

SECTION 404 (3)
CMHSP CONTRACTUAL DATA
REPORTING REQUIREMENTS
FY 2007

CMHSP REPORTING REQUIREMENTS
FY2006 Contract Extension: Amendment #2
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**FY 2007 MDCH/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES
CONTRACT
MENTAL HEALTH REPORTING REQUIREMENTS
FY 2006 Extension, Amendment #2
*Introduction***

The Michigan Department of Community Health (MDCH) reporting requirements for the FY2003-05 Master contract and the FY'07 extension with community mental health services programs (CMHSP) 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 contains 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 2007 CMHSP DETAILED REPORTING SPECIFICATIONS

2006-07 DATA REPORT DUE DATES

	Nov06	Dec	Jan07	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec07	Jan08
1. Consumer level**	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
a. Quality Improvement (monthly) ¹															
b. Encounter (monthly) ¹															
2. Board level			✓					✓							✓
a. Sub-element cost report (annually) ²			✓					✓							✓
b. Section 460 Cost Allocation Report (semi-annually)			✓					✓							✓
b. Performance indicators (quarterly) ²		✓			✓			✓			✓			✓	
c. Death (quarterly) ²		✓			✓			✓			✓			✓	
d. Sentinel events (semi-annually) ²															
e. Recipient Rights (semi-annually) ^{3,4}														✓	

NOTES:

1. Send data to MDCH MIS via DEG unless the CMHSP as affiliate has arranged for its PIHP to submit consumer-level data for non-Medicaid consumers
2. Send data to MDCH, Mental Health and Substance Abuse Administration, Division of Quality Management and Planning
3. Send Recipient Rights reports to MDCH Office of Recipient Rights
4. Per the Mental Health Code, the annual Recipient Rights report is due December 30th.

**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.

Board 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 CMHSP’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 CMHSP 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 CMHSP 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 CMHSP regardless of funding stream. The exception is when a CMHSP contracts with another CMHSP, or a Medicaid Health Plan contracts with a CMHSP to provide mental health services. In that case, the 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. Encounter and QI data for non-Medicaid consumers may be reported by the CMHSP affiliate, as applicable. However, in order to ensure that people who move to and from Medicaid eligibility throughout the year, it is preferred that the PIHP report all encounter and QI data for all mental health consumers in its service area/affiliation.

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. New elements and new options within elements are noted with a ★. ~~Except for Program Eligibility (PE changed from PS) all other field names for elements and options used for 98-02 have remained the same for 2003-05.~~
3. Numbers missing from the sequence of options represent items deleted from previous reporting requirements.
4. 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 acceptable ranges. Failure to meet the 100% standard will result in rejection of the file or record.

5. A “Supplemental Instructions for Encounter and Quality Improvement Data Submissions” issued by MDCH should be used for file layouts.
6. Some demographic items are reported on both the HIPAA 837/4010A1 Health Care Claim transaction and will no longer be reported in the demographic file. Those are noted in the crosswalk between 2001 and 2003 data at the end of this section, and the QI data report for ease of calculating population numbers during the year.
7. Some demographic items will be reported on both the HIPAA.4010 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.

★ = New Data

****1. Reporting Period (REPORTPD)**

The last day of the month during which consumers received services covered by this report.
Report year, month, day: ccyymmdd.

****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 eight-digit integer for consumers with a Medicaid number.
Blank = Unreported [Leave eight blanks]
Consumers with Program Eligibility (#26) indicating Medicaid (26.01, 26.04, and/or 26.06) must have a Medicaid ID number (Standard = 95%)

6. Race/Ethnic Origin (RACE) Leave blank beginning with FY’06 service reporting

7. Corrections Related Status (CORSTAT) Leave blank beginning with FY’07 reporting

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.

- 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)

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 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)
- 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 = Supported Independence Program (lease is held by CMHSP or provider)
- Blank = Unreported

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.

Round to the nearest dollar; do not include commas, dollar signs or decimal points.

-Household income = \$ _____.00 [Example: \$10,358.34 = _10358]

-Blank = Unreported

-Acceptable range is \$0 to \$999,999

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)**

Indicate current employment status as it relates to principal employment for consumers age 18 and over. Use #8 for consumers under 18 years old. Reporting categories are as follows:

- 1 = Employed full time (30 hours or more per week) competitively or self-employed.
- 2 = Employed part time (less than 30 hours per week) in competitively or self-employed.
- 3 = Unemployed - looking for work, and/or on layoff from job
- 4 = Not in the competitive labor force - includes homemaker, student age 18 and over, day program participant, resident or inmate of an institution (including nursing home)
- 6 = Retired from work
- 7 = Sheltered workshop or work services participant in non-integrated setting
- 8 = Not applicable to the person (e.g., child under 18)
- 9 = In supported employment only (See definition page 64)
- 10 = In supported employment and competitive employment
- ★11 = In unpaid work

Blank = Unreported

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

13. *Wraparound Service (WRAP)*

- 1 = Receives Wraparound Services
- 2 = Does not receive wraparound

14. *Functional Assessment (FUNCTOOL)*

Functional assessments are administered with individuals who newly request non-emergent services, with individuals who will be receiving ongoing non-emergent services following emergency services, and annually thereafter with persons receiving non-emergent ongoing services. Indicate which of the following tools was used for the most recent functional assessment:

The **Child and Adolescent Functional Assessment Scale (CAFAS)** must be administered with all children, aged 7 through 17 years, newly requesting non-emergent services, and annually thereafter.

◆ No tool is used with **adults with mental illness or individuals with developmental disabilities**; therefore, this category should be left blank.

- 1 = *CAFAS (used with children 7 through 17)

Blank = None

15. *Scale Scores (SC#1-10)*

Indicate for 15.1 through 15.10 the 8 child functioning subscales and the two caregiver subscales to two decimals for the CAFAS Leave blank for **adults with mental illness and** persons with developmental disabilities.

15.1= Scale Score #1

CAFAS Role Performance - School: Value = 00.00 - 30.00

15.2= Scale Score #2

CAFAS Role Performance - Home: Value = 00.00 - 30.00

15.3= Scale Score #3

CAFAS Role Performance - Community: Value = 00.00 - 30.00

15.4= Scale Score #4

CAFAS Behavior Toward Others: Value = 00.00 - 30.00

15.5= Scale Score #5

CAFAS Moods/Emotions: Value = 00.00 - 30.00

15.6= Scale Score #6

CAFAS Self-Harmful Behavior: Value = 00.00 - 30.00

15.7= Scale Score #7

CAFAS Substance Abuse: Value = 00.00 - 30.00

15.8= Scale Score #8

CAFAS Thinking: Value = 00.00 - 30.00

15.9= Scale Score #9

CAFAS Primary Caregiver - Material Needs: Value = 00.00 - 30.00

15.10= Scale Score #10

CAFAS Primary Caregiver - Family/Social Support: Value = 00.00 - 30.00

16. Interval and Date of Most Recent Functional Assessment

Indicate the interval of the most recent assessment (per #15) and the date of the assessment. For persons with developmental disabilities indicate whether this is a new consumer ("1") or whether this is a continuing consumer for whom recent annual planning took place and needs for assistance were discussed.

16.01 Interval of most recent functional assessment (RECASS)

1 = New consumer

2 = Annual functional assessment for continuing consumer or annual planning for continuing consumer with developmental disabilities

3 = Assessment at termination, if appropriate

4 = Not appropriate for this person

5 = Not assessed during this time period

6= An interval that is neither initial, annual, or termination

Blank = none or unrecorded

16.02 Date of most recent functional assessment (DATASS) Enter the date of the assessment noted above: ccyymmdd

***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 (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 (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) (**SA**)

1 = Yes

2 = No

3 = Not evaluated

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.

19. Predominant Communication Style (People with developmental disabilities only) (COMSTYLE)

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)

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.

- 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 neededBlank =Unreported
- 20.2 Medication Administration includes administering, observing or reminding **(RX)**
 - 1 = Yes, assistance is needed
 - 2 = No, assistance is not neededBlank = 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 neededBlank = 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 neededBlank = 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)

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)

Indicate whether family/friend caregiver status is at risk; including instances of caregiver 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)

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)

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 Medicare (PE_MCARE)

- 1 = Yes
- 2 = No

26.4 Medicaid (except Children's Waiver) (PE_MCAID)

- 1 = Yes
- 2 = No

26.5 MIChild Program (PE_MIC)

- 1 = Yes
- 2 = No

26.6 Medicaid Children's Waiver (PE_CHW)

- 1 = Yes
- 2 = No

26.7 SDA, SSI, SSDI (PE_SSI)

1= Yes

2= No

26.8 Commercial Health Insurance or Service Contract (EAP, HMO) (PE_COM)

1 = Yes

2 = No

26.9 Program or plan is not listed above (PE_OTH)

1= Yes

2= No

26.10 Individual is not enrolled in or eligible for a program or plan (PE_INELG)

1= Yes

2= No

26.11 Individual is enrolled in the Adult Benefit Waiver (PE_ABW)

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 Family Independence Agency

Indicate whether minor child is enrolled in an FIA program. If the consumer is an adult or if the consumer is a child not enrolled in any of the FIA programs, enter 2=No.

28.01 Child served by FIA for abuse and neglect (FIA_AN)

1= Yes

2= No

Blank = Unreported

28.02 Child served by another FIA 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. *Primary Language Spoken (PLS)*

Enter the three-letter ISO/NISO 639-2(B) code of the language that is the primary language the individual speaks. The web site for the code list is <http://lcweb/loc.gov/standards/iso639-2/langhome.html>. If the individual does not speak at all, enter the code of the language that he/she understands. Use blank = Unknown

★ *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

★36. Sentinel Event Data (SE)

Reportable Population - sentinel event reporting is limited to Medicaid beneficiaries who fall into one or more of the following populations:

- Persons living in 24-hour specialized residential settings or in child-caring institutions;
- Persons living in their own homes receiving Community Living Supports;
- Persons receiving Targeted Case Management, ACT, Home-Based, Wraparound, Habilitation Supports Waiver Services;
- Persons enrolled in the Children's Waiver or the Children's SED Waiver programs;
- Persons residing in a substance abuse residential treatment program.

“Sentinel Event” is an “unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, ‘or the risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” (JCAHO, 1998)

Recipient deaths, injuries requiring emergency room treatment and/or hospital admission, physical illnesses requiring hospital admission, serious challenging behaviors, and medication errors that occur for individuals in the reportable population should be reviewed to determine whether the incident meets the criteria for a sentinel event as described above.

36.01 Death of recipient (SE_D)

Report any death that meets the sentinel event definition. Do not report deaths that occur as a natural outcome to a chronic condition (e.g., terminal illness) or old age.

1 = sentinel event death occurred in the month prior to the reporting period

Blank = no sentinel event death occurred or the individual is not in the reportable population

36.02 Injuries requiring emergency room visits and/or hospital admission (SE_I)

Accidents treated at medi-centers and urgent care clinics/centers should be included in the injury reporting along with those treated in emergency rooms. In many communities in the state where hospitals do not exist, medi-centers and urgent care clinics/centers are used in place of emergency rooms.

Report the total number of sentinel event injuries that occurred in the month prior to the reporting period. Leaving the field blank means no sentinel event injuries occurred.

= number of injuries meeting sentinel event definition that occurred in the month

Blank = no sentinel event injury occurred or the individual is not in the reportable population

36.03 Physical Illness requiring admissions to hospital (SE_HA)

"Physical illness resulting in admission to a hospital" does **not** include planned surgeries, whether inpatient or outpatient. It also does **not** include admissions directly related to the natural course of the person's chronic illness, or underlying condition. For example, hospitalization of an individual who has a known terminal illness in order to treat the conditions associated with the terminal illness is not a sentinel event.

Report the total number of sentinel event physical illnesses that occurred in the month prior to the reporting period. Leaving the field blank means no sentinel event physical illnesses occurred.

= number of illnesses meeting sentinel event definition that occurred in the month

Blank = no sentinel event illness occurred or the individual is not in the reportable population

36.04 Serious challenging behaviors (SE_B)

"Serious challenging behaviors" are those not already addressed in a treatment plan and include significant (in excess of \$100) property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence. Serious physical harm is defined by the administrative rules for mental health (330.7001) as "physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the

impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.”

Report the total number of sentinel event serious challenging behaviors that occurred in the month prior to the reporting period. Leaving the field blank means no sentinel event serious challenging behaviors occurred.

= number of challenging behaviors meeting sentinel event definition that occurred in the month

Blank = no sentinel event challenging behavior occurred or the individual is not in the reportable population

36.05 Medication errors (SE_ME)

“Medication Errors” mean a) wrong medication; b) wrong dosage; c) double dosage; or d) missed dosage. It does not include instances in which consumers have refused medication.

Report the total number of sentinel event medication errors that occurred in the month prior to the reporting period. Leaving the field blank means no sentinel event medication errors occurred.

= number of medication errors meeting sentinel event definition that occurred in the month

Blank = no sentinel event medication errors occurred or the individual is not in the reportable population

★37. Corrections Related and Jail Diversion Status (CORSTAT)

For persons under the jurisdiction of a corrections or law enforcement program during treatment, indicate the status of the individual with regard to each of the following areas during the month prior to the reporting month. If the individual was not involved in corrections, law enforcement or jail diversion during the month prior to the reporting month, leave blank.

37.1 Corrections or Law Enforcement Program jurisdiction status (CORSTAT_JU)

1 = under the jurisdiction of a corrections or law enforcement program

blank = not applicable or unknown

37.2 Arrested (CORSTAT_A)

1 = Yes

blank = not applicable or unknown

37.3 Diverted from booking as a result of pre-booking jail diversion activity (CORSTAT_DB)

1 = Yes

blank = not applicable or unknown

37.4 Booked (CORSTAT_B)

- 1 = Yes
- blank = not applicable or unknown
- 37.5 Awaiting trial (CORSTAT_AT)**
 - 1 = Yes
 - blank = not applicable or unknown
- 37.6 Awaiting Sentencing (CORSTAT_AS)**
 - 1 = Yes
 - blank = not applicable or unknown
- 37.7 Court supervision (CORSTAT_CS)**
 - 1 = Yes
 - blank = not applicable or unknown
- 37.8 Diverted from incarceration as a result of post booking jail diversion activity (CORSTAT_DI)**
 - 1 = Yes
 - blank = not applicable or unknown
- 37.9 In jail (CORSTAT_IJ)**
 - 1 = Yes
 - blank = not applicable or unknown
- 37.10 In juvenile detention center (CORSTAT_JV)**
 - 1 = Yes
 - blank = not applicable or unknown
- 37.11 In prison (CORSTAT_IP)**
 - 1 = Yes
 - blank = not applicable or unknown
- 37.12 Probation from jail (CORSTAT_PJ)**
 - 1 = Yes
 - blank = not applicable or unknown
- 37.13 Parole from prison (CORSTAT_PP)**
 - 1 = Yes
 - blank = not applicable or unknown

ENCOUNTERS PER MENTAL HEALTH CONSUMER 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 CMHSP 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 CMHSP. 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 Consumer

Encounter data is collected and reported for every beneficiary for which a claim was adjudicated or service rendered during the month by the CMHSP (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. CMHSPs that contract with another CMHSP or a Medicaid Health Plan contracts with a CMHSP to provide mental health services should include that consumer in the encounter and QI data sets. In those cases the 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 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 CMHSPs 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. 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.

★ **Indicates new data requirement**

****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.

****2. Identification Code/Subscriber Primary Identifier (please see the details in the submitter's manual)**

Eight-digit Medicaid number must be entered for a **Medicaid** 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. Allowed 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 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 837/4010A1 Professional, or the 837/4010A1 Institutional format is used).

FY'07 CMHSP TOTAL SUB-ELEMENT COST REPORT
[Note: no revisions from Instructions and Format used in FY'05 reporting]

This report provides the total service data necessary for MDCH management of CMHSP contracts and reporting to the Legislature. The data set reflects and describes the support activity provided to or on behalf of all consumers receiving services from the CMHSP **regardless of funding stream** (Medicaid, general fund, grant funds, private pay, third party pay, contracts). The new format is presented by procedure code, beginning with facility services reported by revenue code. Most of the activity reported here will also have been reported in the encounter data system. Refer to the Mental Health HCPCS and CPT Code List and the Costing Per Code list on the MDCH web site for cross walk between services and the appropriate codes. Electronic templates for reporting will be issued by MDCH six weeks prior to the due date and are also located on the MDCH web site: www.michigan.gov/mdch, click on Mental Health and Substance Abuse, then Reporting Requirements

RULES FOR REPORTING ON CMHSP TOTAL SUB-ELEMENT COST REPORT

Background:

Per the CMHSP and PIHP contracts with the Department of Community Health, beginning FY'04 the community mental health system is required to submit two 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 Total sub-element cost reports will continue to be used by MDCH to comply with the MDCH Appropriations Act Section 404 boilerplate requirements.

It is not intended that the Sub-element cost expenditures match the Financial Status Report (FSR) expenditures. Each CMHSP should maintain documentation, however, as to the source of variance between the FSR and the sub-element cost report.

Instructions:

I. Total units, cases, and costs per procedure code

- a. Enter the number of **units** per procedure code that were provided during the period of this report for each eligibility group – individuals with a developmental disability, adults with mental illness, and children with mental illness. For most of the procedure codes, the total number of units should be consistent with the number of units for that procedure code that were reported to the MDCH warehouse for all consumers. 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. Report services for Persons with Developmental Disabilities (H), Adults with Mental Illness (I), and Children with Serious Emotional Disturbance (J) in separate columns on the spreadsheet. Note that some procedures are reportable under only one column. An example is out-of-home prevocational service (T2015) that is only a HSW service.

- b. Peer-delivered (H0038) has a row for units, costs, and cases that were reported in the encounter data, and a row for peer-delivered expenditures (typically drop-in center activities) that were **not** captured by encounters 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 either row.
- c. Several codes have rows without modifiers as well as rows with modifiers: 90849 (HS modifier used to distinguish when a beneficiary is not present), H2016 and T1020 (TF and TG modifiers used to distinguish levels of support). For T1017, SE modifier is used to distinguish between targeted case management and case management provided in a nursing home. 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.
- d. A row for residential room and board has been added. If room and board is reported as encounters (S9976) to the warehouse, enter the cases, units, and costs here. If room and board was not reported as encounters, report it in Row VI, "Other."
- e. A row for pharmacy has been added to report drugs, including injectibles, and other biologicals. Do not report "enhanced pharmacy" cases and costs in this row.
- f. A row for "other" has been added to report other procedure codes that are not included in the rows above. These are typically non-mental health activities provided to individual consumers for which CMHSPs use general funds.
- g. Enter the **unique number of cases** per procedure code. This number should reflect the unduplicated number of consumers who were provided the service during the reporting period. Record case, unit, and costs under "Column J" if the child has a mental illness and is less than age 18 on the last day of the reporting period.
- h. Enter the **total expenditures** per procedure code (see exclusions below) by each population group.

II. Prevention- Indirect Service Model

- a. In row II, column K, enter the total expenditures (staff, facility, equipment, staff travel, contract services, supplies and materials) for indirect prevention activities.

III. SA Managed Care Administration

- a. Cost of managed care administration performed by the CMHSP for the substance abuse benefit, if the CMHSP is a PIHP. CMHSP affiliates report 0. If the CMHSP performs non-Medicaid managed care administrative functions for the CA, the CMHSP should report that expense here.
- b. Refer to the document entitled "Establishing Managed Care Administrative Costs" (revised June 2005) for determining the administrative costs to be entered in row III, column K of this report.

IV. **MH/DD Medicaid Managed Care Administration Costs:** Enter in column K the expenditures for the Medicaid managed care functions that were performed by the CMHSP that is a PIHP. Do not include expenditures for functions that were delegated to affiliates. Affiliate CMHSPs report 0 in column K

V. Managed Care Administration MH/DD

Enter in column K the total expenditures for managed care administration performed by the CMHSP for all its services. For affiliates this includes delegated Medicaid managed care administration and includes non-Medicaid managed care administration. In those instances where the PIHP also provides administrative service organization activities for the affiliates for non-Medicaid services, the CMHSP affiliate should include this cost and the PIHP should not include the cost.

VI. **All Other Costs:** In column K report all other costs: room and board, MRS cash match, labs, and pharmacy not already reported in any procedure codes. Please provide an itemized listing of "all other costs" in the Comments box.

VII. **Total MH/DD Cases and Costs:** Enter in the appropriate columns the unduplicated number of cases

and costs for each population group.

Grand Total Expenditures: formula in cell will automatically calculate the sum of all costs included in this report.

Exclusions

The following expenditures **must be excluded** from the CMHSP Sub-Element Cost Report:

1. Room and board costs should be excluded from all rows except VI. "All Other"
2. Local contribution to Medicaid
3. Payments made into internal service funds (ISFs) or risk pools.
4. Provider of administrative service organization (ASO) services to other entities, including PIHP/hub ASO activities provided to CMHSP affiliates/spokes for non-Medicaid services
5. Write-offs for prior years
6. Substance Abuse services provided by the CMHSP under provider contract with CAs (these show up in the report from the CA)
7. Workshop production costs (these costs should be offset by income for the products).
8. Medicare payments for inpatient days (where CMHSP has no financial responsibility)
9. Services provided in the Center for Forensic Psychiatry
10. Mental health services paid for by health plan (MHP) contracts.

Additional Issues

1. Include costs and services that were funded by FY04 savings or carry-forward or by funds pulled out of the ISFs.
2. Include cases, units and costs for Children's Waiver
3. Include costs and services for persons with co-occurring conditions where revenues were used by the CMHSP to purchase or provide such services using funds that were **not** paid to the CA.
4. Report services and costs that match 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. (i.e., report cases, units, and costs for services rendered, but those whose claims have not been adjudicated by the time of report).
5. Assume that the CAs are providing a Total service use/cost report
6. If services are provided by a CMHSP to another CMHSP/PIHP through an earned contract, the COFR CMHSP should report these costs, NOT the providing CMHSP
7. If services were delivered by the CMHSP, but paid for by a Medicaid Health Plan, do not report on the sub-element table.
8. Spend-down is captured separately on the Medicaid Utilization and Net Cost Report but does not need to be separated on this report.
9. Report on separate rows in this report:
 - *Community Psychiatric Inpatient
 - *Inpatient in a community institution for mental disease (IMD)
 - *ICF-MR (Mt. Pleasant)
 - *State Psychiatric Hospitals (includes those persons at Mt. Pleasant who are not ICF-MR eligible)

SECTION 460 CMHSP COST ALLOCATION REPORT

Background

Section 460 of P.A. 154 of 2005 required that the Michigan Department of Community Health develop methods and instructions for allocating administrative costs and reporting requirements for the Pre-Paid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), and their sub-contractors. This document contains MDCH's response to the legislation and is reflective of the values of a public mental health system. The first phase of the activity, to commence October 1, 2006, involves PIHPs, CMHSPs, and their "prime subcontractors" defined as those entities from which administrative functions and/or direct services are purchased and which further sub-contract with other entities for administrative and/or direct services in fulfillment of their obligations to the contract. Prime subcontractors include the affiliate CMHSPs of the PIHPs, substance abuse coordinating agencies (CAs) that manage Medicaid services, Managed Comprehensive Provider Networks (MCPNs) and all other entities that meet the definition of prime subcontractor as defined in the Glossary of Terms. The second phase, to commence in FY'08 adds the major subcontracted providers of PIHPs, CMHSPs and prime sub-contractors.

The administrative cost data reported by PIHPs and CMHSPs on the "Section 460 Report" by January 31st of each year are submitted by MDCH to the Legislature annually. In Attachments A and B to this document you will find in each Table One and Table Two. Attachment A, Table One contains all the PIHP Medicaid direct and administrative costs with an explanation that the Balanced Budget Act defines the administrative functions that a managed care organization must perform, whether a PIHP or HMO. Table One, to be sent to the Legislature, contains each of the 18 PIHP Medicaid direct service costs and administrative costs, and the aggregate prime subcontractors' Medicaid direct service costs and administrative costs. Table Two, to be used also for PIHP reporting to MDCH, contains the Medicaid direct costs and administrative costs for each PIHP's prime sub-contractors. Attachment B, Table One is the CMHSP non-Medicaid direct and administrative costs with an explanation that the Mental Health Code requires certain administrative functions (i.e., the historical "board administration"), with examples like recipient rights, community needs assessment and school-to-community transition services, that are unique to Michigan's public mental health system and therefore not comparable to other health care organizations. As with the PIHP attachment, Attachment Two Table One contains each of the 46 CMHSP non-Medicaid direct service costs and administrative costs, and the aggregate prime subcontractors' non-Medicaid direct service costs and administrative costs. Attachment B Table Two contains each CMHSP's non-Medicaid direct service costs and administrative costs for each their prime sub-contractors.

While many of the administrative functions are derived from the BBA or Mental Health Code requirements, and are delegated by the PIHP and CMHSP to their prime sub-contractors, certain core functions, such as human resources, information systems, and executive director exist in PIHPs, CMHSPs and the prime subcontractors regardless of funding stream. The costs of these core functions must be allocated to the PIHP as Medicaid administrative expenditures and to the CMHSP as non-Medicaid administrative expenditures according to an allocation methodology that is consistent with Office of Management and Budget Circular A-87.

The Cost Allocation model in response to Section 460 uses A-87 as its foundation. PIHPs and CMHSPs might also use the EDIT (Encounter Data Integrity Team) document titled "Establishing Managed Care Administrative Costs", June 20, 2005, to determine the administrative functions that should be allocated to Medicaid

administration regardless of whether they are delegated. The first step of the process requires that each PIHP and CMHSP develop a cost allocation plan and submit it to MDCH prior to the beginning of a fiscal year except for the FY'07 when it will be due prior to the beginning of the 2007 calendar year. It is expected that the cost plans

indicate what has been delegated to another entity and what has not, and the methods being used to allocate costs. MDCH will review the plans, and may comment if a plan contains a questionable allocation methodology, but will not approve plans. The PIHPs' and CMHSPs' annual independent audit will review actual cost allocations and compare to the prospective methodologies in the cost plans.

The remainder of this section contains 1) steps for determining "allowable" expenditures per applicable state and federal regulations; 2) a diagram depicting where the line is drawn between direct service costs and administrative costs; 3) steps for allocating costs to either direct service and administration; 4) glossary of terms; and 5) a flow chart for allocation steps. Electronic templates for reporting will be issued by MDCH six weeks prior to the due date and are also located on the MDCH web site: www.michigan.gov/mdch , click on Mental Health and Substance Abuse, then Reporting Requirements

Steps For Determining Allowable Costs Per State and Federal Regulations

For costs to be reported by pre-paid inpatient health plans (PIHPs) and community mental health services programs (CMHSPs) as allowable costs they must meet the standard for allowable costs in state and federal regulations. Substance abuse costs reported to PIHPs and CMHSPs must also meet standards for allowable costs. The state regulations are the Mental Health Code and PIHP or CMHSP contracts, and, as applicable, the Medicaid Provider Manual. For governmental units (PIHPs and CMHSPs) the federal standards are in Office of Management and Budget (OMB) Circular A-87. It is used in determining the allowable costs incurred by State and local governments under cost reimbursement contracts. For non- profits those federal standards are in OMB circular A-122. It is used to establish principles for determining costs of grants, contracts and other agreements with non-profit organizations. Once costs are determined to be allowable then the PIHP or CMHSP can utilize the Cost Allocation Diagram to determine the classification of the costs between direct services and administration.

All other costs not allowable under any of these regulations should be reported as "expenditures not otherwise reported" on the applicable financial status report (FSR) and must have appropriate administrative costs allocated.

COST ALLOCATION DIAGRAM

Note: PIHPs, CMHSPs, and their prime subcontractors must define all allowable costs (either directly or through allocation) as either “Direct Service” or “Administration.” To be considered an allowable cost, the cost must meet the guidelines defined per OMB Circulars A-87 and 122, the Medicaid Provider Manual or the Mental Health Code.

DIRECT SERVICES

All contract or directly operated services and supports reported as encounters to MDCH data warehouse (the cost of these include face-to-face activities and collateral activities performed on behalf of beneficiary). Note that fiscal intermediary services are now reported as encounters.

Other General Direct Services (not reported as encounters)
 Prevention (not individual-specific)
 Outreach (might include homeless projects)
 Crisis Intervention
 Peer Delivered (not reported as encounter)

Allocated Overhead (examples)
 Building costs (including building security)
 Utilities
 Travel/vehicles
 Clerical
 Equipment (furniture, telephone, personal computer – cabling, server, router, software)
 Medical records – electronic or otherwise
 Supplies
 Training on specific service
 Immediate/First-line supervisors

ADMINISTRATION

All functions and activities that are not “direct services” above

VIII. Staff (examples)

IX. Executive Director

Management/ non-immediate supervisory staff
 Human resources staff
 Budget, Finance and Accounting staff
 Reimbursement staff
 Training staff
 Customer Services staff
 Recipient Rights staff
 Utilization Management staff
 Quality Improvement staff
 Information system staff (+ network mgmnt, help desk, security)

Line Items (examples)

Legal, audit, consultation services
 Advisory councils and committees
 Accreditation & licensing fees
 Association membership fees
 County indirect
 Subscriptions

Allocated Overhead (examples)

Building costs
 Utilities
 Travel/vehicles
 Clerical
 Equipment (personal computer, furniture, fax, telephone)
 Supplies
 Training & conferences related to administrative functions

See Steps for Allocating Administrative Cost for additional details.

Steps for Allocating Administrative Costs

Note: These steps, along with the flow chart attached, are provided as guides when developing a cost allocation plan. In Phase I, to commence October 1, 2006, these steps apply to PIHPs and CMHSPs. Substance abuse coordinating agencies (CAs) and the PIHPs' and CMHSPs' prime subcontractors -those entities from which administrative functions are purchased and/or direct services are purchased and further sub-contract with other entities for administrative and/or direct services in fulfillment of their obligations to the contract shall follow steps three through six and report their administrative costs by program type to the PIHPs or CMHSPs with which they contract.

Phase II, to commence October 1, 2007, requires that similar steps be applied to the subcontractors of PIHPs, CMHSPs, CAs and core providers or prime subcontractors. A determination will be made, in preparation for Phase II, of the materiality of the administrative costs of small subcontractors and/or the relative amount of Medicaid payments that are made to subcontractors. In addition, Phase II will need to address the issue of subcontractors that are community and private hospitals.

Phase I

1. Determine allowable costs under the applicable state and federal regulations.
2. PIHP and CMHSP must identify the methodologies to be used in their cost allocation plans. The cost allocation plans for the PIHP drives their affiliate CMHSP cost allocation plans for Medicaid purposes and determination. The methodologies must meet federal Office of Management and Budget (OMB) Circular A-87 (A87) standards. The cost allocation plan shall be submitted to MDCH by a specified date prior to the start of the fiscal year (except for year one).
3. Identify all costs that are direct service costs; the remaining costs are administrative costs. (See diagram)
4. Allocate overhead costs to direct service or administrative costs.
5. Allocate direct costs by program (Medicaid, GF, etc)
6. Allocate administration costs by program (Medicaid, GF, etc) utilizing the cost allocation methodologies identified in Step 2.
7. Report direct service and administrative costs to MDCH on the Section 460 report, Table 2, to be provided.
8. Independent audit shall verify that costs were allocated correctly and according to the cost allocation plan.

Commentary on the steps

1. The applicable state and federal regulations include, but are not limited to, the Michigan Mental Health Code, the service definitions in the Michigan Medicaid Provider Manual, the contract between MDCH and the PIHPs and CMHSPs, and federal OMB circulars.
2. MDCH is not dictating the methodologies for allocating costs.
 - The allocation methods used must meet A-87 standards.
 - The allocation methods may not be changed during the fiscal year unless a material defect is discovered or the law or organization is changed affecting the validity of the methodology.
 - A cost allocation plan due date in late December 2006 or early January 2007 shall be established by MDCH for the Phase I. Future year allocation plans are due on a date established by MDCH, but no later than October 1st of the year.

- MDCH may review the cost allocation plan to assure it is complete and meets A-87 standards; and will keep the plan on file for future reference.
3. The “direct service” costs are those associated with the covered services that are reported via CPT or HCPCS codes as encounters.
- Direct service also includes services provided face-to-face to mental health consumers or prospective mental health consumers such as outreach, crisis intervention, prevention, and peer-delivered that do not result in encounter reporting.
 - Note that fiscal intermediary service is now a covered service and should be reported in the encounter data system and counted as a direct service cost.
 - The direct service costs include:
 - Staff salary/benefits for the time performing the face-to-face activity and the ancillary activities conducted on behalf of the consumer (progress notes, phone calls, etc.)
 - Salary/benefits of the **immediate** supervisor of the staff providing the service.
 - Only if there is documented evidence that the second or third line supervisor is performing a duty that is normally the duty of a direct care provider or his/her immediate supervisor may they be included as direct services.
 - Materiality is a factor in determining whether to include the staff salary/benefits for a second or third line supervisor, clinical director, etc.
 - A panel of experts established by MDCH will provide a ruling where there are local questions about whether a cost is direct service or administrative.
 - If electronic medical records are used, these shall be reported as direct service
4. Allocate the overhead costs using the methodologies identified in Step 2.
- Equipment shall be allocated to include the personal computers, telephones, fax, and office furniture used by the direct service staff and the clerical staff to direct services.
 - Equipment attributable to other staff shall be included in administration.
 - The cost of training required for a specific covered service shall be reported as a direct service cost.
 - General training that is provided to staff across the service delivery system shall be included in administration.
 - Building costs, including rent and utilities, shall be allocated to direct services and administration.
 - All other costs that are not determined to be direct service costs, or allocable overhead to direct service activities, are administrative costs.
 - While Recipient Rights, Customer Services, and some of Utilization Management and Quality Improvement may include direct service to consumers, these functions are not considered to be the primary business of the public mental health system but are “regulatory” functions and therefore classified as administrative costs.
5. Using the allocation method identified in Step 2, allocate the entire direct service costs by program: Medicaid, Children’s Waiver, GF, Adult Benefits Waiver (ABW), MI-Child, HMO/Other Earned Contract, SA Block Grant, for example.
6. Using the allocation method identified in Step 2 allocate the administrative costs by program: Medicaid, Children’s Wavier, GF, Adult Benefits Waiver (ABW), MI-Child, HMO/Other Earned Contract, SA

Block Grant, for example. CMHSPs shall separately identify non-Medicaid direct service costs and administration on the new Section 460 Report, Table 2. CMHSPs that are affiliates report their Medicaid administrative costs to their PIHP.

7. The PIHP shall aggregate and report the Medicaid administrative costs from their affiliates, the substance abuse coordinating agencies, and their core providers or prime subcontractors on the new Section 460 Report, Table 2. Substance abuse coordinating agencies must report to PIHPs their direct and administrative Medicaid costs as allocated in this manner. CA Medicaid administrative costs may not be allocated to direct Medicaid service costs.
8. The annual independent audit shall review how the administrative and direct service costs were separated and will verify that the methodologies identified in the cost allocation plan were used and that there is evidence to support the allocation of costs was done in compliance with A87 using those methodologies.

SECTION 460 COST ALLOCATION REPORT

GLOSSARY

1. Administrative costs: For purposes of reporting on the Section 460 Cost Allocation report, these are costs of running the PIHP/CMHSP programs that do not meet the classification of direct service costs. These will include both directly assignable costs and those that are not readily assignable. For reporting purposes "Administration" also includes a share of the allocated overhead costs.
2. Allocated Overhead
 - These are costs that can be allocated to a particular cost objective or activity in accordance with the benefit received.
 - Allocated Overhead included in "Direct"
 - In general, these are the minimum requirements for an employee to perform their duties – for example: space, equipment and transportation (if necessary to access clientele)
 - Allocated Overhead included in "Administration"
 - Other costs such as human resources, legal counsel and the executive staff are not strictly required for an employee to perform their duties – therefore they are not allocated, but 100% included in "Administration"
 - Examples of costs that may be included in allocated overhead
 - Building Rent
 - Utilities
 - Telephones
 - Personal Computers
 - Training
 - Specific clinical-type training would be included as "Direct"
 - General training, such as a seminar on HIPAA would be included as "Administration"
3. Allowable expenditures: The expenditures allowed by the state and federal regulations.
4. Cost allocation plan
 - For this reporting purpose a cost allocation plan should, at a minimum, include:
 - For each different allocation basis, include:
 - A description of the cost or service to be allocated. This may require inclusion of an organization chart, a chart of account or other supporting documentation
 - Projected costs to be allocated
 - A detailed description of the method used to allocate costs
 - A summary or pro-forma presentation of the allocation to each activity or program.
5. Cost centers: "Cost objective" means a function, organizational subdivision, contract, grant, or other activity for which cost data are needed and for which costs are incurred.
6. Cost pools: is the accumulated costs that jointly benefit two or more programs or other cost objectives.
7. Direct Service cost: For purposes of reporting on the Section 460 Cost Allocation report, these are all contract or directly operated services and supports reported with CPT or HCPCS codes as encounters to MDCH data warehouse (the cost of these include face-to-face activities and collateral activities performed

on behalf of beneficiary). Other “general” Direct Services not reported as encounters include Prevention (not individual-specific), Outreach (might include homeless projects), Crisis Intervention, Peer Delivered or Drop-in Centers (not reported as encounters).

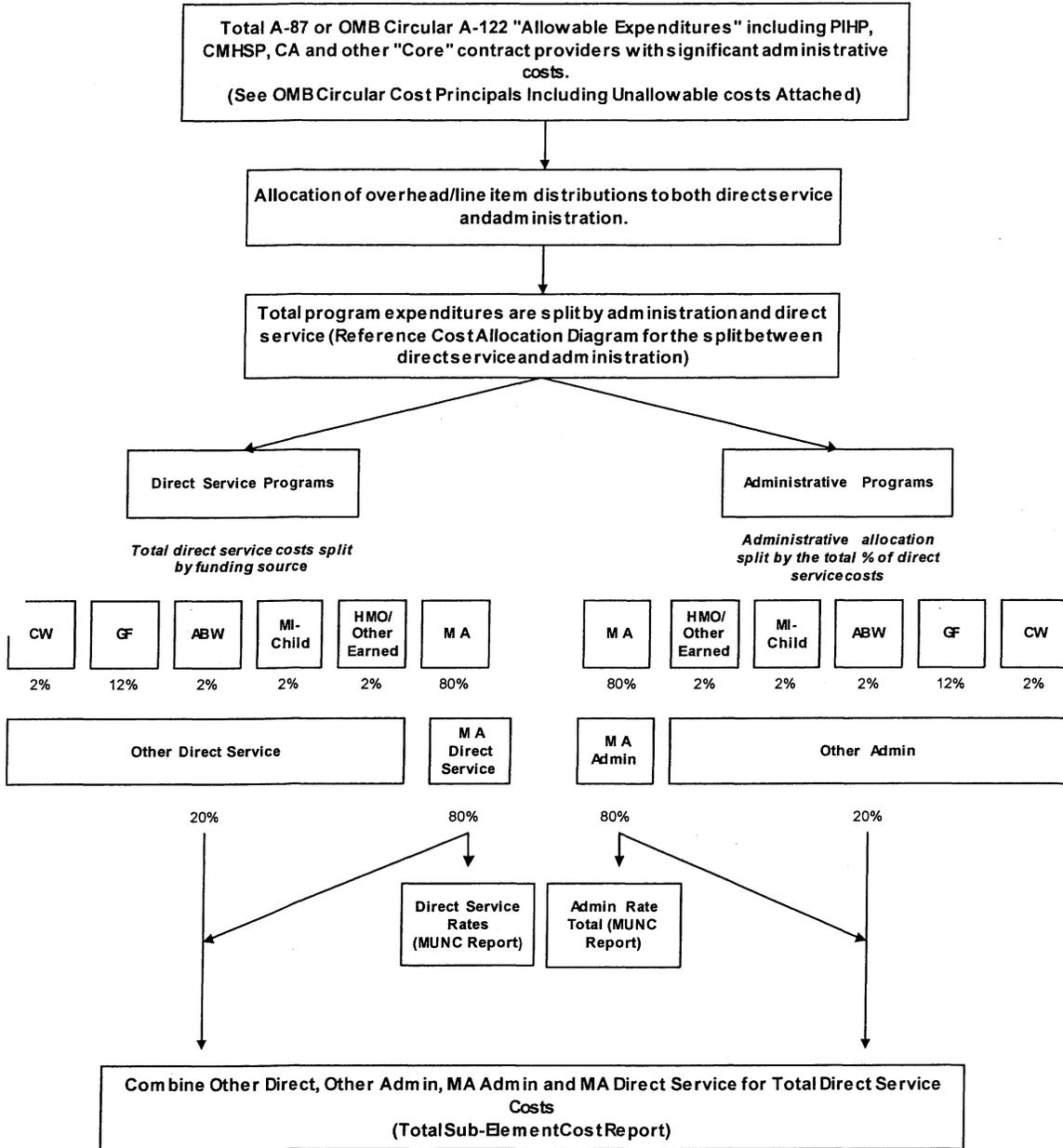
- Examples of direct costs
 - Employee costs directly identified and devoted to providing services that result in a reportable encounter
 - Materials acquired, consumed or expended specifically to provide direct services reported as an encounter

8. Indirect service cost: Allocated Overhead

9. Indirect administrative costs: Allocated Overhead

10. Prime subcontractor: those entities to which administrative functions and/or direct services are delegated and which sub-contract with other agencies. The entities’ responsibilities may be limited to a particular geographic area or a population within the PIHP’s service area, or the CMHSP’s catchment area. The entities may (depending upon the delegation agreement) include CMHSP affiliates, “core providers”, substance abuse coordinating agencies, and Managed Comprehensive Provider Networks (MCPNs).

SECTION 460 COST ALLOCATION REPORT
X. Steps for Allocation of Direct and Administrative Costs



Section 460 CMHSP Cost Allocation Report *INSTRUCTIONS FOR COMPLETION*

CMHSPs will use Table 2 of the Direct Service/Administrative Cost Report for reporting in compliance with Section 460 of Public Act 154, 2005. Please refer to the Requirement for Allocating Administrative Costs for details and definitions of terms.

To complete Table 2:

1. Enter CMHSP name and enter an X in the box to indicate six-month or annual report.
2. Enter in row 1, col. B the cost of the total non-Medicaid direct services that the CMHSP provided directly (not via Prime Subcontractor or other Subcontracted Provider).
3. In row 1, col. E, enter the cost of the non-Medicaid administration for the CMHSP (less the administrative costs of the Prime Subcontractor or other Subcontracted Provider).
4. Cols. H, I, J, and K will self-calculate.
5. In Rows 2 through 14, enter in the Col. A the names of the Prime Subcontractors.
6. In Rows 2 through 14, Col. C, enter the cost of the total non-Medicaid direct services that each Prime Subcontractor provided directly.
7. In Rows 2 through 14, Col. F enter the costs of non-Medicaid administration for the Prime Subcontractor (less the administrative costs for any other Subcontracted Provider).
8. Rows 2 through 14, Cols. H, I, J and K will self-calculate
9. Row 15, Col C and F will automatically calculate the costs of the total non-Medicaid direct services and total non-Medicaid administration for the Prime Subcontractors (total of rows above)
10. Row 16, Col. D, enter the total costs for non-Medicaid direct services and administration performed by Subcontracted Providers as delegated by the CMHSP and/or the Prime Subcontractors.
11. Row 16, Cols. H and J will self calculate.
12. Row 17, cells will automatically fill with totals from Rows 1, 15 and 16, and Col. H, I, J, and K will self-calculate
13. Row 18, enter the amount of Local Contribution to State Medicaid Match allocated to non-Medicaid services and non-Medicaid administration. Cols. H, I, J and K will self-calculate.
14. Row 19, cells will automatically add rows 17 and 18.

**MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM
VERSION 6.0
FOR CMHSPS**

The Michigan Mission Based Performance Indicator System (version 1.0) was first implemented in FY'97. That original set of indicators reflected nine months of work by more than 90 consumers, advocates, CMHSP staff, 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 CMHSP performance, rather than affiliation performance. Therefore performance indicators should be reported by the CMHSP. 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, Version 6.0, August 2005" codebook. Electronic templates for reporting will be issued by MDCH six weeks prior to the due date and are also located on the MDCH web site: www.michigan.gov/mdch, click on Mental Health and Substance Abuse, then Reporting Requirements.

**MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM, VERSION 6.0
FOR CMHSPS**

ACCESS

1. The percent of all adults and children receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**
2. The percent of new persons receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, and DD children). **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 and DD children) **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). **Standard=95%**
5. The percent of face-to-face assessments with professionals that result in decisions to deny CMHSP services. (MI and DD)
6. The percent of Section 705 second opinions that result in services. (MI and DD)

EFFICIENCY

7. The percent of total expenditures spent on managed care administrative functions for CMHSPs.

OUTCOMES

8. The percent of adults with mental illness and the percent of adults with developmental disabilities served by CMHSP who are in competitive employment.
9. The percent of adults with mental illness and the percent of adults with developmental disabilities served by the CMHSP 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 persons served with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.
12. The number of suicides per thousand persons served (MI, DD)..

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	CMHSPs
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	CMHSPs
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	CMHSPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/01 6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	CMHSPs
5. Denials	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	CMHSPs
6. 2 nd Opinions	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	CMHSPs
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	CMHSPs
11. RR complaints	10/01 to 9/30	12/31							CMHSPs
12. Suicides (death report)	10/01 to 3/31	12/31							CMHSPs

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

STATE LEVEL DATA COLLECTION

Functional/Symptom Status

1. Changes in Child and Adolescent Functional Assessment Scale (CAFAS) scores for children with emotional disturbance between **initial or annual and termination** assessments. Indicators:

Percent of children/adolescents who experience increased level of functioning

Percent of children/adolescents who experience decreased level of psychological distress

Percent of children/adolescents who experience increased activities with family, friends, neighbors, or social groups

Average level of impairment in children/adolescents with substance abuse problems

Percent of children/adolescents who were in juvenile detention the past year.

Consumer Satisfaction

~~Data for consumer satisfaction will be collected from a statewide probability sample arranged by MDCH.~~

~~Cooperation between MDCH, its contractor, and PIHP is required, including but not limited to providing the contractor with a sample (frame to be specified by MDCH) of Medicaid beneficiaries/ names and addresses to be surveyed.~~

~~Indicator: Percent of adult beneficiaries (MI, DD and SA) served who report satisfaction with services~~

INSTRUCTIONS FOR COMPLETING THE FY2007 RECIPIENT RIGHTS DATA REPORT

Section I: Complaint Data Summary

→THIS SECTION IS REQUIRED FOR BOTH THE ANNUAL REPORT AND SEMI-ANNUAL REPORT

Part A: Totals

Complaints Received: Enter the total number of complaints received for the reporting period

Allegations Involved: Some complaints contain more than 1 allegation. If you have not counted each allegation as a separate complaint (i.e. given it a separate complaint number) then enter the total number of allegations received here. If you do count each allegation as a separate complaint, the number entered here should be the same as complaints received.

Allegations Investigated: Enter the total number of investigations conducted here.

Part B: Aggregate Summary of Allegations By Category

For each sub-category enter the following information:

- ❖ Number of allegations received
- ❖ Number of these investigated *
- ❖ Number of these in which some intervention ** was conducted
- ❖ Number of allegations substantiated either by investigation or intervention

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

** Intervention: To act on behalf of a recipient to obtain resolution of an allegation of a rights violation contained in a complaint when the facts are clear and the remedy, if applicable, is clear, easily obtainable and does not involve statutorily required disciplinary action. *Interventions are not allowed in allegations of abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation.*

Part C: Remediation of Substantiated Rights Violations:

For each allegation that, through investigation or intervention, it was established that a recipient's right was violated, indicate the following:

- § The category and specific allegation
- § The Name of the Provider
- § The type of Provider (see table on the next page)
- § The Specific remedial action taken
- § The type of remedial action taken (see table on the next page)

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Outpatient	01	Verbal Counseling	01
Residential MI	02	Written Counseling	02
Residential DD	03	Written Reprimand	03
Inpatient	04	Suspension	04
Day Program MI	05	Demotion	05
Day Program DD	06	Staff Transfer	06
Workshop (Prevocational)	07	Training	07
Supported Employment	08	Employment Termination	08
ACT	09	Contract Action	09
Case Management	10	Policy Revision/Development	10
Psychosocial Rehabilitation	11	Environmental Repair/Enhancement	11
Partial Hospitalization	12	Plan of Service Revision	12
SIP	13	Recipient Transfer to Another Provider/Site	13
Other	14	Other	14

Example:

CATEGORY & SPECIFIC ALLEGATION		SPECIFIC PROVIDER	TYPE	SPECIFIC REMEDIAL ACTION	TYPE
7222	Abuse, Class II	Outpatient	01	5 day suspension	04

→THE FOLLOWING SECTION IS REQUIRED FOR THE ANNUAL REPORT ONLY

Section II: Training Activity

Part A: Training Received by Rights Office Staff

Indicate, for each rights staff, the kind of training received during the period and the number of hours for each.

Part B: Training Provided by Rights Office

Indicate the kind of training provided during the period, the number of hours for each, the number of CMH or Hospital Staff involved, the number of contractual staff involved, and/or the number and type of other staff involved.

Section III: Desired Outcomes for the Office

List the outcomes established for the office during the next fiscal year.

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

List any recommendations made to the governing Board regarding the rights office or recipient rights activity as part of the annual report.

REPORT DATES:

Semi-Annual

October 1 through March 31

Section I

Annual

October 1 through September 30

Section, I, II, III, IV

1. Board: _____ The MDCH-assigned 2-digit CMHSP board number must be used with all data transmissions. All data transmitted in report format will identify the submitting Community Mental Health Services Programs by name.

2. Rights Officer: _____ Use alphanumeric characters to identify the LAST NAME of the Rights Officer

Section I: Complaint Data Summary

Part A: Totals

Total		
2	Complaints Received	
4	Allegations Involved	
5	Allegations Investigated	

Part B: Aggregate Summary

1. Freedom from Abuse

	Code	Category	Received	Investigation	Intervention	Substantiated
6.	7221	Class I				
7.	7222	Class II				
8.	7223	Class III				
9.	7224	Sexual Abuse				

2. Freedom from Neglect

	Code	Category	Received	Investigation	Intervention	Substantiated
10.	7225	Class I				
11.	7226	Class II				
12.	7227	Class III				

3. Rights Protection System

	Code	Category	Received	Investigation	Intervention	Substantiated
13.	7760	Access to Rights System				
14.	7780	Retaliation/Harassment				
15.	7545	Notice/Explanation of Rights				
16.	7060	Complaint Investigation Process				
17.	7840	Appeals Process				
18.	7880	Mediation				
19.	7520	Failure to Report				
20.	0772	Other				

4. Admission/Discharge/Second Opinion

	Code	Category	Received	Investigation	Intervention	Substantiated
21.	7050	Second Opinion-Denial of Services				
22.	4090	Second Opinion-Denial of Hospitalization				
23.	4980	Objection to Hospitalization (minor)				
24.	4190	Termination of Voluntary Hospitalization (adult)				
25.	4630	Independent Clinical Examination				
26.	4510	Court Hearing/Process				
27.	0400	Other				

5. Civil Rights

	Code	Category	Received	Investigation	Intervention	Substantiated
28.	7040	Dignity & Respect				
29.	7041	Discrimination				
30.	7042	Accommodation				
31.	7043	Privacy/Search				
32.	7044	Religious Practice				
33.	7045	Voting				
34.	7046	Sexual Expression				
35.	7047	Presumption of Competency				
36.	7048	Marriage/Divorce				
37.	0704	Other				

6. Family Rights

	Code	Category	Received	Investigation	Intervention	Substantiated
38.	7111	Dignity & Respect				
39.	7112	Receipt of General Education Information				
40.	7113	Opportunity to provide information				

7. Communication and Visits

	Code	Category	Received	Investigation	Intervention	Substantiated
41.	7261	Visitation				
42.	7262	Contact with Attorneys or others regarding legal matters				
43.	7263	Access to telephone				
44.	7264	Funds for postage, stationery, telephone usage				
45.	7265	Written and posted limitations, if established				
46.	7266	Uncensored Mail				
47.	7267	Access to entertainment materials, information, news				
48.	0726	Other				

8. Confidentiality/Privileged Communications/Disclosure

	Code	Category	Received	Investigation	Intervention	Substantiated
49.	7481	Access to Record				
50.	7482	Copies of Record Information				
51.	7483	Identification				
52.	7484	Authorization to Release				
53.	7485	Withholding of Information				
54.	7486	Correction of Record				
55.	7487	Access by P & A to record				
56.	7501	Privileged Communication				
57.	0748	Other				

9. Treatment Environment

	Code	Category	Received	Investigation	Intervention	Substantiated
58.	7081	Safe				
59.	7082	Sanitary				
60.	7083	Humane				
61.	7084	Accessible				
62.	7085	Nutrition				
63.	7086	Least Restrictive Setting				
64.	0708	Other				

10. Freedom of Movement

	Code	Category	Received	Investigation	Intervention	Substantiated
65.	7400	Restraint				
66.	7420	Seclusion				
67.	7441	Building and grounds Access				
68.	7442	Limitations				
69.	0744	Other				

11. Financial Rights

	Code	Category	Received	Investigation	Intervention	Substantiated
70.	7301	Safeguarding Money				
71.	7302	Facility Account				
72.	7303	Easy Access to Money in Account				
73.	7304	Ability to Spend or Use as Desired				
74.	7305	Delivery of Money upon Release				
75.	7360	Labor & Compensation				
76.	0730	Other				

12. Personal Property

	Code	Category	Received	Investigation	Intervention	Substantiated
77.	7281	Possession and Use				
78.	7282	Storage Space				
79.	7283	Inspection at Reasonable Times				
80.	7284	Search/Seizure				
81.	7285	Exclusions				
82.	7286	Limitations				
83.	7287	Receipt to recipient and designated individual				
84.	7288	Waiver				
85.	7289	Protection				
86.	0728	Other				

13. Suitable Services

	Code	Category	Received	Investigation	Intervention	Substantiated
87.	7080	Treatment suited to condition				
88.	7049	Treatment by spiritual means				
89.	7100	Physical and mental exams				
90.	7140	Notice of clinical status/progress				
91.	7130	Choice of physician/mental health professional				
92.	7150	Services of mental health professional				
93.	7003	Informed Consent				
94.	7170	ET				
95.	7160	Surgery				
96.	7158	Medication				
97.	7190	Notice of medication side effects				
98.	7180	Psycho tropic Drugs				
99.	7029	Information on Family Planning				
100.	0700	Other				

14. Treatment Planning

	Code	Category	Received	Investigation	Intervention	Substantiated
101.	7121	Person-centered Process				
102.	7122	Timely development				
103.	7123	Request for Review				
104.	7124	Participation by Individual(s) of choice				
105.	7125	Assessment of Needs				
106.	0712	Other				

15. Photographs, Fingerprints, Audiotapes, One-Way Glass

	Code	Category	Received	Investigation	Intervention	Substantiated
107.	7241	Prior Consent				
108.	7242	Identification				
109.	7243	Objection				
110.	7244	Release to others/return				
111.	7245	Storage/destruction				
112.	7246	Treatment				

5. Forensic Issues

	Code	Category	Received	Investigation	Intervention	Substantiated

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113.	2021	I.S.T.				
114.	2022	N.G.R.I.				
115.	2000	Other				

MDCH/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT:
ATTACHMENT C.6.5.5.1, 10/1/06

NOTE: SECTIONS II, III, IV ARE REQUIRED TO BE COMPLETED FOR THE ANNUAL REPORT ONLY AND ARE TO BE SENT ON A WORD PROCESSING FILE TO THE OFFICE OF RECIPIENT RIGHTS, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, MICHIGAN DEPARTMENT OF COMMUNITY HEALTH BY DECEMBER 30, 1999 & 2000.

Section II: Training Activity

Part A: Training Received by Rights Office Staff

Indicate, for each rights staff, the kind of training received during the period and the number of hours for each.

Part B: Training provided by Rights Office

Indicate the kind of training provided during the period, the number of hours for each, the number of CMH or Hospital Staff involved, the number of contractual staff involved, and/ or the number and type of other staff involved.

Section III: Desired Outcomes for the Office

List the outcomes establish for the office during the next fiscal year.

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

List any recommendations made to the governing Board regarding the rights office or recipient rights activity as part of the annual report.

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