process for obtaining customer assistance after hours?

Other Suggested Topics

Customer services phone number in the footer of each page

Safety information

Template #1: Confidentiality and Family Access to Information

You have the right to have information about your mental health treatment kept private. You also have the right to look at your own clinical records and add a formal statement about them if there is something you do not like. Generally, information about you can only be given to others with your permission. However, there are times when your information is shared in order to coordinate your treatment or when it is required by law.

Family members have the right to provide information to [PIHP] about you. However, without a Release of Information signed by you, the [PIHP] may not give information about you to a family member. For minor children under the age of 18 years, parents are provided information about their child and must sign a release of information to share with others.

If you receive substance abuse services, you have rights related to confidentiality specific to substance abuse services.

Under HIPAA (Health Insurance Portability and Accountability Act), you will be provided with an official Notice of Privacy Practices from your community mental health services program. This notice will tell you all the ways that information about you can be used or disclosed. It will also include a listing of your rights provided under HIPAA and how you can file a complaint if you feel your right to privacy has been violated.

If you feel your confidentiality rights have been violated, you can call the Recipient Rights Office where you get services.

[Note to PIHP: you may add additional information to this template]

Template #2: Coordination of Care

To improve the quality of services, [PIHP name] wants to coordinate your care with the medical provider who cares for your physical health. If you are also receiving substance abuse services, your mental health care should be coordinated with those services. Being able to coordinate with all providers involved in treating you improves your chances for recovery, relief of symptoms and improved functioning. Therefore, you are encouraged to sign a “Release of Information” so that information can be shared. If you do not have a medical doctor and need one, contact the [Customer Services Unit] and the staff will assist you in getting a medical provider.

[Note to PIHP: you may add additional information to this template]

Template #3: Emergency and After-Hours Access to Services

A “mental health emergency” is when a person is experiencing a serious mental illness, or a developmental disability, or a child is experiencing a serious emotional disturbance and can reasonably be expected in the near future to harm him/herself or another, or because of his/her inability to meet his/her basic needs is at risk of harm, or the person’s judgment is so impaired that he or she is unable to understand the need for treatment and that their condition is expected to result in harm to him/herself or another individual in the near future. You have the right to receive emergency services at any time, 24-hours a day, seven days a week, without prior authorization for payment of care.

If you have a mental health emergency, you should seek help right away. At any time during the day or night call:

[PIHP insert local emergency telephone numbers and place(s) to go for help]

Post-Stabilization Services

After you receive emergency mental health care and your condition is under control, you may receive mental health services to make sure your condition continues to stabilize and improve. Examples of post-stabilization services are crisis residential, case management, outpatient therapy, and/or medication reviews.

Template #4: Glossary or Definition of Terms

MENTAL HEALTH GLOSSARY

Access: The entry point to the Prepaid Inpatient Health Plan (PIHP), sometimes called an “access center,” where Medicaid beneficiaries call or go to request mental health services.

Adult Benefits Waiver: Michigan health care program for certain low-income adults who are not eligible for the Medicaid program. Contact the [Customer Services Unit] for more information. This is a narrowly defined benefit that does not entitle you to all of the services and supports described in this brochure.

Amount, Duration, and Scope: How much, how long, and in what ways the Medicaid services that are listed in a person’s individual plan of service will be provided.

Beneficiary: An individual who is eligible for and enrolled in the Medicaid program in Michigan.

CA: An acronym for Substance Abuse Coordinating Agency. The CAs in Michigan manage services for people with substance use disorders.

CMHSP: An acronym for Community Mental Health Services Program. There are 46 CMHSPs in Michigan that provide services in their local areas to people with mental illness and developmental disabilities.

Fair Hearing: A state level review of beneficiaries’ disagreements with health plans’ denial, reduction, suspension or termination of Medicaid services. State administrative law judges who are independent of the Michigan Department of Community Health perform the reviews.

Deductible (or Spend-Down): A term used when individuals qualify for Medicaid coverage even though their countable incomes are higher than the usual Medicaid income standard. Under this process, the medical expenses that an individual incurs during a month are subtracted from the individual’s income during that month. Once the individual’s income has been reduced to a state-specified level, the individual qualifies for Medicaid benefits for the remainder of the month.

Developmental Disability: Is defined by the Michigan Mental Health code means either of the following: (a) If applied to a person older than five years, a severe chronic condition that is attributable to a mental or physical impairment or both, and is manifested before the age of 22 years; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration; (b) If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in a developmental disability.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): This legislation is aimed, in part, at protecting the privacy and confidentiality of patient information. “Patient” means any recipient of public or private health care, including mental health care, services.

MDCH: An acronym for Michigan Department of Community Health. This state department, located in Lansing, oversees public-funded services provided in local communities and state facilities to people with mental illness, developmental disabilities and substance use disorders.

Medically Necessary: A term used to describe one of the criteria that must be met in order for a beneficiary to receive Medicaid services. It means that the specific service is expected to help the beneficiary with his/her mental health, developmental disability or substance use (or any other medical) condition. Some services assess needs and some services help maintain or improve functioning.

Michigan Mental Health Code: The state law that governs public mental health services provided to adults and children with mental illness, serious emotional disturbance and developmental disabilities by local community mental health services programs and in state facilities.

MiChild: A Michigan health care program for low-income children who are not eligible for the Medicaid program. This is a limited benefit. Contact the [Customer Services Unit] for more information.

PIHP: An acronym for Prepaid Inpatient Health Plan. There are 18 PIHPs in Michigan that manage the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic areas. All 18 PIHPs are also community mental health services programs.

Recovery: A journey of healing and change allowing a person to live a meaningful life in a community of their choice, while working toward their full potential.

Resiliency: The ability to “bounce back.” This is a characteristic important to nurture in children with serious emotional disturbance and their families. It refers to the individual’s ability to become successful despite challenges they may face throughout their life.

Specialty Supports and Services: A term that means Medicaid-funded mental health, developmental disabilities and substance abuse supports and services that are managed by the Pre-Paid Inpatient Health Plans.

SED: An acronym for Serious Emotional Disturbance, and as defined by the Michigan Mental Health Code, means a diagnosable mental, behavioral or emotional disorder affecting a child that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders; and has resulted in functional impairment that substantially interferes with or limits the child’s role or functioning in family, school or community activities.

Serious Mental Illness: Is defined by the Michigan Mental Health Code to mean a diagnosable mental, behavioral or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders; and that has resulted in function impairment that substantially interferes with or limits one or more major life activities.

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

[Note to PIHP: you may add additional information to this template]

Template #5: Grievance and Appeals Processes

Grievances

You have the right to say that you are unhappy with your services or supports or the staff who provide them, by filing a “grievance.” You can file a grievance *any time* by calling, visiting, or writing to the [Customer Services Office.] Assistance is available in the filing process by contacting _____. You will be given detailed information about grievance and appeal processes when you first start services and then again annually. You may ask for this information at any time by contacting the [Customer Services Office]. *

Appeals

You will be given notice when a decision is made that denies your request for services or reduces, suspends or terminates the services you already receive. You have the right to file an “appeal” when you do not agree with such a decision. There are two ways you can appeal these decisions. There are also time limits on when you can file an appeal once you receive a decision about your services.

You may:

- Ask for a “Local Appeal” by contacting _____ at _____ and/or
- You can ask at any time for a Medicaid Fair Hearing before an administrative law judge (a state appeal).

Your appeal will be completed quickly, and you will have the chance to provide information or have someone speak for you regarding the appeal. You may ask for assistance from [Customer Services] to file an appeal.

*[Note to PIHPs: you may add detailed information about grievance and appeals to this template. In that case, you may wish to modify this last sentence.]

Template #6: Language assistance and accommodations

Language Assistance

If you use a TTY, please contact [customer services] at the following TTY phone number: (number).

If you need a sign language interpreter, contact the [customer services office] at (number) as soon as possible so that one will be made available. Sign language interpreters are available at no cost to you.

If you do not speak English, contact the [customer services office] at (number) so that arrangements can be made for an interpreter for you. Language interpreters are available at no cost to you.

[Note to PIHP: you should add in the handbook any other language assistance they have available]

Accessibility and Accommodations

In accordance with federal and state laws, all buildings and programs of the (PIHP name) are required to be physically accessible to individuals with all qualifying disabilities. Any individual who receives emotional, visual or mobility support from a service animal such as a dog will be given access, along with the service animal, to all buildings and programs of the (PIHP name). If you need more information or if you have questions about accessibility or service/support animals, contact [customer services] at (phone number).

If you need to request an accommodation on behalf of yourself or a family member or a friend, you can contact [customer services] at (phone). You will be told how to request an accommodation (this can be done over the phone, in person and/or in writing) and you will be told who at the agency is responsible for handling accommodation requests.

[Note to PIHP: you may add additional information to this template. To accommodate multiple affiliates, CAs or provider networks, it is acceptable to format names and numbers in the most logical way]

Template #7: Payment for Services

If you are enrolled in Medicaid and meet the criteria for the specialty mental health and substance abuse services, the total cost of your authorized mental health or substance abuse treatment will be covered.

If you are a Medicaid beneficiary with a deductible (“spend-down”), as determined by the Michigan Department of Human Services (DHS), you may be responsible for the cost of a portion of your services.

[Note to PIHP: you may add additional information to this template]

Template #8: Person-Centered Planning

The process used to design your individual plan of mental health supports, service, or treatment is called “Person-centered Planning (PCP).” PCP is your right protected by the Michigan Mental Health Code.

The process begins when you determine whom, beside yourself, you would like at the person-centered planning meetings, such as family members or friends, and what staff from [name of PIHP] you would like to attend. You will also decide when and where the person-centered planning meetings will be held. Finally, you will decide what assistance you might need to help you participate in and understand the meetings.

During person-centered planning, you will be asked what are your hopes and dreams, and will be helped to develop goals or outcomes you want to achieve. The people attending this meeting will help you decide what supports, services or treatment you need, who you would like to provide this service, how often you need the service, and where it will be provided. You have the right, under federal and state laws, to a choice of providers.

After you begin receiving services, you will be asked from time to time how you feel about the supports, services or treatment you are receiving and whether changes need to be made. You have the right to ask at any time for a new person-centered planning meeting if you want to talk about changing your plan of service.

You have the right to “independent facilitation” of the person-centered planning process. This means that you may request that someone other than the [name of PIHP] staff conduct your planning meetings. You have the right to choose from available independent facilitators.

Children under the age of 18 with developmental disabilities or serious emotional disturbance also have the right to person-centered planning. However, person-centered planning must recognize the importance of the family and the fact that supports and services impact the entire family. The parent(s) or guardian(s) of the children will be involved in pre-planning and person-centered planning using “family-centered practice” in the delivery of supports, services and treatment to their children.

Topics Covered during Person-Centered Planning

During person-centered planning, you will be told about psychiatric advance directives, a crisis plan, and self-determination (see the descriptions below). You have the right to choose to develop any, all or none of these.

Psychiatric Advance Directive

Adults have the right, under Michigan law, to a “**psychiatric advance directive.**” A psychiatric advance directive is a tool for making decisions before a crisis in which you may become unable to make a decision about the kind of treatment you want and the kind of treatment you do not want. This lets other people, including family, friends, and service providers, know what you want when you cannot speak for yourself.

Crisis Plan

You also have the right to develop a “**crisis plan.**” A crisis plan is intended to give direct care if you begin to have problems in managing your life or you become unable to make decisions and care for yourself. The crisis plan would give information and direction to others about what you would like done in the time of crisis. Examples are friends or relatives to be called, preferred medicines, or care of children, pets, or bills.

Self-determination

Self-determination is an option for payment of medically necessary services you might request if you are an adult beneficiary receiving mental health services in Michigan. It is a process that would help you to design and exercise control over your own life by directing a fixed amount of dollars that will be spent on your authorized supports and services, often referred to as an “individual budget.” You would also be supported in your management of providers, if you choose such control.

[Note to PIHP: you may add additional information to this template]

Template #9: Recipient Rights

Every person who receives public mental health services has certain rights. The Michigan Mental Health Code protects some rights. Some of your rights include:

- The right to be free from abuse and neglect
- The right to confidentiality
- The right to be treated with dignity and respect
- The right to treatment suited to condition

More information about your many rights is contained in the booklet titled “Your Rights.” You will be given this booklet and have your rights explained to you when you first start services, and then once again every year. You can also ask for this booklet at any time.

You may file a Recipient Rights complaint *any time* if you think staff violated your rights. You can make a rights complaint either orally or in writing.

If you receive substance abuse services, you have rights protected by the Public Health Code. These rights will also be explained to you when you start services and then once again every year. You can find more information about your rights while getting substance abuse services in the “Know Your Rights” pamphlet.

You may contact your local community mental health services program to talk with a Recipient Rights Officer with any questions you may have about your rights or to get help to make a complaint. Customer Services can also help you make a complaint. You can contact the Office or Recipient Rights at: or Customer Services at:

_____.

Freedom from Retaliation

If you use public mental health or substance abuse services, you are free to exercise your rights, and to use the rights protection system without fear of retaliation, harassment, or discrimination. In addition, under no circumstances will the public mental health system use seclusion or restraint as a means of coercion, discipline, convenience or retaliation.

[Note to PIHP: you may add additional information to this template]

Template #10: Recovery & Resiliency

“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential.”

Recovery is an individual journey that follows different paths and leads to different locations. Recovery is a process that we enter into and is a life long attitude. Recovery is unique to each individual and can truly only be defined by the individual themselves. What might be recovery for one person may be only part of the process for another. Recovery may also be defined as wellness. Mental health supports and services help people with mental illness in their recovery journeys. The person-centered planning process is used to identify the supports needed for individual recovery.

In recovery there may be relapses. A relapse is not a failure, rather a challenge. If a relapse is prepared for, and the tools and skills that have been learned throughout the recovery journey are used, a person can overcome and come out a stronger individual. It takes time, and that is why **Recovery** is a process that will lead to a future that holds days of pleasure and the energy to persevere through the trials of life.

Resiliency and development are the guiding principles for children with serious emotional disturbance. Resiliency is the ability to “bounce back” and is a characteristic important to nurture in children with serious emotional disturbance and their families. It refers to the individual’s ability to become successful despite challenges they may face throughout their life.

[Note to PIHP: you may add additional information to this template]

Template #11: Service Array

MENTAL HEALTH MEDICAID SPECIALTY SUPPORTS AND SERVICES DESCRIPTIONS

Note: If you are a Medicaid beneficiary and have a serious mental illness, or serious emotional disturbance, or developmental disabilities, or substance use disorder, you may be eligible for some of the Mental Health Medicaid Specialty Supports and Services listed below.

Before services can be started, you will take part in an assessment to find out if you are eligible for services. It will also identify the services that can best meet your needs. You need to know that not all people who come to us are eligible, and not all services are available to everyone we serve. If a service cannot help you, your Community Mental Health will not pay for it. Medicaid will not pay for services that are otherwise available to you from other resources in the community.

During the person-centered planning process, you will be helped to figure out the medically necessary services that you need and the sufficient amount, scope and duration required to achieve the purpose of those services. You will also be able to choose who provides your supports and services. You will receive an individual plan of service that provides all of this information.

In addition to meeting medically necessary criteria, services listed below marked with an asterisk * require a doctor's prescription.

Note: the Michigan Medicaid Provider Manual contains complete definitions of the following services as well as eligibility criteria and provider qualifications. The Manual may be accessed at www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.

Assertive Community Treatment (ACT) provides basic services and supports essential for people with serious mental illness to maintain independence in the community. An ACT team will provide mental health therapy and help with medications. The team may also help access community resources and supports needed to maintain wellness and participate in social, educational and vocational activities.

Assessment includes a comprehensive psychiatric evaluation, psychological testing, substance abuse screening, or other assessments except for physical health, conducted to determine a person's level of functioning and mental health treatment needs.

***Assistive Technology** includes adaptive devices and supplies that are not covered under the Medicaid Health Plan or by other community resources. These devices help individuals to better take care of themselves, or to better interact in the places where they live, work, and play.

Behavior Management Review: If a person's illness or disability involves behaviors that they or others who work with them want to change, their individual plan of services may include a plan that talks about the behavior. This plan is often called a "behavior

management plan.” The behavior management plan is developed during person-centered planning and then is approved and reviewed regularly by a team of specialists to make sure that it is effective and dignified, and continues to meet the person’s needs.

Clubhouse Programs are programs where members (consumers) and staff work side by side to operate the clubhouse and to encourage participation in the greater community. Clubhouse programs focus on fostering recovery, competency, and social supports, as well as vocational skills and opportunities.

Community Inpatient Services are hospital services used to stabilize a mental health condition in the event of a significant change in symptoms, or in a mental health emergency. Community hospital services are provided in licensed psychiatric hospitals and in licensed psychiatric units of general hospitals.

Community Living Supports (CLS) are activities provided by paid staff that help adults with either serious mental illness or developmental disabilities live independently and participate actively in the community. Community Living Supports may also help families who have children with special needs (such as developmental disabilities or serious emotional disturbance).

Crisis Interventions are unscheduled individual or group services aimed at reducing or eliminating the impact of unexpected events on mental health and well-being.

Crisis Residential Services are short-term alternatives to inpatient hospitalization provided in a licensed residential setting.

***Enhanced Pharmacy** includes doctor-ordered nonprescription or over-the-counter items (such as vitamins or cough syrup) necessary to manage your health condition(s) when a person’s Medicaid Health Plan does not cover these items.

***Environmental Modifications** are physical changes to a person’s home, car, or work environment that are of direct medical or remedial benefit to the person. Modifications ensure access, protect health and safety, or enable greater independence for a person with physical disabilities. Note that other sources of funding must be explored first, before using Medicaid funds for environmental modifications.

Extended Observation Beds (or 23-hour stay units) are used to stabilize a mental health emergency when a person needs to be in the hospital for only a short time. An extended observation bed allows hospital staff to observe and treat the person’s condition for up to one day before they are discharged to another community-based outpatient service or admitted to the hospital.

Family Skills Training is education and training for families who live with and or care for a family member who is eligible for specialty services or the Children’s Waiver Program.

Fiscal Intermediary Services help individuals manage their service and supports budget and pay providers if they are using a “self-determination” approach.

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

Home-Based Services for Children and Families are provided in the family home or in another community setting. Services are designed individually for each family, and can include things like mental health therapy, crisis intervention, service coordination, or other supports to the family.

Housing Assistance is assistance with short-term, transitional, or one-time-only expenses in an individual's own home that his/her resources and other community resources could not cover.

Intensive Crisis Stabilization is another short-term alternative to inpatient hospitalization. Intensive crisis stabilization services are structured treatment and support activities provided by a mental health crisis team in the person's home or in another community setting.

Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) provide 24-hour intensive supervision, health and rehabilitative services and basic needs to persons with developmental disabilities. The state of Michigan has one ICF/MR called the Mt. Pleasant Center.

Medication Administration is when a doctor, nurse, or other licensed medical provider gives an injection, or an oral medication or topical medication.

Medication Review is the evaluation and monitoring of medicines used to treat a person's mental health condition, their effects, and the need for continuing or changing their medicines.

Mental Health Therapy and Counseling for Adults, Children and Families includes therapy or counseling designed to help improve functioning and relationships with other people.

Nursing Home Mental Health Assessment and Monitoring includes a review of a nursing home resident's need for and response to mental health treatment, along with consultations with nursing home staff.

***Occupational Therapy** includes the evaluation by an occupational therapist of an individuals' ability to do things in order to take care of themselves every day, and treatments to help increase these abilities.

Partial Hospital Services include psychiatric, psychological, social, occupational, nursing, music therapy, and therapeutic recreational services in a hospital setting, under a doctor's supervision. Partial hospital services are provided during the day – participants go home at night.

Peer-delivered and Peer Specialist Services. Peer-delivered services such as drop-in centers are entirely run by consumers of mental health services. They offer help with

food, clothing, socialization, housing, and support to begin or maintain mental health treatment. Peer Specialist services are activities designed to help persons with serious mental illness in their individual recovery journey and are provided by individuals who are in recovery from serious mental illness.

Personal Care in Specialized Residential Settings assists an adult with mental illness or developmental disabilities with activities of daily living, self-care and basic needs, while they are living in a specialized residential setting in the community.

***Physical Therapy** includes the evaluation by a physical therapist of a person's physical abilities (such as the ways they move, use their arms or hands, or hold their body), and treatments to help improve their physical abilities.

Prevention Service Models (such as Infant Mental Health, School Success, etc.) use both individual and group interventions designed to reduce the likelihood that individuals will need treatment from the public mental health system.

Respite Care Services provide short-term relief to the unpaid primary caregivers of people eligible for specialty services. Respite provides temporary alternative care, either in the family home, or in another community setting chosen by the family.

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

***Speech and Language Therapy** includes the evaluation by a speech therapist of a person's ability to use and understand language and communicate with others or to manage swallowing or related conditions, and treatments to help enhance speech, communication or swallowing.

Substance Abuse Treatment Services (descriptions follow the mental health services)

Supports Coordination or Targeted Case Management: A Supports Coordinator or Case Manager is a staff person who helps write an individual plan of service and makes sure the services are delivered. His or her role is to listen to a person's goals, and to help find the services and providers inside and outside the local community mental health services program that will help achieve the goals. A supports coordinator or case manager may also connect a person to resources in the community for employment, community living, education, public benefits, and recreational activities.

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

Transportation may be provided to and from a person's home in order for them to take part in a non-medical Medicaid-covered service.

Treatment Planning assists the person and those of his/her choosing in the development and periodic review of the individual plan of services.

Wraparound Services for Children and Adolescents with serious emotional disturbance and their families that include treatment and supports necessary to maintain the child in the family home.

Services for Only Habilitation Supports Waiver (HSW) and Children’s Waiver

Participants

Some Medicaid beneficiaries are eligible for special services that help them avoid having to go to an institution for people with developmental disabilities or nursing home. These special services are called the Habilitation Supports Waiver and the Children’s Waiver. In order to receive these services, people with developmental disabilities need to be enrolled in either of these “waivers.” The availability of these waivers is very limited. People enrolled in the waivers have access to the services listed above as well as those listed here:

Chore Services (for Habilitation Supports Waiver enrollees) are provided by paid staff to help keep the person’s home clean, and safe.

Non-Family Training (for Children’s Waiver enrollees) is customized training for the paid in-home support staff who provide care for a child enrolled in the Waiver.

Out-of-home Non-Vocational Supports and Services (for HSW enrollees) is assistance to gain, retain or improve in self-help, socialization or adaptive skills.

Personal Emergency Response devices (for HSW enrollees) help a person maintain independence and safety, in their own home or in a community setting. These are devices that are used to call for help in an emergency.

Prevocational Services (for HSW enrollees) include supports, services and training to prepare a person for paid employment or community volunteer work.

Private Duty Nursing (for HSW enrollees) is individualized nursing service provided in the home, as necessary to meet specialized health needs.

Specialty Services (for Children’s Waiver enrollees) are music, recreation, art, or massage therapies that may be provided to help reduce or manage the symptoms of a child’s mental health condition or developmental disability. Specialty services might also include specialized child and family training, coaching, staff supervision, or monitoring of program goals.

Services for Persons with Substance Use Disorders

The Substance Abuse treatment services listed below are covered by Medicaid. These services are available through [PIHP or SA Coordinating Agency]

Access, Assessment and Referral (AAR) determines the need for substance abuse services and will assist in getting to the right services and providers.

Outpatient Treatment includes counseling for the individual, and family and group therapy in an office setting.

Intensive Outpatient (IOP) is a service that provides more frequent and longer counseling sessions each week and may include day or evening programs.

Methadone and LAAM Treatment is provided to people who have heroin or other opiate dependence. The treatment consists of opiate substitution monitored by a doctor as well as nursing services and lab tests. This treatment is usually provided along with other substance abuse outpatient treatment.

Sub-Acute Detoxification is medical care in a residential setting for people who are withdrawing from alcohol or other drugs.

Residential Treatment is intensive therapeutic services which include overnight stays in a staffed licensed facility.

If you receive Medicaid, you may be entitled to other medical services not listed above. Services necessary to maintain your physical health are provided or ordered by your primary care doctor. If you receive Community Mental Health services, your local community mental health services program will work with your primary care doctor to coordinate your physical and mental health services. If you do not have a primary care doctor, your local community mental health services program will help you find one.

Note: **Home Help Program** is another service available to Medicaid beneficiaries who require in-home assistance with activities of daily living, and household chores. In order to learn more about this service, you may call the local Michigan Department of Human Services' number below or contact the [Customer Services Office] for assistance.
[Name and phone number of the local MDHS]

Medicaid Health Plan Services

If you are enrolled in a Medicaid Health Plan, the following kinds of health care services are available to you when your medical condition requires them.

- Ambulance
- Chiropractic
- Doctor visits
- Family planning
- Health check ups
- Hearing aids
- Hearing and speech therapy
- Home Health Care
- Immunizations (shots)
- Lab and X-ray
- Nursing Home Care
- Medical supplies
- Medicine
- Mental health (limit of 20 outpatient visits)
- Physical and Occupational therapy
- Prenatal care and delivery
- Surgery
- Transportation to medical appointments

- Vision

If you already are enrolled in one of the health plans listed below you can contact the health plan directly for more information about the services listed above. If you are not enrolled in a health plan or do not know the name of your health plan, you can contact the [Customer Services Office] for assistance.

[List of health plans and contact numbers]

Template #12: Service Authorization

Services you request must be authorized or approved by [the PIHP or its designee]. That agency may approve all, some or none of your requests. You will receive notice of a decision within 14 calendar days after you have requested the service during person-centered planning, or within 3 business days if the request requires a quick decision

Any decision that denies a service you request or denies the amount, scope or duration of the service that you request will be made by a health care professional who has appropriate clinical expertise in treating your condition. Authorizations are made according to medical necessity. If you do not agree with a decision that denies, reduces, suspends or terminates a service, you may file an appeal.

[Note to PIHP: you may add additional information to this template]

**GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT
PIHP GRIEVANCE SYSTEM FOR MEDICAID BENEFICIARIES**

July 2004

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I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with Medicaid Beneficiary Grievance System requirements for grievances and appeals contained in Part 11, 6.3.2 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Community Health (DCH). These requirements are applicable to all PIHPs, affiliate Community Mental Health Services Programs (CMHSPs), Substance Abuse Coordinating Agencies (CAs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance System processes required for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

The term "Grievance system," as used in the federal regulations refers to the overall system for Medicaid beneficiary grievances and appeals, required in the Medicaid managed care context. Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, as defined in this document, and those challenging anything else. A challenge to an action is called an **appeal**. Any other type of complaint is considered a **grievance**.

The Due Process Clause of the U.S. Constitution guarantees that Medicaid beneficiaries must receive "due process" whenever benefits are denied, reduced or terminated. Due Process includes: (1) prior written notice of the adverse action (2) a fair hearing before an impartial decision maker (3) continued benefits pending a final decision and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements.

Consumers of mental health services who are Medicaid beneficiaries eligible for Speciality Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act (BBA) of 1997.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Beneficiaries, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the 'Code") Chapters 7,7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705)

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

Action: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **45 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **three (3) working days** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Note: The term "action" is also referred to as an "adverse action" in this document.

Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as "**B3**" waiver services.

Adequate Notice of Action: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid **services requested**. Notice is provided to the Medicaid beneficiary **on the same date** the action takes effect, or at the time of the signing of the individual plan of services/supports.

Advance Notice of Action: Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided**. Notice to be provided/mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

Appeal: Request for a review of an "action" as defined above.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Expedited Appeal: The expeditious review of an action, requested by a beneficiary or the beneficiary's provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP must grant the request.

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a DCH Administrative Law Judge. Also referred to as "Administrative Hearing".

Grievance: Medicaid Beneficiary's expression of dissatisfaction about PIHP/CMHSP service issues, **other than an action**. Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

Grievance Process: Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues **other than an action**.

Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

Local Appeal Process: Impartial local level PIHP review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Disposition: Written statement of the PIHP decision for each local appeal and/or grievance, provided to the beneficiary.

Recipient Rights Complaint: Written or verbal statement by a consumer, or anyone acting on behalf of the consumer, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

111. GRIEVANCE SYSTEM GENERAL REQUIREMENTS

Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts with PIHPs, that each PIHP has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438.

The grievance system must provide Medicaid beneficiaries:

- A local PIHP appeal process for challenging an "action" taken by the PIHP or one of its agents.
- Access to the state level fair hearing process for an appeal of an "action".
- A local PIHP grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an "action".
- The right to **concurrently** file a PIHP level appeal of an action, **and** request a State fair hearing on an action, **and** file a PIHP level grievance regarding other service complaints.
- The right to request a State fair hearing **before exhausting** the PIHP level appeal of an "action".
- The right to request, and have, Medicaid benefits continued while a local PIHP appeal and/or state fair hearing is pending.
- The right to have a provider, acting on the beneficiary's behalf and with the beneficiary's written consent, file an appeal to the PIHP. The provider may file a grievance or request for a state fair hearing on behalf of the beneficiary **only if** the State permits the provider to act as the beneficiary's authorized representative in doing so.

IV. SERVICE AUTHORIZATION DECISIONS

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP **must provide** the beneficiary written service authorization decision within specified timeframes and as expeditiously as the beneficiary's health condition requires. The service authorization must meet the requirements for either **standard** authorization or **expedited** authorization:

- **Standard Authorization:** Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and **no later than 14 calendar days** following receipt of a request for service.

If the beneficiary or provider requests an extension **OR** if the PIHP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the **14 calendar day** time period by up to **14 additional calendar days**.

Expedited authorization: In cases in which a provider indicates, or the PIHP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

If the beneficiary requests an extension, or if the PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the three (3) working day time period by up to **14 calendar days**.

When a **standard or expedited** authorization of services decision is extended, the PIHP must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

V. NOTICE OF ACTION

A Notice of Action must be provided to a Medicaid beneficiary when a service authorization decision constitutes an "**action**" by authorizing a service in amount, duration or scope@ than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP has taken, or intends to take and the process available to appeal the decision.

PIHP Notice of Action requirements include:

The notice of action to the beneficiary must be in writing and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).

- The requesting provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the provider is not required to be in writing.
- **If** the beneficiary or representative requests a local appeal or a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the appeal.
- **If** the beneficiary's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.
- **If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an action, and requires a written notice of action.**

The notice of action must be either Adequate or Advance:

- **Adequate notice:** is a written notice provided to the beneficiary **at the time of EACH** action. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate notice provisions.
- **Advance notice:** is a written notice required when an action is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed **12 calendar days** before the intended action takes effect.

The content of both adequate and advance notices must include an explanation of:

What action the PIHP has taken or intends to take,

- The reason(s) for the action,
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,
- The beneficiary's or provider's right to file a PIHP appeal, and instructions for doing so,
- The beneficiary's right to request a State fair hearing, and instructions for doing so,
- The circumstances under which expedited resolution can be requested, and instructions for doing so,
- An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend or other spokesman.

The content of an advance notice must also include an explanation of:

The circumstances under which services will be continued pending resolution of the appeal,

- How to request that benefits be continued, and
- The circumstances under which the beneficiary may be required to pay the costs of these services.

NOTE: Examples of adequate and advance notices containing required content are in Exhibits A and B at the end of this document.

There are limited exceptions to the advance notice requirement. The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF:**

- The PIHP has factual information confirming the death of the beneficiary.
- The PIHP receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
- The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
- The beneficiary's whereabouts are unknown and the post office returns PIHP mail directed to him/her indicating no forwarding address.
- The PIHP establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
- A change in the level of medical care is prescribed by the beneficiary's physician
- The date of the action will occur in less than **10 calendar days**.

The Notice of Action must be mailed within the following timeframes:

- **At least 12 calendar days before** the date of an action to terminate suspend or reduce previously authorized Medicaid covered services(s) (Advance)
- **At the time of the decision** to deny payment for a service (Adequate)
- **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services (Adequate).
- **Within 3 working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

If the PIHP is unable to complete either a standard or expedited service authorization to deny or limit services within the timeframe requirement, the timeframe may be **extended up to an additional 14 calendar days**.

If the PIHP extends the timeframe, it must:

- Give the beneficiary written notice, no later than the date the current timeframe expires, of the reason for the decision to extend the timeframe and inform the

beneficiary of the right to file an appeal if he or she disagrees with that decision;
and

- Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

The PIHP **must** continue Medicaid services previously authorized while the PIHP appeal and/or State fair hearing are pending **if**:

- The Beneficiary specifically requests to have the services continued, and
- The Beneficiary or provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

When the PIHP continues or reinstates the beneficiary's services while the appeal is pending, the services must be continued until one of the following occurs:

- The beneficiary withdraws the appeal.
- **Twelve calendar** days pass after the PIHP mails the notice of disposition providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **12 day** timeframe, has requested a State fair hearing with continuation of services until a State fair hearing decision is reached.
- A State fair hearing office issues a hearing decision adverse to the beneficiary. The time period or service limits of the previously authorized service has been met.

If the PIHP, or the DCH fair hearing administrative law judge **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations.

If the PIHP, or the DCH fair hearing administrative law judge **reverses a decision** to deny, limit, or delay services that were **not furnished** while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

VII. STATE FAIR HEARING APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

- A Medicaid beneficiary has the right to request a fair hearing when the PIHP or its contractor takes an "action", or a grievance request is not acted upon within **60 calendar days**. The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary. (See section VI above for Notice information.)
- The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- Beneficiaries are given **90 calendar days** from the date of the notice to file a request for a fair hearing.
- If the beneficiary, or representative, requests a fair hearing not more than 12 **calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the action.
- The parties to the state fair hearing include the PIHP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate.
- Expedited hearings are available.

Detailed information and instructions for the Fair Hearing process can be found in the DCH Administrative Tribunal Policy and Procedures Manual online at:

www.michigan.gov/documents/mdch/ADMN_HEARING_PAMPHLET_MARCH_2008_227657_7.pdf

VIII. LOCAL APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP appeals, like those for fair hearings, are initiated by an "action". The beneficiary may request a local appeal under the following conditions:

- The beneficiary has **45 calendar days** from the date of the notice of action to request a local appeal.
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution.
The beneficiary may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary, or representative, requests a local appeal not more than 12 **calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing.

When a beneficiary requests a local appeal, the PIHP is required to:

- Give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. Acknowledge receipt of each appeal.
- Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program. Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues.
- Provide the beneficiary, or representative with:
 - o Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;
 - o Opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process;
 - o Opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate;
 - o Information regarding the right to a fair hearing and the process to be used to request the hearing.

Notice of Disposition requirements:

- The PIHP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution. The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:
 - o The right to request a state fair hearing, and how to do so;
 - o The right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request; and
 - o That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action.

The Notice of Disposition must be provided within the following timeframes:

- **Standard Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP receives the appeal.

- **Expedited Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties no longer than **three (3) working** days after the PIHP receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.
- The PIHP may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.
- If the PIHP denies a request for expedited resolution of an appeal, it must:
 - o Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP receives the appeal;
 - o Make reasonable efforts to give the beneficiary **prompt oral notice** of the denial, and
 - o Give the beneficiary follow up **written notice** within **two (2) calendar days**.

IX. LOCAL GRIEVANCE PROCESS

Federal regulations provide Medicaid beneficiaries the right to a local grievance process for **issues that are not "actions"**.

Beneficiary grievances:

- Shall be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.
- **Do not** have access to the state fair hearing process **unless**, the PIHP fails to respond to the grievance **within 60 calendar days**. This constitutes an 'action', and can be appealed for fair hearing to the DCH Administrative Tribunal.

For each grievance filed by a beneficiary, the PIHP is required to:

- Give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability
- Acknowledge receipt of the grievance;
- Log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program.

- Ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on the grievance are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance:
 - o Involves clinical issues, or
 - o Involves the denial of an expedited resolution of an appeal (of an action).
- Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written **notice of disposition** not to exceed **60 calendar days** from the day PIHP received the grievance/complaint. The content of the notice of disposition must include:
 - o The results of the grievance process
 - o The date the grievance process was concluded.
 - o The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance and
 - o How to access the fair hearing process.

X. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy.

PIHP Grievance System records should contain sufficient information to accurately reflect:

- The process in place to track requests for Medicaid services denied by the PIHP or any of its providers.
The volume of denied claims for services in the most recent year.

XI. RECIPIENT RIGHTS COMPLAINT PROCESS

Medicaid beneficiaries, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.

EXHIBIT A ADEQUATE NOTICE OF ACTION (SAMPLE FORM)

ADEQUATE ACTION NOTICE

Date
Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear

Following a review of the mental health services for which you have applied, it has been determined that the following service(s) shall not be authorized.

Service(s)	Effective Date
-------------------	-----------------------

The reason for this action is <reason> . The legal basis for this decision is 42 CFR 440.2301d).

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the "Request for Hearing" form, and return it in the enclosed pre-addressed envelope, or mail to:

**ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30195
LANSING, MI 48909-7695**

ADEQUATE ACTION NOTICE

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You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

If you do not agree with this action, you may request a local appeal, either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>

<Address>

<City, State ZIP>

<Phone Number - Voice>

<Phone Number - **FAX**>

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:

Hearing Request Form

Return Envelope

EXHIBIT B ADVANCE NOTICE OF ACTION (SAMPLE FORM)

ADVANCE ACTION NOTICE

Date

Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear

Following a review of mental health services and supports that you are currently receiving, it has been determined that the following service(s) shall be <reduced, terminated or suspended> effective <date>.

Service(s)	Effective Date
-------------------	-----------------------

The reason for this action is <reason>. The legal basis for this decision is 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the enclosed "Request for Hearing" form, and return it in the enclosed pre-addressed envelope, or mail to:

**ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30195
LANSING, MICHIGAN 48909-7695**

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

ADVANCE ACTION NOTICE

Page 2

You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a fair hearing you may be required to repay the benefits. This may occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

If you do not agree with this action, **you may also request a local appeal**, either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>

<Address>

<City, State ZIP>

<Phone Number - Voice>

<Phone Number - **FAX**>

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:

Hearing Request Form

Return Envelope

**Medicaid Managed Specialty
Supports and Services
1915 (b)/(c) Waiver Program**

Contract Attachment

P 6.4.1.1

Procurement Technical Requirement

PROCUREMENT TECHNICAL REQUIREMENT

PROCUREMENT AND SELECTIVE CONTRACTING UNDER MANAGED CARE

Introduction

The assumption of managed care responsibilities for specialized Medicaid mental health, developmental disabilities and/or substance abuse services has implications for the procurement and selective contracting activities of Community Mental Health Service Programs (CMHSPs) and Regional Substance Abuse Coordinating Agencies (RSACAs). Soliciting providers and programs for the service delivery system, acquiring claims processing capabilities, enhancements to management information system capacity, or obtaining general management's services to assist in the administration of the managed care program, must be done with due deliberation and sensitivity to procurement and contracting issues.

Procurement of Automatic Data Processing Services and Comprehensive Administrative or Management Services

The Michigan Department of Community Health's (MDCH) plan to make sole source "sub-awards" for the administration and provision of Medicaid mental health, developmental disability and substance abuse services raises questions about the applicability of federal procurement regulations to CMHSP and RSACA procurement and contracting activities. Federal regulations regarding procurement are described in the Code of Federal Regulations, (45 CFR Part 74; 42 CFR § 434), Office of Management and Budget Circular A-110, and State Medicaid Manual Part 2 (Sections 2083 through 2087).

In general, these regulations and requirements give the State fairly wide latitude in determining the procedural aspects and applicable circumstances for procurement processes. However, the MDCH's preliminary interpretation of these regulations suggests that procurement for significant automatic data processing services related to the operation of the Medicaid carve-out program, and contracts for comprehensive management services (so-called MSO or ASO arrangements) must be conducted in compliance with federal procurement requirements outlined in the documents listed above.

Procurement and Contracting for Service Providers

CMHSPs and RSACAs will also be soliciting providers to furnish programs, services and/or supports for Medicaid recipients needing mental health, developmental disability or substance abuse services. When soliciting providers, it should be the objective of each CMHSP or RSACA to acquire needed services and supports at fair and economical prices, with appropriate attention to quality of care and maintenance of exiting-care relationships and service networks currently used by Medicaid recipients. Procurement processes should be used to solicit such services. Depending on the circumstances (e.g., local area market conditions, kind or quantity of services needed, etc.) various methods for selecting providers may be used including:

1. Procurement for Selective Contracting¹

The CMHSP or RSACA (as the managing entity) purchases services from a limited number of providers who agree to fulfill contractual obligations for an agreed upon price. The managing entity identifies the specific services to be provided, seeks proposals/price bids, and awards contracts to the best bidders. Contracts are let only with a sufficient number of providers to assure adequate access to services. The prospect of increased volume induces providers to bid lower prices.

2. Procurement to Obtain Best Prices Without Selective Contracting

Under an “any willing and qualified provider” process, bids can be solicited and used to set prices for a service, and then contracts or provider agreements can be offered to any qualified provider that is willing to fulfill the contract and meet the bid price.

(NOTE: A procurement process must be used when the managing entity is planning to restrict or otherwise limit the number of providers who can participate in the program.)

3. Non-Competitive Solicitation and/or Selection of Providers

Under certain circumstances, the managing entity may select providers without a competitive procurement process. These circumstances are:

- The service is available only from a single source;
- There is a public exigency or emergency, and the urgency for obtaining the service does not permit a delay incident to competitive solicitation;
- After solicitation of a number of sources, competition is determined inadequate;
- The services involved are professional services (e.g., psychological testing) of limited quantity or duration;
- The services are unique (e.g., financial intermediaries for consumers using vouchers or personal service budgets) and/or the selection of the service provider has been delegated to the consumer under a self-determination program; and

¹ Competitive procurement is usually pursued through either a **COMPETITIVE SEALED BIDDING** method (the process of publicizing government needs, inviting bids, conducting public bid openings, and awarding a contract to the lowest responsive and responsible bidder) or a **COMPETITIVE SEALED PROPOSAL** process (method of publicizing government needs, requesting proposals, evaluating proposals received, negotiating proposals with acceptable or potentially acceptable offerors, and awarding the contract after consideration of evaluation factors in the RFP and the price offered).

- Existing residential service systems, where continuity of care arrangements are of paramount concern.

In these situations, the managing entity may employ noncompetitive negotiation to secure the needed services. The single- or limited-source procurement process involves soliciting interest and negotiating with a single or limit set of providers. Again, this may be used where competition for a service is deemed inadequate or when the uniqueness of the services or other considerations limits competitive procurement possibilities.

Whether a competitive procurement or noncompetitive solicitation process is used, the managing entity must ensure that organizations or individuals selected and offered contracts have not been previously sanctioned by the Medicaid program resulting in prohibition of their participation in the program.

Checklists for Procurement
(adapted from Section 2087 of the State Medicaid Manual)

This checklist is provided as a guide for planning procurement activities. Use is not mandatory.

1. Planning Checklist

- * Has an analysis been conducted to determine if a procurement process should be initiated (need for services, available providers, likelihood of cost savings, etc.)? Have consumers and family members been involved in this analysis?
- * If a procurement process is warranted, what form should it take?
 - * Automatic data processing (ADP) services, significant management information system enhancements, comprehensive management support functions
 - * Full Compliance with CFR regulations, OMB Circulars and HCFA State Medicaid Manual
 - * Acquisition of Service Provider Capacity - Network Participation
 - * Competitive Sealed Bids
 - * Competitive Negotiation
 - * Non-Competitive Negotiations (if solicitation falls under the exception criteria listed above)

2. Request for Proposals Checklist (Competitive Procurement for Providers)

- * Have consumers and families been involved in developing the request for proposals?
- * Are the major time frames of the RFP for response by competitors, evaluation period, award, contract negotiation, implementation and contract start-up time adequate to assure interested contractors a sufficient period to prepare a proposal and assume operations in an orderly manner?
- * Does the RFP contain a detailed and clear description of the scope of work to be contracted?
- * Does the RFP provide for:
 - * Answering written questions from a prospective bidder about the RFP?
 - * Acceptance of a late or alternate proposal or withdrawal of a proposal?

- * Evidence of adequate financial stability of the bidder and of any parent organization?
 - * Performance standards?
 - * A time-frame requirement for guarantee of all prices quoted in the proposal?
 - * Acceptance by a bidder of any reduction in payments for nonperformance?
 - * A bidders' conference?
 - * The general overall evaluation criteria, including maximum points available by category?
 - * A reference to applicable code requirements, administrative rules, board policies, and managed care program stipulations?
- * Does the RFP provide for open solicitation of all technically competent contractors?
 - * Does the RFP list procedures for handling changes to the RFP that occur after some proposals are submitted, identify who will be notified of the changes, and describe how they will be made?
 - * Are there any requirements in the RFP that would unduly or unfairly restrict or limit competition among prospective bidders?
 - * Does the RFP include a copy of the Managing Entity's proposed contract?

Proposal Evaluation Plan (PEP) Checklist

- * Does the PEP consider the following in the evaluation of proposals?
 - * **Contractor Capability**
Staff qualifications and general experience; Experience with Title XIX or similar programs; Experience in service to the target populations; Contractor stability (including financial stability and reputation in the field); Evaluation by previous clients.
 - * **Technical Approach**
Understanding of the scope, objectives, and requirements; Proper emphasis on various job elements; Responsiveness to specifications; Clarity of statement of implementation plan.
 - * **Financial Aspects**
Realism of total cost estimate and cost breakdown; Realism of estimated hours of staff time; Hourly rate structure; Reasonableness of implementation costs; Reasonableness of turnover costs.

4. Report of the Selection Committee Checklist

- * Are consumers and family members included on the proposal evaluation team?
- * If a contractor that did not submit the lowest offer was selected, was its selection justified as being most advantageous to the CMHSP or RSACA?
- * Is the selection committee's tabulation of proposal scores complete and accurate?
- * Is the evaluation process free of bias?
- * Is a meeting for debriefing of unsuccessful bidders offered after the announcement of the contract award?
- * Did the evaluation committee substantiate reasons a prospective bidder was determined to be non-responsive?
- * Did the evaluation committee document valid reasons for not awarding the maximum points in each category and/or the reasons for awarding bonus points?

Department of Community Health Mental Health and Substance Abuse Administration

CREDENTIALING AND RE-CREDENTIALING PROCESSES

A. Overview

This policy covers credentialing, temporary/provisional credentialing and re-credentialing processes for those individual and organizational providers directly or contractually employed by Prepaid Inpatient Health Plans (PIHPs), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Medicaid program. The policy does not establish the acceptable scope of practice for any of the identified providers, nor does it imply that any service delivered by the providers identified in the body of the policy is Medicaid billable or reimbursable. PIHPs are responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements. Please reference the applicable licensing statutes and standards, as well as the Medicaid Provider Manual should you have questions concerning scope of practice or whether Medicaid funds can be used to pay for a specific service.

Note: The individual practitioner and organizational provider credentialing process contains two primary components: initial credentialing and re-credentialing. MDCH recognizes that PIHPs may have a process that permits initial credentialing on a provisional or temporary basis, while required documents are obtained or performance is assessed. The standards that govern these processes are in the sections that follow.

B. Credentialing Individual Practitioners

The PIHP must have a written system in place for credentialing and re-credentialing individual practitioners included in their provider network who are not operating as part of an organizational provider.

1. Credentialing and re-credentialing must be conducted and documented for at least the following health care professionals:
 - a. Physicians (M.D.s and D.O.s)
 - b. Physician's Assistants
 - c. Psychologists (Licensed, Limited License, and Temporary License)
 - d. Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians
 - e. Licensed Professional Counselors

- f. Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses
 - g. Occupational Therapists and Occupational Therapist Assistants
 - h. Physical Therapists and Physical Therapist Assistants
 - i. Speech Pathologists
2. The PIHP must ensure:
- a. The credentialing and re-credentialing processes do not discriminate against:
 - (1) A health care professional, solely on the basis of license, registration or certification; or
 - (2) A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.
 - b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available on their website at <http://exclusions.oig.hhs.gov>. A complete list of sanctioned providers is available on the Michigan Department of Community Health website at www.michigan.gov/mdch. (Click on Providers, click on Information for Medicaid Providers, click on List of Sanctioned Providers)
3. If the PIHP delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this policy, it must retain the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services a provider selected by that entity and meet all requirements associated with the delegation of PIHP functions. The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions.
4. Compliance with the standards outlined in this policy must be demonstrated through the PIHP's policies and procedures. Compliance will be assessed based on the PIHP's policies and standards in effect at the time of the credentialing/re-credentialing decision.
5. The PIHP's written credentialing policy must reflect the scope, criteria, timeliness and process for credentialing and re-credentialing providers. The policy must be approved by the PIHP's governing body, and

- a. Identify the PIHP administrative staff member and/or entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineate their role;
 - b. Describe any use of participating providers in making credentialing decisions;
 - c. Describe the methodology to be used by PIHP staff members or designees to provide documentation that each credentialing or re-credentialing file was complete and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation;
 - d. Describe how the findings of the PIHP's Quality Assessment Performance Improvement Program are incorporated into the re-credentialing process.
6. PIHPs must ensure that an individual credentialing/re-credentialing file is maintained for each credentialed provider. Each file must include:
- a. The initial credentialing and all subsequent re-credentialing applications;
 - b. Information gained through primary source verification; and
 - c. Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and re-credentialing standards.

C. Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of the individual practitioners must require:

1. A written application that is completed, signed and dated by the provider and attests to the following elements:
 - a. Lack of present illegal drug use.
 - b. Any history of loss of license and/or felony convictions.
 - c. Any history of loss or limitation of privileges or disciplinary action.
 - d. Attestation by the applicant of the correctness and completeness of the application.
2. An evaluation of the provider's work history for the prior five years.
3. Verification from primary sources of:

- a. Licensure or certification.
- b. Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.
- c. Documentation of graduation from an accredited school.
- d. National Practitioner Databank (NPDB)/ Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
 - (1) Minimum five-year history of professional liability claims resulting in a judgment or settlement;
 - (2) Disciplinary status with regulatory board or agency; and
 - (3) Medicare/Medicaid sanctions.
- e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a), (b), and (c) above.

D. Temporary/Provisional Credentialing of Individual Practitioners

Temporary or provisional credentialing of individual practitioners is intended to increase the available network of providers in underserved areas, whether rural or urban. PIHPs must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of Medicaid Beneficiaries that providers be available to provide care prior to formal completion of the entire credentialing process. Temporary or provisional credentialing shall not exceed 150 days.

The PIHP shall have up to 31 days from receipt of a complete application, accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.

For consideration of temporary or provisional credentialing, at a minimum a provider must complete a signed application that must include the following items:

1. Lack of present illegal drug use.
2. History of loss of license, registration, or certification and/or felony convictions.
3. History of loss or limitation of privileges or disciplinary action.

4. A summary of the provider's work history for the prior five years.
5. Attestation by the applicant of the correctness and completeness of the application.

The PIHP must conduct primary source verification of the following:

1. Licensure or certification;
2. Board certification, if applicable, or the highest level of credential attained; and
3. Medicare/Medicaid sanctions.

The PIHP's designee must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification as outlined in this Section, should be completed.

E. Re-credentialing Individual Practitioners

At a minimum, the re-credentialing policies for physicians and other licensed, registered, or certified health care providers must identify procedures that address the re-credentialing process and include requirements for each of the following:

1. Re-credentialing at least every two years.
2. An update of information obtained during the initial credentialing.
3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
 - a. Medicare/Medicaid sanctions.
 - b. State sanctions or limitations on licensure, registration or certification.
 - c. Member concerns which include grievances (complaints) and appeals information.
 - d. PIHP Quality issues.

F. Credentialing Organizational Providers

For organizational providers included in its network:

1. Each PIHP must validate, and re-validate at least every two years, that the organizational provider is licensed or certified as necessary to operate in the State, and has not been excluded from Medicaid or Medicare participation.
2. The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and re-credential their directly employed and subcontract direct service providers in accordance with the PIHP's credentialing/re-credentialing policies and procedures (which must conform to MDCH's credentialing process).

G. Deemed Status

Individual practitioners or organizational providers may deliver healthcare services to more than one PIHP. A PIHP may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where a PIHP chooses to accept the credentialing decision of another PIHP, they must maintain copies of the credentialing PIHP's decisions in their administrative records.

H. Notification of Adverse Credentialing Decision

An individual practitioner or organizational provider that is denied credentialing or re-credentialing by the PIHP shall be informed of the reasons for the adverse credentialing decision in writing by the PIHP.

I. Appeal of Adverse Credentialing Decision

Each PIHP shall have an appeal process that is available when credentialing or re-credentialing is denied, suspended or terminated for any reason other than lack of need. The appeal process must be consistent with applicable federal and state requirements.

J. Reporting Requirements

The PIHP must have procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from the PIHP's provider network to appropriate authorities (i.e., DCH, the provider's regulatory board or agency, the Attorney General, etc.). Such procedures shall be consistent with current federal and state requirements, including those specified in the DCH Medicaid Managed Specialty Supports and Services Contract.

Definitions

National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB) The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. HRSA. They can be located on the Internet at www.npdb-hipdb.hrsa.gov/.

Organizational providers are entities that directly employ and/or contract with individuals to provide health care services. Examples of organizational providers include, but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units and partial hospitalization programs; substance abuse programs; and home health agencies.

PIHPs is a Prepaid Inpatient Health Plan under contract with the Department of Community Health to provide managed behavioral health services to Medicaid eligible individuals.

Provider is any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.

**Medicaid Managed Specialty
Supports and Services
1915 (b)/(c) Waiver Program**

Contract Attachment

P 6.4.5.1 A

**CMHSP/PIHP Model Agreement:
Behavioral Health**

CMHSP/HP MODEL AGREEMENT: BEHAVIORAL HEALTH

The agreements between the Health Plan and the local behavioral health contractor (CMHSP) must incorporate and address all of the items and areas listed and described below. These standard provisions are as follows:

- Legal Basis
- Term of Agreement
- Administration
- Areas of Shared Responsibility
- Referral
- Interagency Assessment and Supports/Services Planning
- Emergency Services
- Pharmacy and Laboratory Service Coordination
- Medical Coordination
- Quality Improvement Coordination
- Data and Reporting Requirements
- Grievance and Complaint Resolution
- Dispute Resolution
- Governing Laws

This agreement is made and entered into this ____ day of _____, in the year ____ by and between _____ (Health Plan) and _____ (CMHSP).

A. Legal Basis

Whereas, P.A. 352 of the Public Acts of 1996 permits the Michigan Department of Community Health to increase the enrollment of Medicaid-eligible persons in health plans on a capitated basis; and

Whereas, in order to expand enrollment, the Michigan Department of Community Health has established a competitive bid process that has resulted in contracts with health plans that are deemed to be qualified to provide specified health care services to Medicaid enrollees; and

Whereas, the majority of Medicaid-covered mental health services will be provided through arrangements between the Michigan Department of Community Health and selected behavioral health providers; and

Whereas, Community Mental Health Service Programs (CMHSPs) are designated as the Behavioral Health Provider under contract with the Michigan Department of Community Health and consistent with the Mental Health Code; and

Whereas, Health Plans and CMHSPs should coordinate and collaborate efforts in order to promote and protect the health of the Medicaid-enrolled population;

Now, therefore, the Health Plan and the CMHSP agree as follows:

B. Term of Agreement

This agreement will be effective _____ in the year _____ for a period not to exceed _____. Agreement will be subject to amendment due to changes in the contracts between the Michigan Department of Community Health and the Health Plan or the contract with the CMHSPs.

Upon signed agreement of both parties, the provisions of this agreement will be extended for a time frame consistent with the contract period of the Health Plan and the Michigan Department of Community Health. Either party may cancel the agreement upon 30 days written notice.

C. Administration and Point of Authority

The Health Plan shall designate in writing to the CMHSP the person who has authority to administer this agreement. The CMHSP shall designate in writing to the Health Plan the person who has authority to administer this agreement.

D. Areas of Shared Responsibility

In order to provide the most efficient and coordinated services to Medicaid enrollees, the responsibilities of the Health Plan and CMHSP will include:

1. Referral

Mutually Served Consumers

This refers to health plan members who also receive specialized CMHSP behavioral health services. Mutual consumer groups will be defined according to clinical criteria agreed upon between the individual CMHSP and the Health Plan. For adults with severe and persistent mental illness, and for children and adolescents with severe emotional disturbance, the criteria should be based upon the combination of diagnosis, degree of disability, duration, and prior service utilization. Services to be provided by the Health Plan and by the CMHSP may vary for different clinically-defined groups.

Entry to CMHSP Specialized Behavioral Health Services

This is the process of obtaining CMHSP approval for a health plan member to receive specialized behavioral health services from CMHSP. Specialized behavioral health services means those provided by a psychiatric hospital or inpatient unit of a community hospital, partial hospitalization services, or those unique services of CMHSP that support persons in community environments and/or provide alternatives to, or decrease the need for, psychiatric inpatient services or state facility services. These might include services such as assertive community treatment, specialized residential services, day program services, mental health clinic services, psychosocial rehabilitation services, homebased services, etc.

Services to Be Provided (Benefit Packages and Limitations)

The intent of establishing written procedures between Health Plans and CMHSPs is to assure service coordination and continuity of care for persons receiving services from both organizations. Therefore, it is essential that the parties define the service/coverage package that will be provided by each party to mutual consumers. This must also specify any limitations on amounts of services, including but not restricted to:

- * emergency services;
- * inpatient psychiatric hospital and other hospital services;
- * outpatient mental health services;
- * physician services, especially neurological assessments and treatment, diagnostics, and orders for therapies;
- * pharmacy and laboratory services;
- * therapies (physical, occupational, speech);
- * mental health clinic services;
- * personal care services including Home Help and specialized mental health personal care;
- * substance abuse services; or
- * transportation to medical services and to mental health services.

2. Interagency Assessment and Supports/Services Planning

This includes collaborative joint supports/services, and/or treatment planning activities of the consumer, the CMHSP, and the Health Plan regarding mental health services, specialty developmental disability services and medical services provided by each party to the mutual consumer.

It includes identifying responsibilities to, and processes for: joint service planning meetings, sharing of assessments and background information, employing person-centered processes to develop supports/services plans, assigning supports/services coordination responsibilities, ongoing monitoring (inclusive of health status), and communication about services rendered or additional services needed.

The two parties **must** establish a process for clinical staffings so the clinical staff of the two agencies meet on a regular basis to review the plans and status of mutual consumers.

The interagency treatment/supports planning process further involves sharing of written documents and verbal reports, and discussions at joint supports/services planning meetings.

3. Emergency Services

In accordance with the definition of emergency services described in Section II-I-1 of the Request for Proposal for Comprehensive Health Care Program, emergency services also include those services provided to a person suffering from an acute problem in behavior or mood that requires immediate intervention. The need for the intervention may be identified by the enrollee, the enrollee's family or social unit, other agencies or referral sources, or law enforcement personnel.

It is the responsibility of the Health Plan to ensure that emergency services are available 24 hours a day and 7 days a week. As part of its responsibilities to provide emergency services and mental health outpatient services, the Health Plan must make available mental health crisis services for its enrollees. This applies for all enrollees except those who are receiving specialized behavioral health services. If the emergency is of a medical/physical nature, it is the responsibility of the Health Plan.

The Health Plan has the responsibility to inform all enrollees of emergency service procedures for accessing emergency services, and to inform members of the designated emergency phone number through member services materials and programs. Prior approval by the Health Plan is not required.

It is the responsibility of the CMHSP to provide for emergency mental health services for all enrollees receiving specialized behavioral health services including:

- * access by telephone 24 hours a day, 7 days a week - this number shall be made available to the Health Plan to provide to all enrollees; and
- * provision for face-to-face services to persons in need of crisis evaluation, and admission screening for psychiatric inpatient admissions, intervention and disposition.

4. Pharmacy and Laboratory Services

All pharmacy and laboratory services are covered by the Health Plan. This includes drugs prescribed and laboratory services ordered by the Health Plan or by the behavioral health and developmental disability providers (CMHSP).

Prescriptions and Orders for Laboratory Services:

- a. The Health Plan cannot restrict prescriptions written by the behavioral health physicians as long as:
 - (1) The drug prescribed is for the treatment of mental illness or substance abuse and any side effects of psychopharmacological agents.
 - (2) The purchase is made from an approved Health Plan pharmacy.
- b. The Health Plan cannot restrict orders for laboratory services to test for and monitor the medications prescribed by the behavioral health physician, except that the laboratory must be approved by the Health Plan.
- c. The Health Plan and the CMHSP must develop approval mechanisms for other laboratory and imaging services (e.g., MRI, CAT scans, X-rays, etc).

Coordination:

- a. The Health Plan and the CMHSP must develop procedures for notifying each other of prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete and up-to-date medication records.

- b. The CMHSP, in cooperation with the Health Plan, is responsible to monitor and track pharmaceutical usage in order for the Health Plan to provide comprehensive data and information as required under contract with the Michigan Department of Community Health.

Pharmacies and Laboratories:

The Health Plan must ensure that pharmacy and laboratory services are easily accessible to the recipients of the specialized behavioral health services. Strategies to accomplish this include the location of pharmacies and laboratories in proximity to specialty service locations and/or public transportation, home delivery services, or other methods of the provision of these services. The CMHSP shall assist the Health Plan in identifying existing locations used by consumers and/or alternative delivery strategies.

Drug Formulary:

- a. The Health Plan drug formulary for developmental disabilities and for behavioral health must include all of the drugs currently covered for the Medicaid FFS population.
- b. The Health Plan must have a process to evaluate requests to add products not included in its drug formulary.

5. Medical Coordination

In order to coordinate the appropriate delivery of health care services to Medicaid enrollees, clarity regarding the respective responsibility is necessary. Both parties will develop referral procedures and effective means of communicating the need for individual referrals.

It is the responsibility of Health Plans to provide or arrange for a limited number of outpatient visits (20 visits). The Health Plan may contract with the CMHSP to provide this benefit. Payment for these services are the responsibility of the Health Plan.

It is the responsibility of the CMHSP to provide or arrange for all inpatient (including entry and exit from state facilities) services and specialty mental health services. Payment for these services will be the responsibility of the CMHSP and the Michigan Department of Community Health.

Health and Medical Services: A number of mutually served consumers will be jointly under the care of at least two physicians, namely the Health Plan primary health care physician and the specialty behavioral health physician. The treatment planning process must clearly define the respective responsibilities for these two physicians. On an individual consumer basis, other health-related services will need to be clarified. Such health-related services include nutrition/dietary, maintenance of health and hygiene, nursing services, teaching self-administration of medications, etc.

It is jointly the responsibility of the Health Plan and CMHSP to conduct utilization review for Medicaid enrollees. This is defined as the process of evaluating the necessity,

appropriateness and efficiency of health care services. The information developed in this process is essential to the Quality Improvement Plans of each party.

6. Quality Improvement

Both parties agree that a set of Quality Improvement activities to monitor the coordination of services is necessary. The Quality Improvement process will establish performance standards that will be used to monitor access, coordination, outcome, and satisfaction of services.

7. Data and Reporting Requirements and Release of Information

Both parties will agree to coordinate the data sharing necessary for completing reporting requirements established through their respective contracts with the Michigan Department of Community Health. Such data sharing should involve performance indicators such as:

- * mental health emergency services including pre-admission screening for psychiatric inpatient services;
- * inpatient utilization;
- * referrals to CMHSP specialized mental health services;
- * pharmacy and laboratory utilization;
- * coordination between the Health Plan and the CMHSP; and
- * consumer/enrollee satisfaction with services and coordination.

Both parties shall agree to obtain any necessary signed releases of information from the enrollee so treatment information can be shared without impediment between the two parties to this agreement. The Mental Health Code stipulates that the holder of the mental health record may disclose information “as necessary in order for the recipient to apply for or receive benefits.”

8. Grievance and Complaint

Health Plans are required to establish internal processes for resolution of complaints and grievances from enrollee members. Medicaid enrollees may file a complaint or grievance on any aspect of service provided to them by the health plan or the health plan’s contracted providers.

CMHSPs are required to establish second opinion mechanisms and internal recipient rights processes for resolution of complaints from consumers and others.

Both parties are responsible for informing the other about their consumer grievance and complaint process.

Both parties are responsible to provide information to Medicaid enrollee members regarding the health plan’s grievance and complaint process and that of the CMHSP.

9. Dispute Resolution

The parties must specify the steps that the Health Plan or CMHSP must follow to contest a decision or action by the other party related to the terms of the agreement. The process should specify the responsibilities of the parties and time frame for each step.

The dispute resolution process should include:

For administrative decisions:

- * Request to the other party for reconsideration of the disputed decision or action.
- * Appeal to the Michigan Department of Community Health regarding a disputed decision of a Health Plan, or for a disputed decision of a CMHSP.

For clinical decisions:

- * Request to the other party for reconsideration of the disputed decision or action.
- * Appeal to a locally-established clinical review team comprised of Medical Directors, or their designees, from the CMHSP and the Health Plan.
- * Appeal to a clinical review team consisting of medical professionals representing the Michigan Department of Community Health.

E. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all federal, state, and local laws, regulations, guidelines and directives.

F. Signature

Approved as to form by local Counsel.

**Medicaid Managed Specialty
Supports and Services
1915 (b)/(c) Waiver Program**

Contract Attachment

P 6.4.5.1 B

**CMHSP/PIHP Model Agreement:
Developmental Disabilities**

CMHSP/HP MODEL AGREEMENT: DEVELOPMENTAL DISABILITIES

The agreements between the Health Plan and the local developmental disability contractor (CMHSP) must incorporate and address all of the items and areas listed and described below. These standard provisions are as follows:

- Legal Basis
- Term of Agreement
- Administration
- Areas of Shared Responsibility
- Referral
- Interagency Assessment and Supports/Services Planning
- Emergency Services
- Pharmacy and laboratory service coordination
- Medical Coordination
- Quality Improvement Coordination
- Data and Reporting Requirements
- Grievance and Complaint Resolution
- Dispute Resolution
- Governing Laws

This agreement is made and entered into this _____ day of _____, in the year _____ by and between _____ (Health Plan) and _____ (CMHSP).

A. Legal Basis

Whereas, P.A. 352 of the Public Acts of 1996 permits the Michigan Department of Community Health to increase the enrollment of Medicaid eligible persons in health plans on a capitated basis; and

Whereas, in order to expand enrollment, the Michigan Department of Community Health has established a competitive bid process that has resulted in contracts with health plans that are deemed to be qualified to provide specified health care services to Medicaid enrollees; and

Whereas, specialized services for Medicaid enrollees who have developmental disabilities will be provided through arrangements between the Michigan Department of Community Health and selected developmental disability providers; and

Whereas, Community Mental Health Services Programs (CMHSP) are designated as the Developmental Disability Provider under contract with the Michigan Department of Community Health and consistent with the Mental Health Code; and

Whereas, Health Plans and CMHSPs should coordinate and collaborate efforts in order to promote and protect the health of the Medicaid-enrolled population;

Now, therefore the Health Plan and the CMHSP agree as follows:

B. Term of Agreement

This agreement will be effective _____ in the year _____ for a period not to exceed _____. The agreement will be subject to amendment due to changes in the contracts between the Michigan Department of Community Health and the Health Plan or the contract with the Community Mental Health Services Programs.

Upon signed agreement of both parties, the provisions of this agreement will be extended for a time frame consistent with the contract period of the Health Plan and the Michigan Department of Community Health. Either party may cancel the agreement upon 30 days written notice.

C. Administration and Point of Authority

The Health Plan shall designate in writing to the CMHSP the person who has authority to administer this agreement. The CMHSP shall designate in writing to the Health Plan the person who has authority to administer this agreement.

D. Areas of Shared Responsibility

In order to provide the most efficient and coordinated services to Medicaid enrollees, the responsibilities of the Health Plan and CMHSP will include:

1. Referral

Mutually Served Consumers

This refers to health plan members who also receive community mental health services. Mutual consumer groups will be defined according to clinical criteria agreed upon between the individual CMHSP and the Health Plan. Services to be provided by the Health Plan and by the CMHSP may vary for different clinically defined groups. Eligibility criteria for specialty developmental disability (DD) services are outlined in Attachment 1. It should be noted that persons who receive specialty developmental disability services also have a high likelihood of requiring behavioral health services.

Entry to CMHSP Specialized Services for Persons with DD

This is the process of obtaining CMHSP approval for a health plan member to receive specialized DD services from a CMHSP. Specialized DD services means those unique services of a CMHSP that support persons in community environments and/or provide alternatives to, or decrease the need for, Intermediate Care Facilities for persons with Mental Retardation (ICFs/MR), which includes State DD Centers and Alternative Intermediate Services for Persons with Mental Retardation (AIS/MR) homes. These might include such services as specialized residential services, day program services, outpatient mental health clinic services, supportive services (e.g., family support, supported independent living, etc.).

Services to Be Provided (Benefit Packages and Limitations)

The intent of establishing written procedures between Health Plans and CMHSPs is to assure service coordination and continuity of care for persons receiving services from both organizations. Therefore, it is essential that the parties define the service/coverage package that will be provided by each party to mutual consumers. This must also specify any limitations on amounts of services, including but not restricted to:

- * emergency services;
- * inpatient hospital and outpatient services by type of outpatient service;
- * intermittent/short term LTC nursing facility stays;
- * physician services, especially neurological assessments and treatment, diagnostics, and orders for therapies;
- * pharmacy, particularly drugs used in seizure and/or behavioral management and the OTC and non-prescription items commonly ordered for consumers with DD;
- * laboratory services;
- * dental services;
- * therapies (physical, occupational, speech);
- * mental health clinic services;
- * home health services including hourly nursing;
- * medical equipment and supplies, and assistive technology;
- * specialized DD services including home- and community-based care, crisis stabilization, and long-term supports;
- * personal care services including Home Help and specialized mental health personal care;
- * transportation to medical services and to mental health services.

2. Interagency Assessment and Supports/Services Planning

This includes collaborative joint supports/services, and/or treatment planning activities of the consumer, the CMHSP and the Health Plan regarding specialty developmental disability services, mental health services, and medical services provided by each party to the mutual consumer.

It includes identifying responsibilities to, and processes for: joint service planning meetings; sharing of assessments and background information; employing person-centered processes to develop supports/services plans; assigning supports/services coordination responsibilities; ongoing monitoring (inclusive of health status) and communication about services rendered or additional services needed.

For persons with developmental disabilities, a critical responsibility that needs to be identified relates to the physician responsibilities. This will need to be handled on an individual basis, but the process must be clearly laid out for defining the respective responsibilities of the CMHSP physician and the CHPP primary physician.

The two parties must establish a process for clinical staffing so the clinical staff of the two agencies meet on a regular basis to review the plans and status of mutual consumers.

The interagency treatment/supports planning process further involves sharing of written documents and verbal reports, and discussions at joint supports/services planning meetings.

3. Emergency Services

In accordance with the definition of emergency services described in Section II-I-1 of the Request for Proposal for Comprehensive Health Care Program, emergency services also include those services provided to a person suffering from an acute problem in behavior or mood that requires immediate intervention. The need for the intervention may be identified by the enrollee, the enrollee's family or social unit, other agencies or referral sources, or law enforcement personnel.

It is the responsibility of the Health Plan to ensure that emergency services are available 24 hours a day and 7 days a week. As part of its responsibilities to provide emergency services and mental health outpatient services, the Health Plan must make mental health crisis services available for its enrollees. This applies for all enrollees except for those who are receiving specialized behavioral health services. If the emergency is of a medical/physical nature, it is the responsibility of the Health plan. If the emergency results from crises in the supports system of the consumer, it is the responsibility of the specialty developmental disability provider.

The Health Plan has the responsibility to inform all enrollees of emergency service procedures for accessing emergency services, and to inform members of the designated emergency phone number through member services materials and programs. Prior approval by the Health Plan is not required.

It is the responsibility of the CMHSP to provide for emergency mental health services for all enrollees receiving specialized behavioral health services including:

- * access by telephone 24 hours a day, 7 days a week - this number shall be made available to the Health Plan to provide to all enrollees; and
- * provision for face-to-face services to persons in need of crisis evaluation, and admission screening for psychiatric inpatient admissions, intervention and disposition.

4. Pharmacy and Laboratory Services

All pharmacy and laboratory services are covered by the Health Plan. This includes drugs prescribed and laboratory services ordered by the Health Plan or by the behavioral health and developmental disability providers (CMHSP).

Prescriptions and Orders for Laboratory Services:

- a. The Health Plan cannot restrict prescriptions written by the developmental disability physicians as long as:
 - (1) The drug prescribed is for the treatment of the developmental disability or for any complication due to the developmental disability.
 - (2) The purchase is made from an approved Health Plan pharmacy.
- b. The Health Plan cannot restrict orders for laboratory services to test for developmental disabilities or the complications due to the disability, except that the laboratory must be approved by the Health Plan.
- c. The Health Plan cannot restrict orders for laboratory services to test for and monitor the medications prescribed by the developmental disability services physician, except that the laboratory must be approved by the Health Plan.
- d. The Health Plan and the CMHSP must develop approval mechanisms for other laboratory and imaging services (e.g. MRI, CAT scans, X-rays, etc.).

Coordination:

- a. The Health Plan and the CMHSP must develop procedures for notifying each other of prescriptions, and when deemed advisable, consultation between practitioners before prescribing medication, and sharing complete and up-to-date medication records.
- b. The CMHSP in cooperation with the Health Plan is responsible to monitor and track pharmaceutical usage in order for the Health Plan to provide comprehensive data and information as required under contract with the Michigan Department of Community Health.

Pharmacies and Laboratories:

The Health Plan must ensure that pharmacy and laboratory services are easily accessible to the recipients of developmental disability services. Strategies to accomplish this include the location of pharmacies and laboratories in proximity to specialty service locations and/or public transportation, home delivery services, or other methods of the provision of these services. The CMHSP shall assist the Health Plan in identifying existing locations used by consumers and/or alternative delivery strategies.

Drug Formulary:

- a. The Health Plan drug formulary for developmental disabilities and for behavioral health must include all of the drugs currently covered for the Medicaid FFS population.
- b. The Health Plan must have a process to evaluate requests to add products not included in its drug formulary.

5. Medical Coordination

In order to coordinate the appropriate delivery of health care services to Medicaid enrollees, clarity regarding the respective responsibility is necessary. Both parties will develop referral procedures and effective means of communicating the need for individual referrals.

In addition, both the Health Plan and CMHSP acknowledge respective individual responsibilities as listed below:

Habilitation and rehabilitation services: Habilitation services means those services designed to assist Medicaid enrollees in the development of skills and capacities they have never possessed, (i.e., predominantly in the functioning areas of self-care and/or activities of daily living), and to maintain capacities attained for the first time. Habilitation services are the responsibility of the CMHSP. Rehabilitation services are designed to assist Medicaid enrollees in restoring those self-care skills they once possessed, and is the responsibility of the Health Plan.

Case Management: Case management services means those services that will assist Medicaid enrollees in gaining access to needed medical, social, educational and other services. It is the expectation that Health Plans will demonstrate a commitment to assisting enrollees in managing their complex health care needs (Section II-T of the Request for Proposal for Comprehensive Health Care Program).

Within the developmental disabilities specialty services system, case management includes: assessment, person-centered service plan development, linking/coordination of services, reassessment/follow-up, advocacy, and monitoring of services. Some CMHSP consumers of DD services receive these case management services under a coverage entitled “supports coordination.” As part of the referral procedures described above, the Health Plan and CMHSP shall both indicate the manner in which case management services will be coordinated.

Health and Medical Services: A number of mutually served consumers will be jointly under the care of at least two physicians, namely the Health Plan primary health care physician and the specialty developmental disabilities physician. The treatment planning process must clearly define the respective responsibilities for these two physicians. On an individual consumer basis, other health-related services will need to be clarified. Such health related services include nutrition/dietary, maintenance of health and hygiene, nursing services, teaching self-administration of medications, etc.

It is jointly the responsibility of the Health Plan and CMHSP to conduct utilization review for Medicaid enrollees. This is defined as the process of evaluating the necessity, appropriateness and efficiency of health care services. The information developed in this process is essential to the Quality Improvement Plans of each party.

6. Quality Improvement

Both parties agree that a set of Quality Improvement activities to monitor the coordination of services is necessary. The Quality Improvement process will establish performance standards that will be used to monitor access, coordination, outcome, and satisfaction of services.

7. Data and Reporting Requirements and Release of Information

Both parties will agree to coordinate the data sharing necessary for completing reporting requirements, established through their respective contracts with the Michigan Department of Community Health. Such data sharing should involve performance indicators such as:

- * mental health emergency including pre-admission screening for DD centers or AIS/MR services;
- * referrals to CMHSP specialized developmental disabilities services;
- * pharmacy and laboratory utilization;
- * coordination between the Health Plan and the CMHSP; and
- * consumer/enrollee satisfaction with services and coordination.

Both parties shall agree to obtain any necessary signed releases of information from the enrollee so treatment information can be shared without impediment between the two parties to this agreement. The Mental Health Code stipulates that the holder of the mental health record may disclose information “as necessary in order for the recipient to apply for or receive benefits.”

8. Grievance and Complaint

Health Plans are required to establish internal processes for resolution of complaints and grievances from enrollee members. Medicaid enrollees may file a complaint or grievance on any aspect of service provided to them by the Health Plan or the Health Plan’s contracted providers.

CMHSPs are required to establish second opinion mechanisms and internal recipient rights processes for resolution of complaints from consumers and others.

Both parties are responsible for informing the other about their grievance and complaint processes.

Both parties are responsible to provide information to Medicaid enrollee members regarding the Health Plan’s grievance and complaint processes, and that of the CMHSP.

9. Dispute Resolution

The parties must specify the steps that the Health Plan or CMHSP must follow to contest a decision or action by the other party related to the terms of the agreement. The process should specify the responsibilities of the parties and time frame for each step.

The dispute resolution process should include:

For administrative decisions:

- * Request to the other party for reconsideration of the disputed decision or action.
- * Appeal to the Michigan Department of Community Health regarding a disputed decision of a Health plan, or for a disputed decision of a CMHSP.

For clinical decisions:

- * Request to the other party for reconsideration of the disputed decision or action.
- * Appeal to a locally-established clinical review team comprised of Medical Directors, or their designees, from the CMHSP and the Health Plan.
- * Appeal to a clinical review team consisting of medical professionals representing the Michigan Department of Community Health.

E. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all federal, state, and local laws, regulations, guidelines and directives.

F. Signature

Approved as to form by local Counsel.

PIHP REPORTING REQUIREMENTS FOR MEDICAID SPECIALTY SUPPORTS AND SERVICES BENEFICIARIES

Effective 10/1/10

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**FY 2011 MDCH/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES
CONTRACT
MENTAL HEALTH REPORTING REQUIREMENTS**

Introduction

The Michigan Department of Community Health reporting requirements for the FY2011 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs or Substance Abuse Coordinating Agencies (CAs).

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 MDCH.
- Mental Health Codelist that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDCH 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 MDCH 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 MDCH 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 MDCH 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

Where accuracy standards for collecting and reporting QI data are noted in the contract, it is expected that PIHPs will meet those standards.

Individual consumer level data received at MDCH is kept confidential and published reports will display only aggregate data. Only a limited number of MDCH staff have access to the database that contains social security numbers, income level, and diagnosis, for example. Individual level data will be provided back to the agency that submitted the data for encounter data validation and improvement. This sharing of individual level data is permitted under the HIPAA Privacy Rules, Health Care Operations.

FY 2011 DATA REPORT DUE DATES

	Nov10	Dec	Jan11	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec11	Jan12
1. Consumer level**	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
a. Quality Improvement (monthly) ¹															
b. Encounter (monthly) ¹															
2.PIHP level															
a. Medicaid Utilization and Net Cost Report: annually ²			√					√							√
b. Performance indicators (quarterly) ²					√			√			√			√	
c. Sentinel events (semi-annually) ²					√			√			√			√	
d. Consumer Satisfaction (annually) ²										√					
e. CAFAS ³													√		
f. Critical incidents (monthly) ³															

NOTES:

1. Send data to MDCH MIS via DEG
2. Send data to MDCH, Mental Health and Substance Abuse Administration, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDCH web site at: www.michigan.gov/mhsa 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

QUALITY IMPROVEMENT DATA

Demographic or “quality improvement” (QI) data is required to be reported for each consumer and for whom an encounter data record or fee-for service claim (for Children’s Waiver) is being submitted. Encounter data is reported within 30 days after the claim for the service is adjudicated, or in cases where claims payment is not part of the PIHP’s business practice, within 30 days following the end of the month in which services were delivered. QI data is reported year-to-date. The first report for the fiscal year will contain records for all consumers whose claims were adjudicated the first month, the next month’s report will contain records of all consumers whose claims were adjudicated in month one and month two, etc. Corrective QI file updates are allowed from the PIHP to replace a rejected file, or a file that contained rejected records.

Method for submission: The QI data is to be submitted in a delimited format, with the columns identified by the delimiter, rather than by column “from” and “to” indicators.

Due dates: The first QI data should be submitted during the same month the first encounter data is submitted. Encounter and QI data are due 30 days after a claim is adjudicated or services were rendered (see above note). Reporting adjudicated claims will enable the PIHP to accurately report on the amount paid for the service and on third party reimbursements.

Who to report: Report on each consumer who received a service from the PIHP, and from each CMHSP in the case of an affiliation, regardless of funding stream. The exception is when a PIHP or CMHSP contracts with another PIHP or CMHSP, or a Medicaid Health Plan contracts with a PIHP or CMHSP to provide mental health services. In that case, the PIHP or CMHSP that delivers the service does not report the encounter.

Who submits consumer-level data: The PIHP must report the encounter and QI data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area/affiliation. The PIHP must report the encounter data for all substance abuse Medicaid beneficiaries in its service area. QI data for Medicaid beneficiaries receiving services from the Substance Abuse Coordinating Agencies (CAs) are not required to be reported by the PIHP. Some PIHPs may choose, however, to collect QI data from the CAs and forward it to MDCH. The PIHP shall report all encounter and QI data for all mental health beneficiaries in its service area/affiliation, regardless of the funding stream that paid for the services.

Notes:

1. Demographic Information must be updated at least annually, such as at the time of annual planning. A consumer demographic record must be submitted for each month the consumer receives services, and for which an encounter record or fee-for-service claim (Children’s Waiver) is being submitted. Failure to meet this standard may result in rejection of a file and contract action.
2. Numbers missing from the sequence of options represent items deleted from previous reporting requirements.
3. Items with an * require that 95% of records contain a value in that field and that the values be within acceptable ranges (see each item for the ranges). Items with ** require that 100% of the records contain a value in the field, and the values are in the proper format and within

PIHP REPORTING REQUIREMENTS

acceptable ranges. Failure to meet the 100% standard will result in rejection of the file or record.

4. A “Supplemental Instructions for Encounter and Quality Improvement Data Submissions” issued by MDCH should be used for file layouts.
5. Some demographic items are reported on both the HIPAA/4010A1 Health Care Claim transaction and the QI data report for ease of calculating population numbers during the year.

The following is a description of the individual consumer demographic elements for which data is required of Community Mental Health Services Programs.

****1. Reporting Period (REPORTPD)**

The last day of the month during which consumers received services covered by this report. Report year, month, day: ccyyymmdd.

****2.a. PIHP Payer Identification Number (PIHPID)**

The MDCH-assigned 9-digit payer identification number must be used to identify the PIHP with all data transmissions.

2.b. CMHSP Payer Identification Number (CMHID)

The MDCH-assigned 9-digit payer identification number must be used to identify the CMHSP with all data transmissions.

****3. 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 or CMHSP 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 837/4010A1 encounter for each consumer.

If the consumer identification number does not have 11 characters, it may cause rejection of a file.

4. Social Security Number (SSNO)

The nine-digit integer must be recorded, if available.

Blank = Unreported [Leave nine blanks]

***5. Medicaid ID Number (MCIDNO)**

Enter the ten-digit integer for consumers with a Medicaid number, or ABW number, or MICHild.

Blank = Unreported [Leave eight blanks]

6. Leave blank beginning with FY’06 service reporting

7. Corrections Related Status (CORSTAT)

For persons under the jurisdiction of a corrections or law enforcement program during treatment, indicate the location/jurisdiction involved at the time of annual update

PIHP REPORTING REQUIREMENTS

- 1 = In prison
- 2 = In jail
- 3 = Paroled from prison
- 4 = Probation from jail
- 5 = Juvenile detention center
- 6 = Court supervision
- 7 = Not under the jurisdiction of a corrections or law enforcement program
- 8 = Awaiting trial
- 9 = Awaiting sentencing
- 10= Consumer refused to provide information
- 11= Minor (under age 18) who was referred by the court
- 12= Arrested and booked
- 13= Diverted from arrest or booking
- Blank = Unknown

***8. Residential Living Arrangement (RESID) Effective 10/1/07, 95% completeness required**

Indicate the consumer's residential situation or arrangement at the time of intake if it occurred during the reporting period, or at the time of annual update of consumer information during the period. Reporting categories are as follows:

- 1 = Homeless on the street or in a shelter for the homeless
 - 2 = Living in a private residence with natural or adoptive family member(s). "Family member" means parent, stepparent, sibling, child, or grandparent of the primary consumer; or an individual upon whom the primary consumer is dependent for at least 50% of his or her financial support.
 - 3 = Living in a private residence not owned by the PIHP, CMHSP or the contracted provider, alone or with spouse or non-relative(s).
 - 5 = Foster family home (Include all foster family arrangements regardless of number of beds)
 - 6= Specialized residential home - Includes any adult foster care facility certified to provide a specialized program per DMH Administrative Rules, 3/9/96, R 330.1801 (Include all specialized residential, regardless of number of beds); or a licensed Children's Therapeutic Group Home
 - 8 = General residential home (Include all general residential regardless of number of beds)
"General residential home" means a licensed foster care facility not certified to provide specialized program (per the DMH Administrative Rules)
 - 10 = Prison/jail/juvenile detention center
 - 11 = Deleted (AIS/MR)
 - 12= Nursing Care Facility
 - 13= Institutional setting (congregate care facility, boarding schools, Child Caring Institutions, state facilities)
 - 16 = Living in a private residence that is owned by the PIHP, CMHSP or the contracted provider, alone or with spouse or non-relative.
 - Blank = Unreported
-

PIHP REPORTING REQUIREMENTS

***9. Total Annual Income (TOTINC)**

Indicate the total amount of gross income of the individual consumer if he/she is single; or that of the consumer and his/her spouse if married; or that of the parent(s) of a minor consumer at the time of service initiation or most recent plan review. "Income" is defined as income that is identified as taxable personal income in section 30 of Act No. 281 of the Public Acts of 1967, as amended, being 206.30 of the Michigan Compiled Laws, and non-taxable income, which can be expected to be available to the individual and spouse not more than 2 years subsequent to the determination of liability.

1= Income is below \$10,000

2= Income is \$10,001 to \$20,000

3= Income is \$20,001 to \$30,000

4= Income is \$30,001 to \$40,000

5= Income is \$40,001 to \$60,000

6= Income is more than \$60,000

Blank = Income was not reported

***10. Number of Dependents (NUMDEP)**

Enter the number of dependents claimed in determining ability-to-pay. "Dependents" means those individuals who are allowed as exemptions pursuant to section 30 of Act No. 281 of the Public Acts of 1967, as amended, being 206.30 of the Michigan Compiled Laws. Single individuals living in an AFC or independently are considered one exemption, therefore enter "1" for number of dependents.

of dependents = __ _ Blank = Unreported

***11. Employment Status (EMPLOY) Effective October 1, 2010**

Indicate current employment status as it relates to principal employment for consumers age 18 and over. Reporting categories are as follows:

1= Employed full time (30 hours or more per week) competitively.

2= Employed part time (less than 30 hours per week) competitively.

3= Unemployed – looking for work, and/or layoff from job.

4= Deleted.

5= Deleted.

6= Deleted.

7= Participates in sheltered workshop or facility-based work.

8= Deleted.

9= Deleted.

10= Deleted.

11= In unpaid work (e.g., volunteering, internship, community service).

12= Self-employed (e.g., micro-enterprise).

13= In enclaves/mobile crews, agency-owned transitional employment.

14= Participates in facility-based activity program where an array of specialty supports and services are provided to assist an individual in achieving his/her non-work related goals.

15= Not in the competitive labor force-includes homemaker, child, student age 18 and over, retire from work, resident of an institution (including nursing home), or incarcerated.

Note: "Competitive Employment" means that the individual is working in a job that was open for anyone to apply, not just persons with disabilities.

12. Education (EDUC)

Indicate the level attained at the time of the most recent admission or annual update. For children attending pre-school that is not special education, use "blank=unreported." Reporting categories are as follows:

- 1 = Completed less than high school
- 2 = Completed special education, high school, or GED
- 3 = In school - Kindergarten through 12th grade
- 4 = In training program
- 6 = In Special Education
- 7 = Attended or is attending undergraduate college
- 8 = College graduate
- Blank = Unreported

Items 13 through 16 intentionally left blank

***17. Disability Designation**

Enter yes for all that apply, enter no for all that do not apply. To meet standard at least one field must have a "1."

17.01: Developmental disability (Individual meets the 1996 Mental Health Code Definition of Developmental Disability regardless of whether or not they receive services from the DD or MI services arrays) (**DD**)

- 1 = Yes
- 2 = No
- 3 = Not evaluated

17.02: Mental Illness or Serious Emotional Disturbance (Has DSM-IV diagnosis, exclusive of mental retardation, developmental disability, or substance abuse disorder) (**MI**)

- 1 = Yes
- 2 = No
- 3 = Not evaluated

17.03: Substance Abuse Disorder/SUD (as defined in Section 6107 of the public health code. Act 368 of the Public Health Acts of 1978, being section 333.6107 of the MCL). Indicate the appropriate substance use disorder related status at the time of intake, and subsequently at annual update. (**SA**).

- 2= No, individual does not have an SUD
- 3= Not evaluated for SUD (e.g., person is an infant, in crisis situation, etc.)
- 4= Individual has one or more DSM-IV substance use disorder(s), diagnosis codes 291xx, 292xx, 303xx, 304xx, 305xx, with at least one disorder either

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- active or in partial remission (use within past year).
- 5 = Individual has one or more DSM-IV substance use disorder(s), diagnosis codes 291xx, 292xx, 303xx, 304xx, 305xx, and all coded substance use disorders are in full remission (no use for one year). This includes cases where the disorder is in full remission and the consumer is on agonist therapy or is in a controlled environment.
 - 6 = Results from a screening or assessment suggest substance use disorder. This includes indications, provisional diagnoses, or “rule-out diagnoses.
- 17.04: Individual received an assessment only, and was found to meet none of the disabilities listed above (NA).
- 1 = Yes
 - 2 = No

18. Reporting element deleted in FY’03-04

Leave blank beginning with FY’04 service reporting

PROXY MEASURES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Note: The following 6 elements are proxy measures for level of functioning for people with developmental disabilities. The information is obtained or observed when an individual begins receiving public mental health services for the first time, and/or at the time of annual planning. For purposes of these data elements, “Assistance” means the hands-on help from a paid or un-paid person or technological support needed to enable the individual to achieve the desired future agreed upon during planning. [Note for FY2011: The Improving Oversight Workgroup, a joint committee of MDCH and PIHP representatives, will make recommendations to MDCH for revisions to the proxy measures #19 through #24, and for additional measures that will help the system better identify “vulnerable” people. MDCH will issue requirements, based on the recommendations, by October 1, 2010. PIHPs shall be in compliance with the requirements no later than January 1, 2011.]

***19. Predominant Communication Style (People with developmental disabilities only) (COMSTYLE) 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 sign language interpreter, or someone who knows the consumer well enough to interpret speech or behavior.
 - 4= Alternative language used - this includes a foreign language, or sign language.
- Blank= Unreported

***20. Assistance for Independence Needed (People with developmental disabilities only) 95% completeness and accuracy required**

Indicate below all areas of daily living activities in which the individual needs regular, ongoing assistance. It does not include those situations in which the individual is temporarily unable to perform due to a short illness.

PIHP REPORTING REQUIREMENTS

- 20.1 Mobility Assistance includes technology and equipment such as wheelchairs, and/or personal assistance such as help with transferring and transporting. **(MA)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank = Unreported
- 20.2 Medication Administration includes administering, observing or reminding **(RX)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank = Unreported
- 20.3 Personal Assistance includes help with bathing, toileting, dressing, grooming, and/or eating **(PA)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank = Unreported
- 20.4 Household Assistance includes help with such tasks as cooking, shopping, budgeting, and light housekeeping **(HD)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank = Unreported
- 20.5 Community Assistance includes help with transportation, purchasing, and money handling. **(CA)**
1 = Yes, assistance is needed
2 = No, assistance is not needed
Blank = Unreported

***21. Nature of Support System (People with developmental disabilities only) (NATSUPP) 95% completeness and accuracy required**

Indicate how family and friends are involved with the consumer. “Involved” means consumer gets together with family/friends on a regular basis, for example, monthly or more often.

- 1 = Family and/or friends are not involved
2 = Family and/or friends are involved, but do not provide assistance
3 = Family and/or friends provide limited assistance, such as intermittent or up to once a month
4 = Family and/or friends provide moderate assistance, such as several times a month up to several times a week
5 = Family and/or friends provide extensive assistance, such as daily assistance to full-time care giving
Blank = Information unavailable

***22. Status of Existing Support System (People with Developmental Disabilities only) (STATSUPP) 95% completeness and accuracy required**

Indicate whether family/friend caregiver status is at risk; including instances of caregiver

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disability/illness, aging, and/or re-location. “At risk” means is caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether.

- 1 = Yes, care giver status is at risk
- 2 = No, care giver status is not at risk
- 3 = No care giver is involved
- Blank = Unreported or information unavailable

***23. Health Status (People with developmental disabilities only) 95% completeness and accuracy required**

Indicate below all areas in which assistance (personal or technology) is required:

- 23.1 Vision (requiring accommodations beyond glasses) (**VOS**)
 - 1 = No vision problems, or no assistance needed
 - 2 = Limited assistance is needed such as intermittent help up to once a month
 - 3 = Moderate assistance is needed such as monthly to several times a week
 - 4 = Extensive assistance is needed such as daily to full-time help
 - Blank = Unreported
- 23.2 Hearing (requiring accommodations beyond a hearing aid) (**HEAR**)
 - 1 = No hearing problems, or no assistance needed
 - 2 = Limited assistance is needed such as intermittent help up to once a month
 - 3 = Moderate assistance is needed such as monthly to several times a week
 - 4 = Extensive assistance is needed such as daily to full-time help
 - Blank = Unreported
- 23.3 Other physical/medical characteristics requiring personal intervention (**OTH**)
 - 1 = No physical/medical characteristics, or no assistance needed
 - 2 = Limited assistance is needed such as intermittent help up to once a month
 - 3 = Moderate assistance is needed such as monthly to several times a week
 - 4 = Extensive assistance is needed such as daily to full-time help
 - Blank = Unreported

***24. Assistance for Accommodating Challenging Behaviors (People with developmental disabilities only) (BEHAVIOR) 95% completeness and accuracy required**

Indicate the level of assistance the consumer needs, if any to accommodate challenging behaviors. “Challenging behaviors” include those that endanger self and/or others to those that prohibit functioning independently in the home or participating in the community.

- 1 = No challenging behaviors, or no assistance needed
- 2 = Limited assistance needed, such as intermittent help up to once a month
- 3 = Moderate assistance needed, such as monthly to several times a week
- 4 = Extensive assistance needed, such as daily assistance to full-time help
- Blank = Unreported

25. Gender (GENDER)

Identify consumer as male or female.

- M = Male
- F = Female

***26. Program Eligibility (PE)**

Indicate ALL programs or plans in which the individual is enrolled and/or from which funding is received directly by the individual/family or on his/her/family's behalf.

Every item MUST have a response of "1" or "2" to meet standard.

26.1 Reporting element deleted in FY'03-04

26.2 Adoption Subsidy (**PE_ASUB**)

1 = Yes

2 = No

26.3 Commercial Health Insurance or Service Contract (EAP, HMO) (**PE_COM**)

1 = Yes

2 = No

26.4 Program or plan is not listed above (**PE_OTH**)

1 = Yes

2 = No

26.5 Individual is not enrolled in or eligible for a program or plan (**PE_INELG**)

1 = Yes

2 = No

27. Parental Status (PARSTAT)

Indicate if the consumer (no matter what age) is the natural or adoptive parent of a minor child (under 18 years old)

1 = Yes

2 = No

Blank = Unreported

28. Children Served by Department of Human Services

Indicate whether minor child is enrolled in an DHS program. If the consumer is an adult or if the consumer is a child not enrolled in any of the DHS programs, enter 2=No.

28.01 Child served by DHS for abuse and neglect (FIA_AN)

1 = Yes

2 = No

Blank = Unreported

28.02 Child served by another DHS program (FIA_OT)

1 = Yes

2 = No

Blank = Unreported

29. Children Enrolled in Early On (CHILDEOP)

Indicate whether minor child is enrolled in the Early On program. If the consumer is an adult or if the consumer is a child not enrolled in the Early On program, enter 2=No.

1= Yes

2= No

Blank = Unreported

***30. 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. Use blank = Unknown

31. Intentionally Left Blank

***32. Hispanic (HIS)**

Indicate whether the person is Hispanic or Latino or not, or their ethnicity is unknown. Must use one these codes:

1. Hispanic or Latino
2. Not Hispanic or Latino
3. Unknown

***33. Race 1, Race 2, Race3 (RACE1, RACE2, RACE3)**

There are three separate fields for race, each one character long. RACE1 is required for individuals with service dates after 9/30/2005. RACE2 and RACE3 are for individuals who report more than one race. Report one race in each field. RACE2 and RACE3 are optional, but please use a blank to hold the place if there is no value for either.

Use these codes:

- a. White - A person having origins in any of the original peoples of Europe
- b. Black or African American - A person having origins in any of the Black racial groups of Africa.
- c. American Indian or Alaskan Native - American Indian, Eskimo, and Aleut, having origins in any of the native peoples of North America
- d. Asian - A person having origins in any of the original peoples of the far East, Southeast Asia, or the Indian subcontinent.
- e. Native Hawaiian or other Pacific Islander
- f. Some other race
- g. Unknown Race
- h. Consumer refused to provide

***34. Minimum Wage (MINW)**

Indicate if the consumer is currently earning minimum wage or more.

- 1 = Yes
 - 2 = No
 - 3 = Not Applicable (e.g., person is not working)
 - Blank = Unreported
-

35. Beds (BEDS)

Number of beds must be entered when the consumer resides in one of the following living arrangement reported in #8 RESID:

- Foster family home (#5)
- Specialized residential home (#6)
- General residential home (#8)
- Institutional setting (#13)

Enter the one character that best represents the number of licensed beds in one of the arrangements listed above. The field will be edited for 1,2,3,4 or blank.

- 1 = 1- 3 beds
 - 2 = 4 - 6 beds
 - 3 = 7 - 15 beds
 - 4 = 16+ beds
 - Blank = Unknown or Not Applicable
-
-

PIHP REPORTING REQUIREMENTS
ENCOUNTERS PER MENTAL HEALTH, DEVELOPMENTAL 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.

Encounters per Beneficiary

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. Every MH/DD encounter record reported must have a corresponding quality improvement (QI) or demographic record reported at the same time. Failure to report both an encounter record and a QI record for a consumer receiving services will result in contract action. SA encounter records do not require a corresponding quality improvement (QI) or demographic record to be reported by the PIHP. * PIHP's and CMHSPs that contract with another PIHP or CMHSP or a Medicaid Health Plan contracts with a PIHP or CMHSP to provide mental health services should include that consumer in the encounter and QI data sets. In those cases the PIHP or CMHSP that provides the service via a contract 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 (ASCX12N 837 version 4010A1, hereafter referred to as the 837/4010A1), as appropriate.
- The 837/4010A1 requires a small set of specific demographic data: gender, diagnosis, Medicaid number, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837/4010A includes a "header" and "trailer" that allows it to be uploaded via the DEG (data exchange gateway) to MDCH's Management Information System (MIS).
- The remaining demographic data, in HIPAA parlance called "Quality Improvement" data, shall be submitted in a separate file to MIS. This file is uploaded via the DEG therefore must

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be accompanied by headers and trailers.

The information on HIPAA contained in this contract relates only to the data that MDCH 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/mdch.

Data that is uploaded via the DEG must follow the HIPAA-prescribed formats for the 837/4010A1 (institutional, professional and dental) and MDCH-prescribed formats for QI data. The 837/4010A1 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 Association, 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), and the Michigan Uniform Billing Manual. The procedure codes in these coding systems require standard units that must be used in reporting on the 837/4010A1.

MDCH has produced a codelist 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 codelist is available on the MDCH web site.

The following elements reported on the 837/4010A1 encounter format will be used by MDCH 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 MDCH's web site) for additional elements required of all 837/4010A1 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)***

The MDCH-assigned 9-digit payer identification number must be used to identify the PIHP with all data transactions.

1.b. CMHSP Plan Identification Number (CMHID)

The MDCH-assigned 9-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

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1.c. CA Plan Identification Number (CAID)

The MDCH-assigned 9-digit payer identification number must be used to identify the Substance Abuse Coordinating Agency with all Substance Abuse data 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, ABW or MICHild** beneficiary. If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.

If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID**.

****3. Identification Code/Other Subscriber Primary Identifier (please see the details in the submitter's manual)**

Enter the consumer's unique identification number (**CONID**) assigned by the CMHSP **regardless** of whether it has been used above.

****4. Date of birth**

Enter the date of birth of the beneficiary/consumer.

****5. Diagnosis**

Enter the ICD-9 primary diagnosis of the consumer.

****6. EPSDT**

Enter the specified code indicating the child was referred for specialty services by the EPSDT screening.

****7. Encounter Data Identifier**

Enter specified code indicating this file is an encounter file.

****8. Line Counter Assigned Number**

A number that uniquely identifies each of up to 50 service lines per claim.

****9. Procedure Code**

Enter procedure code from codelist for service/support provided. The codelist is located on the MDCH web site. Do not use procedure codes that are not on the codelist.

***10. Procedure Modifier Code**

Enter modifier as required for Habilitation Supports Waiver services provided to enrollees; 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:**

Enter a value of at least \$1.00.

****12. Quantity of Service**

Enter the number of units of service provided according to the unit code type. **Only whole**

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numbers should be reported.

13. *Facility Code*

Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc.

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 837/4010 Professional, or the 837/4010 Institutional format is used).

PIHP REPORTING REQUIREMENTS

FY'11 PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDCH management of PIHP contracts and rate-setting by the actuary. In the case of an affiliation, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its affiliates. Medicaid Substance Abuse services provided by Substance Abuse Coordinating Agencies are now included in this report, effective 10/1/06. The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries, except Children's Waiver beneficiaries. Refer to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual for the complete and specific requirements for coverage for the State Plan, Additional services provided under the authority of Section 1915(b)(3) of the Social Security Act, and the Habilitation Supports Waiver. All of the aforementioned Medicaid services and supports provided in the PIHP service area (affiliation, if applicable) must be reported on this utilization and cost report.

RULES FOR REPORTING ON MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

Background:

Per the CMHSP and PIHP contracts with the Department of Community Health, beginning FY07 the community mental health system is required to submit three cost reports:

The 18 PIHP Medicaid Utilization and Aggregate Net Cost report replaces the PIHP Medicaid Sub-element cost report. It will be used by the state's actuary in the analysis of the encounter data and costs. As such, the Medicaid report is an internal report. The actuary will use this report to review Medicaid managed care administration costs and determine the administrative load for the future rates. The report will also be used to compare the volume of units reported with the encounter data.

The 46 CMHSP Sub-Element Cost reports will continue to be used by MDCH to comply with the MDCH Appropriations Act Section 404 boilerplate requirements.

The report contained herein resulted from the system's experiences of reporting allowed amounts, the PIHP sub-element reports, and the Medicaid "bucket" reports for FY'04. This report consolidates those three reports into one report per the recommendations of the Encounter Data Integrity Team (EDIT), III. EDIT determined, and MDCH agreed, that "allowed amounts" as defined in the current contract is no longer a valid concept. Instead it was agreed that PIHPs should report the total Medicaid expenditure per procedure code, then a unit rate would be derived from dividing the expenditures by the total number of units. EDIT therefore proposed to MDCH that the requirements for reporting a financial amount with each encounter be waived

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except for those procedures that require an actual amount (e.g., housing assistance, environmental modifications, etc.). Instead, the PIHPs would report at 12 months the total cases, total units and total Medicaid expenditures per procedure code. This report is the result of MDCH's agreement with EDIT's proposal.

This change in reporting is expected to result in information that is consistent with the Financial Status Report, and with the units and cases reported via the encounter data system to the MDCH data warehouse. The reporting template resides on the MDCH web site at www.michigan.gov/mhsa, Click on "Reporting Requirements".

Medicaid Hospital Rate Adjustment (HRA)

Implementation of the HRA that is contained in the annual DCH Appropriations Act requires more detailed information regarding Medicaid community inpatient psychiatric hospital costs. Section 7.8, and Attachment 7.8.1 of the contract lists required financial reports including the Medicaid Community Inpatient Hospital Expenditure Report. This is a community hospital-level Medicaid expenditure reporting requirement encompassing expenditures made by the PIHP and affiliate CMHSPs. The information submitted in this report is required to reconcile to the MUNC report. Correspondingly, whenever a revision to the MUNC report is submitted that involves revised community inpatient costs then a revised Medicaid Community Inpatient Hospital Expenditure Report must also be submitted. Reporting instructions for HRA can be found on the MDCH web site at: http://www.michigan.gov/mdch/0,1607,7-132-2941_38765---,00.html

I. Medicaid units, cases, and costs per procedure code

- a. Enter the number of Medicaid **units** per procedure code that were provided during the period of this report. The number of units should be consistent with the number of Medicaid units for that procedure code that were reported to the MDCH warehouse for Medicaid beneficiaries. Follow the same rules for reporting units in this report that are followed for reporting encounters. Refer to the Mental Health HCPCS and Revenue Code Chart on the MDCH web site, the Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual (also on the MDCH web site) and the Costing Per Code document issued by MDCH.
- b. Report state plan services, 1915(b)(3) or additional services, and Habilitation Supports Waiver (HSW) services in separate columns on the spreadsheet. Note that some procedures are reportable under more than one column. An example is supports coordination which is a (b)(3) service as well as a HSW service. Enter the appropriate number of units and expenditures in the HSW column for HSW enrollees only (distinguished in the encounter data by a HK modifier that accompanies the procedure code).
- c. Peer-delivered: changes have been made to reflect the addition of Peer Specialist H0038, it has a row for units, costs, and cases that were reported in the encounter

PIHP REPORTING REQUIREMENTS

data. There is also a row for Peer-Delivered/drop-ins that were reported in the encounter data as H0023; and finally there remains a row for peer-delivered expenditures (typically drop-in center activities) that were **not** captured by encounter data. **Do not** aggregate the units, cases and costs and report in the row for cost-only peer-delivered. **Do not** combine the costs from any of these rows.

- d. Several codes have rows without modifiers as well as rows with modifiers: 90849 (HS modifier used to distinguish when a beneficiary is not present), H2106 and T1020 (TF and TG modifiers used to distinguish nursing home mental health monitoring from targeted case management). It is important that the appropriate number of units, cases and costs are entered into the correct rows for these procedures. **Do not** aggregate the units, cases and costs for the modified procedures into one row.
- e. Rows for procedure codes that were deleted by CMS effective January 1, 2009, or deleted as a service (HSW Dental) by MDCH, have been retained for any reporting of those codes that may have occurred the first three months of the fiscal year.
- f. Enter the **unique number of Medicaid cases** per procedure code. This number should reflect the unduplicated number of Medicaid beneficiaries who were provided the service during the reporting period.
- g. Enter the total Medicaid expenditures per procedure code (see exclusions below) by State Plan Services in column I, for 1915(b)(3) Services in column K, for HSW Services in column M, and finally in column O the sum of the Medicaid expenditures by procedure.
- h. In the final column (P), calculate the aggregate net cost per unit by dividing the total units in column N by the total expenditures in column O.

II. Total Medicaid MH/DD/SA Cases and Costs

- a. In row II, column G, enter the total unduplicated cases served during the period. This total should not be the sum of the rows above, but rather a count of all Medicaid beneficiaries who received services reported above.
- b. In row II, sums of the costs in columns I, K, M and O will automatically calculate.

III. Total Medicaid MH/DD Cases and Costs

- a. In row III, column G, enter the total unduplicated MH/DD cases served during the period. This total should not be the sum of the rows above, but rather a count of all Medicaid beneficiaries who received services reported above.
- b. In row III, enter the sum of the costs for MH/DD services in columns I, K, M and O.

IV. Medicaid Substance Abuse Cases and Costs

- a. In row IV, column G, enter the total unduplicated Medicaid SA cases served during the period. This total should not be the sum of the rows above, but rather a count of all Medicaid SA beneficiaries who received services reported above. Enter the sum of the costs for Medicaid SA services in columns I, K and O.

PIHP REPORTING REQUIREMENTS

V. Medicaid Program Administration MH/DD/SA

- a. In row V, column N, enter any Medicaid Program Administrative cost that are included in the Total Medicaid costs in row II, column O above.

VI. Medicaid Direct Service Costs MH/DD/SA

- a. Row VI will automatically deduct Medicaid Program Administration from row V, column N, above to yield Direct Service Costs. This amount must equal the Direct Service Costs reported on the Section 460 Cost Allocation Report.

VII. Medicaid Managed Care Administration MH/DD/SA

- a. Cost of Medicaid managed care administration performed by the PIHP (including administrative functions delegated to CMHSP affiliates, CAs, and/or prime subcontractors-for the MH/DD/SA benefit).
- b. Refer to the document entitled “Establishing Managed Care Administrative Costs” (revised January 2010) for determining the Medicaid administrative costs to be entered in row VII, column N of this report.

VIII. Total Medicaid Administrative Costs: The costs of Medicaid administration will automatically calculate by adding rows V and VII.

IX. Total Medicaid MH/DD/SA Service and Administration Costs: Sum of the service and administration costs will automatically calculate

X. Spend-down

- a. Enter in column O the amount of general fund expended for spend-down that needs to be deducted from the amount above; OR
- b. Enter in column N the amount of general fund expended for spend-down that has already been deducted from the amount above.

XI. Medicaid MH/DD/SA Net Expenses: Spend-down in column O will automatically be deducted from total expenses to yield the net expenses.

XII. Reconciling items to Financial Status Report (FSR)

- a. Current Period ISF Contributions (deposits) to ISF from Current Year Reserve Accounts & Internal Service Fund report ,section 3 row b.2
- b. Enter Medicaid costs charged to GF for Medicaid services that are not included in PIHP reported Medicaid costs. Such as affiliate (spoke CMHSP) redirection of GF.
- c. QAAP tax from FSR row K 4.
- d. Prior year adjustments included in costs on the PIHP FSR not included in the MUNC encounter rates
- e. SSI and other reimbursements from FSR row K2
- f. Other. Adjustments needed to reconcile costs on the MUNC report to the Medicaid costs on the FSR. For each amount reported also provide a short description of the type of cost/adjustment. Such as dental services not on the MUNC and IBNR included in the FSR. If more than three lines are needed please attach a detail listing for amount included on row f.

PIHP REPORTING REQUIREMENTS

- g. Total reconciling items to Financial Status Report Sum of XI. a. b. c. d. e. and f.

XIII. Adjusted MUNC report Medicaid costs.

This is the sum of rows X and XI g.

XIV. Financial Status Report (FSR)

- a. Prior year savings expended for MH/DD Medicaid services from FSR row G.2,
- b. Medicaid ISF abatement from FSR row G.3
- c. Medicaid expenses from FSR row K
- d. FSR total Medicaid Expenses. Sum of rows XIII. a., b, and c.

Difference between row XII and row XIII d

EXCLUSIONS

The following expenditures must be excluded from the Medicaid Utilization and Cost Report:

1. Local contribution to Medicaid
2. Payments made into internal service funds (ISFs) or risk pools. (Note: these payments must **not** be incorporated into allowable amounts either; the actuary will use the ISF reports submitted with the final FSR to identify use of fiscal year Medicaid revenues for funding of ISF)
3. Provider of administrative service organization (ASO) services to other entities, including PIHP/hub ASO activities provided to CMHSP affiliates/spokes for non-Medicaid services
4. Write-offs for prior years
5. Substance Abuse services provided by the CMHSP under provider contract with CAs (these show up in the report from the CA)
6. Workshop production costs (these costs should be offset by income for the products).
7. Medicare payments for inpatient days

ADDITIONAL DO'S AND DON'TS

1. Do **exclude room and board** costs
2. Do include costs and services that were funded by FY03 savings or carry-forward or by funds pulled **out** of the ISFs.
3. Do include costs and services for persons with co-occurring conditions where Medicaid revenues were used by the PIHP or its affiliate CMHSPs to purchase or provide such services using Medicaid funds that were **not** paid to the CA.
4. Do submit an encounter that matches the accrual assumptions for fee-for-service activities where an end-of-year financial accrual is made for services incurred but where a claim has not been processed.
5. Do assume that the CAs are providing a Medicaid and a Total service use/cost report
6. Do **not** include the 1915(c) Developmental Disabilities Children's Waiver, Adult Benefits Waiver, MI Child, or Fee for Service Medicaid Injectable medications in this Medicaid report
7. If services are provided by a CMHSP to another CMHSP/PIHP though an earned

contract, the COFR CMHSP should report these costs, NOT the providing CMHSP

8. Do report on separate rows in this report:

- Community Psychiatric Inpatient
- Inpatient in a community institution for mental disease (IMD)

PIHP REPORTING REQUIREMENTS

**MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM
VERSION 6.0
FOR PIHPS**

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, MDCH 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 databased mechanism to assist MDCH in the management of PIHP contracts that would impact the quality of the service delivery system statewide.
- To the extent possible, facilitate the development and implementation of local quality improvement systems; and
- To link with existing health care planning efforts and to establish a foundation for future quality improvement monitoring within a managed health care system for the consumers of public mental health services in the state of Michigan.

All of the indicators here are measures of PIHP performance. Therefore performance indicators should be reported by the PIHP for all the Medicaid beneficiaries for whom it is responsible. 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 MDCH six weeks prior to the due date and also available on the MDCH website: www.michigan.gov/mdch.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM, VERSION 6.0 FOR PIHPS

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**
2. The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SA). **Standard = 95% in 14 days.**
3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults, DD children, and Medicaid SA) **Standard = 95% in 14 days**
4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults (MI, DD) and all Medicaid SA (sub-acute detox discharges))
5. The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SA)

ADEQUACY/APPROPRIATENESS

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

EFFICIENCY

7. The percent of total expenditures spent on managed care administrative functions for PIHPs.

OUTCOMES

8. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who are in competitive employment. New standard for FY11:
Adult Medicaid Beneficiaries with Serious Mental Illness:
 - For PIHPs with a three-year average of 15% or less of total persons served in competitive employment, an increase of 7% of the base number over the last year.
 - For PIHP with a three-year average of more than 15%, but less than 20% of total persons served in competitive employment, an increase of 5% of the base number over the last year.
 - For PIHPs with a three-year average of 20% or more of total persons service who are

PIHP REPORTING REQUIREMENTS

in competitive employment, an increase of 3% of the base number over the last year.
Adult Medicaid Beneficiaries with Developmental Disabilities:

- For PIHPs with a three-year average of 10% or less of total persons served in competitive employment, an increase of 7% of the base number over the last year.
- For PIHP with a three-year average of more than 10%, but less than 15% of total persons served in competitive employment, an increase of 3% of the base number over the last year.
- For PIHPs with a three-year average of 25% or more of total persons served who are in competitive employment, an increase of 2% of the base number over the last year.

Adult Medicaid Beneficiaries with Dual Diagnosis (MI/DD)

- For PIHPs with a three-year average of 8% or less of total persons served in competitive employment, an increase of 7% of the base number over the last year.
- For PIHP with a three-year average of more than 8%, but less than 16% of total persons served in competitive employment, an increase of 5% of the base number over the last year.
- For PIHPs with a three-year average of 16%, but less than 30% of total persons served who are in competitive employment, an increase of 3% of the base number over the last year.
- For PIHPs with a three-year average of 30% or more of total persons served who are in competitive employment, an increase of 2% of the base number over the last year.

A minimum increase of one or more persons competitively employed will be expected when numbers are less than ten.

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who earn minimum wage or more from employment activities (competitive, supported or self employment, or sheltered workshop).
10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days
11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.
12. The quarterly number of sentinel events per thousand Medicaid beneficiaries served (MI adults, MI children, persons with DD, HSW enrollees, and SA).
13. The percent of adults with developmental disabilities served, who live in a private

residence alone, or with spouse or non-relative.

14. The percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative.
15. The percent of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and respite.

Note: Indicators #2, 3, 4, 5 and 12 include Medicaid beneficiaries who receive substance abuse services managed by the Substance Abuse Coordinating Agencies.

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1 st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1 st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
5. Medicaid penetration*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDCH
6. HSW services*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDCH
7. Admin. Costs*	10/01 to 9/30	1/31							MDCH
8. Competitive employment*	10/01 to 9/30								MDCH
9. Minimum wage*	10/01 to 9/30								MDCH
10. Readmissions	10/01 to 9/30	3/31	1/01 to 3/31	6/30	4-01 to 6-30	9/30	7/01 to 9/30	12/31	PIHPs
11. RR complaints	10/01 to 9/30	12/31							PIHPs
12. Sentinel Events	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
13. & 14. Living arrangements	10/1 to 9/30	N/A							MDCH
15. Children with DD	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDCH

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

PIHP REPORTING REQUIREMENTS

STATE LEVEL DATA COLLECTION

Change for CAFAS Reporting effective 10/1/10:

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. MDCH uses aggregate reports from the LOF Project for internal planning and decision-making. In FY'11 MDCH 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 MDCH. The report is automatically generated by the FAS Outcomes program. **Methodology and instructions for submitting the reports are posted on the MDCH web site at www.michigan.gov/mhsa. Click on “Reporting Requirements”**

Consumer Satisfaction Survey: Adults with Serious Mental Illness & Children with Serious Emotional Disturbance

-An annual survey using MHSIP 28 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 MDCH each year on an Excel template to be provided by MDCH.

Critical Incident Reporting effective 10/1/10

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 an 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.

PIHP REPORTING REQUIREMENTS

- **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 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 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 MDCH web site at www.michigan.gov/mhsa. Click on “Reporting Requirements”

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PRE-PAID INPATIENT HEALTH PLANS

The State requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a quality assessment and performance improvement program (QAPIP) which meets the standards below. These standards are based upon the Guidelines for Internal Quality Assurance Programs as distributed by then Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002. This document also reflects: concepts and standards more appropriate to the population of persons served under Michigan's current 1915(b) specialty services and supports waiver; Michigan state law; and existing requirements, processes and procedures implemented in Michigan.

Michigan Standards

- I. The PIHP must have a written description of its QAPIP which specifies 1) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2) the components and activities of the QAPIP, including those as required below; 3) the role for recipients of service in the QAPIP; and 4) the mechanisms or procedures to be used for adopting and communicating process and outcome improvement.

- II. The QAPIP must be accountable to a Governing Body that is a Community Mental Health Services Program Board of Directors. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:
 - A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.
 - B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.
 - C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.
 - D. The Governing Body submits the written annual report to MDCH following its review. The report will include a list of the members of the Governing Body

- III There is a designated senior official responsible for the QAPIP implementation.

- IV There is active participation of providers and consumers in the QAPIP processes.

- V The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

- A. PIHP must utilize performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as established in contract.
 - B. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.
- VI The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur.
- VII The PIHP's QAPIP includes affiliation-wide performance improvement projects that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction.
- A. Performance improvement projects must address clinical and non-clinical aspects of care.
 - 1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.
 - 2. Non-clinical areas would include, but not be limited to, appeals, grievances and complaints; and access to, and availability of, services.
 - B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.
 - C. Performance improvement projects may be directed at state or PIHP-established aspects of care. The statewide project for FY'09 is improving the access to services for children who are Medicaid beneficiaries and adult beneficiaries with substance use disorders as measured by the performance targets individually negotiated between MDCH and each PIHP. Future state-directed projects will be selected by MDCH with consultation from the Mental Health Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.
 - D. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department.
 - E. The PIHP must engage in at least two projects during the waiver renewal period.
- VIII The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events.
- A. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate. The PIHP or its delegate has three

business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event.

- B. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.
- C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:
 - 1.Screens of individual deaths with standard information (e.g., coroner’s report, death certificate)
 - 2.Involvement of medical personnel in the mortality reviews
 - 3.Documentation of the mortality review process, findings, and recommendations
 - 4.Use of mortality information to address quality of care
 - 5.Aggregation of mortality data over time to identify possible trends.

* “unexpected deaths” include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

- D. Following immediate event notification to MDCH (See Section 6.1.1 of this contract) the PIHP will submit to MDCH, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient’s discharge from a state-operated service.

The written report will include:

2. Beneficiary’s name
3. Beneficiary ID number (Medicaid, ABW or MiChild)
4. Consumer ID number if he/she does not have a beneficiary ID (CONID)
5. Date, time and place of death (if in a foster care setting, the foster care license #)
6. Final determination of cause of death (from coroner’s report or autopsy)
7. Summary of conditions (physical, emotional) and treatment or interventions preceding death
8. Any quality improvement actions taken as a result of an unexpected or preventable death
9. The PIHP’s plan for monitoring to assure any quality improvement actions are implemented

Following immediate event notification to MDCH (See Section 6.1.1 of this contract) the PIHP will submit to MDCH, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient’s discharge from a state-operated service

The written report will include:

10. Beneficiary's name
11. Beneficiary ID number (Medicaid, ABW or MiChild)
12. Consumer ID number if he/she does not have a beneficiary ID (CONID)
13. Date, time and place of death (if in a foster care setting, the foster care license #)
14. Final determination of cause of death (from coroner's report or autopsy)
15. Summary of conditions (physical, emotional) and treatment or interventions preceding death
16. Any quality improvement actions taken as a result of an unexpected or preventable death
17. The PIHP's plan for monitoring to assure any quality improvement actions are implemented

IX. The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management has been used in an emergency situation. Only techniques that have been approved during person-centered planning by the beneficiary or his/her guardian, and are supported by current peer-reviewed psychological and psychiatric literature may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and accessibility of care.

B. As a result of the assessments, the organization:

- 1 Takes specific action on individual cases as appropriate;
- 2 Identifies and investigates sources of dissatisfaction;
- 3 Outlines systemic action steps to follow-up on the findings; and
- 4 Informs practitioners, providers, recipients of service and the governing body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization insures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDCH and the PIHPs) clinical standards,

evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served.

- XII. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. The PIHP must have written policies and procedures for the credentialing process which are in compliance with MDCH's Credentialing and Re-credentialing Processes, January 2007, Attachment P.6.4.3.1, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also insure, regardless of funding mechanism (e.g., voucher):

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:
 - a. Educational background
 - b. Relevant work experience
 - c. Cultural competence
 - d. Certification, registration, and licensure as required by law
2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.
3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

- XIII. The written description of the PIHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates (as applicable), providers and subcontractors.

- A. The PIHP must submit to the state for approval its methodology for verification.
- B. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.

- XIV. The organization operates a utilization management program.

- A. Written Plan - Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.
- B. Scope - The program has mechanisms to identify and correct under-utilization as well as over-utilization.
- C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:

1. Review decisions are supervised by qualified medical professionals. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.
2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
3. The reasons for decisions are clearly documented and available to the member.
4. There are well-publicized and readily-available appeals mechanisms for both providers and patients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal.
5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

XV. The PIHP annually monitors its provider network(s), including any affiliates or sub-contractors to which it has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any provider network monitoring of its subcontractors.

XVI. The PIHP shall conduct additional special targeted monitoring activities of people who are identified as “vulnerable.”_By October 1, 2010, MDCH will issue requirements for the process and content of the PIHP’s monitoring of vulnerable people. The PIHP will be in compliance with the requirements within 90 days of their issuance.

The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDCH review.

Integrated Dual Disorders Treatment (IDDT) Services

1. The PIHP/CMHSP follow the IDDT model outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services and show progress in fidelity ratings over time. Information regarding this model can be accessed from SAMHSA at <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/default.asp>.
2. The PIHP/CMHSP must meet the following requirements for IDDT services:
 - a. PIHP/CMHSP must have policies and procedures that are consistent with the IDDT model. At a minimum each CMHSP must have an IDDT team.
 - b. A multi-disciplinary team that includes representation, at a minimum, of the following disciplines: a psychiatrist, a nurse, a qualified mental health professional, a peer support specialist and a substance abuse professional. The number and patterns of IDDT team in agency will be guided by the needs and number of consumers being supported. The team shall include individuals with knowledge and training in IDDT skills including co-occurring disorders, motivational interviewing, stage-wise treatment, cognitive behavioral strategies and substance use disorders treatment. Residential/housing services and vocational/supported employment services will be available and accessible, through referral or provided directly, until a specialist in these areas can be added to the team.
 - c. All IDDT team members are expected to pursue professional development in the area of IDDT. IDDT team members will also have a training plan developed which addresses specific IDDT philosophies, as well as motivational interviewing, stage-wise treatment, pharmacological treatment, cognitive behavioral interventions and substance use treatment. If an individual staff has less than one year of experience in IDDT, he/she must be actively acquiring 24 hours of training in IDDT specific content and receive supervision from experienced IDDT staff.
 - d. Staff must be able to provide individual counseling, group counseling, and assessment based on their scope of practice.
 - e. Quality improvement plan includes monitoring adherence of IDDT program philosophy and mission statement, identifying and measuring consumer outcomes specific to IDDT treatment, and consumer satisfaction.
 - f. Services will be delivered according to the IDDT model; will be time unlimited with the intensity modified according to level of need and degree of recovery; will include specific interventions to promote physical health; and will target specific services to non-responders. The following will be expected:
 - All consumers receive a screening for both mental health and substance use disorders. If a consumer presents with both mental health and substance use identified service needs, then consumer(s) will receive integrated mental health/substance abuse assessment, which identifies service needs as well as the individual's stage of readiness to change. The assessment of readiness to

change should be multi-dimensional and address a variety of life areas, symptoms, etc.

- An integrated treatment plan will be developed by the consumer and the multi-disciplinary team. For persons with both mental health and substance use disorders, the treatment plan will always address mental health and substance use, and will typically involve building both skills and supports for recovery goals. All interventions are consistent with and determined by the individual's stage of treatment (engagement, persuasion, active treatment, relapse prevention) that is identified.
 - IDDT services will include crisis intervention, medication services, medication administration, community support, outreach/engagement, co-occurring individual counseling, co-occurring group counseling, and co-occurring group education. Until and unless housing and vocational specialists are part of the multidisciplinary team, referral arrangements must be established and available for those services. Referral arrangements and linking/coordination must also be established and available for those needing detoxification or hospitalization services.
 - Staff will help consumer(s) in the engagement and persuasion stages recognize the consequences of their substance use, resolve ambivalence related to their addiction, and introduce them to self-help principles. Consumer(s) in the active treatment or relapse prevention stage are assisted to connect with self-help programs in the community.
 - In order to establish an understanding of the nature of the mental illness and its interaction with substance use, families and significant others will receive education and, as appropriate, be involved in therapy.
3. Fidelity to the IDDT model and successful consumer outcomes is the goal of this evidence based practice. Fidelity to the IDDT model is a developmental process. PIHP at a minimum evaluate the team(s) annually using the fidelity scales included in the SAMHSA tool kit. The expectation is that PIHPs/CMHSPs will develop a plan and make gradual steps to full fidelity.
 4. PIHPs report IDDT services after receiving department approval using HH&TG modifier.
 5. IDDT teams must obtain an integrated treatment license.

Family Psychoeducation Services:

1. The PIHP follows the FPE model outlined in the Substance Abuse and Mental Health Services Administration (SAMHSA) toolkit and shows progress in fidelity ratings over time. Information regarding the FPE model can be found at: <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/default.asp>.
FPE Fidelity can be accessed at : http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_38495_38496_38502--,00.html
2. The PIHP must meet the following requirements for FPE services:
 - a. The PIHP must have policies and procedures that are consistent with the FPE model.
 - b. All FPE providers must have completed minimally, training at the Facilitator level, plus 1 year of supervision; Advanced Facilitators complete Facilitator training and 1 year of supervision and Advanced Facilitator training with another 1 year of supervision; Trainers complete the first two steps and additional Trainer training and supervision (See Credentialing and Sustainability Guide to FPE on website.) Training is a developmental process that seeks to enhance professional development and create a sustainable FPE system of Trainers/Supervisors and Facilitators.
 - c. For each Multi-Family group least two FPE trained facilitators working with a Trainer who provides supervision and consultation.
 - a. The FPE facilitation team shall include individuals with knowledge and training in FPE as defined by SAMHSA and Multi-Family Groups and the Treatment of Severe Psychiatric Disorders (William R. McFarland, Gilford Press 2002).
 - b. The FPE facilitation team may include one FPE trained Peer, who must meet the requirements of a FPE Facilitator, or the Peer may work as additional staff assisting the group. The Peer must be credentialed as a Certified Peer Support Specialist.
 - c. The FPE facilitation team may include persons with a BA/BS in Psychology who must meet the FPE training/supervision requirements.
 - d. The treatment plan, goals and objectives are consistent with the needs of the consumer and reflect the FPE process.
 - e. The Quality Improvement Plan includes monitoring adherence of FPE philosophy and mission, identifying and measuring consumer outcomes specific to FPE and consumer satisfaction.
 - a. Fidelity Scales to FPE (above website) include Joining, Workshop and Multi-Family group scales.
 - i. Fidelity is a developmental process and FPE teams should be evaluated on the Fidelity Scales at least annually in addition to required supervision in the provision of FPE.
 - f. FPE services will be delivered according to the FPE model; with consumers and families participating in Joining, Workshops and problem-solving Multifamily groups.

- g. BILLING CODES Multi Family Group Family Psycho-education face to face encounters with family (report one encounter per family no matter how many family members are present)
- a. If provided as a group modality where families of several beneficiaries are present, report an encounter for *each consumer represented*.
 - b. FPE codes:
 - **T1015 should be used for the single-family joining session.** It is a clinic visit and reported as an encounter. **Maximum of 6** joining sessions can be billed per consumer. Standard length of encounter is 45 – 60 minutes.
 - **S5110/15 minute units for Family Skills Workshop. Maximum of 32** units per consumer.
 - **G0177 should be used for problem-solving groups.** Standard length of group is 90 minutes.

When the beneficiary is not present for any one of these activities, add an HS modifier.

INCLUSION PRACTICE GUIDELINE

NOTE: Replicated from the MDCH Inclusion Guideline as included in the Public Mental Health Manual, Volume II, Section 1116(j), Subject GL-01, Chapter 01-C, Dated 2/13/95.

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 Community Health (MDCH).
- B. Regional centers for developmental disabilities and community placement agencies operated by MDCH.
- C. Children's psychiatric hospitals operated by MDCH.
- D. Special facilities operated by MDCH.
- E. Community Mental Health Services Programs (CMHSPs) as specified in their master contract with MDCH.

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 Mental Health Agencies (RMHAs) 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. RMHA's shall organizationally promote inclusion by establishing internal mechanisms that:

1. assure all recipients of mental health services will be treated with dignity and respect.

2. assure all recipients, including those who have advocates or guardians, have genuine opportunities for consumer choice and self-representation.
 3. provide for a review of recipient outcomes.
 4. provide opportunities for representation and membership on planning committees, work groups, and agency service evaluation committees.
 5. invite and encourage recipient participation in sponsored events and activities of their choice.
- C. RMHAs shall establish policies and procedures that support the principle of normalization through delivery of clinical services and supports that:
1. address the social, chronological, cultural, and ethnic aspects of services and outcomes of treatment.
 2. help recipients gain social integration skills and become more self reliant.
 3. 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.
 4. assist adult recipients to obtain/ maintain permanent, individual housing integrated in residential neighborhoods.
 5. help families develop and utilize both informal interpersonal and community based networks of supports and resources.
 6. provide children with treatment services which preserve, support and, in some instances, create by means of adoption, a permanent, stable family.
- D. RMHAs 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:

1. learn how to make their own decisions and take responsibility for them.
2. understand his or her social obligations.

VI. REFERENCES AND LEGAL AUTHORITY

MCL330.116, et.seq.
MCL330.1704, et.seq.

VII. EXHIBITS

None

HOUSING PRACTICE GUIDELINE

NOTE: Replicated from the MDCH 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 (MDCH).
- B. Regional centers for developmental disabilities operated by MDCH.
- C. Special facilities operated by MDCH.
- D. Residential placement agencies operated by MDCH.
- E. Community Mental Health Services Programs (CMHSPs) as specified in their master contract with MDCH.

III. POLICY

The Michigan Department of Community Health 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. RMHA's shall foster the provision of services and supports independent of where the consumer resides.

When requested, RMHAs 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 RMHA 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 MDCH hospital, center or CMHSP responsible for providing and contracting for mental health services and/or arranging and coordinating the provision of other services to meet the consumers needs.

V. STANDARDS

RMHAs shall develop policies and create mechanisms that give predominant consideration to consumers' choice in selecting where and with whom they live. These policies and mechanisms shall also:

- A. Ensure that RMHA-supported housing blends into the community. Supported housing units are to be scattered throughout a building, a complex, or the community in order to achieve community integration when possible. Use of self-contained campuses or otherwise segregated buildings as service sites is not the preferred mode.
- B. Promote and support home ownership, individual choice, and autonomy. The number of people who live together in RMHA-supported housing shall not exceed the community's norms for comparable living settings.
- C. Assure that any housing arranged or subsidized by the RMHA is accessible to the consumer and in compliance with applicable state and local standards for occupancy, health, and safety.

- D. Be sensitive to the consumer's cultural and ethnic preferences and give consideration to them.
- E. Encourage and support the consumer's self-sufficiency.
- F. Provide for ongoing assessment of the consumer's housing needs.
- G. Provide assistance to consumers in coordinating available resources to meet their basic housing needs. RMHAs may give consideration to the use of housing subsidies when consumers have a need for housing that cannot be met by the other resources which are available to them.

VI. REFERENCES AND LEGAL AUTHORITY

MCL 330.1116(j).

VII. EXHIBITS

Federal Housing Subsidy Quality Standards based on 24 CFR § 882.10

CONSUMERISM PRACTICE GUIDELINE

6/27/96

I. SUMMARY

This guideline sets policy and standards for consumer inclusion in the service delivery design and delivery process for all public mental health services. This guideline ensures the goals of a consumer-driven system which gives consumers choices and decision-making roles. It is based on the active participation by primary consumers, family members and advocates in gathering consumer responses to meet these goals.

This participation by consumers, family members and advocates is the basis of a provider's evaluation. Evaluation also includes how this information guides improvements.

II. APPLICATION

- A. Psychiatric hospitals operated by the Michigan Department of Community Health (MDCH).
- B. Centers for persons with developmental disabilities and community placement agencies operated by the MDCH.
- C. Children's psychiatric hospitals operated by the MDCH.
- D. Special facilities operated by the MDCH.
- E. Community Mental Health Services Programs (CMHSPs) under contract with MDCH.
- 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 Community Health 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 policies, 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.

**Medicaid Managed Specialty
Supports and Services
1915 (b)/(c) Waiver Program**

Contract Attachment

P 6.8.2.4

**Personal Care in Non-Specialized
Residential Settings
Technical Requirement**

PERSONAL CARE IN NON-SPECIALIZED RESIDENTIAL SETTINGS TECHNICAL REQUIREMENT

NOTE: Replicated from the MDCH Personal Care in Non-Specialized Residential Settings Guideline as included in the Public Mental Health Manual, Volume 01-C, Section 1116(j), Subject GL-00, Chapter 01, Dated 10/9/96.

I. SUMMARY

This guideline establishes operational policy; program and clinical documentation requirements for issuing payments through the Model Payment System (MPS) for mental health recipients who need personal care services when placed in a non-specialized residential foster care setting.

II. APPLICATION

- A. Community Mental Health Services Programs (CMHSPs) when specified in the master contract with the Michigan Department of Community Health (MDCH).
- B. Psychiatric Hospitals and Centers operated by, or under contract with the MDCH.
- C. Special facilities operated by the MDCH.
- D. Children's units operated by the MDCH.

III. POLICY

Upon placement of a mental health recipient into a non-specialized residential foster care setting, the Responsible Mental Health Agency (RMHA) shall insure that any need for personal care services are identified in their plan is addressed in keeping with Medicaid (MA) standards. In addition, RMHA shall take the required action(s) to further insure that payment(s) for personal care services are issued, and all payment problems are resolved.

IV. DEFINITIONS

Client Services Management: a related set of activities which link the recipient to the public mental health system and which staff coordinate to achieve a successful outcome.

Family Member: means a parent or step-parent of a minor child or spouse.

Individual Plan of Service (IPS): a written plan which identifies mental health services; as defined in Section 712, Act 290 of the Public Acts of 1995.

Medicaid (MA) Designated Case Manager: case manager must be either a qualified mental retardation professional (QMRP) as defined in 42 CFR 483.430, or a qualified mental health professional (QMHP) as defined in Michigan's Medicaid Mental Health Clinic Provider Manual, Chapter III.

Non-Specialized Residential Foster Care Setting: a licensed dependent living arrangement which provides room, board and supervision, but does not provide in-home specialized mental health services.

Personal Care Services: services provided in accordance with an individualized plan of service that assist a recipient by hands-on assistance, guiding, directing, or prompting of Personal Activities of Daily Living (PADL) in at least one of the following activities:

- A. **EATING/FEEDING:** the process of getting food by any means from the receptacle (plate, cup, glass) into the body. This item describes the process of eating after food is placed in front of an individual.
- B. **TOILETING:** the process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleansing self after elimination, and adjusting clothes.
- C. **BATHING:** the process of washing the body or body parts, including getting to or obtaining the bathing water and/or equipment, whether this is in bed, shower or tub.
- D. **GROOMING:** the activities associated with maintaining personal hygiene and keeping one's appearance neat, including care of teeth, hair, nails, skin, etc.
- E. **DRESSING:** the process of putting on, fastening and taking off all items of clothing, braces and artificial limbs that are worn daily by the individual, including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual.
- F. **TRANSFERRING:** the process of moving horizontally and/or vertically between the bed, chair, wheelchair and/or stretcher.
- G. **AMBULATION:** the process of moving about on foot or by means of a device with wheels.
- H. **ASSISTANCE WITH SELF-ADMINISTERED MEDICATION:** the process of assisting the client with medications that are ordinarily self administered, when ordered by the client's physician.

V. STANDARDS

- A. Recipient must be Medicaid active during effective dates of service.
- B. Providers of non-specialized residential services must be licensed and meet minimum requirements of the Michigan Department of Consumer and Industry Services (MDCIS) and MDCH as defined and contained therein, Act 117, Public Acts of 1973, as amended and Act 218, Public Acts of 1979, as amended, for non-specialized residential settings such as: homes for the aged, adult foster care family home, adult foster care small group home, adult foster care large group home, adult foster care congregate facility, foster family home, foster family group home, and child caring institutions.
- C. Personal care services are covered when ordered by a physician or Medicaid (MA) designated case manager based upon face to face contact with recipient, and in accordance an Individual Plan of Service (IPS) and rendered by a qualified person who is not a member of the individual family.
- D. Supervision of personal care services is required, and may be provided by a registered nurse, physician assistant, a MA designated case manager supervisor or a MA designated case manager other than the case manager who ordered services. Supervision of personal care services is a two-part/sign-off process which includes:
 - 1. Approval of covered personal care services, occurs after a Medicaid designated case manager or physician has ordered personal care services, which must be either written in the IPS or on a program approved form.
 - 2. A re-evaluation or review of personal care services must occur within a calendar year of the last plan for personal care services or last re-evaluation or review whichever occurred last, based upon either a face-to-face contact with recipient or an administrative review of plan of service. A Medicaid designated case manager shall initiate a re-evaluation or review on a program approved form.
- E. Provider of service must maintain a service log that documents specific days on which personal care services were delivered consistent with the recipients individual plan of services.
- F. Compliance with the Personal Care/Model Payments standards of MDCH.

VI. REFERENCES AND LEGAL AUTHORITY

- A. Social Security Act, Section 1905(a) (17).
- B. 42 CFR 440.170 and 42 CFR 483.430.

- C. Act 258 of the Public Acts of 1974 (MCLA -330.1116) and Act 290 of the Public Acts of 1995 (MCLA -330.1712).
- D. Michigan's Medicaid State provisions for Title XIX of the Social Security Act.
- E. Michigan Department of Social Services/Family Independence Agency, Service Manual, Adult and Family Services Item -314 and 372, Home Help Adult, Community Placement and Personal Care Services, Adults Foster Care (AFC) and Homes for the Aged (HA), Personal Care/Supplemental Payments.
- F. Michigan Department of Community Health, Personal Care/Model Payment Manual, 1996.

VII. EXHIBITS

None.

Attachment P 6.8.4.1

**Adult Jail Diversion Policy Practice Guideline
February 2005**

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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 Community Health (MDCH) 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.

This document supersedes and replaces, for adults with serious mental illness or developmental disability, the Jail Diversion Practice Guideline found as Attachment C 6.9.5.1 to the 2003-2005 MDCH/CMHSP Managed Mental Health Supports and Services Contract, and as Attachment P.6.8.4.1. to the 2003-2005 MDCH/PIHP Medicaid Managed Specialty Supports and Services 1915(b)(c) Wavier Program Contract.

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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.

MDCH: Michigan Department of Community Health.

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

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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).

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III. Background Summary

During the 1990s, CMHSPs and MDCH 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 MDCH 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,

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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.

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- 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.

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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

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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

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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.

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V. Resources

Council of State Governments
Criminal Justice/Mental Health Consensus Project
Report, June 2002
www.consensusproject.org/infocenter

The National GAINS Center for People with Co-Occurring Disorders in the Justice System
www.gainsctr.com

The President's New Freedom Commission on Mental Health
Achieving the Promise: Transforming Mental Health Care in America
Final Report, July 2003
www.mentalhealthcommission.gov/reports/FinalReport

The Technical Assistance and Policy Analysis Center for Jail Diversion (TAPA)
www.tapacenter.org

SPECIAL EDUCATION-TO-COMMUNITY TRANSITION PLANNING PRACTICE RECOMMENDATION GUIDELINE

I. Statement of Purpose

The purpose of this practice recommendation guideline is to provide community mental health service programs (CMHSPs) direction and guidance in planning for the transition of students with disabilities from special education programs to adult life as required by the MI Mental Health Code Section 330.1227, School-to-Community Transition Services. Section 330.1100d(11) of the MI Mental Health Code states: “Transition services means a coordinated set of activities for a special education student designed within an outcome-oriented process that promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living, or community participation.” This practice guideline provides information about state and federal statutes relevant to school services and the CMHSPs responsibilities. In addition, information is being provided regarding key elements of school programs which appear to better prepare students with disabilities for transition from special education to adult life.

Although this guideline focuses only on special education to community transition, it is important to note CMHSP responsibilities described in Section 208 of the Mental Health Code: “(1) Services provided by a community mental health service program shall be directed to individuals who have a serious mental illness, serious emotional disturbance, or developmental disability. (3) Priority shall be given to the provision of services to persons with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability.” In addition, any Medicaid recipient requiring medically necessary services must also be served.

Children meeting the criteria described above, but not in special education, also face issues of transition to adult life. These may include sub-populations of youth such as runaway youth, children with emotional disturbance at risk of expulsion from school, and youth who “age out” of: 1) the DSM-IV diagnosis for which they are receiving mental health services; 2) Children’s Waiver; 3) Children’s Special Health Care Services plan; and 4) foster care placement, making them at risk for being homeless. The Michigan Department of Community Health (MDCH) recognizes the importance of these issues and is seeking service models to assist CMHSPs to meet the needs of this population. For example, Dr. Hewitt “Rusty” Clark of the Florida Mental Health Institute, a national expert on transition, has presented and discussed issues regarding transition to independent living for youth and young adults with emotional and behavioral disturbances with department staff and Michigan stakeholders. In addition, the MDCH funded three interagency transition services pilot programs targeted at this population in FY 99. While it is recognized that these are important issues which need attention and guidance, they are not the focus of this transition guideline document.

II. Summary

The completion of school is the beginning of adult life. Entitlement to public education ends, and young people and their families are faced with many options and decisions about the future. The most common choices for the future are pursuing vocational training or further academic education, getting a job, and living independently.

The Michigan Mental Health Code requires: “Each community mental health service program shall participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. This planning and development shall be done in conjunction with the individual's local school district or intermediate school district as appropriate and shall begin not later than the school year in which the individual student reaches 16 years of age. These services shall be individualized. This section is not intended to increase or decrease the fiscal responsibility of school districts, community mental health services programs, or any other agency or organization with respect to individuals described in this section.”

The effectiveness of primary and secondary school programming for students with disabilities directly affects services and financial planning of CMHSPs. Schools that best prepare students with disabilities to live and work in the community and to access generic community services such as transportation and recreation create fewer demands on the adult services system and foster better community participation for individuals with disabilities. It is important for CMHSPs to develop a knowledge base of the federal statutes underlying school programming in order to assess whether students with mental health-related disabilities are receiving school services that will lead to independence, employment, and community participation when their school experience ends.

CMHSPs have a responsibility to provide information about eligibility requirements, types of services, and person-centered planning in the public mental health system to students, families, caregivers, and school systems.

III. Development

For the past two years, the MDCH has been involved in activities to increase the knowledge base and to become more familiar with the issues of transition. Activities have included:

1. Membership on the Transition Network Team, a statewide project comprised of representatives from state agencies, selected school systems, Social Security Administration and advocacy groups. The goal of the Transition Network Team is to resolve policy issues and barriers so that community partners can work collaboratively.
2. Review of the Transition Initiative findings with the project evaluator. The Transition Initiative was a five-year, federally-funded grant to the State of Michigan focused on transition services.
3. Attendance at a training program on the Individuals with Disabilities Education Act (IDEA) amendments of 1997, sponsored by CAUSE and provided by the Center for Law and

Education of Boston, Massachusetts.

4. Attendance at annual School-To-Work conferences.
5. Attendance at the Michigan Association of Transition Services Personnel conference.

In July 1999, the MDCH convened a work group consisting of department staff and representatives of seven CMHSPs with experience in planning and facilitating transition initiatives in their local communities. The work group presented and discussed current field practices and reviewed articles and research related to transition.

IV. Practice

A. Current CMHSP Involvement

There is a broad range of CMHSP involvement with schools around transition services. Generally, CMHSPs are concerned with knowing the number of students who will be completing their school program and who are projected to need services from the CMHSP, such as case management (resource coordination), housing, therapy(ies), employment (placement and/or supports), and social/recreational opportunities. To a lesser degree, CMHSPs participate in the final Individual Educational Program (IEP) prior to the student completing their school program.

Some CMHSPs actively participate with the schools and other community services providers. In a few communities, employment services are well coordinated with the student maintaining the same community job after completion of their school program. A few of these individuals keep the same vocational services provider. In addition, there may be social and recreational programs that are available to persons with disabilities who are still in school, as well as for those who are out of school. There is a need for more CMHSP involvement to promote: 1) Local school systems implementing the values of IDEA, with particular focus on integration, early vocational exploration and community-based work experiences; and 2) CMHSPs becoming more knowledgeable regarding desirable components of school programs which appear to lead to students with disabilities being more successful in their transition to adult life.

For CMHSPs to know if local school systems are providing appropriate programming, CMHSPs must have some knowledge of the applicable laws and must have knowledge of local school programming. CMHSPs also have a responsibility to provide students, caregivers and school systems information regarding eligibility for services from the public mental health system. Clearly part of that responsibility involves presenting the mental health service principles of person-centered planning, self-determination, inclusion and recovery.

B. Major Federal Legislation Regarding Transition

1. Education of the Handicapped Act (EHA)

The EHA, Public Law (P.L.) 94-142, is the primary legislation which guides school services. This Act, passed in 1975, is better known through its latest amendments, as the Individuals with Disabilities Education Act (IDEA).

P.L. 94-142 established the concept of a free and appropriate (public) education for all children. The following points are presented to show that the public laws guiding school services for students with disabilities match up well with Michigan Mental Health Code principles:

- All children with disabilities, regardless of the severity of their disability will receive a Free (and) Appropriate Public Education (FAPE) at public expense.
- Education of children and youth with disabilities will be based on a complete and individual evaluation and assessment of the specific, unique needs of each child.
- An Individualized Education Program (IEP), or an Individualized Family Services Plan (IFSP), will be drawn up for every child or youth found eligible for special education or early intervention services, stating precisely what kinds of special education and related services, or the types of early intervention services, each infant, toddler, preschooler, child or youth will receive.
- To the maximum extent appropriate, all children and youth with disabilities will be educated in the regular education environment.
- Children and youth receiving special education have the right to receive the related services necessary to benefit from special education instruction. Related services include: Transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education that includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation (including therapeutic recreation), early identification and assessment of disabilities in children, counseling services (including rehabilitation counseling), and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

2. P.L. 98-524, the Vocational Education Act of 1984 (the Carl D. Perkins Act)

The Perkins Act has a goal to improve the access of students with disabilities to vocational education. The Act requires vocational education be provided for students with disabilities.

3. P.L. 93-112, the Rehabilitation Act of 1973

The Rehabilitation Act of 1973 is primarily important because of Section 504. Section 504 states no person shall be excluded from participation in, denied the benefits of, or

subjected to discrimination under any program or activity receiving federal financial assistance by means of a disability.

The full history of the related Public Laws is available through the National Information Center for Children and Youth with Disabilities (NICHCY). Their web site is a good source of past and current information (<http://www.aed/nichcy>).

C. Review of the Literature

A publication by the Transition Research Institute, University of Illinois at Urbana-Champaign, authored by Paula D. Kohler, Ph.D. and Saul Chapman, Ph.D., dated March 1999 and updated in April 1999, reviewed 106 studies which have attempted to empirically validate transition practices used by school systems. The report indicates that a “rigorous screening” narrowed the field to 20 studies for further review. The report found that there were many problems with the studies reviewed, including: Not enough information about specific interventions and practices; specific practices not directly tested making it difficult to establish specific outcomes to specific practices; studies focused on higher functioning students; lack of random sampling; lack of baseline data; too many subjects lost during the studies, and lack of use of appropriate evaluation methods. A conclusion from this report states “...there is some evidence to support various practices but also that no strong body of evidence exists that unequivocally confirms any particular approach to transition, nor is there any strong evidence to support individual practices.”

The NICHCY publishes a variety of resources on transition. The resources include ideas and information on how students, families, school personnel, service providers and others can work together to help students make a smooth transition. In particular, the focus is on creative transition planning and services that use all of the resources that exist in communities, not just agencies that have traditionally been involved.

These practice guidelines incorporate certain practices and models which, while not empirically validated, are consistent with MDCH values and principles. These practices and models are being utilized across the country by many schools and these schools consider these practices to be positive. It appears that many transition practices for students with disabilities are practices being utilized as part of the School-To-Work services for all students. Simply assuring that students with disabilities are included in the broader programming at the same time as other students is a positive practice.

V. Philosophy and Values

The MDCH deems that CMHSP transition services must be based on values that reflect person-centered planning, and services and supports that promote individuals to be:

- empowered to exercise choice and control over all aspects of their lives
- involved in meaningful relationships with family and friends
- supported to live with family while children and independently as adults

- engaged in daily activities that are meaningful, such as school, work, social, recreational, and volunteering
- fully included in community life and activities

VI. Essential Elements

MI Mental Health Code 330.1227, Sec 227 requires that “transition planning begin no later than the school year in which the individual student reaches 16 years of age.” CMHSPs, however, should be involved with schools early enough to develop a mutual relationship based on the principles of inclusion, self-determination and age appropriateness which underlie both IDEA and the MI Mental Health Code. The practice(s) that would lead to the most consistent relationships between schools and CMHSPs for students under 16 years of age, or more than two years away from graduation, are:

A. Early and Active Involvement with the Schools.

1. Current federal regulation requires that IEP (transition) planning for students with disabilities must begin at age 14. IEPs must be held once a year plus when there is a significant change in programming. Rather than attending each IEP, particularly early in an individual student’s educational career, a better strategy for CMHSPs would be to look more broadly at the type of programming each individual school system is providing to students with disabilities.
2. Key questions to consider when reviewing school programming for students with disabilities include: Are all students with disabilities being included with all students in School-To-Work (STW) activities? Are all students with disabilities being given opportunities to experience community-based work and independent living activities? Are all students with disabilities being experientially taught how to access generic community services? Are all students with disabilities learning about making choices as they move into adulthood?
3. Examples of STW activities in school systems are career days, job shadowing, student portfolios of work and educational achievements, summer work experiences, student internships, and student co-op experiences. All students with disabilities should be participating in these activities simultaneously with other students their own age.
4. All available community resources should be pursued, particularly for out-of-school and summer programming. The Michigan Department of Career Development, Rehabilitation Services (DCD-RS) is very active in many parts of the state working with students with disabilities. The DCD-RS is a particularly valuable resource for career/employment-related services for students exiting secondary schools.

B. Participating in IEP Meetings and Sharing Information with Schools

While CMHSPs need not attend all IEP meetings, they do need to ensure that schools, students, families and caregivers have basic knowledge of what CMHSPs can provide to persons with disabilities and eligibility criteria for those services. It is also important that

CMHSPs provide information on the MDCH requirement that all CMHSP services be based on a person-centered plan. There are a variety of mechanisms available to CMHSPs for providing information. Brochures, community information events, direct mailings, special group presentations, local media, etc. Based on CMHSP experience to date, no one or two methods will be adequate.

CMHSPs shall provide schools with the following information through the CMHSP customer services efforts:

1. Values governing public mental health services including:
 - Recovery
 - Self-determination
 - Full community inclusion
 - Person-centered planning
2. Eligibility criteria
 - MI Mental Health Code priority populations
 - Medicaid
 - Specialty medically necessary services (including the boundary with the Qualified Health Plans)
 - Children's Model Waiver
 - Local service selection guidelines/protocols/etc.
3. Local service array for both adult and child service providers
4. The name and telephone number for a CMHSP liaison to the school for systemic service-related issues

C. Providing Information about CMHSP Service Populations

CMHSPs have the responsibility to provide information to appropriate local school staff about specific conditions which would indicate the likelihood that a student would need assessment and/or service from the CMHSP upon graduation.

Students classified under the school system as Severely Multiply Impaired (SXI), Trainable Multiply Impaired (TMI), Severely Mentally Impaired (SMI) and Educable Mentally Impaired (EMI) are generally eligible for CMHSP services. Other student classifications would indicate a closer look by CMHSPs to determine eligibility for adult services from the CMHSP. The classification of Autistically Impaired (AI) covers students with a very broad range of skills and abilities often necessitating further assessment to determine eligibility for CMHSP services. Students classified as Emotionally Impaired (EI) would have to be assessed for eligibility for adult services from the CMHSP. In the mental health system, Emotional Impairment, by definition, ends at the age of 18. Students classified as EI as well as Learning Disabled (LD) and Physically or Otherwise Health Impaired (POHI) would need to be assessed for an appropriate developmental disability or mental illness diagnosis. Where the school diagnosis is not appropriate, it is the responsibility of the CMHSP to provide an assessment. CMHSPs must look at factors in addition to diagnosis. Other factors include:

risk for expulsion from school, need for assistance in multiple life domains, or absence of a stable natural support network.

D. Using Local Councils and Committees

CMHSPs can also use Multi-Purpose Collaborative Bodies (MPCBs) to address issues regarding the systemic implementation of transition services and to identify additional community resources for transition services. Regional Inter-Agency Coordination Committees (RICC) and Transition Councils are additional local bodies which may be used for the same purpose.

The following are the practice protocols that would lead to the most consistent relationship between CMHSPs and the schools for students 16 years of age, or two years away from completion of their school program.

For students within two years of completing their school program, or for students where the CMHSP is already providing or arranging services, the CMHSP shall:

E. Request Information from Schools

It is expected that CMHSPs will need the following from the schools to determine future needs and manage available resources including, but not limited to, information for each student age 16 or older who is expected to receive a diploma more than two years from the present:

- special education classification
- whether or not it is expected the student will need assistance in multiple life domains
- the stability of the student's natural support system
- any transition services currently being provided
- any mental health related services being provided by the school (e.g. school based Medicaid services)
- post-graduation goals, if identified

Based on this information and the CMHSP's knowledge of, and relationship with, the school district, the CMHSP may decide to initiate contact with the school for specific students.

F. Initiate Transition Planning

1. The CMHSP shall identify for the school, the student and his/her family a contact person at the CMHSP to act as a contact for the student's transition plan.
2. The CMHSP shall initiate CMHSP transition planning as part of each student's IEP. In the event that the student/family does not want the CMHSP to have a representative present, the CMHSP shall work with the school district to assure that the CMHSP has input into the student's transition plan and to obtain the necessary information (such as that outlined in E above) so that future services can be projected. CMHSPs shall plan to participate in individual IEP meetings for students who meet the eligibility criteria in section E above, and those students who may need assessment or services from the CMHSP as they near completion of their school

program. Attendance or other active participation at IEP meetings the last two years will ensure that the student and the CMHSP have sufficient time to prepare for transition.

3. The CMHSP shall provide mental health services as part of a comprehensive transition plan which promotes movement from school to the community, including: vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living or community participation. It should be noted that the CMHSP does not have sole responsibility for any of these post-school activities and it may not use its state or federal funds to supplant the responsibility of another state agency. It is highly recommended that CMHSPs look at cooperative agreements and the pooling of resources to develop the best services possible for students with disabilities.

VII. Definitions

Carl D. Perkins Act, P.L. 98-524, the Vocational Education Act of 1984, also known as the Carl D. Perkins Act--The Perkins Act has a goal to improve the access of students with disabilities to vocational education. The Act requires that vocational education be made available as appropriate for students with disabilities.

CAUSE - Citizens Alliance to Uphold Special Education--A statewide parent training and information center for special education-related activities.

CMHSP - Community Mental Health Service Program

EHA - Education of the Handicapped Act, P. L. 94-142--The primary legislation which guides school services for students with disabilities. Passed in 1975, it is better known as IDEA, based on later amendments labeled as the "Individuals with Disabilities Education Act."

EI - Emotionally Impaired--An impairment determined through manifestation of behavioral problems primarily in the affective domain, over an extended period of time, which adversely affect the person's education to the extent that the person cannot profit from regular learning experiences without special education support.

EMI - Educable Mentally Impaired--An impairment which is manifested through all of the following characteristics:

- Development at a rate approximately two to three standard deviations below the mean as determined through intellectual assessment
- Lack of development primarily in the cognitive domain
- Impairment of adaptive behavior

FAPE - Free and Appropriate Public Education

IDEA - See EHA

IEP - Individualized Education Program--A program developed by an individualized educational planning committee which shall be reviewed (at least) annually.

IEPT - Individualized Educational Planning Team--A committee of persons appointed and invited by the superintendent to determine a person's eligibility for special education programs and services and, if eligible, to develop an individualized education program

Inclusion - A MDCH value which directs funding organizations and service providers to enable persons with disabilities to participate in the community, i.e., use community transportation, work in real paid jobs, access generic community social and recreation opportunities and live in their own apartments and houses. Inclusion includes the availability of flexible professional and natural supports that reinforce the individual's own strengths, and expands their opportunities and choices.

NICHCY - National Information Center for Children and Youth with Disabilities

Multi-Purpose Collaborative Body - An inclusive planning and implementation body of stakeholders at the county or multi-county level, focused on a shared vision and mission to improve outcomes for children and families

Person-Centered Planning - A highly individualized process designed to respond to the expressed needs/desires of the individual. The Michigan Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a person-centered planning process regardless of age, disability or residential setting. Person-centered planning is based on the following values and principles:

- Each individual has strengths, and the ability to express preferences and to make choices.
- The individual's choices and preferences shall always be considered if not always granted. Professionally trained staff will play a role in the planning delivery of treatment and may play a role in the planning and delivery supports. Their involvement occurs if the individual has expressed or demonstrated a need that could be met by professional intervention.
- Treatment and supports identified through the process shall be provided in environments that promote maximum independence, community connections and quality of life.
- A person's cultural background shall be recognized and valued in the decision-making process.

Recovery - Recovery is the nonlinear process of living with psychiatric disability in movement toward a quality life. The Recovery model for individuals involves the movement from anguish, awakening, insight action plan and determined commitment for wellness. The external factors influencing recovery are support, collaboration, building trust, respect, and choice and control. The development of hope provided by caregivers and generated from within the individual is a base for transformation into well-being and recovery.

The concept of recovery was introduced in the lay writings of consumers beginning in the 1980s. It was inspired by consumers who had themselves recovered to the extent that they were able to write about their experiences of coping with symptoms, getting better, and gaining an identity. Recovery also was fueled by longitudinal research uncovering a more positive course for a significant number of patients with severe mental illness. Recovery is variously called a process, an outlook, a vision,

a guiding principle. There is neither a single agreed-upon definition of recovery nor a single way to measure it. But the overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity, and on attaining meaningful roles in society.

Self-Determination - Self-determination incorporates a set of concepts and values which underscore a core belief that people who require support from the public mental health system as a result of a disability should be able to define what they need in terms of the life they seek, should have access to meaningful choices, and control over their lives. Within Michigan's public mental health system, self-determination involves accomplishing major system change which can assure that services and supports for people are not only person-centered, but person-defined and person-controlled. Self-determination is based on the following four principles:

- **FREEDOM** The ability for individuals, with assistance from their allies (chosen family and/or friends), to plan a life based on acquiring necessary supports in desirable ways, rather than purchase a program.
- **AUTHORITY** The assurance for a person with a disability to control a certain sum of dollars in order to purchase these supports, with the backing of their allies, as needed.
- **SUPPORT** The arranging of resources and personnel, both formal and informal, to assist the person to live their desired life in the community, rich in community associations and contributions.
- **RESPONSIBILITY** The acceptance of a valued role by the person in their community through employment, affiliations, spiritual development, and caring for others, as well as accountability for spending public dollars in ways that are life-enhancing.

A hallmark of self-determination is assuring a person the opportunity to control a fixed sum of dollars which is derived from the person-centered planning process and called an individual budget. The person, together with their allies controls the use of the resources in their individual budget, determining themselves which services and supports they will purchase from whom, and under what circumstances.

SMI - Severely Mentally Impaired--An impairment manifested through all of the following behavioral characteristics:

- 1) Development at a rate approximately four and one-half or more standard deviations below the mean as determined through intellectual assessment
- 2) Lack of development primarily in the cognitive domain
- 3) Impairment of adaptive behavior

Supported Employment - Competitive work in integrated settings for persons with the most significant disabilities for whom competitive work has not traditionally occurred or has been interrupted as a result of a significant disability.

SXI - Severely Multiply Impaired--An impairment determined through the manifestation of either of the following:

- 1) Development at a rate of two to three standard deviations below the mean and two or more

of the following conditions:

- a hearing impairment so severe that the auditory channel is not the primary means of developing speech and language skills
- a visual impairment so severe that the visual channel is not sufficient to guide independent mobility
- a physical impairment so severe that activities of daily living cannot be achieved without assistance
- a health impairment so severe that the student is medically at risk

2) Development at a rate of three or more standard deviations below the mean, or students for whom evaluation instruments do not provide a valid measure of cognitive ability and one or more of the following conditions:

- a hearing impairment so severe that the auditory channel is not the primary means of developing speech and language skills
- a visual impairment so severe that the visual channel is not sufficient to guide independent mobility
- a physical impairment so severe that activities of daily living cannot be achieved without assistance
- a health impairment so severe that the student is medically at risk

TMI - Trainable Mentally Impaired--An impairment manifested through all of the following behavioral characteristics:

- 1) Development at a rate approximately three to four and one-half standard deviations below the mean as determined through intellectual assessment
- 2) Lack of development primarily in the cognitive domain
- 3) Impairment of adaptive behavior

Transition Services - A coordinated set of activities for a student which is designed within an outcome-oriented process and which promotes movement from school to post-school activities, including: Post-secondary education; vocational training; integrated employment including supported employment; continuing and adult education; adult services; independent living; or community participation. The coordinated set of activities shall be based on the individual student's needs and shall take into account the student's preferences and interests, and shall include needed activities in all of the following areas:

- 1) Instruction
- 2) Community experiences
- 3) Development of employment and other post-school adult living objectives
- 4) If appropriate, acquisition of daily living skills and functional vocational evaluation

VIII. Literature and Resources

ARTICLES AND PAPERS

Clark, H.B.

Transition to Independence Process (TIP): TIP System Development and Operations Manual

Florida Mental Health Institute, University of South Florida, 1998 (Revised)

Clark, H.B. & Foster-Johnson

Serving Youth in Transition into Adulthood (pp.533-551

In B.A. Stroul (Ed.), Children's Mental Health: Creating Systems of Care in a Changing Society

Baltimore, MD Paul H. Brookes Publishing Co., Inc. 1996

Dague, Bryan, Van Dusen, Roy, Burns, Wendy

Transition: The 10 Year Plan

Presentation at the Association for Persons in Supported Employment Conference

Chicago, IL July 1999

Deschenes, Nicole, Clark, Hewitt B.

Seven Best Practices in Transition Programs for Youth

Reaching Today's Youth Summer 1998

Everson, Jane M., Moon, M. Sherril

Transition Services for Young Adults with Severe Disabilities: Defining Professional and Parental Roles and Responsibilities

Virginia Commonwealth University

Reprinted in September 1987 from the Journal of the Association of Persons with Severe Handicaps (JASH)

Halpern, A.S.

Transition: Is It Time for Another Rebooting?

Paper presented at the 1999 Annual OSEP Project Director's Meeting

Washington D.C. June 1999

Kohler, Paula D. Ph.D.

Facilitating Successful Student Transitions from School to Adult Life

An analysis of Oklahoma Policy and Systems Support Strategies March 1999

Sale, P., Metzler, H.D., Everson, J.M., Moon, M.S.

Quality Indicators of Successful Transition Programs

Journal of Vocational Rehabilitation: 1(4): 47-63

NEWSLETTERS

C.E.N. Newsline

Eaton Intermediate School District

1790 East Packard Highway

Charlotte, MI 48813

Networks

National Technical Assistance Center for State Mental Health Planning

66 Canal Center Plaza, Suite 302
Alexandria, VA 22314

Special Education Mediation Reporters

Michigan Special Education Mediation Program
SCAO
309 N. Washington Square, P.O. Box 30048
Lansing, MI 48909

Transition

The College of Education & Human Development
Transition Technical Assistance Project
Institute on Community Integration
University of Minnesota
109 Pattee Hall, 150 Pillsbury Dr., S.E.
Minnesota, MN 55455

Transitions

Michigan Transition Services Association
John Murphy, Charlevoix-Emmet ISD
08568 Mercer Blvd.
Charlevoix, Michigan 49720

UCP Pathways

United Cerebral Palsy Association of Michigan, Inc.
320 N. Washington Sq., Suite #60
Lansing, MI 48933

WEB SITES

<http://www.ed.wuc.edu/sped/tri/institute.html>

Transition Research Institute at Illinois, NTA Headquarters
117 Children's Research Center, 51 Gerty Drive
Champaign, IL 61820

<http://www.ici.coled.umn.edu/schooltowork/profiles.html>

School-to-Work Outreach Project
Institute on Community Integration (UAP), University of Minnesota
111 Pattee Hall, 150 Pillsbury Drive SE
Minneapolis, MN 55455

<http://www.mde.state.mi.us/off/sped/index.html>

Michigan Department of Education
Office of Special Education and Early Intervention Services
P.O. Box 30008, Lansing, MI 48909

<http://www.nichcy.org>

National Information Center for Children and Youth with Disabilities

P.O. Box 1492

Washington, D.C. 20013-1492

<http://www.vcu.edu/rrteweb/facts>

Virginia Commonwealth University, Rehabilitation Research and Training Center on Supported Employment

IX. Authority

Mental Health Code, Act 258 MI, Sec. 330.1208 - Individuals to which service directed; priorities; denial of service prohibited

Mental Health Code, Act 258 MI, Sec.330.1227 - School-to-Community Transition (1974 & Supp 1996)

Mental Health Code, Act 258 MI, Sec. 330.1712 - Individualized written plan of service (1974 & Am. 1996)

Attachment P.7.0.1

MDCH Funding

Performance Objectives

Community Mental Health
COMPLIANCE EXAMINATION GUIDELINES
Michigan Department of Community Health



October 2010

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INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Community Health (MDCH) 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 MDCH 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 MDCH to manage the Concurrent 1915(b)/(c) Medicaid Program (hereinafter referred to as “Medicaid Program”), contracts between PIHPs and MDCH to manage the Michigan Medicaid Non-Pregnant Childless Adults Waiver (hereinafter referred to as “ABW Program”) Section 1115 Demonstration Program, contracts between CMHSPs and MDCH 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 Program”), and, in certain circumstances, contracts between CMHSPs and MDCH 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 \$500,000 or more in federal awards¹, the PIHP or CMHSP must obtain a Single Audit.

These CMH Compliance Examination Guidelines do not address compliance examinations for CMHSPs for the Medicaid funds received under contract with PIHPs. PIHPs are ultimately responsible for the Medicaid funds received from MDCH, and are responsible for monitoring the activities of affiliated CMHSPs as necessary to ensure expenditures of Medicaid Program 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 affiliated CMHSPs, or require the affiliated CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 7, 8, & 9).

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2011 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

MDCH Responsibilities

MDCH 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 six months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs 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 Program, ABW Program, GF Program, and CMHS Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDCH will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Program and GF Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDCH 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. MDCH 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 MDCH examination or review:
 - a. Significant changes from one year to the next in reported line items on the FSR.
 - b. A PIHP entering the MDCH risk corridor.
 - c. A large percentage or amount of ABW program funding converting to local.
 - d. A large addition to an ISF per the cost settlement schedules.
 - e. A material non-compliance issue identified by the independent auditor.
 - f. The CPA that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.
 - g. 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 Program and ABW Program that provides reasonable assurance that the PIHP is managing the programs in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the programs.
2. Comply with laws, regulations, and the provisions of contracts related to the Medicaid Program and ABW Program. Examples of these would include, but not be limited to: the Medicaid Managed Specialty Supports & Services Concurrent 1915(b)(c) Waiver Program Contract (Medicaid Program Contract), the Adult Benefits Waiver Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), OMB Circular A-87 (Cost Principles for State, Local, and Indian Tribal Governments), OMB Circular A-102 (Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments found at 45 CFR 92), 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 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. The PIHP will provide an additional response to each deficiency noted in the Comments or Recommendations section included in the auditor's report. If the PIHP does not agree with the examination findings or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons. The PIHP should 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 MDCH and the PIHP will be notified of any required action in the management decision.
7. Monitor the activities of affiliated CMHSPs as necessary to ensure the Medicaid Program and ABW Program 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 affiliated CMHSP for compliance with the Medicaid Program and ABW Program provisions, or (b.) require the affiliated CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program and ABW Program. 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.
8. If requiring an examination of the affiliated CMHSP, review the examination reporting packages submitted by affiliated CMHSPs to ensure completeness and adequacy.
 9. If requiring an examination of the affiliated CMHSP, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in affiliated CMHSP's examination reporting packages.

CMHSP Responsibilities

(as a recipient of Medicaid and ABW funds from PIHP and a recipient of GF funds from MDCH and a recipient of CMHS Block Grant funds from MDCH)

CMHSPs must:

1. Maintain internal control over the Medicaid, ABW, GF, and CMHS Block Grant Programs that provides reasonable assurance that the CMHSP is managing the Medicaid, ABW, GF, and CMHS Block Grant Programs in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid, ABW, GF, and CMHS Block Grant Programs.
2. Comply with laws, regulations, and the provisions of contracts related to the Medicaid, ABW, GF, and CMHS Block Grant Programs. Examples of these would include, but not be limited to: the Medicaid Managed Specialty Supports & Services Concurrent 1915(b)(c) Waiver Program Contract (Medicaid Contract), the Managed Mental Health Supports and Services Contract (General Fund Contract), the Adult Benefits Waiver Contract, the CMHS Block Grant Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), OMB Circular A-87 (Cost Principles for State, Local, and Indian Tribal Governments), OMB Circular A-102 (Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments found at 45 CFR 92), 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 funds are properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.

Prepare a corrective action plan to address each examination finding 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. The CMHSP will provide an additional response to each deficiency noted in the Comments and Recommendations Section included in the auditor's report. If the CMHSP does not agree with the examination findings or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons. The CMHSP should 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 MDCH, and the PIHP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

PIHPs under contract with MDCH to manage the Medicaid Program and ABW Program, and CMHSPs under contract with MDCH to manage the GF Program 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) (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 MDCH to provide CMHS Block Grant Program services 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 prescribed by the Grants Management Common Rule (A-102 Common Rule). The codified common rule for PIHPs and CMHSPs is located at 45 CFR 92, Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments. Procurement standards are addressed in Section 92.36. 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, 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 including the applicable finding detail listed in OMB Circular A-133, Section 510(b) that includes the following:
 - a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid, ABW, GF, and/or CMHS Block Grant Program(s).
 - b. Material noncompliance with the provisions of laws, regulations, or contracts related to the Medicaid, ABW, GF, and/or CMHS Block Grant Program(s).
 - c. Known fraud affecting the Medicaid, ABW, GF, and/or CMHS Block Grant Program(s).
2. A schedule showing reported Financial Status Report (FSR) amounts, as of 1/31/XX, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below)], and examined FSR amounts. The examination adjustments must be explained. This schedule is called the “Examined FSR Schedule.”
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.”

4. A Comments and Recommendations Section that includes deficiencies that are not individually or cumulatively material weaknesses in internal control over the Medicaid, ABW, GF, and/or CMHS Block Grant program(s), but are matters that are opportunities for strengthening internal controls, improving compliance, and increasing operating efficiency.

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDCH 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 to MDCH at the following address:

Michigan Department of Community Health
Office of Audit
Quality Assurance and Review Section
P.O Box 30479
Lansing, Michigan 48909-7979
Or
400 S. Pine Street
Capital Commons Center
Lansing, Michigan 48933

Alternatives to paper filing may be viewed at www.michigan.gov/mdch by selecting Inside Community Health – MDCH Audit.

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 MDCH, MDCH 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. MDCH may retain the withheld amount if the reporting package is delinquent more than 120 days from the due date and MDCH has not granted an extension.

Incomplete or Inadequate Examinations

If MDCH 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

MDCH will issue a management decision on findings and questioned costs 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 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, MDCH 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 and/or questioned costs, MDCH 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-K specified requirements below. 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 L-O specified requirements below that specifically relate to the CMHS Block Grant.

COMPLIANCE REQUIREMENTS A-K (APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reconciliation

The auditor must reconcile the 1/31/XX Financial Status Report (FSR) to the general ledger, and determine if amounts reported on the FSR are supported by the PIHP's or CMHSP's general ledger. Any differences between the general ledger and FSR should be adequately explained and justified, and all FSR reporting must comply with the contractual FSR reporting instructions. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule."

B. Expenditure Reporting

The auditor must determine if the PIHP's or CMHSP's expenditures reported on the 1/31/XX FSR comply with the Office of Management and Budget (OMB) Circular A-87 cost principles (relocated to 2 CFR 225), the Mental Health Code (Code), and contract provisions. Any reported expenditures that do not comply with the OMB Circular A-87 cost principles, the Code, or contract provisions must be shown on the auditor's "Examined FSR Schedule."

Generally, OMB Circular A-87 cost principles require that for costs to be allowable they must meet the following general criteria:

- a. Be necessary and reasonable for proper and efficient performance and administration of the grant.
- b. Be allocable to the grant under the provisions of the applicable OMB Circular.
- c. Be authorized or not prohibited under State or local laws or regulations.
- d. Conform to any limitations or exclusions set forth in the applicable OMB Circular, other applicable laws and regulations, or terms and conditions of the grant and agreement.
- e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
- f. Be accorded consistent treatment.

- g. Be determined in accordance with generally accepted accounting principles.
- h. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period.
- i. Be the net of all applicable credits.
- j. Be adequately documented.

All reported expenditures must be traceable to the agency's general ledger, and adequately supported.

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. 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 OMB Circular A-87 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. 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 costs for **less-than-arms-length transactions** must be limited to underlying cost. For example, the agency may rent their office building from the agency's board member/members, but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in OMB Circular A-87.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost.

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. 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, Adult Benefits Waiver Costs must be charged to the Adult Benefits Waiver, 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.

Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported by personnel activity reports that meet the standards listed in OMB Circular A-87.

Expenditures relating to providing the **20 outpatient visit services** for Qualified Health Plans (QHPs) must be recorded as earned contract expenditures, NOT matchable expenditures.

The costs incurred in providing mental health services to an **inmate incarcerated in a county jail** are ultimately the responsibility of the county under MCL 801.4. Therefore, the costs incurred in providing mental health services to an inmate incarcerated in a county jail can NOT be included in matchable expenditures on the FSR. Furthermore, the community mental health program serving the county in which the jail is located must seek to obtain payment from available insurance or other sources before billing the county for payment in accordance with MCL 801.4(2). Eligible MA beneficiaries who are incarcerated are covered for acute treatment once they are outside the jail/prison walls, and served in a community hospital.

C. Administration Cost Report

The auditor must determine if the PIHP's or CMHSP's Administration Cost Report complies with the standards in, ESTABLISHING ADMINISTRATIVE COSTS WITHIN AND ACROSS THE CMHSP SYSTEM and contract provisions.

D. Revenue Reporting

The auditor must determine if the PIHP or CMHSP has properly reported all revenue on the 1/31/XX FSR.

SSI revenue and other reimbursements that support matchable Medicaid and GF expenditures must be properly recorded to offset matchable expenditures.

SSA Revenue received and then sent to residential providers cannot be recorded as a matchable expenditure.

Revenue received from QHPs for providing 20 outpatient visits must be recorded as earned contract revenue.

E. Procurement

The auditor must determine if the acquisition of assets or services complied with contractual and regulatory requirements.

F. Rate Setting and Ability to Pay

The auditor must determine if the PIHP/CMHSP annually determines the insurance coverage and ability to pay of individuals who continue to receive services and of any additional responsible party. The auditor must also determine if the PIHP/CMHSP completes a new determination if informed of a significant change in a responsible party's ability to pay. Both of these requirements are in accordance with MCL 330.1828.

The auditor must also determine if service rates based on the CMHSP's actual costs are updated at least annually.

G. Internal Service Fund (ISF)

The auditor must determine if the establishment, funding, and maintenance of any Internal Service Fund complies with the contractual provisions.

H. Medicaid Savings and General Fund Carryforward

The auditor must determine that Medicaid Savings and General Fund Carryforward earned in the previous year was used in the current year on allowable expenditures and it was properly recorded on the FSR (matchable expenditures must be properly reduced).

I. Match Requirement

The auditor must determine if the PIHP or CMHSP met the local match requirement. As part of this determination, the auditor must determine if items considered as local match actually qualify as local match. **(See section 7.2.4 of the 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, and (e.) **MHP reimbursements for MHP purchased services that have been paid at less than the CMHSPs 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 Chapter 3 sec. 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

J. Service Documentation

The auditor must determine if services are adequately documented according to contractual and Code provisions.

K. Consumer Fund Review

The auditor must determine that consumer funds are maintained separate from other CMH funds, amounts are accurate, SSI revenue is properly recorded, rent payments made on behalf of consumers are accurate, consumers' funds are not commingled and used for each others' expenses, and sufficient controls exist to protect the consumers' funds.

COMPLIANCE REQUIREMENTS L-O

(APPLICABLE TO CMHSPs WITH A CMHS BLOCK GRANT THAT DID NOT HAVE A SINGLE AUDIT OR THE CMHS BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

L. Activities Allowed or Unallowed

The auditor must determine if the CMHS Block Grant (CFDA 93.958) funds were expended only on allowable activities in accordance with the OMB Circular A-133 Compliance Supplement and the Grant Agreement between MDCH and the CMHSP.

M. Cash Management

The auditor must determine if the CMHSP complied with the applicable cash management compliance requirements that are contained in the OMB Circular A-133 Compliance Supplement. 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 MDCH.

N. Period of Availability of Federal Funds

The auditor must determine if the CMHS Block Grant (CFDA 93.958) funds were obligated within the period of availability and obligations were liquidated within the required time period.

O. Subrecipient Monitoring

If the CMHSP contracts with other subrecipients (“subrecipient” per the OMB Circular A-133 definition) to carry out the Federal CMHS Block Grant Program, the auditor must determine if the CMHSP:

1. properly identified Federal award information and compliance requirements to the subrecipient, and approved only allowable activities in the award documents;
2. monitored subrecipient activities to provide reasonable assurance that the subrecipient administered Federal awards in compliance with Federal requirements;
3. ensured required audits are performed, issued a management decision on audit findings within 6 months after receipt of the sub-recipient’s audit report, and ensured that the subrecipient took timely and appropriate corrective action on all audit findings; and
4. took appropriate action using sanctions if a subrecipient had a continued inability or unwillingness to have the required audits performed.

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 MDCH. 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 Community Health, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and affiliate CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDCH CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2010/2011 examinations. Any questions relating to these guidelines should be directed to:

Gregory S. Anderson, Manager
Office of Audit
Michigan Department of Community Health
Capital Commons Center
400 S. Pine Street
Lansing, Michigan 48933
Andersong7@michigan.gov
Phone: (616) 356-0124 Fax: (616)356-0672

Debra S. Hallenbeck, Manager
Quality Assurance and Review, Office of Audit
Michigan Department of Community Health
Capital Commons Center
400 S. Pine Street
Lansing, Michigan 48933
hallenbeckd@michigan.gov
Phone: (517) 241-7598 Fax: (517) 335-5443

GLOSSARY OF ACRONYMS AND TERMS

- AICPA.....American Institute of Certified Public Accountants.

- CMHS Block Grant Program.The program managed by CMHSPs under contract with MDCH 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 EngagementA 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 MDCH 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.

- MDCH.....Michigan Department of Community Health

- Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program managed by PIHPs under contract with MDCH.

- Adult Benefits WaiverThe Michigan Medicaid Non-Pregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration Program managed by PIHPs under contract with MDCH

- PIHPPrepaid Inpatient Health Plan. 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 401 et al June 14, 2002, regarding Medicaid managed care, and manages services under the state’s approved Michigan Medicaid Non-Pregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration Program.

Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.

SSAE.....AICPA’s Statements on Standards for Attestation Engagements.

APPEAL PROCESS FOR COMPLIANCE EXAMINATION MANAGEMENT DECISIONS

The following process shall be used to appeal MDCH management decisions relating to the Compliance Examinations that are required in Section 7.6 of the Master Contract.

STEP 1: MANAGEMENT DECISION

<p>MDCH Office of Audit</p>	<p>Within six months after the receipt of a complete and final Compliance Examination, MDCH shall issue to the PIHP/CMHSP a management decision on findings and questioned costs contained in the PIHP/CMHSP examination report. The management decision will include whether or not the examination finding 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.</p>
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STEP 2: SETTLEMENT AND DISPUTE OF FINDINGS AND QUESTIONED COSTS

<p>PIHP/CMHSP</p>	<ol style="list-style-type: none"> 1. Within 30 days of receipt of the management decision: <ol style="list-style-type: none"> A. Submits payment to MDCH for amounts due other than amounts resulting from disputed items; and B. If disputing items. <ol style="list-style-type: none"> i. Requests a conference with the Director of the MDCH Operations Administration, or his or her designee, to attempt to reach resolution on the audit findings, or submits to the MDCH 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. as specified in ii below. <p>Any resolution as a result of a conference with the Director of the MDCH Operations Administration</p>
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	<p>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 MDCH to produce a report of the conference process.</p> <p>Matters that remain unresolved, after these discussions, would move to the Administrative Hearing process, at the discretion of the CMHSP/PIHP.</p> <p>Administrative Hearing process</p> <p>ii. Submits to the MDCH 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.</p> <p>If MDCH 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 MDCH's Final Determination Notice according to MAC R 400.3405.</p> <p>C. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDCH Office of Audit, MDCH Contract Management, and</p>
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	MDCH Accounting.
MDCH 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.
MDCH Contract Management Unit	3. Ensures audited PIHP/CMHSP resolves all findings in a satisfactory manner. Works with the audited PIHP/CMHSP on developing performance objectives, as necessary.

STEP 3. MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS

MDCH 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.
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INTERNAL SERVICE FUND TECHNICAL REQUIREMENT

Purpose

The establishment of an Internal Service Fund (ISF) is one method for securing funds as part of the overall strategy for covering risk exposure under the MDCH/CMHSP Managed Mental Health Supports and Services Contract (MDCH/CMHSP Contract). The ISF should be kept at a minimum to assure that the overall level of CMHSP funds are directed toward consumer services. General provisions and restrictions for establishing an ISF are outlined below:

General Provisions

- A. CMHSPs may establish an ISF for risk corridor financing in accordance with shared risk provisions contained in the MDCH/CMHSP Contract with the Michigan Department of Community Health.
- B. An ISF may be established for the purpose of securing funds necessary to meet expected risk corridor financing requirements under the MDCH/CMHSP Contract.
- C. When establishing an ISF, the CMHSP may apply any method it considers appropriate to determine the amounts to be charged to the various funds covered by the ISF provided that:
 - 1. The total amount charged to the various funds does not exceed the amount of the estimated liability determined pursuant to Governmental Accounting Standards Board (GASB) Statement No.10, *General Principles of Liability Recognition*, or such other authoritative guidance as issued by the American Institute of Certified Public Accountants (AICPA); and
 - 2. The estimated liability is computed based on an actuarial method or historical cost information as provided under Office of Management and Budget (OMB) Circular A-87, Attachment B, paragraph 25(d), which is attached to this document, and accordingly, made a part of this Technical Requirement. Under this method, additional charges may be made to various funds that represent a reasonable provision for expected future catastrophic losses.
- D. Non-compliance with the provisions of GASB Statement No. 10 and OMB Circular A-87 relative to any applicable matter herein will cause the ISF charges to be unallowable for purposes of the MDCH/CMHSP Contract.
- E. The CMHSP shall not commingle the ISF with funds of other departments, agencies, governmental funds or entities. The ISF shall not be used to finance any activities or costs other than ISF eligible expenses.

- F. All programs exposed to the risk corridor shall be charged their proper share of the ISF charges to the extent that those programs are covered for the risk of financial loss. Such charges must be allocated to the various programs/cost categories based on the relative proportion of the total contractual obligation, actual historical cost experience, or reasonable historical cost assumptions. If actual historical cost experiences or reasonable historical cost assumptions are used, they must cover, at a minimum, the most recent two years in which the books are closed.
- G. A set of self-balancing accounts shall be maintained for the ISF in compliance with generally accepted accounting principles (GAAP).
- H. The CMHSP shall restrict the use of the ISF to the defined purpose.
- I. The amount of funds paid to the ISF shall be determined in compliance with reserve requirements as defined by GAAP and applicable federal and state financing provisions contained in the MDCH/CMHSP Contract.
- J. To establish an adequate funding level to cover risk corridor requirements, the CMHSP may make payments up to the lesser of: (1) the total potential liability relative to the risk corridor and the overall risk management strategy of the CMHSP's operating budget; or (2) the risk reserve requirements determined under paragraph C above and the applicable financing provisions contained in the MDCH/CMHSP Contract.
- K. The CMHSP shall establish a policy and procedure for increasing payments to the ISF in the event that it becomes inadequate to cover future losses and related expenses.
- L. Payments to the ISF shall be based on either actuarial principles, actual historical cost experiences, or reasonable historical cost assumptions, pursuant to the provisions of OMB Circular A-87, Attachment B, paragraph 25(d)(3). If actual historical cost experiences or reasonable historical cost assumptions are utilized, they must cover, at a minimum, the most recent two years in which the books have been closed.
- M. Payments and funding levels of the ISF shall be analyzed and updated at least biannually pursuant to the provisions of OMB Circular A-87, Attachment B, paragraph 25(d)(3).
- N. If the ISF becomes over-funded, it shall be reduced within one fiscal year through the abatement of current charges or, if such abatements are inadequate to reduce the ISF to the appropriate level, it shall be reduced through refunds in accordance with OMB Circular A-87, Attachment B, paragraph 25(d)(5).
- O. Upon dissolution of the ISF, any funds remaining in the ISF after all of its claims and related liabilities have been liquidated shall be refunded pursuant to OMB Circular A-87, Attachment B, paragraph 25(d)(5).

General Restrictions

Use of funds held in the ISF shall be restricted to the following:

- A. The CMHSP shall restrict the use of the ISF to the defined purpose. The defined purpose of the ISF is to secure funds necessary to meet expected future risk corridor requirements established in accordance with the MDCH/CMHSP Contract between the CMHSP and the Michigan Department of Community Health. All expenses, for the purpose intended to be financed from the ISF, shall be made from the ISF. No expenses from this fund will be matchable--only the payments to the ISF will be matchable. No other expenses may be paid from the ISF.
- B. Payment of the CMHSP's risk corridor obligation.
- C. The CMHSP may invest ISF funds in accordance with statutes regarding investments (e.g., *Mental Health Code* 330.1205, Sec. 205(g)). The earnings from the investment of ISF funds shall be used to fund the risk reserve requirements of the ISF in accordance with OMB Circular A-87, Attachment B, paragraph 25(d)(2).
- D. The ISF may not loan or advance funds to any departments, agencies, governmental funds, or other entities in accordance with OMB Circular A-87, Attachment B 25(d)(5).
- E. Funds paid to the ISF shall not be used to meet federal cost sharing or used to match federal or state funds pursuant to OMB Circular A-87, Attachment A, paragraph C(1).
- F. State funds paid to the ISF shall retain its character as state funds in accordance with the Mental Health Code and shall not be used as local funds.

General Accounting Standards

The ISF shall be established and accounted for in compliance with the following standards:

- A. Generally accepted accounting principles (GAAP).
- B. GASB Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*, or other current standards.
- C. Financial Accounting Standards Board (FASB) Statement No. 60, *Accounting and Reporting by Insurance Enterprises*, or other current standards.
- D. FASB Statement No.5, *Accounting for Contingencies*, or other current standards.
- E. OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, or other current standards.
- F. Other financing provisions contained in the MDCH/CMHSP Contract.
- G. The financial requirements set forth in the HCFA Federal 1915(b) waiver.

OMB Circular A-87, Attachment B, Paragraph 25(d)

“Contributions to a reserve for certain self-insurance programs including workers compensation, unemployment compensation, and severance pay are allowable subject to the following provisions:

1. The type of coverage and the extent of coverage and the rates and premiums would have been allowed had insurance (including reinsurance) been purchased to cover the risks. However, provision known or reasonably estimated self-insured liabilities, which do not become payable for more than one year after the provision is made, shall not exceed the discounted present value of the liability. The rate used for discounting the liability must be determined by giving consideration to such factors as the governmental unit’s settlement rate for those liabilities and its investment rate of return.
2. Earnings or investment income on reserves must be credited to those reserves.
3. Contributions to reserves must be based on sound actuarial principles using historical experience and reasonable assumptions. Reserve levels must be analyzed and updated at least biennially for each major risk being insured and take into account any reinsurance, coinsurance, etc. Reserve levels related to employee-related coverages will normally be limited to the value of claims (a) submitted and adjudicated but not paid, (b) submitted but not adjudicated, and (c) incurred but not submitted. Reserve levels in excess of the amounts based on the above must be identified and justified in the cost allocation plan or indirect cost rate proposal.
4. Accounting records, actuarial studies, and cost allocations (or billings) must recognize any significant differences due to types of insured risk and losses generated by the various insured activities or agencies of the governmental unit. If individual departments or agencies of the governmental unit experience significantly different levels of claims for a particular risk, those differences are to be recognized by the use of separate allocations or other techniques resulting in an equitable allocation.
5. Whenever funds are transferred from a self-insurance reserve to other accounts (e.g., general fund), refunds shall be made to the Federal Government for its share of funds transferred, including earned or imputed interest from the date of transfer.”

PIHP contract attachment 7.8.1 Financial Planning, Reporting and Settlement

The PIHP shall provide the financial reports to MDCH as listed below. Forms and instructions are posted to the MDCH website address at:

http://www.michigan.gov/mdch/0,1607,7-132-2941_38765---,00.html

<u>Due Date</u>	<u>Report Title</u>	<u>Report Period</u>
5/31/2011	Mid-Year Status Report	October 1 to March 31
8/15/2011	Financial Status Report – Medicaid v 2009-1	Refer to contract section 7.8
8/15/2011	Medicaid – Shared Risk Calculation & Risk Financing v 2009-1	Refer to contract section 7.8
8/15/2011	Medicaid – Internal Service Fund v 2009-1	Refer to contract section 7.8
8/15/2011	Projection Medicaid Contract Settlement Worksheet v 2009-1	October 1 to September 30
8/15/2011	Projection Medicaid Contract Reconciliation & Cash Settlement v 2009-1	October 1 to September 30
8/15/2011	Projection Financial Status Report – Medicaid v 2009-1	October 1 to September 30
8/15/2011	Projection Medicaid – Shared Risk Calculation & Risk Financing v 2009-1	October 1 to September 30
8/15/2011	Projection Medicaid – Internal Service Fund v 2009-1	October 1 to September 30
10/15/2011	Estimated Medicaid Contract Reconciliation & Cash Settlement v 2009-1 IF SUBMITTED BY OCT 15 TH , THEN NO INTERIM REPORT IS DUE	October 1 to September 30
10/15/2011	Medicaid Year End Accrual Schedule v 2009-1	October 1 to September 30
11/10/2011	Interim Financial Status Report – Medicaid v 2009-1	October 1 to September 30
11/10/2011	Interim Medicaid – Shared Risk Calculation & Risk Financing v 2009-1	October 1 to September 30
11/10/2011	Interim Medicaid – Internal Service Fund v 2009-1	October 1 to September 30
11/10/2011	Interim Medicaid Contract Settlement Worksheet v 2009-1	October 1 to September 30
11/10/2011	Interim Medicaid Contract Reconciliation & Cash Settlement v 2009-1 DISREGARD IF A OCT 15 TH CRCS WAS SUBMITTED.	October 1 to September 30
1/31/2012	Final Financial Status Report – Medicaid v 2009-1	October 1 to September 30
1/31/2012	Final Shared Risk Calculation & Risk Financing v 2009-1	October 1 to September 30
1/31/2012	Final Medicaid – Internal Service Fund v 2009-1	October 1 to September 30
	Final Medicaid Contract Settlement Worksheet	October 1 to September 30

1/31/2012	v 2009-1	
1/31/2012	Final Medicaid Contract Reconciliation & Cash Settlement v 2009-1	October 1 to September 30
1/31/2012	Medicaid Utilization and Cost Report	See Attachment P 6.5.1.1
1/31/2012	Medicaid Community Inpatient Psychiatric Services Expenditure Report	FY 10 expenditures
3/31/2012	Administrative Cost Report	For the fiscal year ending October 1 to September 30, 2011
30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter. Compliance exam and plan of correction	October 1 to September 30

MDCH 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

MDCH Office of Audit	<ol style="list-style-type: none"> 1. Completes audit of PIHP and holds an exit conference with PIHP management. 2. Issues a preliminary analysis within 60 days of the exit conference. The preliminary analysis is a working document and is not subject to Freedom of Information Act requests.
Audited PIHP	<ol style="list-style-type: none"> 3. Within 10 days of receipt of the preliminary analysis, requests a meeting with the MDCH Office of Audit to discuss disputed audit findings and conclusions in the preliminary analysis. Since the preliminary analysis serves as the basis for the final report, the PIHP shall take advantage of this opportunity to ensure that any factual disagreements or wording changes are considered before the final report is issued.
MDCH Office of Audit	<ol style="list-style-type: none"> 4. <u>If a meeting is requested</u>, convenes a meeting to discuss concerns regarding the preliminary analysis.
Audited PIHP	<ol style="list-style-type: none"> 5. Within 14 days of the meeting with the MDCH Office of Audit to discuss the preliminary analysis, submits to the MDCH Office of Audit any additional evidence to support its arguments.
MDCH Office of Audit	<ol style="list-style-type: none"> 6. Within 30 days of either the meeting to discuss the preliminary analysis, or receipt of additional information from the PIHP, whichever is later, revises and issues the preliminary analysis as appropriate based on factual information submitted at the meeting or other supporting documentation provided subsequent to the meeting.

Audited PIHP	<p>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.</p> <p>8. <u>If a meeting is not requested</u>, 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.</p>
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STEP 2. FINAL AUDIT REPORT

MDCH Office of Audit	<p>1. Within 30 days of receipt of the PIHP'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.</p> <p>2. Forwards final audit report to audited PIHP and other relevant parties. The letter bound with the final audit report describes the audited PIHP's appeal rights.</p>
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STEP 3. SETTLEMENT AND DISPUTE OF FINDINGS

Audited PIHP	<p>1. Within 30 days of receipt of the final audit report:</p> <p>A. Submits payment to MDCH for amounts due other than amounts resulting from disputed findings; and</p> <p>B. If disputing findings, submits to the MDCH Administrative Tribunal & Appeals Division a request for the <u>Medicaid Provider Reviews and Hearings Process</u> pursuant to MCL 400.1 et seq. and MAC R 400.3401, et seq. This process will be used</p>
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	<p>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.</p> <p>If MDCH 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 MDCH's Final Determination Notice according to MAC R 400.3405.</p> <p>C. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDCH Office of Audit, MDCH Contract Management, and MDCH Accounting.</p>
<p>MDCH Accounting</p>	<p>2. If the PIHP has not requested the Medicaid Provider Reviews and Hearings Process within the time frame specified, implements the adjustments as outlined in the final report. If repayment is not made, recovers funds by withholding future payments.</p>
<p>MDCH Contract Management Unit</p>	<p>3. Ensures audited PIHP resolves all findings in a satisfactory manner. Works with the audited PIHP on developing performance objectives, as necessary.</p>
<p>STEP 4. MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS</p>	
<p>MDCH Administrative Tribunal & Appeals Division</p>	<p>Follows the rules contained in MAC R 400.3401, et seq., and various internal procedures regarding meetings, notifications, documentation, and decisions.</p>