Amendment No. 1 to the Agreement Between  
Michigan Department of Health & Human Services  
And  
CMHSP: ______________________________  
For  
Managed Mental Health Supports and Services

1. **Period of Agreement:** This agreement shall commence on October 1, 2017 and continue through September 30, 2018.

2. **Period of Amendment:** October 1, 2017 through September 30, 2018.

3. **Program Budget and Agreement Amount:** Payment to the CMHSP will be paid based on the total funding available for managed mental health supports and services as identified in the annual Legislative Appropriation for community mental health services programs for the period of October 1, 2017 through September 30, 2018. The estimated value of this contingent upon and subject to enactment of legislative appropriations and availability of funds.

4. **Amendment Purpose:** This amendment is for changes to the following:
   - Contract attachment C6.3.2.1 CMHSP Local Dispute Resolution Process
   - Contract attachment C6.3.2.3A TR for Continuing Education Requirements for RR Staff
   - Contract attachment C6.3.2.3B TR for RR Course Content Requirements for CMHSP and Provider Staff
   - Contract attachment C6.3.2.4 TR for RR Rights Process
   - Contract attachment C6.5.1.1 CMHSP Reporting Requirements to include revised Annual Submission fiscal year dates, add DD and MH as required fields in the DD proxy measurement files, LARA license is required on the 837 for specialized licensed facilities and a revised RR data reporting process
   - Contract attachment C6.8.3.1 TR for Behavior Treatment Plan Review

5. **Original Agreement Conditions:** It is understood and agreed that all other conditions of the original agreement remain the same.

6. **Special Certification**
The individual or officer signing this amendment certifies by his or her signature that he or she is authorized to sign this amendment on behalf of the responsible governing board, official or contractor.

**Signature Section**

For the Michigan Department of Health and Human Services

Christine H. Sanches, Director  
Bureau of Budget and Purchasing  
Date

For the CONTRACTOR:

Name (print)  
Title (print)  
Signature  
Date

V-2018-1
CMHSP LOCAL DISPUTE RESOLUTION PROCESS

I. SUMMARY BACKGROUND

All consumers have the right to a fair and efficient process for resolving local disputes and complaints regarding their services and supports managed and/or delivered by Community Mental Health Services Programs (CMHSPs) and their provider networks. A consumer of or applicant for public mental health services may access several options to pursue the resolution of local disputes and complaints. These options are defined through the Recipient Rights requirements referenced in the Michigan Mental Health Code (hereafter referred to as the Code) for all recipients of public mental health services, and the MDHHS/CMHSP contract. [Additional options for Medicaid beneficiaries are explained in the Appeal and Grievance Technical Requirement located in Attachment P6.3.1.1 of the MDHHS contracts with the Pre-paid Inpatient Health Plans (PIHPs).] It is important to note that a consumer receiving mental health services and supports may pursue his/her dispute through the local appeals or grievance processes described below in this attachment or the consumer may pursue his/her complaint through the Recipient Rights process referenced in the next paragraph. The intent here would be to not duplicate processes.
I. **Background/Regulatory Overview**

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

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

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

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

II. **Definitions**

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

B. **Category I Credits: Operations**
   This category includes programs that support and enhance the fundamental scope of responsibilities and effective work of recipient rights staff. These may be directly related to prevention, complaint resolution, and monitoring and education that support the fundamental scope of a Rights Office’s operations.
Examples include:
- Rights Office Operations Techniques
- Enhancing Investigative Skills
- Inpatient Rights
- Out-of-catchment rights protection
- Writing effective rights-related contract language
- Conducting effective site visits
- How to protect rights in a dual rights protection system

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

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

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

F. CMHSP: Community Mental Health Services Program

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

I. LPH/U: Licensed Private Hospital/Unit

III. Standards

A. Basic Requirements
All staff of the Department, a community mental health services program (CMHSP), or a licensed private Hospital (LPH/U), employed for the purpose of providing recipient rights services shall, within the first 90 days of employment, attend, and successfully complete, the Basic Skills Training curriculum as determined by the Michigan Department of Health and Human Services Office of Recipient Rights. The Basic Skills curriculum shall consist of the following classes:

- Basic Skills – Part 1
  The first part of the mandatory training, this course is designed to provide participants with the knowledge of the laws required to carry out the mandates of the Mental Health Code and the activities necessary to operate an ORR office in compliance with applicable laws, rules, and standards.
- Basic Skills – Part 2
  The second part of the mandatory training, this course is designed to provide participants with the skills related to investigation, report writing and processing, that are needed to carry out the requirements of the Michigan Mental Health Code.

B. Continuing Education Requirements

1. All staff employed or contracted to provide recipient rights services shall receive education and training oriented toward maintenance, improvement or enhancement of the skills required to effectively perform the functions as rights staff.
2. A minimum of 36 contact hours of education or training shall be required over a three (3) year period subsequent to the completion of the Basic Skills requirements, and in every three (3) year period thereafter.
3. The 36 contact hours obtained must be in rights-related activities and must fall within one or more of the categories identified in the definitions above.
4. A minimum of 12 contact hours must be obtained in programs classified as Category I or II.
5. No more than 12 credits in a 3 year period may be earned through the use of online learning resources.
6. CEU’s may be received by attending programs or conferences developed by the Department, other rights-related organizations, organizations that have applied to the Office of Recipient Rights Education, Training and Compliance Unit for approval of their programs or through online training.
7. Rights staff may request approval for other educational programs by utilizing the established approval process described within this document.
8. Recipient rights staff should retain documentation of meeting the CEU requirements for a period of four (4) years from the date of attendance. It is suggested that the following information be kept on file:
   a. The title of the course or program and any identification number assigned to it by the MDHHS ORR Education, Training, and Compliance Unit.
   b. The number of CEU hours completed.
   c. The provider's name.
   d. Verification of attendance by the provider.
   e. The date and location of the course.

9. Reviews will be conducted by the MDHHS Office of Recipient Rights staff at each assessment of a recipient rights program to determine if all rights staff have met both the basic and continuing education requirements.

10. CMHSPs who contract with Licensed Private Hospitals/Units shall mandate compliance with the standards in this Technical Requirement by the Recipient Rights Office staff of those entities.

C. Procedures for Training approval

1. Training that is automatically approved for CEU credits:
   a) MDHHS ORR training excluding Basic Skills
   b) All sessions at the MDHHS-ORR Annual Conference, including the Pre-Conference session
   c) Training provided by, or sponsored by, MDHHS Office of Recipient Rights

2. Training that may be approved for CEU credits, if meeting the criteria above and with the submission of the necessary documents by the applicant:
   a) ROAM sponsored training
   b) CMH/LPH/U sponsored training
   c) Training provided by other agencies, entities, or professionals, accreditation bodies, risk management, corporation counsel/lawyer, etc.
   d) Training provided to the Rights Officer/Advisor for their profession’s licensure.
   e) Other training in the community at large, including on-line training, if requirements as detailed above are met.

3. CEU Documentation and Notification
   a) Application
      To apply for CEU credits for a training, complete the MDHHS ORR Continuing Education Course Summary (Exhibit A) form and send by email, mail or FAX, within 30 calendar days of the event to:

      MDHHS ORR Education, Training, and Compliance Unit
      18471 Haggerty Road
b) Verification of attendance.
   Attendance can be verified through provision of a Certificate of Attendance, copies of a training record, copy of an attendance/sign in sheet, a copy of the training agenda or outline with a self-attestation statement that the applicant did attend the training. Verification of attendance shall be kept on file with the applicant and be readily available for review by MDHHS-ORR, if requested.

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

d) Application Review, Approval and Appeal
   Applications from organizations outside the Department, or applications from individuals who have attended, or plan to attend, training programs shall be reviewed and approved or rejected by the Continuing Education Committee. If an application is rejected by the Continuing Education Committee it may be appealed to the director of the Office of Recipient Rights. The decision of the Director of ORR is the final MDHHS position on the application.
Exhibit A: APPLICATION FOR RECIPIENT RIGHTS CEU CREDIT

OFFICE OF RECIPIENT RIGHTS
APPLICATION FOR RECIPIENT RIGHTS CEU CREDIT

<table>
<thead>
<tr>
<th>APPLICANT (ORGANIZATION OR INDIVIDUAL)</th>
<th>EMAIL:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHONE:</td>
</tr>
<tr>
<td></td>
<td>ADDRESS:</td>
</tr>
<tr>
<td></td>
<td>CITY/ZIP:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COURSE DATE</th>
<th>COURSE TITLE</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COURSE PRESENTER</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COURSE DESCRIPTION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COURSE OBJECTIVES</th>
<th>Description of Learning Objectives</th>
<th>Class Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requested Category</th>
<th>Category I Operations</th>
<th>Category II Legal Foundations</th>
<th>Category III Leadership</th>
<th>Category IV Augmented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Category I Operations</td>
<td>Category II Legal Foundations</td>
<td>Category III Leadership</td>
<td>Category IV Augmented</td>
</tr>
</tbody>
</table>

Describe how the content relates to Rights?

Please attach a detailed agenda.
Technical Requirement
Recipient Rights Training Standards Requirements for CMH and Provider Staff

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

Authority
330.1753 Recipient rights system; review by department.
The department shall review the recipient rights system of each community mental health services program in accordance with standards established under section 232a, to ensure a uniformly high standard of recipient rights protection throughout the state. For purposes of certification review, the department shall have access to all information pertaining to the rights protections system of the community mental health services program.

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

330.1755 Office of recipient rights; establishment by community mental health services program and hospital.
(5) Each office of recipient rights established under this section shall do all of the following: (f) Ensure that all individuals employed by the community mental health services program, contract agency, or licensed hospital receive training related to recipient rights protection before or within 30 days after being employed.

Definitions
Content Requirements:
The content requirements are a set of skills necessary for an understanding of the rights of mental health recipients. These requirements reflect foundational knowledge that professionals and paraprofessionals engaging in the provision of services to public mental health recipients, as well as ancillary bodies such as committees and board members, must have in order to provide services in accordance with Chapter 7 of the Michigan Mental Health Code.

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

Resident:
An individual who receives services in either a state operated facility, a licensed psychiatric hospital or unit or an adult foster care facility.
STANDARDS:
1. Training for newly hired agency and provider staff shall encompass the entirety of the core learning areas identified in Exhibit A.

2. If provided or required, annual rights training may focus on any or all of the learning areas.

3. Agencies may require documentation of competency in these areas through testing.

Exhibit A – Areas to be covered in Training

This chart represents the topics that minimally must be covered for the specific groups listed.

<table>
<thead>
<tr>
<th>Area</th>
<th>Direct Care Staff</th>
<th>Direct Care Staff - Specialized Residential</th>
<th>Clinical Staff - Non-Residential</th>
<th>Outpatient Clinic - All Staff</th>
<th>Appeals Committee</th>
<th>Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse and Neglect</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Civil Rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications and Visits</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Consent/Informed Consent</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Dignity &amp; Respect</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Entertainment, Information, and News</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Fingerprint, Photographs, Recording</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Freedom of Movement</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Limitations/Restrictions</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Psychotropic Medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Person Centered Planning</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Personal Property</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rights of Family Members</td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Safe, Sanitary, Humane Environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Seclusion/Restraint</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Suitable Services - Family Planning</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suitable Services - Svcs Suited to Condition</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suitable Services - Choice of Physician</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suitable Services - Notice of Clinical Status</td>
<td></td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THE RECIPIENT RIGHTS SYSTEM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role of the Advisory Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeals Process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORR Investigative Process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overview of the Rights System</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibilities of the Agency Director</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibilities of the Board of Directors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Exhibit B – Training Standards for New Hire Training

<table>
<thead>
<tr>
<th>Code Citation and Title</th>
<th>MHC 330.1722 ABUSE AND NEGLECT</th>
</tr>
</thead>
</table>

**Code Language**

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

**CONTENT REQUIREMENTS**

- Explain that the agency has a zero-tolerance stance regarding abuse and neglect
- Abuse is defined as:
  - An act (or provocation of another to act) by an employee, volunteer or agent of the provider that causes or contributes to a recipient’s death, sexual abuse, serious or non-serious physical harm or emotional harm.
  - The use of unreasonable force on a recipient with or without apparent harm;
  - An action taken on behalf of a recipient by a provider, who assumes the recipient is incompetent, which results in substantial economic, material, or emotional harm to the recipient;
  - An action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient’s property or funds for the benefit of an individual or individuals other than the recipient
  - The use of language or other means of communication by an employee, volunteer, or agent of a provider to degrade, threaten, or sexually harass a recipient.
- Agents of the Provider: people who work for agencies that contract with the Department, a CMHSP or PIHP, or a LPH/U
- Neglect is defined as:
  - Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service:
    1. that caused or contributed to the death, sexual abuse of, serious, or non-serious physical harm or emotional harm to a recipient, or
    2. that placed, or could have placed, a recipient at risk of physical harm or sexual abuse.
  - The failure to report apparent or suspected abuse or neglect of a recipient.
- "Bodily function" means the usual action of any region or organ of the body.
- "Emotional harm" means impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.
- "Nonserious physical harm" means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.
- "Physical management" means a technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself, or others.
- "Serious physical harm" means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
- "Sexual abuse" means any of the following:
  - Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.
  - Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
  - Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.
• "Sexual contact" means the intentional touching of the recipient’s or employee’s intimate parts or the touching of the clothing covering the immediate area of the recipient’s or employee’s intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following:
  ▪ Revenge.
  ▪ To inflict humiliation.
  ▪ Out of anger.
• "Sexual harassment" means sexual advances to a recipient, requests for sexual favors from a recipient, or other conduct or communication of a sexual nature toward a recipient.
• "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person’s body or of any object into the genital or anal openings of another person’s body, but emission of semen is not required.
• "Time out" means a voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.
• "Unreasonable force" means physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances:
  ▪ There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.
  ▪ The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
  ▪ The physical management used is not in compliance with the emergency interventions authorized in the recipient’s individual plan of service.
  ▪ The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.

<table>
<thead>
<tr>
<th>Code Citation and Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHC 330.1704 AR 330.7009 CIVIL RIGHTS</td>
</tr>
</tbody>
</table>

**Code Language**

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

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

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

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

**CONTENT REQUIREMENTS**

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

**Code Citation and Title**

| MHC 330.1748  | CONFIDENTIALITY |

**Code Language**

- Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and shall not be open to public inspection.
- If information made confidential by this section is disclosed, the identity of the individual to whom it pertains shall be protected and shall not be disclosed unless it is germane to the authorized purpose for which disclosure was sought; and, when practicable, no other information shall be disclosed unless it is germane to the authorized purpose for which disclosure was sought.
- Individuals receiving information made confidential by this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.
- For case record entries made subsequent to March 28, 1996, information made confidential by this section shall be disclosed to an adult recipient, upon the recipient’s request, if the recipient does not have a guardian and has not been adjudicated legally incompetent.
- Information may be shared as necessary for the treatment, coordination of care, or payment for the delivery of mental health services in accordance with the health insurance portability and accountability act of 1996. (Public Law 104-91)

**CONTENT REQUIREMENTS**

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

**Code Citation and Title**

| MHC 330.1708  | DIGNITY AND RESPECT |

**Code Language**

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

**CONTENT REQUIREMENTS**

Showing respect for recipients shall include:

- Discuss what it means to treat someone with dignity and respect.
- Provide definitions of dignity and respect (Use dictionary definitions below or agency’s definitions if they are in policy)
  
  Dignity: To be treated with esteem, honor, politeness; to be addressed in a manner that is not patronizing, condescending or demeaning; to be treated as an equal; to be treated the way any individual would like to be treated.
Respect: To show deferential regard for; to be treated with esteem, concern, consideration or appreciation; to protect the individual's privacy; to be sensitive to cultural differences; to allow an individual to make choices.

- Examples:
  - Calling a person by his or her preferred name
  - Knocking on a closed door before entering
  - Using positive language
  - Encouraging the person to make choices instead of making assumptions about what he or she wants
  - Taking the person's opinion seriously, including the person in conversations; allowing the person to do things independently or to try new things.

Code Citation and Title
MHC 330.1711 RIGHTS OF FAMILY MEMBERS

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

CONTENT REQUIREMENTS

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

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

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

CONTENT REQUIREMENTS

- Prior written consent from the recipient, the recipient's guardian or a parent with legal and physical custody of a minor recipient must be obtained before fingerprinting, photographing, audio-recording, or viewing through one-way glass.
- The procedures above shall only be utilized in order to provide services (including research) to identify, recipient, or for education and training purposes.
- Photographs include still pictures, motion pictures and videotapes.
Photographs may be taken for purely personal or social purposes and must be treated as the recipient’s personal property. Photographs must not be taken for this purpose if the recipient has objected.

Fingerprints, photographs and audio-recordings and any copies of these are to be made part of the recipient record and are to be destroyed or returned to the recipient when no longer essential or upon discharge, whichever occurs first.

If fingerprints, photographs or audio-recordings are done and sent out to others to help determine the name of the recipient, the individual receiving the items must be informed that return is required for inclusion in the recipient record.

Restrictions may be put in place if the recipient is receiving services pursuant to the criminal provisions of Chapter 10 of the Mental Health Code – Incompetent to Stand Trial, Not Guilty by Reason of Insanity, recipient of the Department of Corrections Mental Health Services Program

<table>
<thead>
<tr>
<th>Code Citation and Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCL 330.1744 FREEDOM OF MOVEMENT</td>
</tr>
<tr>
<td>MCL 330.1708 LEAST RESTRICTIVE SETTING</td>
</tr>
</tbody>
</table>

Code Language

Mental health services shall be offered in the least restrictive setting that is appropriate and available. The freedom of movement of a recipient shall not be restricted more than necessary to provide mental health services to him or her, to prevent injury to him or her or to others, or to prevent substantial property damage, except that security precautions appropriate to the condition and circumstances of an individual admitted by order of a criminal court or transferred as a sentence-serving convict from a penal institution may be taken.

CONTENT REQUIREMENTS

- Mental health services shall be offered in the least restrictive setting that is appropriate and available.
- The freedom of movement of a recipient shall not be restricted more than necessary to provide mental health services, to prevent injury to himself, herself or others, or to prevent substantial property damage.
- House rules may restrict freedom of movement only by general restrictions:
  - From areas that could cause health or safety or problems
  - Temporary restrictions from areas for reasonable unforeseeable activities including repair or maintenance
  - For emergencies in case of fire, tornadoes, floods, etc.
- Seclusion and restraint are prohibited except in a MDHHS operated or licensed hospital. Every patient in one of those settings has the right not to be secluded or restrained unless it is essential to prevent the patient from physically harming himself, herself or others.
- Time out, defined as a VOLUNTARY response to a therapeutic suggestion to a recipient to remove himself or herself from a stressful situation to another area to regain control. (AR 330.7001[x])
- Physical management, defined as a technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself or others. (AR 330.7001[m])
- Physical management may only be used when a recipient is presenting an imminent risk of serious or non-serious physical harm to himself, herself or others and lesser restrictive interventions have been unsuccessful in reducing or eliminating an imminent risk of serious or non-serious physical harm.
- Physical management must not be included as a component of a behavior treatment plan.
• Prone immobilization of a recipient for the purpose of behavioral control is prohibited (by agency policy) or (implementation of physical management techniques other than prone immobilization is medically contraindicated and documented in the recipient’s record) (AR 330.7243 [11][i][ii])
• This right can be limited but only as allowed in the individual plan of service (IPOS) following review and approval by the Behavior Treatment Plan Review Committee (CMH only) and the special consent of the 47

Code Citation and Title

| MHC 330.1712 | AR 330.7199 | INDIVIDUALIZED WRITTEN PLAN OF SERVICES |
| MDHHS PRACTICE GUIDELINE | TECHNICAL REQUIREMENT FOR BEHAVIOR TREATMENT REVIEW COMMITTEES |

**Code Language**

*The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release.*

**CONTENT REQUIREMENTS**

• The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient.
• A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release.
• The individual plan of services shall consist of a treatment plan, a support plan, or both.
• A treatment plan shall establish meaningful and measurable goals with the recipient.
• The individual plan of services shall address, as either desired or required by the recipient, the recipient’s need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation.
• The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the plan of services shall be designated in the plan.
• If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.
• An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual’s exclusion shall be documented in the case record.

Code Citation and Title

| MCL 330. 1708 (1) (2) | AR 330.7171 | SAFE, SANITARY, HUMANE,TREATMENT ENVIRONMENT |

**Code Language**

*Mental health services shall be provided in a safe, sanitary, and humane treatment environment*

**CONTENT REQUIREMENTS**

• Mental Health Code requires safe, sanitary, humane treatment environment
The MHC does not define what this means so we use Adult Foster Care Licensing Rules (400.14401 – 14403) to determine if the residential setting was safe, sanitary or humane.

- Assure pressurized hot and cold water
- Hot water temp no more than 105 degrees to 120 degrees at the faucet
- Assure all sewage is disposed of in a public sewer system or as approved by the health department
- Maintain an insect, rodent or pest control program
- Store and safeguard poisons, caustics and other dangerous materials in non-resident and non-food reparation storage areas
- Assure adequate preparation and storage of food items.
- Assure premises are constructed, arranged and maintained to adequately provide for the health, safety and well-being of occupants

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

<table>
<thead>
<tr>
<th>Code Citation and Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>VARIOUS CODE SECTIONS PERTAINING TO THE RECIPIENT RIGHTS SYSTEM</td>
</tr>
</tbody>
</table>

**Code Language**

330.1706 Notice of rights. Except as provided in section 707, applicants for and recipients of mental health services and in the case of minors, the applicant’s or recipient’s parent or guardian, shall be notified by the providers of those services of the rights guaranteed by this chapter. Notice shall be accomplished by providing an accurate summary of this chapter and chapter 7a to the applicant or recipient at the time services are first requested and by having a complete copy of this chapter and chapter 7a readily available for review by applicants and recipients.

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

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

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

**CONTENT REQUIREMENTS**

- Discuss the operation of the Rights Office
- What are the various roles: Prevention, Monitoring, Education, Complaints Resolution
- Discuss the complaint process
- What is your (staff) role in complaints (1776)?
- Employee Rights (retaliation/harassment (1755 3), Whistleblowers (Civil Action), Bullard-Plawecki (by HR or waived): emphasis on non-retaliation & disciplinary action)
- Basics of rights appeals - What do staff need to know and be able to explain about appeals? (1784)
- Access by ORR to all evidence
Preponderance of Evidence standard
Discuss the role of the Advisory Committee
Discuss the provision of required notice of rights; availability of complaints

**Code Citation and Title**

**MHC 330.1100(a) (19) AR 330.1703 CONSENT AND INFORMED CONSENT**

**Code Language**

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

**CONTENT REQUIREMENTS**

(1) All of the following are elements of informed consent:

(a) Legal competency. An individual shall be presumed to be legally competent. This presumption may be rebutted only by a court appointment of a guardian or exercise by a court of guardianship powers and only to the extent of the scope and duration of the guardianship. An individual shall be presumed legally competent regarding matters that are not within the scope and authority of the guardianship.

(b) Knowledge. To consent, a recipient or legal representative must have basic information about the procedure, risks, other related consequences, and other relevant information. The standard governing required disclosure by a doctor is what a reasonable patient needs to know in order to make an informed decision. Other relevant information includes all of the following:

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

(c) Comprehension. An individual must be able to understand what the personal implications of providing consent will be based upon the information provided under subdivision (b)

(d) Voluntariness. There shall be free power of choice without the intervention of an element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion, including promises or assurances of privileges or freedom. There shall be an instruction that an individual is free to withdraw consent and to discontinue participation or activity at any time without prejudice to the recipient.

**Code Citation and Title**

**MHC 330.7029 SUITABLE SERVICES – FAMILY PLANNING**

**Code Language**

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

**CONTENT REQUIREMENTS:**

- Discuss the procedures for how this is accomplished in your agency

**Code Citation and Title**

**SUITABLE SERVICES – TREATMENT BY SPIRITUAL MEANS**

R 330.7135 Treatment by spiritual means.

A provider shall permit a recipient to have access to treatment by spiritual means upon the request of the recipient, a guardian, if any, or a parent of a minor recipient.
Code Citation and Title
MHC 330.1708 SUITABLE SERVICES – MENTAL HEALTH SERVICES SUITED TO CONDITION

Code Language
A recipient shall receive mental health services suited to his or her condition.
CONTENT REQUIREMENTS:
- Discuss the procedures for how this is accomplished in your agency

Code Citation and Title
MHC 330.1713 SUITABLE SERVICES – CHOICE OF PHYSICIAN/MHP

Code Language
A recipient shall be given a choice of physician or other mental health professional in accordance with the policies of the community mental health services program, licensed hospital, or service provider under contract with the community mental health services program, or licensed hospital providing services and within the limits of available staff in the community mental health services program, licensed hospital, or service provider under contract with the community mental health services program, or licensed hospital
CONTENT REQUIREMENTS:
- Discuss the procedures for how this is accomplished in your agency

Code Citation and Title
MHC 330.1714 SUITABLE SERVICES – NOTICE OF CLINICAL STATUS

Code Language
A recipient shall be informed orally and in writing of his or her clinical status and progress at reasonable intervals established in the individual plan of services in a manner appropriate to his or her clinical condition.
CONTENT REQUIREMENTS:
- Discuss the procedures for how this is accomplished in your agency

Code Citation and Title
330.1715 SUITABLE SERVICES – SERVICES OF MENTAL HEALTH PROFESSIONAL

Code Language
If a resident is able to secure the services of a mental health professional, he or she shall be allowed to see the professional at any reasonable time.
CONTENT REQUIREMENTS
- Discuss the procedures for how this is accomplished in your agency

Code Citation and Title
330.1719 SUITABLE SERVICES – PSYCHOTROPIC DRUG TREATMENT

Code Language
Before initiating a course of psychotropic drug treatment for a recipient, the prescriber or a licensed health professional acting under the delegated authority of the prescriber shall do both of the following: (a) Explain the specific risks and the most common adverse effects that have been associated with that drug. (b) Provide the individual with a written summary of the most common adverse effects associated with that drug.
CONTENT REQUIREMENTS
• Discuss the specifics of this section with medical professionals and those who pass medication.

<table>
<thead>
<tr>
<th>Code Citation and Title</th>
<th>MHC 330.1726 COMMUNICATIONS AND VISITS</th>
</tr>
</thead>
</table>

**Code Language**

*Every resident is entitled to unimpeded, private and uncensored communication with others by mail, telephone and to visit with person of his/her choice. Each facility shall endeavor to implement the rights guaranteed by subsection (1) by making telephones reasonably accessible, by ensuring that correspondence can be conveniently and confidentially received and mailed, and by making space for visits available. Writing materials, telephone usage funds, and postage shall be provided in reasonable amounts to residents who are unable to procure such items.*

**CONTENT REQUIREMENTS**

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

<table>
<thead>
<tr>
<th>Code Citation and Title</th>
<th>AR 330.7139 ENTERTAINMENT MATERIALS, INFORMATION AND NEWS</th>
</tr>
</thead>
</table>

**Code Language**

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

**CONTENT REQUIREMENTS**

- Provider must never prevent a resident from exercising this right for reasons of, or similar to, censorship.
- Provider must establish written policies and procedures that provide for all of the following:
  - Any general program restrictions on access to material for reading, listening or viewing
  - Determining a resident’s interest in, and provide for, a daily newspaper
  - Assure material not prohibited by law may be read or viewed by a minor unless there is an objection by the minor’s parent or guardian
  - Permit attempts by the staff person in charge of the minor’s IPOS to persuade a parent or guardian of a minor to withdraw objections to material desired by the minor.
- Provider may require that materials acquired by the resident that are of a sexual or violent nature be read or viewed in the privacy of the resident’s room.
**TECHNICAL REQUIREMENT**

**RECIPIENT RIGHTS APPEAL PROCESS**

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

II. **Definitions**

A. **Appeals Committee:**
A committee appointed by the Michigan Department of Health and Human Services (MDHHS) Director, by the board of a Community Mental Health Services program (CMHSP), or by the governing board of a licensed private psychiatric hospital/unit (LPH/U).

B. **Appellant:** The complainant, the recipient (if someone filed on the recipient’s behalf), or the legal guardian of the recipient (if any), who seeks review by an appeals committee or the MDHHS pursuant to sections 330.1784 and 330.1786 of the Code.

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

D. **Grounds for appeal:**
   i. The investigative findings of the office are not consistent with the facts or with law, rules, policies or guidelines
   ii. The action taken or plan of action proposed by the respondent does not provide an adequate remedy
   iii. An investigation was not initiated or completed on a timely basis

E. **Legal Guardian:** A judicially appointed guardian or parent who has legal custody of a minor recipient.

F. **Office:** Any of the following:
   i. With respect to a rights complaint involving services provided directly by the MDHHS, the MDHHS Office of Recipient Rights created under section 330.1754 of the Code.
ii. With respect to a rights complaint involving services provided directly or 
under contract to a community mental health services program, the Office 
of Recipient Rights created by the community mental health services 
program under section 330.1755 of the Code.

iii. With respect to a rights complaint involving services provided directly or 
under contract to a licensed private psychiatric hospital/unit, the Office of 
Recipient Rights created by the licensed hospital under section 330.1755 of 
the Code.

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

H. Responsible Mental Health Agency (RMHA): The hospital, center, or community 
mental health services program that has primary responsibility for the recipient's 
care or for the delivery of services or supports to that recipient.

III. Procedure – Local Appeals Committee

A. Jurisdiction
An appeal shall be reviewed by the committee designated by the governing body. 
The appeals committee of a CMHSP shall have jurisdiction over their recipients 
placed for treatment in an LPH/U. For non-CMHSP recipients, the LPH/U, may 
appoint its own Appeals Committee in compliance with section 330.1774(4)(a) of 
the Code or, by agreement with MDHHS, designate the MDHHS Appeals 
Committee to hear appeals against the LPH/U under section 330.1774(4)(b) of the 
Code.

B. Training
The Office of Recipient Rights with the MDHHS, a CMHSP, or an LPH/U shall assure 
that training is provided to the Appeals Committee, as required by Section 
330.1755(2)(a) of the Code. Topics shall include the following:

- Categories of rights violations
- The complaint investigation process
- Types and weighing of evidence
- Explanation of the preponderance of the evidence standard used by the 
  rights office in determining whether a rights violation has occurred
- Statutory definition of “appropriate remedial action”
- Agency disciplinary guidelines
- Agency policy/procedures on the appeal process and functions of the 
  Appeals Committee

C. Notice of Right to Appeal
Every complainant, recipient (if different than the complainant) and the recipient’s legal guardian (if one has been appointed) shall be informed in the Summary Report issued by the MDHHS facility director, executive director of a CMHSP or the director of an LPH/U of the right to appeal to the designated Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 330.1784(2), the time frame for submission of the appeal, advocacy organizations that may assist with filing the written appeal, and an offer of assistance by the Office of Recipient Rights in the absence of assistance from an advocacy organization.

D. Notification when the Summary Report Contains a Plan of Action
A Summary Report which contains a plan of action shall indicate a date the action is to be completed. The MDHHS facility director, CMHSP executive director or director of the LPH/U shall assure that the complainant, recipient (if different than the complainant), the recipient’s legal guardian, (if any), and the office are provided written notice that the action described in the plan has been completed. If the action taken differs from the original plan, a description of that action shall be provided.

E. Time Frame
Not later than 45 calendar days after receipt of the Summary Report, or 45 days from the mailing of a notice regarding the action that was taken when the Summary Report provided only a plan of action, the appellant may file a written appeal with the Appeals Committee having jurisdiction to act upon it. The only ground for appeal of a notice of action taken is that the action failed to provide adequate remedy.

F. Preliminary Review
Within 5 business days of receipt of the appeal, members of the appeals committee shall review the appeal to determine if the appellant has standing to appeal and if the appeal meets the criteria found in the definition. This review may be conducted by the full Committee, or by a subcommittee consisting of at least two committee members designated by the full Committee to fulfill this responsibility. The Committee shall maintain a log of all appeals received and the disposition of each.

G. Notice of Preliminary Review Decision
Within 7 business days of receipt of the appeal, written notice that the appeal has been accepted, or rejected, shall be provided to the appellant and a copy of the appeal shall be provided to the respondent, the RMHA, and the Rights Office. A notice of rejection shall describe the reason for not accepting the appeal.

H. Committee Appeal Review
No later than 30 calendar days after receipt of a written appeal the Appeals Committee shall meet in closed session to review the facts as stated in all complaint investigation documents in light of the reason for appeal. The Committee shall not consider allegations that were not part of the original complaint, but shall inform
appellant of his/her right to file a complaint with the office. Upon completion of their review, the Appeals Committee shall do one of the following:

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

ii. If the appeal concerns the investigative findings of the office, either:
   a. Return the investigation to the office and direct that it be reopened or reinvestigated, or
   b. Recommend that the board (CMHSP) or governing body (LPH/U) request an external investigation by the state Office of Recipient Rights.

iii. If the appeal concerns the action taken, directs that the respondent take additional, or different, action to remedy the violation. The Appeals Committee shall base its determination upon any or all of the following:
   a. Action taken or proposed did not correct or remedy the rights violation.
   b. Action taken or proposed was/will not be taken in a timely manner.
   c. Action taken or proposed did not/will not prevent a future recurrence of the violation.

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

iv. If the appeal concerns the timeliness of the investigation and the Committee confirms that the investigation was not initiated or completed in a timely manner, recommend that the MDHHS-ORR director, executive director of the CMHSP or director of the LPH/U address the root cause of the lack of timeliness.

I. Recusal

Any member of an Appeals Committee who has a personal or professional relationship with an individual involved in the appeal shall abstain from participating in that appeal.

J. Decision

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

IV. Subsequent Action
A. If the Appeals Committee directs that the office reopen or reinvestigate the complaint, the office shall submit another investigative report in compliance with section 330.1778(5) within 45 calendar days of receipt of the written decision of the Committee to the MDHHS facility directors, CMHSP executive director or the director of the LPH/U. The 45 calendar day time frame may be extended at the discretion of the Appeals Committee upon a showing of good cause by the office. At no time shall the time frame exceed 90 days.

B. Within 10 business days of receipt of the reinvestigate report, the MDHHS facility director, executive director of the CMHSP or the director of the LPH/U shall issue new Summary Report in compliance with section 330.1782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient’s legal guardian, if any, the office and the Appeals Committee. The Summary Report shall contain information regarding the appellant’s right to further appeal, the time frame for the appeal and the ground for appeal. The report shall also inform the appellant of advocacy organizations that may assist in filing the written appeal or offer the assistance of the office in the absence of an advocacy organization.

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

D. If the Appeals Committee directs that the respondent take additional or different action, that direction shall be based on the fact that the action taken was not in compliance with section 330.1780 of the Code.

E. Within 30 calendar days of receipt of the determination from the Appeals Committee, respondent shall provide written notice to the Appeals Committee that the action has been taken or justification as to why it was not taken. The written notice shall also be sent to the appellant, recipient if different than appellant, the recipient’s legal guardian, if any, the RMHA if different than the respondent, and the office.

F. If the action taken by the respondent is determined by the Appeals Committee and/or the appellant still to be inadequate to remedy the violation, the appellant shall be informed by the Appeals Committee of his/her right to file a recipient rights complaint against the RMHA, i.e., MDHHS facility director, executive director of a CMHSP or the director of an LPH/U for violation of section 330.1754(3)(c) or 330.1755(3)(b) of the Code.
G. If the Appeals Committee recommends that the board or governing body of the RMHA (a CMHSP or a LPH/U), request an external investigation by MDHHS-Office of Recipient Rights, the Board of Directors may make the request to MDHHS-ORR, in writing, within 5 business days of receipt of the request from the Appeals Committee.

i. Within 10 business days of receipt of the investigative report from MDHHS-ORR, the executive director of the CMHSP, or the director of the LPH/U, shall issue a Summary Report in compliance with section 330.1782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient’s legal guardian, if any, the office and the Appeals Committee.

ii. The complainant, recipient if different than the complainant, and the recipient’s legal guardian, if any, shall be informed in the Summary Report issued by the executive director of a CMHSP or the director of an LPH/U of the right to appeal to the MDHHS Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 330.1784(2), the time frame for submission of the appeal, advocacy organizations that may assist with filing the written appeal, and an offer of assistance by the Office of Recipient Rights in the absence of assistance from an advocacy organization.

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

V. Level 2 Appeals

A. Grounds and Timeframe
An appeal to Level 2 Appeals may be made only if the original appeal was based on the question of whether the investigative findings of the office were inconsistent with the facts or with law, rules, policies or guidelines; and 1) only after a decision to uphold the findings has been made on the original appeal by the local Appeals Committee or, 2) when upon reinvestigation by ORR at the request of the local appeals committee, the findings of the office remain unsubstantiated. Within 45 calendar days after receiving written notice of the decision of the Appeals Committee or the Summary Report from MDHHS-ORR the appellant may file a written appeal with Level 2 Appeals. The appeal shall be mailed to:

Level 2 ORR Appeal
MDHHS-Appeals
PO Box 30807
Lansing, MI 48909
FAX: (517) 241-7973

B. Written Notice
Upon receipt of the appeal, Level 2 Appeals shall give written notice of the receipt to the respondent, local Office of Recipient Rights holding the record of the complaint and the RMHA. If the appeal involves the findings of a rights advisor with the MDHHS Office of Recipient Rights, the MDHHS-ORR Director shall also receive written notice of receipt of the appeal. The respondent, local office holding the record of the complaint, MDHHS-ORR Director, and the RMHA shall ensure that Level 2-Appeals has access to all necessary documentation and other evidence cited in the complaint and local appeal.

C. Review
Level 2 Appeals shall review the record generated by the local appeal. It shall not consider additional evidence or information that was not available during the local appeal.

D. Level 2 Action
i. Within 30 calendar days after receiving the appeal, Level 2 Appeals shall review the appeal and do one of the following:
   a. Uphold the findings of the office.
   b. Affirm the decision of the Appeals Committee.
   c. Return the matter to the director of the department’s Office of Recipient Rights, the executive director of the CMHSP or the director of the LPH/U with instruction for additional investigation or consideration.

ii. Level 2 Appeals shall provide copies of its action to the respondent, the appellant, recipient if different than appellant, the recipient’s legal guardian, if any, the board of a CMHSP, the governing body of the LPH/U and the local Office of Recipient Rights holding the record. If the appeal involves the findings of a MDHHS-ORR rights advisor, the MDHHS-ORR director shall also be provided copies of the action.

iii. If Level 2 APPEALS upholds the findings of the office, notice shall be provided to the appellant of his/her legal right to seek redress through the circuit court.

iv. If Level 2 APPEALS instructs that additional investigation be conducted, the director of MDHHS-ORR, the executive director of the CMHSP or the director of the LPH/U shall assure that such investigation is completed in a fair and impartial manner within 45 calendar days of his/her receipt of the written notice from MDHHS-APPEALS. The 45 calendar day time frame may be extended at the department’s discretion upon a showing of good cause by the MDHHS-ORR director, CMHSP executive director or LPH/U director. At no time shall the time frame exceed 90 calendar days. In cases of re-investigation by MDHHS-ORR, the director of that office shall be responsible for the submission of the investigative report to the appropriate MDHHS facility director.

E. Subsequent Action
i. Within 10 business days of the receipt of the investigative report, the facility director, executive director of the CMHSP, or the director of the LPH/U shall issue a Summary Report in compliance with section 330.1782 of the Code to the department, appellant, recipient if different than appellant and the recipient’s legal representative, if any.

ii. If the findings of the additional investigation remain the same as those appealed, the department shall inform appellant, recipient (if different than appellant) and the recipient’s legal guardian, if any, in writing of the right to seek redress through the circuit court. Copies of this notice will be provided to the:

   a. MDHHS Bureau of State Hospital and Behavioral Administrative Services (if the investigation was conducted by staff of the MDHHS-ORR)
   b. MDHHS Bureau of Community Based Services (if the investigation was conducted by a CMHSP)
   c. Michigan Department of Licensing & Regulatory Affairs, Bureau of Community and Health Systems (if the investigation was conducted by an LPH/U).

If the additional investigation results in the substantiation of previously unsubstantiated violation, but the appellant disagrees with the adequacy of the action taken, or plan of action proposed to remedy the violation, the department shall inform the individual(s) of the right to appeal this to the local Appeals Committee.
Table of Contents

Introduction ................................................................................................................................................................... 2
FINANCIAL PLANNING, REPORTING AND SETTLEMENT .................................................................................. 3
FY 2018 DATA REPORT DUE DATES .................................................................................................................... 6
BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS) COLLECTION/RECORDING AND REPORTING REQUIREMENTS ................................................................................................................................. 7
PROXY MEASURES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES .................................................. 9
ENCOUNTERS PER MENTAL HEALTH, DEVELOPMENTAL DISABILITY, AND SUBSTANCE ABUSE BENEFICIARY ........................................................................................................................................................... 17
FY’17 SUB-ELEMENT COST REPORT .................................................................................................................. 23
FY17 CMHSP GENERAL FUND COST REPORT ................................................................................................. 23
MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM ............................................................ 24
CMHSP PERFORMANCE INDICATOR SYSTEM .............................................................................................. 25
CMHSP PERFORMANCE INDICATOR REPORTING DUE DATES .................................................................... 28
CAFAS ........................................................................................................................................................................ 29
RECIPIENT RIGHTS DATA REPORT ..................................................................................................................... 31
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:
MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY18 - Attachment C6.5.1.1

Amendment #1

- 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.

<table>
<thead>
<tr>
<th>Due Date</th>
<th>Report Title</th>
<th>Report Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/31/2018</td>
<td>1Q Special Fund Account – Section 226a, PA of the MHC</td>
<td>October 1 to December 31</td>
</tr>
<tr>
<td>4/30/2018</td>
<td>2Q Special Fund Account – Section 226a, PA of the MHC</td>
<td>October 1 to March 31</td>
</tr>
<tr>
<td>5/31/2018</td>
<td>Mid-Year Status Report</td>
<td>October 1 to March 31</td>
</tr>
<tr>
<td>6/30/2018</td>
<td>Semi-annual Recipient Rights Data Report</td>
<td>October 1 to March 31. Section I only. See section “Recipient Rights Data Report” for additional information in this attachment.</td>
</tr>
<tr>
<td>8/15/2018</td>
<td>3Q Special Fund Account – Section 226a, PA of the MHC</td>
<td>October 1 to June 30</td>
</tr>
<tr>
<td>8/15/2018</td>
<td>Projection Financial Status Report – All Non-Medicaid,</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>8/15/2018</td>
<td>Projection State Services Utilization, Reconciliation &amp; Cash Analysis</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>8/15/2018</td>
<td>Projection General Fund Contract Settlement Worksheet</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>8/15/2018</td>
<td>Projection General Fund Reconciliation and Cash Settlement</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>10/1/2018</td>
<td>General Fund – Year End Accrual Schedule</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
<td>Report Date</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>FY18 Monthly</td>
<td>PASARR Agreement Monthly Billing</td>
<td>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.</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>Interim Financial Status Report – All Non-Medicaid</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>Interim State Services Utilization, Reconciliation &amp; Cash Analysis</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>Interim Special Fund Account – Section 226a, PA of the MHC</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>Interim General Fund Contract Settlement Worksheet</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>Interim General Fund Reconciliation and Cash Settlement</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>Categorical Funding – Multi-cultural Annual Report</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>12/30/2018</td>
<td>Annual Recipient Rights Data Report</td>
<td>October 1 to September 30. Sections I, II, III &amp; IV. See section “Recipient Rights Data Report” for additional information in this attachment.</td>
</tr>
<tr>
<td>1/31/2019</td>
<td>Annual Report on Fraud and Abuse Complaints</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Final Financial Status Report – All Non-Medicaid</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Final State Services Utilization, Reconciliation &amp; Cash Analysis</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Final Special Fund Account – Section 226a, PA of the MHC</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Final General Fund Reconciliation and Cash Settlement</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Final General Fund Contract Settlement Worksheet</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Sub-Element Cost Report</td>
<td>See Attachment 6.5.1.1 Submit report to: <a href="mailto:QMPMeasures@michigan.gov">QMPMeasures@michigan.gov</a></td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Estimated FTE Equivalents</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Requests for Services and Disposition of Requests</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 1</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 2</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Waiting List</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Specialized Residential</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Community Needs Assessment</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>CMHSP Administrative Cost Report</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Executive Administrative Expenditures Survey for Sec. 904(2)(k)</td>
<td>October 1 to September 30, 2017</td>
</tr>
<tr>
<td>30 days after receipt, but no later than June 30, 2018</td>
<td>Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter. Compliance exam and plan of correction</td>
<td>October 1 to September 30th Submit reports to: <a href="mailto:MDHHS-AuditReports@michigan.gov">MDHHS-AuditReports@michigan.gov</a></td>
</tr>
</tbody>
</table>
## FY 2018 DATA REPORT DUE DATES

<table>
<thead>
<tr>
<th></th>
<th>Nov17</th>
<th>Dec</th>
<th>Jan18</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec18</th>
<th>Jan19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Consumer level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographic BHTEDS (monthly)</td>
<td>√</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Encounter (monthly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. PIHP level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Medicaid Utilization and Net Cost Report: annually</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Performance indicators (quarterly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Consumer Satisfaction (annually)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. CAFAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Critical incidents (monthly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

* **Disability Designation**  

* **Developmental disability** (Individual meets the Mental Health Code Definition of Developmental Disability regardless of whether or not they receive services from the I/DD or MI services arrays) (DD)  

1 = Yes  
2 = No  
3 = Not evaluated
*Mental Illness or Serious Emotional Disturbance* individual has been evaluated and/or individual has a DSM MI diagnosis, exclusive of intellectual disability, developmental disability, or substance abuse disorder OR the individual has a Serious Emotional Disturbance.

1 = Yes
2 = No
3 = Not evaluated

**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.

<table>
<thead>
<tr>
<th>Data Record</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Element #</th>
<th>Data Element Name</th>
<th>Usage</th>
<th>Format</th>
<th>From</th>
<th>To</th>
<th>Validated</th>
<th>Required</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Submitter ID</td>
<td>Char(4)</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>Yes</td>
<td>Yes</td>
<td>Service Bureau ID (DEG Mailbox ID)</td>
</tr>
<tr>
<td>2</td>
<td>Consumer ID</td>
<td>Char(11)</td>
<td>11</td>
<td>5</td>
<td>15</td>
<td>No</td>
<td>Yes</td>
<td>Unique Consumer ID</td>
</tr>
</tbody>
</table>

Page 15 of 37
<table>
<thead>
<tr>
<th>Element #</th>
<th>Data Element Name</th>
<th>Picture</th>
<th>Usage</th>
<th>Format</th>
<th>From</th>
<th>To</th>
<th>Validated</th>
<th>Required</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Medicaid ID</td>
<td>Char(10)</td>
<td>10</td>
<td></td>
<td>16</td>
<td>25</td>
<td>Yes</td>
<td>Conditional</td>
<td>Must present on file if available.</td>
</tr>
<tr>
<td>4</td>
<td>MiChild ID</td>
<td>Char(10)</td>
<td>10</td>
<td></td>
<td>26</td>
<td>35</td>
<td>Yes</td>
<td>Conditional</td>
<td>MiCHILD ID [CIN] Must present on file if available.</td>
</tr>
<tr>
<td>5</td>
<td>Begin Date</td>
<td>Date</td>
<td>8</td>
<td>YYYYM MDD</td>
<td>36</td>
<td>43</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
ENCOUNTERS PER MENTAL HEALTH, DEVELOPMENTAL DISABILITY, AND SUBSTANCE ABUSE BENEFICIARY
DATA REPORT

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

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 837 includes 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). If the Billing Provider is a specialized licensed residential facility also report the LARA license facility number (See Instructions for Reporting Specialized Residential Facility Details 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. **Facility Location of the Specialized Residential Facility**
In instances in which the specialized licensed residential facility is not the Billing Provider, report the name, address, NPI (if applicable) and LARA license of the facility in the Facility Location (2310C loop). (See Instructions for Reporting Specialized
Residential Facility Details at [www.michigan.gov/mdhhs/bhdda](http://www.michigan.gov/mdhhs/bhdda). Click on Reporting Requirements)
**19. 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
The Michigan Mission Based Performance Indicator System (version 1.0) was first implemented in FY’97. That original set of indicators reflected nine months of work by more than 90 consumers, advocates, CMHSP staff, MDHHS staff and others. The original purposes for the development of the system remain. Those purposes include:

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

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

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

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

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

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

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

5. The percent of face-to-face assessments with professionals that result in decisions to deny CMHSP services. (MI and DD) (Old Indicator #6)
   a. Quarterly report
   b. CMHSP
   c. Scope: all MI/DD consumers
6. The percent of Section 705 second opinions that result in services. (MI and DD) (Old Indicator #7)
   a. Quarterly report
   b. CMHSP
   c. Scope: all MI/DD consumers

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

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

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

10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. (Old Indicator #12)
    a. Standard = 15% or less within 30 days
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. 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**

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

*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 REV 06/2017) 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 semiannual report memo can be sent by email.

Demographic Data

1. Select the Agency name from the drop down in cell C2.

2. CMHSPs: Insert the number of consumers served (unduplicated count) in cell E6.

Service Site Information

1. Enter the number of sites in your catchment area
2. Enter the number of sites out of catchment area.
3. In the third column type in only the number of sites that must be visited.
4. In the fourth column type in the number of site visits conducted. If a site is visited twice, it is only counted on the first visit. Sites should not be counted more than once (return visits to assure compliance are not counted).
5. If a site is visited twice, it is only counted on the first visit, but you may enter the additional visits in the fifth column.
**Staffing Information:**

1. FTE’s are defined as hours paid for recipient rights functions. List the full-time equivalents for your office.
2. Explain the breakdown of staff (if there is one); investigators/administrators, clerical/support, trainers.
3. If there is only 1 person for all functions, fill in only cell C41

**Appeal Information:**

Insert the number of appeals submitted (to the committee), the number accepted and the disposition of the appeals heard.
## Section 1: Complaint Data Summary

### Part A: Totals

1. Insert the name of the Rights Office Director in cell C2. The number of Allegations will populate from the Aggregate Summary.
2. 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”.

---

**Complaint Data**

**THESE SECTIONS ARE REQUIRED TO BE COMPLETED FOR THE ANNUAL REPORT AND SEMI-ANNUAL REPORT**

---

**Section 1: Complaint Data Summary**

**Part A: Totals**

1. Insert the name of the Rights Office Director in cell C2.
2. 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”.

---

**Rights Office Director:**

<table>
<thead>
<tr>
<th>Reporting Period:</th>
<th>10/1/2016 to 9/30/2017</th>
</tr>
</thead>
</table>

**Section 1: Complaint Data Summary**

<table>
<thead>
<tr>
<th>Allegations</th>
<th>0</th>
<th>(This cell will fill)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions</td>
<td>0</td>
<td>(This cell will fill)</td>
</tr>
<tr>
<td>Investigations</td>
<td>0</td>
<td>(This cell will fill)</td>
</tr>
<tr>
<td>Interventions Substantiated</td>
<td>0</td>
<td>(This cell will fill)</td>
</tr>
<tr>
<td>Investigations Substantiated</td>
<td>0</td>
<td>(This cell will fill)</td>
</tr>
</tbody>
</table>

**COMPLAINT SOURCE**

<table>
<thead>
<tr>
<th>Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
</tr>
<tr>
<td>ORR</td>
</tr>
<tr>
<td>Guardian/Family</td>
</tr>
<tr>
<td>Anonymous</td>
</tr>
<tr>
<td>Community/General Public</td>
</tr>
<tr>
<td>Total Complaints Received</td>
</tr>
</tbody>
</table>

---

33
**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).

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>≤30</th>
<th>≤60</th>
<th>≤90</th>
<th>&gt;90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse/Neglect I &amp; II</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All others</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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)

*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.

** 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.

*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 1)
- The Specific remedial action taken (be sure to only list 1 action per column) (see table 2)
- The number of the type of population (see table 3)
TABLE 1

<table>
<thead>
<tr>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
</tr>
<tr>
<td>Residential MI</td>
</tr>
<tr>
<td>Residential DD</td>
</tr>
<tr>
<td>Mixed Residential (MI/DD)</td>
</tr>
<tr>
<td>Inpatient</td>
</tr>
<tr>
<td>Day Program MI</td>
</tr>
<tr>
<td>Day Program DD</td>
</tr>
<tr>
<td>Workshop (Prevocational)</td>
</tr>
<tr>
<td>Supported Employment</td>
</tr>
<tr>
<td>ACT</td>
</tr>
<tr>
<td>Case Management</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
</tr>
<tr>
<td>SIP</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

TABLE 2

<table>
<thead>
<tr>
<th>Remedial Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Counseling</td>
</tr>
<tr>
<td>Written Counseling</td>
</tr>
<tr>
<td>Written Reprimand</td>
</tr>
<tr>
<td>Suspension</td>
</tr>
<tr>
<td>Demotion</td>
</tr>
<tr>
<td>Staff Transfer</td>
</tr>
<tr>
<td>Training</td>
</tr>
<tr>
<td>Employment Termination</td>
</tr>
<tr>
<td>Employee left the agency, but substantiated**</td>
</tr>
<tr>
<td>Contract Action</td>
</tr>
<tr>
<td>Policy Revision/Development</td>
</tr>
<tr>
<td>Environmental Repair/Enhancement</td>
</tr>
<tr>
<td>Plan of Service Revision</td>
</tr>
<tr>
<td>Recipient Transfer to Another Provider/Site</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

**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.

Section II: Annual Complaint Data Summary for: 0

<table>
<thead>
<tr>
<th>Category (from Complaint Data)</th>
<th>Specific Provider Type</th>
<th>Specific Remedial Action(s)</th>
<th>Specific Remedial Action(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Population

<table>
<thead>
<tr>
<th>MI</th>
<th>DD</th>
<th>SED</th>
<th>SEDW</th>
<th>DD-CWP</th>
<th>HSW</th>
</tr>
</thead>
</table>
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.

THESE SECTIONS ARE REQUIRED TO BE COMPLETED FOR THE ANNUAL REPORT ONLY

Section II: Training Activity

Part A: Training Received by Rights Office Staff
1. Enter the name of each staff who receive training in column A (Last name, First name).
2. Fill in each staff in column C using the drop-down box.
3. Indicate, for each rights staff, the course number assigned by MDHHS-ORR (available on the web site)
4. Enter the name of the rights related training received during the period,
5. Enter the CEU Category (Operations, Legal/Foundations, Leadership, Augmented)
6. Enter the number of hours for each
Part B: Training Provided by Rights Office

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

Indicate: the topic of the training provided during the period (2), the length of the session (3), the number of CMH (4), contractual staff (5), consumers (6), the number of other staff (7) involved, type of “others” trained (8). Indicate the method(s) used (9), and a description, if necessary (10). (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).

### TYPES OF TRAINING

<table>
<thead>
<tr>
<th></th>
<th>Face-to-Face</th>
<th>Video</th>
<th>Computer</th>
<th>Paper</th>
<th>Video Face-to-Face</th>
<th>Computer Face-to-Face</th>
<th>Paper Face-to-Face</th>
<th>Other (Describe)</th>
</tr>
</thead>
</table>

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:

- CMHSPs are NOT to include LPH/U data on the Annual & Semi-Annual Reports

<table>
<thead>
<tr>
<th>REPORT</th>
<th>SEMI-ANNUAL</th>
<th>ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period Covered</td>
<td>October 1 - March 31</td>
<td>October 1 – September 30</td>
</tr>
<tr>
<td>Due Date to MDHHS</td>
<td>June 30</td>
<td>December 30</td>
</tr>
<tr>
<td>Sections to be completed</td>
<td>Section I only</td>
<td>Section I, II, III, IV</td>
</tr>
<tr>
<td>Additional Information</td>
<td>Cover Letter from Rights Office</td>
<td>Cover Letter from Executive Director</td>
</tr>
<tr>
<td>Sent to</td>
<td>MDHHS &amp; Rights Committee</td>
<td>MDHHS, Rights Committee, Board</td>
</tr>
</tbody>
</table>
APPLICATION:
Prepaid Inpatient Health Plans (PIHPs)
Community Mental Health Services Programs (CMHSPs)
Public mental health service providers

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

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

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

- Adheres to any legal psychiatric advance directive that is present for an adult with serious mental illness;
- Employs positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches;
- Considers other kinds of behavior treatment or interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions, if positive behavior supports and interventions are documented to be unsuccessful; or
As a last resort, when there is documentation that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee.

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

I. POLICY

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

II. COMMITTEE STANDARDS

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

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

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

D. The Committee shall meet as often as needed.

E. Expedited Review of Proposed Behavior Treatment Plans:

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

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

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

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

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

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

1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.

2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques [see definitions].

3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.

4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.

5. Assure that inquiry has been made about any known medical, psychological or other factors that the individual has, which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.

6. As part of the PIHP’s Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP’s Quality Improvement Program (QIP), arrange for an evaluation of the committee’s effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the individuals served.

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

I. On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:

1. Dates and numbers of interventions used.

2. The settings (e.g., individual’s home or work) where behaviors and interventions occurred.
3. Observations about any events, settings, or factors that may have triggered the behavior.
4. Behaviors that initiated the techniques.
5. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
6. Description of positive behavioral supports used.
7. Behaviors that resulted in termination of the interventions.
8. Length of time of each intervention.
9. Staff development and training and supervisory guidance to reduce the use of these interventions.
10. Review and modification or development, if needed, of the individual's behavior plan.

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

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

III. BEHAVIOR TREATMENT PLAN STANDARDS

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

B. Behavior treatment plans must be developed through the person-centered planning process and written special consent must be given by the individual, or his/her guardian on his/her behalf if one has been appointed, or the parent with legal custody of a minor prior to the implementation of the behavior treatment plan that includes intrusive or restrictive interventions.

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

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

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

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

8. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

IV. DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomical support</td>
<td>Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient’s physical functioning.</td>
</tr>
<tr>
<td>Aversive techniques</td>
<td>Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management, control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to cons equate target behavior or to accomplish a negative association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purposed of this technical requirement.</td>
</tr>
<tr>
<td>Bodily function</td>
<td>The usual action of any region or organ of the body.</td>
</tr>
<tr>
<td>Emotional harm</td>
<td>Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.</td>
</tr>
<tr>
<td>Consent</td>
<td>A written agreement signed by the individual, the parent of a minor, or an individual’s legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.</td>
</tr>
<tr>
<td>Functional Behavioral Assessment (FBA)</td>
<td>An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or “function” of a particular behavior and guide the development of an effective and efficient behavior treatment plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a target behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the target behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the target behavior itself so that a new behavior or skill will be developed to provide the same function or meet the identified need of the recipient. Functional assessments should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.</td>
</tr>
<tr>
<td>Emergency Interventions</td>
<td>There are only two emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>enforcement intervention. Each agency shall have protocols specifying what physical management techniques are approved for use.</td>
<td></td>
</tr>
<tr>
<td>Imminent Risk</td>
<td>An event/action that is about to occur that will likely result in the serious physical harm of one’s self or others.</td>
</tr>
<tr>
<td>Intrusive Techniques</td>
<td>Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control an individual’s behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual’s condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.</td>
</tr>
<tr>
<td>Medical and dental procedures restraints</td>
<td>The use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.</td>
</tr>
<tr>
<td>Physical management</td>
<td>A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations.</td>
</tr>
<tr>
<td>Practice or Treatment Guidelines</td>
<td>Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.</td>
</tr>
<tr>
<td>Prone immobilization</td>
<td>Extended physical restraint of an individual in a face down (prone) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position for the purpose of control. Note: <strong>PRONE IMMOBILIZATION IS PROHIBITED UNDER ANY CIRCUMSTANCES</strong></td>
</tr>
<tr>
<td>Positive Behavior Support (PBS)</td>
<td>A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.</td>
</tr>
<tr>
<td>Protective device</td>
<td>A device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective devices as defined in this subdivision and incorporated in written individual plan of service shall not be considered a restraint as defined in below.</td>
</tr>
<tr>
<td>Provider</td>
<td>The department, each community mental health service program, each licensed hospital, each psychiatric unit, and each psychiatric partial hospitalization program</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>licensed under section 137 of the act, their employees, volunteers, and contractual agents.</td>
<td></td>
</tr>
<tr>
<td>Psychotropic drug</td>
<td>Any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior.</td>
</tr>
<tr>
<td>Request for Law Enforcement Intervention</td>
<td>Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance only when: caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.</td>
</tr>
<tr>
<td>Restraint</td>
<td>The use of physical devise to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support.</td>
</tr>
<tr>
<td>Restrictive Techniques</td>
<td>Those techniques which, when implemented, will result in the limitation of the individual’s rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.</td>
</tr>
<tr>
<td>Serious physical harm</td>
<td>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.</td>
</tr>
<tr>
<td>Special Consent</td>
<td>Obtaining the written consent of the individual, the legal guardian, or parent with legal custody of a minor child, or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual’s rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the individual, guardian or parent of a minor may only occur when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.</td>
</tr>
<tr>
<td>Therapeutic de-escalation</td>
<td>An intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the recipient is placed in an area or room, accompanied by staff who shall therapeutically engage the recipient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.</td>
</tr>
<tr>
<td>Time out</td>
<td>A voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.</td>
</tr>
<tr>
<td>Unreasonable force</td>
<td>Physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1.</td>
<td>There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.</td>
</tr>
<tr>
<td>2.</td>
<td>The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.</td>
</tr>
<tr>
<td>3.</td>
<td>The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service. The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.</td>
</tr>
</tbody>
</table>

**Person-centered planning**

A process for planning and supporting the individual receiving services that builds upon the individual’s capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

**Seclusion**

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

**Support Plan**

A written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.

**Treatment Plan**

A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, which are to be developed with and provided for a recipient.

V. **LEGAL REFERENCES**

1973 PA 116, MCL 722.111 to 722.128.
1997 federal Balanced Budget Act at 42 CFR 438.100
MCL 330.1700, Michigan Mental Health Code
MCL 330.1704, Michigan Mental Health Code
MCL 330.1712, Michigan Mental Health Code
MCL 330.1740, Michigan Mental Health Code
MCL 330.1742, Michigan Mental Health Code
MCL 330.1744, Michigan Mental Health Code
MDHHS Administrative Rule 7001(l)
MDHHS Administrative Rule 7001(r)
Department of Health and Human Services Administrative Rule 330.7199(2)(g)
Amendment No. 2 to the Agreement Between
Michigan Department of Health & Human Services
And
CMHSP: __________________________
For
Managed Mental Health Supports and Services

1. Period of Agreement: This agreement shall commence on October 1, 2017 and continue through September 30, 2018.


3. Program Budget and Agreement Amount: Payment to the CMHSP will be paid based on the total funding available for managed mental health supports and services as identified in the annual Legislative Appropriation for community mental health services programs for the period of October 1, 2017 through September 30, 2018. The estimated value of this contingent upon and subject to enactment of legislative appropriations and availability of funds.

4. Amendment Purpose: This amendment is for changes to the following:
   - Contract attachment C3.3.1 Person Centered Planning
   - Contract attachment C4.5.1 PASSAR Agreement
   - Contract attachment C6.5.1.1 CMHSP Reporting Requirements
   - Contract attachment C6.9.8.1 Employment Works!

5. Original Agreement Conditions: It is understood and agreed that all other conditions of the original agreement remain the same.

6. Special Certification
   The individual or officer signing this amendment certifies by his or her signature that he or she is authorized to sign this amendment on behalf of the responsible governing board, official or contractor.

Signature Section

For the Michigan Department of Health and Human Services

__________________________________________  _________________________
Christine H. Sanches, Director                  Date
Bureau of Budget and Purchasing

For the CONTRACTOR:

__________________________________________  _________________________
Name (print)                                   Title (print)

__________________________________________  _________________________
Signature                                      Date

V-2018-2                                       1
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
PERSON-CENTERED PLANNING POLICY
April, 2018

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

I. WHAT IS THE PURPOSE OF THE MICHIGAN MENTAL HEALTH SYSTEM?

The purpose of the community mental health system is to support adults and children with intellectual and developmental disabilities, adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance to live successfully in their communities—achieving community inclusion and participation, independence, and productivity. Person-Centered Planning (PCP) enables individuals to identify and achieve their personal goals. As described below, PCP for minors (family-driven and youth-guided practice) involves the whole family.

PCP is a way for people to plan their lives in their communities, set the goals that they want to achieve, and develop a plan for how to accomplish them. PCP is required by state law [the Michigan Mental Health Code (the Code)] and federal law [the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules] as the way that people receiving services and supports from the community mental health system plan how those supports are going to enable them to achieve their life goals. The process is used to plan the life that the person aspires to have, considering various options—taking the individual’s goals, hopes, strengths, and preferences and weaving them into plans for the future. Through PCP, a person is engaged in decision making, problem solving, monitoring progress, and making needed adjustments to goals and supports and services provided in a timely manner. PCP is a process that involves support and input from those people who care about the person doing the planning. The PCP process is used any time an individual’s goals, desires, circumstances, choices, or needs change. While PCP is the required planning approach for mental health and I/DD services provided by the CMHSP system, PCP can include planning for other public supports and privately-funded services chosen by the person.

The HCBS Final Rule requires that Medicaid-funded services and supports be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree
of access as individuals not receiving such services and supports. 42 CFR 441.700 et. seq. The HCBS Final Rule also requires that PCP be used to identify and reflect choice of services and supports funded by the mental health system.

Through the PCP process, a person and those he or she has selected to support him or her:

a. Focus on the person’s life goals, interests, desires, choices, strengths and abilities as the foundation for the PCP process.

b. Identify outcomes based on the person’s life goals, interests, strengths, abilities, desires and choices.

c. Make plans for the person to achieve identified outcomes.

d. Determine the services and supports the person needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.

e. After the PCP process, develop an Individual Plan of Services (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

PCP focuses on the person’s goals, while still meeting the person’s basic needs [the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code]. As appropriate for the person, the PCP process may address Recovery, Self-Determination, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning as described in the relevant MDHHS policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the person to work toward and achieve their personal goals.

For minor children, the concept of PCP is incorporated into a family-driven, youth-guided approach (see the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline). The needs of the child are interwoven with the needs of the family, and therefore supports and services impact the entire family. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the person reaches adulthood, his or her needs and goals become primary.
There are a few circumstances where the involvement of a minor’s family may be not appropriate:

a. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Code.

b. The minor is emancipated.

c. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the minor or substantial disruption of the planning process. Justification of the exclusion of parents shall be documented in the clinical record.

II. HOW IS PCP DEFINED IN LAW?

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

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

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

The HCBS Final Rule does not define PCP, but does require that the process be used to plan for Medicaid-funded services and supports. 42 CFR 441.725. The HCBS Final Rule also sets forth the requirements for using the process. These requirements are included in the PCP Values and Principles and Essential Elements below.
III. WHAT ARE THE VALUES AND PRINCIPLES THAT GUIDE THE PCP PROCESS?

PCP is an individualized process designed to respond to the unique needs and desires of each person. The following values and principles guide the PCP process whenever it is used.

a. Every person is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the person’s ability to make choices.

b. Every person has strengths, can express preferences, and can make choices. The PCP approach identifies the person’s strengths, goals, choices, medical and support needs and desired outcomes. In order to be strength-based, the positive attributes of the person are documented and used as the foundation for building the person’s goals and plans for community life as well as strategies or interventions used to support the person’s success.

c. The person’s choices and preferences are honored. Choices may include: the family and friends involved in his or her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships and friendships, and transportation. Individual choice must be used to develop goals and to meet the person’s needs and preferences for supports and services and how they are provided.

d. The person’s choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the person to implement their choices or preferences over time.

e. Every person contributes to his or her community, and has the right to choose how supports and services enable him or her to meaningfully participate and contribute to his or her community.

f. Through the PCP process, a person maximizes independence, creates connections and works towards achieving his or her chosen outcomes.

g. A person’s cultural background is recognized and valued in the PCP process. Cultural background may include language, religion, values, beliefs, customs, dietary choices and other things chosen by the person. Linguistic needs, including ASL interpretation, are also recognized, valued and accommodated.
IV. WHAT ARE THE ESSENTIAL ELEMENTS OF THE PERSON-CENTERED PLANNING PROCESS?

The following elements are essential to the successful use of the PCP process with a person and the people invited by the person to participate.

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

b. **Person-Centered.** The planning process focuses on the person, not the system or the person’s family, guardian, or friends. The person’s goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the person’s needs or choices, rather than viewed as an annual event.

c. **Outcome-Based.** The person identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.

d. **Information, Support and Accommodations.** As needed, the person receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the IPOS. Support and accommodations to assist the person to participate in the process are provided. The person is offered information on the full range of services available in an easy-to-understand format.

e. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process.

f. **Pre-Planning.** The purpose of pre-planning is for the person to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Each person must use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person’s needs, is used anytime the PCP process is used.

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

   1. When and where the meeting will be held.

   2. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).
3. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them. (What will be discussed and not discussed.

4. The specific PCP format or tool chosen by the person to be used for PCP.

5. What accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).

6. Who will facilitate the meeting.

7. Who will take notes about what is discussed at the meeting.

g. **Wellness and Well-Being.** Issues of wellness, well-being, health and primary care coordination support needed for the person to live the way he or she want to live are discussed and plans to address them are developed. People are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, eating candy or other sweets). If the person chooses, issues of wellness and well-being can be addressed outside of the PCP meeting.

 PCP highlights personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the person’s right to assume some degree of personal risk. The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).

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

V. **WHAT IS INDEPENDENT FACILITATION?**

An Independent Facilitator is a person who facilitates the person-centered planning process in collaboration with the person. In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their person-centered planning process. The terms independent and external mean that the facilitator is independent of or external to the community mental health system. It means that the person has no financial interest in the outcome of the
supports and services outlined in the person-centered plan. Using an independent facilitator is valuable in many different circumstances, not just situations involving disagreement or conflict.

The PIHP/CMHSP must contract with a sufficient number of independent facilitators to ensure availability and choice of independent facilitators to meet their needs. The independent facilitator is chosen by the individual and serves as the individual’s guide (and for some individuals, assisting and representing their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The independent facilitator must not have any other role within the PIHP/CMHSP. The role of the independent facilitator is to:

a. Personally know or get to know the individual who is the focus of the planning, including what he or she likes and dislikes, personal preferences, goals, methods of communication, and who supports and/or is important to the person.

b. Help the person with all pre-planning activities and assist in inviting participants chosen by the person to the meeting(s).

c. Assist the person to choose planning tool(s) to use in the PCP process.

d. Facilitate the PCP meeting(s) or support the individual to facilitate his or her own PCP meeting(s).

e. Provide needed information and support to ensure that the person directs the process.

f. Make sure the person is heard and understood.

g. Keep the focus on the person.

h. Keep all planning participants on track.

i. Develop an individual plan of service (IPOS) in partnership with the person that expresses the person’s goals, is written in plain language understandable by the person, and provides for services and supports to help the person achieve their goals.

The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called “Treatment Planning” (MPM MH&SAA Chapter, Section 3.25.) If the independent facilitator is paid for the provision of these activities, the PIHP/CMHSP may report the service under the code H0032.

An individual may use anyone he or she chooses to help or assist in the person-centered planning process, including facilitation of the meeting. If the person does not meet
the requirements of an Independent Facilitator, he or she cannot be paid, and responsibility for the Independent Facilitator duties described above falls to the Supports Coordinator/Case Manager. A person may choose to facilitate his or her planning process with the assistance of an Independent Facilitator.

VI. **HOW IS PERSON-CENTERED PLANNING USED TO WRITE AND CHANGE THE INDIVIDUAL PLAN OF SERVICE?**

The Code establishes the right for all people to develop Individual Plans of Services (IPS) through the PCP process. The PCP process must be used at any time the person wants or needs to use the process, but must be used at least annually to review the IPS. The agenda for each PCP meeting should be set by the person through the pre-planning process, not by agency or by the fields or categories in a form or an electronic medical record.

Assessments may be used to inform the PCP process, but is not a substitute for the process. Functional assessments must be undertaken using a person-centered approach. The functional assessment and the PCP process together should be used as a basis for identifying goals, risks, and needs; authorizing services, utilization management and review. No assessment scale or tool should be utilized to set a dollar figure or budget that limits the person-centered planning process.

While the Code requires that PCP be used to develop an Individual Plan of Services (IPS) for approved community mental health services and supports, the purpose of the PCP process is for the person to identify life goals and decide what medically necessary services and supports need to be in place for the person to have, work toward or achieve those life goals. The person or representative chooses what services and supports are needed. Depending on the person, community mental health services and supports may play a small or large role in supporting him or her in having the life he or she wants. When a person is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life that he or she desires to have.

People are often at different points in the process of achieving their life goals. The PCP process should be individualized to meet each person’s needs of the person for whom planning is done, i.e. meeting a person where he or she is. Some people may be just beginning to define the life they want and initially the PCP process may be lengthy as the person’s goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once an IPS is developed, subsequent use of the PCP process, discussions, meetings, and reviews will work from the existing IPS to amend or update it as circumstances and preferences change. The extent to which an IPS is updated will be determined by the needs and desires of the person. If and when necessary, the IPS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs of the person as they arise.
An IPOS must be prepared in person-first singular language and be understandable by the person with a minimum of clinical jargon or language. The person must agree to the IPOS in writing. The IPOS must include all of the components described below:

a. A description of the individual’s strengths, abilities, plans, hopes, interests, preferences and natural supports.

b. The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.

c. The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports.

d. The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system. The PIHP/CMHSP is responsible for ensuring it meets these requirements of the HCBS Final Rule.

e. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

f. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.

g. Documentation of any restriction or modification of additional conditions must meet the standards.

h. The services which the person chooses to obtain through arrangements that support self-determination.

i. The estimated/prospective cost of services and supports authorized by the community mental health system pursuant to Contract Attachment P.6.3.2.1B.ii.

j. The roles and responsibilities of the person, the supports coordinator or case manager, the allies, and providers in implementing the IPOS.

k. The person or entity responsible for monitoring the plan.

l. The signatures of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).
m. The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.

n. A timeline for review.

o. Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

Once a person has developed an PCP through the IPOS process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the person’s needs, changes in the person’s condition as determined through the IPOS process or changes in the personal preferences for support).

The person and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. A person or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the person and his/her guardian or authorized representative, if any, shall occur not less than annually. Reviews will work from the existing IPOS to review progress on goals, assess personal satisfaction and to amend or update the IPOS as circumstances, needs, preferences or goals change or to develop a completely new plan, if the person desires to do so. The review of the IPOS at least annually is done through the IPOS process.

The IPOS process often results in personal goals that aren’t necessarily supported by the CMHSP services and supports. Therefore, the IPOS process must not be limited by program specific functional assessments. The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the PCP. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented. Non-paid supports, chosen by the person and agreed to by the unpaid provider, needed to achieve the goals must be documented. With the permission of the person, the IPOS should be discussed with family/friends/caregivers chosen by the person so that they fully understand it and their role(s).

The person must be provided with a written copy of his or her IPOS within 15 business days of conclusion of the IPOS process. This timeframe gives the case manager/supports coordinator a sufficient amount of time to complete the documentation described above.

VII. HOW MUST RESTRICTIONS ON A PERSON’S RIGHTS AND FREEDOMS BE DOCUMENTED IN THE IPOS?
Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the IPOS process and documented in the IPOS.

The rights and freedoms listed in the HCBS Final Rule are:

- A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.
- Sleeping or living units lockable by the individual with only appropriate staff having keys.
- Individuals sharing units have a choice of roommate in that setting.
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.
- Individuals are able to have visitors of their choosing at any time.

The following requirements must be documented in the IPOS when a specific health or safety need warrants such a restriction:

1. The specific and individualized assessed health or safety need.
2. The positive interventions and supports used prior to any modifications or additions to the IPOS regarding health or safety needs.
3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.
4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.
5. A regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Informed consent of the person to the proposed modification.
8. An assurance that the modification itself will not cause harm to the person.
VIII. **WHAT DO PIHPS, CMHSPS AND OTHER ORGANIZATIONS NEED TO DO TO ENSURE SUCCESSFUL USE OF THE PERSON-CENTERED PLANNING PROCESS?**

Successful implementation of the PCP Process requires that agency policy, mission/vision statements, and procedures incorporate PCP standards. A process for monitoring PCP should be implemented by both the PIHPs and CMHSP, along with the monitoring process through the MDHHS site review.

The following elements are essential for organizations responsible implementing the PCP process:

a. **Person-Centered Culture.** The organization provides leadership, policy direction, and activities for implementing PCP at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.

b. **Individual Awareness and Knowledge.** The organization provides easily understood information, support and when necessary, training, to people using services and supports, and those who assist them, so that they understand their right to and the benefits of PCP, know the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).

c. **Conflict of Interest.** The organization ensures that the conflict of interest requirements of the HCBS Final Rule are met and that the person responsible for the PCP process is separate from the eligibility determination, assessment, and service provision responsibilities.

d. **Training.** All Staff receive competency-based training in PCP so that they have consistent understanding of the process. Staff who are directly involved in IPOS services or supports implementation are provided with specific training.

e. **Roles and Responsibilities.** As an individualized process, PCP allows each person to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.

f. **System wide Monitoring.** The Quality Assurance/Quality Management (QA/QM) System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful use of the PCP process. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and
standards are in place to assure that the person directs the PCP process and ensures that PCP is consistently followed.

IX. WHAT DISPUTE RESOLUTION OPTIONS ARE AVAILABLE?

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). When a person is receiving services and no agreement on IPOS can be made through the person-centered planning process during the annual review, services shall continue until a notice of a denial, reduction, suspension, or termination is given in which case the rights and procedures for grievance and appeals take over. Other options are available to all recipients of Michigan mental health services and supports. Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate the dispute resolution processes.
PASARR AGREEMENT

I. PURPOSE

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

II. REQUIREMENTS

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

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


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

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

PRE-ADMISSION SCREENING

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

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

**ANNUAL RESIDENT REVIEW**

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

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

### III. RECORDS, BILLINGS, AND REIMBURSEMENT

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

B. The CMHSP will submit monthly billings to the DEPARTMENT for services provided based on an actual cost basis as defined in "Revised Billing Procedures for OBRA Pre-Admission Screening, and Annual Resident Review for Nursing Facility Clients" DCH memorandum, William J. Allen, October 2, 1996, which is included to this agreement. Only one (1) bill will be considered for payment per month, and should be submitted for payment to the DEPARTMENT within forty-five (45) days after the end of the month in which the service was provided, except for the September bill which shall be submitted within fifteen (15) days after the end of the month. In the event that the CMHSP realizes costs incurred after a billing
has been submitted, the CMHSP may submit a revised billing. In any event, all bills for services provided under this Agreement must be received by the DEPARTMENT within fifteen (15) days following the end of the fiscal year. Submitted bills will also include the number of evaluations completed during the month being billed by completing the "Detail of Services Billed" form. The PASARR forms located in the MDHHS OBRA Operations Manual must be utilized by the CMHSP for reporting and billing.

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

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

IV. DEPARTMENT RESPONSIBILITIES

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

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

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

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

### DETAIL OF SERVICES BILLED

**Nursing Facility Evaluations**

<table>
<thead>
<tr>
<th>CMH Board Name: ______________________________</th>
<th>Month/Year: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Resident</th>
<th>Date of Birth</th>
<th>*Type of Screening</th>
<th>MI or DD</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Indicate PAS or ARR
SUMMARY BILLING FOR PRE-ADMISSION SCREENING and ANNUAL RESIDENT REVIEWS (PASARR)
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CMH BOARD ___________________________ TELEPHONE NUMBER: _______________________
PERSON COMPLETING FORM: ___________________________ DATE SUBMITTED: ______________
MONTH ENDING: _______________ DATE SUBMITTED: ______________
NUMBER of Reviews: DD_____________ MI_____________ TOTAL_________________

I. DIRECT COSTS TOTAL

A. Direct labor(excluding overtime, shift or holiday premiums and fringe benefits) $___________
B. Other Labor(overtimes, shift or holiday premiums and fringe benefits). $___________
C. Other Direct Costs(contractual services, supplies/materials, travel, equipment, telephone, office space, etc.) $___________
D. Subtotal Direct Costs: $___________

II. INDIRECT COSTS

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

III. TOTAL COSTS (Direct and Indirect Costs) $___________

IV. FEDERAL REIMBURSEMENT

(Total Costs ..III Above) Total Costs $___________ x .75 = $___________

CMHSP CERTIFICATION

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

COMMUNITY MENTAL HEALTH SERVICES PROGRAMS DIRECTOR

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

MDHHS Authorized Staff

V2018-2
CERTIFICATE OF INDIRECT COSTS

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

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

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

I declare that the foregoing is true and correct.

Community Mental Health Agency:

Name:___________________________________________
Signature:________________________________________
Title:____________________________________________
Date:__________________________________________
Amendment #2

STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF COMMUNITY HEALTH

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

October 2, 1996

TO: Executive Directors
Community Mental Health Services Programs

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

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

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

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

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

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

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

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

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

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

WJA:SOH:eed
Attachments

c. David Verseput
   David Viele
   Richard Miles
MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY18 - Attachment C6.5.1.1

Amendment #2

Table of Contents

Introduction ................................................................................................................................................................... 2
FINANCIAL PLANNING, REPORTING AND SETTLEMENT .................................................................................. 3
FY 2018 DATA REPORT DUE DATES ...................................................................................................................... 6
BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS) COLLECTION/RECORDING AND REPORTING REQUIREMENTS ................................................................................................................................. 7
PROXY MEASURES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES .................................................. 9
ENCOUNTERS PER MENTAL HEALTH, DEVELOPMENTAL DISABILITY, AND SUBSTANCE ABUSE BENEFICIARY ........................................................................................................................................................... 17
FY18 SUB-ELEMENT COST REPORT .................................................................................................................... 23
FY18 CMHSP GENERAL FUND COST REPORT ................................................................................................... 23
MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM ........................................................... 24
CMHSP PERFORMANCE INDICATOR SYSTEM .................................................................................................. 25
CMHSP PERFORMANCE INDICATOR REPORTING DUE DATES .................................................................... 28
CAFAS ........................................................................................................................................................................ 29
RECIPIENT RIGHTS DATA REPORT .................................................................................................................... 31
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
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](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](mailto:MDHHS-BHDDA-Contracts-MGMT@michigan.gov) except for reports noted in table below.

<table>
<thead>
<tr>
<th>Due Date</th>
<th>Report Title</th>
<th>Report Frequency</th>
<th>Report Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/31/2018</td>
<td>1Q Special Fund Account – Section 226a, PA of the MHC</td>
<td>Quarterly (Use standalone form)</td>
<td>October 1 to December 31</td>
</tr>
<tr>
<td>4/30/2018</td>
<td>2Q Special Fund Account – Section 226a, PA of the MHC</td>
<td>Quarterly (Use standalone form)</td>
<td>October 1 to March 31</td>
</tr>
<tr>
<td>5/31/2018</td>
<td>Mid-Year Status Report</td>
<td>Mid-Year</td>
<td>October 1 to March 31</td>
</tr>
<tr>
<td>6/30/2018</td>
<td>Semi-annual Recipient Rights Data Report</td>
<td>Mid-Year</td>
<td>October 1 to March 31. Section I only. See section “Recipient Rights Data Report” for additional information in this attachment.</td>
</tr>
<tr>
<td>8/15/2018</td>
<td>3Q Special Fund Account – Section 226a, PA of the MHC</td>
<td>Quarterly (Use standalone form)</td>
<td>October 1 to June 30</td>
</tr>
<tr>
<td>8/15/2018</td>
<td>CMHSP FSR Bundle – All Non-Medicaid,</td>
<td>Projection (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• State Services Utilization, Reconciliation &amp; Cash Analysis</td>
<td>Projection (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• General Fund Contract Settlement Worksheet</td>
<td>Projection (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• General Fund Reconciliation and Cash Settlement</td>
<td>Projection (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• Special Fund Account – Section 226a, PA of the MHC</td>
<td>Projection (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>10/1/2018</td>
<td>General Fund – Year End Accrual Schedule</td>
<td>Final</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
<td>Frequency</td>
<td>Submission Dates</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>FY18 Monthly</td>
<td>PASARR Agreement Monthly Billing</td>
<td>Monthly</td>
<td>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.</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>CMHSP FSR Bundle – All Non-Medicaid,</td>
<td>Interim (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• State Services Utilization, Reconciliation &amp; Cash Analysis</td>
<td>Interim (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• Special Fund Account – Section 226a, PA of the MHC</td>
<td>Interim (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• General Fund Contract Settlement Worksheet</td>
<td>Interim (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• General Fund Reconciliation and Cash Settlement</td>
<td>Interim (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• Special Fund Account – Section 226a, PA of the MHC</td>
<td>Interim (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>11/10/2018</td>
<td>Categorical Funding – Multicultural Annual Report</td>
<td>Annually</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>12/30/2018</td>
<td>Annual Recipient Rights Data Report</td>
<td>Annually</td>
<td>October 1 to September 30. Sections I, II, III &amp; IV. See section “Recipient Rights Data Report” for additional information in this attachment.</td>
</tr>
<tr>
<td>1/31/2019</td>
<td>Annual Report on Fraud and Abuse Complaints</td>
<td>Annually</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>CMHSP FSR Bundle – All Non-Medicaid,</td>
<td>Final (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• State Services Utilization, Reconciliation &amp; Cash Analysis</td>
<td>Final (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• Special Fund Account – Section 226a, PA of the MHC</td>
<td>Final (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• General Fund Reconciliation and Cash Settlement</td>
<td>Final (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• General Fund Contract Settlement Worksheet</td>
<td>Final (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td></td>
<td>• Special Fund Account – Section 226a, PA of the MHC</td>
<td>Final (Use tab in FSR Bundle)</td>
<td>October 1 to September 30</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Sub-Element Cost Report</td>
<td>Annually</td>
<td>See Attachment 6.5.1.1 Submit report to: <a href="mailto:QMPMeasures@michigan.gov">QMPMeasures@michigan.gov</a></td>
</tr>
</tbody>
</table>

Page 4 of 37
### Annual Submission Requirement

<table>
<thead>
<tr>
<th>Date</th>
<th>Requirement Description</th>
<th>Frequency</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Estimated FTE Equivalents</td>
<td>Annually</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Requests for Services and Disposition of Requests</td>
<td>Annually</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 1</td>
<td>Annually</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 2</td>
<td>Annually</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Waiting List</td>
<td>Annually</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Specialized Residential</td>
<td>Annually</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Annual Submission Requirement Form – Community Needs Assessment</td>
<td>Annually</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>CMHSP Administrative Cost Report</td>
<td>Annually</td>
<td>For the fiscal year ending September 30, 2018</td>
</tr>
<tr>
<td>2/28/2019</td>
<td>Executive Administrative Expenditures Survey for Sec. 904(2)(k)</td>
<td>Annually</td>
<td>October 1 to September 30, 2017</td>
</tr>
<tr>
<td>30 days after receipt, but no later than June 30, 2018</td>
<td>Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.</td>
<td>Annually</td>
<td>October 1 to September 30th Submit reports to: <a href="mailto:MDHHS-AuditReports@michigan.gov">MDHHS-AuditReports@michigan.gov</a></td>
</tr>
<tr>
<td>30 days after receipt, but no later than June 30, 2018</td>
<td>Compliance exam and plan of correction</td>
<td>Annually</td>
<td>October 1 to September 30th Submit reports to: <a href="mailto:MDHHS-AuditReports@michigan.gov">MDHHS-AuditReports@michigan.gov</a></td>
</tr>
</tbody>
</table>
**FY 2018 DATA REPORT DUE DATES**

<table>
<thead>
<tr>
<th></th>
<th>Nov 17</th>
<th>Dec</th>
<th>Jan18</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec 18</th>
<th>Jan 19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Consumer level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demographic BHTEDS (monthly)</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Encounter (monthly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. PIHP level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Performance indicators (quarterly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Consumer Satisfaction (annually)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. CAFAS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Critical incidents (monthly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

*Disability Designation*

*Developmental disability* (Individual meets the Mental Health Code Definition of Developmental Disability regardless of whether or not they receive services from the I/DD or MI services arrays) (DD)
1 = Yes
2 = No
3 = Not evaluated
*Mental Illness or Serious Emotional Disturbance* individual has been evaluated and/or individual has a DSM MI diagnosis, exclusive of intellectual disability, developmental disability, or substance abuse disorder OR the individual has a Serious Emotional Disturbance.

1 = Yes
2 = No
3 = Not evaluated

**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
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

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

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](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.

<table>
<thead>
<tr>
<th>Data Record</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Record Format:</strong> rc1041.06</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element #</th>
<th>Data Element Name</th>
<th>Picture</th>
<th>Usage</th>
<th>Format</th>
<th>From</th>
<th>To</th>
<th>Validated</th>
<th>Required</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Submitter ID</td>
<td>Char(4)</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>Yes</td>
<td>Yes</td>
<td>Service Bureau ID (DEG Mailbox ID)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Consumer ID</td>
<td>Char(11)</td>
<td>11</td>
<td>5</td>
<td>15</td>
<td>No</td>
<td>Yes</td>
<td>Unique Consumer ID</td>
<td></td>
</tr>
<tr>
<td>Element #</td>
<td>Data Element Name</td>
<td>Picture</td>
<td>Usage</td>
<td>Format</td>
<td>From</td>
<td>To</td>
<td>Validated</td>
<td>Required</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------</td>
<td>---------</td>
<td>-------</td>
<td>--------</td>
<td>------</td>
<td>----</td>
<td>-----------</td>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>3</td>
<td>Medicaid ID</td>
<td>Char(10)</td>
<td>10</td>
<td>16</td>
<td>25</td>
<td>Yes</td>
<td>Conditional</td>
<td>Must present on file if available.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>MiChild ID</td>
<td>Char(10)</td>
<td>10</td>
<td>26</td>
<td>35</td>
<td>Yes</td>
<td>Conditional</td>
<td>MICHILD ID [CIN] Must present on file if available.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Begin Date</td>
<td>Date</td>
<td>8</td>
<td>YYYYMMDD</td>
<td>36</td>
<td>43</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
ENCOUNTERS PER MENTAL HEALTH, DEVELOPMENTAL DISABILITY, AND SUBSTANCE ABUSE BENEFICIARY
DATA REPORT

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

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 837 includes 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). If the Billing Provider is a specialized licensed residential facility also report the LARA license facility number (See Instructions for Reporting Specialized Residential Facility Details 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. Facility Location of the Specialized Residential Facility
In instances in which the specialized licensed residential facility is not the Billing Provider, report the name, address, NPI (if applicable) and LARA license of the facility in the Facility Location (2310C loop). (See Instructions for Reporting Specialized
Residential Facility Details at [www.michigan.gov/mdhhs/bhdda](http://www.michigan.gov/mdhhs/bhdda). Click on Reporting Requirements)
**19. 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’18 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

FY18 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
The Michigan Mission Based Performance Indicator System (version 1.0) was first implemented in FY’97. That original set of indicators reflected nine months of work by more than 90 consumers, advocates, CMHSP staff, MDHHS staff and others. The original purposes for the development of the system remain. Those purposes include:

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

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

5. The percent of face-to-face assessments with professionals that result in decisions to deny CMHSP services. (MI and DD) (Old Indicator #6)
   a. Quarterly report
   b. CMHSP
   c. Scope: all MI/DD consumers
6. The percent of Section 705 second opinions that result in services. (MI and DD) (Old Indicator #7)
   a. Quarterly report
   b. CMHSP
   c. Scope: all MI/DD consumers

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

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

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

10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. (Old Indicator #12)
   a. Standard = 15% or less within 30 days
   b. Quarterly report
   c. PIHP for all Medicaid beneficiaries
   d. 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**

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

*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 REV 06/2017) 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 semiannual report memo can be sent by email.

Demographic Data

1. Select the Agency name from the drop down in cell C2.

2. CMHSPs: Insert the number of consumers served (unduplicated count) in cell E6.

Service Site Information

1. Enter the number of sites in your catchment area
2. Enter the number of sites out of catchment area.
3. In the third column type in only the number of sites that must be visited.
4. In the fourth column type in the number of site visits conducted. If a site is visited twice, it is only counted on the first visit. Sites should not be counted more than once (return visits to assure compliance are not counted).
5. If a site is visited twice, it is only counted on the first visit, but you may enter the additional visits in the fifth column.

<table>
<thead>
<tr>
<th>Type of Site</th>
<th>In Catchment Area</th>
<th>Out of Catchment Area</th>
<th>Total Sites Visited</th>
<th>Annual Site Visits Conducted</th>
<th>Additional Site Visits Conducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential MH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential DD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential R &amp; DD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dropout</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Program MH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Program DD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone (intravenous)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial Rehab</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Foster Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Drop-in Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSFB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Determination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Number of Service Sites that Require Site Visits: 0
Total Number of Site Visits Conducted: 0
**Staffing Information:**
1. FTE’s are defined as hours paid for recipient rights functions. List the full-time equivalents for your office.
2. Explain the breakdown of staff (if there is one); investigators/administrators, clerical/support, trainers.
3. If there is only 1 person for all functions, fill in only cell C41

**Appeal Information:**
Insert the number of appeals submitted (to the committee), the number accepted and the disposition of the appeals heard.
Complaint Data

THESE SECTIONS ARE REQUIRED TO BE COMPLETED FOR THE ANNUAL REPORT AND SEMI-ANNUAL REPORT

Section 1: Complaint Data Summary

Part A: Totals

1. Insert the name of the Rights Office Director in cell C2
   The number of Allegations will populate from the Aggregate Summary.
2. 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”.
**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).

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
<th>≤30</th>
<th>≤60</th>
<th>≤90</th>
<th>&gt;90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse/Neglect I &amp; II</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All others</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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)

*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.

** 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.

*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 1)
- The Specific remedial action taken (be sure to only list 1 action per column) (see table 2)
- The number of the type of population (see table 3)
**TABLE 1**

<table>
<thead>
<tr>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
</tr>
<tr>
<td>Residential MI</td>
</tr>
<tr>
<td>Residential DD</td>
</tr>
<tr>
<td>Mixed Residential (MI/DD)</td>
</tr>
<tr>
<td>Inpatient</td>
</tr>
<tr>
<td>Day Program MI</td>
</tr>
<tr>
<td>Day Program DD</td>
</tr>
<tr>
<td>Workshop (Prevocational)</td>
</tr>
<tr>
<td>Supported Employment</td>
</tr>
<tr>
<td>ACT</td>
</tr>
<tr>
<td>Case Management</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
</tr>
<tr>
<td>SIP</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

**TABLE 2**

<table>
<thead>
<tr>
<th>Remedial Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Counseling</td>
</tr>
<tr>
<td>Written Counseling</td>
</tr>
<tr>
<td>Written Reprimand</td>
</tr>
<tr>
<td>Suspension</td>
</tr>
<tr>
<td>Demotion</td>
</tr>
<tr>
<td>Staff Transfer</td>
</tr>
<tr>
<td>Training</td>
</tr>
<tr>
<td>Employment Termination</td>
</tr>
<tr>
<td>Employee left the agency, but substantiated**</td>
</tr>
<tr>
<td>Contract Action</td>
</tr>
<tr>
<td>Policy Revision/Development</td>
</tr>
<tr>
<td>Environmental Repair/Enhancement</td>
</tr>
<tr>
<td>Plan of Service Revision</td>
</tr>
<tr>
<td>Recipient Transfer to Another Provider/Site</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

**TABLE 3**

**Section II: Annual Complaint Data Summary for:**

<table>
<thead>
<tr>
<th>Category (from Complaint Data)</th>
<th>Specific Provider Type</th>
<th>Specific Remedial Action(s)</th>
<th>Specific Remedial Action(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Population**

<table>
<thead>
<tr>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD</td>
</tr>
<tr>
<td>SED</td>
</tr>
<tr>
<td>SEDW</td>
</tr>
<tr>
<td>DD-CWP</td>
</tr>
<tr>
<td>HSW</td>
</tr>
</tbody>
</table>

**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.

THESE SECTIONS ARE REQUIRED TO BE COMPLETED FOR THE ANNUAL REPORT ONLY

Section II: Training Activity

Part A: Training Received by Rights Office Staff
1. Enter the name of each staff who receive training in column A (Last name, First name).
2. Fill in each staff in column C using the drop-down box.
3. Indicate, for each rights staff, the course number assigned by MDHHS-ORR (available on the web site)
4. Enter the name of the rights related training received during the period,
5. Enter the CEU Category (Operations, Legal/Foundations, Leadership, Augmented)
6. Enter the number of hours for each
Part B: Training Provided by Rights Office

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

Indicate: the topic of the training provided during the period (2), the length of the session (3), the number of CMH (4), contractual staff (5), consumers (6), the number of other staff (7) involved, type of “others” trained (8). Indicate the method(s) used (9), and a description, if necessary (10). (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).

<table>
<thead>
<tr>
<th>TYPES OF TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face-to-Face</td>
</tr>
<tr>
<td>Video Face-to-Face</td>
</tr>
</tbody>
</table>

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:

- CMHSPs are NOT to include LPH/U data on the Annual & Semi-Annual Reports
Employment Works! Policy

MDHHS recognizes that employment is an essential element of quality of life for most people, including individuals with a serious mental illness or a developmental disability; including persons with the most significant disability.

The Michigan Employment First Executive Order No. 2015-15 “recognizes that competitive employment within an integrated setting is the first priority and optimal outcome for persons with disabilities, regardless of level or type of disability; …” Therefore, in accordance with this Executive Order, it is the policy of MDHHS that:

Each eligible working age individual over 16 years old (to correlate with transition planning and related MDHHS policy Attachment C 6.9.6.1) and ongoing to the age of their chosen retirement will be supported to pursue his or her own unique path to work and a career. All individuals will be afforded the opportunity to pursue individual competitive, integrated employment. MDHHS shall define individual competitive integrated employment using the definition in the Workforce Innovation & Opportunity Act stated below.

Competitive integrated employment:

(i) Is performed on a full-time or part-time basis (including self-employment);

(ii) The individual is compensated at a rate that;

   a. Is not less than the higher of the rate specified in the Fair Labor Standards Act of 1938, or the State minimum wage law

   b. Is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; and

   c. In the case of an individual who is self-employed, yields an income that is comparable to the income received by other individuals who are not individuals with disabilities and who are self-employed in similar occupations or on similar tasks and who have similar training, experience, and skills; and

   d. Is eligible for the level of benefits provided to other employees;

(iii) Is at a location that is typically found in the community;

(iv) The employee with a disability interacts for the purpose of performing the duties of the position with other employees within the particular work unit and the entire work site, and, as appropriate to the work performed, other persons (e.g., customers and vendors), who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that employees who are not individuals with disabilities and who are in comparable positions interact with these persons; and

(v) Presents, as appropriate, opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions.

Furthermore, specifically, individuals with disabilities hired by community
rehabilitation programs to perform work under service contracts, either alone or in groups (e.g., landscaping or janitorial crews), whose interaction with persons without disabilities (other than their supervisors and service providers) is with persons working in or visiting the work locations (and not with employees of the community rehabilitation programs without disabilities in similar positions) would not be performing work in an integrated setting.

Each time a pre-planning meeting is held to prepare for a person’s plan of service (at least annually); a person’s options for work will be encouraged as noted in Contract Attachment C 3.4.1.1 and will be documented during the pre-planning meeting. Competitive employment within an integrated setting will be underscored and encouraged as the first priority and optimal outcome for persons with disabilities, regardless of level or type of disability.

In the case of employment for persons with mental illness, MDHHS has adopted the evidence-based practice of Individual Placement and Support (IPS). The definition for the outcome of competitive employment for this specific population remains; individual jobs that anyone can apply for rather than jobs created specifically for people with disabilities. These jobs pay at least minimum wage or the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled. Further, the jobs do not have artificial time limits imposed by the social service agency.

This proposed policy shall support persons with serious mental illness and developmental disabilities to receive services and supports to achieve and maintain competitive employment. It is imperative that this Employment Works! Policy be shared and reinforced as an expectation with staff responsible for employment services and outcomes and with all supports coordinators and case managers.

In order to measure employment outcomes, MDHHS will compare baseline numbers for all individual competitive integrated employment. Additionally, MDHHS will measure facility-based and group employment each year. It is expected that the total percentage of individuals competitively employed in integrated settings will increase individual competitive integrated employment. It is also expected that as individual competitive integrated employment increases, the percentage of individuals in facility-based and group employment will decrease.

**Expectations for MDHHS:**

- Retain a permanent state-level staff who has responsibility for further developing and directing overall employment policies, messaging, and services for Michigan citizens supported through contracted provider networks. This person will:
  - Encourage progressive use of funding to support services that advance the optimal outcome of individual competitive integrated employment.
  - Strengthen effective working relationships and partnering with Michigan Rehabilitation Services, the Bureau of Services for Blind Persons, and Michigan Department of Education/Office of Special Education, Michigan Developmental Disabilities Council, the Michigan Workforce Development Agency, and other stakeholder organizations.
  - Provide technical assistance to contracted provider networks for program implementation and sustainability and also provide opportunities for training and development to enhance individual competitive integrated employment.
  - Review existing employment data sources, and establish a strategy for collecting and sharing accurate employment outcome data with stakeholders within current technology and resources.
  - Research and advise on emerging employment goals for the contracted provider networks system data and promote prompt commitment to completion of such
goals in current contracted provider networks’ contracts.

- Encourage and promote the use of best employment practices. (Examples include the evidence based supported employment, customized employment, self-employment, discovery/career exploration, evidence-based Individual Placement & Support model for persons with mental illness etc.)
- Identify contracted provider networks with best employment outcomes, learn from their successes, and highlight these practices.
- Assist PIHPs/CMHSPs in developing expertise in benefits planning.
- Collaborate with existing employment work group(s) as possible.

**Expectations for PIHPs/CMHSPs:**

- Designate a contracted provider network staff as liaison to the State-level designee who shall be responsible for local support and implementation of the *Employment Works!* Policy. Designate this liaison to participate in State employment meetings whenever possible (presently held every four (4) months). Designate this liaison to share employment information and strategies with local partners as feasible. This liaison will:
  - Promote progressive use of funding and services to advance the optimal outcome of individual competitive integrated employment.
  - Enhance opportunities and support for contracted provider network consumers through strengthened working relationships and partnering with Michigan Rehabilitation Services, the Bureau of Services for Blind Persons, and local Intermediate School Districts and schools.
  - Work with contracted provider network to provide timely and accurate employment outcome data to MDHHS based on current contractual requirements.
  - Review local employment data and encourage increases annually by establishing a tracking mechanism related to local employment goals. (Examples include the evidence based supported employment, customized employment, self-employment, discovery/career exploration, evidence-based Individual Placement & Support model for persons with mental illness, etc.)
  - Share best employment practices across the contracted provider networks through conferences, webinars, conference calls, newsletters, cross-agency presentations, etc.
  - Work with contracted provider network to designate at least one (preferably two) staff that have successfully completed a BHDDA sponsored benefits planning training (or comparable) that develops needed expertise regarding access to timely and accurate information to address immediate employment interests of persons with disabilities.