

Grant Agreement Between
{dept_name} Services
hereinafter referred to as the "Department" or "MDHHS"
and
{agency_name}
{add_line_1}
{add_line_2}
Federal I.D.#: {fed_id}, Unique Entity Identifier: {uei_no}
hereinafter referred to as the "Grantee" or "CMHSP"
for
{pgm_desc}

1. Period of Agreement:

This Agreement will commence on the date of the Grantee's signature or {start_dt}, whichever is later, and continue through {end_dt}. No service will be provided and no costs to the state will be incurred prior to {start_dt} or the effective date of the Agreement, whichever is later. Through the Agreement, the date of the Grantee's signature or {start_dt}, whichever is later, will be referred to as the start date. This Agreement is in full force and effect for the period specified.

2. Program Budget and Agreement Amount:

A. Agreement Amount:

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

The terms and conditions of this contract are those included in: (a) Part I: Contractual Services Terms and Conditions; (b) Part II: Statement of Work; and (c) all Attachments as specified in Parts I and II of the contract.

The Agreement is designated as a:

{sub_recp_rel} Subrecipient relationship (federal funding); or
{recp_rel} Recipient (non-federal funding).

The Agreement is designated as:

Research and development project; or
X Not a research and development project.

3. **Grantee's Financial Contact for the Agreement:**

The financial contact acting on behalf of the Grantee for this Agreement is:

{fin_name}

Name

Title

{fin_email}

E-Mail Address

Telephone No.

4. **Special Certification:**

The individuals signing this Agreement certify by their signatures that they are authorized to sign this Agreement on behalf of the organization specified.

5. **Signature Section:**

FOR the GRANTEE

{agency_name}

{auth_name}

Name

Title

Date

For the {dept_name}

Christine H. Sanches

{current_date}

Christine H. Sanches, Director
Bureau of Grants and Purchasing

Date

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Definitions/Explanation of Terms

DRAFT

Part I
Contractual Services Terms and Conditions

1.0 Purpose

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

2.0 Issuing Office

This contract is issued by the Michigan Department of Health & Human Services (MDHHS). The MDHHS is the sole point of contact regarding all procurement and contractual matters relating to the services described herein. MDHHS is the only entity authorized to change, modify, amend, clarify, or otherwise alter the specifications, terms, and conditions of this contract. Inquiries and requests concerning the terms and conditions of this contract, including requests for amendment, shall be directed by the CMHSP to the attention of the Director of MDHHS's Behavioral and Physical Health and Aging Services Administration and by the MDHHS to the contracting organization's Executive Director.

3.0 Contract Administrator

The person named below is authorized to administer the contract on a day-to-day basis during the term of the contract. However, administration of this contract implies no authority to modify, amend, or otherwise alter the payment methodology, terms, conditions, and specifications of the contract. That authority is retained by the Department of Health & Human Services, subject to applicable provisions of this Agreement regarding modifications, amendments, extensions or augmentations of the contract (Section 16.0). The Contract Administrator for this project is:

Kristen Jordan, Director
Bureau of Specialty Behavioral Health Services
Behavioral and Physical Health and Aging Services Administration
Department of Health & Human Services
400 S. Pine
Lansing, Michigan 48913

4.0 Term of Contract

The term of this contract shall be from October 1, 2023 through September 30, 2024. The contract may be extended in increments no longer than 12 months, contingent upon mutual agreement to an amendment to the financial obligations reflected in Attachment C 7.0.1 and other changes agreed upon by the parties for no more than three one-year extensions after September 30, 2024. Fiscal year payments are contingent upon and subject to enactment of legislative appropriations.

5.0 Payment Methodology

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

6.0 Liability

6.1 Cost Liability

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

6.2 Contract Liability

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

7.0 CMHSP Responsibilities

The CMHSP shall be responsible for the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract. The CMHSP is responsible for complying with all reporting requirements as specified in this contract. Data reporting requirements are specified in Part II, Section 6.5 of the contract. Finance reporting requirements are specified in Part II, Section 7.8. Additional requirements are identified in Attachment C 7.0.2 (Performance Objectives).

7.1 MDHHS Standard Consent Form

MDHHS Standard Consent Form Michigan PA 129 of 2014 was enacted to promote the use and acceptance of a standard consent form. Contractor must implement a written policy that requires the provider network to use, accept, and honor the standard consent form created as a result of the Public Act (Form MDHHS-5515). Per PA 559 of 2016, the policy must recognize written consent is not always required.

8.0 Acknowledgment of MDHHS Financial Support

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

9.0 Disclosure

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

10.0 Contract Invoicing and Payment

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

11.0 Litigation

The state, its departments, and its agents shall not be responsible for representing or defending the CMHSP, the CMHSP's personnel, or any other employee, agent or sub-contractor of the CMHSP, named as a defendant in any lawsuit or in connection with any tort claim. The MDHHS and the CMHSP agree to make all reasonable efforts to cooperate with each other in the defense of any litigation brought by any person or people not a party to the contract.

The CMHSP shall submit annual litigation reports to MDHHS, providing the following detail for all civil litigation that the CMHSP, sub-contractor, or the CMHSP's insurers or insurance agents are parties to:

1. Case name and docket number
2. Name of plaintiff(s) and defendant(s)
3. Names and addresses of all counsel appearing
4. Nature of the claim
5. Status of the case

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

12.0 Cancellation

Material Default

The MDHHS may cancel this contract for material default of the CMHSP. Material default is defined as the substantial failure of the CMHSP to meet CMHSP certification requirements as stated in the Michigan Mental Health Code (Section 232a) or other Mental Health Code mandated provisions. In case of material default by the CMHSP, the MDHHS may cancel this contract without further liability to the state, its departments, agencies, or employees and procure services from other CMHSPs or other providers of mental health services that the department has determined can operate in compliance with applicable standards and are capable of maintaining the delivery of services within the county or counties.

In canceling this contract for material default, the MDHHS shall provide written notification at least 90 days prior to the cancellation date of the MDHHS intent to cancel this contract to the CMHSP and the relevant County (or Counties) Board of Commissioners. The CMHSP may correct the problem during the 90 day interval, in which case cancellation shall not occur. In the event that this contract is canceled, the CMHSP shall cooperate with the MDHHS to implement a transition plan for recipients. The MDHHS shall have the sole authority for approving the adequacy of the transition plan, including providing for the financing of said plan, with the CMHSP responsible for providing the required local match funding. The transition plan shall set forth the process and time frame for the transition. The CMHSP will assure continuity of care for all people being served under this contract until all service recipients are being served under the jurisdiction of another contractor selected by the MDHHS.

The CMHSP will cooperate with the MDHHS in developing a transition plan for the provision of services during the transition period following the end of this contract, including the systematic transfer of each recipient and clinical records from the CMHSP's responsibility to the new contractor.

13.0 Closeout

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

- A. Within 45 days (interim), and 90 days (final), following the end date imposed by Part I, Section 12.0, the CMHSP shall provide to the MDHHS, all financial, performance and other reports required by this contract.
- B. Payment for any and all valid claims for services rendered to covered recipients prior to the effective end date shall be the CMHSP's responsibility, and not the responsibility of the MDHHS.
- C. The portion of all reserve accounts maintained by the CMHSP that were funded with MDHHS funds and related interest are owed to the MDHHS within 90 days, less amounts needed to cover outstanding claims or liabilities unless otherwise directed in writing by the MDHHS.
- D. Reconciliation of equipment with a value exceeding \$5,000, purchased by the CMHSP within the last two fiscal years, will occur as part of settlement of this contract. The CMHSP will submit to the MDHHS an inventory of equipment meeting the above specifications within 45 days of the end date. The inventory listing must identify the current value and proportion of GF funds used to purchase each item, and also whether or not the equipment is required by the CMHSP as part of continued service provision to the continuing service population. The MDHHS will provide written notice within 90 days or less of any needed settlements concerning the portion of funds ending. If the CMHSP disposes of the equipment, the appropriate portion of the value must be returned to the MDHHS (or used to offset costs in the final financial report).
- E. All earned carry-forward funds and savings from prior fiscal years that remain unspent as of the end date, must be returned to the MDHHS within 90 days. No carry-forward funds or savings as provided in Part II, Section 7.7.1 and 7.7.1.1, can be earned during the year this contract ends, unless specifically authorized in writing by the MDHHS.
- F. All financial, administrative and clinical records under the CMHSP's responsibility must be retained according to the retention schedules in place by the Department of Management and Budget's (DTMB) General Schedule #20 at: https://www.michigan.gov/documents/dtmb/RMS_GS20_640204_7.pdf unless directed otherwise in writing by the MDHHS.

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

14.0 Confidentiality

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

15.0 Assurances

The following assurances are hereby given to the MDHHS:

15.1 Compliance with Applicable Laws

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

15.2 Anti-Lobbying Act

With regard to any federal funds received or utilized under this Agreement, the CMHSP will comply with the Anti-Lobbying Act (31 U.S.C. 1352) as revised by the Lobbying Disclosure Act of 1995 (2 U.S.C. 1601 et seq.), Federal Acquisition Regulations 52.203.11 and 52.203.12, and Section 503 of the Departments of Labor, Health & Human Services, and Education, and Related Agencies section of the current fiscal year Omnibus Consolidated Appropriations Act. Further, the CMHSP must require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including sub-contracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients must certify and disclose accordingly.

15.3 Non-Discrimination

In the performance of any contract or purchase order resulting here from, the CMHSP agrees not to discriminate against any employee or applicant for employment or service delivery and access, with respect to their hire, tenure, terms, conditions or privileges of employment, programs and services provided or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. The CMHSP further agrees that every sub-contract entered into for the performance of any contract or purchase order resulting here from will contain a provision requiring non-discrimination in employment, service delivery and access, as herein specified binding upon each sub-contractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act (1976 PA 453, as amended, MCL 37.2201 et seq.) and the Persons with Disabilities Civil Rights Act (1976 P.A. 220, as

amended, MCL 37.1101 et seq.), and Section 504 of the Federal Rehabilitation Act 1973, P.L. 93-112, 87 Stat. 394, and any breach thereof may be regarded as a material breach of the contract or purchase order.

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

15.4 Debarment and Suspension

With regard to any federal funds received or utilized under this Agreement, assurance is hereby given to the MDHHS that the CMHSP will comply with federal regulation 2 CFR 180 and 22 CFR 513 and certifies to the best of its knowledge and belief that it, including its employees and sub-contractors:

- A. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or CMHSP;
- B. Per 22 CFR 513.320(a), have not within a five-year period preceding this Agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) or private transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, or obstruction of justice;
- C. Are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in section B, and;
- D. Have not within a five-year period preceding this Agreement had one or more public transactions (federal, state or local) terminated for cause or default; and
- E. Per 22 CFR 513.320(a), have not committed an act of so serious or compelling a nature that it affects the Grantee's present responsibilities.

15.5 Pro-Children Act and Smoke-Free Activities

Assurance is hereby given to the MDHHS that the CMHSP will comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 U.S.C. 6081 et seq, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the

services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The CMHSP also assures that this language will be included in any sub-awards, which contain provisions for children's services.

The CMHSP also assures, in addition to compliance with P.L. 103-227, any activity funded in whole or in part through this Agreement will be delivered in a smoke-free facility or environment. Smoking must not be permitted anywhere in the facility, or those parts of the facility under the control of the Grantee. If activities are delivered in facilities or areas that are not under the control of the Grantee (e.g., a mall, restaurant or private work site), the activities must be smoke-free.

15.6 Hatch Act and Intergovernmental Personnel Act

The CMHSP will comply with the Hatch Act (5 U.S.C. 1501-1508, 5 U.S.C. 7321-7326), and the Intergovernmental Personnel Act of 1970 (P.L. 91-648) as amended by Title VI of the Civil Service Reform Act of 1978 (P.L. 95-454). Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally assisted programs.

15.7 Limited English Proficiency

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

15.8 Health Insurance Portability and Accountability Act

To the extent that the Health Insurance Portability and Accountability Act (HIPAA) is applicable to the Grantee under this Agreement, the Grantee assures that it is in compliance with the requirements of HIPAA including the following: The HIPAA Privacy Rule; 45 CFR Part 160, Subparts A – C; 45 CFR Part 164, Subparts A, C, D, E.; 42 CFR Part 2, Subparts A – E (SUD Specific); and Michigan Mental Health Code 330.1748:

- A. The Grantee must not share any protected health information provided by the Department that is covered by HIPAA except as permitted or

required by applicable law, or to a subcontractor as appropriate under this Agreement.

- B. The Grantee will ensure that any subcontractor will have the same obligations as the Grantee not to share any protected health data and information from the Department that falls under HIPAA requirements in the terms and conditions of the subcontract.
- C. The Grantee must only use the protected health data and information for the purposes of this Agreement.
- D. The Grantee must have written policies and procedures addressing the use of protected health data and information that falls under the HIPAA requirements. The policies and procedures must meet all applicable federal and state requirements including the HIPAA regulations. These policies and procedures must include restricting access to the protected health data and information by the Grantee's employees.
- E. The Grantee must have a policy and procedure to immediately report to the Department any suspected or confirmed unauthorized use or disclosure of protected health information that falls under the HIPAA requirements of which the Grantee becomes aware. The Grantee will work with the Department to mitigate the breach and will provide assurances to the Department of corrective actions to prevent further unauthorized uses or disclosures. The Department may demand specific corrective actions and assurances and the Grantee must provide the same to the Department.
- F. Failure to comply with any of these contractual requirements may result in the cancellation of this Agreement in accordance with Part 1, Section 12.0.
- G. In accordance with HIPAA requirements, the Grantee is liable for any claim, loss or damage relating to unauthorized use or disclosure of protected health data and information, including without limitation the Department's costs in responding to a breach, received by the Grantee from the Department or any other source.
- H. The Grantee will enter into a business associate agreement should the Department determine such an agreement is required under HIPAA.

15.9 State Data - Reserved

15.10 Data Privacy and Information Security - Reserved

16.0 Modifications, Consents and Approvals

This contract will not be modified, amended, extended, or augmented, except by a writing executed by the parties hereto, and any breach or default by a party shall not be waived or released other than in writing signed by the other party.

17.0 Entire Agreement

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

- A. This contract including attachments and appendices
- B. Michigan Mental Health Code and Administrative Rules
- C. Michigan Public Health Code and Administrative Rules
- D. MDHHS Appropriations Act in effect during the contract period
- E. All other pertinent federal and state statutes, rules and regulations
- F. All final MDHHS guidelines, final technical requirements as referenced in the contract - Additional guidelines and technical requirements may be added as provided for in Part I, Section 16.0 of this contract.

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

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

18.0 Dispute Resolution

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

In the event of the unsatisfactory resolution of a non-emergent contractual dispute or compliance/performance dispute, and if the CMHSP desires to pursue the dispute, the CMHSP shall request that the dispute be resolved through the dispute resolution process. This process shall involve a meeting between agents of the CMHSP and the MDHHS. The MDHHS Deputy Director of Behavioral and Physical Health and Aging Services Administration will identify the appropriate Deputy Director(s) or other department representatives to participate in the process for resolution. The Deputy Director may handle disputes involving financial matters unless the MDHHS Director has delegated these duties to the Administrative Tribunal.

The CMHSP shall provide written notification requesting the engagement of the dispute resolution process. In this written request, the CMHSP shall identify the nature of the dispute, submit any documentation regarding the dispute, and state a proposed resolution to the dispute. The MDHHS shall convene a dispute resolution meeting within 20 calendar days of receipt of the CMHSP request. The Deputy Director shall provide the CMHSP and MDHHS representative(s) with a written decision regarding the dispute within 14 calendar days following the dispute resolution meeting. The decision of the Deputy Director shall be the final MDHHS position regarding the dispute.

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

In the event of an emergent compliance dispute, the dispute resolution process shall

be initiated and completed within five (5) working days.

19.0 No Waiver of Default

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

20.0 Severability

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

21.0 Disclaimer

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

Captions and headings used in this contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of this contract.

22.0 Relationship of the Parties (Independent Contractor)

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

23.0 Notices

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

Either party may change its address where notices are to be sent by giving written notice in accordance with this section.

24.0 Unfair Labor Practices

Under MCL 423.324, MDHHS may void any Agreement with a Grantee who appears on the Unfair Labor Practice register compiled under MCL 423.322.

25.0 Survivor

Any provisions of the contract that impose continuing obligations on the parties including, but not limited to, the CMHSP's indemnity and other obligations, shall

survive the expiration or cancellation of this contract for any reason.

26.0 Governing Law

This Agreement is governed, construed, and enforced in accordance with Michigan law, excluding choice-of-law principles, and all claims relating to or arising out of this Agreement are governed by Michigan law, excluding choice-of-law principles. Any dispute arising from this Agreement must be resolved in the Michigan Court of Claims. Complaints against the State must be initiated in Ingham County, Michigan. Grantee waives any objections, such as lack of personal jurisdiction or forum non conveniens. Grantee must appoint an agent in Michigan to receive service of process.

DRAFT

Attachments

Part II Statement of Work

C 1.3.1 County of Financial Responsibility COFR

C 3.1.1 Access System Standards

C 3.3.1 Person-Centered Planning

C 3.3.4 Self-Determination & Fiscal Intermediary Guideline

C 3.3.5.1 Recovery Policy & Practice Advisory

C.4.4 Special Populations Metrics and Reporting Template

C 4.5.1 PASARR Agreement

C 4.7.2 Technical Requirement for SED Children

C 6.3.2.1 CMHSP Local Dispute Resolution Process

C 6.3.2.2 FSS Guidelines for Determining Eligibility of Applicants

C 6.3.2.3A CEU Requirements for RR Staff

C 6.3.2.3B RR Training Standards for CMH and Provider Staff TR

C 6.3.2.4 Recipient Rights Appeal Process

C 6.5.1.1 CMHSP Reporting Requirements

C 6.8.1.1 QI Programs for CMHSPs

C.6.8.3.1 TR for Behavior Treatment Plan Review Committees

C 6.9.1.1 IST & NGRI Protocol

C 6.9.1.2 State Facility Contract

C 6.9.3.1 Housing Practice Guideline

C 6.9.3.2 Inclusion Practice Guideline

C 6.9.3.3 Consumerism Practice Guideline

C 6.9.5.1 Jail Diversion Practice Guideline

C 6.9.6.1 Special Education to Community Transition Planning Policy

C 6.9.8.1 Family-Driven and Youth-Guided Policy & Practice Guideline

C 6.9.9.1 Employment Works! Policy

C 6.9.7.1 CMHSP Trauma Policy

C 7.0.1 MDHHS Funding

C 7.0.2 Performance Objectives

C 7.6.1 CMH Compliance Examination Guidelines

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DEFINITIONS/EXPLANATION OF TERMS

The terms used in this contract shall be construed and interpreted as defined below unless the contract otherwise expressly requires a different construction and interpretation.

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

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

Clean Claim: A clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Michigan Mental Health Code - Act 258 of 1974 as amended.

Cultural Competency: An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations.

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

Developmental Disability: Means either of the following:

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

2. If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in item 1 if services are not provided.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Public Law 104-191, 1996 to improve the Medicare program under Title XVIII of the Social Security Act, the Medicaid program under Title XIX of the Social Security Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

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

HIPAA was amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), as set forth in Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009. The United States Department of Health and Human Services (DHHS) promulgated administrative rules to implement HIPAA and HITECH, which are found at 45 C.F.R. Part 160 and Subpart E of Part 164 (the “Privacy Rule”), 45 C.F.R. Part 162 (the “Transaction Rule”), 45 C.F.R. Part 160 and Subpart C of Part 164 (the “Security Rule”), 45 C.F.R. Part 160 and Subpart D of Part 164 (the “Breach Notification Rule”) and 45 C.F.R. Part 160 subpart C (the “Enforcement Rule”). DHHS also issued guidance pursuant to HITECH and intends to issue additional guidance on various aspects of HIPAA and HITECH compliance. Throughout this contract, the term “HIPAA” includes HITECH and all DHHS implementing regulations and guidance.

Healthy Michigan Plan: The Healthy Michigan Plan is a new category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Acts 107 of 2013 that began April 1, 2014.

Healthy Michigan Plan Beneficiary: An individual who has met the eligibility requirements for enrollment in the Healthy Michigan Plan and has been issued a Medicaid card.

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

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

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

1. The individual can reasonably be expected within the near future to physically injure himself, herself, or another individual, either intentionally or unintentionally.

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

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

Policy Manuals of the Medical Assistance Program: The Michigan Department of Health & Human Services periodically issues notices of proposed policy for the Medicaid program. Once a policy is final, MDHHS issues policy bulletins that explain the new policy and give its effective date. These documents represent official Medicaid policy and are included in the policy manual of the Medical Assistance Program.

Practice Guideline: MDHHS-developed guidelines for CMHSPs for specific service, support or systems models of practice that are derived from empirical research and sound theoretical construction and are applied to the implementation of public policy. MDHHS guidelines issued prior to June 2000 were called "Best Practice Guidelines." All guidelines are now referred to as Practice Guidelines.

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

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

Serious Mental Illness: Diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders are included only if they occur in conjunction with another diagnosable serious mental illness:

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

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

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

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

PART II: STATEMENT OF WORK

1.0 SPECIFICATIONS

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

1.1 Targeted Geographical Area for Implementation

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

1.2 Target Population

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

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

1. to provide services that are not covered under the 1915(b) and 1915(c) Medicaid Habilitation Supports waiver to Medicaid beneficiaries who are individuals with serious mental illness, serious emotional disturbances or developmental disabilities; or
2. to underwrite a portion of the cost of covered services to these beneficiaries if Medicaid payment for services to the PIHP is exhausted; and
3. for CMHSPs that are under subcontract with the PIHP, when the contract with the PIHP stipulates conditions regarding such use of General Funds. MDHHS reserves the right to disallow such use of General funds if it believes that the PIHP-CMHSP contract conditions were not met

1.3 Responsibility for Payment of Authorized Services

The CMHSP shall be responsible for the payment of services that the CMHSP authorizes. This provision presumes the CMHSP and its agents are fulfilling their responsibility to customers according to terms specified in the contract.

Services shall not be delayed or denied as a result of a dispute of payment responsibility between two or more CMHSPs. In the event there is an unresolved

dispute between CMHSPs, either party may request MDHHS involvement to resolve the dispute, and the MDHHS will make such determination. Likewise, services shall not be delayed or denied as a result of a dispute of payment responsibility between the CMHSP and another agency. The COFR Agreement included as Attachment C1.3.1 shall be followed by the CMHSP to resolve county of financial responsibility disputes.

2.0 SUPPORTS AND SERVICES

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

2.1 Availability of Services

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

3.0 ACCESS ASSURANCE

3.1 Access Standards

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

A. Mental Health

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

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

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

- C. The CMHSP shall be responsible for outreach and ensuring adequate access to services to the priority populations.
- D. In addition, the CMHSP shall assure access according to the following standard and shall report its performance on the standard in accordance with Attachment C 6.5.1.1.

100% of people who meet the OBRA Level II Assessment criteria for specialized mental health services for people residing in nursing homes, as determined by the MDHHS, shall receive CMHSP managed mental health services. 3.1 Access Standards

REQUIREMENTS FOR DENIAL OF HOSPITALIZATION

Sections 409(4), 498e(4) and 498h(5) of the Code provide an opportunity for an individual denied hospitalization to request a second opinion from the CMHSP executive director. The executive director shall arrange for an additional evaluation to be performed within three days, excluding Sundays and legal holidays, after he/she receives the request. If the conclusion of the second opinion is different from the conclusion of the children's diagnostic and treatment service or the pre-admission screening unit, the executive director, in conjunction with the medical director, shall make a decision within one business day based upon all clinical information available.

APPEAL OF DENIAL PROCESS FOR NON-MEDICAID RECIPIENTS

A. Background

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

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

The Code provides protections, second opinions and dispute resolution mechanisms for all individuals receiving public mental health services, with the expectation that all disputes will be resolved locally, with the ability to appeal to the MDHHS in only those instances where it is alleged that the investigative

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

B. Expedited Processes for Service Denials:

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

If access to psychiatric inpatient service is denied, the individual or, if a minor, his/ her parent or guardian, must be informed of his/her right to a second opinion consistent with Sections 409(4), 498e(4) and 498h(5) of the Code and the CMHSP Local Dispute Resolution Process as described in Section RECIPIENT RIGHTS REQUIREMENTS REGARDING THE DENIAL OF SERVICES Denial of Hospitalization.

3.2 Medical Necessity

The CMHSP may implement the medical necessity criteria specified by the MDHHS. Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet the person's mental health needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment and is consistent with clinical industry standards of care. In addition, the CMHSP must also consider social services and community supports that are crucial for full participation in community life, must apply person-centered planning for individuals with mental health needs, and must consider environmental factors and other available resources that might address the situation. The criteria are intended to ensure appropriate access to care, to protect the rights of recipients and to facilitate an appropriate matching of supports and services to individual needs for the priority populations, consistent with the resources (general fund allocation) available to the CMHSP to serve these individuals. The level and scope of such services are contingent on available funding, and services provided through the use of general funds are not an entitlement to any individual recipient.

3.3 Other Access Requirements

3.3.1 Person-Centered Planning

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

3.3.2 Limited English Proficiency

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

3.3.3 Cultural Competence

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

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

3.3.4 Self-Determination Policy and Practice Guideline

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

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

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

3.3.5 Recovery Policy

All Supports and Services provided to individuals with mental illness, including those with co-occurring conditions, shall be based in the principles and practices of recovery outlined in the Michigan Recovery Council document "Recovery Policy and Practice Advisory" included as Attachment C3.3.5.1 to this contract.

4.0 SPECIAL COVERAGE PROVISIONS

If funds are appropriated the following sub-sections describe special considerations, services, and/or funding arrangements required by this contract. The parties recognize that some persons served under these special considerations, services or arrangements may be Medicaid beneficiaries, and that the CMHSP may discharge its obligations and service

provision responsibilities specified below to such individuals using both general funds dollars and available Medicaid specialty service benefits and coverages.

4.1 Nursing Home Placements

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

4.2 Nursing Home Mental Health Services

All designated state funds that the MDHHS has authorized to the CMHSP for nursing home mental health and/or developmental disability-related services shall continue to be used for this purpose until such time that MDHHS approves an alternative. Residents of nursing homes with mental health needs shall be given the same opportunity for access to CMHSP services as other individuals covered by this contract.

4.3 Prevention Services

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

4.4 Categorical Funding

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

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

2. The annual report shall include the following:

- A. Describe the population served. Include the number of unduplicated individuals served during this fiscal year. Include relevant demographic or diagnostic data.
- B. Briefly summarize specific mental health services that were provided and corresponding activities that occurred for special populations throughout the fiscal year.

4.5 OBRA Pre-Admission Screening and Annual Resident Review

The CMHSP shall be responsible for the completion of Pre-Admission Screenings and Annual Resident Reviews (PASRR) for individuals who are located in the CMHSP service area presenting for nursing home admission, or who are currently a resident of a nursing home located in the CMHSP service area. A copy of the MDHHS/CMHSP PASRR Agreement is attached (Attachment C 4.5.1).

4.6 Long Term Care

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

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

4.7 Disaster Behavioral Health CMHSP Responsibilities

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

1. Designate a primary and alternate emergency preparedness coordinator (EPC).
 - a. Participate in local emergency management disaster planning and exercises in collaboration with local health department, regional healthcare coalitions, and jurisdictionally appropriate emergency manager(s).
 - b. Attend/host trainings geared toward disaster mental/behavioral health planning, response, and recovery.
2. Provide emergency response support, including memoranda of agreement (MOA) both formal and informal, in collaboration with private sector or mental/behavioral health service providers and Non-governmental organizations (NGOs) such as the American Red Cross, Regional Health Care Coalitions and/or Michigan Crisis Response Association.
 - a. Coordinate local community assessments of disaster behavioral health to determine the psychological impact of a disaster on survivors and disaster response personnel.
 - b. Provide psychological triage of individuals as appropriate (example,

PsySTART triage).

- c. According to the time frames recommended for the application of each intervention, provide appropriate disaster behavioral health services, including, but not limited to:
 - i. Psychological First Aid
 - ii. Crisis intervention/stabilization
 - iii. Grief/bereavement counseling
 - iv. Critical Incident Stress Management (CISM)
 - v. Post-Traumatic Stress Disorder Counseling
 - vi. Substance use disorder counseling
 - vii. Provide community outreach activities as needed
 - viii. Advise local Public Information Officer (PIO) of appropriate disaster behavioral health messaging
 - ix. Request additional disaster behavioral health resources according to pre-established emergency management channels
3. Develop and maintain formal and informal mutual aid agreements (MUA) with other agencies outside of their jurisdiction. The number and type should be individualized by need but at least one (1) MUA should be developed.

4.8 RESERVED

4.9 Pooled Funding Arrangements

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

4.10 Guardian Reimbursement

As stated in PA 166 of 2022 (HB 5783), MDHHS shall allocate \$5,000,000.00 to reimburse court-appointed public guardians for recipients who also receive CMHSP services, at a reimbursement of \$50.00 per month.

By September 15 of the current fiscal year, each CMHSP that has provided reimbursement to court-appointed public guardians shall provide the department a report that shall be shared with the house and senate appropriations subcommittees on the department budget, the house and senate fiscal agencies, the house and senate policy offices, and the state budget office on the number of court-appointed public guardians who were reimbursed, the amount of reimbursement for each court-appointed public guardian and the number of court-appointed public guardians who received these funds, the number of court-appointed public guardians who were also reimbursed by the counties, and the per-month reimbursement rates provided by the counties. CMHSP shall provide this report to the MDHHS as specified in Attachment C6.5.1.1 CMHSP Reporting Requirements.

5.0 OBSERVANCE OF FEDERAL, STATE AND LOCAL LAWS

The CMHSP agrees that it will comply with all state and federal statutes, accompanying regulations, and administrative procedures that are in effect, or that become effective during the term of this contract. The state must implement any changes in state or federal statutes, rules, or administrative procedures that become effective during the term of this contract. This includes laws and regulations regarding human subject research and data projections set forth in 45 CFR and HIPAA.

5.1 Fiscal Soundness of the CMHSP

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

5.2 Suspended Providers

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

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

The United States General Services Administration (GSA) maintains a list of parties excluded from federal programs. The "excluded parties lists" (EPLS) and any rules and/or restrictions pertaining to the use of EPLS data can be found on GSA's web page at the following internet address: www.arnet.gov/epls.

5.3 Public Health Reporting

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

6.0 CMHSP ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE SERVICES

6.1 Organizational Structure

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

6.2 Administrative Personnel

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

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

- Administrator (Chief Executive Officer)
- Medical Director
- Recipient Rights Officer

6.3 Customer Services

6.3.1 Customer Services: General

Customer Services is an identifiable function that operates to enhance the relationship between the recipient and the CMHSP. This includes orienting new recipients to the services and benefits available including how to access them, helping recipients with all problems and questions regarding benefits, handling customer/recipient complaints and grievances in an effective and efficient manner, and tracking and reporting patterns of problem areas for the organization. This requires a system that will be available to assist at the time the customer/recipient has a need for help and is able to help on the first contact in most situations.

6.3.2 Recipient Rights and Grievance/Appeals

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

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

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

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

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

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

6.3.2.1 CMHSP Local Dispute Resolution Process

The CMHSP shall conduct CMHSP local dispute resolution processes in accordance with Attachment C 6.3.2.1.

6.3.2.1B Mediation in Mental Health Dispute Resolution

Mediation means a confidential process in which a neutral third party facilitates communication between parties, assists in identifying issues, and helps explore solutions to promote a mutually acceptable resolution. A recipient or recipient's representative is allowed to request mediation at any time when there is a dispute related to service planning or the services, supports provided by a Community Mental Health Services Program (CMHSP). The CMHSP must participate in Mediation processes in accordance with the Mediation in Mental Health Dispute Resolution Technical Requirement, which can be found on the MDHHS website at [Policies & Practice Guidelines \(michigan.gov\)](http://michigan.gov).

6.3.2.2 Family Support Subsidy Appeals

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

6.3.2.3 Continuing Education Requirements for Recipient Rights Staff

The CMHSP shall conduct continuing education activities in accordance with Attachment C 6.3.2.3.A.

6.3.2.3B Recipient Rights Training Standards for CMHSP Staff

The CMHSP shall conduct training standards in accordance with Attachment C 6.3.2.3.B.

6.3.2.4 Recipient Rights Appeal Process

The CMHSP shall conduct recipient rights appeals processes in accordance with Attachment C 6.3.2.4.

6.3.3 Marketing

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

- A. All such materials shall be written at the 4th grade reading level to the extent possible (i.e., sometimes necessary to include medications, diagnoses, and conditions that do not meet the 4th grade criteria).
 - B. All materials shall be available in the languages appropriate to the people served within the CMHSP's area. Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002 Federal Register Volume 65, August 16, 2002).
 - C. All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA).
 - D. Material shall not contain false and/or misleading information.
- Marketing materials shall be available to the MDHHS for review of

consistency with these standards.

6.4 Provider Network Services

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

In this regard, the CMHSP agrees to:

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

6.4.1 Provider Contracts

The CMHSP is responsible for the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract.

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

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

- A. Duty to treat and accept referrals
- B. Prior authorization requirements

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

In addition, sub-contracts shall:

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

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

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

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

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

This is applicable to any staff training area. This includes the required staff training in the areas of abuse and neglect (recipient rights), person-centered planning: HIPAA security, and certificates earned from specific clinical training in evidence-based, best and promising practices such as ACT, DBT, PMTO, FPE, and motivational interviewing.

6.4.2 Provider Credentialing

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

providers and for sanctioning providers who are out of compliance with the CMHSPs standards.

6.4.3 Collaboration with Community Agencies

CMHSPs must work closely with local public and private community-based organizations and providers to address prevalent human conditions and issues that relate to a shared customer base. Such agencies and organizations include local health departments, local MDHHS human service offices, regional PIHP entity for substance abuse services, community and migrant health centers, nursing homes, Area Agency and Commissions on Aging, Medicaid Waiver agents for the HCBW program, school systems, and Michigan Rehabilitation Services. Local coordination and collaboration with these entities will make a wider range of essential supports and services available to the CMHSP's recipients. CMHSPs are encouraged to coordinate with these entities through participation in multipurpose human services collaborative bodies, and other similar community groups. The CMHSP shall have a written coordination agreement with each of the pertinent agencies noted above describing the coordination arrangements agreed to and how disputes between the agencies will be resolved when the other party is willing. To ensure that the services provided by these agencies are available to all CMHSPs, an individual contractor shall not require an exclusive contract as a condition of participation with the CMHSP.

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

6.5 Management Information Systems

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

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

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

6.5.1 Uniform Data and Information

To measure the CMHSP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures, the CMHSP must provide the MDHHS with uniform data and information as specified in this contract, and other such additional or different reporting requirements or data elements as the parties may agree upon from time to time. Any changes in the reporting requirements

required by state or federal law will be communicated to the CMHSP at least 90 days before they are effective unless state or federal law requires otherwise. Other changes beyond routine modifications to the data reporting requirements must be agreed to by both parties.

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

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

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

A. Recipient Level Information

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

B. CMHSP Level Information

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

C. The CMHSP shall submit a written review of death for every recipient whose death occurred within six (6) months of the recipient's discharge from a state-operated service. The review shall include:

1. Recipient's name
2. Gender
3. Date of birth
4. Date, time, place of death
5. Diagnoses (mental and physical)
6. Cause of death
7. Recent changes in medical or psychiatric status, including notation of most recent hospitalization
8. Summary of condition and treatment (programs and services being provided to the recipient) preceding death
9. Any other relevant history
10. Autopsy findings if one was performed and available
11. Any action taken as a result of the death

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

Reporting Requirements for the period October 1, 2021 to September 30, 2022 are included in Attachment C 6.5.1.1

6.5.2 Encounter Data Reporting

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

6.5.3 Level of Care Utilization System (LOCUS)

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

The CMHSP will:

1. Ensure that the LOCUS is incorporated into the initial assessment process for all Non- Medicaid eligible individuals 18 and older seeking supports and services for a severe mental illness using one of the MDHHS approved methods for scoring the tool.
2. Approved methods:
 - a. Use of the online scoring system, through Journey Health-Deerfield Behavioral Health, with cost covered by BHDDA through Mental Health Block Grant (MHBG) funding; or
 - b. Use of software purchased through Journey Health-Deerfield Behavioral Health with costs covered by BHDDA through MHBG funding.
3. Ensure that each Non-Medicaid individual 18 years and older with a severe mental illness has a LOCUS completed as part of any assessment and re-assessment process if they are not receiving Early Periodic Screening Diagnosis and Treatment Services (EPSDT) services. If the child/youth aged 18-21 years is receiving EPSDT services in the CMHSP system, the CAFAS needs to be completed at intake, quarterly and at exit up to age 21.
4. Collaborate with BHDDA for ongoing fidelity monitoring on the use of the tool.
5. Provide the composite score for each LOCUS that is completed in accord with the established reporting guidelines.

6.5.4 State of Michigan Systems with Confidential Information

Contract staff will be given access to State of Michigan systems with confidential information. To ensure that information is used only for purposes stated in this contract, the contractor is required to notify the State of Michigan Program Manager within one business day when staff associated with this contract leave or change roles and no longer require access to the State of Michigan system, and remove any access that the Contractor staff member has to the State of Michigan information system(s) addressed under this contract. Also, the Contractor will provide documentation identifying the process which removes and provides verification that the Contractor staff member no longer has access to any State of Michigan data associated with the above-mentioned information system(s).

6.6 Financial Management System

6.6.1 General

The CMHSP shall maintain all pertinent financial and accounting records and evidence pertaining to this contract based on financial and statistical records that can be verified by qualified auditors. The CMHSP will comply with generally accepted accounting principles (GAAP) for governmental units when preparing financial statements. The CMHSP will use the principles and standards of 2 CFR 200 Subpart E Cost Principles for determining all costs reported on the financial status report, except for a) local funds, not obligated to meet local match requirements nor required as reserve against possible obligations or liabilities; b) selected items of allowable cost – agreed upon by the CMHSP and MDHHS – where state law or county regulations differ from federal policy as outlined in 2 CFR 200 Subpart E Cost Principles and requires adherence to different principles or a different methodology for cost allocation, distribution or estimation, c) earned revenue not encumbered to satisfy local match obligations, nor required as an adjustment or credit or distribution to offset or reduce expense items allocated to a federal award or to state general fund allocation; d) other grants or awards where the grantor requires principles and standards other than those described in 2 CFR 200 Subpart E Cost Principles. Expenditures of General Fund Formula Funds reported on the financial status report must comply with Sections 240 241 and 242 of the Mental Health Code. Cost settlement of the General Fund Formula Funding to the CMHSP will be based upon costs reported on the financial status report. If a conflict exists between 2 CFR 200 Subpart E Cost Principles and Section 242 of the Mental Health Code regarding expenditures the more restrictive sections of Section 242 of Mental Health Code will prevail.

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

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

6.6.2 Claims Management System

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

A clean claim is a valid claim completed in the format and time frames specified by the CMHSP and that can be processed without obtaining additional information from the provider of service or a third party. It does not include a claim from a provider who is under investigation for fraud. A valid claim is a claim for supports and services that the CMHSP is responsible for under this contract.

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

6.6.3.1 Post-payment Review

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

6.6.3.2 Total Payment

The CMHSP or its providers shall not require any co-payments, recipient pay amounts, or other cost sharing arrangements unless specifically authorized by state or federal regulations. The CMHSP's providers may not bill recipients for the difference between the provider's charge and the CMHSP's payment for services. The providers shall not seek nor accept additional supplemental payment from the recipient, his/her family, or representative, for services authorized by the CMHSP.

6.6.3.3 Electronic Billing Capacity

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

6.6.3.4 Third Party Resource Requirements

CMHSPs are payers of last resort and will be required to identify and seek recovery from all other liable third parties in order to make themselves whole. Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicaid, Medicare) that has liability for all or part of a recipient's covered benefit. The CMHSP shall collect all payments available from other parties for services provided to its recipients. The CMHSP shall be responsible for identifying and collecting third party liability information and may retain third party collections, as provided for in Section 226a of the Michigan Mental Health Code.

6.6.3.5 Vouchers

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

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

The use of vouchers is not subject to the provisions of Part II, Section 6.4.1 (Provider Contracts). However, the CMHSP remains responsible for ensuring the appropriate use of funds allocated to the recipient through a voucher, for establishing and verifying relevant qualifications of service providers, and for maintaining and reporting required fiscal, demographic and service data.

6.6.3.6 Payment of State-Delivered Services

A. The CMHSP shall authorize payment, within forty-five (45) days of receiving

the bill, for the actual number of authorized days of care provided to its recipients in state facilities.

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

6.7 State Lease Expiration

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

6.8 Quality Assessment and Performance Improvement Program Standards

6.8.1 General

The CMHSP shall have a fully operational Quality Assessment and Performance Improvement Program in place that meets the conditions specified in the Quality Assessment and Performance Improvement Program Technical Requirement.

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

6.8.2 Annual Effectiveness Review

The CMHSP shall annually conduct an effectiveness review of its QAPIP. The effectiveness review must include analysis of whether there have been improvements in the quality of health care and services for recipients as a result of quality assessment and improvement activities and interventions carried out by the CMHSP. The analysis should take into consideration trends in service delivery and health outcomes over time and include monitoring of progress on performance goals and objectives. Information on the effectiveness of the CMHSP's QAPIP must be provided annually to network providers and to recipients upon request. Information on the effectiveness of the CMHSP's QAPIP must be provided to the MDHHS upon request.

6.8.3 Behavior Treatment Plan Review Committee

The CMHSP shall use a specially constituted committee, such as a behavior treatment plan review committee, to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health

system who exhibit seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. The Committee shall substantially incorporate the standards in Attachment C 6.8.3.1 Technical Requirement for Behavior Treatment Plans.

6.9 Service and Utilization Management

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

6.9.1 State Managed Services

- A. The CMHSP shall authorize inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. The CMHSP shall review treatment at intervals determined jointly between the authorizing CMHSP and the State Facility and authorize continued stay. The application of this provision to NGRI and IST cases requires additional clarification stemming from the conditions specified in Chapter 10 of the Michigan Mental Health Code. The clarification and requirements are specified in the IST & NGRI Protocol, Attachment C 6.9.1.1. The provisions of Chapter 10 shall apply to all authorizations.
- B. The MDHHS and CMHSP agree that admissions must meet the criteria specified in the Michigan Mental Health Code for adults and children with mental illness, or that the criteria for judicial or administrative admission of a person with developmental disabilities must be met, and that inpatient care in a state hospital/center must be the most appropriate level of care available. The parties further agree that continued stay will be authorized, as long as the criteria for continued stays is met.
- C. The CMHSP's authorization of admission and of continued treatment shall be the basis on which the CMHSP will reimburse the MDHHS for the state cost of inpatient services provided in a state-managed hospital/center. The CMHSP's obligation for the local match cost of such services shall not be affected by this section. Service authorizations shall be conveyed in writing to the hospital/center. The MDHHS contract manager shall be notified by the CMHSP within seven (7) days of the decision when the CMHSP determines that continued inpatient care is no longer warranted based on the criteria stated in the above item B, but the hospital/center did not discharge the recipient according to the recognized placement plan developed according to Sections 209(a) and 209(b) of the Michigan Mental Health Code. The CMHSP shall not be liable for any inpatient services that have not been authorized by the CMHSP in this circumstance. Likewise, the MDHHS contract manager shall be notified by the hospital/center whenever an authorization of continued stay by the CMHSP is clinically unwarranted in the judgment of the hospital/center. Such notification shall initiate a process for resolution of the differences.
- D. The CMHSP shall comply with the requirements of attachment C 6.9.1.2 of this contract.
- E. MDHHS Community Transition Program - While placed by MDHHS in the MDHHS Community Transition Program (MCTP), SHA maintains responsibility for

management of contract reimbursements. The discharging hospital, in conjunction with SHA, will maintain primary oversight of treatment, care, and services. CMH maintains liaison function, collaborating with SHA in person centered treatment and discharge planning. The CMH duties are unchanged from the patient's inpatient hospital stay with focus on moving the patient timely for ongoing treatment, care, services in the least restrictive setting. CMH co-engages with SHA and vendor in order to plan treatment, care, and services in a person-centered fashion and in the least restrictive setting. Matters between CMH/State Hospitals that are not reconciled locally shall be referred to directors of SHA and BHDDA for resolution and shall include the CMH director.

6.9.2 Individual Service Records

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

6.9.3 Other Service Requirements

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

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

6.9.4 Coordination

The CMHSP shall assure that services to each individual are coordinated with primary health care providers and other service agencies in the community that are serving the recipient. In this regard, the CMHSP will implement practices and agreements described in Part II, Section 6.4.3 of this contract.

6.9.5 Jail Diversion

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

6.9.6 Special Ed-to Community Transition

The CMHSP shall participate in the development of special ed-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. Participation shall be consistent with the MDHHS Special Ed-to-Community Transition Guideline, Attachment 6.9.6.1 to this contract.

6.9.7 CMHSP Trauma Policy

The CMHSPs, through their direct service operations and their network providers, shall develop a trauma-informed system for all ages and across the services spectrum in

accordance with attachment C6.9.7.1 Trauma Policy.

6.9.8 Family-Driven and Youth-Guided Policy & Practice Guideline

The purpose of this guideline is to establish standards for the Community Mental Health Services Programs (CMHSPs), and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children, youth and their families. The CMHSP shall implement Family-Driven and Youth-Guided Guideline in accordance with attachment C6.9.8.1.

7.0 CONTRACT FINANCING

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

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

7.1 Local Obligation

The CMHSP shall provide the local financial obligation for services requiring local match, as stipulated by the Mental Health Code. In the event a CMHSP is unable to provide the required local obligation, the CMHSP shall notify the MDHHS immediately. This may result in MDHHS reducing the state portion of total financing available through this contract. The state obligation shall continue to be at the reduced level in the subsequent year unless the CMHSP provides the MDHHS with a plan and assurances that the local obligation shortfall has been rectified.

7.2 Revenue Sources for Local Obligation

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

7.2.1 County Appropriations

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

7.2.2 Other Appropriations and Service Revenues

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

7.2.3 Gifts and Contributions

Grants, bequests, donations, gifts from local non-governmental sources, charitable institutions or individuals -- Gifts that specify the use of the funds for any particular individual identified by name or relationship may not be used as local match funds.

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

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

7.2.4 Special Fund Account

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

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

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

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

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

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

7.2.5 Investment Interest

Interest earned on funds deposited or invested by or on behalf of the CMHSP, except as otherwise restricted by GAAP or 2 CFR 200 Subpart E Cost Principles. Also, interest earned on MDHHS funds by contract agencies and/or network providers as specified in its contracts with the CMHSP.

7.2.6 Other Revenues for Mental Health Services

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

7.3 Local Obligations - Requirement Exceptions

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

- A. Residential programs as defined in Section 309 of the Michigan Mental Health Code. Specialized residential services, as defined in Section 100d (6) of the Michigan Mental

Health Code, includes mental health services that are expressly designed to provide rehabilitation and therapy to a recipient, that are provided in the residency of the recipient, and that are part of a comprehensive individual plan of services.

- B. Services provided to people whose residency is transferred according to the provisions in Section 307 of the Michigan Mental Health Code.
- C. Programs for which responsibility is transferred to the CMHSP and the state is responsible for 100% of the cost of the program, consistent with the Michigan Constitution.
- D. Services provided to an individual under criminal sentence to a state prison.

7.4 MDHHS Funding

MDHHS funding includes both state and federal funds (federal block grants), which the state is responsible to manage. MDHHS financial responsibility is specified in Chapter 3 of the Michigan Mental Health Code (P.A. 258 of the Public Acts of 1974, as amended) and the level of funding contained in the current year state legislative Appropriations Act. The financing in this contract is always contingent on the annual Appropriations Act.

7.4.1 State Mental Health General Fund Formula Funding

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

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

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

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

7.4.1.1 GF Formula Funds Calculation

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

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

7.4.2 Special and/or Designated Funds: Exclusions

Special and/or Designated Funds (including categorical and earned revenue funds) are those

funds that are earmarked by the MDHHS for a specific purpose, project, and/or target population and are not included in the GF formula funding.

These funds and programs may be authorized through separate contractual arrangements between the CMHSP and the MDHHS. These agreements typically include performance and outcome expectations, reporting requirements, and finance-related specifications. The CMHSP shall identify the revenues and expenditures associated with these projects as part of financial reporting required by this contract.

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

7.4.3 Implementation of Current Year Appropriation Act

The CMHSP, if required by Section 928, will participate in the implementation of the current year appropriation act which requires each PIHP shall provide, from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation rates for the PIHPs.

As required by this Act, the CMHSP agrees to provide local funds to the MDHHS through the PIHP. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a CMHSP or an affiliation of CMHSPs. In the event that a CMHSP fails to meet this obligation and the PIHP has not made available other bona fide local funds to offset this obligation, MDHHS will reduce the CMHSP State Mental Health General Fund authorization/payment to the CMHSP by an equivalent amount.

7.4.4 The General Fund Distribution Model

The General Fund Distribution Model in the 4.13.17 Attachment A which is incorporated into this contract by reference identifies a 5-year implementation plan effective Oct. 1, 2018 phasing in a reallocation of general funds according to a New GF distribution model through fiscal year 2023. The data sources used in developing this GF Distribution Model are included in the Attachment A and shall continue to inform the new model. Additional funds appropriated by the legislature shall be included in the non-base GF component of the model.

7.5 Operating Practices

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

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

7.6 Audits

The CMHSP shall ensure the completion of a fiscal year-end Financial Statement Audit conducted in accordance with Generally Accepted Auditing Standards (GAAS); and a fiscal year end Compliance Examination conducted in accordance with the American Institute of CPA's (AICPA's) Statements on Standards for Attestation Engagements (SSAE) 10 - Compliance

Attestation, (as amended by SSAE 11, 12 and 14) and the CMH Compliance Examination Guidelines in Attachment C 7.6.1.)

The CMHSP shall submit to the MDHHS the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDHHS-funded programs, and management letter (if issued) with a response within 30 days after receipt of the practitioner's report, but no later than June 30th following the contract year end. The CMHSP must submit the reporting package by e-mail to MDHHS at MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. MDHHS reserves the right to request a hard copy of the compliance examination report materials if for any reason the electronic submission process is not successful.

If the CMHSP does not submit the required Financial Statement Audit Report, Compliance Examination Report, management letter (if issued) with a response, and Corrective Action Plan by the due date and an extension has not been approved by MDHHS, MDHHS may withhold from the current funding an amount equal to five percent of the audit year's grant funding (not to exceed \$200,000) until the required filing is received by MDHHS. MDHHS may retain the amount withheld if the CMHSP is more than 120 days delinquent in meeting the filing requirements and an extension has not been approved by MDHHS.

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

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

7.7 Financial Planning

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

7.7.1 Savings Carry Forward

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

7.7.1.1 General Fund Carry Forward

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

unexpended in the subsequent year shall be returned to the MDHHS.

7.7.2 Expenditures to Retire Unfunded Pension Liabilities

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

7.8 Finance Planning, Reporting and Settlement

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

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

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

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

7.9 Legal Expenses

The following legal expenses are ALLOWABLE:

- 1) Legal expenses required in the administration of the program on behalf of the State of Michigan or Federal Government.
- 2) Legal expenses relating to employer activities, labor negotiation, or in response to employment related issues or allegations, to the extent that the engaged services or actions are not prohibited under federal principles of allowable costs.
- 3) Legal expenses incurred in the course of providing consumer care. The CMHSP must maintain documentation to evidence that the legal expenses are allowable. Invoices with no detail regarding services provided will not be sufficient documentation.

8.0 CONTRACT REMEDIES AND SANCTIONS

The state will utilize a variety of means to assure compliance with contract requirements. The state will pursue remedial actions and possibly sanctions as needed to resolve outstanding contract violations and performance concerns. The application of remedies and sanctions shall be a matter of public record. The MDHHS may utilize actions in the following order:

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

E. Initiate contract termination.

The implementation of any of these actions does not require a contract amendment to implement. The sanction notice to the CMHSP is sufficient authority according to this provision. The use of remedies and sanctions will typically follow a progressive approach,

but the MDHHS reserves the right to deviate from the progression as needed to seek correction of serious, or repeated, or patterns of substantial non-compliance or performance problems. The CMHSP can utilize the dispute resolution provision of the contract to dispute a contract compliance notice issued by the MDHHS.

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

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

9.0 RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES

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

9.1 General Provisions

- A. Notify the CMHSP of changes in contractual services or conditions of providing contractual services.
- B. Protect against fraud and abuse involving MDHHS funds and recipients in cooperation with appropriate state and federal authorities.
- C. Administer an alternative dispute resolution process for recipients not Medicaid eligible to consider issues regarding suspension, termination or reduction of services and supports defined in the Grievance and Appeal Technical Requirement.
- D. Collaborate with the CMHSP on quality improvement activities, fraud and abuse issues, and other activities that impact on the services provided to recipients.
- E. Conduct a recipient quality of life survey and publish the results.
- F. Review CMHSP marketing materials.
- G. Apply contract remedies necessary to assure compliance with contract requirements.
- H. Monitor the operation of the CMHSP to ensure access to quality care for all individuals in need of and qualifying for services.
- I. Monitor quality of care provided to recipients of CMHSP services and supports.
- J. Refer local issues back to the CMHSP.
- K. Coordinate efforts with other state departments involved in services to these populations.
- L. Administer the PASARR Program.

9.2 Contract Financing

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

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

- A. Action by the Michigan state legislature that removes any MDHHS funding for, or authority to provide for, specified services.
- B. Action by the Governor pursuant to Const. 1963, Art. 5, 320 that removes the MDHHS's funding for specified services or that reduces the MDHHS's funding level below that required to maintain services on a statewide basis.
- C. A formal directive by the Governor, or the Michigan Department of Management and Budget (State Budget Office) on behalf of the Governor, requiring a reduction in expenditures.

In the event that any of the conditions specified in the above items A through C occur, the MDHHS shall issue an amendment to this contract reflective of the above condition.

9.3 State Facilities

The MDHHS agrees:

- A. To supply to the CMHSP, at the time of completion, copies of the State Facilities' ability-to-pay determination on each county resident admitted to a state facility, to inform the CMHSP of any claims on the financial assets of recipients and their families, and of any appeals by recipients or their families.
- B. To pursue all possible first- and third-party reimbursements.
- C. The protection and investigation of the rights of recipients while on inpatient status at the state hospital or center shall be the responsibility of the MDHHS Office of Recipient Rights. When requested, the MDHHS Office of Recipient Rights shall share appropriate information on investigations related to the CMHSP's residents in accordance with the

confidentiality provisions of the Michigan Mental Health Code (P.A. 258 of 1974 as amended, Section 748).

- D. To comply with the IST & NGRI Protocol C 6.9.1.1.
- E. To comply with attachment C 6.9.1.2.

9.4 Reviews and Audits

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

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

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

9.4.1 MDHHS Reviews

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

- A. As used in this section, a review is an examination or inspection by the MDHHS or its agent, of policies and practices, in an effort to verify compliance with requirements of this contract.
- B. The MDHHS will schedule reviews at mutually acceptable start dates to the extent possible, with the exception of those reviews for which advance announcement is prohibited by rule or federal regulation, or when the deputy director for the Health Care Administration determines that there is demonstrated threat to consumer health and welfare or substantial threats to access to care.
- C. Except as precluded in Section 9.4.1 (B) above, the guideline, protocol and/or instrument to be used to review the CMHSP, or a detailed agenda if no protocol exists, shall be provided to the CMHSP at least 30 days prior to the review.
- D. At the conclusion of the review, the MDHHS shall conduct an exit interview with the CMHSP. The purpose of the exit interview is to allow the MDHHS to present the preliminary findings and recommendations.
- E. Following the exit review, the MDHHS shall generate a report within 45 days identifying the findings and recommendations that require a response by the CMHSP.
 - 1. The CMHSP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The CMHSP may also present new information to the MDHHS that demonstrates they were in compliance with questioned provisions at the time of the review. (New information can be provided anytime between the exit interview and the POC.) When access or care to individuals is a serious issue, the CMHSP may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified in (D) above.
 - 2. The MDHHS will review the POC, seek clarifying or additional information from the CMHSP as needed, and issue an approval of the POC within 30 days of having required information from the CMHSP. The MDHHS will

- take steps to monitor the CMHSPs implementation of the POC as part of performance monitoring.
- 3. The MDHHS shall protect the confidentiality of the records, data and knowledge collected for or by individuals or committees assigned a peer review function in planning the process of review and in preparing the review or audit report for public release.
- F. The CMHSP can appeal findings reflected in review reports through the dispute resolution process identified in this contract.

9.4.2 MDHHS Audits

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

- A. As used in this section, an audit is an examination of the CMHSP and its contract service providers' financial records, policies, contracts, and financial management practices, conducted by the MDHHS Office of Audit or its agent, to verify the CMHSP's compliance with legal and contractual requirements.
- B. The MDHHS will schedule audits at mutually acceptable start dates to the extent possible. The MDHHS will provide the CMHSP with a list of documents to be audited at least 30 days prior to the date of the audit. An entrance meeting will be conducted with the CMHSP to review the nature and scope of the audit.
- C. The MDHHS audits of CMHSPs will generally supplement the independent auditor's Compliance Examination and may include one or more of the following objectives:
 - 1. To assess the CMHSP's effectiveness and efficiency in complying with the contract, and establishing and implementing specific policies and procedures as required by the contract;
 - 2. To assess the CMHSP's effectiveness and efficiency in reporting their financial activity to the MDHHS in accordance with contractual requirements; applicable federal, state, and local statutory requirements, and applicable accounting standards; and
 - 3. To determine the MDHHS's share of costs in accordance with applicable MDHHS requirements and agreements, and any balance due to/from the CMHSP.To accomplish the above listed audit objectives, MDHHS auditors will review CMHSP documentation, interview CMHSP staff members, and perform other audit procedures as deemed necessary.
- D. The audit report and appeal process is identified in Attachment C 9.3.2.1 and is a part of this contract.

10.0 RESPONSIBILITIES OF THE DEPARTMENT OF ATTORNEY GENERAL

The MDHHS has responsibility and authority to make all fraud and/or abuse referrals to the Department of the Attorney General, Health Care Fraud Division. Contractors who have any suspicion or knowledge of fraud and/or abuse within any of the MDHHS's programs must report directly to the MDHHS by calling (855) MI-FRAUD (643-7283) or by sending a memo to:

Office of Inspector General
Michigan Department of Health & Human Services
P. O. Box 30062
Lansing, MI 48909

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

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

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

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

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

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

COUNTY OF FINANCIAL RESPONSIBILITY

Technical Requirement for CMHSPs

I. INTRODUCTION

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

This technical requirement is based on the following principles:

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

II. ESTABLISHING COUNTY OF RESPONSIBILITY

- A. General Rule.** For persons served under the terms of this contract, the financially responsible CMHSP is the one that served them in the county where they last lived independently.
- B. Children.** The COFR will be the county where the child and parents have their primary residence. For temporary and permanent wards of the State or court (including tribal), the COFR is the county where the child currently resides in the community (i.e., licensed foster care home, relative placement, or independent living) as long as the foster care case remains open. For adopted children, once

adoption proceedings are completed, the COFR is the county where the adoptive parents have their primary residence.

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

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

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

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

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

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

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

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

- There is an existing agreement between County A and County B; or

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

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

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

D. Persons Living in Unlicensed Settings.

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

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

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

F. Jail.

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

G. State Correctional Facility.

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

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

H. Extent of Financial Liability.

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

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

I. Standard for Response by COFR.

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

J. PEPM Payments/Medicaid Residency Status.

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

K. Contractual Arrangements.

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

1. It is optional; all parties agree to the arrangement
2. It applies to adult consumers only
3. The contract applies to consumers who are in stable, long-term living arrangements outside their 'home' CMHSP, without plans to move
4. The principles underlying the COFR agreement remain intact, including the consumer's right to choose
5. The consumer's service array, based on needs assessment and consumer choice will not be altered as a function of this contract

6. For HSW enrollees, the HSW certificate will be transferred upon MDHHS receipt of documentation from both the 'home' and the 'serving' PIHPs with an effective date of transfer
7. The end date of the contract is the beginning of the fiscal year when the capitation rate of the 'serving' county includes the costs reported

III. DISPUTE RESOLUTION

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

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

A. Dispute Resolution Committee.

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

B. Initiation of Dispute Resolution.

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

C. Fact Finding.

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

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

D. Dispute Resolution Meeting.

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

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

IV. DEFINITIONS

“Living Independently”. The following factors will be used to determine whether a person is ‘living independently’:

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

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

Last Revision Date: October 28, 2021

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Developmental Disabilities Administration

ACCESS STANDARDS

PREAMBLE

It is the expectation of the Michigan Department of Health and Human Services (MDHHS) that Prepaid Inpatient Health Plans' (PIHPs) and Community Mental Health Services Programs' (CMHSPs) Access Systems function not only as the front doors for obtaining services from their helping systems, but that they provide an opportunity for residents with perceived problems resulting from trauma, crisis, or problems with functioning to be heard, understood, and provided with options. The Access System is expected to be available and accessible to all individuals on a telephone and a walk-in basis. Rather than screening individuals "in" or "out" of services, it is expected that Access Systems first provide the person "airtime" and express the message: "How may I help you?" This means that individuals who seek assistance are provided with guidance and support in describing their experiences and identifying their needs in their own terms, then assistance with linking them to available resources. PIHPs and CMHSPs are also expected to conduct active outreach efforts throughout their communities to assure that those in need of behavioral health services are aware of service entry options and encouraged to make contact. In order to be welcoming to all who present for services, the Access Systems must be staffed by workers who are skilled in listening and assisting the person with trauma, crisis, or functioning difficulties to sort through their experience and to determine a range of options that are, in practical terms, available to that individual. Access Systems are expected to be capable of responding to all local resident groups within their services area, including being culturally competent and able to address the needs of persons with co-occurring disorders and Substance Use Disorders (SUD). Furthermore, it is expected that the practices of Access Systems and conduct of their staff reflect the philosophies of support and care that MDHHS promotes and requires through policy and contract, including person-centered, self-determined, recovery-oriented, trauma-informed, and least restrictive environments.

FUNCTIONS

The key functions of an Access System are to:

1. **Welcome** all individuals by demonstrating empathy and providing opportunity for the person presenting to describe situation, problems, and functioning difficulties; exhibiting excellent customer service skills; and working with them in a non-judgmental way.
2. **Screen** individuals who approach the Access System to determine whether they are in crisis and, if so, assure that they receive timely appropriate attention.
3. **Determine** individuals' eligibility for Medicaid specialty services and supports, MICHild, Healthy Michigan Plan, Substance Abuse Block Grant (SABG) or, for those who do not have any of these benefits as a person who is presenting needs for behavioral health services, make them a priority to be served.

4. **Collect information** from individuals for decision-making and reporting purposes.
5. **Refer** individuals in a timely manner to the appropriate behavioral health practitioners for assessment, person-centered planning (PCP), and/or supports and services or, if the individual is not eligible for PIHP or CMHSP services, to community resources that may meet their needs.
6. **Inform** individuals about all the available mental health and substance abuse services and providers and their due process rights under Medicaid, MICHild, Healthy Michigan Plan, SABG, and the Michigan Mental Health Code.
7. **Conduct outreach** to under-served and hard-to-reach populations and be accessible to the community-at-large.

STANDARDS

These standards apply to all PIHPs and CMHSPs, whether the Access System functions are directly provided by the PIHP or CMHSP or are ‘delegated’ in whole or in part to a subcontract provider(s). Hereinafter, the above entities are referred to as “the Organization.” These standards provide the framework to address all populations that may seek out or request services of a PIHP or CMHSP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorder.

I. WELCOMING

- A. The Organization’s Access System services shall be available to all residents of the State of Michigan, regardless of where the person lives, or where he/she contacts the system. Staff shall be welcoming, accepting, and helping with all applicants for service¹.
- B. The Access System shall operate or arrange for an access line that is available 24 hours per day, seven days per week, including in-person and by-telephone access for hearing impaired individuals. Telephone lines are toll-free, accommodate Limited English Proficiency (LEP), are accessible for individuals with hearing impairments, using interpreters, text messaging or videophone access, and have electronic caller identification, if locally available².
 1. Callers encounter no telephone “trees” and are not put on hold or sent to voicemail until they have spoken with a live representative from the Access System, and it is determined, following an empathetic opportunity for the caller to express their situation and circumstances, that their situation is not urgent or emergent.
 2. All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back.

¹MDHHS Specialty Prepaid Health Plan 2002 Application for Participation (AFP), Section 3.1

²42 CFR § 438.10 and 438.206. Michigan Mental Health Code, P.A. 258 of 1974 (MHC) §330.1206.

MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.2. MDHHS AFP, Section 3.1.8

3. For non-emergent calls, a person's time on hold awaiting a screening must not exceed **three (3) minutes** without being offered an option for callback or talking with a non-professional in the interim.
 4. All non-emergent callbacks must occur within **one (1) business day** of initial contact.
 5. For Organizations with decentralized Access Systems, there must be a mechanism in place to forward the call to the appropriate access portal without the individual having to redial.
- C. The Access System shall provide a timely, effective response to all individuals who walk in.
1. For individuals who walk in with urgent or emergent needs³, an intervention shall be immediately initiated.
 2. Those individuals with routine needs must be screened or other arrangements made within **thirty (30) minutes**.
 3. **It is expected that the Access Center unit or function will operate minimally eight (8) hours daily, Monday through Friday, except for holidays.**
- D. The Access System shall maintain the capacity to immediately accommodate individuals based on their language skills and in the language of the individual's preference who present with:
1. LEP and other linguistic needs
 2. Diverse cultural and demographic backgrounds
 3. Visual impairments
 4. Alternative needs for communication
 5. Mobility challenges⁴
 6. Hearing loss or deafness
- E. The Access System shall address financial considerations, including County of Financial Responsibility (COFR) as a secondary administrative concern, only after any urgent or emergent needs of the person are addressed. Access System screening and crisis intervention shall never require prior authorization, nor shall Access System screening and referral ever require any financial contribution from the person being served⁵.

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

⁴42 CFR § 438.10. MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.2. MDHHS AFP, Section 3.1.8

⁵42 CFR §438.114

- F. The Access System shall provide applicants with a summary of their rights guaranteed by the Michigan Mental Health Code, including information about their rights to the PCP process and assure that they have access to the pre-planning process as soon as the screening and coverage determination processes have been completed⁶.
- G. The Access System shall provide information regarding confidentiality (42 CFR) and recipient rights of SUD clients to all individuals requesting services.

II. SCREENING FOR CRISES

- A. The Access System staff shall first determine whether the presenting mental health need is urgent, emergent, or routine and, if so, will address emergent and urgent need first. To assure understanding of the problem from the point of view of the person who is seeking help, methods for determining urgent or emergent situations must incorporate “caller or client-defined” crisis situations. Workers must be able to demonstrate empathy as a key customer service method.
- B. The Organization shall have emergency intervention services with sufficient capacity to provide clinical evaluation of the problem, to provide appropriate intervention, and to make timely disposition to admit to inpatient care or refer to outpatient services⁷. The Organization may use telephonic crisis intervention counseling, face-to-face crisis assessment, mobile crisis team, and dispatching staff to the emergency room, as appropriate. The Access System shall perform or arrange for inpatient assessment and admission, or alternative hospital admissions placements, or immediate linkage to a crisis practitioner for stabilization, as applicable⁸.
- C. The Access System shall inquire as to the existence of any established medical or psychiatric advance directives relevant to the provision of services⁹.
- D. The Organization shall assure coverage and provision of post stabilization services for Medicaid beneficiaries once their crises are stabilized¹⁰. Individuals who are not Medicaid beneficiaries, but who need mental health services and supports following crisis stabilization, shall be referred to the Access System for assistance.

III. PRIORITY POPULATION MANAGEMENT

- A. The following chart indicates the current admission priority standards for each population along with the current interim service requirements. The SABG requirements indicate that clients who are pregnant or injecting drug users have admission preference over any other client accessing the system and are identified as a priority population. Priority population clients must be admitted to services as specified below.¹¹

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

⁷MDHHS Administrative Rule 330.2006

⁸MHC § 330.1206 and 1409

⁹42 CFR §438.6; MCL 700.5501 et seq

¹⁰42 CFR §438.114. MDHHS/PIHP Contract, Part I, Section 1

¹¹45 CFR §96.131, MHC §333.6232

In a situation where a referred MDOC individual meets the criteria for one of the previous populations listed below, the admission standards for that population must be followed. Suggested additional interim services are in italics below.

Admission Priority Standards

Population	Admission Requirement	Interim Service Requirement	Authority
Pregnant Injecting Drug User	1) Screened and referred within 24 hours . 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours . Other Levels or Care – Offer admission within 48 business hours .	<u>Begin within 48 hours:</u> 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. d) Effects of alcohol and drug use on the fetus. 2. Referral for prenatal care. 3. <i>Early intervention clinical services.</i>	CFR 96.121; CFR 96.131; Tx Policy #04 Recommended
Pregnant Substance User	1) Screened and referred within 24 hours . 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours . Other Levels or Care – Offer admission within 48 business hours .	<u>Begin within 48 hours:</u> 1. Counseling and education on: a) HIV and TB. b) Risks of transmission to sexual partners and infants. c) Effects of alcohol and drug use on the fetus. 2. Referral for prenatal care. 3. <i>Early intervention clinical services.</i>	CFR 96.121; CFR 96.131; Recommended
Injecting Drug User	Screened and referred within 24 hours . Offer admission within 14 days .	<u>Begin within 48 hours – maximum waiting time 120 days:</u> 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. 2. <i>Early intervention clinical services.</i>	CFR 96.121; CFR 96.126; Recommended
Parent at Risk of Losing Children	Screened and referred within 24 hours . Offer admission within 14 days .	<u>Begin within 48 business hours:</u> <i>Early intervention clinical services.</i>	<u>MI Public Health Code Sec. 6232</u> Recommended

Population	Admission Requirement	Interim Service Requirement	Authority
Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from MDOC Without Supervision and Referred by MDOC	Screened and referred within 24 hours . Offer admission within 14 days .	<i>Begin within 48 business hours.</i> Recovery Coach Services <i>Early intervention clinical services.</i>	MDHHS & PIHP Contract Recommended
All Others	Screened and referred within 7 calendar days . Capacity to offer admission within 14 days .	Not required.	CFR 96.131(a) – sets the order of priority. MDHHS & PIHP contract

- B. It is the expectation that the PIHP provide SUD services to priority population clients before any other non-priority client is admitted for any other treatment services. Exceptions can be made when it is the client's choice to wait for a program that is at capacity.

IV. DETERMINING COVERAGE ELIGIBILITY FOR PUBLIC MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT SERVICES

- A. The Organization shall ensure access to public mental health services in accordance with the MDHHS/PIHP and MDHHS/CMHSP contracts¹² and:
1. The Mental Health and Substance Abuse Chapter of the MPM if the individual is a Medicaid beneficiary.
 2. The MIChild Provider Manual if the individual is a MIChild beneficiary.
 3. The Michigan Mental Health Code and the MDHHS Administrative Rules if the individual is not eligible for Medicaid or MIChild¹³. For mental health services, CMHSPs shall serve individuals with serious mental illness, serious emotional disturbance, and developmental disabilities giving priority to those with the most serious forms of illness and those in urgent and emergent situations. Once the needs of these individuals have been addressed, MDHHS expects that individuals with other diagnoses of mental disorders with a diagnosis found in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM)¹⁴, will be served based upon agency priorities and within the funding available.
- B. The responsible Organization shall ensure access to public substance abuse treatment services in accordance with the MDHHS/PIHP contract¹⁵ and:
1. The Mental Health and Substance Abuse Chapter of the MPM if the individual is a Medicaid beneficiary.
 2. The MIChild Provider Manual if the individual is a MIChild beneficiary.
 3. The priorities established in the Michigan Public Health Code if the individual is not eligible for Medicaid or MIChild¹⁶.
 4. Provisional diagnostic impression using all five axes of the current version of the DSM.
 5. Medical necessity and level of care determination criteria utilizing the American Society of Addiction Medicine (ASAM) Criteria.

¹²MDHHS PIHP & CMHSP Contracts, Part II, Section 3

¹³MHC §330.1208

¹⁴The **DSM** is an [American](#) handbook for [mental health professionals](#) that lists different categories of [mental disorders](#) and the criteria for diagnosing them, according to the publishing organization the [American Psychiatric Association](#)

¹⁵MDHHS CA contract, Attachment A, Statement of Work, and Attachment E, Methadone Enrollment Criteria and Access Management Policy

¹⁶Public Health Code P.A. 368 of 1978 §333.6100 and 6200 and MDHHS Administrative Rule 325.14101

- a. Dimension 1 – Alcohol Intoxication and/or Withdrawal Potential.
 - b. Dimension 2 – Biomedical Conditions and Complications.
 - c. Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications.
 - d. Dimension 4 – Readiness to Change.
 - e. Dimension 5 – Relapse, Continued Use, or Continued Problem Potential.
 - f. Dimension 6 – Recovery Environment.
- C. The Organization shall ensure that screening tools and admission criteria are based on eligibility criteria in parts III.a. and III.b. above and are valid, reliable, and uniformly administered¹⁷.
- D. The Organization shall be capable of providing the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) corrective or ameliorative services that are required by the MDHHS PIHP specialty services and supports contract¹⁸.
- E. When clinical screening is conducted, the Access System shall provide a written (hard copy or electronic) screening decision of the person's eligibility for admission based upon established admission criteria. The written decision shall include:
- 1. Identification of presenting problem(s) and need for services and supports.
 - 2. Initial identification of population group (DD, MI, SED, or SUD) that qualifies the person for public mental health and SUD services and supports.
 - 3. ASAM Criteria
 - 4. Legal eligibility and priority criteria (where applicable).
 - 5. Documentation of any emergent or urgent needs and how they were immediately linked for crisis service.
 - 6. Identification of screening disposition.
 - 7. Rationale for system admission or denial.
- F. The Access System shall identify and document any third-party payer source(s) for linkage to an appropriate referral source, either in network, or out-of-network.

¹⁷MDHHS AFP, Section 3.1.5

¹⁸MDHHS/PIHP Contract, Part II, Section 3.4.3. Michigan Medicaid Provider Manual, Practitioner Chapter

- G. The Organization shall not deny any eligible individual a service because of individual/family income or third-party payer source¹⁹.
- H. The Access System shall document the referral outcome and source, either in-network or out-of-network.
- I. The Access System shall document when a person with mental health needs, but who is not eligible for Medicaid or MIChild, is placed on a 'waiting list' and why²⁰.
- J. The Organization shall assure that an individual who has been discharged back into the community from outpatient services and is requesting entrance back into the PIHP/CMHSP or provider, within one year, will not have to go through the duplicative screening process. They shall be triaged for presenting mental health needs per urgent, emergent, or routine.

V. COLLECTING INFORMATION

- A. The Access System shall avoid duplication of screening and assessments by using assessments already performed or by forwarding information gathered during the screening process to the provider receiving the referral, in accordance with applicable federal/state confidentiality guidelines (e.g., 42 CFR Part 2 for SUDs).
- B. The Access System shall have procedures for coordinating information between internal and external providers, including Medicaid Health Plans (MHPs) and primary care physicians (PCPs)²¹.
- C. Coordination of Care with the Court System²²
 - 1. The Access System must be able to utilize the SUD screening information and treatment needs provided by district court probation officer assessments when the probation officer has the appropriate credentialing through the Michigan Certification Board for Addiction Professionals (MCBAP). A release of information form must accompany the district court probation officer referral. The information provided by the probation officer should supply enough information to the Access System to apply ASAM Criteria to determine Level of Care (LOC) and referral for placement. In situations where information is not adequate, the release of information will allow the Access System to contact the district court probation officer to obtain other needed information. The Access System must be able to authorize these services based on medical necessity so PIHP funds can be used to pay for treatment.

¹⁹MHC §330.1208

²⁰MHC §330.1226

²¹42 CFR §438.208

²²45 CFR §96.132

VI. REFERRAL TO PIHP or CMHSP PRACTITIONERS

- A. The Access System shall assure that applicants are offered appointments for assessments with mental health professionals of their choice within the MDHHS PIHP and CMHSP contract-required standard timeframes²³. Staff follows up to ensure the appointment occurred.
- B. The Access System shall ensure that, at the completion of the screening and coverage determination process, individuals who are accepted for services have access to the PCP process²⁴.
- C. The Access System shall ensure that the referral of individuals with co-occurring mental illness and SUDs to PIHP or CMHSP or other practitioners must be in compliance with confidentiality requirements of 42 CFR.

VII. REFERRAL TO COMMUNITY RESOURCES

- A. The Access System shall refer Medicaid beneficiaries who request mental health services, but do not meet eligibility for specialty supports and services, to their MHPs²⁵ or Medicaid fee-for-service providers.
- B. The Access System shall refer individuals who request mental health or substance abuse services but who are neither eligible for Medicaid, Healthy Michigan Plan, or MIChild mental health and substance abuse services, nor who meet the priority population to be served criteria in the Michigan Mental Health Code or the Michigan Public Health Code for substance abuse services, to alternative mental health or substance abuse treatment services available in the community.
- C. The Access System shall provide information about other non-mental health community resources or services that are not the responsibility of the public mental health system to individuals who request it²⁶.

VIII. INFORMING INDIVIDUALS

A. General

The Access System shall provide information about and help people connect as needed with the Organization's Customer Services Unit, peer supports specialists, family advocates, and local community resources, such as: transportation services, prevention programs, local community advocacy groups, self-help groups, service recipient groups, and other avenues of support, as appropriate²⁷.

²³Choice of providers: 42 CFR §438.52. MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.4. Timeframes for access: Section 3.1

²⁴MDHHS AFP, Section 3.2. MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.1 and Attachment 3.4.1.1

²⁵42 CFR §438.10

²⁶MDHHS AFP, Section 2.9

²⁷MDHHS AFP, Section 2.9

B. Rights

1. The Access System shall provide Medicaid, Healthy Michigan Plan, and MIChild beneficiaries information about the local dispute resolution process and the state Medicaid Fair Hearing process²⁸. When an individual is determined ineligible for Medicaid specialty service and supports, Healthy Michigan Plan, or MIChild mental health services, he/she is notified both verbally and in writing of the right to request a second opinion, and/or file an appeal through the local dispute resolution process, and/or request a state Fair Hearing.
2. The Access System shall provide individuals with mental health needs or persons with co-occurring substance use/mental illness with information regarding the local community mental health Office of Recipient Rights (ORR)²⁹. The Access System shall provide individuals with SUDs or persons with co-occurring substance use/mental illness with information regarding the local substance abuse coordinating ORR³⁰.
3. When an individual with mental health needs who is not a Medicaid beneficiary is denied community mental health services, for whatever reason, he/she is notified of the right under the Mental Health Code to request a second opinion and/or file an appeal through the local dispute resolution process³¹.
4. The Access System shall schedule and provide for a timely second opinion, when requested, from a qualified health care professional within the network or arrange for the person to obtain one outside the network at no cost. The person has the right to a face-to-face determination, if requested³².
5. The Access System shall ensure the person and any referral source (with the person's consent) are informed of the reasons for denial and shall recommend alternative services and supports or disposition³³.

C. Services and Providers Available

1. The Access System shall assure that applicants are provided comprehensive and up-to-date information about the mental health and substance abuse services that are available and the providers who deliver them³⁴.
2. The Access System shall assure that there are available alternative methods for providing the information to individuals who are unable to read or understand written material or who have LEP³⁵.

²⁸42 CFR § 438.10, MDHHS/PIHP Contract, Part II, Section 6.3.2, and Attachment 6.3.2.1

²⁹MHC §330.1706

³⁰MDHHS Administrative Rule 325.14302

³¹MHC §330.1706, MDHHS/CMHSP Contract, Part II, Attachment 6.3.2.1

³²MDHHS/PIHP & CMHSP Contract, Part II, Section 3.4.5

³³42 CFR § 438.10

³⁴42 CFR § 438.10, MDHHS/PIHP Contract, Part II, Section 6.3.3, MDHHS AFP, Section 3.1.1

³⁵42 CFR § 438.10, MDHHS/PIHP Contract, Part II, Section 6.3.3

IX. ADMINISTRATIVE FUNCTIONS

- A. The Organization shall have written policies, procedures, and plans that demonstrate the capability of its Access System to meet the standards herein.

B. Community Outreach and Resources

1. The Organization shall have an active outreach and education effort to ensure the network providers and the community are aware of the Access System and how to use it.
2. The Organization shall have a regular and consistent outreach effort to commonly unserved or underserved populations who include children and families; older adults; homeless persons; members of ethnic, racial, linguistic, and culturally diverse groups; persons with dementia; and pregnant women.³⁶
3. The Organization shall assure that the Access System staff are informed about, and routinely refer individuals to, community resources that not only include alternatives to public mental health or substance abuse treatment services, but also resources that may help them meet their other basic needs.
4. The Organization shall maintain linkages with the community's crisis/emergency system, liaison with local law enforcement, and have a protocol for jail diversion.

C Oversight and Monitoring

1. The Organization's Medical Director shall be involved in the review and oversight of the Access System policies and clinical practices.
2. The Organization shall assure that the Access System staff are qualified, credentialed, and trained consistent with the MPM, MICHild Provider Manual, the Michigan Mental Health Code, the Michigan Public Health Code, and the specialty services and support contract³⁷.
3. The Organization shall have mechanisms to prevent conflict of interest between the coverage determination function and access to, or authorization of, services.
4. The Organization shall monitor provider capacity to accept new individuals and be aware of any provider organizations not accepting referrals at any point in time³⁸.
5. The Organization shall routinely measure telephone answering rates, call abandonment rates, and timeliness of appointments and referrals. Any resulting performance issues are addressed through the Organization's Quality Improvement Plan.

³⁶MDHHS AFP, Section 3.1.2

³⁷42 CFR §438.214. MDHHS PIHP Contract, Part II, Attachment 6.7.1.1

³⁸42 CFR §438.10

6. The Organization shall assure that the Access System maintains medical records in compliance with state and federal standards³⁹.
- 7 The Organization staff shall work with individuals, families, local communities, and others to address barriers to using the Access System, including those caused by lack of transportation⁴⁰.

D. Waiting Lists

1. The Organization shall have policies and procedures for maintaining a waiting list for individuals not eligible for Medicaid or MIChild and who request community mental health services but cannot be immediately served⁴¹. The policies and procedures shall minimally assure:
 - a. No Medicaid or MIChild beneficiaries are placed on waiting lists for any medically necessary Medicaid or MIChild service.
 - b. A local waiting list shall be established and maintained when the CMHSP is unable to financially meet requests for public mental health services received from those who are not eligible for Medicaid or MIChild⁴². Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
 - c. Persons who are not eligible for Medicaid or MIChild who receive services on an interim basis that are other than those requested shall be retained on the waiting list for the specific requested program services. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
 - d. Use of a defined process, consistent with the Mental Health Code, to prioritize any service applicants and recipients on its waiting list.
 - e. Use of a defined process to contact and follow-up with any individual on a waiting list who is awaiting a mental health service.
 - f. Reporting, as applicable, of waiting list data to MDHHS as part of its annual program plan submission report in accordance with the requirements of the Mental Health Code.

³⁹Michigan Medicaid Provider Manual, General Information Chapter, Section 13.1

⁴⁰MDHHS AFP, Section 3.1.10

⁴¹MHC §330.1124

⁴²MHC §330.1208

- g. The PIHP is responsible for maintaining a SABG waiting list by contacting clients who are placed on it every 30 days to check their status/well-being and continued interest in services until they are linked with the appropriate level of care. Attempts and contacts shall be documented to ensure that the list is properly maintained. Those clients who are not able to be contacted or who do not respond after 90 days may be removed.
- h. Priority population clients placed on a waiting list are required to be offered interim services⁴³. Interim services must minimally include:
 - i. Counseling and education about the human immunodeficiency virus (HIV) and tuberculosis (TB).
 - ii. The risks of needle sharing.
 - iii. The risks of transmission to sexual partners and infants and steps that can be taken to ensure that HIV and TB transmission does not occur.
 - iv. HIV or TB treatment service referrals.
 - v. Counseling on the effects of alcohol and drug use on a fetus and referral for prenatal care are required for pregnant women.

⁴³Section 96.121 of the Substance Abuse Block Grant (SABG)

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION

PERSON-CENTERED PLANNING PRACTICE GUIDELINE

“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 honors the individual’s preferences, choices, and abilities.” MHC 330.1700(g)

I. What is the Purpose of the Community Mental Health System?

The purpose of the community mental health system is to support adults and children with intellectual and developmental disabilities (DD), adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance (SED) 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 individuals to plan their life in their community, set the goals that they want to achieve, and develop a plan for how to accomplish those goals. PCP is required by state law, (the Michigan Mental Health Code (MMHC)), and federal law, (the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules), as the way that individuals 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 individual 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, an individual 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 individuals who care about the individual 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 intellectual and DD services provided by the CMHSP system, PCP can include planning for other public supports and privately funded services chosen by the individual.

The Home and Community Based Services (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 community mental health system.

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Through the PCP process, an individual and those he/she has selected to support him/her:

- a. Focus on the individual's life goals, interests, desires, choices, strengths, and abilities as the foundation for the PCP process.
- b. Identify outcomes based on the individual's life goals, interests, strengths, abilities, desires, and choices.
- c. Make plans for the individual to achieve identified outcomes.
- d. Determine the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, those 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 individual's goals while still meeting his/her basic needs (food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code). As appropriate for the individual, 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 Michigan Department of Health and Human Services (MDHHS) policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the individual to work toward and achieve his/her 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 individual reaches adulthood, his/her needs and goals become primary.

There are a few circumstances where the involvement of a minor's family may not be appropriate:

- a. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, a guardian, or an individual in loco parentis within the restrictions stated in the MMHC.
- 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 MMHC, "'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. The person-centered planning process involves families, friends, and professionals as the individual desires or requires." MHC 330.1700(g).

The MMHC also requires use of PCP for development of an IPOS:

"(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 individual 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 that Guide the PCP Process and the Essential Elements of the PCP Process 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 every individual. The following values and principles guide the PCP process whenever it is used.

- a. Every individual is presumed competent to direct the planning process, achieve his/her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the individual's ability to make choices.
- b. Every individual has strengths, can express preferences, and can make choices. The PCP approach identifies the individual's strengths, goals, choices, medical and support needs, and desired outcomes. In order to be strength-based, the positive attributes of the individual are documented and used as the foundation for building the individual's goals and plans for community life as well as strategies or interventions used to support the individual's success.
- c. The individual's choices and preferences are honored. Choices may include the family and friends involved in his/her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships, friendships, and transportation. Individual choice must be used to develop goals and to meet the individual's needs and preferences for supports and services and how they are provided. Therefore, it is important that the individual has the ability to communicate with those involved in the individual's life and care.

- d. The individual'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 individual to implement his/her choices or preferences over time.
- e. Every individual contributes to his/her community and has the right to choose how supports and services enable him/her to meaningfully participate and contribute to his/her community.
- f. Through the PCP process, an individual maximizes independence, creates connections, and works towards achieving his/her chosen outcomes.
- g. An individual's cultural background is recognized and valued in the PCP process. Cultural background may include language preference, religion, values, beliefs, customs, dietary choices, and other things chosen by the individual. Linguistic needs, including American Sign Language (ASL) interpretation, text messaging, video phone access, assistive technology and Computer Assisted Realtime Translation (CART), are also recognized, valued, and accommodated.

IV. What are the Essential Elements of the PCP Process?

The following elements are essential to the successful use of the PCP process with an individual and those invited by the individual to participate.

- a. **Person-Directed.** The individual directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.
- b. **Person-Centered.** The planning process focuses on the individual, not the system or the individual's family, guardian, or friends. The individual's goals, interests, desires, and 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 individual's needs or choices, rather than viewed as an annual event.
- c. **Outcome-Based.** The individual identifies outcomes to achieve in pursuing his/her goals. The way that progress is measured toward achievement of outcomes is identified.
- d. **Information, Support, and Accommodations.** As needed, the individual 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 individual to participate in the process are provided. The individual is offered information on the full range of services available in an easy-to-understand format.
- e. **Independent Facilitation.** Every individual has the information and support to choose an independent facilitator to assist him/her in the planning process.
- f. **Pre-Planning.** The purpose of pre-planning is for the individual to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Every individual must use pre-planning to ensure successful PCP. Pre-planning, individualized for the individual's needs, is used anytime the PCP process is used.

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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 individual has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and plan for how to deal with them as to what will be discussed and not discussed.
 3. The specific PCP format or tool chosen by the individual to be used for PCP.
 4. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).
 5. Who will facilitate the meeting.
 6. 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 individual to live the way he/she wants to live are discussed and plans to address them are developed. Individuals 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, and eating candy or other sweets). If the individual 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 individual's right to assume some degree of personal risk. The plan must assure the health and safety of the individual. 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 individual selects allies (friends, family members, and others) to support him/her through the PCP process. Pre-planning and planning help the individual explore who is currently in his/her life and what needs to be done to cultivate and strengthen desired relationships.

V. What is Independent Facilitation?

An Independent Facilitator is an individual who facilitates the PCP process in collaboration with the individual. In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their PCP 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 individual 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.

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The PIHP and/or the 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/her hopes, interests, desires, preferences, and concerns are heard and addressed. The independent facilitator must not have any other role within the PIHP and/or the 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/she likes and dislikes, personal preferences, goals, methods of communication, and who supports and/or is important to the individual.
- b. Help the individual with all pre-planning activities and assist in inviting participants chosen by the individual to the meeting(s).
- c. Assist the individual to choose planning tool(s) to use in the PCP process.
- d. Facilitate the PCP meeting(s) or support the individual to facilitate his/her own PCP meeting(s).
- e. Provide needed information and support to ensure that the individual directs the process.
- f. Make sure the individual is heard and understood.
- g. Keep the focus on the individual.
- h. Keep all planning participants on track.
- i. Develop an IPOS in partnership with the individual that expresses the individual's goals, is written in plain language understandable by the individual, and provides for services and supports to help the individual 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 and/or the CMHSP may report the service under the code H0032.

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

VI. How is PCP used to Write and Change the IPOS?

The MMHC establishes the right for all individuals to develop an IPOS through the PCP process. The PCP process must be used at any time the individual wants or needs to use the process but must be used at least annually to review the IPOS. The agenda for each PCP meeting should be set by the individual through the pre-planning process, not by the 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 PCP process.

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

Individuals are often at different points in the process of achieving his/her life goals. The PCP process should be individualized to meet every individual's needs of the individual for whom planning is done, i.e. meeting an individual where he/she is. Some individuals may be just beginning to define the life he/she wants and initially the PCP process may be lengthy as the individual's goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once an IPOS is developed, subsequent use of the PCP process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent to which an IPOS is updated will be determined by the needs and desires of the individual. If and/or when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs of the individual as they arise. An IPOS must be prepared in person-first singular language and be understandable by the individual with a minimum of clinical jargon or language. The individual must agree to the IPOS in writing. The IPOS must include all 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 individual and how progress toward achieving those outcomes will be measured.
- c. The services and supports needed by the individual to work toward or achieve his/ her outcomes, including those available through the CMHSP and other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS), community resources, and natural supports.)

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- d. The setting in which the individual lives was chosen by himself/herself and what alternative living settings were considered by him/her. 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 community mental health system. The PIHP and/or the 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 individual 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 the Technical Requirement for Explanation of Benefits.
- j. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and the providers in implementing the IPOS.
- k. The individual or entity responsible for monitoring the plan.
- l. The signatures of the individual and/or representative, the case manager or the support coordinator, and the support broker/agent (if one is involved).
- m. The plan for sharing the IPOS with family, friends, and/or caregivers with the permission of the individual.
- 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 an individual has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of his/her needs, changes in his/her condition as determined through the PCP process, or changes in his/her personal preferences for support).

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The individual and the case manager or the supports coordinator should work on and review the IPOS on a routine basis as part of regular conversations. An individual or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the individual 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 individual desires to do so. The review of the IPOS, at least annually, is done through the PCP process.

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

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

VII. How Must Restriction on an Individual'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 PCP process and documented in the IPOS.

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

- a. A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.
- b. Sleeping or living units lockable by the individual with only appropriate staff having keys.
- c. Individuals sharing units have a choice of roommate in that setting.
- d. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- e. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.
- f. Individuals can 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 individual to the proposed modification.
8. An assurance that the modification itself will not cause harm to the individual.

VIII. What do the PIHPS, the CMHSPS and Other Organizations Need to do to Ensure Successful Use of the PCP 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 the CMHSPs, 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 individuals 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 to, 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 the individual 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 every individual to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; and 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 individual 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 appeals, grievances, and recipient rights as set forth in detail in the Appeal and Grievance Resolution Processes Technical Requirement. As described in this Technical Requirement, 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 an individual is receiving services and no agreement on IPOS can be made through the PCP 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 appeals and grievances take over. Other options are available to all recipients of community mental health services and supports.

Supports Coordinators, Case Managers, and Customer Services at the PIHPs and/or the CMHSPs must be prepared to help people understand and negotiate the dispute resolution processes.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES BEHAVIORAL HEALTH AND DISABILITIES ADMINISTRATION

SELF-DIRECTED SERVICES TECHNICAL REQUIREMENT

Purpose:

This document sets the standards for the use of self-directed and choice vouchered services, supports, and individual budgets for behavioral health services delivered through the Community Mental Health Service Programs (CMHSPs) and Prepaid Inpatient Health Plans (PIHPs) in Michigan.

The CMHSPs and PIHPs must assure self-directed services are available to all individuals, no matter where they live in Michigan and must actively assist individuals that choose to self-direct. Any reference to Self-Directed Services also applies to Choice Voucher with appropriate substitutions for family and child throughout the document.

The CMHSPs and PIHPs must meet the following requirements:

1. Self-Directed Services and supports are set up using a Person-Centered Planning Process from which an Individual Plan of Service (IPOS) for medically necessary services and an individual budget are developed.
2. Self-Directed Services (Choice Voucher for under 18 year old individuals) must be offered to all individuals receiving CMHSP or PIHP services.
3. Options must include all of the following:
 - Direct employment (the individual is the employer of record).
 - Use of any qualified provider agency that can serve as employer of record for staff selected by the individual (Agency Supported Self-Direction). The CMHSP and/or PIHP contractual language with provider agencies assures personal selection and changes of staff.
 - Direct contract (Purchase of Service Agreements) arrangement between individual and independent provider(s).
 - Financial Management/Fiscal Intermediary Services and Supports Brokers must be available.
4. Self-Directed Services are implemented through partnerships between the CMHSPs/PIHPs and the individual directing his/her services through a Self-Direction Agreement. This agreement describes the responsibilities and authority of both parties.
5. Choosing Self-Directed Services does not change an individual's access to the services he/she needs or those available from the CMHSP and/or PIHP so long as medical necessity criteria and benefit coverage eligibility remains.

6. Self-Directed Services do not reduce the PIHPs responsibilities to individuals receiving services nor negate its responsibility to assist individuals in finding providers for services.
7. All Medicaid Services and Supports terms apply (i.e. documentation, financial accountability, monitoring, quality improvement) including reporting and provider qualifications.
8. The Office of Recipient Rights has investigative authority for Specialty Mental Health Services and Supports including Self-Directed Supports and Services.
9. The CMHSP/PIHP must have procedures to make sure there are no gaps in services during transition to or from Self-Directed Service arrangements.
10. Individuals will be fully informed about the meaning of Self-Directed Services and all models and possible ways to control, manage, and account for their individual budget.
11. The CMHSPs/PIHPs must provide education and training to ensure a common understanding of Self-Directed Services is made available throughout its network, including:
 - Administrators
 - Case Managers/Supports Coordinators
 - Direct Support Professionals
 - Supports Brokers
 - Individuals and their Families
 - Agency-based Staff
 - Others
12. All person-centered planning processes, service delivery, and budget planning will support individuals to make decisions about and control their own lives. This means the CMHSP/PIHP will actively commit to promoting self-direction and support the decisions individuals who self-direct make about how to meet the goals of their IPOS within the parameters of the individual budget.
13. Accountability for the use of public funds must be a shared responsibility of the CMHSP/PIHP and the individual, consistent with the fiduciary obligations of the CMHSP/PIHP. Fiscal responsibility and the wise use of public funds shall guide the individual and the CMHSP/PIHP in reaching an agreement on the allocation and use of funds comprising an individual budget.
14. Each CMHSP/PIHP must make sure that information and outreach materials about Self-Directed Services (or choice voucher) is offered to all individuals served. Individuals must have all information in a format accessible to them.

15. The PIHP with the CMHSP will provide ongoing support and assistance to individuals managing and controlling the supports they are directing. Examples include, but are not limited to:

- Information about the options for Self-Directed Services
- Individual rights and responsibilities
- Available resources
- Supported decision making
- Training – including documentation, service delivery, role of employer, role of employee, and budgeting
- The use of a supports broker
- Informal representative
- Access to independent advocacy organizations (e.g. Disability Rights Michigan, local Arcs, United Cerebral Palsy, etc.)
- Active management of the individual budget
- Staff recruitment, selection, management and dismissal

In addition to the above, the CMHSPs/PIHPs will provide support for other issues related to Self-Directed Services such as coaching, mentoring, training, or other paid services needed for success.

Key Elements of Self-Directed Supports and Services:

1. Employer Authority

Employer authority means the individual recruits, hires, supervises, directs, and fires the support staff. The individual acts as the common law employer.

2. Budget Authority

Controlling an individual budget is a core part of Self-Directed Services. The individual budget is a projected amount of public mental health funds named in dollar terms within the context of medical necessity. With the budget spending plan, the spending authority is with the individual.

In order for an individual to have budget authority, the budget must be:

Accessible – meaning the individual has complete understanding of how they can control and make changes to the budget when needed.

Portable – meaning the individual must be able to change and transfer budget resources from one provider to another (includes one CHMSP/PIHP to another).

Flexible – meaning flexible spending – individual controlled use of dollars and amount of services identified in the IPOS within a fixed budget. Changes to the budget should not require a change to the IPOS unless services are terminated or increased.

3. Financial Management/Fiscal Intermediary Services

A CMHSP is required to contract with a Financial Management Service provider. The Financial Management Service provider maintains compliance with its CMHSP contract requirements. Financial Management Service Providers are here to support the independent lifestyle that self-direction offers. The Financial Management Service providers assist individuals with payroll processing, taxes, budget management, and other fiscal aspects of employing staff and assists individuals with managing funds consistent with the Financial Management Services Technical Requirements.

4. Ending Self-Directed Services, Grievance and Appeal Rights

An individual may voluntarily end a Self-Directed Service arrangement at any time for any reason. The CMHSP and/or PIHP must work together with the individual to transition to another service arrangement through the person-centered planning process. Discontinuation of a self-direction agreement, by itself, shall neither change the IPOS, nor eliminate the obligation of the CMHSP/PIHP to assure Specialty Mental Health Services and Supports required in the IPOS are provided.

Ending self-directed service arrangements may be initiated by either the individual or the CMHSP and/or PIHP. Before they can end Self-Directed Services, the CMHSP and/or PIHP must inform the individual of the issues that have led to the possibility of ending self-direction arrangements, in writing. They also must provide opportunities for problem solving. The individual must be involved in all problem solving attempts. Ending self-direction arrangements are only done if other mutually agreeable solutions have been exhausted.

Termination of a self-direction services agreement by a CMHSP/PIHP is not a Medicaid Fair Hearings Issue. Only a suspension, reduction, or termination of Medicaid services can be appealed through the Medicaid Fair Hearings Process, not the use of self-direction arrangement to obtain those services. As it pertains to termination of Self-Directed Service arrangements, ending the Financial Management Services (formerly Fiscal Intermediary) can be appealed through the Medicaid Fair Hearings Process.

Definition of Terms

Agency Supported Self-Direction (Also Known as Agency with Choice)

This allows the individual to direct as much or as little employer and administrative responsibilities as agreed upon in the IPOS and Agency Agreement while a provider agency serves as employer of record.

Choice Voucher Arrangements

Choice Voucher is the name for Self-Directed Services for individuals under the age of 18. This is because children cannot independently direct their services until adulthood.

Direct Hire or Direct Employment Model

The Direct Hire or Direct Employment Model is an option of self-direction where the individual is considered the employer of record and has the authority to hire, fire, supervise, and manage individual, aide level workers.

Employer of Record

The Employer of Record is the term for the individual who is a legal employer. In much of this document, an individual who is self directing will be considered the employer of record or a managing employer.

Financial Management Service Provider/Fiscal Intermediary

A Fiscal Intermediary is an organization or individual independent of the CMH system that assists employers to manage the dollars self-directed budgets.

Individual

For the purposes of this document, “individual” means an individual receiving behavioral health services and supports.

Individual Budget

An individual budget is the amount of money from CMH given to pay for behavioral health services and supports as listed in the IPOS. By using an individual budget, individuals have the power to make meaningful choices about how they control their services and live their lives.

Managing Employer

A managing employer is the individual or designee who is acting in a supervisory role, but is not considered the legal employer of record. All parents/guardians in a Choice Voucher Arrangement are considered managing employers.

Person-Centered Planning

Person-centered planning is a collaborative, person-directed process designed to assist an individual to plan their life and supports.

Prepaid Inpatient Health Plan(PIHP)

A PIHP is a managed care organization that provides Medicaid services and money to the CMHSP to pay for Specialty Mental Health Services and Supports in an area of the state. There are 10 PIHPs in Michigan.

Purchase of Service Agreement or Direct Contract

A Purchase of Service Agreement is an option of self-direction where the individual can contract directly with a professional level provider including those who are not already on the provider panel. The individual has the authority to terminate the contract and set wages based on the CMHSP contracted rate for that service.

Qualified Provider

A qualified provider is an individual or agency that meets the federal and state requirements in their contract to provide mental health services and supports.

Self-Determination

Self-determination (SD) is the right of all individuals to have the power to make decisions for themselves; to have free will. The goals of SD, on an individual basis, are to promote full inclusion in community life, to feel important, and increase belonging while reducing the isolation and segregation of individuals who receive services. SD builds upon choice, autonomy, competence, and relatedness which are building blocks of psychological wellbeing.

Self-Direction or Self Directed Services

Self-direction is an alternative method for obtaining supports and services. It is the act of selecting, directing and managing one's services and supports. Individuals who self-direct their services are able to decide how to spend their CMH services budget with support, as desired.

The methods of self-direction are crafted with the principles of self-determination.

Principles of Self-Determination	Self-Directed Outcome
Freedom	Deciding how to live a good life
Authority	Controlling a targeted amount of dollars
Support	Organizing resources in ways that are life enhancing and meaningful
Responsibility	Using public funds wisely
Confirmation	Having a role in redesigning the service system

Supported Decision-Making

Supported Decision-Making is a process that enables individuals receiving services to retain and exercise their rights and make and communicate choices in regard to personal and legal matters assisted by a group of people they know, trust, and have chosen to support them.

Supported Decision-Making is an alternative to guardianship. Instead of having a guardian make a decision *for* the individual, Supported Decision-Making allows the individual to make his/her own decisions.

Supports Broker

A Supports Broker is a paid individual that helps the individual find and get the needed services and supports in their IPOS. A Supports Broker has a clear focus on helping individuals identify and meet goals to increase independence and quality of life. Supports Broker(s) may be employed by a CMHSP or other entities.

APPENDIX A: Core Elements Reference to 2013 Policy and Practice Guideline

Self-Directed Services Requirement	Self Determination Policy and Practice Guideline Core Element
1	See below
2	See below
3	See below
4	V. Realization of the principles of SD requires arrangements that are partnerships between the CMHSP/PIHP and the individual. They require the active commitment of the CMHSP/PIHP to provide a range of options for individual choice and control of personalized provider relationships within an overall environment of person-centered supports.
5	IX. Arrangements that support SD are administrative mechanisms, allowing an individual to choose, control, and direct providers of Specialty Mental Health Services and Supports. With the exception of fiscal intermediary services, these mechanisms are not themselves covered services within the array of state plan and Mental Health Specialty Services and Supports. SD arrangements must be developed and operated within the requirements of the respective contracts between the CMHSPs and PIHPs and the Michigan Department of Health and Human Services (MDHHS) and in accordance with federal and state law. Using arrangements that support SD does not change an individual's eligibility for particular Specialty Mental Health Services and Supports.
6	VI. In the context of this partnership, the CMHSPs/PIHPs must actively assist individuals with prudently selecting qualified providers and otherwise support them with successfully using resources allocated in an individual budget.
7	X. All the requirements for documentation of Medicaid-funded supports and services, financial accountability for Medicaid funds, and CMHSP/PIHP monitoring requirements apply to services and supports acquired using arrangements that support SD.
8	XI. Arrangements that support SD involve Mental Health Specialty Services and Supports; and therefore, the investigative authority of the Recipient Rights office applies.
9	See below
10	I. Individuals are provided with information about the principles of SD and the possibilities, models, and arrangements involved. Individuals have access to the tools and mechanisms supportive of SD, upon request. SD arrangements commence when the CMHSP/PIHP and the individual reach an agreement on an IPOS, the amount of mental health and other public resources to be authorized to accomplish the IPOS, and the arrangements through which authorized public mental health resources will be controlled, managed, and accounted for.

11	I. Individuals are provided with information about the principles of SD and the possibilities, models, and arrangements involved. Individuals have access to the tools and mechanisms supportive of SD, upon request. SD arrangements commence when the CMHSP/PIHP and the individual reach an agreement on an IPOS, the amount of mental health and other public resources to be authorized to accomplish the IPOS, and the arrangements through which authorized public mental health resources will be controlled, managed, and accounted for.
12	II. Within the obligations that accompany the use of funds provided to them, the CMHSPs/PIHPs shall ensure that their services planning and delivery processes are designed to encourage and support individuals to decide and control their own lives. The CMHSP/PIHP shall offer and support easily-accessed methods for individuals to control and direct an individual budget. This includes providing them with methods to authorize and direct the delivery of Specialty Mental Health Services and Supports from qualified providers selected by the individual.
13	IV. Fiscal responsibility and the wise use of public funds shall guide the individual and the CMHSP/PIHP in reaching an agreement on the allocation and use of funds comprising an individual budget. Accountability for the use of public funds must be a shared responsibility of the CMHSP/PIHP and the individual, consistent with the fiduciary obligations of the CMHSP/PIHP.
14	I. Individuals are provided with information about the principles of SD and the possibilities, models, and arrangements involved. Individuals have access to the tools and mechanisms supportive of SD, upon request. SD arrangements commence when the CMHSP/PIHP and the individual reach an agreement on an IPOS, the amount of mental health and other public resources to be authorized to accomplish the IPOS, and the arrangements through which authorized public mental health resources will be controlled, managed, and accounted for.
	Other Core Elements
Covered in Managed Care Rule	III. Individuals receiving services and supports through the public mental health system shall direct the use of resources in order to choose meaningful Specialty Mental Health Services and Supports in accordance with their IPOS as developed through the person-centered planning process.
This element is included in the PCP Policy	VII. Issues of wellness and well-being are central to assuring successful accomplishment of a individual's IPOS. These issues must be addressed and resolved using the person-centered planning process, balancing individual preferences and opportunities for SD with CMHSP/PIHP obligations under federal and state law and applicable Medicaid Waiver regulations. Resolutions should be guided by the individual's preferences and needs, and implemented in ways that maintain the greatest opportunity for personal control and direction.

Stricken	VIII. SD requires recognition that there may be strong inherent conflicts of interest between an individual's choices and current methods of planning, managing, and delivering Specialty Mental Health Services and Supports. The CMHSP/PIHP must watch for and seek to minimize or eliminate either potential or actual conflicts of interest between itself and its provider systems, and the processes and outcomes sought by the individual
Covered in the Technical Requirements under Key Elements and at the end of the document	IX. Arrangements that support SD are administrative mechanisms, allowing an individual to choose, control, and direct providers of Specialty Mental Health Services and Supports. With the exception of fiscal intermediary services, these mechanisms are not themselves covered services within the array of state plan and Mental Health Specialty Services and Supports. SD arrangements must be developed and operated within the requirements of the respective contracts between the CMHSPs and PIHPs and the MDHHS and in accordance with federal and state law. Using arrangements that support SD does not change an individual's eligibility for particular Specialty Mental Health Services and Supports.
Requirement	Explanation or citation to other parts of the SD Policy and Practice Guidelines
1	SD Policy sec II (A-C)
2	SD Services were expanded to all waivers in the 2019 1915(c) waiver applications
3	SD Policy sec III (B) 4
9	SD Policy sec II (E) 7

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)
OFFICE OF RECOVERY ORIENTED SYSTEMS OF CARE (OROSC)
Transformation Steering Committee, Recovery Oriented System of Care
Recovery Policy and Practice Advisory # 12
Version: 7.30.19

Purpose and Application

It is the policy of Michigan Department of Health and Human Services (MDHHS) that services and supports provided to individuals with behavioral health disorders (the term 'behavioral health' equates to substance use and mental health disorders) are based in recovery and embedded within a recovery oriented system of care. This policy and practice guideline specifies the expectations for the Pre-paid Inpatient Health Plans (PIHPs), Community Mental Health Service Programs (CMHSPs) and their provider networks. It is the culmination of a series of intentional milestones that include: the creation and evolution of the Recovery Oriented System of Care (ROSC) Transformation Steering Committee (TSC); the intension inclusion of persons with lived experience within all aspects of the behavioral health system (to give voice); establishment of Michigan Recovery Voices (to share resources) and the development of a peer workforce to provide services and supports (to enhance the recovery services system).

In order to move toward a recovery-based system of services, the beliefs and knowledge about recovery must be strengthened. MDHHS has worked diligently over the past several years toward the goal of effective transformation of behavioral health services to be recovery oriented and based in a recovery-oriented system. To that end, MDHHS requested that the ROSC/TSC to develop and has adopted the following recovery statement, guiding principles and expectations for systems change:

Recovery Statement

[An individual's] Recovery from Mental Disorders and/or Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA 2012) (ROSC/TSC 2015)

Recovery oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities. (ROSC TSC 2010)

Guiding Principles of Recovery

The following principles outline essential features of recovery for the individual, as well for creating and enhancing a behavioral health recovery-oriented system of care in which to embed recovery services and supports:

Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that people can do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

The system of care promotes person driven recovery will be individualized, person/family/community-centered, comprehensive, stage-appropriate, and flexible. It will adapt to the needs of individuals and communities, rather than requiring them to adapt to it. Individuals receiving services will have access to a menu of stage-appropriate choices that fit their needs throughout the recovery process. The approach will change from an acute, episode-based model to one that helps people manage this chronic disorder throughout their lives. Prevention services will be developmentally appropriate and engage the multiple systems and settings that have an impact on health and wellness. Prevention efforts will be individualized based on the community's needs, resources, and concerns.

Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experience—that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is nonlinear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the

goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

This system will offer a continuum of care that includes prevention, early intervention, treatment, continuing care, and support throughout recovery. Individuals will have a full range of stage-appropriate services to choose from at any point in the recovery process. Prevention services will involve the development of coordinated community systems that provide ongoing support, rather than isolated, episodic programs.

Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

This system of care will promote ongoing involvement of peers, through peer support opportunities for youth and families and peer recovery support services for individuals with behavioral health disorders. Individuals with relevant lived experiences will assist in providing these valuable supports and services.

Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

The system of care will be culturally sensitive, gender competent, and age appropriate. There will be recognition that beliefs and customs are diverse and can impact the outcomes of prevention and treatment efforts.

Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

The system of care that fosters this dynamic will acknowledge the important role that families, significant others and communities can play in promoting wellness for all and recovery for those with behavioral health disorder challenges. It will be incorporated, whenever it is appropriate, into needs-assessment processes, community planning efforts, recovery planning and

all support processes. In addition, our system will provide prevention, treatment, and other support services for the family members and significant others of people with behavioral health disorders.

Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

Inclusion of the voices and experiences of recovering individuals, youth, family, and community members

The voices and experiences of all community stakeholders will contribute to the design and implementation of our system. People in recovery, youth, and family members will be included among decision-makers and have oversight responsibilities for service provision. Recovering individuals, youth, family, and community members will be prominently and authentically represented on advisory councils, boards, task forces, and committees at state and local levels.

Integrated strength-based services

The system will coordinate and/or integrate efforts across service systems, particularly with primary care services, to achieve an integrated service delivery system that responds effectively to the individual's or the community's unique constellation of strengths, desires, and needs. An integral aspect of this system is the partnership/consultant model that focuses more on collaboration and less on hierarchy. Systems will be designed so that individuals, families, and communities feel empowered to direct their own journeys of recovery and wellness.

Services that promote health and wellness will take place within the community

Our system of care will be centered within the community, to enhance its availability and support the capacities of families, intimate social networks, community-based institutions, and other people in recovery. By strengthening the positive social support networks and addressing environmental determinants to health in which individuals participate, we can increase the chances for successful recovery and community wellness.

Outcomes-driven

Our system will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery and with the community. Outcome measures will be diverse and encompass measures of community wellness as well as the long-term global effects of the recovery process on the individual, family, and community – not just the remission of behavioral and biomedical symptoms. Outcomes will focus on individual, family, and community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

System-wide education and training

Our behavioral health system will seek to ensure that concepts of prevention, recovery, and wellness are foundational elements of curricula, certification, licensure, accreditation, and testing mechanisms. The workforce also requires continuing education, at every level, to reinforce the tenets of ROSC. Our education and training commitments are reinforced through policy, practice, and the overall service culture.

Research-based

Our system will be data driven and informed by research. Additional research with individuals in recovery, recovery venues, and the processes of recovery (including cultural and spiritual aspects) will be essential to these efforts. Research related to Behavioral health disorders will be supplemented by the experiences of people in recovery.

Expectations for Implementation of Recovery Practices

Based on the above guiding principles, the ROSC/TSC established the following expectations to guide organizations at all levels in creating an environment and system of behavioral health services and supports that foster recovery and create a recovery-oriented system of care:

1. Promote changes in state law and policies at all levels to create a system with an expanded recovery service array that can be easily accessed via many pathways by individuals needing services and supports.

Requirements:

- Provide ongoing education to stakeholders on recovery principles and practices in conjunction with state level policies influencing recovery service and supports.

- Develop and maintain a plan to educate and increase communication within the broader community using guidance and leadership from local and regional service providers, community prevention advocates, and recovery committees/councils.
- Provide knowledge and education in partnership with the ROSC/TSC to stakeholders on recovery related policies and practices.

2. Develop policies and procedures that ensure seamless and timely entry and re-entry into services and supports.

Requirements:

- Utilize data and electronic recordkeeping to facilitate confidential access to individual information and service records that will expedite access to services and supports and reduce excess and duplicative information gathering and redundant paperwork.
- Assure pathways are in place for expedited reentry into services for individuals who have been away from services, but once again need services and supports from the public behavioral health system.
- Provide guidance during ongoing recovery planning including verbal and written information on how to access behavioral health and other community-based services.

3. Align policies, procedures and practices to; 1) foster and protect individual choice, control, and self-determination; 2) assure the provision of services that are holistic, culturally based and influenced, strength- and research-based, and trauma informed, and 3) are inclusive of person-centered planning process, community based services and supports, and enhanced collaborative partnerships.

Requirements:

- Develop and enhance recovery planning processes using baseline data and ongoing regional recovery survey results to improve and expand the behavioral health recovery services system of care, and to strengthen the quality and delivery of recovery services and supports.

- Assess an estimate of the impact on cost of services annually, when significant changes occur to the individualized services plan via person-centered selection of culturally influenced, research and strength-based services within a recovery-oriented environment.
 - Provide training and mentoring opportunities to individuals receiving services/peers to become independent facilitators of both person-centered planning and self-determination practices.
4. Encourage the availability of peer services and supports including the option of working with Certified Peer Support Specialists (CPSS) and/or Recovery Coaches as a choice for individuals throughout the service array, and within the individualized planning process.

Requirements:

- Develop and implement an educational approach with written materials to provide information to stakeholders on peer services and supports.
 - Provide information on the choices and options of working with peers in a journey of recovery including CPSS/Recovery Coaches as part of the person-centered planning process.
 - Collect baseline data on the number of individuals who receive peer services and supports - include a proactive plan on increasing the number of individuals utilizing these serves.
5. Align services and supports to promote and ensure access to quality health care and the integration of behavioral and physical health care. Specific services and concerns to address include screening; increased risk assessments; holistic health education; primary prevention; smoking cessation and weight reduction.

Requirements:

- Regularly offer and provide classes ideally promoted, led and encouraged by peers related to whole health, including Personal Action Toward Health (PATH), Wellness Recovery Action Planning (WRAP), physical activity, smoking cessation, weight loss and management etc.

- Collect information on behavioral health morbidity, mortality and co-morbid conditions with a strategic planning process to address and decrease risk factors associated with early death. Include information on identified community resources for healthcare services.
 - Provide referrals and outreach to assist individuals with meeting their basic needs, including finding affordable housing, having enough income to address risk factors associated with poverty, employment and education assistance, etc.
 - Identify, develop and strengthen community partnerships to promote models and access for the integration of physical and behavioral health.
 - Discuss and coordinate transportation for individuals to attend appointments, classes and health-related activities discussed in the person-centered planning process.
6. Assess and continually improve recovery promotion, competencies, and the environment in organizations throughout the recovery services system of care.

Requirements:

- Complete a strategic planning process that builds on the actions of and information from the ROSC/TSC, including results from the recovery survey implementation and review identified as part of the statewide RFA process.
- Provide ongoing education on recovery services, recovery-oriented systems of care, and environments that promote recovery with all staff (executive management, psychiatrists, physicians, case managers, clinicians/counselors, support staff), leadership, board members, recovery councils, community members, etc.
- Include a list of recovery-oriented competencies (protocols and practice) in employee job descriptions and performance evaluations.
- Work in partnership with individuals receiving services, CPSS/Recovery Coaches, program staff (medical, clinical, supervisory/administrative, support), and community and family members in all aspects of the development and delivery of recovery-oriented services and supports, needed trainings and recovery-oriented activities.

How Michigan's Efforts Align with Federal Policy

MDHHS recognizes that recovery is highly individualized and requires support from a recovery-oriented system of care. It is also a process, vision, conceptual framework that should adhere to guiding principles, but most importantly it is recognized and supported through a series of initiatives, trainings, and education resources as well as state and national policies. Recovery emphasizes individual circumstances and needs, the strong voice and advocacy of people with lived experience, a broad array of services and supports within a recovery-oriented system of care, and the commitment of partners and key stakeholders. By drawing on a combination of personal experiences, a knowledgeable services system that promotes and supports recovery, communities committed to health and wellness, a driving force for recovery-oriented systems transformation is created and maintained.

In 2012, the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) published this definition of recovery from Mental Disorders and/or Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. This definition along with Guiding Principles of Recovery, including those from SAMHSA are provided earlier in this Policy and Practice Advisory, and are at the core of Michigan's behavioral health recovery system and infrastructure.

After the review of recovery and recovery-oriented systems of care definitions and guiding principles, the ROSC TSC has identified the following Elements of ROSC/Recovery to be adhered to by those providing behavioral health services.

Elements of a ROSC/Recovery:

- Holistic and integrated services beyond symptom reduction
- Person-Driven
- Continuity of care - assertive outreach and engagement; and ongoing monitoring and support
- Culturally responsive services.
- Occurs via many pathways
- Peer supports and services
- Community health and wellness.
- Family and Significant Other Involvement
- Systems/services anchored in the community
- Evidence- and Strength- based practices
- Trauma informed
- Based in respect

True change will require a series of legislative actions, state and federal policies and Mental Health and Public Health Code changes intentionally designed to promote the construct and elements of recovery supports and services. Few states, Michigan included, have developed a policy and practice guideline on recovery, thus, MDHHS relied on the work, ideas of the now disbanded Michigan Recovery Council and the ongoing work and initiatives of the ROSC/TSC to craft this document.

Successful implementation of these guiding principles and recommendations for systems change will demand an active response from MDHHS, the Behavioral Health and Developmental Disabilities Administration, the Pre-paid Inpatient Health Plans, the CMHSPs, and the behavioral health provider system, with active support from persons with lived experience, persons in recovery, and communities across the state. This policy and practice advisory must be treated like recovery itself, with meaning, purpose, and dedication to support individual and system change that will support recovery as “ongoing personal and unique journey of hope, growth, resilience and wellness.” Great effort will be required to ensure that this policy and practice advisory is embraced and implemented. The ROSC/TSC and MDHHS look forward to assessing progress toward these principles every year.

**Framework and Infrastructure for
Recovery Oriented Systems of Care
and Individual Recovery Initiatives**

This attachment is to be utilized for educational and informational purposes.

Orientation and Definitions.....Page 13
Recovery and ROSC Elements, Guidelines and Priorities.....Pages 14-17
Reasoning and Philosophy to Gain Insight That Will Motivate Change.....Pages 18 - 21

Effective pursuit and support of recovery has a dual focus: 1) the development and maintenance of a recovery-oriented services system anchored in the community and 2) a process that is dedicated to supporting personal recovery through the provision of necessary and needed services and supports. One cannot exist without the other.

A ROSC is not a program; it is a philosophical construct by which a behavioral health system (SUD and mental health) shapes its perspective on how they will address recovery from alcoholism, addiction and other disorders. A ROSC approach is the basis of the development of the behavioral health service system. Its philosophy completely encompasses all aspects of SUD and Mental Health prevention and treatment services, including program structure and content, agency staffing, collaborations, partnerships, policies, regulations, trainings and staff/peer/volunteer orientation.

Within a ROSC, SUD and mental health service entities, as well as their collaborators and partners, cooperatively provide a flexible and fluid array of services in which individuals can move. People should be able to move among and within the system's service opportunities, without encountering rigid boundaries or silo-embedded services, to obtain the assistance needed to pursue recovery, and approach and maintain wellness. In Michigan we believe that behavioral health recovery is possible and can be achieved by individuals, families and communities.

As PIHPs develop recovery plans for their region, it is this type of system of care and this type of service array that should be considered.

'Recovery is a process not an event'

An individual's recovery relies on the existence of a recovery-oriented system of care. Without a services system built on recovery practices, policies, and programs, providing the infrastructure to support an individual's recovery efforts there would be no foundation from which to work and flourish.

Recovery is possible when a multi-faceted infrastructure of services and supports exists to enable and enhance the recovery efforts and environments of individuals, families and communities.

BHDDA Recognized Definitions:

[An individual's] Recovery from Mental Disorders and/or Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA 2012

Accepted by BHDDA 2013

Recovery oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and

Individual Recovery and Recovery Oriented System of Care Guiding Principles:

These Guiding Principles will be utilized by BHDDA and the TSC to support and guide the development of a recovery oriented behavioral health services system.

SAMHSA's Ten Guiding Principle of Recovery [for individual recovery] and Additional Guiding Principles for Recovery Oriented Systems of Care:

The numbered Guiding Principles, items one through ten, are those identified by SAMHSA. In instances where there two separate statements under one number the second statement is an enhancement to include additional recovery systems information to the guiding principle. Guiding principles eleven through sixteen are additional principles to enhance the connection between an individual's personal recovery and the services systems that support their efforts.

1) Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

2) Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

The system of care promotes person driven recovery will be individualized, person/family/community-centered, comprehensive, stage-appropriate, and flexible. It will adapt to the needs of individuals and communities, rather than requiring them to adapt to it. Individuals receiving services will have access to a menu of stage-appropriate choices that fit their needs throughout the recovery process. The approach will change from an acute, episode-based model to one that helps people manage this chronic disorder throughout their lives. Prevention services will be developmentally appropriate and engage the multiple systems and settings that have an impact on health and wellness. Prevention efforts will be individualized based on the community's needs, resources, and concerns.

3) Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experience—that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is nonlinear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe

Five ROSC Priority Areas:

1. Behavioral health and primary healthcare integration.
2. Community health promotion.
3. Recovery support services that are peer-based.
4. Prevention services that are environmental and population-based.
5. Services and supports whose focus is expanded, including both the continuum of care (from pre-treatment services to post-treatment services and supports) and the content of care (beyond supporting abstinence) to promoting community health and helping people build meaningful lives in the community.

for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

4) Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

This system will offer a continuum of care that includes prevention, early intervention, treatment, continuing care, and support throughout recovery. Individuals will have a full range of stage-appropriate services to choose from at any point in the recovery process. Prevention services will involve the development of coordinated community systems that provide ongoing support, rather than isolated, episodic programs.

5) Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

This system of care will promote ongoing involvement of peers, through peer support opportunities for youth and families and peer recovery support services for individuals with behavioral health disorders. Individuals with relevant lived experiences will assist in providing these valuable supports and services.

6) Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

7) Recovery is culturally based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

The system of care will be culturally sensitive, gender competent, and age appropriate. There will be recognition that beliefs and customs are diverse and can impact the outcomes of prevention and treatment efforts.

8) Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

9) Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

The system of care that fosters this dynamic will acknowledge the important role that families, significant others and communities can play in promoting wellness for all and recovery for those with behavioral health disorder challenges. It will be incorporated, whenever it is appropriate, into needs-assessment processes, community planning efforts, recovery planning and all support processes. In addition, our system will provide prevention, treatment, and other support services for the family members and significant others of people with behavioral health disorders.

10) Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

11) Inclusion of the voices and experiences of recovering individuals, youth, family, and community members

The voices and experiences of all community stakeholders will contribute to the design and implementation of our system. People in recovery, youth, and family members will be included among decision-makers and have oversight responsibilities for service provision. Recovering individuals, youth, family, and community members will be prominently and authentically represented on advisory councils, boards, task forces, and committees at state and local levels.

12) Integrated strength-based services

The system will coordinate and/or integrate efforts across service systems, particularly with primary care services, to achieve an integrated service delivery system that responds effectively to the individual's or the community's unique constellation of strengths, desires, and needs. An integral aspect of this system is the partnership/consultant model that focuses more on collaboration and less on hierarchy. Systems will be designed so that individuals, families, and communities feel empowered to direct their own journeys of recovery and wellness.

13) Services that promote health and wellness will take place within the community

Our system of care will be centered within the community, to enhance its availability and support the capacities of families, intimate social networks, community-based institutions, and other people in recovery. By strengthening the positive social support networks and addressing environmental determinants to health in which individuals participate, we can increase the chances for successful recovery and community wellness.

14) Outcomes-driven

Our system will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery and with the community. Outcome measures will be diverse and encompass measures of community wellness as well as the long-term global effects of the recovery process on the individual, family, and community – not just the remission of behavioral and biomedical symptoms. Outcomes will focus on individual, family, and community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

15) System-wide education and training

Our behavioral health system will seek to ensure that concepts of prevention, recovery, and wellness are foundational elements of curricula, certification, licensure, accreditation, and testing mechanisms. The workforce also requires continuing education, at every level, to reinforce the tenets of ROSC. Our education and training commitments are reinforced through policy, practice, and the overall service culture.

16) Research-based

Our system will be data driven and informed by research. Additional research with individuals in recovery, recovery venues, and the processes of recovery (including cultural and spiritual aspects) will be essential to these efforts. Research related to Behavioral health disorders will be supplemented by the experiences of people in recovery.

**Embracing the Reasoning and Philosophy Behind Recovery and Recovery Oriented Systems of Care:
Gaining Insight that will Motivate Change**

Information to Support the Need for Behavioral Health Systems and Services Recovery Transformation

What is known about Mental Health and Substance Use Disorders, and why the system needs change:

1. People typically enter treatment after ten years of active addiction. The longer people use, the more difficult it is for them to enter and sustain recovery.
2. The longer the use, due to Substance Use Disorders, the higher the negative impacts for families and communities.
3. 90 percent of persons with mental health or substance use disorders have experienced trauma. 100 percent of persons with co-occurring disorders have experienced trauma.
4. Genetic and Social predisposition increase risk behavior and risk of developing the disease of addiction. [Look for data for co-occurring and co-morbidity]
5. Risk for suicide is higher among those with mental health, substance use, and co-occurring disorders.

Why we need change:

1. Fifty percent of clients entering treatment have already had at least one prior episode of care.
2. SUD is a chronic condition, but we currently have an acute care treatment model. This model does not sustain the support necessary to stabilize recovery. All of our resources are needed to change this.
3. Cycling in and out of a series of disconnected treatment episodes is a product of the challenges within the current system – an inability to support sustained recovery.
4. Scope of the system of services needs to be broadened.
5. Coordination of prevention, follow up and continuing care lacks integration and needs enhancement.
6. Working together in partnership and collaboration is the only way to provide all services needed to achieve and sustain recovery.
7. Limited Attraction: Less than 10% of people who meet the DSM (current version) criteria for a SUD currently seek treatment.
8. Poor Engagement and Retention: Less than half of those in treatment complete their treatment program.
9. Lack of Continuing Care: Post-discharge continuing care can enhance recovery outcomes, but only one in five receives it.
10. High Rates of Relapse: The majority of people completing addiction treatment resume alcohol and other drug use within one year, and most within 90 days following discharge.
11. Resource Expenditures: Most resources are expended on a small portion of the population requesting services.

12. Readiness for Change: Services are not aligned with the client's readiness for change.
13. Data is not utilized in a manner that enhances services and monetary support- we need to empower change and enforce accountability.
14. Current system is fragmented and not cost effective. There is poor use of resources and lack of communication between systems – separate locations for services create challenges.
15. Society, legislators, law enforcement, and physicians have a negative perception of individuals with mental health and/or substance use disorders along with a low expectation of change.
16. Significant stigma exists within the behavioral health and primary health care systems.
17. It takes four to five years for the risk of SUD relapse to drop below 15%.
18. Current services system focuses on acute treatment.
19. Admission and discharge protocols compromise fluidity of service provision.

What we know about services that support recovery and resilience.

Effective ROSC services focus on:

1. Greater emphasis on continuity of care: effective prevention, assertive outreach and engagement, treatment, and ongoing monitoring and support.
2. Continuum of care in which services are holistic and integrated, culturally responsive, and with systems that are anchored in the community.
3. Expanded availability of non-clinical services such as: peer supports, prevention, faith-based initiatives, etc.
4. Resources to help prevent the onset of substance use disorders.
5. A public health approach being taken to help create healthy communities.
6. More assertive outreach to families and communities impacted by substance use disorders.
7. More assertive post-treatment monitoring and support is provided.
8. A partnership/consultation approach rather than an expert/patient model.
9. Valued lives and experiences of other people in recovery used to help others on their journey.
10. Person-centered self-directed approach to recovery,
11. Use of peer support services to sustain an individualized recovery effort.
12. Use of services that build on each individual's recovery capital.
13. Sustained relationships help to maintain engagement.
14. Ongoing recovery activities are critical for sustaining recovery efforts.
15. Expanded knowledge and increased education efforts regarding all populations served.

Examples of how a ROSC differs from traditional service systems:

1. Treatment goals extend beyond abstinence or symptom management to helping people achieve a full, meaningful life in the community.
2. Prior treatment is not viewed as a predictor of poor treatment outcomes and is not used as grounds for denial of treatment.
3. People are not discharged from treatment for relapsing and confirming their original diagnosis of addiction, which is a chronic and often relapsing brain disease.
4. Post-treatment continuing care services are an integrated part of the service continuum rather than an afterthought.
5. Focus is on all aspects of the individual and the environment, using a strength-based perspective and emphasizing assessment of recovery capital.
6. Service system includes not just behavioral health providers but collaborators, stakeholders, and community partners as well.
7. Expansion to include innovative services that are comprehensive, dynamic, and always evolving.
8. Utilization of multi-disciplinary teams personalized to the individual's needs and goals (strength-based).
9. Provider/client relationship is key and partner oriented – not hierarchal.
10. Streamlined documentation and consistent reimbursement.

What are some implications for recovery services and supports?

1. Greater emphasis on outreach, pre-treatment supports, and engagement.
2. More diverse menu of services and supports available for people to choose from based on their needs.
3. A more assertive effort by providers to connect individuals to families and natural supports.
4. Expanded availability of non-clinical/peer-based recovery supports.
5. Post-treatment recovery check-ups.
6. Service relationships shift from an expert/patient model to a partnership/consultation approach.
7. Understanding of the impact of trauma.
8. Reduction of recidivism.
9. Reduction of stigma.

Embracing the philosophy, perspective and practice of Recovery/ROSC by:

1. Establishing a proactive partnership with the individual, that is person-centered.
2. Establishing and maintaining a system of care that is recovery oriented and supports recovery services.
3. Establishing and nurturing relationships with other community support service providers.
4. Creating the expectation that full recovery is a life-long pursuit sustained through service intervention and community support.
5. Acknowledging that multiple episodes needing treatment do occur and are reasonable, considering the nature of behavioral health disorders.
6. Respecting that recovery requires ongoing relationships rather than brief interventions.
7. Being open to new and innovative approaches.
8. Confronting stigma whenever encountered.

Mental Health Services for Special Populations Metrics and Reporting Template

Metrics for all Special Population Providers

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

Report Narrative to describe:

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

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

PASRR AGREEMENT

I. PURPOSE

The CMHSP will complete PRE-ADMISSION SCREENINGS AND RESIDENT REVIEWS (hereinafter referred to as PASRR) 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 and resources:

1. Medicaid Provider Manual, Nursing Facility Chapter, .
<https://www.michigan.gov/mdhhs/0,5885,7-339--87572--,00.html>
2. Federal Register/Vol 57, No. 230/Monday, November 30, 1992/Rules and Regulations/Subpart C -- Pre-admission Screening and Annual Resident Review of Mentally Ill and Developmental Disabled Individuals.
<https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part483.pdf>
3. The CMHSP must ensure that all new employees and contracted workers, who administer PASRR, are trained at least one time on the policies and procedures with respect to the OBRA/PASRR process through Improving MI Practices website at: www.improvingmipractices.org.
- 4.
5. The OBRA Operations Manual (8th Edition, 2017) is provided for reference in the OBRA Electronic Application.

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.

RESIDENT REVIEW (Hospital Exempt Discharged, Change in Condition)

- D. The CMHSP will complete Resident Reviews (Level II Evaluations) to all nursing facility residents who are located in the CMHSP's service area and who have been identified through the PASRR 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 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 Resident Reviews of persons who have been admitted to a nursing facility without a Pre-admission screening as an exempted hospital discharge (HED), 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 OBRA PASRR Grant Application annually through the State of Michigan EGrAMS Application. This application will identify CMHSP's estimated yearly cost, certification/contacts information, project synopsis and target

MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY24 Attachment C4.5.1 area, and work plan. The yearly cost will show all Direct Expenses, Other Expenses, and Indirect Expenses. Indirect Costs will need to be calculated on Attachment B.4 Form DeMinimis Rate Calculation. Contractual Cost over \$25,000 per subcontract/subaward are disallowed to be calculated from the Indirect Cost. Additional Other Expenses are also not allowed to be calculated for the Indirect Cost. These costs include Tuition Remissions, Rental Costs, Scholarships/Fellowships, Participant Support Costs, and Patient Care. Any OBRA PASRR Grant Application Amendments will be required to follow the MIE-Grants Project Based Amendment Schedule.

- C. 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 Resident Review for Nursing Facility Clients". 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 PASRR 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.

- D. 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. PASRR 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. The funding source consists of 75% Federal funds, and 25% State match.

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.

MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY24 Attachment C4.5.1

- 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.

DETAILED OF SERVICES BILLED

NURSING FACILITY EVALUATIONS

CMH BOARD NAME:			MONTH/YEAR:	
NAME OF RESIDENT	D.O.B.	*TYPE OF SCREEN	MI OR DD	DATE OF SERVICE
1.				
2.				
3.				
4.				
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19.				
20.				

*INDICATE PAS/ARR/CIC/HED/REV

Completing Detailed Billing Summary Instructions

1. List each consumer who had a Completed Level II Evaluation submitted during the respective month.
 - a. If consumer had two completed Level II Evaluations in one month, list twice.
2. **Do Not** include any consumer who only had a Partial Level II Completed on this form.
3. **Do Not** include hours, visits, or costs on this form.

**SUMMARY BILLING FOR PRE-ADMISSION
SCREENING and RESIDENT REVIEWS (PASRR)
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

CMH BOARD _____ TELEPHONE NUMBER: _____
PERSON COMPLETING FORM: _____
MONTH ENDING: _____ DATE SUBMITTED: _____
NUMBER of Reviews: DD _____ MI _____ TOTAL _____

I. DIRECT COSTS

TOTAL

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

II. INDIRECT COSTS

- A. Please Check Appropriate Indirect Method: DeMinimis ☐ Cost Allocation Plan ☐ Federal Approval Rate
☐
B. 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 DATE
DIRECTOR

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

MDHHS Authorized Staff

DATE

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIRECT COST: 10% DE MINIMIS RATE CALCULATION
FISCAL YEAR 2020 Grant Agreements**

Grantee Name:	
Grant Program Name:	
Grant Project (if applicable)	

		BUDGETED AMOUNT																									
A.	TOTAL DIRECT EXPENDITURES Enter the total direct expenditures from the EGrAMS budget line called Total Direct Expenditures.		\$0																								
B.	COSTS DISALLOWED FROM 10% DE MINIMIS RATE INDIRECT BASE EXPENDITURES Enter all costs for each category from the EGrAMS budget listed below.	DISALLOWED COSTS (The worksheet will calculate this column).																									
C.	Fringe Benefits:																										
	Tuition Remissions	\$0	\$0																								
D.	Calculation of disallowed "Contractual" costs over \$25,000 per subcontract/subaward. Enter the total subcontract amount in column E for each subcontract/sub-award. The worksheet will calculate the disallowed costs in column F. Contractual (List Subcontracts/Sub awards, Agency Name, and Amount): <table border="1"> <thead> <tr> <th></th> <th>NAME</th> <th>TOTAL AMOUNT</th> <th></th> </tr> </thead> <tbody> <tr> <td>1)</td> <td></td> <td align="right">\$0</td> <td align="right">\$0</td> </tr> <tr> <td>2)</td> <td></td> <td align="right">\$0</td> <td align="right">\$0</td> </tr> <tr> <td>3)</td> <td></td> <td align="right">\$0</td> <td align="right">\$0</td> </tr> <tr> <td>4)</td> <td></td> <td align="right">\$0</td> <td align="right">\$0</td> </tr> <tr> <td>5)</td> <td></td> <td align="right">\$0</td> <td align="right">\$0</td> </tr> </tbody> </table>				NAME	TOTAL AMOUNT		1)		\$0	\$0	2)		\$0	\$0	3)		\$0	\$0	4)		\$0	\$0	5)		\$0	\$0
	NAME	TOTAL AMOUNT																									
1)		\$0	\$0																								
2)		\$0	\$0																								
3)		\$0	\$0																								
4)		\$0	\$0																								
5)		\$0	\$0																								
E.	Equipment:	\$0	\$0																								
G.	Other Expenses: List total cost for the following sub-categories included in "Total Other Expenses" budget category: <table border="1"> <tbody> <tr> <td>Rental Costs</td> <td align="right">\$0</td> <td align="right">\$0</td> </tr> <tr> <td>Scholarships/Fellowships</td> <td align="right">\$0</td> <td align="right">\$0</td> </tr> <tr> <td>Participant Support Cost</td> <td align="right">\$0</td> <td align="right">\$0</td> </tr> <tr> <td>Patient Care</td> <td align="right">\$0</td> <td align="right">\$0</td> </tr> </tbody> </table>			Rental Costs	\$0	\$0	Scholarships/Fellowships	\$0	\$0	Participant Support Cost	\$0	\$0	Patient Care	\$0	\$0												
Rental Costs	\$0	\$0																									
Scholarships/Fellowships	\$0	\$0																									
Participant Support Cost	\$0	\$0																									
Patient Care	\$0	\$0																									
F.	Specific Assistance to Individuals:	\$0	\$0																								
H.	TOTAL DISALLOWED EXPENDITURES:		\$0																								
I.	BASE EXPENDITURES (A-G) (Enter amount for indirect calculation on budget):		\$0																								
J.	10% De Minimis Rate - up to 10%: (Enter amount for indirect calculation on budget):		10%																								
K.	INDIRECT COST: (enter amount on budget)		\$0																								
Expenditures for Capital Outlay are not allowable for MDHHS Grants. If an exception is approved contact MDHHS Grants Section for further instructions.																											

MDHHS/CMHSP Managed Mental Health Supports and Services Contract: FY24 Attachment C4.5.1
Indirect Cost Calculations
 FY_____

	Current Month Total Expenses	Current Month Expenses Allowed for Indirect Cost	Total Year to Date Expenses
Salary			
Fringe Benefits			
Travel			
Supplies & Materials			
Rent			
Contractual			
Equipment			
TOTAL EXPENSES			
Indirect Cost Rate		%	
Total Indirect Cost Billed			

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: _____

**TECHNICAL REQUIREMENT FOR WITH SERIOUS EMOTIONAL DISTURBANCE SED CHILDREN
REVISED July 29, 2021**

REGARDING: 1) MEDICAID ELIGIBILITY CRITERIA FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED), BIRTH TO TWENTY-ONE YEARS OF AGE; AND 2) ESTABLISHING GENERAL FUND PRIORITY FOR MENTAL HEALTH SERVICES FOR CHILDREN WITH SED, BIRTH TO EIGHTEEN YEARS OF AGE.

General Considerations:

This requirement provides a framework to be used by Prepaid Inpatient Health Plans (PIHPs) for determining eligibility for Medicaid specialty mental health services for children with serious emotional disturbance (SED), and Community Mental Health Services Programs (CMHSPs) for establishing general fund priority for mental health services to children with SED according to the requirements of the Michigan Mental Health Code (Section 330.1208). The criteria framework for Medicaid eligibility and general fund priority for non-Medicaid children is based on the definition of serious emotional disturbance delineated in the Mental Health Code (Section 330.1100d) which includes the three dimensions of diagnosis, functional impairment, and duration.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

- (a) A substance use disorder.
- (b) A developmental disorder.
- (c) "V" codes in the Diagnostic and Statistical Manual of Mental Disorders.

A key feature of the general fund and Medicaid priority framework in the Technical Requirement is that diagnosis alone is not sufficient to determine eligibility for Medicaid or general fund priority for specialty mental health services. This means that the practice of using a defined or limited set of diagnoses to determine Medicaid eligibility or general fund priority for services should cease.

The criteria delineated in this document is intended to: (1) assist Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs) in determining severity, complexity and duration that would indicate a need for specialty mental health services and supports for Medicaid children and non-Medicaid children (to establish priority for service) under the Michigan Mental Health Code, (2) ensure uniformity to these decisions for children across the system and (3) meeting the requirements of Early and Periodic, Screening, Diagnostic and Treatment Program (EPSDT). Young children, youth and young adults meeting the criteria delineated in this document are considered to have a serious emotional disturbance, as defined in the Mental Health Code.

Selection of Services

For Medicaid children, once an eligibility determination has been made based on the criteria delineated in this document, selection of services is determined based on person-centered planning and family-driven, youth guided practice and medical necessity criteria. An elevated score on a standardized, validated Trauma Screen/Assessment appropriate for the age of the child/youth informs the selection of services and the discussion during the person-centered planning which uses a family drive, youth guided approach.

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

Age Range

Since Medicaid is utilized for children/youth, birth through 20 years of age (up to 21 years), criteria for young adults (18 through 20 years of age), has been included in this document. For the purposes of this document, EPSDT covers all Medicaid medically necessary behavioral health services, birth to 21 years of age.

In the January 15, 2016, MSA 16-01 Bulletin, the intent of EPSDT is defined as, “to provide necessary health care, diagnostic services, treatment, and other measures according to section 1905(a) and 1905(r) [42 U.S.C. 1396d] of the Social Security Act (1967) to correct or ameliorate defects and physical and mental illnesses and conditions whether or not such services are covered under the state plan. State Medicaid programs are required to provide for any services that are included within the mandatory and optional services that are determined to be medically necessary for children under 21 years of age.”

Definition of Child with Serious Emotional Disturbance, Birth through 3 Years (47 months of age)

Unique criteria must be applied to define serious emotional disturbance for the birth through age three population, given:

- the magnitude and speed of developmental changes through pregnancy and infancy and early childhood;
- the limited capacity of the very young to symptomatically present underlying disturbances.
- the extreme dependence of infants and toddlers upon caregivers for their survival and well-being; and
- the vulnerability of the very young to relationship and environmental factors.

Operationally, the above parameters dictate that the mental health professional must be cognizant of:

- the primary indicators of serious emotional disturbance in infants and toddlers, and
- the importance of assessing the constitutional/physiological and/or care- giving/environmental factors that reinforce the severity and intractability of the infant-toddler's disorder.

Furthermore, the rapid development of infants and toddlers results in transitory disorders and/or symptoms, requiring the professional to regularly re-assess the infant-toddler in the appropriate developmental context.

The access eligibility criteria delineated below do not preclude the provision of services to an adult beneficiary who is pregnant or a parent of an infant or toddler and who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the infant or toddler at high risk for serious emotional disturbance.

The following is the criteria for determining when an infant or toddler beneficiary is considered to have a serious emotional disturbance or is at high risk for serious emotional disturbance and qualifies for specialty mental health services and supports. All of the dimensions must be considered when determining eligibility.

The child shall meet each of the following:

Diagnosis

An infant or toddler has a mental, behavioral, or emotional disturbance sufficient to meet the diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association consistent with the DC: 0-5, *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* that has resulted in functional impairment as indicated below. The following disorders are

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

Degree of Disability/Functional Impairment

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

Area I:

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

Indicators are:

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

Area II:

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

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

- hypo-sensitive/under-responsive
- sensory stimulating-seeking/impulsive

Area III:

Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of infant/toddler, parent/caregiver and environmental characteristics. Indicators in the infant or toddler are:

- does not meet developmental milestones (i.e., delayed motor, cognitive, social/emotional speech and language) due to lack of critical nurturing,
- has severe difficulty in relating and communicating,
- disorganized behaviors or play,
- directs attachment behaviors non-selectively,
- resists and avoids the caregiver(s) which may include childcare providers,
- developmentally inappropriate ability to comply with adult requests, disturbed intensity of emotional expressiveness (anger, blandness or is apathetic) in the presence of a parent/caregiver who often interferes with infant's goals and desires, dominates the infant or toddler through over-control, does not reciprocate to the infant or toddler's gestures, and/or whose anger, depression or anxiety results in inconsistent parenting. The parent/caregiver may be unable to provide critical nurturing and/or be unresponsive to the infant or toddler's needs due to diagnosed or undiagnosed peri-natal depression, other mental illness, etc.

The required standardized assessment tool specifically targeting social-emotional functioning for infants is the Devereaux Early Childhood Assessment (Infant, Toddler or Clinical Version).

Duration/History

The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endure without intervention include one or more of the following:

- (1) The infant or toddler's disorder(s) is affected by persistent multiple barriers to normal development (inconsistent parenting or caregiving, chaotic environment, etc.); or
- (2) The infant or toddler has been observed to exhibit the functional impairments for more days than not for a minimum of two weeks (see Areas I-III above); or

- (3) An infant or toddler has experienced a traumatic event involving actual or threatened death or serious injury or threat to the physical or psychological integrity of the child, parent or caregiver, such as abuse (physical, emotional, sexual), medical trauma and/or domestic violence.

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

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

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

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

The parameters delineated below do not preclude the provision of services to an adult beneficiary of a young child who is a parent and who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance.

The following is the criteria for determining when a young child beneficiary is considered to have a serious emotional disturbance. All of the dimensions must be considered when determining whether a young child is specialty eligible for mental health services and supports.

The child shall meet each of the following:

Diagnosis

A young child has a mental, behavioral, or emotional disturbance sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the department that has resulted in functional impairment as delineated below. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Degree of Disability/Functional Impairment

Interference with, or limitation of, a young child's proficiency in performing developmentally appropriate tasks, when compared to other children of the same age, across life domain areas and/or consistently within specific domains as demonstrated by at least one indicator drawn from at least three of the following areas:

Area I:

Limited capacity for self-regulation, inability to control impulses, or modulate emotions as indicated by:

Internalized Behaviors:

- prolonged listlessness or sadness
- inability to cope with separation from primary caregiver
- shows inappropriate emotions for situation
- anxious or fearful
- cries a lot and cannot be consoled
- frequent nightmares
- makes negative self-statements that may include suicidal thoughts

Externalized Behaviors:

- frequent tantrums or aggressiveness toward others, self and animals
- inflexibility and low frustration tolerance
- severe reaction to changes in routine
- disorganized behaviors or play
- shows inappropriate emotions for situation
- reckless behavior
- danger to self, including self-mutilation

- need for constant supervision
- impulsive or danger seeking
- sexualized behaviors inappropriate for developmental age
- developmentally inappropriate ability to comply with adult requests
- refuses to attend childcare and/or school
- deliberately damages property
- fire starting
- stealing

Area II:

Physical symptoms, as indicated by behaviors that are not the result of a medical condition, include:

- bed wetting
- sleep disorders
- eating disorders
- encopresis
- somatic complaints

Area III:

Disturbances of thought, as indicated by the following behaviors:

- inability to distinguish between real and pretend
- difficulty with transitioning from self-centered to more reality-based thinking
- communication is disordered or bizarre
- repeats thoughts, ideas or actions over and over
- absence of imaginative play or verbalizations commonly used by preschoolers to reduce anxiety or assert order/control on their environment

Area IV:

Difficulty with social relationships as indicated by:

- inability to engage in interactive play with peers

- inability to maintain placements in childcare or other organized groups
- frequent suspensions from school
- failure to display social values or empathy toward others
- threatens or intimidates others
- inability to engage in reciprocal communications
- directs attachment behaviors non-selectively

Area V:

Care-giving factors that reinforce the severity or intractability of the childhood disorder and the need for intervention strategies such as:

- a chaotic household/constantly changing care-giving environments
- parental expectations are inappropriate considering the developmental age of the young child
- inconsistent parenting
- subjection to others' violent or otherwise harmful behavior
- over-protection of the young child
- parent/caregiver is insensitive, angry and/or resentful to the young child
- impairment in parental judgment or functioning (mental illness, domestic violence, substance use, etc.)
- failure to provide emotional support to a young child who has been abused or traumatized

The standardized assessment tool specifically targeting social-emotional functioning for children 4 through 6 years of age required for use in determining degree of functional impairment is the Pre-School and Early Childhood Functional Assessment Scale (PECFAS).

Duration/History

The young age and rapid transition of young children through developmental stages makes consistent symptomatology over a long period of time unlikely.

However, indicators that a disorder is not transitory and will endure without intervention include one or more of the following:

- (1) Evidence of three continuous months of illness; or

- (2) Three months of symptomatology/dysfunction in a six-month period; or
- (3) Conditions that are persistent in their expression and are not likely to change without intervention; or
- (4) A young child has experienced a traumatic event involving actual or threatened death or serious injury or threat to the physical or psychological integrity of the child, parent or caregiver, such as abuse (physical, emotional, sexual), medical trauma and/or domestic violence.

Definition of Child with Serious Emotional Disturbance 7 through 17 Years

The definition of SED for children 7 through 17 years delineated below is based on the Mental Health Code, Section 330.1100d. The parameters delineated below do not preclude the diagnosis of and the provision of services to an adult beneficiary who is a parent and who has diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance.

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

Diagnosis

Serious emotional disturbance means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment as indicated below. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the diagnostic and statistical manual of mental disorders.

Degree of Disability/Functional Impairment

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

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

Duration/History

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

Definition of Young Adults, Ages 18 through 20 years, with Serious Emotional Disturbance (SED) under Early and Periodic, Screening, Diagnosis and Treatment (EPSDT)

The young adult population ages 18 through 20 with SED served by the PIHP system requires a specialized and individualized approach to address their behavioral health needs during transition. The definition of SED in the Michigan Mental Health Code, which mirrors the federal definition, applies to minors. However, EPSDT services are required under federal and state policy to be offered to young adults up to 21 years of age. It is recommended that the SED criteria be utilized to determine eligibility for behavioral health services for young adults, ages 18 through 20 years.

In an effort to address the unique behavioral health needs of young adults ages 18 through 20, the following criteria is intended to for use in determining the most clinically appropriate, medically necessary specialty mental health service array for this young adult population. Parents and family are an integral part of the ongoing treatment team with consent of the young adult. The family driven youth guided approach begins to move towards youth and young adult driven and family involved.

Diagnosis

SED means a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment as indicated below. The following disorders are included only

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

Degree of Disability/Functional Impairment

Functional impairment that substantially interferes with or limits the young adult's role or results in impaired functioning in family, school, or community activities. For young adults ages 18 to 21, new or currently receiving PIHP/CMHSP services, the CAFAS is completed. This is defined as:

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

The young adult population is unique due to many factors and these need to be considered when determining functional impairment, medical necessity, and service array. Is the young adult:

- Involved in other transition systems (foster care, housing, legal involvement, alternative education and/or vocational rehabilitation services)?
- Lacking social and emotional skills to live independently?
- Displaying difficulty in gaining and/or maintaining employment?
- In need of connection to family/natural supports to maintain level of functioning?
- In need of connection to community supports in order to maintain their level of functioning?
- A parent themselves? If so, what best meets their service needs for themselves and their infant/toddler?

Duration/History

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

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 P.6.3.1.1 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.

Chapters 7, 7a, 4 and 4a of the Code describe the broad set of rights and protections for recipients of public mental health services as well as the procedures for the investigation and resolution of recipient rights complaints. For details on the Recipient Rights processes refer to C6.3.2.5. For Family Support Subsidy appeals refer to Attachment C6.3.2.2.

For the purposes of this attachment, the focus will be on those disputes related to an “action” the denial, reduction, suspension or termination of services and supports or a “grievance” which relates to the general satisfaction with services and/or the process, for the non-Medicaid consumer. Specifically, the purpose of this document is to provide operational guidance to CMHSPs to meet the requirements of the MDHHS/CMHSP contract regarding grievance and local appeal systems for consumers who are not Medicaid eligible, contained in Section 6.3.2.1 - CMHSP Local Dispute Resolution Process.

All consumers of public mental health services will receive notice of their rights and an explanation of the local dispute processes. This attachment in no way requires the exhaustion of local dispute or alternative dispute resolution processes prior to the filing of a recipient rights complaint pursuant to Chapter 7 and 7a of the Code.

II. UNDERLYING VALUES AND PRINCIPLES

Properly structured local dispute processes for consumers should promote the resolution of concerns, as well as support and enhance the overall goal of improving the quality of care. The local dispute processes should be:

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

In addition, the process should:

- Not interfere with communication between consumers and his/her CMHSP service provider(s).
- Assure that service providers who participate in the local dispute process, on behalf of consumers should be free from discrimination or retaliation.
- Assure that consumers who file local disputes should be free from discrimination or retaliation.

III. DEFINITIONS

- A. Local dispute – For the purposes of this attachment, a local appeal or local grievance. (Recipient rights complaints would be referred to that process)
- B. Local appeal – dispute related to the denial, suspension, termination or reduction of services and/or supports
- C. Local grievance – An expression of dissatisfaction about any matter, service related, other than an action.
- D. Expedited review – The review of an appeal that must be done within 3 working days.
- E. Recipient Rights complaint - a written or verbal statement by a recipient or anyone acting on behalf of a recipient alleging a violation of a Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

IV. REQUIRED LOCAL DISPUTE RESOLUTION PROCESS

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

Each CMHSP must have a written description of its local dispute resolution process available for review by MDHHS. The description must reflect all of the requirements below and indicate if the local dispute process should be used or if it is more appropriate that the CMHSP ORR system is to be used.

- B. The local dispute resolution process at a minimum must possess the following characteristics:
 - 1. Provides for a timeframe in which a consumer has to initiate a local dispute – thirty (30) days from the time Notice is received (for reduction, suspension or termination)

2. Provides for prompt resolution; 45 calendar days for local appeals and 60 calendar days for local grievances
3. Assures the participation of individuals with the authority to require corrective action. Someone with the authority to act upon the recommendations of the dispute resolution process must be involved. This would include the executive director or designee.
4. Assures that the person reviewing the local appeal or local grievance will not be the same person(s) who made the initial decision that is subject to the dispute.
5. Provides a mechanism for expedited review of a local appeal involving denial of psychiatric hospitalization.
NOTE: Applicants and consumers are entitled to a second opinion, under the Code, for this same type of denial. Please see C3.1.1.
6. Provides the consumer with written notification of the local dispute resolution process decision and subsequent avenues available to the consumer if he or she is not satisfied with the result, including the right of consumers without Medicaid coverage to access the MDHHS Alternative Dispute Resolution process after exhausting local dispute resolution procedures.
 - a. Provides reports of local disputes, i.e., local appeals and grievances, periodically to the CMHSP governing body.
 - b. Reports of local disputes will be reviewed by the CMHSP Quality Improvement Program to identify opportunities for improvement.
 - c. Records of local disputes must be made available to the MDHHS for review upon request.

V. SPECIFIC PROCESSES

A. Expedited Processes for Psychiatric hospitalization Denials:

1. In the event that a physician or licensed psychologist, external to the CMHSP, attests in writing that the individual meets the definition of an emergency situation as defined in Section 100a (29(a) or (c) of the Code, the CMHSP must assess the individual to determine if he/she meets the inpatient admission certification criteria, as defined in the Code. If psychiatric inpatient services are denied, the individual his/her guardian, or his/her parent in the case of a minor child, must be informed of their right to the Local Dispute Resolution Process, with the decision from that process to be reached within three (3) business days.

2. If the CMHSP does not recommend hospitalization and an alternative service requested by the individual, his/her guardian, or in the case of a minor child, his/her parent is denied, the CMHSP must inform the individual, his/her guardian, or in the case of a minor child, his/her parent, of his/her ability to access the Local Dispute Resolution Process.
3. The CMHSP must communicate the decision of the Local Dispute Resolution Process and inform the individual, his/her guardian, or his/her parent of a minor child of the right to access the MDHHS Alternative Dispute Resolution Process, if not satisfied with the outcome of the local dispute resolution process.

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

1. Whenever a currently authorized service or support or currently authorized services are to be suspended, terminated, or reduced by the CMHSP or its provider network provider, (whether through a utilization review (UR) function, or when the action is taken outside of the person-centered planning process when the CMHSP does not have an identifiable UR unit), the CMHSP must inform the consumer with written notification of the change at least 30 days prior to the effective date of the action. The notice shall include:
 - a. A statement of what action the CMHSP intends to take;
 - b. The reasons for the intended action;
 - c. The specific justification for the intended action;
 - d. An explanation of the Local Dispute Resolution Process

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

2. In the event that the individual utilizes the Local Dispute Resolution Process the CMHSP must communicate in writing the outcome of that process to the individual. That communication must include notification to the person of his/her right to request access to the MDHHS Alternative Dispute Resolution Process, after having exhausted the local appeal process, by sending such request to:

Department of Health and Human Services
Division of Contracts & Quality Management
Bureau of Specialty Behavioral Health Services
ATTN: Request for MDHHS Level Dispute Resolution
400 S. Pine St., 6th Floor
Lansing, MI 48913

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

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

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

1. MDHHS shall review all requests within two (2) business days of receipt.
2. If the MDHHS representative, using a “knowledge of mental health services access” standard believes that the denial, suspension, termination or reduction of services and/or supports will pose an immediate and adverse impact upon the consumer’s health and safety, the issue is referred within one (1) business day to the Community Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the MDHHS/CMHSP contract.
3. In all other cases, the MDHHS representative shall attempt to resolve the issue with the consumer and the CMHSP within 15 business days. The recommendations of the MDHHS representative are non-binding in those cases where the decision poses no immediate impact to the health and safety of the consumer. If MDHHS agrees with the CMHSP the consumer may be required to pay for the extended services.

FAMILY SUPPORT SUBSIDY PROGRAM FSS GUIDELINES FOR DETERMINING ELIGIBILITY OF APPLICANTS

Revised: May 2018

I. SUMMARY/BACKGROUND

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

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

II. VALUES AND PRINCIPLES

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

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

III. FAMILY SUPPORT SUBSIDY GUIDELINES

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

A. Determining the eligibility of applicants includes:

- 1) Helping families understand the requirements of the program
- 2) Providing assistance in completing the application
- 3) Application processing to determine eligibility
- 4) Requesting technical assistance from MDHHS as appropriate
- 5) Liaison between families and MDHHS
- 6) Outreach to schools, medical offices, clinics, hospitals, etc.
- 7) Participating in the FSS program annual survey

- 8) Arranging a hearing, at the family's written request, if the community mental health agency denies or terminates a family support subsidy
 - 9) Participating in efforts to recapture monies received by families after the child/family's change in eligibility.
- B. Applicants to this program must complete MDHHS-1181, FSS application. The community mental health services program (CMHSP) FSS coordinator may assist the applicant and provide direction.
- C. The child's date of birth must be verified. A copy of the child's legal birth certificate is preferable.
- D. The name(s) and address as written on the application is the way it will appear on the subsidy warrant (check). Please make sure that all information is legible and accurate. If two names are listed on the application, both names will be used as dual payees on the warrant.
- E. The educational eligibility category must be documented annually by certification from the Michigan local public or intermediate school district the child attends (or would attend if he/she were in the public-school system). Certification can be in the form of the child's Multidisciplinary Evaluation Team (MET) report, Individual Educational Program Team (IEPT) report or by a letter or memorandum on school letterhead. Suggested checklist language has been developed for this purpose and schools wishing to utilize it may contact the local CMHSP.
- 1) If the child's educational eligibility category is cognitive impairment, eligibility can be determined by the school psychologist or other qualified school representative who can verify, in writing, that the child's latest intellectual assessment shows development at a rate of 4.5 or more standard deviations below the mean.
 - 2) If the child's educational eligibility category is autism spectrum disorder, the school must verify the child's special education programming. Eligible programming for children with autism spectrum disorder is limited to the following: program for students with severe cognitive impairment (R340.1738), program for students with severe multiple impairments (R340.1748), or programs for students with autism spectrum disorder (R340.1758).
 - a) Please note that special education rule number 340.1758 describes two alternatives for educating children with ASD. Rule number 340.1758(1)(a) describes the traditional classroom for children with ASD, taught by a teacher of students with ASD. Rule number 340.1758(1)(b) describes a special education program, tailored to an individual student's needs, that assures the provision of educational programming for students with ASD. A 340.1758(1)(b) program can be carried out in many different school settings including the general education classroom or resource room. If a child's IEP states the special education rule number associated with a particular classroom setting and the programming

includes components of 340.1758(1)(b), FSS educational eligibility could be determined if school authorities are able to assert, in writing, that the child's educational program also meets the requirements of 340.1758(1)(b).

- F. A copy of the family's most recently filed Michigan income tax form documents the family's taxable income. To be eligible for this program, the taxable income must be \$60,000 or less.
 - 1) Other documentation is acceptable only if the family did not file a Michigan income tax form - having recently moved here from another state or country or having too little income to require filing. Other documentation that is acceptable if a state form is not filed includes (in descending order): a family's most recently filed federal income tax form, Supplemental Security Income statement, Michigan Department of Human Services statement, W-2 form, recent check stub or a handwritten, signed note attesting to no taxable income. **A Medicaid card is not an acceptable proof of income.**
- G. **For new applicants only:** If the family's most recently filed Michigan income tax form shows a taxable income of more than \$60,000, but the family's financial worth has decreased since filing (layoff, death, divorce, etc.), documentation of projected income can be used to determine eligibility. When projected income is used to determine eligibility, the following year's tax form must reflect a taxable income of \$60,000 or less. If it is above \$60,000, the family must pay back the total amount of subsidy dollars received.
- H. The parent or legal guardian completing the application must verify that the child is living with him/her or temporarily with a relative.
- I. A parent or legal guardian must sign the form attesting to the truth of all information provided.
- J. The CMHSP FSS coordinator's signature on the bottom of the application confirms that all back up documentation proving eligibility is on file at the CMHSP and that the CMHSP is verifying that the family is entitled to receive FSS payments. If the CMHSP FSS coordinator receives information that would cause a family to no longer be eligible to receive FSS payments, they must notify without delay, the statewide FSS coordinator by submitting via fax or other HIPAA compliant method, a MDHHS-1181, change of status, noting the change in the family's eligibility. Failure to do so by the CMHSP may result in the CMHSP reimbursing MDHHS for any payments issued to families who are ineligible to receive them.

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

Family Support Subsidy Program
Michigan Department of Health and Human Services
235 S. Grand Avenue, Suite 1310, Grand Tower Building
Lansing, MI 48933
FAX: 517-241-5777

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

IV. DENIAL OF FAMILY SUPPORT SUBSIDY

- A. Pursuant to Section 159(3) of the Code, "if an application for a family support subsidy is denied or a family support subsidy is terminated by a community mental health services program, the parent or legal guardian of the affected eligible minor may demand, in writing, a hearing by the community mental health services program. The hearing shall be conducted in the same manner as provided for contested case hearings under Chapter 4 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, being Sections 24.271 to 24.287 of the Michigan Compiled Laws."
- B. Pursuant to the Administrative Rules: Copies of blank application forms, parent report forms, the forms for changed family circumstances, and appeal forms shall be available from the community mental health services program. (R330.1616 Availability of forms) (Note: It is acceptable to ask families to write a letter to the CMHSP requesting an appeals hearing, in lieu of a standardized form.)
- C. A community mental health services program shall review an application and promptly approve or deny the application and shall provide written notice to the applicant and to the Michigan Department of Health and Human Services (MDHHS) Family Support Subsidy (FSS) office of its action and of the opportunity to administratively appeal the decision if the decision is to deny the application. If the denial is due to the insufficiency of the information on the application form or the required attachments, the CMHSP shall identify the insufficiency. (Rule R330.1641 Application review) The notice to the MDHHS FSS office must be a change in status on the MDHHS-1181 form noting the change in eligibility and must be submission by fax or other HIPAA compliant method within 10 working days.
- D. If an application is denied or the subsidy terminated, a parent or legal guardian may file an appeal. The appeal shall be in writing and be presented to the community mental health service program within two months of the notice of denial or termination. (R330.1643 Appeal)

- E. If an appeals hearing is held at the CMHSP and the presiding officer upholds the family's appeal in violation of Mental Health Code language, MDHHS shall require that the CMHSP reimburse MDHHS the disputed amount.
- F. Families wishing to appeal the decision of the CMHSP hearings officer may do so through circuit court in their county of residence.
- G. If a CMHSP approves an application in violation of Mental Health Code language or without full documentation proving eligibility, MDHHS shall require that the CMHSP reimburse MDHHS the disputed amount.

V. LEGAL REFERENCES

Mental Health Code Act, 258 MI. 330.1156-330.1161

Technical Requirement

Continuing Education Requirements for Recipient Rights Staff

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 is 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 contains information that would help rights staff have a better understand the people they serve, their disabilities, their families, or training indirectly related to rights but affecting rights. These may include trainings in mental health conditions and disabilities, treatment and support modalities, recovery, and self-determination as long as these topics can be ascertained to have a component that relates to assisting the attendee in the protection of rights. Examples include:

- Understanding MI/SUD Co-occurring disorders
- How to communicate with people with disabilities
- Ethics
- 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 Licensed Private Hospital

III. Standards

A. Basic Requirements

All staff of the Department, a community mental health services program (CMHSP), or a licensed private Hospital (LPH), 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. At least 3 credits must be earned each calendar year.
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, 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
Northville, MI 48168
FAX: 248-348-9963

Email: MDHHS-ORR-Training@michigan.gov

- b. Verification of attendance.
Attendance can be verified through provision of a Certificate of Attendance, copies of a training record, copy of an attendance/sign in sheet, a copy of the training agenda or outline with a self-attestation statement that the applicant did attend the training. Verification of attendance shall be kept on file with the applicant and be readily available for review by MDHHS-ORR, if requested.
 - c. Notification
Applicants will receive notification of approval determination for CEU credits no later than 30 business days following receipt of the required documents. Approved courses, credit and category information will be posted on the ORR website.

d. Application Review, Approval and Appeal

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

Exhibit A: APPLICATION FOR RECIPIENT RIGHTS CEU CREDIT

OFFICE OF RECIPIENT RIGHTS
APPLICATION FOR RECIPIENT RIGHTS CEU CREDIT

APPLICANT (ORGANIZATION OR INDIVIDUAL)				
APPLICANT'S CONTACT INFORMATION	EMAIL: PHONE: ADDRESS: CITY/ZIP:			
COURSE DATE COURSE TITLE LOCATION				
COURSE PRESENTER				
COURSE DESCRIPTION				
COURSE OBJECTIVES	Description of Learning Objectives			Class Time
	1			
	2			
	3			
	4			
	5			
Requested Category	Category I Operations	Category II Legal Foundations	Category III Leadership	Category IV Augmented
Describe how the content relates to Rights?				

Please attach a detailed agenda.

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.

	Board of Directors	Administration	Clinical Staff - Non-Residential	Clinical Staff - Specialized Residential	Direct Care Staff - Specialized Residential	Direct Care Staff - Non-Residential	Outpatient Clinic - All Staff	Advisory Committee	Volunteers	Appeals Committee
Abuse and Neglect	*	*	*	*	*	*	*	*	*	*
Civil Rights		*	*	*	*	*	*	*		
Communications and Visits		*		*	*	*	*			
Confidentiality	*	*	*	*	*	*	*	*	*	*
Consent/Informed Consent		*	*	*	*	*	*	*		
Dignity & Respect	*	*	*	*	*	*	*	*		
Entertainment, Information, and News		*		*	*	*	*			
Fingerprints, Photographs, Recording		*		*	*	*	*			
Freedom of Movement		*		*	*	*	*			
Limitations/Restrictions		*	*	*	*	*	*	*		
Psychotropic Medication		*		*	*	*	*			
Person Centered Planning		*	*	*	*	*	*	*		
Personal Property		*		*	*	*	*			
Rights of Family Members	*	*	*	*	*	*	*	*		
Safe, Sanitary, Humane Environment		*	*	*	*	*	*	*		
Seclusion/Restraint		*		*	*	*	*			
Suitable Services - Family Planning		*	*		*	*	*	*		
Suitable Services - Svcs Suited to Condition		*	*	*	*	*	*	*		
Suitable Services - Choice of Physician		*	*	*	*	*	*	*		
Suitable Services - Notice of Clinical Status		*	*	*	*	*	*	*		
THE RECIPIENT RIGHTS SYSTEM										
Role of the Advisory Committee	*	*			*				*	
Appeals Process	*	*			*				*	*
Employee Rights		*	*	*	*	*	*			
ORR Investigative Process	*	*	*	*	*	*	*	*	*	*
Overview of the Rights System	*	*	*	*	*	*	*	*	*	*
Reporting Requirements	*	*	*	*	*	*	*	*	*	
Responsibilities of the Agency Director	*	*			*				*	*
Responsibilities of the Board of Directors	*	*			*				*	*

Exhibit B – Training Standards for New Hire Training

Code Citation and Title
MHC 330.1722 ABUSE AND NEGLECT

Code Language

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

CONTENT REQUIREMENTS

- “Abuse” means:
 - 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 an LPH
- "Bodily function" means the usual action of any region or organ of the body.
- “Degrade” means
 - (a) Treat humiliatingly: to cause somebody a humiliating loss of status or reputation or cause somebody a humiliating loss of self-esteem; make worthless; to cause a person to feel that they or other people are worthless and do not have the respect or good opinion of others. (syn) degrade, debase, demean, humble, humiliate. These verbs mean to deprive of self-esteem or self-worth; to shame or disgrace. (b) Degrading behavior shall be further defined as any language or epithets that insult the person's heritage, mental status, race, sexual orientation, gender, intelligence, etc.
- "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.
- “Neglect” means:
 - 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:
 - that caused or contributed to the death, sexual abuse of, serious, or non-serious physical harm or emotional harm to a recipient, or
 - 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.
- "Non-serious physical harm" means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.
- “Physical management" means a technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself, or others.

- "Serious physical harm" means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
- "Sexual abuse" means any of the following:
 - Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.
 - Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
 - Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.
- "Sexual contact" means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following:
 - Revenge.
 - To inflict humiliation.
 - Out of anger.
- "Sexual harassment" means sexual advances to a recipient, requests for sexual favors from a recipient, or other conduct or communication of a sexual nature toward a recipient.
- "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.
- "Threaten" means to tell someone that you will hurt them or cause problems if they do not do what you want.
- "Time out" means a voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.
- "Unreasonable force" means physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances:
 - There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.
 - The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
 - The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service.
 - The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force

Code Citation and Title		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; padding: 2px;">MHC 330.1704 AR 330.7009</td> <td style="padding: 2px;">CIVIL RIGHTS</td> </tr> </table>	MHC 330.1704 AR 330.7009	CIVIL RIGHTS
MHC 330.1704 AR 330.7009	CIVIL RIGHTS	

Code Language

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

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

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

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

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 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.
- Provide some examples such as:
 - 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

Code Citation and Title

MCL 330.1724 FINGERPRINTS, PHOTOGRAPHS, AUDIORECORDINGS, VIDEORECORDINGS AND USE OF ONE-WAY GLASS
--

- Be aware of the location of these materials
- Assure that family members are treated with dignity and respect

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 to be taken for purely personal or social purposes and must be treated as the recipient's personal property. Photographs must not be taken for this purpose if the recipient has objected.
- Fingerprints, photographs and audio-recordings and any copies of these are to be made part of the recipient record and are to be destroyed or returned to the recipient when no longer essential or upon discharge, whichever occurs first.
- If fingerprints, photographs or audio-recordings are done and sent out to others to help determine the name of the recipient, the individual receiving the items must be informed that return is required for inclusion in the recipient record.
- Restrictions may be put in place if the recipient is receiving services pursuant to the criminal provisions of Chapter 10 of the Mental Health Code – Incompetent to Stand Trial, Not Guilty by Reason of Insanity, recipient of the Department of Corrections Mental Health Services Program

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

Code Language

Mental health services shall be offered in the least restrictive setting that is appropriate and available.

The freedom of movement of a recipient shall not be restricted more than is 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 in the least restrictive setting.
- 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 preparation storage areas
 - Assure adequate preparation and storage of food items.
 - Assure premises are constructed, arranged and maintained to adequately provide for the health, safety and well-being of occupants
- Provide for resident health, hygiene and personal grooming including assistance and training in personal grooming practices, including bathing, tooth brushing, shampooing, hair grooming, shaving and care of nails. Provider must supply toilet articles, toothbrush and dentifrice, opportunity to shower or bathe at least once every 2 days, regular services of a barber or beautician and the opportunity to shave daily (males) [AR 7171]

Code Citation and Title

VARIOUS CODE SECTIONS PERTAINING TO THE RECIPIENT RIGHTS SYSTEM
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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.

Code Citation and Title

MHC 330.1726 COMMUNICATIONS AND VISITS

Code Language

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

Code Citation and Title

AR 330.7139 ENTERTAINMENT MATERIALS, INFORMATION AND NEWS
--

Code Language

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

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. 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 within 30 days, and does not involve statutorily required disciplinary action. Interventions, at a minimum, must contain the following elements: the specific action taken by ORR, on behalf of the complainant, to resolve the complaint, identification of the code protected right, a statement indicating whether the allegation of a rights violation is substantiated or not substantiated. Additionally, if the allegation is substantiated, the specific remedial action taken is identified.

F. Investigation: A detailed inquiry into and systematic examination of an allegation raised in a rights complaint, as outlined in 330.1778 of PA 258 of 1974

- G. Legal Guardian: A judicially appointed guardian or parent who has legal custody of a minor recipient.
- H. 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.
- I. 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.
- J. 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 executive director of a CMHSP of the right to appeal to the designated Appeals Committee. Notice shall include the address for filing the appeal, the grounds for appeal as stated in section 330.1784(2) of the Mental Health Code, the time frame for submission of the appeal, information on advocacy organizations that may assist with filing the written appeal, and, in the absence of assistance from an advocacy organization, an offer of assistance by the Office of Recipient Rights.

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 request for appeal, members of the appeals committee shall review the request for appeal to determine if the appellant has standing to appeal and if the appeal request meets the timeframe and grounds. 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 request for 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 request for 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 as required by Sec 1780 of the MHC.
 - 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 with their Rights Advisor.

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 CMHSP executive director. 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 executive director of the CMHSP 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. If the Summary Report indicates the decision in the case remains unsubstantiated, 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, in the absence of an advocacy organization, offer the assistance of the office.
- C. If, upon review, the Committee feels that the reinvestigated results in the Report of Investigative Findings is still inadequate, the Committee shall inform the appellant of the ability to further appeal to Level 2.
- D. 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
- E. 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.
- F. 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.

- G. 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.
- H. If the Appeals Committee recommends that the board or governing body of the CMHSP, 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 CMHSP Director.

C. Review

The respondent, local office holding the record of the complaint, and the CMHSP shall ensure that Level 2 Appeals has access to all necessary documentation and other evidence cited in the complaint and local appeal. Level 2 Appeals shall review the record generated by the local appeal. Level 2 Appeal 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 Administration 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.

MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
REPORTING REQUIREMENTS
Effective 10/1/23
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MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT REPORTING REQUIREMENTS

Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2024 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

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

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

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

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

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management
- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- Actuarial activities

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

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

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

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

<u>Due Date</u>	<u>Report Title</u>	<u>Report Frequency</u>	<u>Report Period</u>
1/31/2024	1Q Special Fund Account – Section 226a, PA of the MHC	Quarterly (Use standalone form)	October 1 to December 31
4/30/2024	2Q Special Fund Account – Section 226a, PA of the MHC	Quarterly (Use standalone form)	October 1 to March 31
5/31/2024	Mid-Year Status Report	Mid-Year	October 1 to March 31
6/30/2024	Semi-annual Recipient Rights Data Report	Mid-Year	October 1 to March 31. Section I only. See section “Recipient Rights Data Report” for additional information in this attachment.
8/15/2024	CMHSP FSR Bundle – All Non-Medicaid	Projection (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> State Services Utilization, Reconciliation & Cash Analysis 	Projection (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> General Fund Contract Settlement Worksheet 	Projection (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> General Fund Reconciliation and Cash Settlement 	Projection (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Special Fund Account – Section 226a, PA of the MHC 	Projection (Use tab in FSR Bundle)	October 1 to September 30
9/15/24	Guardian Reimbursement Distribution Report	Annually	June 30, 2023 to July 1, 2024
10/1/2024	General Fund – Year End Accrual Schedule	Final	October 1 to September 30
FY24 Monthly	PASARR Agreement Monthly Billing	Monthly	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.
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11/10/2024	CMHSP FSR Bundle – All Non-Medicaid,	Interim (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> State Services Utilization, Reconciliation & Cash Analysis 	Interim (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Special Fund Account – Section 226a, PA of the MHC 	Interim (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> General Fund Contract Settlement Worksheet 	Interim (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> General Fund Reconciliation and Cash Settlement 	Interim (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Special Fund Account – Section 226a, PA of the MHC 	Interim (Use tab in FSR Bundle)	October 1 to September 30
11/10/2024	Categorical Funding – Multi-cultural Annual Report	Annually	October 1 to September 30
12/30/2024	Annual Recipient Rights Data Report	Annually	October 1 to September 30. Sections I, II, III & IV. See section “Recipient Rights Data Report” for additional information in this attachment.
1/31/2025	Annual Report on Fraud and Abuse Complaints	Annually	October 1 to September 30
2/28/2025	CMHSP FSR Bundle – All Non-Medicaid	Final (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> State Services Utilization, Reconciliation & Cash Analysis 	Final (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Special Fund Account – Section 226a, PA of the MHC 	Final (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> General Fund Reconciliation and Cash Settlement 	Final (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> General Fund Contract Settlement Worksheet 	Final (Use tab in FSR Bundle)	October 1 to September 30
	<ul style="list-style-type: none"> Special Fund Account – Section 226a, PA of the MHC 	Final (Use tab in FSR Bundle)	October 1 to September 30
2/28/2025	Sub-Element Cost Report	Annually	See Attachment 6.5.1.1 Submit report to: QMPMeasures@michigan.gov
2/28/2025	Annual Submission Requirement Form – Estimated FTE Equivalents	Annually	For the fiscal year ending September 30, 2024
2/28/2025	Annual Submission Requirement Form – Requests for Services and Disposition of Requests	Annually	For the fiscal year ending September 30, 2024
2/28/2025	Annual Submission Requirement Form – Waiting List	Annually	For the fiscal year ending September 30, 2024

2/28/2025	Annual Submission Requirement Form – Community Needs Assessment	Annually	For the fiscal year ending September 30, 2024
2/28/2025	Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30, 2024
4/01/2024	Special Education to Community Transition Data Tracking Report	Annually	October 1 to September 30 Submit reports to: MDHHS-CPI-Section@michigan.gov
30 days after receipt, but no later than June 30, 2024	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually	October 1 to September 30 th Submit reports to: MDHHS-AuditReports@michigan.gov
30 days after receipt, but no later than June 30, 2024	Compliance exam and plan of correction	Annually	October 1 to September 30 th Submit reports to: MDHHS-AuditReports@michigan.gov

FY 2024 DATA REPORT DUE DATES

	Nov 23	Dec	Jan 24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec 24	Jan 25
1. Consumer level** Demographic BHTEDS (monthly) ¹ b. Encounter (monthly) ¹	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2.PIHP level a. Medicaid Utilization and Net Cost Report: annually ²				√											
b. Performance indicators (quarterly) ²					√			√			√			√	
c. Consumer Satisfaction (annually) ²										√					
d. CAFAS and PECFAS ³													√		
e. Critical incidents (monthly) ³															

NOTES:

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

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

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

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

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at:

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

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

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

A. Basis of Data Reporting

The basis for data reporting policies for Michigan behavioral health includes:

1. Federal funding awarded to Michigan through the Combined SABG/MHBG Behavioral Health federal block grant.
2. SAMHSA's Behavioral Health Services Information Systems (BHSIS) award agreement administered through Synectics Management, Inc that awards MDHHS a contracted amount of funding if the data meet minimum timeliness, completeness and accuracy standards
3. Legislative boilerplate annual reporting and semi-annual updates

B. Policies and Requirements Regarding Data

BH-TEDS Data reporting will encompass Behavioral Health services provided to persons supported in whole or in part with MDHHS-administered funds.

Policy:

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

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

1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

2. All SUD data collected and recorded on BH-TEDS shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDHHS at the program level.
3. There must be a unique Person identifier assigned and reported. It must be 11 characters in length, and alphanumeric. This same number is to be used to report data for BH-TEDS and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.
4. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.
5. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDHHS.
6. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.
7. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.
8. Statements of MDHHS policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

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

Due dates: BH-TEDS data are due monthly. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

Who to report: The PIHP must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and substance use disorders who receive services funded in whole or in part with MDHHS-administered funding. PIHPs participating in the Medicare/Medicaid integration project are not to report BH-TEDS records for beneficiaries for

whom the PIHP's financial responsibility is to a non-contracted provider during the 180-day continuity of care.

PROXY MEASURES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

For FY23, 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.

*	<i>Reporting Period (REPORTPD)</i> The last day of the month in which the consumer data is being updated. Report year, month, day: yyyyymmdd.
*	<i>PIHP Payer Identification Number (PIHPID)</i> The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transmissions.
*	<i>CMHSP Payer Identification Number (CMHID)</i> The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all data transmissions.
*	<i>Consumer Unique ID (CONID)</i> 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 jejunum – e.g., J-tube or PEG-J tube
- 9 = Parenteral feeding only—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
- Blank = Missing

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

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

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

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

Indicate whether or not the individual has "natural supports" defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

- 1 = Extensive involvement, such as daily emotional support/companionship
- 2 = Moderate involvement, such as several times a month up to several times a week
- 3 = Limited involvement, such as intermittent or up to once a month
- 4 = Involved in planning or decision-making, but does not provide emotional support/companionship
- 5 = No involvement
- Blank = Missing

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

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. “At risk” means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver’s help is in place.

1 = Care giver status is not at risk

2 = Care giver is likely to reduce current level of help provided

3 = Care giver is likely to cease providing help altogether

4 = Family/friends do not currently provide care

5 = Information unavailable

Blank = Missing

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

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. “Challenging behaviors” include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

1 = No challenging behaviors, or no support needed

2 = Limited Support, such as support up to once a month

3 = Moderate Support, such as support once a week

4 = Extensive Support, such as support several times a week

5 = Total Support – Intermittent, such as support once or twice a day

6 = Total Support – Continuous, such as full-time support

Blank = Missing

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

Indicate the presence of a behavior plan during the past 12 months.

1 = No Behavior Plan

2 = Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee

3 = Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee

Blank = Missing

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

Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of “anti-psychotic” and “other psychotropic” and a list of the most common medications.

51.1: Number of Anti-Psychotic Medications (AP) ____

Blank = Missing

51.2: Number of Other Psychotropic Medications (OTHPSYCH) ____

Blank = Missing

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

This measure identifies major mental illnesses characterized by psychotic symptoms or

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

1 = One or more MMI diagnosis present

2 = No MMI diagnosis present

Blank = Missing

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

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

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

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

Data Record

Record Format: rc1041.06									
Element #	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
1	Submitter ID	Char(4)	4		1	4	Yes	Yes	Service Bureau ID (DEG Mailbox ID)
2	Consumer ID	Char(11)	11		5	15	No	Yes	Unique Consumer ID
3	Medicaid ID	Char(10)	10		16	25	Yes	Conditional	Must present on file if available.

Record Format: rc1041.0 6									
Element #	Data Element Name	Picture	Usage	Format	From	To	Validated	Required	Definition
4	MICChild ID	Char(10)	10		26	35	Yes	Conditional	MICHILD ID [CIN] Must present on file if available.
5	Begin Date	Date	8	YYYYMMDD	36	43	Yes	Yes	

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

the encounter being rejected by the CHAMPS system.

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

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

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

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

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

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

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

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

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

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

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

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

If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.
If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID**.

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

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

****4. Date of birth**

Enter the date of birth of the beneficiary/consumer.

****5. Diagnosis**

Enter the ICD-10 primary diagnosis of the consumer.

****6. EPSDT**

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

****7. Encounter Data Identifier**

Enter specified code indicating this file is an encounter file.

****8. Line Counter Assigned Number**

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

****9. Procedure Code**

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

***10. Procedure Modifier Code**

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

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

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

****12. Quantity of Service**

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

13. Place of Service Code

Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc. (See PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes Chart at <http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html> [Click on Reporting](#))

[Requirements, then the codes chart\)](#)

14. *Diagnosis Code Pointer*

Points to the diagnosis code at the claim level that is relevant to the service.

****15. *Date Time Period***

Enter date of service provided (how this is reported depends on whether the Professional, or the Institutional format is used)

****16. *Billing Provider Name***

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

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

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 (-e.g., Medicaid, or Children's Waiver) but who are also receiving a general fund-covered service like family friend respite or state inpatient, or are on spend-down and receiving some of their services funded by general fund. The format is presented by procedure code, beginning with facility services reported by revenue code. Most of the activity reported here will also have been reported in the encounter data system. Refer to the PIHP/CMHSP Encounter Reporting Costing per Code and Code Chart on the MDHHS web site for a crosswalk between services and the appropriate codes.

Instructions and reporting templates can be found at:

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

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

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

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

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

CMHSP PERFORMANCE INDICATOR SYSTEM

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

ACCESS

1. The percent of all adults and children receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.

- a. Standard = 95% in three hours
- b. Quarterly report
- c. PIHP for all Medicaid beneficiaries
- d. CMHSP for all consumers

2. The percent of new persons receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, and DD children).

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

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults and DD children)

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

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults -MI, DD).

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

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

5. The percent of face-to-face assessments with professionals that result in decisions to deny CMHSP services. (MI and DD) (Old Indicator #6)

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

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

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

EFFICIENCY

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

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

OUTCOMES

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

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

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

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

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

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

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

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

- a. Annual report (MDHHS calculates from QI data)
- b. PIHP for Medicaid beneficiaries
- c. CMHSP for all adults

d. Scope: DD adults only

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

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

CMHSP PERFORMANCE INDICATOR REPORTING DUE DATES
FY 2024 Due Dates

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screening	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
2. 1 st request	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
3. 1 st service	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
4. Follow-up	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
5. Denials	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
6. 2 nd Opinions	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
7. Admin Costs*	10/01 to 9/30	2/27/24							CMHSPs
8. Competitive employment*	10/01 to 9/30	N/A							MDHHS
9. Minimum wage*	10/01 to 9/30	N/A							MDHHS
10. Readmissions	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4-01 to 6-30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
11. RR complaints	10/01 to 9/30	12/31/24							CMHSPs
13. Residence (DD)*	10/01 to 9/30	N/A							MDHHS
14. Residence (MI)*	10/01 to 9/30	N/A							MDHHS

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

STATE LEVEL DATA COLLECTION

Please see the separate document for CAFAS/PECFAS reporting

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"

TECHNICAL REQUIREMENT FOR RECIPIENT RIGHTS DATA REPORTING REQUIREMENTS

I. Background/Regulatory Overview

The purpose of this Technical Requirement is to establish processes for mandated data reporting requirements for Community Mental Health Services Programs (CMHSP) set forth in the following sections of the Michigan Mental Health Code:

330.1232 (a) (1) Subject to section 114a, the department shall promulgate rules to establish standards for certification and the certification review process for community mental health services programs. The standards shall include but not be limited to all of the following: (b) Promotion and protection of recipient rights.

330.1232 (a) (6) The department shall conduct an annual review of each community mental health services program's recipient rights system to ensure compliance with standards established under subsection (1)(b). An on-site review shall be conducted once every 3 years.

330.1755 (5) Each office of recipient rights established under this section shall do all of the following: (j) Semiannually provide summary complaint data consistent with the annual report required in subsection (6), together with a summary of remedial action taken on substantiated complaints by category, to the department and to the recipient rights advisory committee of the community mental health services program or licensed hospital.

330.1755 (6) The executive director or hospital director shall submit to the board of the community mental health services program or the governing board of the licensed hospital and the department an annual report prepared by the office of recipient rights on the current status of recipient rights in the community mental health services program system or licensed hospital system and a review of the operations of the office of recipient rights.

II. Reporting Requirements for CMHSP Triennial On-Site Assessments

- A. Every January, MDHHS-ORR will provide notice to all CMHSPs of the reporting requirements and assessment dates for on-site assessments during that year.
- B. CMHSP-ORRs will be required to provide requested data to MDHHS-ORR no later than 30 business days prior to the start date of the assessment. Data requested will address, at a minimum,
 - i. Complete case log information (redacting the names of complainants and recipients) *;
 - ii. Complete information (dates of visits, remedial action requested, and results of plans of correction) regarding all visits to service sites for the three-year period prior to the start date of the assessment*;
 - iii. Dates of hire and dates of recipient rights training for all persons hired by the CMHSP and all of its contractual providers*;
 - iv. One signed, current contract for each type of service provided:
 - a) Residential providers (both in and out of service area)
 - b) Other service providers
 - c) Inpatient psychiatric units (both in and out of service area)
 - d) Professional staff (psychiatrists, OTs, PTs, etc.)
 - v. The training checklist identifying where each item on the Required Training Standards (Attachment 5.3.2.3B) can be found within your training materials and all materials used in Recipient Rights training.

- vi. The ORR Policy Review Standards document, identifying the name and number of the policy as well as the page numbers where policy elements can be found.

*Note: Information for items B i, ii, and iii must be provided utilizing the excel templates provided by MDHHS-ORR in the January distribution of assessment information,

C. At the time of the on-site visit the CMHSP will be required to provide the following items:

- i. Agency organization chart.
- ii. Job description for rights officer and rights advisors.
- iii. A list of recipient rights advisory committee members.
- iv. A list of categories represented on the committee.
- v. Minutes of the RRAC committee for the assessment period.
- vi. Informational packets/brochures given to the public or consumers. (Include any poster which identifies the Rights Officer/Advisors and the means of contacting them).
- vii. Documentation from all site monitoring activities for the period covered in the excel spreadsheet.
- viii. Access to policies/procedures of any service providers allowed by contract to develop their own policies.
- ix. Records that document attendance at rights training for all agency staff and all contract employees.
- x. Documents reflecting approved training received by all staff employed by the rights office since the last assessment.

III. Reporting Requirements for the Semi-Annual Data Report

- A. The period covered for the semi-annual report will be from October 1 – March 31.
- B. The report is due to MDHHS-ORR on June 30 of each year.
- C. An Excel spreadsheet must be utilized to submit the required data and information. The Excel template will be provided to CMHSP rights offices by March 31st of each year.
- D. Content will include statistical data on complaints received for the reporting period and a summary of remedial action taken on substantiated complaints by category.

IV. Reporting Requirements for the Annual Data Report

- A. The period covered for the semi-annual report will be from October 1 – March 31.
- B. The report is due to MDHHS-ORR on December 30 of each year.
- C. An Excel spreadsheet must be utilized to submit the required data and information. The Excel template will be provided to CMHSP rights offices by September 30 of each year.
- D. Content will include:
 - i. Summary data by category regarding the rights of recipients receiving services from the community mental health services program or licensed hospital including complaints received, the number of reports filed, and the number of reports investigated by provider.
 - ii. The number of substantiated rights violations by category and provider.
 - iii. The remedial actions taken on substantiated rights violations by category and provider.
 - iv. Training received by staff of the office of recipient rights.
 - v. Training provided by the office of recipient rights to contract providers.
 - vi. Desired outcomes established for the office of recipient rights and progress toward these outcomes.
 - vii. Recommendations to the community mental health services program board.

QUALITY IMPROVEMENT PROGRAMS FOR CMHSPs TECHNICAL REQUIREMENT

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

Michigan Standards

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

- A. The organization has a written description of its QIP. The written description contains a detailed description of the structure of the QI system and a set of QI objectives that are developed annually and include a timetable for implementation and accomplishment. The plan must evaluate the QI program at least annually.
- B. Scope - The written QIP plan includes a description for how the organization shall assure that all demographic groups, care settings, and types of services are included in the scope of the QIP.
- C. The written plan must reflect the specific activities of the QIP, including:
 - 1. The process for the identification and selection of aspects of clinical care and non-clinical services to be monitored and considered for process improvement projects;
 - 2. The methods used to gather, analyze, report, and utilize customer satisfaction;
 - 3. The mechanisms that will be used to evaluate and annually revise the QIP written plan.
 - 4. The responsibilities of the governing body, executive director, medical director, managers, direct staff and subcontracting agencies in the QI process.
 - 5. The structure responsible for performing QI functions and assuring that program improvements are occurring within the CMHSP. This committee or other structure must:
 - a. Demonstrate that it meets or occurs with a frequency that is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions.

- b. Established parameters for the role, structure and function of the structure/committee.
 - c. Maintain records documenting the structure's/committee's activities, findings, recommendations and actions.
- D. Continuous Activity - The written description provides for continuous performance of the activities, including tracking of issues over time.
- E. Follow Through - The plan must delineate the mechanisms or procedures to be used for adopting and communicating process and outcome improvements.
- F. Focus on Health Outcomes - The plan must address the role for mental health outcomes, of value to purchasers and individuals, to the extent possible within existing technology.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT - The QIP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality assessment and performance improvement projects, and related activities, and pursues opportunities for improvement on an ongoing basis.

The QIP has written guidelines for its quality-related activities, which include:

- A. Specification of clinical or health services delivery areas to be monitored
 - 1. The monitoring and evaluation of care reflects the population served by the CMHSP in terms of age groups, disease categories, and special risk status.
 - 2. At its discretion and/or as required by the State Medicaid agency, the organization's QIP also monitors and evaluates other important aspects of care and service.
- B. Use of quality indicators
 - 1. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.
 - 2. Indicators shall include, but not be limited to, those selected by the state agency.
 - 3. Methods and frequency of data collection are appropriate and sufficient to detect need for program change.
- C. Use of clinical care standards/practice guidelines

1. When there are nationally accepted or mutually agreed upon clinical standards/practice guidelines, QI activities monitor quality of care against those standards/guidelines.
2. When guidelines exist, a mechanism is in place for continually updating the standards/guidelines.

D. Implementation of remedial action plans

1. The QIP requires that appropriate remedial action be taken whenever inappropriate or substandard services are furnished as determined by substantiated recipient rights complaints, clinical indicators, or clinical care standards or practice guidelines where they exist.
2. Follow-up remedial actions are documented.

E. Assessment of effectiveness of corrective actions

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.
2. The CMHSP assures follow-up on identified issues to ensure that actions for improvement have been effective.

F. The Quality Improvement Program describes the process of the review and follow-up of sentinel events for persons enrolled in the Children's Waiver (CW), the Children with Serious Emotional Disturbance Waiver (SEDW), and who receive services funded by these programs from CMHSPs. CMHSPs that are service providers of PIHPs, should reach agreement on how sentinel events will be handled for individuals receiving 1915(b) services or Habilitation Supports Waiver services managed by the PIHP.

1. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate, with root cause analyses to commence within two business days of the sentinel event.
2. Staff involved in reviewing and analyzing the sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involved death or serious medical conditions, must involve a physician or nurse.
3. All unexpected* deaths of Children's Waiver, and SED Waiver beneficiaries, who at the time of their deaths were receiving specialty supports and services from CMHSPs, must be reviewed and must include:

- a. Screens of individual deaths with standard information (e.g. coroner's report, death certificate).
- b. Involvement of medical personnel in the mortality reviews.
- c. Documentation of the mortality review process, findings, and recommendations.
- d. Use of mortality information to address quality of care.
- e. Aggregation of mortality data over time to identify possible trends.

*"Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY - Responsibilities of the Governing body for monitoring, evaluating, and making improvements to care include:

- A. Oversight of QIP - There is documentation that the Governing Body has approved the overall QIP and an annual QI plan.
- B. QIP progress reports - The Governing Body routinely receives written reports from the QIP describing actions taken, progress in meeting QI objectives, and improvements made.
- C. Annual QIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QIP that includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered to assess the QIP's continuity, effectiveness and current acceptability.
- D. Program modification - Upon receipt of regular written reports from the QIP delineating actions taken and improvements made, the Governing Body assures that the Executive Director takes action when appropriate and directs that the operational QIP be modified on an ongoing basis to accommodate review findings and issues of concern within the Community Mental Health Service Program (CMHSP).

STANDARD IV: QIP SUPERVISION - There is a designated senior executive who is responsible for the QI program implementation. The organization's Medical Director has an identifiable role in the QIP.

STANDARD V: Provider Qualification and Selection - The QIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the State and who are employees of the CMHSP or under contract to the CMHSP, are qualified to perform their services. The QIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs.

The CMHSP must have written policies and procedures for the credentialing process that includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QIP are incorporated into this re-credentialing process.

The CMHSP must also insure:

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:
 - a. Educational background;
 - b. Relevant work experience;
 - c. Cultural competence;
 - d. Certification, registration, and licensure as required by law.
2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.
3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

STANDARD VI: ENROLLEE RIGHTS AND RESPONSIBILITIES - The organization demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

- A. The CMHSP monitors and assures that each individual has all of the rights established in Federal and State law.
- B. The CMHSP shall have a local recipient rights office found to be in substantial compliance with the requirements of Chapter 7 of the Michigan Mental Health Code, as evidenced by a site review conducted by the state agency.
- C. The CMHSP shall submit an annual report of the CMHSP's Office of Recipient Rights to the state office as required by Chapter 7 of the Michigan Mental Health Code.
- D. The organization conducts periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.
 1. The assessments must address the issues of the quality, availability, and accessibility of care.
 2. As a result of the assessments, the organization:
 - a. Takes specific action on individual cases as appropriate;
 - b. Identifies and investigates sources of dissatisfaction;
 - c. Outlines systemic action steps to follow-up on the findings; and

- d. Informs practitioners, providers, recipients of service, and the governing body of assessment results.
3. The organization evaluates the effects of the above activities.
4. The organization ensures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

STANDARD VIII: UTILIZATION MANAGEMENT

- A. Written Program Description - The organization has a written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.
- B. Scope - The program has mechanisms to identify and correct under-utilization and overutilization.
- C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:
 1. Review decisions are supervised by qualified medical professionals.
 2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
 3. The reasons for decisions are clearly documented and available to the member.
 4. There are well-publicized and readily available appeals mechanisms for both provider and patients. Notification of, a denial includes a description of how to file an appeal.
 5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
 6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
 7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral and Physical Health and Aging Services
Administration

TECHNICAL REQUIREMENT FOR BEHAVIOR TREATMENT PLANS

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 active symptoms of a substantiated serious mental illness or serious emotional disturbance as defined in sec. 100d of PA 258 of 1974.

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 (BBA) 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 or psychiatric unit 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 (MPM), 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 (ORR) shall participate on the Committee as 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 Adult Foster Care (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 ORR 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, 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 (PCP) 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 PIHPs Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSPs 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 Individual Plan of Service (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 PCP 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, 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 PIHPs QAPIP or the CMHSPs 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.

II. BEHAVIOR TREATMENT PLAN STANDARDS

- A. The PCP process used in the development of a written IPOS 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 PCP 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 written IPOS must be revisited through the PCP process and modified accordingly, if needed. MDHHS Administrative Rules prohibit emergency interventions from inclusion as a component or step in any behavior plan. The plan may note, however, that should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.

- D. Behavior treatment plans that propose to use restrictive or intrusive techniques as defined by this policy shall be reviewed and approved (or disapproved) by the Committee.
- E. Plans that are forwarded to the Committee for review shall be accompanied by:
1. Results of assessments performed to rule out relevant physical, medical and environmental causes of the challenging behavior.
 2. A functional behavioral assessment.
 3. Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.
 4. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been used to ameliorate the behavior and have proved to be unsuccessful.
 5. Evidence of continued efforts to find other options.
 6. Practice guidelines that support the proposed restrictive or intrusive intervention.
 7. References to peer reviewed 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

TERM	DEFINITION
Anatomical support	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.
Aversive techniques	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 or control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist, or other noxious substance to consequence 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 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 purpose of this technical requirement.
Bodily function	The usual action of any region or organ of the body.
Emotional harm	Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.
Consent	A written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.
Facility	A residential facility for the care or treatment of individuals with serious mental illness, serious emotional disturbance, or developmental disability that is either a state facility or a licensed facility. Facility includes a preadmission screening unit established under section 409 that is operating a crisis stabilization unit.

Functional Behavioral Assessment (FBA)	An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose or “function” of a particular behavior and guide the development of an effective and efficient behavior 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
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	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.
Emergency interventions	There are only two emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention. Each agency shall have protocols specifying what physical management techniques are approved for use.
Imminent risk	An event/action that is about to occur that will likely result in the serious physical harm of oneself or others.
Intrusive techniques	Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control of a seriously aggressive, self-injurious, or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage 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.
Medical and dental procedures restraints	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 written IPOS for medical or dental procedures.
Physical management	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.
Practice or treatment guidelines	Guidelines published by professional organizations such as the American Psychiatric Association, or the federal government.

Prone immobilization	Extended physical restraint of an individual in a face down (prone) position, usually on the floor, where force is applied to his/her body in a manner that prevents him/her from moving out of the prone position for the purpose of control. NOTE: PRONE IMMOBILIZATION IS PROHIBITED UNDER ANY CIRCUMSTANCES
Positive Behavior Support (PBS)	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, teaching new skills, and making changes in a person's environment. PBS 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. PBSs are most effective when they are implemented across all environments, such as home, school, work, and in the community.
Protective device	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 device, as defined in this subdivision and incorporated in written IPOS, shall not be considered a restraint as defined below. Use of protective devices/physical barriers to prevent a recipient from causing serious self-injury associated with documented and/or frequent incidents of behavior requires BTPRC review/approval. (See section II. Behavior Treatment Plan Standards, for all required elements)
Provider	The department, each community mental health service program, each licensed hospital, each psychiatric unit, and each psychiatric partial hospitalization program licensed under section 137 of the act, their employees, volunteers, and contractual agents.
Psychotropic drug	Any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior.
Request for Law Enforcement intervention	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

Restraint	The use of physical device to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support
Restrictive Techniques	Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal BBA. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the individual; access to personal property when that access would be harmful to the individual; or any limitation of the freedom of movement of an individual for behavior control purposes. Use of any restrictive techniques for behavior control purposes requires the review and approval of the Committee (see Section II. Behavior Treatment Plan Standards for all required elements).
Serious emotional disturbance	a diagnosable mental, behavioral, or emotional disorder affecting a minor that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) A substance use disorder. (b) A developmental disorder. (c) "V" codes in the Diagnostic and Statistical Manual of Mental Disorders.
Serious mental illness	a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and approved by the department and that has resulted in functional impairment that substantially interferes with or limits 1 or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbance but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders also are included only if they occur in conjunction with another diagnosable serious mental illness: (a) A substance use disorder. (b) A developmental disorder. (c) A "V" code in the Diagnostic and Statistical Manual of Mental Disorders.

Serious physical harm	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/her bodily functions, or caused the permanent disfigurement of a recipient.
Special consent	Obtaining the written consent of the individual, the legal guardian, the parent with legal custody of a minor child, or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the written IPOS 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.
Therapeutic de-escalation	An intervention, the implementation of which is incorporated in the written IPOS, 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.
Time out	A voluntary response to the therapeutic suggestion to a recipient to remove himself/herself from a stressful situation to prevent a potentially hazardous outcome.

Unreasonable force	<p>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:</p> <ol style="list-style-type: none"> 1. There is no imminent risk of serious or non-serious physical harm to the recipient, staff, or others. 2. The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency. 3. The physical management used is not in compliance with the emergency interventions authorized in the recipient's written IPOS. 4. 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.
Person-centered planning (PCP)	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 honors the individual's preferences, choices, and abilities. The PCP 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 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

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)

MDHHS Administrative Rule 7199(2)(g)

FORENSIC PROCESS FOR NGRI
(Not Guilty by Reason of Insanity)
Effective July, 2021

NGRI Process and Responsibilities

DEFINITIONS:

Alternative Treatment Report

A report developed and submitted by the responsible community mental health services program (CMHSP) to the probate court during the hearing for involuntary hospitalization offering a community treatment alternative during the involuntary hospitalization hearing.

Assisted Outpatient Treatment (AOT) Order

A directive issued by a probate court requiring an individual to undergo AOT consistent with §468(2)(c) and (d) of the Michigan Mental Health Code (MMHC). Assisted outpatient treatment can be both an order to adhere to outpatient services or it may incorporate both outpatient and admission to a hospital.

Assisted Outpatient Treatment (AOT)

Services ordered by a probate court under §468 or 469a of the MMHC. Assisted outpatient treatment may include a case management plan and related services to provide care coordination under the supervision of a psychiatrist and developed in accordance with person-centered planning under §712 of the MMHC. This definition also may include one or more of the following:

- Medication.
 - Periodic blood tests or urinalysis to determine compliance with prescribed medications.
 - Individual or group therapy.
 - Day or partial day programming activities.
 - Vocational, educational, or self-help training or activities.
 - Assertive community treatment team services.
 - Alcohol or substance use disorder treatment and counseling and periodic tests for the presence of alcohol or illegal drugs for an individual with a history of alcohol abuse or substance use disorder.
 - Supervision of living arrangements, and
 - Any other services within a local or unified services plan developed under the MMHC that are prescribed to treat the individual's mental illness and to assist the individual in living and functioning in the community or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide, the need for hospitalization, or serious violent behavior.
-
- The medical review and direction included in AOT must be provided under the supervision of the psychiatrist.

Diagnostic Period

A period of time, not to exceed 60 days, that the Center for Forensic Psychiatry (CFP) has to thoroughly examine and evaluate the present mental condition of a person adjudicated as being not guilty by reason of insanity (NGRI) to determine whether they meet criteria as requiring treatment.

Discharge

An absolute, unconditional release of an individual from a hospital by action of the hospital or a court. Discharge decisions must be based on each person's actual, real, and individualized risk mitigation and behavioral health treatment needs. For purposes of this policy, a discharge also includes a person's release from a hospital on an AOT order pursuant to §468(2)(c) and (d). This document does not address an individual's discharge from an AOT order.

Forensic Liaison

An individual assigned by CFP, another hospital operated by the department, or community mental health services program to provide administrative management and coordination between the treating parties. Such coordination activities include, but may not necessarily be limited to, leave of absences (LOAs) and discharges.

Hospital

An inpatient program operated by the department for the treatment of individuals with serious mental illness, serious emotional disturbance, or intellectual/developmental disability.

Individual Plan of Service (IPOS)

The fundamental document in the person's record, developed in partnership with the person using a person-centered planning process that establishes meaningful goals and measurable objectives including risk mitigation strategies overseen by the NGRI Committee. The plan must identify services (including discharge planning), supports and treatment as desired or required by the person.

Leave of Absence (LOA)

A temporary leave from a hospital ordered by a physician for treatment or community engagement purposes that does not exceed one year. The NGRI committee will be notified of LOAs and evaluate and approve any non-medical LOAs that include an overnight stay. Any LOA may require an NGRI committee evaluation and approval, if indicated in the IPOS and based upon the individualized treatment needs including appropriate risk mitigation strategies.

Not Guilty by Reason of Insanity (NGRI)

An affirmative defense to a prosecution of a criminal offense that the defendant was legally insane when they committed the acts constituting the offense. An individual is legally insane if, because of a mental illness as defined in § 400 of the MMHC, or because of having an intellectual disability as defined in §100b of the MMHC, that person lacks substantial capacity either to appreciate the nature and quality or the wrongfulness of their conduct or to conform their conduct to the requirements of the law. Mental illness or having an intellectual disability does not otherwise constitute a defense of legal insanity.

Not Guilty by Reason of Insanity (NGRI) Committee

A multidisciplinary team consisting of forensic clinical staff (psychiatrists, psychologists, and social workers) who are certified or consulting forensic examiners. Members of the committee are appointed by the CFP director.

Person

For purposes of this document, an individual who has been adjudicated NGRI.

Plan Coordinator

A licensed social worker or psychologist who integrates, coordinates, monitors and assures implementation of each person's IPOS. Monitoring includes ongoing review of the IPOS, recording progress and changes, and initiating modification of the IPOS, as necessary. A member of the treatment team will be designated as the plan coordinator for the hospital treatment team or community treatment team where indicated.

Risk Mitigation Strategies

Strategies in a person's IPOS designed to reduce a person's risk of harming themselves or others. Risk mitigations strategies must be tied to the person's behavioral health treatment needs.

Supervisory Level Forensic Psychiatrist

A forensic psychiatrist assigned by the CFP director who coordinates services between the hospital treatment team, the NGRI Committee and the forensic liaison. This position advises the hospital treatment team to ensure, at a minimum, that risk mitigation strategies have been addressed based upon the person's behavioral health needs.

Treatment Team

Those individuals who work together to develop and implement an IPOS. A treatment team includes the person, the person's guardian, a multidisciplinary team of mental health care professionals, including the plan coordinator, and involved direct care staff, A treatment team may be either a hospital treatment team or community treatment team.

Violent Crime

First-, second- and third-degree murder, voluntary manslaughter, and criminal sexual conduct crimes.

NOT GUILTY BY REASON OF INSANITY

1. Overview

Persons adjudicated NGRI will be immediately committed to CFP. During the diagnostic period CFP will:

- Examine and evaluate the present mental condition of the person to determine whether they meet the criteria of the person requiring treatment as defined by §401 of the MMHC.
- File a report to the court indicating the findings of the individual's condition and whether they meet § 401 criteria. If the person is determined to be a person requiring treatment, the court may direct the prosecutor to file a petition pursuant to §434 for an order of hospitalization.

The contractual provisions below describe the responsibilities of the NGRI Committee, CFP, regional hospitals (RH), and CMHSP in the coordination of care, treatment, and transition to community living.

2. Petitions of Involuntary Treatment / Assisted Outpatient Treatment Orders

Petitions for involuntary mental health treatment must accurately reflect the treatment the individual will receive. Petitions for hospitalization should only be filed if the person meets the criteria for in-patient hospitalization and will receive treatment in the hospital. If the person is going to receive treatment in the community, the petition must request AOT or combined AOT/hospitalization. This is the case regardless of an individual's NGRI status.

Individuals adjudicated NGRI may be discharged from a hospital on an AOT order. The NGRI Committee will collaborate with the CMHSP on the AOT order to ensure appropriate risk mitigation strategies are incorporated into the IPOS. The NGRI committee's involvement will end after the individual has been in the community for five continuous years on an AOT order. Nothing in this contract precludes the CMHSP from petitioning for an AOT order following NGRI involvement if the CMHSP determines it is clinically appropriate.

3. Roles and Responsibilities

a. NGRI Committee

- i. Consult with the supervisory level forensic psychiatrist to incorporate appropriate risk mitigation strategies into the IPOS. The risk mitigation strategies should be designed to promote the person's discharge to a less restrictive setting.
- ii. Receive clinical information from, and provide feedback to, the hospital treatment teams and the CMHSP on proposed changes to the IPOS as it relates to risk mitigation strategies.
- iii. Review and authorize request for discharges and LOAs based on whether the person continues to meet the criteria of a person requiring treatment pursuant to §401.
- iv. Submit requests for discharge or LOA for individuals charged with a violent crime to a forensic psychiatrist independent of the NGRI committee designated by the senior deputy director of the State Hospital Administration (SHA) in accordance with APF 106.
- v. Provide written notification to the person, hospital treatment team and CMHSP of the approval or disapproval of the requested discharge or LOA that includes a detailed reason for the decision and treatment recommendations that will lead the person towards approval.
- vi. Consult with the CMHSP on appropriate risk mitigation strategies to be included in an IPOS once a person is discharged to the community on an AOT order.
- vii. End NGRI involvement when the risk mitigation goals are met and the person no longer meets treatment criteria, or after five continuous years in the community whether on an AOT order or under an ALS contract, whichever happens first.

b. Hospital Treatment Team

- i. Consult with the supervisory level forensic psychiatrist to ensure risk mitigation strategies, based on the person's behavioral health needs, are addressed in the IPOS.
- ii. Consult with the CMHSP on an individualized pre-release plan for appropriate community placement and aftercare services appropriate for each person in accordance with §209a of the MMHC.
- iii. Request in writing a request for discharge or LOA to the NGRI committee in accordance with MDHHS Hospital Policy APF 106.
- iv. Provide advance notice to the CMHSP of a person's anticipated release to the community.
- v. Notify and provide a Petition for Discharge (PCM 220) to the person and their guardian, of the ability to file a petition for discharge in accordance with §484 of the MMHC if a discharge is denied by the NGRI Committee.
- vi. Notify the person and their guardian of the right to request an administrative review of a denial for discharge or LOA in accordance with MDHHS Hospital Policy APF 106.

- vii. Notify the NGRI committee of any significant changes in the behavioral or medical health status of the individual as its impacts risk mitigation.
- viii. Request an emergent consultation with the NGRI Committee as necessary.

c. Community Mental Health Service Providers

- i. Identify a primary and secondary Forensic Liaison that is primarily responsible for:
 - 1. Tracking, reviewing, and monitoring court documentation and statutorily required reports. See Exhibit A.
 - 2. Documenting and summarizing the risk mitigation strategies recommended by the NGRI Committee. These strategies will be monitored and submitted to Disability Rights Michigan by the NGRI Committee upon request.
 - 3. Notify the court pursuant to §475 of the MMHC when mental health professional who is supervising an individual's assisted outpatient treatment program determines that the individual is not complying with the court order or that the assisted outpatient treatment has not been or will not be sufficient to prevent harm that the individual may inflict on himself or herself or upon others.
 - 4. Notify the NGRI Committee as outlined in Exhibit B.
 - 5. Transition all ALS/hospitalization order to an AOT order with appropriate risk mitigation strategies incorporated into the IPOS at the expiration of a hospitalization order or upon request. AOT orders should only be pursued if the person meets the criteria for treatment.
 - 6. Ensure that each person currently in the community is provided a NGRI Handbook.
 - 7. Include the following language in the IPOS when there is NGRI committee oversight:

AOT IPOS Notification Language

As an individual adjudicated NGRI, risk mitigation strategies are incorporated into your IPOS. The NGRI Committee is consulted on these risk mitigation strategies, and the NGRI Committee reviews and approves your IPOS. These risk mitigation strategies cannot be restrictions that are not clinically indicated.

If you believe that your IPOS contains risk mitigations strategies or restrictions that are not related to your mental health treatment, or have other issues with your treatment, contact Disability Rights Michigan at 517-487-1755.

You also have the right to submit a complaint to the State Office of Recipient Rights. Phone number 1-800-854-9090, send written complaints to:

**Michigan Department of Community Health
Office of Recipient Rights
Lewis Cass Building-Garden Level
Lansing, MI 48933**

8. Notify people who have received treatment in the community for five years or longer that they are no longer under NGRI supervision.
- ii. Participate in prerelease planning services in accordance with §209a and §209b. This includes but is not limited to consulting with the hospital treatment team, the NGRI Committee, and the person on an individualized pre-release plan for appropriate community placement as well as appropriate aftercare services. The release plan must include individualized risk mitigation strategies as recommended by the NGRI Committee.
- iii. Supervise treatment and the individualized risk mitigation strategies in the IPOS in accordance with the individual's clinical needs. This includes, but is not limited to, developing and monitoring IPOS, medication management, providing day or residential programs, counseling, psychotherapy, and other treatment deemed necessary by the individual's treatment team.
- iv. Provide an opportunity to resolve disputes regarding the planning and provision of services and supports in accordance with MCL 330.1206a.
- v. Attend MDHHS trainings on NGRI processes.
- vi. Submit all petitions and reports by fax to the NGRI committee the Forensic Liaison at the responsible RH, and the person in accordance with Exhibit A.
- vii. All notification and authorization requirements are to be in writing and faxed to the NGRI Committee and Forensic Liaison as provided in Sec. 6 of this agreement.
- viii. Must seek authorization from the NGRI committee within 14 days of the recommended changes in treatment or living arrangements.
- ix. Must notify the NGRI Committee and Forensic Liaison at the RH within 72 hours of occurrence giving rise to the notification requirement described in Exhibit B.
- x. Will seek NGRI Committee Authorization or Notification as outlined in in Exhibit B.

- xi. If a person adjudicated NGRI is receiving treatment in the community on an AOT order and is determined to be on Unauthorized Leave of Absence, the CMH Forensic Liaison/designee will:
 - 1) Notify the NGRI Committee and SHA Regional Hospital Forensic Liaison as soon as possible but no later than 72 hours of determination of the ULOA status.
 - 2) Contact the local police to file a missing person's report.
 - 3) Report and any additional updates/information to the NGRI Committee and SHA Regional Hospital Forensic Liaison.
 - 4) Once the person is located, coordinate with local police and hospital personnel to facilitate admission if rehospitalization is indicated.
 - 5) If a determination has been made that the patient needs to be readmitted to CFP, send a CMH Approval Letter to the SHA Regional Hospital Forensic Liaison to facilitate the administrative transfer process.
- xii. If a person adjudicated NGRI is receiving treatment in the community on an AOT order or in LOA status, and is displaying a dangerous behavior or poses a safety risk that may require rehospitalization, the CMH Forensic Liaison/designee will:
 - 1) Secure local hospitalization to ensure stability and inform the local hospital that patient is on a current court order.
 - 2) Notify the NGRI Committee and SHA Regional Hospital Forensic Liaison of the circumstances.
 - 3) Maintain contact with the RH staff and convey information to the NGRI Committee and SHA Regional Hospital Forensic Liaison.
 - 4) If stabilization cannot occur locally and additional hospitalization is required, will coordinate with the RH admissions staff and the NGRI Committee to secure a bed at a RH.
 - 5) Upon securing a bed at a RH, prepare a rehospitalization packet and arrange admission.
 - 6) If the person needs to be readmitted to CFP, provide a CMH Approval Letter to the hospital to facilitate the administrative transfer process.

4. Notices

All notices and other communications required or permitted under this Contract must be in writing and will be considered given and received when:

- Verified by written receipt if sent by courier.
- Received if sent by mail without verification of receipt; or
- Verified by automated receipt or electronic logs if sent by facsimile or email

NGRI Committee

Insert Fax/ phone/email

CMH Forensic Liaison

Insert Fax/ phone/email

EXHIBIT A

Court Documentation and Reporting

CMH required court forms and Reports	When	Court Form	MCL /MCR
Order and Report on Alternative Mental Health Treatment	14 prior to the expiration of the current order	PCM 216	330.1453a, 330.1468 MCR 5.741
Petition for continuing Mental Health Treatment Order	14 days prior to expiration of current order	PCM 218a	MCL 330.1472a, MCL 330.1473
Ninety-day reports	90 days and 270 days after the date the current order was signed	x	x
(3) Thirty - Day Reports when individuals are released to community directly from CFP.	At 30, 90 and 120 days from the date of release.		

Exhibit B

Authorization from NGRI Committee 14 days prior to event.		Notification to NGRI/RH Forensic Liaison within 72 hours.
Significant changes in treatment plans		Any significant changes in the behavioral or medical health status of the individual.
Overnight leaves of absence from the designated living setting		Community Hospital Admissions, including the reason for the hospitalizations, facility name, date of admission and date of discharge
Movement between dependent living settings		Contacts with law enforcement
Any changes from one independent setting to another		Any change in case manager or case management providers/ contractual agencies
Any change in the patients permanent living address		
Permission to leave the state of Michigan		

EXHIBIT C

SAMPLE 30/90 DAY REPORT

EXHIBIT D

Community Leave of Absence Request

Exhibit E

Flow Chart

CMHSP/Contractual CMH Agency 30 or 90 Day Progress Report

☐ 30 Day Report

☐ 90-Day Report

MEMORANDUM

To: NGRI Committee
Center for Forensic Psychiatry
Box 2060
Ann Arbor, MI 48106-2060
Phone: (734)295-4295/(734)295-4328
Fax: (734) 429-0487

FROM: Aftercare Agency Representative Name
Agency Address
Phone Number
Email Address
Fax Number

DATE:

RE: Patient's Name, DOB, CFP Number

Date of most recent release to community from state hospital setting:

- 1. The patient was adjudicated NGRI on charges(s) of:**
- 2. Present mental status:** *(Clinical assessment including individual's appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment, suicidal or homicidal ideation)*
 - Customize to individual's pattern of symptoms, note any changes in acuity, and indicate status of persistent, long-standing symptoms if present.
- 3. Current Medication List:**
 - Include all medications and dosages (psychotropic and medical)
 - Please identify all recent medication changes/dosage adjustments, and rationale for changes.
- 4. Living arrangements, level of care, and current address:**

5. Describe therapeutic services:

- Frequency of individual and group sessions, day treatment/clubhouse participation, substance abuse treatment, Urine Drug Screens, work hours

6. Describe patient's progress towards treatment goals in IPOS:

- Level of participation/engagement in treatment

7. Additional comments/concerns:

Signature: _____ **Date:** _____
Printed name

Cc: Supervising Hospital

CMHSP/Contractual CMH Agency NGRI Request Form

☐ LOA Request ☐ Move Request ☐ Special Request

MEMORANDUM

To: NGRI Committee
Center for Forensic Psychiatry
Box 2060
Ann Arbor, MI 48106-2060
Phone: (734)295-4295/(734)295-4328
Fax: (734)429-0487

FROM: Aftercare Agency Representative Name
Agency Address
Phone Number
Email Address
Fax Number

DATE:

RE: Patient's Name, DOB, CFP Number

Date of most recent release to community from state hospital setting:

- 1. The patient was adjudicated NGRI on charges(s) of:**
- 2. Present mental status:** *(Clinical assessment including individual's appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgment, suicidal or homicidal ideation)*
 - Customize to individual's pattern of symptoms, note any changes in acuity, and indicate status of persistent, long-standing symptoms if present.
- 3. Current Medication List:**
 - Include all medications and dosages (psychotropic and medical)
 - Please identify all recent medication changes/dosage adjustments, and rationale for changes.
- 4. Living arrangements, level of care, and current address:**

5. Describe therapeutic services:

- Frequency of individual and group sessions, day treatment/clubhouse participation, substance abuse treatment, Urine Drug Screens, work hours

6. Describe patient's progress towards treatment goals in IPOS:

- Level of participation/engagement in treatment

7. Request:

☐ LOA (*date, location, purpose, degree of supervision, etc.*)

- Does individual who is monitoring patient on LOA understand the patient's illness and warning signs? Have they been involved in treatment?
- How will patient get to LOA (family picks up/public transportation/etc)?
- Prior successful LOAs? Any concerns/problematic behavior on previous LOAs?
- Please make note of any special considerations that may impact this individual (PPOs, Crime Victim Notifications, Limitations on unsupervised contacts, etc)
- Include Emergency Plan
- Does team support request?

☐ Move Request

- Provide rationale why move is indicated
- Please include proposed level of supervision/level of care/frequency of services/who will be living in residence/etc.
- Please make note of any special considerations that may impact this individual (PPOs, Crime Victim Notifications, Limitations on unsupervised contacts, etc)
- Does team support request?

☐ Special Request _____

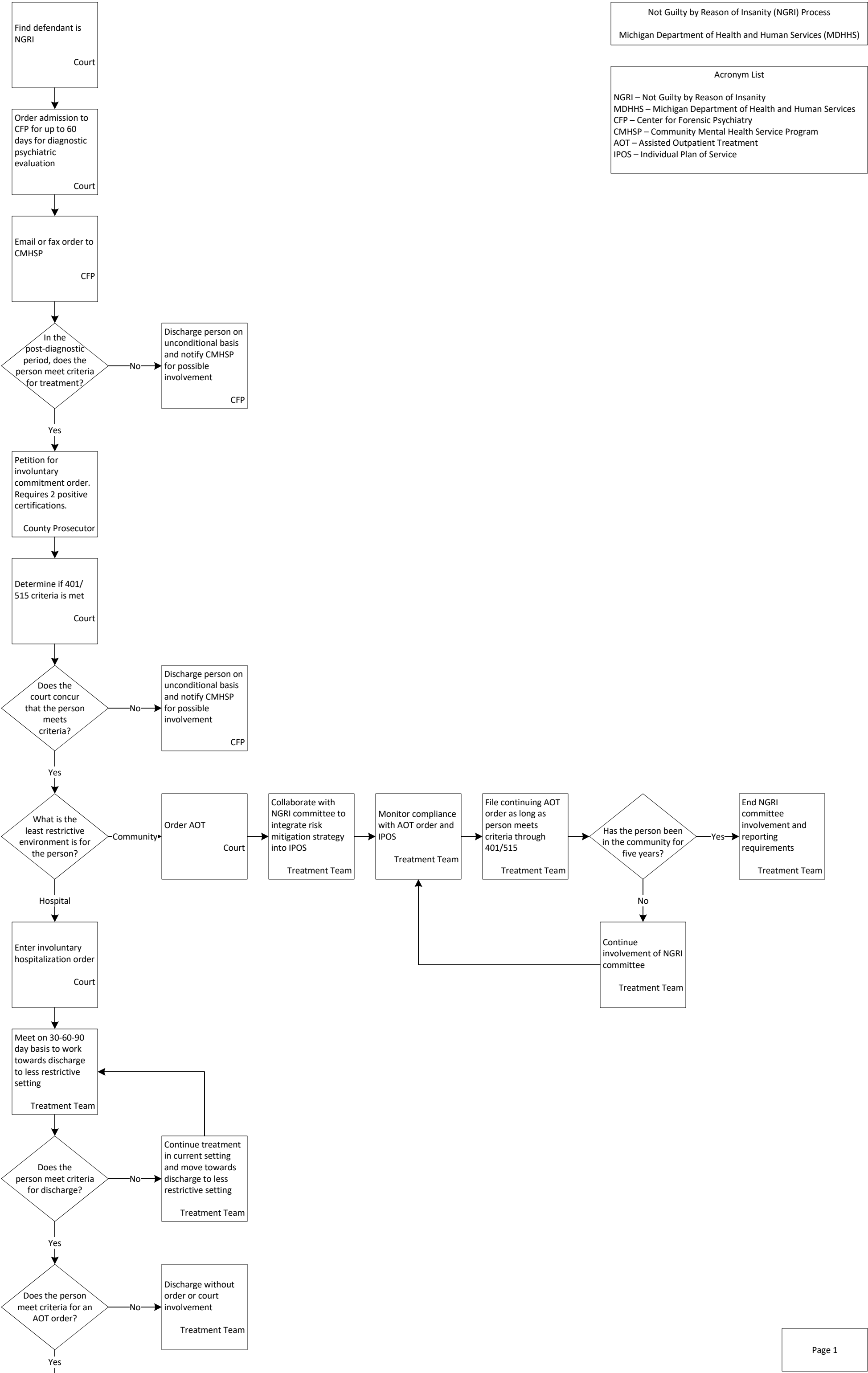
- Level of Service change (Please include level of supervision/frequency of services/why indicated)
- Employment Request-if approval indicated in IPOS (Please describe in detail type of employment, number of hours, shift hours)
- Does team support request?

Signature: _____

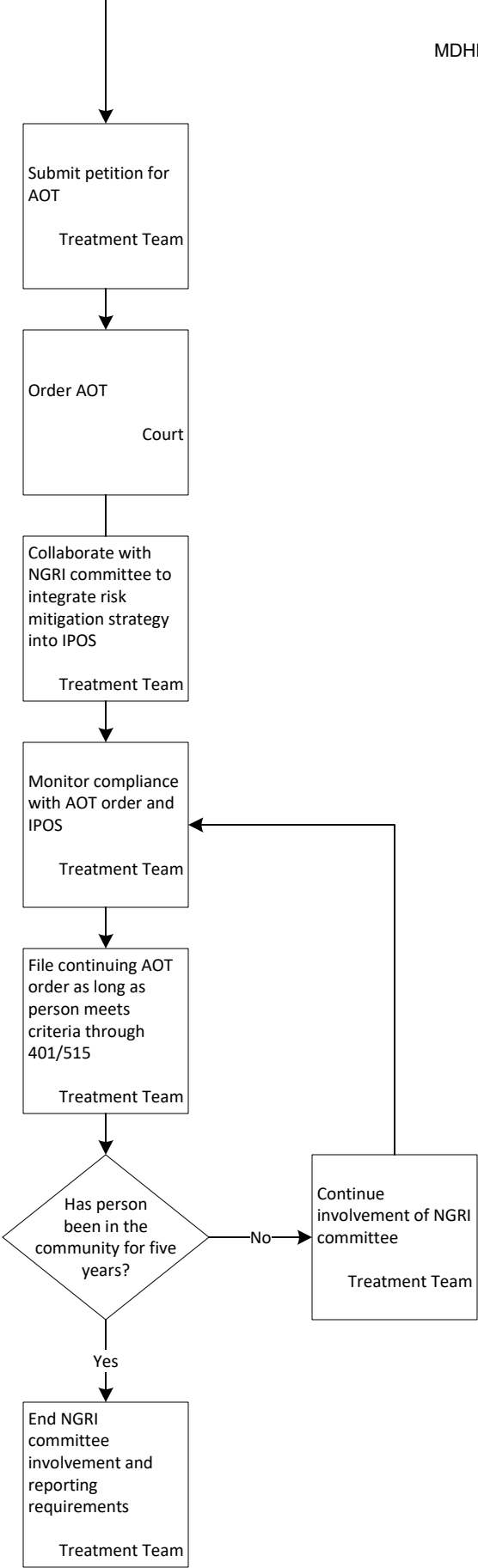
Printed name

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**DEPARTMENT OF HEALTH & HUMAN SERVICES
STATE FACILITY ATTACHMENT
October 1, 2013**

Purpose of Attachment

Section 6.9.1 of the MDHHS/CMHSP Managed Mental Health Supports and Services Contract requires Community Mental Health Services Programs (CMHSPs) to authorize medically necessary inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. It further requires CMHSPs to participate in treatment planning, treatment monitoring and other related activities at agreed upon intervals and authorize medically necessary continued stay. This attachment outlines the responsibilities of the Department of Health and Human Services and the Community Mental Health Services Program with respect to State Facility use.

I. Responsibility of the State Facility

- A. The Department's State Facilities shall provide appropriate services to Consumers served by the State Facility in all its inpatient service settings.
- B. The Department's State Facilities shall inform the individual designated by the CMHSP Executive Director of any significant change in the mental or physical condition or mental health service requirements of a Consumer at the State Facility, including any unusual incidents, i.e. elopement, serious self-harm, injury and death, according to the procedures specified in this attachment.
- C. The Department's State Facilities shall provide access to all essential information, including clinical and service records and billing records and billing source data, to authorized representatives of the CMHSP for the purpose of participating in treatment planning, monitoring and reviewing the provision of services by the State Facility to Consumers, under the terms of this attachment.

II. Responsibilities of the CMHSP

- A. The CMHSP shall serve as the single point of entry to and exit from the State Facility for all of consumers of the CMHSP.
- B. The CMHSP shall advise all Consumers applying for admission to the State Facility that joint treatment planning will occur between the State Facility and the CMHSP staff.
- C. The CMHSP shall evaluate and screen all requests for admittance of its consumers to the State Facility. The CMHSP shall provide the State Facility with:
 - 1. Evaluations and recommendations for admission to the State Facility;
 - 2. A report of all known medical issues related to the consumer;
 - 3. The consumer's most recent individual plan of service as applicable; and
 - 4. A list of the consumer's medications, as well as information on any medication tapering plans or history of failed trials of monotherapy.

- D. The CMHSP shall participate in the development of the Individual Plan of Service (IPOS) for consumers by the State Facility under this attachment, utilizing the Person-Centered Planning (PCP) process.
- E. The CMHSP shall lead in planning for and arranging appropriate community placement services and facilitating the discharge planning of its consumers from the State Facility.
- F. The CMHSP shall be responsible for making determinations on its authorizations, in advance, for consumers as to all admissions of and continued stay at the State Facility, according to the procedures specified in this attachment. The CMHSP shall be responsible for the preparation of an alternative treatment plan and report(s) pertaining to consumers.
- G. The CMHSP may enter into subcontracts and have a contract provider carry out the CMHSP duties designated in this Agreement. However, the duties remain the responsibility of the CMHSP, and the CMHSP is responsible for providing and keeping the State Facility updated with a list of authorized subcontractors.

III. Liaisons

The CMHSP Executive Director and the Department's State Facilities Directors shall designate specific members of their staff who shall serve as liaisons between the parties. The primary objective of these staff shall be to facilitate the ongoing working relationship between the parties hereto and their staff, and the implementation and monitoring of the terms and conditions of this attachment. The CMHSP Executive Director and the State Facility Directors shall provide each other with an updated list of staff members having liaison responsibilities, a written description of their liaison responsibilities, duties and functions, the programs for which they work, and the phone numbers and office hours for the staff and programs.

IV. Services and Coordination

Under this attachment is the intent of the CMHSP and the State Facility to promote cooperation, collaboration and coordination among their respective representatives for the benefit of the mutual mental health provisions for consumers and residents.

A. PRE-ADMISSION SCREENING

The CMHSP shall evaluate and screen consumers who present themselves or are presented in the community or at the State Facility for potential admission to the State Facility. Any determination to hospitalize a CMHSP consumer at the State Facility shall be based on evaluation and screening conducted in accordance with Chapter 4 ("Civil Admission and Discharge Procedures: Mental Illness"), Chapter 4A ("Civil Admission and Discharge Procedures for Emotionally Disturbed Minors"), or Chapter 5 ("Civil

Admission and Discharge Procedures: Developmentally Disabilities”) of the Michigan Mental Health Code.

B. SERVICE UTILIZATION

1. The CMHSP authorization of admission and continued stay at the State Facility constitutes the basis on which the CMHSP shall reimburse the MDHHS for the fixed net state cost of inpatient services provided at the State Facility. The CMHSP authorizations shall be conveyed in written form to the State Facility, and shall accompany the consumer upon admission to the State Facility.

Any CMHSP authorization of continued stay of a CMHSP consumer at the State Facility shall be based upon the continued need of the individual for inpatient services at the State Facility and established after reviewing the clinical status of the individual and consultation with the State Facility staff. The CMHSP and the State Facility agree that continued stay will be authorized so long as the requirements for medical necessity are met and the CMHSP cannot implement an alternative that provides the Consumer with the appropriate level of care.

If a Consumer is involuntarily court-ordered for admission to the State Facility, the CMHSP shall be considered as having authorized the admission for purposes of billing. If the admission is not accompanied by a CMHSP authorization, the Facility will notify the CMHSP of the admission, within three (3) business days of the admission, with a request for an authorization of continued treatment or plan for discharge. The facility may bill the CMHSP for the period from admission through the first business day of service without specific authorization and for the services provided from the date of notification until discharge as specified in the CMHSP plan.

2. The MDHHS shall bill the CMHSP only for daily units of services actually rendered by the State Facility for the CMHSP consumers. The CMHSP and the State Facility agree that the actual total number of days of service provided by the State Facility, pursuant to the MDHHS/CMHSP Contract and this attachment, are subject to verification from billings and statistical data from the MDHHS and from State Facility service documentation accessible for review by the CMHSP staff.

The State Facility shall provide information to the MDHHS Accounting Division that specifies the type, amount, and the days of each contractual service provided, to enable the MDHHS to bill the CMHSP for billable services provided by the State Facility to consumers and to enable the CMHSP to continuously monitor State Facility utilization and to continuously track services and all incurred costs of the services. All such information shall be provided to the CMHSP by the State Facility within ten (10) business days following the completion of each service month that this attachment remains in effect.

C. COORDINATION OF TREATMENT PLANNING AND SERVICES

The CMHSP and the State Facility shall exchange clinical information and cooperate mutually in treatment planning and services, including as follows:

1. The CMHSP shall provide the State Facility with relevant mental, physical, education, social histories, and testing data, etc. for consumers who have had treatment in CMHSP programs and services. As soon as possible, but not later than five (5) business days after the admission of a CMHSP consumer to the State Facility, the State Facility shall be provided with the CMHSP's determination of the presenting problem and/or behavior that led to hospitalization, projected length of stay, objectives to be accomplished during hospitalization, possible community placements, and community treatment alternatives upon discharge from the State Facility.
2. The CMHSP shall be provided access to the State Facility treatment staff for consultation about the status of CMHSP consumers who are patients or residents of the State Facility, and shall be provided access to the CMHSP consumers at the State Facility, upon reasonable notice.
3. The CMHSP is responsible for all guardianship matters concerning its consumers, including hearings. The State Facility will support the CMHSP as necessary with regard to documents and issues.
4. If an individual is admitted to the State Facility on an Incompetent to Stand Trial (IST) order, the State Facility shall actively pursue a release of information at the time of admission to ensure early involvement of the CMHSP.
5. The State Facility shall involve the CMHSP in ongoing joint treatment team meetings for consumers who are CMHSP consumers. The State Facility will also provide reasonable notice of treatment team meetings for all CMHSP consumers, including new consumers.
6. The CMHSP, in concert with the State Facility, shall assess the discharge potential of each CMHSP consumer currently hospitalized at the State Facility at each treatment team meeting. For consumers on Not Guilty by Reason of Insanity (NGRI) status, the State Facility agrees to abide by the terms and conditions of the NGRI Agreement, which is Attachment C.6.9.1.1 of the MDHHS/CMHSP contract.
7. If a CMHSP consumer's planned discharge is delayed, the State Facility staff designated to coordinate the discharge shall inform the CMHSP as to the cause and anticipated duration of the delay, so that placement can still be facilitated by the CMHSP.

D. DISCHARGE PLANNING AND COMMUNITY PLACEMENT

The State Facility hereby assures the CMHSP that all requests for consumer discharge will be processed and coordinated through its responsible treatment teams and, if applicable, the designated placement review committee, with the involvement of CMHSP staff, as applicable, for all CMHSP consumers who no longer meet the criteria for admission as established in Chapter 4, Chapter 4A, or Chapter 5, respectively, of the Michigan Mental Health Code. It shall be the responsibility of the CMHSP to plan and implement community placement for each of its consumers discharged from the State Facility.

1. The process involving all requests for discharge and placement of CMHSP consumers shall include the following:
 - To facilitate an orderly transition from the State Facility to community settings, the appropriate representatives of the CMHSP and the State Facility shall participate in the consumer's discharge planning process.
 - The CMHSP shall coordinate discharge planning with the State Facility.
 - The CMHSP shall submit a discharge plan that will address specific services appropriate to the needs of the Consumer upon discharge from the State Facility.
 - The State Facility will include all discharge planning information contained in the Person-Centered Planning (PCP) process documents.
 - It is expected that if the State Facility agrees with the CMHSP discharge plans, it will support the CMHSP in coordinating the discharge.
2. In those instances when the CMHSP has determined a consumer is ready for discharge from the State Facility, but the State Facility disagrees, the consumer shall be discharged AMA (against medical advice).
3. In the case of a disagreement on the suitability for discharge from the State Facility of a CMHSP consumer who is judicially admitted, the CMHSP may seek relief through a re-determination by the Probate Court.
4. The State Facility shall consult with the CMHSP prior to any decision to place a CMHSP consumer on convalescent status with the State Facility.
5. The State Facility shall provide the CMHSP with discharge information for a CMHSP consumer and with discharge summaries, including medical information, immediately upon discharge.
6. When medically appropriate, the State Facility will provide a one-week (7 days) supply of medication and, in addition, a prescription for a two-week

(14 days) supply of medication. The CMHSP may request a prescription for an additional two (2) weeks. If medication will not be provided, the CMHSP will be informed prior to discharge. The CMHSP psychiatrist is responsible to write prescriptions within the first two (2) weeks following discharge. The CMHSP may request the assistance of a prescription from the State Facility.

7. When a CMHSP consumer, under the age of twenty-six (26), is being discharged from the State Facility, the State Facility shall notify the respective Intermediate School District (ISD) of the consumer's discharge from the State Facility. Upon discharge of the consumer from the State Facility, the CMHSP shall assume responsibility for the coordination of services between the local ISD and the CMHSP.

E. TRANSFER OF CMHSP CONSUMERS FROM A STATE FACILITY TO ANOTHER STATE FACILITY

1. In the case of a court-ordered transfer of a CMHSP consumer from the State Facility to another State Facility for inpatient care, the State Facility will provide the CMHSP with an informational notice of any court-ordered transfers. This notice will be provided within five (5) business days following issuance of the court's transfer order.
2. If a CMHSP consumer makes an election of placement permitted by the Mental Health Code or Administrative Rules, the State Facility will provide notice to the CMHSP of the request for a transfer.
3. A CMHSP consumer may be discharged from the State Facility for subsequent transfer to an inpatient or residential care unit of a non-state hospital/center upon written request and approval of the CMHSP.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Developmental Disabilities Administration

HOUSING PRACTICE GUIDELINE

NOTE: Replicated from the Michigan Department of Health and Human Services (MDHHS) Housing Guideline as included in the Public Mental Health Code Manual, Volume III, Section 1708, Subject GL-05, Chapter 07-C.

I. SUMMARY

This guideline establishes policy and procedure for ensuring that the provision of mental health services and supports are not affected by where individuals choose to live: their own home, the home of another, or in a licensed setting. In those instances when public money helps subsidize an individual's living arrangement, the housing unit selected by the individual shall comply with applicable occupancy standards.

II. APPLICATION

- a. Psychiatric hospitals operated by the MDHHS.
- b. Special facilities operated by the MDHHS.
- c. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) as specified in their contracts with the MDHHS.

III. POLICY

The MDHHS recognizes housing to be a basic need and affirms the right of all individuals of public mental health services to pursue housing options of their choice. Just as individuals living in licensed dependent settings may require many different types of services and supports, individuals living in their own homes or sharing their household with another individual may have similar service needs. RHMAAs shall foster the provision of services and supports independent of where the individual resides.

When requested, RHMAAs shall educate individuals about the housing options and supports available, and assist individuals in locating habitable, safe, and affordable housing. The process of locating suitable housing shall be directed by the individual's interests, involvement, and informed choice. Independent housing arrangements in which the cost of housing is subsidized by the PIHP and CMHSP are to be secured with a lease or deed in the individual's name.

This guideline is not intended to subvert or prohibit occupancy in or participation with community-based treatment settings, such as an adult foster care home, when needed by an individual recipient.

IV. DEFINITIONS

Affordable: is a condition that exists when an individual's means or the combined household income of several individuals is sufficient to pay for food, basic clothing, healthcare, and personal needs and still have enough left to cover all housing related costs including rent/mortgage, utilities, maintenance, repairs, insurance, and property taxes. In situations where there are insufficient resources to cover both housing costs and basic living costs, individual housing subsidies may be used to bridge the gap when they are available.

Habitable and safe: means those housing standards established in each community that define and require basic conditions for tenant/resident health, security, and safety.

Housing: refers to dwellings that are typical of those sought out and occupied by members of a community. The choices an individual of mental health services makes in meeting his/her housing needs are not to be linked in any way to any specific program or support service needs he/she may have.

Responsible Mental Health Agency (RMHA): means the MDHHS hospital, center, PIHP, or CMHSP responsible for providing and contracting for mental health services and/or arranging and coordinating the provision of other services to meet the individual's needs.

V. STANDARDS

RMHAs shall develop policies and create mechanisms that predominantly consider an individual's choice in selecting where and with whom they live. These policies and mechanisms shall also:

- A. Ensure that RMHA-supported housing blends into the community. Supported housing units are to be scattered throughout a building, complex, or the community to achieve community integration when possible. Use of self-contained campuses or otherwise segregated buildings as service sites is not the preferred mode.
- B. Promote and support home ownership, individual choice, and autonomy. The number of individuals who live together in RMHA-supported housing shall not exceed the community's norms for comparable living settings.
- C. Assure that any housing arranged or subsidized by the RMHA is accessible to the individual and in compliance with applicable state and local standards for occupancy, health, and safety.
- D. Be sensitive to the individual's cultural and ethnic preferences and give consideration to them.
- E. Encourage and support the individual's self-sufficiency.
- F. Provide for ongoing assessment of the individual's housing needs.

- G. Assist individuals in coordinating available resources to meet their basic housing needs. RMHAs may consider the use of housing subsidies when individuals have a need for housing that cannot be met by the other resources which are available to them.

VI. REFERENCES AND LEGAL AUTHORITY

MCL 330.1116(j)

VII. EXHIBITS

Federal Housing Subsidy Quality Standards based on 24 CFR § 882.10

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Developmental Disabilities Administration

INCLUSION PRACTICE GUIDELINE

I. SUMMARY

This guideline establishes policy and standards to be incorporated into the design and delivery of all public mental health services. Its purpose is to foster the inclusion and community integration of recipients of mental health service.

II. APPLICATION

- a. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).
- b. Regional centers for developmental disabilities and community placement agencies operated by the MDHHS.
- c. Children's psychiatric hospitals operated by the MDHHS.
- d. Special facilities operated by the MDHHS.
- e. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) as specified in their contracts with the MDHHS.

III. POLICY

It is the policy of the MDHHS to support inclusion of all recipients of public mental health services.

No matter where individuals live or what they do, all community members are entitled to fully exercise and enjoy the human, constitutional, and civil rights which collectively are held in common. These rights are not conditional or situational. They are constant throughout our lives. Ideally, they are also unaffected if a member receives services or supports from the public mental health system for a day or over a lifetime. In addition, by virtue of an individual's membership in his/her community, he/she is entitled to fully share in all the privileges and resources that the community has to offer.

IV. DEFINITIONS

Community: refers to both society in general and the distinct cities, villages, townships, and neighborhoods where individuals, under a local government structure, come together and establish a common identity, develop shared interests, and share resources.

Inclusion: means recognizing and accepting individuals with mental health needs as valued members of their community.

Integration: means enabling mental health service recipients to become, or continue to be, participants and integral members of their community.

Normalization: means rendering services in an environment and under conditions that are culturally normative. This approach not only maximizes an individual's opportunities to learn, grow, and function within generally accepted patterns of human behavior, but it also serves to mitigate social stigma and foster inclusion.

Self-determination: means the right of a recipient to exercise his/her own free will in deciding to accept or reject, in whole or in part, the services which are being offered. Individuals cannot develop a sense of dignity unless they are afforded the freedom and respect that comes from exercising opportunities for self-determination.

Self-representation: means encouraging recipients, including those who have guardians or employ the services of advocates, to express their own point of view and have input regarding the services that are being planned or provided by the Responsible Mental Health Agency (RMHA).

V. STANDARDS

- a. Responsible PIHPs and CMHSPs shall design their programs and services to be congruent with the norms of their community.

This includes giving first consideration to using a community's established conventional resources before attempting to develop new ones that exclusively or predominantly serve only mental health recipients.

Some of the resources which can be used to foster inclusion, integration, and acceptance include the use of the community's public transportation services, leisure and recreation facilities, general health care services, employment opportunities (real work for real pay), and traditional housing resources.

- b. PIHPs and CMHSPs shall organizationally promote inclusion by establishing internal mechanisms that:
 - i. assure all recipients of mental health services will be treated with dignity and respect.
 - ii. assure all recipients, including those who have advocates or guardians, have genuine opportunities for consumer choice and self-representation.
 - iii. provide for a review of recipient outcomes.
 - iv. provide opportunities for representation and membership on planning committees, work groups, and agency service evaluation committees.
 - v. invite and encourage recipient participation in sponsored events and activities of their choice.

- c. PIHPs and CMHSPs shall establish policies and procedures that support the principle of normalization through delivery of clinical services and supports that:
 - i. address the social, chronological, cultural, and ethnic aspects of services and outcomes of treatment.
 - ii. help recipients gain social integration skills and become more self-reliant.
 - iii. encourage and assist adult recipients to obtain and maintain integrated, remunerative employment in the labor market(s) of their communities, irrespective of their disabilities. Such assistance may include, but is not limited to, helping them develop relationships with co-workers both at work and in non-work situations. It also includes making use of assistive technology to obtain or maintain employment.
 - iv. assist adult recipients to obtain/maintain permanent, individual housing integrated in residential neighborhoods.
 - v. help families develop and utilize both informal interpersonal and community-based networks of supports and resources.
 - vi. provide children with treatment services which preserve, support, and, in some instances, create by means of adoption, a permanent, stable family.
- d. PIHPs and CMHSPs shall establish procedures and mechanisms to provide recipients with the information and counsel they need to make informed treatment choices. This includes helping recipients examine and weigh their treatment and support options, financial resources, housing options, education options, and employment options. In some instances, this may also include helping recipients:
 - i. learn how to make their own decisions and take responsibility for themselves.
 - ii. understand his/her social obligations.

VI. REFERENCES AND LEGAL AUTHORITY

MCL 330.116, et seq. MCL 330.1704, et seq.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Developmental Disabilities Administration

CONSUMERISM PRACTICE GUIDELINE

I. SUMMARY

This guideline sets policy and standards for consumer inclusion in the service delivery design and delivery process for all public mental health services. This guideline ensures the goals of a consumer-driven system which gives consumers choices and decision-making roles. It is based on the active participation by primary consumers, family members, and advocates in gathering consumer responses to meet these goals.

This participation by consumers, family members, and advocates is the basis of a provider's evaluation. Evaluation also includes how this information guides improvements.

II. APPLICATION

- A. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).
- B. Centers for individuals with developmental disabilities (DD) and community placement agencies operated by the MDHHS.
- C. Children's psychiatric hospitals operated by the MDHHS.
- D. Special facilities operated by the MDHHS.
- E. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) under contract with the MDHHS.
- F. All providers of mental health services who receive public funds, either directly or by contract, grant, or third-party payers including managed care organizations (MCOs) or other reimbursements.

III. POLICY

This guideline supports services that advocate for and promote the needs, interests, and well-being of primary consumers. It is essential that consumers become partners in creating and evaluating these programs and services. Involvement in treatment planning is also essential.

Services need to be consumer-driven and may also be consumer-run. This guideline supports the broadest range of options and choices for consumers in services. It also supports consumer-run programs which empower consumers in decision-making of their own services.

All consumers need opportunities and choices to reach their fullest potential and live independently. They also have the rights to be included and involved in all aspects of society.

Accommodations shall be made available and tailored to the needs of consumers as specified by consumers for their full and active participation as required by this guideline.

IV. DEFINITIONS

Informed Choice: an individual receives information and understands his/her options.

Primary Consumer: an individual who receives services from the MDHHS, the PIHP, or the CMHSP and an individual who has received the equivalent mental health services from the private sector.

Consumerism: active promotion of the interests, service needs, and rights of mental health consumers.

Consumer-Driven: any program or service focused and directed by participation from consumers.

Consumer-Run: any program or service operated and controlled exclusively by consumers.

Family Member: a parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer and any individual upon whom a primary consumer depends for 50 percent or more of his/her financial support.

Minor: an individual under the age of 18 years.

Family Centered Services: services for families with minors which emphasize family needs and desires with goals and outcomes defined. Services are based on families' strengths and competencies with active participation in decision-making roles.

Person-Centered Planning (PCP): the process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life. It honors the individual's preferences, choices, and abilities.

Person-First Language: refers to an individual first before any description of disability.

Recovery: means the process of personal change in developing a life of purpose, hope, and contribution. The emphasis is on abilities and potentials. Recovery includes positive expectations for all consumers. Learning self-responsibility is a major element to recovery.

V. STANDARDS

A. All services shall be designed to include ways to accomplish each of these standards.

1. "Person-First Language" shall be utilized in all publications, formal communications, and daily discussions.
 2. Provide informed choices through information about available options.
 3. Respond to an individual's ethnic and cultural diversities. This includes the availability of staff and services that reflect the ethnic and cultural makeup of the service area. Interpreters needed in communicating with non-English and limited-English-speaking consumers shall be provided.
 4. Promote the efforts and achievements of consumers through special recognition of consumers.
 5. Through customer satisfaction surveys and other appropriate individual related methods, gather ideas and responses from consumers concerning their experiences with services.
 6. Involve consumers and family members in evaluating the quality and effectiveness of service. Administrative mechanisms used to establish service must also be evaluated. The evaluation is based upon what is important to consumers, as reported in customer satisfaction surveys.
 7. Advance the employment of consumers within the mental health system and in the community at all levels of positions including mental health service provision roles.
- B. Services, programs, and contracts concerning consumers with mental illness and related disorders shall actively strive to accomplish these goals.
1. Provide information to reduce the stigma of mental illness that exists within communities, service agencies, and among consumers.
 2. Create environments for all consumers in which the process of "recovery" can occur. This is shown by an expressed awareness of recovery by consumers and staff.
 3. Provide basic information about mental illness, recovery, and wellness to consumers and the public.
- C. Services, programs, and contracts concerning individuals with DD shall be based upon these elements.
1. Provide personal preferences and meaningful choices with consumers in control over the choice of services and supports.
 2. Through educational strategies: promote inclusion, both personal and in the community; strive to relieve disabling circumstances; actively work to prevent occurrence of increased disability; and promote consumers in exercising their abilities to their highest potentials.

3. Provide roles for consumers to make decisions in policies, programs, and services that affect their lives including PCP processes.
- D. Services, programs, and contracts concerning minors and their families shall be based upon these elements:
1. Services shall be delivered in a family-centered approach, implementing comprehensive services that address the needs of the minor and his/her family.
 2. Services shall be individualized and respectful of the minor and family's choice of services and supports.
 3. Roles for families to make decisions in policies, programs, and services that affect their lives and the minor's life.
- E. Consumer-run programs shall receive the same consideration as all other providers of mental health services. This includes these considerations:
1. Clear contract performance standards.
 2. Fiscal resources to meet performance expectations.
 3. A contract liaison individual to address the concerns of either party.
 4. Inclusion in provider coordination meetings and planning processes.
 5. Access to information and supports to ensure sound business decisions.
- F. Current and former consumers, family members, and advocates must be invited to participate in implementing this guideline. Provider organizations must develop collaborative approaches for ensuring continued participation.

Organizations' compliance with this guideline shall be locally evaluated. Foremost, this must involve consumers, family members, and advocates. Providers, professionals, and administrators must be also included. The CMHSP shall provide technical assistance. Evaluation methods shall provide constructive feedback about improving the use of this guideline. This guideline requires that it be part of the organization's Continuous Quality Improvement.

VI. REFERENCES AND LEGAL AUTHORITY

Act 258, Section 116(e), Public Acts of 1974 as amended, being MCL 330.1116, 1704, 1708.

Adult Jail Diversion Policy Practice Guideline February 2005

I. Statement of Purpose

There is a general consensus with the principle that the needs of the community and society at large are better served if persons with serious mental illness, serious emotional disturbance or developmental disability who commit crimes are provided effective and humane treatment in the mental health system rather than be incarcerated by the criminal justice system. It is recognized that many people with serious mental illness have a co-occurring substance disorder.

This practice guideline reflects a commitment to this principle and conveys Michigan Department of Health and Human Services (MDHHS) jail diversion policy and resources for Community Mental Health Services Programs (CMHSPs). The guideline is provided as required under the authority of the Michigan Mental Health Code, PA 258 of 1974, Sec. 330.1207.

Section 207 of the Code states:

“Each community mental health service program shall provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate. These services shall be consistent with policy established by the department.”

The guideline outlines CMHSP responsibilities for providing jail diversion programs to prevent incarceration of individuals with serious mental illness or developmental disability who come into contact with the criminal justice system.

Jail diversion programs are intended for individuals alleged to have committed misdemeanors or certain, usually non-violent, felonies and who voluntarily agree to participate in the diversion program.

II. Definitions

The following terms and definitions are utilized in this Practice Guideline:

Arraignment: The stage in the court process where the person is formally charged and enters a plea of guilty or not guilty.

Booking: The stage in the law enforcement custody process following arrest, when the individual is processed for formal admission to jail.

CMHSP: Community Mental Health Services Program. A program operated under Chapter 2 of the Mental Health Code as a county mental health agency, a community mental health organization or a community mental health authority.

Co-Occurring Disorder: A dual diagnosis of a mental health disorder and a substance disorder.

GAINS Center: SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation ([GAINS Center for Behavioral Health and Justice Transformation | SAMHSA](#)) focuses on

expanding access to services with mental and/or substance use disorders who come into contact with the adult criminal justice system.

In-jail Services: Programs and activities provided in the jail to address the needs of people with serious mental illness, including those with a co-occurring substance use disorder, or a developmental disability. These programs or activities vary across the state and may include crisis intervention, screening, assessment, diagnosis, evaluation, case management, psychiatric consultation, treatment, medication monitoring, therapy, education and training. Services delivered are based on formal or informal agreements with the justice system.

Jail Diversion Training: Cross training of law enforcement, court, substance abuse and mental health personnel on the diversion system and how to recognize and treat individuals exhibiting behavior warranting jail diversion intervention.

Jail Diversion Program: A program that diverts individuals with serious mental illness (and often co-occurring substance use disorder) or developmental disability in contact with the justice system from custody and/or jail and provide linkages to community-based treatment and support services. The individual thus avoids or spends a significantly reduced time period in jail and/or lockups on the current charge. Depending on the point of contact with the justice system at which diversion occurs, the program may be either a **pre-booking or post-booking** diversion program. Jail diversion programs are intended for individuals alleged to have committed misdemeanors or certain, usually non-violent, felonies and who voluntarily agree to participate in the diversion program.

Post-booking Diversion program: Diversion occurs after the individual has been booked and is in jail, out on bond, or in court for arraignment. Often located in local jails or arraignment courts, post-booking jail diversion programs staff work with stakeholders such as prosecutors, attorneys, community corrections, parole and probation officers, community-based mental health and substance abuse providers and the courts to develop and implement a plan that will produce a disposition outside the jail. The individual is then linked to an appropriate array of community-based mental health and substance abuse treatment services.

Pre-booking Diversion Program: Diversion occurs at the point of the individual's contact with law enforcement officers before formal charges are brought and relies heavily on effective interactions between law enforcement officers and community mental health and substance abuse services. Most pre-booking programs are characterized by specialized training for law enforcement officers. Some model programs include a 24-hour crisis drop-off center with a no-refusal policy that is available to receive persons brought in by the law enforcement officers. The individual is then linked to an appropriate array of community-based mental health and substance abuse treatment services.

Screening: Evaluating a person involved with the criminal justice system to determine whether the person has a serious mental illness, co-occurring substance disorder, or a developmental disability, and would benefit from mental health services and supports in accordance with established standards and local jail diversion agreements.

III. **Background Summary**

During the 1990s, CMHSPs and MDHHS focused resources on development of in-jail and in-detention services. In-jail services provided by most community mental health services program (CMHSPs) included services ranging from crisis intervention, assessment, counseling, consultation, and other mental health services. Some CMHSPs provided similar services in detention centers. An effective prototype for adults using the Assertive Community Treatment (ACT) model for persons exiting state prison, county jail or an alternative treatment program was also developed. These programs are important for assuring that individuals with mental health needs receive services while incarcerated and are linked to appropriate services and supports upon release. While in-jail services are an important part of the comprehensive service array provided by CMHSPs, they **are not** considered to constitute a jail diversion program, **unless** they have been specifically designed as part of a “fast track” release to community treatment within a post-booking diversion program.

Some individuals with serious mental illness or developmental disability must be held in jail because of the seriousness of the offense and should receive mental health treatment within the jail. However, other individuals who have been arrested may be more appropriately diverted to community-based mental health programs. In response to views of consumers, advocates and policy makers, the requirement for a jail diversion program in each CMHSP is included in the Michigan Mental Health Code, P.A. 258 of 1974.

The first MDHHS Jail Diversion Best Practice Guideline was promulgated as an administrative directive in 1998. The directive defined the department’s jail diversion procedures and set forth conditions for establishing and implementing an integrated and coordinated program as required by the 1996 Code amendments. New information has been used to update the guideline and to incorporate suggestions for improving current practice.

Effective programs support cross-system collaboration and recognize that all sectors of the criminal justice system need to have access to training. Training should be available to police officers, sheriffs, jail personnel, parole and probation officers, judges, prosecutors, and the defense bar.

The availability of a comprehensive, community-based service array is essential for jail diversion programs to be effective and may allow many individuals to avoid criminal justice contact altogether. People who receive appropriate mental health treatment in the community usually have a better long-term prognosis and less chance of returning to jail for a similar offense.

SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation provides technical assistance and support to professionals working in the fields of behavioral health and criminal justice, as well as states and communities across the country who are working to achieve integrated systems of mental health and substance use services. The GAINS model was developed when the center was first established and is still at the heart of the Center today. The model includes the following core strategies:

- Gather: Screen for and collect new research findings and best practices
- Assess: Synthesize this information into appropriate and targeted communication for various types of users

- Integrate: Organize facilitated learning and follow through
- Network: Build and strengthen networks and infrastructure
- Stimulate: Identify and use the most cost-effective ways of achieving significant results

The GAINS Center provides information and skills training to help individuals and organizations at the local, state, regional, and national levels implement effective, integrated programming that will transform the criminal justice and behavioral health systems. Additionally, the GAINS Center maintains databases of all adult and juvenile mental health treatment courts. The databases contain the following information and are updated periodically:

- The location of each mental health court
- The year the court was established
- Target participants (e.g., people who have been charged with a felony, misdemeanor, or violent or nonviolent crime)
- Approximate annual enrollments (or total enrollments)
- Contact information

Based on the results of field research and program evaluations, the GAINS Center asserts that the “best diversion programs see detainees as citizens of the community who require a broad array of services, including mental health care, substance abuse treatment, housing and social services. They recognize that some individuals come into contact with the criminal justice system as a result of fragmented services, the nature of their illnesses and lack of social supports and other resources. They know that people should not be detained in jail simply because they are mentally ill. Only through diversion programs that fix this fragmentation by integrating an array of mental health and other support services, including case management and housing, can the unproductive cycle of decompensation, disturbance and arrest be broken.”

Strategies for creating effective diversion programs are also highlighted in the report from the “New Freedom Commission on Criminal Justice” published in June 2004. This report was published as part of the President’s New Freedom Commission on Mental Health.

Several key factors are recognized as being important components of an effective jail diversion program. An effective program should:

- Recognize the complex and different needs of the population; be designed to meet the different needs of various groups within the population (such as individuals with a co-occurring substance disorder); **and** be culturally sensitive.
- Integrate all the services individuals need at the community level, including corrections, the courts, mental health care, substance abuse treatment, and social services (such as housing and entitlements), with a high level of cooperation among all parties.
- Incorporate regular meetings among the key players to encourage coordination services and sharing of information. Meetings should begin in the early stages of planning and implementing the diversion program and should continue regularly.
- Utilize liaisons to bridge the barriers between the mental health and criminal justice systems and to manage the interactions between corrections, mental health, and judicial

staff. These individuals need to have the trust and recognition of key players from each of the systems to be able to effectively coordinate the diversion effort.

- Have a strong leader with good communication skills and an understanding of the systems involved and the informal networks needed to put the necessary pieces in place.
- Provide for early identification of individuals with mental health treatment needs who meet the diversion program's criteria. This is done through the initial screening and evaluation that usually takes place in the arraignment court, at the jail, or in the community for individuals out on bond. It is important to have a process in place that assures that people with mental illness are screened in the first 24 to 48 hours of detention.
- Utilize case managers who have experience in both the mental health and justice systems and who are culturally and racially similar to the clients they serve. An effective case management program is one of the most important components of successful diversion. Such a program features a high level of contact between clients and case managers, in places where clients live and work, to ensure that clients will not get lost along the way.

IV. Essential Elements for Michigan CMHSPs

- A. CMHSPs shall provide a pre-booking and a post-booking jail diversion program intended for individuals:
 1. Alleged to have committed misdemeanors or certain, usually non-violent, felonies, and,
 2. Who voluntarily agree to participate in the diversion program.
- B. PIHPs shall ensure CMHSPs in their geographic regions operate a jail diversion program that is in compliance with the provisions of this practice guideline.
- C. Offenses considered appropriate for diversion shall be negotiated at the local level.
- D. Pre-booking jail diversion programs shall:
 1. Restrict eligibility to individuals who have or are suspected of having a serious mental illness, including those with a co-occurring substance disorder, or a developmental disability who have committed a minor or serious offense that would likely lead to arrest, or have been removed from a situation that could potentially lead to arrest.
 2. Have a diversion mechanism or process that clearly describes the means by which an individual is identified at some point in the arrest process and diverted into mental health services. Specific pathways of the pre-booking diversion programs are defined and described in an interagency agreement for diversion.
 3. Assign specific staff to the pre-booking program to serve as liaisons to bridge the gap between the mental health, substance abuse, and criminal justice systems, and to manage interactions between these systems. It is important to have a strong leader with good communication skills and understanding of the systems involved and the informal networks needed to put the necessary pieces in place.
 4. Provide cross training for, and actively promote attendance of, law enforcement and mental health personnel on the pre-booking jail diversion program, including but not limited to target group for diversion; specific pathways for diversion; key players and their responsibilities; data collection requirements; and other information necessary to facilitate an effective diversion program.

5. Maintain a management information system that is HIPAA compliant and that can identify individuals brought or referred to the mental health agency as a result of a pre-booking diversion. Include the unique consumer ID as assigned by the CMHSP and the date of diversion, the type of crime, and the diagnosis. The unique ID can be used to link to the encounter data to obtain information regarding services. The CMHSP must be prepared to share its jail diversion data with MDHHS upon request.
 6. Outline the program and processes in a written inter-agency agreement, or document efforts to establish an inter-agency agreement, with every law enforcement entity in the service area. Inter-agency agreements shall include but not be limited to the following information: identification of the target population for pre-booking jail diversion; identification of staff and their responsibilities; plan for continuous cross-training of mental health and criminal justice staff; specific pathways for the diversion process; description of specific responsibilities/services of the participating agencies at each point in the pathway; data collection and reporting requirements; and process for regular communications including regularly scheduled meetings.
 7. CMHSPs are responsible for reporting prebooking jail diversion activities to the PIHP in the form/format and timelines established by the PIHP.
- E. Post-booking jail diversion programs shall:
1. Restrict eligibility to individuals who have or are suspected of having a serious mental illness, including those with a co-occurring substance disorder, or a developmental disability who have been arrested for the commission of a crime.
 2. Have a clearly described mechanism or process for screening jail detainees for the presence of a serious mental illness, co-occurring substance disorder, or developmental disability within the first 24 to 48 hours of detention. The process shall include:
 - Evaluating eligibility for the program;
 - Obtaining necessary approval to divert;
 - Linking eligible jail detainees to the array of community-based mental health and substance abuse services.
 3. Assign specific staff to program including liaisons to bridge the barriers between the mental health, substance abuse and criminal justice systems, and to manage interactions between these systems. It is important to have a strong leader with good communication skills and understanding of the systems involved and the informal networks needed to put the necessary pieces in place.
 4. Establish regular meetings among the key players, including police/sheriffs, court personnel, prosecuting attorneys, judges, and CMHSP representatives to encourage coordination of services and the sharing of information.
 5. Include case managers and other clinical staff who have experience in both the mental health and criminal justice systems whenever possible. If this is not possible, documentation of recruitment efforts must be documented, and an intensive training program with specific criminal justice focus must be in place for case managers. Case managers and other clinical staff must provide care in a culturally competent manner.

6. Provide cross training for, and actively promote attendance of, law enforcement and mental health personnel on the post-booking jail diversion program, including but not limited to target group for diversion; specific pathways for diversion; key players and their responsibilities; data collection requirements; and other information necessary to facilitate an effective diversion program.
7. Maintain a management information system that is HIPAA compliant and that can identify individuals brought or referred to the mental health agency as a result of a post-booking diversion. Include the unique consumer ID as assigned by the CMHSP and the date of diversion, the type of crime, and the diagnosis. The unique ID can be used to link to the encounter data to obtain information regarding services. The CMHSP must be prepared to share its jail diversion data with the department upon request.
8. Outline the program and processes in a written inter-agency agreement, or document efforts to establish an inter-agency agreement, with every law enforcement entity in the service area. Inter-agency agreements shall include but not be limited to the following information: identification of the target population for post-booking jail diversion; identification of staff and their responsibilities; plan for continuous cross-training of mental health and criminal justice staff; specific pathways for the diversion process, description of specific responsibilities/services of the participating agencies at each point in the pathway; data collection and reporting requirements and process for regular communications including regularly scheduled meetings.
9. CMHSPs are responsible for reporting post booking jail diversion activities to the PIHP in the form/format and timelines established by the PIHP.

V. Resources

- Michigan Mental Health Code, P.A. 258 of 1974.
- [GAINS Center for Behavioral Health and Justice Transformation | SAMHSA](#)
- Council of State Governments Criminal Justice/Mental Health Consensus Project Report, June 2002
- The President's New Freedom Commission on Mental Health Achieving the Promise: Transforming Mental Health Care in America Final Report, July 2004

Special Education-to-Community Transition Planning Policy

Revised: July 2023

Statement of Purpose

The purpose of this policy is to underscore the BPHASA/MDHHS's expectation of CMHSPs to support schools with students with disabilities to transition to full community inclusion. Such services are required by the Michigan Mental Health Code Section 330.1227, Special Education-to-Community Transition Services.

"Each community mental health services program shall participate in the development of special education-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. This planning and development shall be done in conjunction with the individual's local school district or intermediate school district as appropriate and shall begin no later than the school year in which the individual student reaches 16 years of age. These services shall be individualized. This section is not intended to increase or decrease the fiscal responsibility of school districts, community mental health services programs, or any other agency or organization with respect to individuals described in this section."

In other words, this does not usurp the primary responsibility of DOE for special education to community transition.

Furthermore; Section 330.1100d(11) of the Michigan Mental Health Code states:

"Transition services" means a coordinated set of activities for a special education student designed within an outcome-oriented process that promotes movement from school to post-school activities, including postsecondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living, or community participation."

Although this policy focuses only on special education to community transition, it is important to note CMHSP responsibilities described in Section 208 of the Mental Health Code:

"(1) Services provided by a community mental health service program shall be directed to individuals who have a serious mental illness, serious emotional disturbance, or developmental disability.
(2) Priority shall be given to the provision of services to persons with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability." In addition, any Medicaid recipient requiring medically necessary services must also be served.

Children meeting the criteria described above, but not in special education, also face issues of transition to adult life. These may include sub-populations of youth such as:

- Runaway/Homeless youth
- Children with emotional disturbance at risk of expulsion from school
- Youth who "age out" of:
 1. The DSM diagnosis for which they are receiving mental health services; who do not qualify for adult service or criteria for SMI/ID/DD;
 2. Children's Waiver;
 3. Children's Special Health Care Services plan;
 4. Foster care placement, making them at risk for being homeless.
- Children/Youth involved in multiple systems – Child Welfare/Juvenile Justice/Substance Use Disorder, etc.

Summary:

The effectiveness of primary and secondary special education programming for students with disabilities; inclusive of behavioral health challenges or needs, directly affects services and financial planning of CMHSPs. Schools that best prepare students with disabilities to live, learn, and work in the community and to access generic community services such as transportation and recreation create fewer demands on the adult services system including CMHSPs and foster better community participation and integration for individuals with disabilities. CMHSPs have a responsibility to grow community partnerships and provide information about eligibility requirements, types of services, and the person-centered planning process in the public mental health system to school systems initially and update as needed and to student, parents or legal guardians when requested. It is also important to share options like supported decision making / alternatives to guardianship. Often families/students are unaware of other options and are often advised by school and/or medical personnel to seek guardianship upon turning age 18. MDHHS policy and practice also support maintaining and regaining one's civil rights in supporting self-determination.

Recognizing limited resources and funding for such transition efforts, it is imperative that CMHSPs begin this process as the school identifies those students reaching 16 years of age. The intent of this policy is to:

1. Ensure students and their families are fully informed about CMHSP services and supports in partnership with the school.
2. Maximize young adult outcomes, including participation in employment, access to natural supports, and access to needed adult support services.
3. With the school, identify the number of likely students to be eligible for CMHSP services after the student reaches 18 years of age to allow CMHSPs to anticipate future service needs and ideally lower long-term support costs by assisting the student to smoothly transition into community with as many natural supports as possible.
4. Ensure collaboration between CMHSPs, schools, and other local partners.

CMHSPs should actively participate with schools and other community services providers to effectively braid resources that best assure the student transitions to the community as independently as possible.

*NOTE: It is allowable to braid resources from community partners to support individuals seeking to obtain, return to competitive employment, or increase their employment objectives. This service can be used concurrently to supplement/complement services to help individuals achieve their desired employment outcomes **as long as there is no duplication of resources for the same service element(s) at the same time.** Documentation is maintained that same service is not presently available under a program funded under WIOA, Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

It remains imperative that CMHSPs jointly promote:

- Implementing the values of Individuals with Disabilities Education Act (IDEA) with particular focus on community inclusion in the least restrictive environment, keenly focused on vocational exploration, work experiences, and ideally paid work.
- Becoming more knowledgeable of special education practices better preparing youth for adult life.

CMHSPs need to ensure that schools, students, families, caregivers, and community partners have basic knowledge of what CMHSPs can provide to youth/adults with disabilities, and eligibility criteria for these services through a family-centered/youth guided process and plan. This information should be distributed to applicable schools and also available on-line.

CMHSPs shall make available the following information through the CMHSP customer services efforts:

1. Values governing public mental health services including:
 - a. Recovery
 - b. Self-determination
 - c. Full community inclusion
 - d. Person-centered planning
2. Eligibility criteria:
 - a. Michigan Mental Health Code priority populations
 - b. Specialty behavioral health (including the boundary with the Qualified Health Plans)
 - c. Local service selection guidelines/protocols/etc.
3. Local service array for child, youth, and adult service providers, including contact information at the CMHSP to the school for systemic service-related issues.

Additionally, CMHSPs have the responsibility to provide information to appropriate local school administrators about specific conditions which would indicate the likelihood that a student would need assessment and/or service from the CMHSP upon turning 18 years of age including:

- Students classified under the school system as Severe Multiple Impairments (SXI), Severe Cognitive Impairment (SCI), Moderate Cognitive Impairment (MoCI), and/or Mild Cognitive Impairment (MiCI) are generally eligible for CMHSP services.
- Other student classifications would indicate a closer look by CMHSPs to determine eligibility for adult services from the CMHSP.
- The classification of Autism Spectrum Disorder (ASD) covers students with a very broad range of skills and abilities often necessitating further assessment to determine eligibility for CMHSP services.
- Students classified as Emotional Impairment (EI) would have to be assessed for eligibility for adult services from the CMHSP. In the public mental health system, Serious Emotional Disturbance (SED), by definition, ends at the age of 18. Students classified as SED as well as Specific Learning Disabled (SLD) and Physical Impairment (PI) or Otherwise Health Impaired (OHI) would need to be assessed with consent for an appropriate developmental disability or mental illness diagnosis.
- When the legal guardian is considering CMHSP services, the CMHSP will provide a screening and possibly an assessment. CMHSPs will look at factors that include: risk for expulsion from school, need for assistance in multiple life domains, or absence of a stable natural support network.

Essential elements with suggested tracking, activities, and measurement criteria are outlined in the following table:

Essential elements:	Tracking:	Activities:	Measurement Criteria:
Outreach and communication to youth/young adults and family through coordination with local school districts and school staff	Examples could include the following: <i>-Documentation to track completed Annual Training can include:</i> <ul style="list-style-type: none"> • <i>Copy of Event Flyer</i> • <i>Copy of sign-in sheets</i> 	CMHSP to present at least annually at school or ISD group presentations about potential CMHSP eligibility to youth/young adults, parents, guardians, and	- Examples could include the following:

	<ul style="list-style-type: none"> <i>Verification from school of completed training</i> <p><i>-Provide number of IEP's invited to for FY and then number of IEP's CMH attended.</i></p> <p><i>-Use demographic information at access point asking, "How individual was referred" and report number of individuals who were referred by School/Transition (18-26) for that FY.</i></p>	<p>school staff at local transition fairs, etc.</p> <p>Following invited attendance at a youth/young adult's IEP – and informing such individual of eligibility criteria for future CMHSP services</p>	<p>-One completed training to the local ISD or School District.</p> <p>-Future trainings scheduled with the local ISD and School Districts.</p> <p>-CMHSP is invited to attend IEPs of individuals who are not served and aged 16 and above.</p> <p>-CMHSP has established contacts with ISD and local schools.</p> <p>-Collaborative initiatives are developed between the schools and CMHSP.</p> <p>-CMHSP is able to use data to anticipate future needs of individuals between the ages of 18 and 26.</p>
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Data tracked during the fiscal year is to be submitted on an annual basis by April 1st following the end of the fiscal year and will be outlined in attachment C6.5.1.1 CMHSP Reporting Requirements.

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration**

FAMILY-DRIVEN AND YOUTH-GUIDED POLICY AND PRACTICE GUIDELINES

Updated May 2021

A. Summary/Background

The purpose of this guideline is to establish standards for the Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), and their contract agencies regarding the delivery of family-driven and youth-guided services and supports for children, youth and their families. For the purposes of this policy “families” are intended to include parents, primary caregivers, foster parents and family members. For the purposes of this policy the term “children” typically refers to the age range up to 12 years old. The term “youth” typically refers to the age range of 13-17 years and “young adult” generally refers to the age range of 18 up to 21 years. This guideline will outline essential elements of family-driven and youth-guided policy and practice at the child, youth and family level, programmatic level, which includes peer delivered services and system level (the community or state level.)

Person-centered planning (PCP) is the method for individuals served by the publically supported community behavioral and mental health system to plan how they will work toward and achieve personally defined outcomes in their own lives. The Michigan Mental Health Code established the right for all individuals to develop individual plans of services (IPOS) through a PCP process regardless of disability or residential setting.

For children, youth and families, the Person-Centered Planning Policy Guideline states: “The Michigan Department of Health and Human Services (MDHHS) has advocated and supported a family-driven and youth-guided approach to service delivery for children, youth and their families. A family-driven and youth-guided approach recognizes that services and supports impact the entire family, not just the identified child or youth receiving mental health services. In the case of minors, the child, youth and family are the focus of service planning, and family members are integral to a successful planning process. The wants and needs of the child, youth and they/their family are considered in the development of the Individual Plan of Service.” As the child or youth matures toward transition age, the focus of the treatment planning, services and supports should be youth/young/adult driven to accommodate the youth as they gain skills towards independence.

As a result of the effort to develop family-driven and youth-guided services, the Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with the Federation of Families for Children’s Mental Health, has developed a set of principles (described in section C of this guideline) which serve as the basis for the delivery of family-driven and youth-guided services. These principles comprise the standards which should guide the delivery of services and supports to children, youth and their families and are

essential to the development of an effective system of care. The system of care approach is an organizational philosophy and framework that involves collaboration across agencies, families, children, and youth for the purpose of improving services and access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a serious emotional disturbance and their families.

While agencies are expected to collaborate, they are not intended to be the primary decision-makers on behalf of a child, youth or family. It is important for systems to actively partner with families and support them in leading all decisions about the care of their child or youth. Similarly, as appropriate, based on their age and functioning, youth should be supported to make decisions about their own care. Active family, child and youth participation is also necessary on a broader level with an expectation that they are supported and empowered to be equal partners in system-level governance and planning.

B. Policy

It is the policy of the MDHHS that all publicly-supported community behavioral and mental health agencies and their contract agencies shall implement family-driven and youth-guided practices with children, youth and families. They will support and empower family members, children and youth to be key stakeholders at the program, evaluation and governance levels.

How this policy will be supported:

- The MDHHS staff in partnership with statewide family organizations will work with PIHPs, CMHSPs, and contract agencies to support successful implementation of the family-driven and youth-guided policy and practice requirements.
- The MDHHS will work with other system partners at the state level to ensure PIHPs, CMHSPs, and contract agencies can build an effective system of care.

C. Family-Driven and Youth-Guided Principles

Family-driven and youth-guided principles should be implemented at several different levels: the child, youth and family level, programmatic level which includes peer-delivered services the system level (the community or state level). These principles incorporate all levels and will be detailed under section D: Essential Elements of this guideline.

- Families, children and youth as well as providers and administrators share decision-making and responsibility for outcomes.
- Families, children and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the individualized and potential services and supports for their child or youth and their

family as a whole.

- Children, youth and parents or caregivers have the right to invite an external support and/or advocate to participate as part of their planning and treatment team.
- CMHSPs can partner with family-run organizations engage in peer support activities to reduce isolation, gather, and disseminate accurate information, and strengthen the family voice.
- Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices.
- PIHP/CMHSPs and contract providers will take the initiative to change policy and practice from provider-driven to family-driven and youth-guided by prioritizing family-driven and youth-guided practices by allocating staff, training, support and resources.
- Community culture shift efforts focus on removing barriers and discrimination created by stigma is supported.
- Communities including public and private agencies embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate behavioral health disparities and implicit bias.
- Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness so that the needs of diverse populations are appropriately addressed with an emphasis on diversity, equity and inclusion.

D. Essential Elements for Family-Driven and Youth-Guided Care

1. “Family-driven” means that families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children and youth in their community. This includes:
 - Being given the necessary information to make informed decisions regarding the care of their child or youth
 - Choosing culturally and linguistically competent supports, services, and providers will be available,
 - Setting individualized goals and outcomes,
 - Designing, implementing, and evaluating programs by determining effectiveness,
 - Monitoring goals and outcomes, and

- Partnering in funding decisions.
2. “Youth-guided” means that children and youth have the right to be empowered, educated, and given a decision-making role in their own care as well as the policies and procedures governing the care of all youth in the community, state, and nation. A youth-guided approach views children and youth as experts and considers them equal partners in creating system change at the individual, state, and national level (SAMHSA).
 3. “Family-run organization” means advocacy and support organizations that are led by family members and young adults with lived experience raising children with behavioral health needs including serious emotional disturbance (SED) and/or intellectual and developmental disabilities (I/DD) thus creating a level of expertise. These organizations often provide peer-to-peer support, education, advocacy, and information/referral services to reduce isolation for family members, gather, and disseminate accurate information so families can partner with providers and make informed decisions and strengthen the family voice at the child and family level as well as the systems level.
 4. Hiring parents or caregivers and young adults with lived experience to provide peer delivered Medicaid services such as Parent Support Partner, Youth Peer Support and other peer delivered services.
 5. Child and Family-Level Action Strategies:
 - Strength and Culture Discovery – Children, youth, and family strengths and culture will be identified and linked to treatment strategies within the plan of service.
 - Cultural Preferences – The IPOS will incorporate the cultural preference unique to each youth and family.
 - Access – Children, youth, and families are provided understandable and meaningful information to make informed choices regarding services and supports and have a voice in determining the services they receive. Services and supports are delivered in the home and community whenever possible.
 - Voice – Children, youth, and families are active partners in the treatment process, their voice is solicited and respected, and their needs/wants are written into the IPOS in language that indicates their ownership.
 - Ownership – The plan reflects the unique strengths, culture, and priorities as identified by the child, youth, and family.
 - Outcome-based – Plans are developed to produce results that the child, youth and family identify. All services, supports, and interventions support outcomes achievement as defined by the child, youth and family.
 - Parent and Caregiver/Youth/Professional Partnerships – Parents or caregivers, children and youth are recognized for having expertise, are active partners in the

treatment process, and share ownership of the outcomes.

- Increase Confidence and Resiliency – The plan will identify specific interventions that maximize the strengths of the child, youth, and family, increase the skills of the youth to live independently and advocate for self, and equip the family with skills to successfully navigate systems and manage the needs of their child, youth and family.
- Participation in Planning Meetings – Children, youth and families determine who participates in the planning meetings.
- Crisis and Safety Planning – Crisis and safety plans should be developed to decrease safety risks, increase competence, skills and confidence of the child, youth and family, and respect the needs/wants of the child, youth and family.

6. Programmatic, including peer-delivered services

- All services need to reflect family-driven and youth guided practices
- Parents/primary caregivers who have first-hand experience raising children and youth with behavioral health needs are recruited, trained, and supported in their role as Parent Support Partners. This Medicaid service outlined under the Family Support and Training section of the current Medicaid Provider Manual is a required as part of the service array delivered to parents or caregivers of children with SED and I/DD.
- Young adults who have lived experience with behavioral health challenges are recruited, trained, and supported in their role as Youth Peer Support Specialists. This Medicaid service outlined under the Peer Delivered section of the current Medicaid Provider Manual is a required as part of the service array delivered to youth and young adults with SED/SMI.
- CMHSPs or their contract providers can directly hire Parent Support Partners and Youth Peer Support Specialists or contract with a Family Organization.
- The Statewide Family Organization, Association for Children's Mental Health provides the training, professional development, coaching and technical assistance for Parent Support Partners, Youth Peer Support Specialists and their supervisors.
- MDHHS will contract with a family run organization to provide and inform the training and technical assistance for peer delivered services for youth and families.

7. System-level Action Strategies:

- Agencies have policies that ensure that all providers of services to children, youth, and families incorporate parent/caregivers and youth on decision-making groups, CMHSP boards, and committees that support family-driven and youth-guided policy and practice with policies and examples of practice sent to BHDDA upon request.

- Agencies have policies that ensure training, support, and compensation for parents/caregivers and youth who participate in decision-making groups, CMHSP boards, and committees and serve as co-facilitators/trainers.
- Policies are in place within the agency to support employment of youth and parents/caregivers in addition to peer delivered Medicaid service providers.
- Children, youth and parents or caregivers are part of the program and service design, evaluation, and implementation of services and supports.
- Children, youth, and families are sought out to share their experience, expertise and knowledge in presentations, training and education opportunities for other families and youth as well as service providers and administrators.
- Services occur where the children, youth, and family choose and in a way that is aligns with relevant to the family culture.
- All stakeholder groups including CMHSP boards include diverse membership including children, youth and family members who represent the population the agency/community serves.

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 for the duration of eligibility for these services/supports. 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 Person-Centered Planning and Practice Guideline at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html 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 to 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 PIHP/CMHSP 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.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Developmental Disabilities Administration

TRAUMA POLICY

The purpose of this policy is to address the trauma in the lives of the individuals served by the community mental health system. This policy is promulgated to promote the understanding of trauma and its impact, ensure the development of a trauma-informed system, and the availability of trauma specific services for all populations served. Trauma is defined as:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.¹

Policy

It is the policy of the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) that Prepaid Inpatient Health Plans (PIHPs), through their direct service operations and their network providers, shall develop a trauma-informed system for all ages across the services spectrum and shall ensure that the following essential elements are provided:

- I. Adoption of trauma-informed culture: values, principles, and development of a trauma-informed system of care ensuring safety and preventing re-traumatization.
- II. Engagement in organizational self-assessment of trauma informed care.
- III. Adoption of approaches that prevent and address secondary trauma of staff (See Exhibit A).
- IV. Screening for trauma exposure and related symptoms for each population.
- V. Trauma-specific assessment for each population.
- VI. Trauma-specific services for each population using evidence-based practice(s) (EBPs), or evidence-informed practice(s) are provided in addition to EBPs.
- VII. The PIHP shall, through its direct service operations and its network providers, join with other community organizations to support the development of a trauma-informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders.^{2, 3}

¹Substance Abuse Mental Health Services Administration (SAMHSA),
<http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx>

²Substance Abuse and Mental Health Services Administration, Leading Change: SAMHSA's Role and Actions 2011-2012.

³SAMHSA's Initiatives, Preventing Substance Abuse and Mental Illness, 2010.

Standards

To ensure a trauma informed behavioral health system, the following standards are required to meet the stated policy.

Policy

- I. Adoption of trauma-informed culture: values, principles, and development of a trauma-informed system of care ensuring safety and preventing re-traumatization.

Standards – Requirements

- a.) The PIHP shall, through its direct service operations and its network providers, develop and support a Quality Improvement committee with representatives from children, adult, SUD, I/DD services, and individuals. The committee's primary focus is to ensure the building and maintaining of trauma informed care within the PIHPs direct service operations and its network providers.
- b.) The PIHP shall, through its direct service operations and its network providers, ensure that all staff, including direct care staff, are trained and has ongoing training in trauma-informed care. An online module is available for use in training, but other curriculums can be utilized if they address the points delineated in the next paragraph. (Online Module: *Creating Cultures of Trauma-Informed Care* with Roger Fallot, Ph.D. of Community Connections, Washington, DC. This online module is available at <http://improvingmipractice.org>).

Training needs to be updated on a regular basis due to changes in the research and/or evidence-based approaches. Staff trained in trauma-informed care should (1.) understand what trauma is and the principles of trauma-informed care; (2.) know the impact of trauma on a child's and/or adult's life; (3.) know strategies to mitigate the impact of the trauma(s);

(4) understand re-traumatization and its impact; and (5) understand traumatic loss which may include the loss of a therapeutic, direct care or service relationship.

c.) Policies and procedures shall ensure a trauma-informed system of care is supported and the policies address trauma issues, re-traumatization, and secondary trauma of staff.

II. Engagement in organizational self-assessment of trauma-informed care.

a.) The PIHP Quality Improvement committee conducts an organizational self-assessment to evaluate the extent to which current agency's policies are trauma-informed and to identify organizational strengths and barriers, including an environmental scan to ensure that the environment/building(s) do(es) not re-traumatize. An online module is available to assist the committee in their self-assessment. No specific self-assessment tool is recommended, but it is recommended that the tool being used is comprehensive and ensures that all aspects of the organization is assessed (administration, clinical services, staff capacity, environment, etc.). (Online module: *Creating Cultures of Trauma-Informed Care: Assessing your Agency* with Roger Fallot, Ph.D. & Lori L. Beyer, LICSW, of Community Connections, Washington, DC. This online module is available at <http://improvingmipractice.org>).

The self-assessment is updated every three (3) years.

- III. Adoption of approaches that prevent and address secondary trauma of staff. (See Exhibit A)
- a.) The PIHP shall, through its direct service operations and its network providers, adopt approaches that prevent and address secondary traumatic stress of all staff, including, but not limited to:
- Opportunity for supervision
 - Trauma-specific incident debriefing
 - Training
 - Self-care
 - Other organizational support (e.g., employee assistance program)
- IV. Screening for trauma exposure and related symptoms for each population.
- a.) The PIHP shall, through its direct service operations and its network providers, use a culturally competent, standardized, and validated screening tool appropriate for each population during the intake process and other points as clinically appropriate.^{1, 2}
- V. Trauma-specific assessment for each population.
- a.) The PIHP shall, through its direct service operations and its provider network, use a culturally competent, standardized, and validated assessment instrument appropriate for each population. Trauma assessment is administered based on the outcome of the trauma screening.³
- VI. Trauma-specific services for each population using evidence-based practice(s) (EBPs). Evidence-informed practice(s) are provided in addition to EBPs.
- a.) The PIHP shall, through its direct service operations and its network providers, use evidence-based trauma specific services for each population in sufficient capacity to meet the need. The services are delivered within a trauma-informed environment.⁴

¹ACE tool is a population screen and does not screen for related symptoms.

²Examples of standardized, validated screening tools are provided in the trauma section of the website, www.improvingMlpractices.org.

³Examples of standardized, validated assessment tools are provided in the trauma section of the website, www.improvingMlpractices.org.

⁴Examples of trauma-specific services are provided in the trauma section of the website, www.improvingMlpractices.org

- VII. The PIHP shall, through its direct service operations and its network providers, join with other community organizations to support the development of a trauma-informed community that promotes behavioral health and reduces the likelihood of mental illness and SUD.
- a.) The PIHP and its network providers shall join with community organizations, agencies, community collaboratives (i.e., MPCBs), and community coalitions (i.e., Substance Abuse Coalitions, Child Abuse and Neglect Councils, Great Start Collaboratives, neighborhood coalitions, etc.) to support the development of a trauma-informed community that promotes healthy environments for adults, children, and their families.
 - b.) Education on recovery and the reduction of stigma are approaches supported in a trauma-informed community.
 - c.) Substance abuse prevention programs are provided using a SAMHSA approved, evidence-based, and trauma-informed approach.

Exhibit A

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary Traumatic Stress refers to the presence of post-traumatic stress disorder (PTSD) symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

Compassion fatigue is a less stigmatizing way to describe secondary traumatic stress and has been used interchangeably with the term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another individual's traumatic material.

Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues and the conviction that one's work makes a meaningful contribution to clients and society.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops because of general occupational stress. The term is not used to describe the effects of indirect trauma exposure specifically.

Source: The National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. Los Angeles, CA, and Durham, NC. National Center for Child Traumatic Stress.

MDHHS CONTRACT FINANCING

- 1. GF allocation will be in E-Grams agreement**
- 2. Insert 428 Schedule**

MDHHS Performance Objectives

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Community Mental Health Service Programs
COMPLIANCE EXAMINATION GUIDELINES
Michigan Department of Health and Human Services



Fiscal Year End September 30, 2024

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INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Health and Human Services (MDHHS) to assist independent audit personnel and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDHHS and CMHSPs, and to assure examinations are completed in a consistent and equitable manner.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDHHS to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, Flint 1115 and Substance Use Disorder Community Grant Programs (hereinafter referred to as “Medicaid Contract”); the contracts between CMHSPs and MDHHS to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208 (hereinafter referred to as “GF Contract”); and, in certain circumstances, contracts between CMHSPs and MDHHS to manage the Community Mental Health Services Block Grant Program (hereinafter referred to as “CMHS Block Grant Program”). These CMH Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a CMHSP expends \$750,000 or more in federal awards¹, the CMHSP must obtain a Single Audit.

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2024 and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

Failure to meet the requirements contained in these CMH Compliance Examination Guidelines may result in the withholding of current funds or the denial of future awards.

RESPONSIBILITIES

MDHHS Responsibilities

MDHHS must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code, and federal and state audit requirements; and to ensure the **COMPLIANCE REQUIREMENTS** contained in the CMH Compliance Examination Guidelines are complete and accurately represent requirements of PIHPs and CMHSPs; and distribute revised CMH Compliance Examination Guidelines to PIHPs and CMHSPs.
2. Review the examination reporting packages submitted by PIHPs and CMHSPs to ensure completeness and adequacy within eight months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination reporting package within eight months after the receipt of a complete and final reporting package.

¹ Medicaid payments to PIHPs and CMHSPs for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended for the purposes of determining Single Audit requirements.

4. Monitor the activities of PIHPs and CMHSPs as necessary to ensure the Medicaid Contract, GF Contract, and CMHS Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Contract, and GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely on PIHP or CMHSP Single Audits or the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure CMHSP Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS may, however, determine it is necessary to also perform a limited scope compliance examination or review of selected areas. Any additional reviews or examinations shall be planned and performed in such a way as to build upon work performed by other auditors. The following are some examples of situations that may trigger an MDHHS examination or review:
 - a. Significant changes from one year to the next in reported line items on the FSR.
 - b. A PIHP entering the MDHHS risk corridor.
 - c. A large addition to an ISF per the cost settlement schedules.
 - d. A material non-compliance issue identified by the independent auditor.
 - e. The CPA that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.
 - f. The CPA issued an adverse opinion on compliance due to their inability to draw conclusions because of the condition of the agency's records.

CMHSP Responsibilities

(as a recipient of Medicaid Contract funds from PIHP and a recipient of GF funds from MDHHS and a recipient of CMHS Block Grant funds from MDHHS)

CMHSPs must:

1. Maintain internal control over the Medicaid Contract, GF Contract, and CMHS Block Grant Program that provides reasonable assurance that the CMHSP is managing the Medicaid Contract, GF Contract, and CMHS Block Grant Program in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid Contract, GF Contract, and CMHS Block Grant Program.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract, GF Contract, and CMHSP Block Grant Program. Examples of these would include, but not be limited to: the Medicaid Contract, the Managed Mental Health Supports and Services Contract (General Fund Contract), the CMHS Block Grant Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines, and any examination required by the PIHP from which the CMHSP receives Medicaid Program funds are properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with an examination finding or

comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.

7. The CMHSP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS, and the CMHSP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

Unless the PIHP managing the Medicaid Contract requires their independent auditor to perform a compliance examination at the CMHSP, the CMHSPs under contract with MDHHS to manage the GF Contract are required to contract annually with a certified public accountant in the practice of public accounting (hereinafter referred to as a practitioner) to examine the CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 18 –Attestation Standards – Clarification and Recodification AT-C Section 205. The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Additionally, CMHSPs under contract with MDHHS to provide CMHS Block Grant Program services with a total contract amount of greater than \$187,500 are required to ensure the above referenced examination engagement includes an examination of compliance with specified requirements related to the CMHS Block Grant Program **IF** the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program. The specified requirements and specified criteria related to the CMHS Block Grant Program are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Practitioner Selection

In procuring examination services, CMHSPs must engage an independent practitioner, and must follow the Procurement Standards contained in 2 CFR 200.318 through 200.320. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, the results of MDHHS reviews, and price. When possible, CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the CMHSP's compliance with specified requirements is to express an opinion on the CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that the CMHSP complied, in all material respects, based on the specified criteria.

Practitioner Requirements

The practitioner should exercise due care in planning, performing, and evaluating the results of his or her examination procedures; and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected. The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the

Section titled “Compliance Requirements.” In the examination of the CMHSP’s compliance with specified requirements, the practitioner should follow the requirements of AT-C 105 and 205.

Practitioner’s Report

The practitioner’s examination report on compliance should include the information detailed in AT-C 205.63 through 205.86, which includes the practitioner’s opinion on whether the entity complied, in all material respects, with specified requirements based on the specified criteria. When an examination of the CMHSP’s compliance with specified requirements discloses noncompliance with the applicable requirements that the practitioner believes have a material effect on the entity’s compliance, the practitioner should modify the report as detailed in AT-C 205.68 through AT-C 205.75.

In addition to the above examination report standards, the practitioner must prepare:

1. A Schedule of Findings that includes the following:
 - a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant Program.
 - b. Material noncompliance with the provisions of laws, regulations, or contract provisions related to the Medicaid Contract, GF Contract, and/or CMHS Block Grant Program.
 - c. Known fraud affecting the Medicaid Contract, GF Contract, and/or CMHS Block Grant Program.

Finding detail must be presented in sufficient detail for the CMHSP to prepare a corrective action plan and for MDHHS to arrive at a management decision. The following specific information must be included, as applicable, in findings:

- a. The criteria or specific requirement upon which the finding is based including statutory, regulatory, contractual, or other citation. **The Compliance Examination Guidelines should NOT be used as criterion.**
 - b. The condition found, including facts that support the deficiency identified in the finding.
 - c. Identification of applicable examination adjustments and how they were computed.
 - d. Information to provide proper perspective regarding prevalence and consequences.
 - e. The possible asserted effect.
 - f. Recommendations to prevent future occurrences of the deficiency(ies) noted in the finding.
 - g. Views of responsible officials of the CMHSP.
 - h. Planned corrective actions.
 - i. Responsible party(ies) for the corrective action.
 - j. Anticipated completion date.
2. A schedule showing final **reported** Financial Status Report (FSR) amounts, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below) and examined FSR amounts. **All examination adjustments must be explained.** This schedule is called the “Examined FSR Schedule.” All applicable FSRs must be included in the practitioner’s report regardless of the lack of any examination adjustments.

3. A schedule showing a revised cost settlement for the CMHSP based on the Examined FSR Schedule. This schedule is called the “Examined Cost Settlement Schedule.” This must be included in the practitioner’s report regardless of the lack of any examination adjustments.
4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant program, only in the event the individual comment or recommendation is expected to have an impact greater than or equal to \$25,000; and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency.

Examination Report Submission

The examination must be completed, and the reporting package described below must be submitted to MDHHS within the earlier of 30 days after receipt of the practitioner’s report, or June 30th following the contract year end. The CMHSP must submit the reporting package by e-mail to MDHHS at MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. MDHHS reserves the right to request a hard copy of the compliance examination report materials if for any reason the electronic submission process is not successful.

Examination Reporting Package

The reporting package includes the following:

1. Practitioner’s report as described above;
2. Corrective action plan prepared by the CMHSP.

Penalty

If the CMHSP fails to submit the required examination reporting package by June 30th following the contract year end and an extension has not been granted by MDHHS, MDHHS may withhold from current funding five percent of the examination year’s grant funding (not to exceed \$200,000) until the required reporting package is received. MDHHS may retain the withheld amount if the reporting package is delinquent more than 120 days from the due date and MDHHS has not granted an extension.

Incomplete or Inadequate Examinations

If MDHHS determines the examination reporting package is incomplete or inadequate, the CMHSP, and possibly its independent auditor will be informed of the reason of inadequacy and its impact in writing. The recommendations and expected time frame for resubmitting the corrected reporting package will be provided to the CMHSP.

Management Decision

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

documentation, as a way of mitigating disallowed costs. The appeal process available to the CMHSP is included in the applicable contract.

If there are no findings, comments, and/or questioned costs, MDHHS will notify the CMHSP when the review of the examination reporting package is complete and the results of the review.

COMPLIANCE REQUIREMENTS

The practitioner must examine the CMHSP's compliance with the specified requirements based on the specified criteria stated below related to the Medicaid Contract and GF Contract. If the CMHSP does not have a Single Audit or the Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the specified requirements based on the specified criteria stated below that specifically relate to the CMHS Block Grant, but only if the CMHSP's total contract amount for the CMHS Block Grant is greater than \$187,500.

COMPLIANCE REQUIREMENTS

(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

The final FSRs (entire reporting package applicable to the entity) comply with contractual provisions as follows:

- a. FSRs agree with agency financial records (general ledger) as required by the reporting instructions. (Reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).
- b. FSRs include only allowed activities as specified in the contracts; allowable costs as specified in the Federal cost principles (located at 2 CFR 200, Subpart E)(GF Contract, Section 6.6.1; and Medicaid Contract, Section 1.S.9); and allowed activities and allowable costs as specified in the Mental Health Code, Sections 240, 241, and 242.
- c. FSRs include revenues and expenditures in proper categories and according to reporting instructions.

Differences between the general ledger and FSRs should be adequately explained and justified. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule." Any reported expenditures that do not comply with the Federal cost principles, the Code, or contract provisions must be shown as adjustments on the auditor's "Examined FSR Schedule."

The following items should be considered in determining allowable costs:

Federal cost principles (2 CFR 200.402) require that for costs to be allowable they must meet the following general criteria:

- a. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under the principles.
- b. Conform to any limitations or exclusions set forth in the principles or in the Federal award as to types or amount of cost items.
- c. Be consistent with policies and procedures that apply uniformly to both federally financed and other activities of the non-Federal entity.
- d. Be accorded consistent treatment.
- e. Be determined in accordance with generally accepted accounting principles.

- f. Not be included as a cost or used to meet cost sharing or matching requirements of any other federally financed program in either the current or a prior period.
- g. Be adequately documented.

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness criteria of 2 CFR Part 200, Subpart E – Cost Principles, 200.404 was met. If subcontractors are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). When the PIHP pays Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported rental costs for **less-than-arms-length transactions** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (c)). For example, the agency may rent their office building from the agency's board member/members but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in 2 CFR Part 200.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (b)).

Capital asset purchases that cost greater than \$5,000 must be capitalized and depreciated over the useful life of the asset rather than expensing it in the year of purchase (2 CFR Part 200, Subpart E – Cost Principles, 200.436 and 200.439). All invoices for a remodeling or renovation project must be accumulated for a total project cost when determining capitalization requirements; individual invoices should not simply be expensed because they are less than \$5,000.

Costs must be allocated to programs in accordance with relative benefits received. Accordingly, **Medicaid costs must be charged to the Medicaid Program and GF costs must be charged to the GF Program**. Additionally, **administrative/indirect costs** must be distributed to programs on bases that will produce an equitable result in consideration of relative benefits derived in accordance with 2 CFR Part 200, Appendix VII.

Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported in accordance with the standards listed in 2 CFR Part 200, Subpart E – Cost Principles, 200.430 (i).

B. Procurement

The CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326.

The CMHSP completed the required Federal database checks in accordance with 42 CFR 455.436. The Lists of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) have been completed by the CMHSP no less frequently than monthly.

Subcontracts entered into by the CMHSP have addressed A through M in Part II section 6.4.1 (Provider Contracts) of the GF contract. Furthermore, subcontracts that contain provisions for a financial incentive, bonus, withhold, or sanctions must provision that protect recipients from practices that result in the inappropriate limitation or withholding of required (MCL 330.1206-1) services that would otherwise be provided to eligible individuals (MCL 330.1208).

Note: A *provider* means one who furnishes medical or pharmaceutical services or supplies (42 CFR 50.502). This provider check is not required administrative contracts.

C. Cost of Service and Ability to Pay

The CMHSP determined the cost of services for the purposes of compliance with MCL 330.1804. Cost of services means the total operating and capital costs incurred (MCL 330.1800). In the comparison of cost to ability to pay the practitioner may consider a cost-based rate sheet or other documentation that is supported by cost records as evidence of costs of services.

The CMHSP determined responsible parties' insurance coverage and ability to pay before, or as soon as practical after, the start of services as required by MCL 330.1817. Also, the CMHSP annually determined the insurance coverage and ability to pay of individuals who continue to receive services and of any additional responsible party as required by MCL 330.1828.

The CMHSP's charges for services represent the lesser of ability to pay determinations or cost of services according to MCL 330.1804. Until the CMHSP has determined the ability to pay in accordance with the department promulgated rules (MCL 330.1818(2), the responsible party's ability to pay is considered to be \$0. If the responsible party willfully refuses to apply for insurance benefits or provide information in accordance with MCL 330.1814, the CMHSP may charge for the full cost of services. Once ability to pay is determined in accordance with MCL 330.1818(2), the CMHSP may, but is not required to, bill for services up to 2 years in the past (MCL 330.1824).

Medicaid eligible consumers are deemed to have zero ability to pay so there is no need to determine their ability to pay. The one exception is during the period when a Medicaid eligible consumer has a deductible. In that case, an ability to pay determination does apply.

D. General Fund Carryforward

The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

E. Match Requirement

The CMHSP met the local match requirement, and all items considered as local match actually qualify as local match according to Section 7.2 of the General Fund Contract. Some examples of funds that do NOT qualify as local match are: (a.) revenues (such as workers' compensation refunds) that should be offset against related expenditures, (b.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (c.) donations of funds from subcontractors of the CMHSP, (d.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSP's actual costs, and (e)

donations of items that would not be an item generally provided by the CMHSP in providing plan services.

If the CMHSP does not comply with the match requirement in the Mental Health Code, Section 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDHHS. All examination working papers must be accessible and are subject to review by representatives of the Michigan Department of Health and Human Services, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and provider network CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2023/2024 examinations. Any questions relating to these guidelines should be directed to:

Jackie Sproat, Director
Division of Contracts & Quality Management
Bureau of Specialty Behavioral Health Services
Michigan Department of Health and Human Services
Capitol Commons Center
400 S. Pine Street
Lansing, Michigan 48913
SproatJ@michigan.gov
Phone: (517) 230-8847 Fax: (517) 335-5376

GLOSSARY OF ACRONYMS AND TERMS

AICPA.....American Institute of Certified Public Accountants.

CMHS Block Grant Program.The program managed by CMHSPs under contract with MDHHS to provide Community Mental Health Services Block Grant program services under CFDA 93.958.

CMHSPCommunity Mental Health Services Program (CMHSP). A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended.

Examination EngagementA CMHSP’s engagement with a practitioner to examine the entity’s compliance with specified requirements in accordance with the AICPA’s Statements on Standards for Attestation Engagements (SSAE) 18 –Attestation Standards – Clarification and Recodification – AT-C 205 (Codified Section of AICPA Professional Standards).

Flint 1115 Waiver	The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014 through a state-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act, and is effective as of March 3, 2016 the date of the signed approval through September 30, 2026. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the state plan. All such persons will have access to Targeted Case Management services under a fee for service contract between MDHHS and Genesee Health Systems (GHS). The fee for service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.
GF Program.....	The program managed by CMHSPs under contract with MDHHS to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.
MDHHS	Michigan Department of Health and Human Services
Medicaid Program.....	The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by PIHPs under contract with MDHHS.
PIHP	Prepaid Inpatient Health Plan. In Michigan a PIHP is an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. The PIHP, also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program, also manages the Autism iSPA (Autism benefit under the 1915i State Plan Amendment), Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.
Practitioner.....	A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.
SSAE.....	AICPA's Statements on Standards for Attestation Engagements.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

MDHHS APPEAL PROCESS FOR COMPLIANCE EXAMINATION DECISIONS

The following process shall be used to appeal the MDHHS management decisions relating to the Compliance Examinations that are required in Section 39.0 of the Master Contract.

STEP 1: MANAGEMENT DECISION

The MDHHS Bureau of Audit, Reimbursement, and Quality Assurance:

The MDHHS shall issue to the PIHP and/or the CMHSP a management decision on findings, comments, and examination adjustments contained in the PIHP and/or the CMHSP examination report, within **eight (8) months** after the receipt of a complete and final Compliance Examination. The management decision will include whether or not the examination finding or comment is sustained; the reasons for the decision; the expected PIHP and/or the expected CMHSP action to repay disallowed costs, make financial adjustments, or take other action; and a description of the appeal process available to the PIHP and/or the CMHSP.

STEP 2: SETTLEMENT AND DISPUTE OF FINDINGS AND QUESTIONED COSTS

The PIHP and/or the CMHSP:

Within **30 days** of the PIHPs and/or the CMHSPs receipt of the management decision:

- A. Submits payment to the MDHHS for amounts due other than amounts resulting from disputed items; and
- B. If disputing items:
 - i. Requests a conference with the Director of the Operations Administration, or his/her designee, to attempt to reach resolution on the audit findings, or files an appeal pursuant to MCL 400.1, et seq. and MAC R400.3402, et seq. as specified in ii. below.

Any resolution because of a conference with the Director of the MDHHS Operations Administration would not be binding upon either party unless both parties agree to the resolution reached through these discussions. If the parties agree to a resolution, the terms will be reduced to a written settlement agreement and signed by both parties. If no resolution is reached, then there will be no obligation on the part of the MDHHS to produce a report of the conference process.

Matters that remain unresolved after these discussions would move to the appeal process, at the discretion of the PIHP and/or the CMHSP.

Administrative Hearing process:

- ii. Submits an appeal pursuant to MCL 400.1, et seq. and MAC R 400.3401, et seq. This process will be used for all PIHP and/or CMHSP disputes involving Compliance Examinations whether they involve Medicaid funds or not. Requests must identify the

specific item(s) under dispute, explain the reason(s) for the disagreement, and state the dollar amount(s) involved, if any. The request must also include any substantive documentary evidence to support the position. Requests must specifically identify whether the agency is seeking a conference with the Director of the Operations Administration, an internal conference, or an administrative hearing.

To request an internal conference, submit a written request within **30 days** of the receipt of the management decision to:

MDHHS Appeals Section
P.O. Box 30807
Lansing, MI 48909

To request an administrative hearing, submit a written request within **30 days** of receipt of the management decision to:

Michigan Administrative Hearing Systems
Michigan Licensing and Regulatory Affairs
P.O. Box 30763
Lansing, MI 48909

If the MDHHS does not receive an appeal within **30 days** of the date of the management decision, the management decision will constitute the MDHHS Final Determination.

- C. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance, the MDHHS Contract Management, and the MDHHS Accounting.

The MDHHS Accounting:

2. Implements the adjustments as outlined in the management decision if the PIHP and/or the CMHSP has not requested a conference with the Director of the Operations Administration or the Medicaid Provider Reviews and Hearings Process within the timeframe specified. If repayment is not made, recovers funds by withholding future payments.

The MDHHS Contract Management Unit:

3. Ensures the audited PIHP and/or the audited CMHSP resolves all findings in a satisfactory manner. Works with the audited PIHP and/or the audited CMSHP on developing performance objectives, as necessary.

STEP 3. MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS

The MDHHS Appeals Section:

Follows the rules contained in MAC R 400.3401, et seq. and various internal procedures regarding meetings, notifications, and decisions.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

MDHHS AUDIT REPORT AND APPEAL PROCESS

The following process shall be used to issue audit reports, appeal audit findings, and recommendations. Established time frames may be extended by mutual agreement of the parties involved.

STEP 1: AUDIT, PRELIMINARY ANALYSIS, AND RESPONSE

The MDHHS Bureau of Audit, Reimbursement, and Quality Assurance:

1. Completes an audit of the PIHP and holds an exit conference with the PIHP management.
2. Issues a preliminary analysis within **60 days** of the exit conference. The preliminary analysis is a working document and is not subject to Freedom of Information Act (FOIA) requests.

The Audited PIHP:

3. Requests a meeting with the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance to discuss disputed audit findings and conclusions in the preliminary analysis within **10 days** of receipt of the preliminary analysis. Since the preliminary analysis serves as the basis for the final report, the PIHP shall take advantage of this opportunity to ensure that any factual disagreements or wording changes are considered before the final report is issued.

The MDHHS Bureau of Audit, Reimbursement, and Quality Assurance:

4. Convenes a meeting to discuss concerns regarding the preliminary analysis if a meeting is requested.

The Audited PIHP:

5. Submits to the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance any additional evidence to support its arguments within **14 days** of the meeting with the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance to discuss the preliminary analysis.

The MDHHS Bureau of Audit, Reimbursement, and Quality Assurance:

6. Revises and issues the preliminary analysis, as appropriate, based on factual information submitted at the meeting or other supporting documentation provided subsequent to the meeting within **30 days** of either the meeting to discuss the preliminary analysis or receipt of additional information from the PIHP, whichever is later

The Audited PIHP:

7. Submits a brief written response indicating agreement or disagreement with each finding and recommendation within **30 days** of receipt of the revised preliminary analysis. If there is any disagreement, the response shall explain the basis or rationale for the disagreement and shall include additional documentation, if appropriate. If there is agreement, the response shall briefly describe the actions to be taken to correct the deficiency and an expected completion date. Include responses on the Corrective Action Plan forms included in the preliminary analysis.
8. Submits a brief written response to each finding and recommendation as described in STEP 1, 7. above, if a meeting is not requested within **30 days** of receipt of the preliminary analysis.

STEP 2: FINAL AUDIT REPORT**The MDHHS Bureau of Audit, Reimbursement, and Quality Assurance:**

1. Prepares and issues the final audit report incorporating the PIHPs paraphrased responses, within **30 days** of receipt of the PIHPs response to the preliminary analysis, as well as the Bureau of Audit, Reimbursement, and Quality Assurance responses, as deemed necessary.
2. Forwards the final audit report to the audited PIHP and other relevant parties. The letter, bound with the final audit report, describes the audited PIHPs appeal rights.

STEP 3: SETTLEMENT AND DISPUTE OF FINDINGS**The Audited PIHP:**

1. Within 30 days of receipt of the final audit report:
 - A. Submits payment to the MDHHS for amounts due other than amounts resulting from disputed findings; and
 - B. If any disputed findings, appeals under MCL 400.1 et seq. and MAC R 400.340 1, et seq. This process will be used for all the CMHSP audits regarding the Specialty Service and Supports Contract whether they involve Medicaid funds or not. Requests must identify the specific audit adjustment(s) under dispute, explain the reason(s) for the disagreement, and state the dollar amount(s) involved, if any. The request must also include any substantive documentary evidence to support the position. Requests must specifically identify whether the agency is seeking a preliminary conference, a bureau conference, or an administrative hearing.

To request an internal conference, submit a written request within **30 days** of the receipt of the management decision to:

MDHHS Appeals Section
P.O. Box 30807
Lansing, Michigan 48909

To request an administrative hearing, submit a written request within **30 days** of receipt of the management decision to:

Michigan Administrative Hearing Systems
Michigan Licensing and Regulatory Affairs
P.O. Box 30763
Lansing, MI 48909

If the MDHHS does not receive an appeal within **30 days** of the date of the letter transmitting the final audit report, the letter will constitute the MDHHS's Final Determination Notice, according to MAC R 400.3405.

- C. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance, the MDHHS Contract Management, and the MDHHS Accounting.

The MDHHS Accounting:

2. Implements the adjustments as outlined in the final report if the PIHP has not requested the Medicaid Provider Reviews and Hearings Process within the time frame specified. If repayment is not made, recovers funds by withholding future payments.

The MDHHS Contract Management Unit:

3. Ensures the audited PIHP resolves all findings in a satisfactory manner. Works with the audited PIHP on developing performance objectives, as necessary.

STEP 4: MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS

The MDHHS Appeals Section:

1. Follows the rules contained in MAC R 400.3401, et seq., and various internal procedures regarding meetings, notifications, documentation, and decisions

GF Distribution Model**GF to be Distributed**

\$95,225,104

\$120,050,400

*

**

COMMUNITY MENTAL HEALTH SERVICES PROGRAM (CMHSP)	Operating Base	Jail Diversion	Spend Down	Total Base	2015 ACS 200% FPL	% of Total	Medicaid Eligibles (DAB & TANF)	HMP Eligibles	GF Model Population 200% FPL less Medicaid HMP	% of Total	Non-Base GF Distribution Model	Total Funding With Full Model Implementation
COPPER COUNTRY	\$150,000	\$25,000	\$132,040	\$307,040	21,703	0.64%	8,174	3,334	10,195	0.99%	\$941,431	\$1,248,471
GOGEBIC	\$150,000	\$25,000	\$54,932	\$229,932	6,259	0.18%	2,861	1,087	2,311	0.22%	\$213,403	\$443,336
HIAWATHA	\$150,000	\$25,000	\$114,811	\$289,811	22,190	0.65%	8,801	3,371	10,017	0.97%	\$925,025	\$1,214,836
NORTHPOINTE	\$150,000	\$25,000	\$160,946	\$335,946	22,862	0.67%	9,853	3,591	9,418	0.91%	\$869,712	\$1,205,657
PATHWAYS	\$150,000	\$25,000	\$233,554	\$408,554	41,570	1.23%	17,621	7,406	16,544	1.60%	\$1,527,682	\$1,936,236
Region 1 Total:	\$750,000	\$125,000	\$696,283	\$1,571,283	114,584	3.38%	47,310	18,789	48,485	4.70%	\$4,477,253	\$6,048,536
AU SABLE	\$150,000	\$25,000	\$197,554	\$372,554	23,696	0.70%	11,837	4,666	7,193	0.70%	\$664,219	\$1,036,773
MANISTEE/BENZIE	\$150,000	\$25,000	\$111,365	\$286,365	14,656	0.43%	6,714	2,782	5,160	0.50%	\$476,487	\$762,852
NORTH COUNTRY	\$150,000	\$25,000	\$387,608	\$562,608	53,278	1.57%	25,490	10,167	17,621	1.71%	\$1,627,197	\$2,189,804
NORTHEAST	\$150,000	\$25,000	\$183,040	\$358,040	24,655	0.73%	11,036	4,471	9,148	0.89%	\$844,748	\$1,202,789
NORTHERN LAKES	\$150,000	\$25,000	\$504,202	\$679,202	68,101	2.01%	31,852	12,140	24,109	2.34%	\$2,226,283	\$2,905,486
Region 2 Total:	\$750,000	\$125,000	\$1,383,769	\$2,258,769	184,386	5.44%	86,929	34,226	63,231	6.13%	\$5,838,934	\$8,097,703
ALLEGAN	\$150,000	\$25,000	\$206,392	\$381,392	36,266	1.07%	17,125	4,777	14,363	1.39%	\$1,326,345	\$1,707,737
MUSKEGON	\$150,000	\$25,000	\$408,608	\$583,608	68,672	2.03%	39,939	12,677	16,056	1.56%	\$1,482,681	\$2,066,288
NETWORK 180/KENT	\$150,000	\$25,000	\$1,009,134	\$1,184,134	205,973	6.07%	104,253	31,782	69,938	6.78%	\$6,458,244	\$7,642,378
OTTAWA	\$150,000	\$25,000	\$314,229	\$489,229	71,739	2.12%	27,189	7,893	36,656	3.55%	\$3,384,935	\$3,874,164
WEST MICHIGAN	\$150,000	\$25,000	\$188,554	\$363,554	29,038	0.86%	14,494	4,762	9,782	0.95%	\$903,294	\$1,266,847
Region 3 Total:	\$750,000	\$125,000	\$2,126,917	\$3,001,917	411,688	12.14%	203,000	61,892	146,796	14.24%	\$13,555,498	\$16,557,415
BARRY	\$150,000	\$25,000	\$103,095	\$278,095	17,442	0.51%	7,760	2,565	7,117	0.69%	\$657,232	\$935,326
BERRIEN	\$150,000	\$25,000	\$280,540	\$455,540	59,238	1.75%	30,578	9,678	18,982	1.84%	\$1,752,844	\$2,208,384
KALAMAZOO	\$150,000	\$25,000	\$369,365	\$544,365	90,922	2.68%	40,122	14,456	36,345	3.52%	\$3,356,154	\$3,900,519
PINES	\$150,000	\$25,000	\$108,284	\$283,284	17,381	0.51%	8,546	2,366	6,469	0.63%	\$597,332	\$880,616
ST. JOSEPH	\$150,000	\$25,000	\$148,581	\$323,581	23,894	0.70%	12,606	3,502	7,786	0.76%	\$718,978	\$1,042,559
SUMMIT POINTE	\$150,000	\$25,000	\$305,351	\$480,351	52,781	1.56%	29,436	9,006	14,339	1.39%	\$1,324,129	\$1,804,480
VAN BUREN	\$150,000	\$25,000	\$180,567	\$355,567	30,360	0.90%	16,234	5,010	9,116	0.88%	\$841,793	\$1,197,361
WOODLANDS	\$150,000	\$25,000	\$105,811	\$280,811	17,883	0.53%	8,763	2,771	6,349	0.62%	\$586,282	\$867,093
Region 4 Total:	\$1,200,000	\$200,000	\$1,601,593	\$3,001,593	309,901	9.14%	154,045	49,353	106,503	10.33%	\$9,834,745	\$12,836,338
BAY/ARENAC	\$150,000	\$25,000	\$280,581	\$455,581	42,424	1.25%	21,722	8,027	12,675	1.23%	\$1,170,471	\$1,626,052
CENTRAL MICHIGAN	\$150,000	\$25,000	\$538,621	\$713,621	110,772	3.27%	43,915	17,273	49,584	4.81%	\$4,578,707	\$5,292,328
CLINTON EATON INGHAM	\$150,000	\$25,000	\$588,729	\$763,729	157,790	4.65%	69,011	26,018	62,761	6.09%	\$5,795,503	\$6,559,232
GRATIOT	\$150,000	\$25,000	\$78,932	\$253,932	14,196	0.42%	7,553	2,281	4,362	0.42%	\$402,798	\$656,730
HURON	\$150,000	\$25,000	\$59,635	\$234,635	11,611	0.34%	4,955	1,731	4,925	0.48%	\$454,756	\$689,391
IONIA	\$150,000	\$25,000	\$106,135	\$281,135	22,132	0.65%	10,035	3,041	9,055	0.88%	\$836,191	\$1,117,326

GF Distribution Model

COMMUNITY MENTAL HEALTH SERVICES PROGRAM (CMHSP)	*				**		***		****			
	Operating Base	Jail Diversion	Spend Down	Total Base	2015 ACS 200% FPL	% of Total	Medicaid Eligibles (DAB & TANF)	HMP Eligibles	GF Model Population 200% FPL less Medicaid HMP	% of Total	Non-Base GF Distribution Model	Total Funding With Full Model Implementation
LIFEWAYS	\$150,000	\$25,000	\$397,216	\$572,216	73,219	2.16%	37,573	12,442	23,204	2.25%	\$2,142,744	\$2,714,960
MONTCALM	\$150,000	\$25,000	\$138,527	\$313,527	25,053	0.74%	12,221	4,066	8,766	0.85%	\$809,504	\$1,123,031
NEWAYGO	\$150,000	\$25,000	\$146,716	\$321,716	19,698	0.58%	10,284	3,279	6,134	0.59%	\$566,459	\$888,175
SAGINAW	\$150,000	\$25,000	\$310,175	\$485,175	76,224	2.25%	42,532	14,333	19,359	1.88%	\$1,787,688	\$2,272,863
SHIAWASSEE	\$150,000	\$25,000	\$146,270	\$321,270	23,956	0.71%	12,150	3,980	7,826	0.76%	\$722,641	\$1,043,911
TUSCOLA	\$150,000	\$25,000	\$123,324	\$298,324	19,884	0.59%	10,248	3,635	6,002	0.58%	\$554,208	\$852,533
Region 5 Total:	\$1,800,000	\$300,000	\$2,914,862	\$5,014,862	596,959	17.60%	282,200	100,105	214,654	20.82%	\$19,821,670	\$24,836,532
LENAWEE	\$150,000	\$25,000	\$182,919	\$357,919	32,271	0.95%	16,016	4,999	11,256	1.09%	\$1,039,406	\$1,397,325
LIVINGSTON	\$150,000	\$25,000	\$180,081	\$355,081	32,115	0.95%	14,061	5,712	12,341	1.20%	\$1,139,629	\$1,494,710
MONROE	\$150,000	\$25,000	\$238,581	\$413,581	40,928	1.21%	19,561	7,111	14,256	1.38%	\$1,316,403	\$1,729,984
WASHTENAW	\$150,000	\$25,000	\$319,865	\$494,865	96,130	2.83%	35,567	16,132	44,430	4.31%	\$4,102,804	\$4,597,669
Region 6 Total:	\$600,000	\$100,000	\$921,445	\$1,621,445	201,444	5.94%	85,206	33,955	82,283	7.98%	\$7,598,242	\$9,219,687
DETROIT/WAYNE	\$150,000	\$25,000	\$3,095,511	\$3,270,511	789,976	23.30%	473,203	168,453	148,320	14.38%	\$13,696,228	\$16,966,739
Region 7 Total:	\$150,000	\$25,000	\$3,095,511	\$3,270,511	789,976	23.30%	473,203	168,453	148,320	14.38%	\$13,696,228	\$16,966,739
OAKLAND	\$150,000	\$25,000	\$1,424,310	\$1,599,310	276,173	8.14%	130,324	51,382	94,466	9.16%	\$8,723,250	\$10,322,559
Region 8 Total:	\$150,000	\$25,000	\$1,424,310	\$1,599,310	276,173	8.14%	130,324	51,382	94,466	9.16%	\$8,723,250	\$10,322,559
MACOMB	\$150,000	\$25,000	\$1,289,877	\$1,464,877	245,777	7.25%	131,193	52,013	62,571	6.07%	\$5,777,988	\$7,242,866
Region 9 Total:	\$150,000	\$25,000	\$1,289,877	\$1,464,877	245,777	7.25%	131,193	52,013	62,571	6.07%	\$5,777,988	\$7,242,866
GENESEE	\$150,000	\$25,000	\$693,364	\$868,364	164,560	4.85%	95,768	35,231	33,560	3.25%	\$3,099,042	\$3,967,407
LAPEER	\$150,000	\$25,000	\$153,811	\$328,811	25,802	0.76%	12,828	4,788	8,187	0.79%	\$755,977	\$1,084,787
SANILAC	\$150,000	\$25,000	\$105,689	\$280,689	16,748	0.49%	7,377	2,434	6,937	0.67%	\$640,610	\$921,299
ST. CLAIR	\$150,000	\$25,000	\$367,865	\$542,865	52,982	1.56%	27,612	10,147	15,222	1.48%	\$1,405,667	\$1,948,532
Region 10 Total:	\$600,000	\$100,000	\$1,320,729	\$2,020,729	260,092	7.67%	143,585	52,600	63,907	6.20%	\$5,901,296	\$7,922,025
Grand Total:	\$6,900,000	\$1,150,000	\$16,775,296	\$24,825,296	3,390,980		1,736,995	622,768	1,031,217	100%	\$95,225,104	\$120,050,400

* Figures in the "Spend Down" column were compiled by Milliman at the request of the GF Allocation Workgroup.

** Figures in the "2015 ACS 200% FPL" column are from the 2015 American Community Survey [U.S. Census Bureau (www.census.gov)].

*** Figures in the "Medicaid Eligibles" column are the average member payments made in the 3rd Quarter (April - June) [DHHS CHAMPS Medicaid Capitation Payment Report by County, MC 0030].

**** Figures in the "HMP Eligibles" column are the average member payments made in the 3rd Quarter (April-June) [DHHS CHAMPS Medicaid Capitation Payment Report by County, MC 0040].