MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
FY18 REPORTING REQUIREMENTS
Effective 10/1/17

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MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
FY18 REPORTING REQUIREMENTS
Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2018 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are
- "Supplemental Instructions for Encounter and Quality Improvement Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter and quality improvement (demographic) data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- Mental Health Code list that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDHHS and EDIT have assigned to them.
- Cost per code instructions that contain instructions on use of modifiers; the acceptable activities that may be reflected in the cost of each procedure; and whether an activity needs to be face-to-face in order to count.
- "Establishing Managed Care Administrative Costs" that provides instructions on what managed care functions should be included in the allocation of expenditures to managed care administration
- "Michigan's Mission-Based Performance Indicator System, Version 6.0" is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators

These documents are posted on the MDHHS web site and are periodically updated when federal or state requirements change, or when in consultation with representatives of the public mental health system it deemed necessary to make corrections or clarifications. Question and answer documents are also produced from time to time and posted on the web site.

Collection of each element contained in the master contract attachment is required. Data reporting must be received by 5 p.m. on the due dates (where applicable) in the acceptable format(s) and by the MDHHS staff identified in the instructions. Failure to meet this standard will result in contract action.

The reporting of the data by PIHPs described within these requirements meets several purposes at MDHHS including:

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

- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- Actuarial activities

Individual consumer level data received at MDHHS is kept confidential and published reports will display only aggregate data. Only a limited number of MDHHS staff members have access to the database that contains social security numbers, income level, and diagnosis, for example. Individual level data will be provided back to the agency that submitted the data for encounter data validation and improvement. This sharing of individual level data is permitted under the HIPAA Privacy Rules, Health Care Operations.

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

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

Submit completed reports electronically (Excel or Word) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov except for reports noted in table below.

Due Date	Report Title	Report Period
1/31/2018	1Q Special Fund Account – Section 226a, PA of the MHC	October 1 to December 31
4/30/2018	2Q Special Fund Account – Section 226a, PA of the MHC	October 1 to March 31
5/31/2018	Mid-Year Status Report	October 1 to March 31
6/30/2018	Semi-annual Recipient Rights Data Report	October 1 to March 31. Section I only. See section "Recipient Rights Data Report" for additional information in this attachment.
8/15/2018	3Q Special Fund Account – Section 226a, PA of the MHC	October 1 to June 30
8/15/2018	Projection Financial Status Report – All Non-Medicaid,	October 1 to September 30
8/15/2018	Projection State Services Utilization, Reconciliation & Cash Analysis	October 1 to September 30
8/15/2018	Projection General Fund Contract Settlement Worksheet	October 1 to September 30
8/15/2018	Projection General Fund Reconciliation and Cash Settlement	October 1 to September 30
10/1/2018	General Fund – Year End Accrual Schedule	October 1 to September 30
FY18 Monthly	PASARR Agreement Monthly Billing	Only one (1) bill will be considered for payment per month, and should be submitted for payment to the DEPARTMENT within forty-five (45) days after the end of the month in

		which the service was provided, except for the September bill which shall be submitted within fifteen (15) days after the end of the month.
11/10/2018	Interim Financial Status Report – All Non-Medicaid,	October 1 to September 30
11/10/2018	Interim State Services Utilization, Reconciliation & Cash Analysis	October 1 to September 30
11/10/2018	Interim Special Fund Account – Section 226a, PA of the MHC	October 1 to September 30
11/10/2018	Interim General Fund Contract Settlement Worksheet	October 1 to September 30
11/10/2018	Interim General Fund Reconciliation and Cash Settlement	October 1 to September 30
11/10/2018	Categorical Funding – Multi-cultural Annual Report	October 1 to September 30
12/30/2018	Annual Recipient Rights Data Report	October 1 to September 30. Sections I, II, III & IV. See section "Recipient Rights Data Report" for additional information in this attachment.
1/31/2019	Annual Report on Fraud and Abuse Complaints	October 1 to September 30
2/28/2019	Final Financial Status Report – All Non-Medicaid	October 1 to September 30
2/28/2019	Final State Services Utilization, Reconciliation & Cash Analysis	October 1 to September 30
2/28/2019	Final Special Fund Account – Section 226a, PA of the MHC	October 1 to September 30
2/28/2019	Final General Fund Reconciliation and Cash Settlement	October 1 to September 30
2/28/2019	Final General Fund Contract Settlement Worksheet	October 1 to September 30
2/28/2019	Sub-Element Cost Report	See Attachment 6.5.1.1 Submit report to: QMPMeasures@michigan.gov
2/28/2019	Annual Submission Requirement Form – Estimated FTE Equivalents	For the fiscal year ending October 1 to September 30, 2016
2/28/2019	Annual Submission Requirement Form – Requests for Services and Disposition of Requests	For the fiscal year ending October 1 to September 30,2016
2/28/2019	Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 1	For the fiscal year ending October 1 to September 30, 2016
2/28/2019	Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 2	For the fiscal year ending October 1 to September 30, 2016
2/28/2019	Annual Submission Requirement Form – Waiting List	For the fiscal year ending October 1 to September 30, 2016
2/28/2019	Annual Submission Requirement Form – Specialized Residential	For the fiscal year ending October 1 to September 30, 2016
2/28/2019	Annual Submission Requirement Form – Community Needs Assessment	For the fiscal year ending October 1 to September 30, 2016
2/28/2019	CMHSP Administrative Cost Report	For the fiscal year ending October 1 to September 30, 2016

2/28/2019	Executive Administrative Expenditures Survey for Sec. 904(2)(k)	October 1 to September 30, 2017
30 days after receipt, but no later than June 30, 2018	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter. Compliance exam and plan of correction	October 1 to September 30th Submit reports to: MDHHS-AuditReports@michigan.gov

FY 2018 DATA REPORT DUE DATES

	Nov17	Dec	Jan18	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec18	Jan19
1. Consumer level** Demographic BHTEDS (monthly)[1] b. Encounter (monthly)[1]	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2.PIHP level a. Medicaid Utilization and Net Cost Report: annually)[2]				√											
b. Performance indicators (quarterly)[2]					√			√			√			√	
c. Consumer Satisfaction (annually) [2]										√					
d. CAFAS [3]												√			
e. Critical incidents (monthly)[3]															

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

**Consumer level data must be submitted immediately within 30 days following adjudication of claims for services provided, or in cases where claims are not part of the PIHP's business practices within 30 days following the end of the month in which services were delivered.

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

**BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS)
COLLECTION/RECORDING AND REPORTING REQUIREMENTS**

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at:
http://www.michigan.gov/mdhhs/0,4612,7-132-2941_38765---,00.html

Reporting covered by these specifications includes the following:

>**-BH -TEDS Start Records (due monthly)**

>**-BH-TEDS Discharge/Update/End Records (due monthly)**

A. **Basis of Data Reporting**
>The basis for data reporting policies for Michigan behavioral health includes:

>1. Federal funding awarded to Michigan through the Combined SABG/MHBG Behavioral Health federal block grant.

>2. SAMHSA's Behavioral Health Services Information Systems (BHSIS) award agreement administered through Synectics Management, Inc that awards MDHHS a contracted amount of funding if the data meet minimum timeliness, completeness and accuracy standards

>3 Legislative boilerplate annual reporting and semi-annual updates

B. **Policies and Requirements Regarding Data**
>BH-TEDS Data reporting will encompass Behavioral Health services provided to persons supported in whole or in part with MDHHS-administered funds.

Policy:
Reporting is required for all persons whose services are paid in whole or in part with state administered funds regardless of the type of co-pay or shared funding arrangement made for the services.

For purposes of MDHHS reporting, an admission, or start, is defined as the formal acceptance of a client into behavioral health services. An admission or start has occurred if and only if the person begins receiving behavioral health services.

>1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information

developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

2. All SUD data collected and recorded on BH-TEDS shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDHHS at the program level.

3. There must be a unique Person identifier assigned and reported. It must be 11 characters in length, and alphanumeric. This same number is to be used to report data for BH-TEDS and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.

4. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.

5. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDHHS.

6. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

7. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.

8. Statements of MDHHS policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

Method for submission: BH-TEDS data are to be submitted in a fixed length format, per the file specifications.

Due dates: BH-TEDS data are due monthly. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly

data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

Who to report: The PIHP must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and substance use disorders who receive services funded in whole or in part with MDHHS-administered funding. PIHPs participating in the Medicare/Medicaid integration project are not to report BH-TEDS records for beneficiaries for whom the PIHP's financial responsibility is to a non-contracted provider during the 180-day continuity of care.

PROXY MEASURES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

For FY18, the CMHSPs are required to report a limited set of data items in the Quality Improvement (QI) file for consumers with an intellectual or developmental disability. The required items and instructions are shown below. Detailed file specifications are (will be) available on the MDHHS web site.

Instructions: The following elements are proxy measures for people with developmental disabilities. The information is obtained from the individual's record and/or observation. Complete when an individual begins receiving public mental health services for the first time and update at least annually. Information can be gathered as part of the person-centered planning process.

For purposes of these data elements, when the term "support" is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- *"Limited" means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.*
- *"Moderate" means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.*
- *"Extensive" means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.*
- *"Total" means the person is unable to complete the activity and the caregiver is providing 100% support.*

Fields marked with an asterisk * cannot be blank or the file will be rejected.

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*   *Reporting Period* (**REPORTPD**)
        The last day of the month in which the consumer data is being updated. Report year, month, day: yyyymmdd.

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*   *PIHP Payer Identification Number* (**PIHPID**)

The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transmissions.

* *CMHSP Payer Identification Number* **(CMHID)**
The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all data transmissions.

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* *Consumer Unique ID* **(CONID)**
A numeric or alphanumeric code, of 11 characters that enables the consumer and related services to be identified and data to be reliably associated with the consumer across all of the PIHP's services. The identifier should be established at the PIHP level so agency level or sub-program level services can be aggregated across all program services for the individual. The consumer's unique ID must not be changed once established since it is used to track individuals, and to link to their encounter data over time. **A single shared unique identifier must match the identifier used in 837 encounter for each consumer.**

Social Security Number **(SSNO)**
The nine-digit integer must be recorded, if available.
Blank = Unreported [Leave nine blanks]

Medicaid ID Number **(MCIDNO)**
Enter the ten-digit integer for consumers with a Medicaid number.
Blank = Unreported [Leave ten blanks]

MIChild Number (CIN)
Blank = Unreported [Leave ten blanks]

Gender (GENDER)
Identify consumer as male or female.
   M = Male
   F = Female

Date of birth **(DOB)**
Date of Birth - Year, month, and day of birth must be recorded in that order. Report in a string of eight characters, no punctuation: YYYYMMDD using leading zeros for days and months when the number is less than 10. For example, January 1, 1945 would be reported as 19450101.

Predominant Communication Style (People with developmental disabilities only)
(COMTYPE) 95% completeness and accuracy required

Indicate from the list below how the individual communicates **most of the time**:
1 = English language spoken by the individual
2 = Assistive technology used (includes computer, other electronic devices) or symbols such as Bliss board, or other "low tech" communication devices.
3 = Interpreter used - this includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.
4 = Alternative language used - this includes a foreign language, or sign language without an interpreter.
5 = Non-language forms of communication used – gestures, vocalizations or behavior.
6 = No ability to communicate
Blank = Missing

Ability to Make Self Understood (People with developmental disabilities only) **(EXPRESS)** **95% completeness and accuracy required.**

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff
1 = Always Understood – Expresses self without difficulty
2 = Usually Understood – Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
3 = Often Understood – Difficulty communicating AND prompting usually required
4 = Sometimes Understood - Ability is limited to making concrete requests or understood only by a very limited number of people
5 = Rarely or Never Understood – Understanding is limited to interpretation of very person-specific sounds or body language
Blank = Missing

Support with Mobility (People with developmental disabilities only) **(MOBILITY) 95% completeness and accuracy required**

1 = Independent - Able to walk (with or without an assistive device) or propel wheelchair and move about
2 = Guidance/Limited Support - Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support.
3 = Moderate Support - May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed
4 = Extensive Support - Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed
5 = Total Support - Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day
Blank = Missing

Mode of Nutritional Intake (People with developmental disabilities only) **(INTAKE) 95% completeness and accuracy required**

1 = Normal – Swallows all types of foods
2 = Modified independent – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
3 = Requires diet modification to swallow solid food – e.g., mechanical diet (e.g., purée, minced) or only able to ingest specific foods
4 = Requires modification to swallow liquids – e.g., thickened liquids
5 = Can swallow only puréed solids AND thickened liquids
6 = Combined oral and parenteral or tube feeding
7 = Enteral feeding into stomach – e.g., G-tube or PEG tube
8 = Enteral feeding into jejunem – e.g., J–tube or PEG-J tube
9 = Parenteral feeding only—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
Blank = Missing

Support with Personal Care (People with developmental disabilities only) (**PERSONAL**) 95% completeness and accuracy required.

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score a "2" to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

1 = Independent - Able to complete all personal care tasks without physical support
2 = Guidance/Limited Support - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity
3 = Moderate Physical Support - Able to perform personal care tasks with moderate support of another person
4 = Extensive Support - Able to perform personal care tasks with extensive support of another person
5 = Total Support – Requires full support of another person to complete personal care tasks (unable to participate in tasks)
Blank = Missing

Relationships (People with developmental disabilities only) (**RELATION**) 95% completeness and accuracy required

Indicate whether or not the individual has "natural supports" defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.
1 = Extensive involvement, such as daily emotional support/companionship
2 = Moderate involvement, such as several times a month up to several times a week
3 = Limited involvement, such as intermittent or up to once a month
4 = Involved in planning or decision-making, but does not provide emotional support/companionship

5 = No involvement
Blank = Missing

Status of Family/Friend Support System (People with developmental disabilities only)
(SUPPSYS) 95% completeness and accuracy required

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.
1 = Care giver status is not at risk
2 = Care giver is likely to reduce current level of help provided
3 = Care giver is likely to cease providing help altogether
4 = Family/friends do not currently provide care
5 = Information unavailable
Blank = Missing

Support for Accommodating Challenging Behaviors (People with developmental disabilities only) **(BEHAV) 95% completeness and accuracy required**

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging behaviors" include those that are self-injurious, or place others at risk of harm.   (Support includes direct line of sight supervision)
1 = No challenging behaviors, or no support needed
2 = Limited Support, such as support up to once a month
3 = Moderate Support, such as support once a week
4 = Extensive Support, such as support several times a week
5 = Total Support – Intermittent, such as support once or twice a day
6 = Total Support – Continuous, such as full-time support
Blank = Missing

Presence of a Behavior Plan (People with developmental disabilities only) **(PLAN) 95% accuracy and completeness required**

Indicate the presence of a behavior plan during the past 12 months.
1 = No Behavior Plan
2 = Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
3 = Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
Blank = Missing

Use of Psychotropic Medications (People with developmental disabilities only) **95% accuracy and completeness required**

Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of "anti-psychotic" and "other

psychotropic" and a list of the most common medications.

51.1:   Number of Anti-Psychotic Medications **(AP)** ___
         Blank = Missing
51.2:   Number of Other Psychotropic Medications **(OTHPSYCH)** ___
         Blank = Missing

Major Mental Illness (MMI) Diagnosis (People with developmental disabilities only) **95% accuracy and completeness required**

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each "x" in the codes.

1 = One or more MMI diagnosis present
2 = No MMI diagnosis present
Blank = Missing

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

Purpose: In the past basic consumer information from the QI (MH) and TEDS (SUD) files were sent to CHAMPS to be used as a validation that the consumer being reported in the Encounters is a valid consumer for the reporting PIHP. With QI eventually being phased out during FY16 and TEDS ending on 9/30/2015, BHTEDS will be replacing them both beginning 10/1/2015. To use BHTEDS to create the CHAMPS validation file would be difficult as there would be three different types of records – mental health, substance use disorder and co-occurring.

Requirement: To simplify the process of creating this validation file, BHDDA is introducing a new file called the Behavioral Health Registry file. For this file, PIHPs are required to report five fields of data with only three being required. The required fields are: PIHP Submitter ID, Consumer ID and Begin Date (date less than or equal to first Date of Service reported in Encounters.) The following two fields will only be reported if the consumer has either: Medicaid ID and MIChild ID.

The file specifications and error logic for the Registry are (will be) available on the MDHHS web site at: http://www.michigan.gov/mdhhs/0,4612,7-132-2941_38765---,00.html Submissions of the BH Registry file by CHAMPS will be ready by 10/1/2015.

Data Record

Record Format: rc1041.06									
Element #	**Data Element Name**	**Picture**	**Usage**	**Format**	**From**	**To**	**Validated**	**Required**	**Definition**
1	Submitter ID	Char(4)	4		1	4	Yes	Yes	Service Bureau ID (DEG Mailbox ID)
2	Consumer ID	Char(11)	11		5	15	No	Yes	Unique Consumer ID
3	Medicaid ID	Char(10)	10		16	25	Yes	Conditional	Must present on file if available.
4	MIChild ID	Char(10)	10		26	35	Yes	Conditional	MICHILD ID [CIN] Must present on file if available.
5	Begin Date	Date	8	YYYYMMDD	36	43	Yes	Yes	

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE ABUSE BENEFICIARY
DATA REPORT

Due dates: Encounter data are due within 30 days following adjudication of the claim for the service provided, or in the case of a PIHP whose business practices do not include claims payment, within 30 days following the end of the month in which services were delivered. It is expected that encounter data reported will reflect services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the PIHP. Submit the encounter data for an individual on any claims adjudicated, regardless of whether there are still other claims outstanding for the individual for the month in which service was provided. In order that the department can use the encounter data for its federal and state reporting, it must have the count of units of service provided to each consumer during the fiscal year. Therefore, the encounter data for the fiscal year must be reconciled within 90 days of the end of the fiscal year. Claims for the fiscal year that are not yet adjudicated by the end of that period, should be reported as encounters with a monetary amount of "0." Once claims have been adjudicated, a replacement encounter must be submitted.

Who to Report: The CMHSP must report the encounter data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area for all services provided under MDHHS benefit plans. The PIHP must report the encounter data for all substance use disorder Medicaid beneficiaries in its service area. Encounter data is collected and reported for every beneficiary for which a claim was adjudicated or service rendered during the month by the PIHP (directly or via contract) regardless of payment source or funding stream. PIHP's and CMHSPs that contract with another PIHP or CMHSP to provide mental health services should include that consumer in the encounter data set. In those cases the PIHP or CMHSP that provides the service via a contract should not report the consumer in this data set. Likewise, PIHPs or CMHSPs that contract directly with a Medicaid Health Plan, or sub-contract via another entity that contracts with a Medicaid Health Plan to provide the Medicaid mental health outpatient benefit, should not report the consumer in this data set.

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all consumer level data reported after October 16, 2002 must be compliant with the transaction standards. A summary of the relevant requirements is:

- Encounter data (service use) is to be submitted electronically on a Health Care Claim 5010 as appropriate.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.

- The 837includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
- Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

The information on HIPAA contained in this contract relates only to the data that MDHHS is requiring for its own monitoring and/or reporting purposes, and does not address all aspects of the HIPAA transaction standards with which PIHPs must comply for other business partners (e.g., providers submitting claims, or third party payers). Further information is available at www.michigan.gov/MDHHS.

Data that is uploaded to CHAMPS must follow the HIPAA-prescribed formats for encounter data. The 837/5010 includes header and trailer information that identifies the sender and receiver and the type of information being submitted. If data does not follow the formats, entire files could be rejected by the electronic system.

HIPAA also requires that procedure codes, revenue codes and modifiers approved by the CMS be used for reporting encounters. Those codes are found in the Current Procedural Terminology (CPT) Manual, Fifth Edition, published by the American Medical Associations, the Health Care Financing Administration Common Procedure Coding System (HCPCS), the National Drug Codes (NDC), the Code on Dental Procedures and Nomenclature (CDPN), the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), ICD-10 and the Michigan Uniform Billing Manual. The procedure codes in these coding systems require standard units that must be used in reporting on the 837/5010.

MDHHS has produced a code list of covered Medicaid specialty and Habilitation Supports waiver supports and services names (as found in the Medicaid Provider Manual) and the CPT or HCPCS codes/service definition/units as soon as the majority of mental health services have been assigned CPT or HCPCS codes. This code list is available on the MDHHS web site.

The following elements reported on the 837/ 5010 encounter format will be used by MDHHS Quality Management and Planning Division for its federal and state reporting, the Contracts Management Section and the state's actuary. The items with an ** are required by HIPAA, and when they are absent will result in rejection of a file. Items with an ** must have 100% of values recorded within the acceptable range of values. Failure to meet accuracy standards on these items will result in contract action.

Refer to HIPAA 837 transaction implementation guides for exact location of the elements. Please consult the HIPAA implementation guides, and clarification documents (on MDHHS's web site) for additional elements required of all 837/5010 encounter formats. The Supplemental Instructions contain field formats and specific instructions on how to submit encounter level data.

**1.a. *PIHP Plan Identification Number* (PIHPID) or PIHP CA Function ID

The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transactions.

1.b. *CMHSP Plan Identification Number* **(CMHID)**

The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

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

Ten-digit Medicaid number must be entered for a **Medicaid, or MIChild** beneficiary.

If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.

If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID.**

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

Enter the consumer's unique identification number (**CONID**) assigned by the CMHSP **regardless** of whether it has been used above**.**

**4. *Date of birth*

Enter the date of birth of the beneficiary/consumer.

**5. *Diagnosis*

Enter the ICD-10 primary diagnosis of the consumer.

**6. *EPSDT*

Enter the specified code indicating the child was referred for specialty services by the EPSDT screening.

**7. *Encounter Data Identifier*

Enter specified code indicating this file is an encounter file.

**8. *Line Counter Assigned Number*

A number that uniquely identifies each of up to 50 service lines per claim.

**9. *Procedure Code*

Enter procedure code from code list for service/support provided. The code list is located on the MDHHS web site.

*10. *Procedure Modifier Code*

Enter modifiers as required for Habilitation Supports Waiver services provided to enrollees; for Autism Benefit services; for Community Living Supports and Personal Care levels of need; for Nursing Home Monitoring; and for evidence-based practices. See Costing per Code List.

*11. *Monetary Amount (effective 10/1/13)*:

Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

**12. *Quantity of Service*
Enter the number of units of service provided according to the unit code type. **Only whole numbers should be reported.**

13. *Place of Service Code*
Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc. (See PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes Chart at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements, then the codes chart)

14. *Diagnosis Code Pointer*
Points to the diagnosis code at the claim level that is relevant to the service.

**15. *Date Time Period*
Enter date of service provided (how this is reported depends on whether the Professional, or the Institutional format is used)

**16. *Billing Provider Name*
Enter the name of the Billing Provider for all encounters. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

**17. *Rendering Provider Name*
Enter the name of the Rendering Provider when different from the Billing Provider (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

**18. *Provider National Provider Identifier (NPI), Employer Identification Number (EIN) or Social Security Number (SSN)*
Enter the appropriate identification number for the Billing Provider, and as applicable, the Rendering Provider. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

FY'17 SUB-ELEMENT COST REPORT

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

Instructions and reporting templates can be found at:

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

FY17 CMHSP GENERAL FUND COST REPORT

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

Instructions and reporting templates can be found at:

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

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM
VERSION 6.0
FOR CMHSPS

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

- To clearly delineate the dimensions of quality that must be addressed by the Public Mental Health System as reflected in the Mission statements from <u>Delivering the Promise</u> and the needs and concerns expressed by consumers and the citizens of Michigan. Those domains are: ACCESS, EFFICIENCY, and OUTCOME.
- To develop a state-wide aggregate status report to address issues of public accountability for the public mental health system (including appropriation boilerplate requirements of the legislature, legal commitments under the Michigan Mental Health Code, etc.)
- To provide a data-based mechanism to assist MDHHS in the management of CMHSP contracts that would impact the quality of the service delivery system statewide.
- To the extent possible, facilitate the development and implementation of local quality improvement systems; and
- To link with existing health care planning efforts and to establish a foundation for future quality improvement monitoring within a managed health care system for the consumers of public mental health services in the state of Michigan.

All of the indicators here are measures of CMHSP performance. Therefore, performance indicators should be reported by the CMHSP for all the Medicaid beneficiaries for whom it is responsible. Medicaid beneficiaries who are not receiving specialty services and supports (1915(b)(c) waivers) but are provided outpatient services through contracts with Medicaid Health Plans, or sub-contracts with entities that contract with Medicaid Health Plans are not covered by the performance indicator requirements. Due dates for indicators vary and can be found on the table following the list of indicators. Instructions and reporting tables are located in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by MDHHS six weeks prior to the due date and also available on the MDHHS website: www.michigan.gov/MDHHS. Click on Mental Health and Substance Abuse, then Reporting Requirements.

CMHSP PERFORMANCE INDICATOR SYSTEM

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

ACCESS

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

2. The percent of new persons receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, and DD children).
   - a. Standard = 95% in 14 days
   - b. Quarterly report
   - c. PIHP for all Medicaid beneficiaries
   - d. CMHSP for all consumers
   - e. Scope: MI adults, MI children, DD adults, DD children, and Medicaid SA

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults and DD children)
   - a. Standard = 95% in 14 days
   - b. Quarterly report
   - c. PIHP for all Medicaid beneficiaries
   - d. CMHSP for all consumers
   - e. Scope: MI adults, MI children, DD adults, DD children, and Medicaid SA

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults -MI, DD).
   - a. Standard = 95%
   - b. Quarterly report
   - c. PIHP for all Medicaid beneficiaries
   - d. CMHSP for all consumers
   Scope: All children and all adults (MI, DD) - Do not include dual eligibles (Medicare/Medicaid) in these counts.

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

22

6. The percent of Section 705 second opinions that result in services. (MI and DD) (Old Indicator #7)
>   a. Quarterly report
>   b. CMHSP
>   c. Scope: all MI/DD consumers

EFFICIENCY

*7. The percent of total expenditures spent on administrative functions for CMHSPs. (Old Indicator #9)
>   a. Annual report (MDHHS calculates from cost reports)
>   b. PIHP for Medicaid administrative expenditures
>   c. CMHSP for all administrative expenditures

OUTCOMES

*8. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by CMHSP who are in competitive employment. (Old Indicator #10)
>   a. Annual report (MDHHS calculates from QI data)
>   b. PIHP for Medicaid adult beneficiaries
>   c. CMHSP for all adults
>   d. Scope: MI only, DD only, dual MI/DD consumers

*9. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop). (Old Indicator #11)
>   a. Annual report (MDHHS calculates from QI data)
>   b. PIHP for Medicaid adult beneficiaries
>   c. CMHSP for all adults
>   d. Scope: MI only, DD only, dual MI/DD consumers

10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge**.** (Old Indicator #12)
>   a. Standard = 15% or less within 30 days
>   b. Quarterly report
>   c. PIHP for all Medicaid beneficiaries
>   c. CMHSP
>   d. Scope: All MI and DD children and adults - Do not include dual eligibles (Medicare/Medicaid) in these counts.

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

*13. The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).
        a. Annual report (MDHHS calculates from QI data)
        b. PIHP for Medicaid beneficiaries
        c. CMHSP for all adults
        d. Scope: DD adults only

*14. The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).
        a. Annual report (MDHHS calculates from QI data)
        b. PIHP for Medicaid beneficiaries
        c. CMHSP for all adults
        d. Scope: DD adults only

CMHSP PERFORMANCE INDICATOR REPORTING DUE DATES
FY 2018 Due Dates

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screening	10/01 to 12/31	3/31/18	1/01 to 3/31	6/30/18	4/01 to 6/30	9/30/18	7/01 to 9/30	12/31/18	CMHSPs
2. 1st request	10/01 to 12/31	3/31/18	1/01 to 3/31	6/30/18	4/01 to 6/30	9/30/18	7/01 to 9/30	12/31/18	CMHSPs
3. 1st service	10/01 to 12/31	3/31/18	1/01 to 3/31	6/30/18	4/01 to 6/30	9/30/18	7/01 to 9/30	12/31/18	CMHSPs
4. Follow-up	10/01 to 12/31	3/31/18	1/01 to 3/31	6/30/18	4/01 to 6/30	9/30/18	7/01 to 9/30	12/31/18	CMHSPs
5. Denials	10/01 to 12/31	3/31/18	1/01 to 3/31	6/30/18	4/01 to 6/30	9/30/18	7/01 to 9/30	12/31/18	CMHSPs
6. 2nd Opinions	10/01 to 12/31	3/31/18	1/01to 3/31	6/30/18	4/01 to 6/30	9/30/18	7/01 to 9/30	12/31/18	CMHSPs
7. Admin Costs*	10/01 to 9/30	2/27/19							CMHSPs
8. Competitive employment*	10/01 to 9/30	N/A							MDHHS
9. Minimum wage*	10/01 to 9/30	N/A							MDHHS
10. Readmissions	10/01 to 12/31	3/31/18	1/01 to 3/31	6/30/18	4-01 to 6-30	9/30/18	7/01 to 9/30	12/31/18	CMHSPs
11. RR complaints	10/01 to 9/30	12/31/18							CMHSPs
13. Residence (DD)*	10/01 to 9/30	N/A							MDHHS
14. Residence (MI)*	10/01 to 9/30	N/A							MDHHS

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

STATE LEVEL DATA COLLECTION

CAFAS

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

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

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

DECA

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

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

Consumer Satisfaction Survey: Adults with Serious Mental Illness & Children with Serious Emotional Disturbance

-An annual survey using MHSIP 44 items for adults with MI and substance use disorder, and MHSIP Youth and Family survey for families of children with SED will be conducted. Surveys are available on the MHSIP web site and have been translated into several languages. See www.mhsip.org/surveylink.htm

-The PIHPs will conduct the survey in the month of May for all people (regardless of medical assistance eligibility) currently receiving services in specific programs.

-Programs to be selected annually by QIC based on volume of units, expenditures, complaints and site review information.

-The raw data is due August 31st to MDHHS each year on an Excel template to be provided by MDHHS.

Critical Incident Reporting

PIHPs will report the following events, except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on consumer ID, event date, and event type:

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

- **Non-suicide death** for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.

- **Emergency Medical treatment due to Injury or Medication Error** for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.

- **Hospitalization due to Injury or Medication Error** for individuals who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

- **Arrest of Consumer** for individuals who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

   Methodology and instructions for reporting are posted on the MDHHS web site at www.michigan.gov/MDHHS. Click on Mental Health and Substance Abuse, then "Reporting Requirements"

RECIPIENT RIGHTS DATA REPORT

INSTRUCTIONS FOR COMPLETING THE RECIPIENT RIGHTS DATA REPORT

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

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

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

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

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

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

Staffing Information:

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

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

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

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

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

Appeal Information

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

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

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

Complaint Data:

Section 1: Complaint Data Summary

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

Part A: Totals

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

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

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

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

Part B: Aggregate Summary of Allegations by Category
For each sub-category, insert the following:
-
- Number of allegations involved
- Number of these in which some **intervention **** was conducted
- Number of allegations substantiated by investigation.
- Number of these **investigated ***
- Number of allegations substantiated by intervention.
In each subcategory: If "0", enter 0 in ALL appropriate boxes of the row where an allegation is received

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

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

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

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

Part C: Remediation of Substantiated Rights Violations:

For each allegation, which, through investigation **or intervention,** it was established that a recipient's right was violated indicate (from the drop down):
- The category name
- The Specific Provider type (see table)
- The Specific remedial action taken (be sure to list 1 action per column)
- The number of the type of population

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

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

SEDW

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

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

HSW

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

THE FOLLOWING SECTION IS REQUIRED FOR THE ANNUAL REPORT ONLY

Section II: Training Activity

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

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

Part B: Training Provided by Rights Office
Indicate if update training is required. If it is required, indicate how often.
Indicate the name of the training provided during the period, the length of the session, the number of

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

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

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

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

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

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

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

General Information:

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

REPORT DATES:

Semi-Annual	**Annual**
October 1 through March 31	October 1 through September 30
Section I	Section, I, II, III, IV
Cover letter from Rights Office	Cover Letter from Executive Director or
Hospital	Director

To "the department" & Advisory Committee

To "the department" & Board of CMHSP or governing board of licensed hospital

Due at MDHHS: June 30

Due at MDHHS: December 30