APPLICATION FOR PARTICIPATION

Michigan Department of Community Health

MDCH

John Engler, Governor
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INTRODUCTION

The purpose of the Michigan Department of Community Health (MDCH) Application for Participation for procurement of Medicaid Specialty Prepaid Health Plans is to describe the necessary information and documentation that will be required from the applicant Community Mental Health Services Program (CMHSP) to determine whether the CMHSP meets the MDCH requirements for selection to become a prepaid health plan on October 1, 2002. The Application for Participation is the official vehicle for solicitation and selection of specialty prepaid health plans. It provides the details and specifications for the general application requirements and selection criteria that were presented in the October 11, 2001, MDCH Implementation Guide. Specifically, the Application for Participation identifies the required capabilities and qualifications that must be demonstrated by a successful applicant in the areas of organizational status and configuration, public policy management and public interest considerations, administrative capabilities and management, and regulatory management.

The Application for Participation is targeted exclusively to Michigan CMHSPs in compliance with Michigan's application for renewal of its 1915(b) Specialty Services and Supports Waiver and the approval letter received in February 2001 from the federal Centers for Medicare and Medicaid Services. In the waiver application, Michigan proposed that a first opportunity should be afforded to CMHSPs since these entities have the necessary expertise with the target populations and strong coordination linkages with other community agencies; control other resource streams (i.e. state funds); sustain local systems of care; have already made durable investments in specialized care management strategies and unique service/support arrangements; and have statutorily prescribed protection, equity and justice functions important to individuals, policymakers and Michigan's citizens.

The Application for Participation builds on the Readiness Checklist that was presented in the Implementation Guide by specifying the documentation that is to be submitted to the MDCH by the CMHSPs, and the documentation that must be available locally for the on-site readiness review. It also identifies the relative weighting of the items to be scored during the application review process. The Application for Participation is designed to address how the CMHSP affiliations achieve efficiencies among their members while continuing quality services to individuals through a seamless system of care and support.

This application process differs from typical request for proposal processes because a) the bid does not include pricing; and b) the process is not competitive at this stage. Applicants are indicating their capacity and commitment to performance in a variety of areas. Pricing is determined by the MDCH in compliance with Medicaid regulations, the 1915(b) waiver, and state appropriations. The MDCH is soliciting these applications in the context of current capitation rates and methodology, with no intent for changes in FY 03. Pertinent financing provisions, along with other contract provisions, are specified in the draft contract included with the Application for Participation as Attachment C. Other significant MDCH policy decisions impacting applicants that need to be considered are as follows:

1. Capitation Payments

The base capitation rates and methodology will remain unchanged for fiscal year 2003. The intensity factors will change as required. Affiliation capitation payments will be derived from a new intensity factor for the consolidated service area that will push the same level of funding (within rounding limitations) as the sum of the current individual rates would have been. The data files distributed through the Data Exchange Gateway (DEG) will be a single file for each consolidated service area. This file will be available only to the PHP.

2. Sub-capitation

An applicant may sub-capitate for shared risk with affiliates or established risk-sharing entities. The actuarially-sound methodology and rates for sub-capitation, by contractor, must be submitted to MDCH. MDCH retains the right to disapprove any sub-capitation arrangement when it is determined that the arrangement has a high probability to adversely impact the state's risk-sharing. Sub-capitation rates shall be reasonable when compared to other service rates for similar services. Sub-capitation shall not contribute to risk reserve accumulation that exceeds seven and one-half percent (7.5 percent) of annual per eligible/per month, or an amount consistent with Governmental Accounting Standards Board Statement 10, whichever is less, within the applicant's region.

3. Internal Service Fund

The internal service fund risk reserves that exist on September 30, 2001, may be continued under the new contract, up to the level justifiable by Governmental Accounting Standards Board Statement 10 and the current internal service fund technical requirement in the contract. For affiliated CMHSPs, established internal service fund risk reserves shall be transferred to the prepaid health plan between October 1, 2002 and March 31, 2003, up to the level justified by the Governmental Accounting Standards Board Statement 10 and pursuant to the affiliation agreement. The portion of funds eligible for transfer will depend on the scope of financial management transferred by affiliation agreement to the prepaid health plan which may be limited or inclusive of general fund and corresponding local funds. A three party agreement consistent with that used for the coordinating agency internal service fund transfers will be employed. The portion of MDCH risk reserve funds not transferred by March 31, 2003, will need to be returned to the MDCH unless they are enabled by the CMHSP contract with MDCH.

4. Public Act 423

Public Act 423 grant funds will continue to be earned by participating CMHSPs that bill and collect first and third party revenues. For affiliated CMHSPs, those grant funds may be transferred among the affiliated CMHSPs that are enrolled Public Act 423 participants if methods and procedures are clearly specified in the affiliation agreement.

5. Earned Interest

Earned interest will continue to be available to CMHSPs as a source of local match. For affiliations, interest earned by the prepaid health plan can be transferred to affiliated CMHSPs to the extent that methods and procedures are clearly specified in the affiliation agreement.

6. General Fund Redirect

General fund redirect of Medicaid state match will continue to be an available option for CMHSPs that overspend general fund finances. However, for affiliations, this option is limited to the applicant unless the affiliation agreement transfers responsibility for the general fund dollars to the prepaid health plan and MDCH contracts for affiliate(s)' general fund dollars with the applicant.

As stated in the Implementation Guide, the MDCH is raising its expectations of CMHSPs' performance in serving individuals with serious mental illness, serious emotional disturbances, developmental disabilities, and substance use disorders. The applications submitted in response to the Application for Participation must demonstrate that the CMHSPs are able to meet, or have viable plans with specified dates for completion that meet this challenge.

OVERVIEW OF THE APPLICATION FOR PARTICIPATION DOCUMENT

The Implementation Guide noted that specialty prepaid health plans will have responsibilities for ensuring freedom, opportunities for achievement, equity, and participation consistent with the history and mission of CMHSPs. In an effort to link the larger purposes of the managed care program to the qualification requirements for specialty prepaid health plans, the Application for Participation solicits applicant information in the following four domains:

- **Organizational Status and Configuration** - CMHSPs have certain characteristic, statutorily-prescribed obligations, and experience with the target population that promotes inclusion, integration, and participation for individuals. This section of the application seeks to verify organizational status, statutory adherence, and regulatory compliance, and also to examine the composition of affiliation arrangements established by CMHSPs submitting a consolidated application.

- **Public Policy Management and Public Interest Considerations** - Specialty prepaid health plans are not simply managed care organizations. They are also managers of public policy, as articulated in statutes, rules, decisions, directives, guidelines, statements, and practice models. This section of the application focuses on evaluating an applicant's policies in areas such as person-centered planning, recipient rights, health and safety, public interest, and other similar concerns.

- **Administrative Capabilities and Management** - The MDCH specialty waiver program is a managed care plan with all of the administrative, managerial, and operational complexities inherent in such an enterprise. Specialty prepaid health plans, along with their affiliate members if applicable, must be able to perform these functions with a high degree of effectiveness and efficiency. This section of the application is concerned with the applicant's capabilities to provide access to care, appeals and grievances management, an adequate service array, substance abuse services either directly or through a contract with an existing substance abuse coordinating agency or other entity, customer services, provider network development and management, quality management activities, a strong information management system, fiscal management, and other related administrative/management functions.

- **Regulatory Oversight and Management** - Specialty prepaid health plans are subject to complex protective, procedural, clinical, and fiduciary regulations. Given the scope of regulatory concern and risk liability, specialty prepaid health plans require dynamic internal mechanisms to assimilate, analyze, apply, monitor, and enforce regulatory compliance throughout the organization and the associated network. This section of the application calls for the applicant to document established processes and practices for ensuring regulatory compliance, including compliance monitoring activities and tools, risk management, and a plan for compliance with such recent federal requirements as the Health Insurance Portability and Accountability Act and the Balanced Budget Act.

Additional sections of the document include:

- **Tables and/or Diagrams** - This section exists at the end of each submitted Acrobat® document and may be used for any requested or desired tables, diagrams, or other artwork. The data entry boxes within the document are formatted for text and will not allow insertion of artwork. Unless specifically noted in the Application for Participation, these are at the discretion of the applicant. Each item placed here must support a specific, numbered item and must be clearly labeled as to which numbered item it supports. Please be sure any tables, diagrams, or artwork placed here are of a size that is easily read without being enlarged and has page margins of at least 0.5 inches on the top, bottom, and sides. Make sure the text of the response for the numbered item clearly indicates that a table, diagram, or other artwork is at the end of the document. These should be appended to the Acrobat® document sequentially according to the numbered item they support. If a particular piece of artwork supports more than one numbered item, multiple copies should be used, with each clearly identified as to which item it supports.

- **Appendices** - Appendices are components of the application that may be common to more than one section. Any supporting documentation that should be placed in the Appendix will be clearly noted in the Application for Participation.

- **Attachments** – The following attachments are included in the Application for Participation document:
  - A) Medicaid Covered Lives
  - B) Glossary of Terms
  - C) Contracting Requirements for FY 02/03
  - D) Standards for Quality Assessment and Performance Improvement Programs
  - E) Person-centered Planning Revised Practice Guideline
  - F) Memorandum Regarding Coordinating Agency Designation (5/17/01)
  - G) Services to Native Americans Technical Advisory
  - H) State Managed Services and Financial Liability for Persons Acquitted of a Criminal Charge by Reason of Insanity
  - I) Best Value Description
  - J) Self-Determination Policy and Practice Guideline
  - K) Resources

GENERAL INFORMATION AND REQUIREMENTS FOR APPLICATIONS

[Note: The term "Application for Participation" refers to this document, while "application" refers to the response to this document.]

General Instructions

1. Responses must be inserted into the electronic version of the application which has been distributed in Microsoft® Word 2000. It should be equally readable in Microsoft® Word 97. The responses must be submitted in Adobe® Acrobat® format on Read-Only CDs. Any artwork that cannot be inserted into the text boxes provided, must be converted to Adobe® Acrobat® PDF format and merged in at the end of the appropriate PDF document.

2. All "standards" or expectations (numbered items with response boxes) are applicable to both the applicants for stand-alone prepaid health plans, as well as applicants for regional or affiliated prepaid health plans, unless otherwise noted. In the case of affiliations, if any one of the affiliate members does not meet the standard, do not mark the item, but rather provide an explanation as to what way and to what degree the standard is not fully met by all affiliates. Provide detail as to how and when the standard will be met. The response in the text box following the item is strictly limited to two pages.

3. Place an "X" in the box next to each item that applies to the current performance of the prepaid health plans. If an item is marked, do not submit any further explanation or supporting documentation unless specifically requested to do so.

4. If an item cannot be marked, applicants must explain why it is not, and provide a plan for achieving the standard. In most cases, the plan will need to achieve the standard by June 1, 2002, unless otherwise noted. Unmarked items (boxes) without explanation and plan will be considered "missing information" and given a zero score. Items marked and found to be untrue during the readiness site review could be given a zero score, could be penalized double the points possible for that question, and/or could disqualify the applicant.

5. Explanations must include:
   a) in the case of affiliations, which affiliate(s) does not meet the standard;
   b) the current performance;
   c) any attempts that have been made to improve performance (list activities and relevant success); and
   d) the existing barriers to achieving performance.

6. Plans for achieving the standard must specify:
   a) action steps to be taken;
   b) time frames for completing each step;
   c) measurement criteria (how will one know if an objective has been achieved); and
   d) who is responsible for each action.

Explanations and plans must not be lengthy (there is a two page limit, strictly enforced), but need to be specific and complete. Explanations do not automatically receive credit. An unmarked question with an explanation may receive full credit, partial credit, or a zero score, depending upon the explanation for noncompliance and the quality of the plan for correction.

7. Explanations and plans must be inserted into the document immediately following the item. The font and type size are pre-selected and cannot be changed. Explanations are strictly limited to two pages.

8. The subsections of the application will be reviewed by different teams. Please refrain from referring the reader to another subsection for any explanation. If the same explanation is relevant to more than one subsection, copy and insert it in each subsection. The data entry boxes within the document are formatted for text and will not allow insertion of artwork. Unless specifically noted in the Application for Participation, these are at the discretion of the applicant. Each item placed here must support a specific, numbered item and must be clearly labeled as to which numbered item it supports. Please be sure any tables, diagrams, or artwork placed here are of a size that is easily read without being enlarged and has page margins of at least 0.5 inches on the top, bottom, and sides. Make sure the text of the response for the numbered item clearly indicates that a table, diagram, or other artwork is at the end of the document. These should be appended to the Acrobat® document sequentially according to the numbered item they support. If a particular piece of artwork supports more than one numbered item, multiple copies should be used, with each clearly identified as to which item it supports.

   Exception to this requirement is reference in the Application for Participation to policies, flowcharts, or organizational charts that are contained in the Appendix. The appendices will need to be available to all reviewers and should be inserted into the Appendix section in Adobe® Acrobat® PDF. As noted previously, any supporting documentation that should be placed in the Appendix will be clearly noted in the Application for Participation. Items placed in the Appendix have no defined page limitation. Please make sure they are clearly labeled and readable without being enlarged.

9. "Bonus items" can be found in the public policy management section for areas that were considered the highest priority by the consumer/advocate workgroup that advised the MDCH in the Application for Participation development. Bonus items are also in the administrative capabilities section for selected areas that are a priority at this time. In order to earn the highest scores for bonus items, responses are expected to be detailed reflecting current practice and, in most cases, showing evidence of consumer, family, and advocate involvement. As with any other item, place the text of your response in the box following the question and electronically attach any required artwork at the end of the document. Bonus items requiring a written response must be done in a maximum of three pages.

10. Update the table of contents in each part prior to submitting the application to the MDCH to reflect the accurate page numbers and appendices for the application. These were correct when the document was distributed, but as data is entered, page numbers will change.

11. Appendices must be labeled as directed in the application and inserted into the Appendix section using Adobe® Acrobat® PDF, unless specific instructions in a particular section call for other handling.

12. Appendices must be electronically inserted into the document. Items, such as policies or organizational charts for which an electronic version is not available, should be scanned into the document. Specific exceptions to this are noted in the Application for Participation with instructions on how to handle each case.

Signatures

1. The first section of the Application for Participation, Organizational Status and Configuration, 1.0, requires, in the hard copy response, the signatures of: executive director of the applicant CMHSP, the executive director of each CMHSP that is part of the legal affiliation if applicable, and the chair person of the board of directors of each CMHSP. These signatures verify that the information contained in the application is accurate and true, and certifies that the applicant agrees to uphold and comply with the Application for Participation provisions and responses.

2. A statement of support for the application from the consumer/advocate group(s) that participated in the development of the application, with typed names and signatures of all members, must be placed as Appendix 0.1 in the hard copy. Identify the numbers of individuals representing each priority population and the names of the advocacy organizations represented. These signatures verify that individuals and advocates were involved in the development of the application.

Submission of the document

- **Application Format** - Two hard copies of the complete application must be submitted on white paper measuring 8.5 x 11 inches. Two electronic copies must be submitted on Read-Only CDs. Package the CDs in appropriate cases for mailing and storage. The hard copies must include copies of the required appendices A, B, and C.

- **Economy of Preparation** - Each application should be prepared simply and economically, providing a straightforward, concise response to the application requirements as written in the Application for Participation. Emphasis should be placed on completeness and clarity of content.

- **Incurring Costs** - MDCH is not liable for any cost incurred by the applicant CMHSP in preparing and submitting an application in response to the Application for Participation.

Please submit the CDs and two hard copies of the complete response that have the original authorized signatures in blue ink. All materials **must be delivered by 5:00 p.m. on February 22, 2002**, to:

Michigan Department of Community Health
Lewis Cass Building, Sixth Floor
320 S. Walnut Street
Lansing, Michigan 48913
Attn: Carol Danieli

In order to be considered "on time," the hard copy documents **must be received at the MDCH by 5:00 p.m.**, or if mailed, **post-marked by midnight, February 22, 2002.** Late applications will not be considered and will be returned immediately to the sender.

Hand-delivered documents will result in a receipt on the spot. The MDCH will E-mail receipt of surface-mailed documents.

Follow-up by MDCH

If an applicant does not meet any one of the criteria in the "Organizational Status and Configuration" section, the response is considered a "failure." Failed applicants will be notified within one week of the application response due date.

Following review of the submitted responses, the MDCH may notify the applicant of the need for additional information or for clarification if an explanation or plan is insufficient. The applicant will be given a short time to respond.

All applicants that pass Section 1, and meet an acceptable scoring threshold, will receive a readiness site visit by a team of MDCH staff following review of the responses. The purpose of the site visit is to verify the responses, the explanations, the plans, and to meet with the consumer/advocate group that provided input prior to final development. Scores for subsections may be impacted as a result of information gained during the site visit. Please see Scoring Methodology below for more detail.

Additional Information

The following information is provided in an effort to assist applicant CMHSPs in responding to the Application for Participation:

- **Pre-Bid Meeting** - MDCH staff will hold a pre-bid meeting on the following date and location:

  January 10, 2002, 10:00 a.m.
  G. Mennen Williams Building Auditorium
  525 West Ottawa
  Lansing, Michigan 48909

The purpose of the meeting will be to discuss the Application for Participation document with prospective applicant CMHSPs and to answer questions raised during the meeting.

- **Application for Participation Questions and Answers On Web Site** - Questions may be submitted by applicant CMHSPs **by 5:00 p.m. on January 15, 2001**, via E-mail to mongeau@michigan.gov. Answers by MDCH staff will be posted on the MDCH web site at www.mdch.state.mi.us as soon as possible.

- **Changes to the Application for Participation** - Changes made to the Application for Participation as the result of MDCH responses to questions or concerns raised by the applicant CMHSPs will be put in writing and sent to each CMHSP. Changes will also be posted on the MDCH web site identified above.

SCORING METHODOLOGY

The questions and topics included in the Application for Participation are not intended to be exhaustive or comprehensive. They have been selected as likely indicators of a quality operation and are a sample of the capacities required by applicants. The Application for Participation and response is not a substitute for the contract, however, the application submitted and corrected as necessary will be attached to the FY 03 contract. Successful participants will be bound by the terms and conditions of the application and contract.

Organizational Status and Configuration. Each of the Application for Participation prerequisites and conditions must be met for the application to be considered. Particular attention should be paid to completing this section – a complete valid response including any noted appendices is mandatory prior to being referred for scoring.

There are five factors to the scoring process. Each factor is addressed in four steps.

Definitions

Score – is the raw grade assigned by the evaluation team. It has no numerical meaning. Points are the result of calculations based on the weighted distribution of importance and scores. Points are actual percentage points or decimal fractions of percentage points.

Five Factors

The five factors in the scoring process are:

1. Public Policy Management and Public Interest Considerations. This section is weighted at 40 percent of the application submission.

2. Administrative Capabilities and Management. This section is weighted at 40 percent of the application submission.

3. Regulatory Management. This section is weighted at 20 percent of the application submission.

4. Review of Data Submissions. This part is weighted at 10 total points.

5. Bonus Items. These items are weighted at 10 total points. Bonus items are an opportunity for an agency to highlight particular strengths. Note that for a score of 100 percent on the application taken as a whole, an applicant must respond successfully to at least five of the bonus items. The remaining five bonus items are purely optional.

The first section is a list of prerequisites and carries no score or points. Sections two, three, and four each have a variety of weighted subsections and some subsections have multiple components. The subsections are weighted so that those with more questions do not necessarily carry more weight and not all questions carry equal weight.

Weights were established with consumer/advocate input. About half of the bonus items were designed based on consumer/advocate input.

Four Steps

1. The application will be evaluated for valid responses to all items and inclusion of all required appendices in Section one.

2. Each subsection in Sections two through four will be separately scored by three or more individuals. The scores will be resolved and assigned points based on the weighting scheme established.

3. Site reviews will be done to verify responses and any necessary adjustments will be made to the initial scores.

4. The application and points awarded will be presented to the selection panel for review and evaluation.

Scoring

Each item with an adjacent box for an "X" will be scored. In some cases there is a list of components that must all be true in order for the item to be marked. All scored items are numbered. Components are bulleted and not numbered.

If an applicant meets all of the requirements spelled out in the item, place an "X" in the appropriate box. In any case where all conditions are not met, do not place an "X" in the box by the item and insert an explanation and plan.

A Score of "2" indicates either:

1. The item was marked, claiming full compliance with all point(s); or
2. The item was not marked, and the detailed explanation fully and acceptably addressed the component(s). The detailed response must specifically address the component(s), as written in the Application for Participation.

A score of "2" will receive full points for the subsection.

A Score of "1" indicates:

1. The item was not marked and the detailed explanation did not fully and acceptably address the component(s) as written in the Application for Participation.

A score of "1" requires an explanation from the reviewers identifying what improvements need to be made.

A Score of "0" indicates either:

1. The item was not marked, and no explanation was provided; or
2. The item was not marked, and the detailed explanation or plan was unacceptable.

A score of "0" requires an explanation from the reviewers identifying the deficiencies.

Scoring will be done independently by three or more individuals. Variations in the scores will be resolved by using the most common score. If no score is most common, the evaluators will be asked to reconsider the responses provided.

Site Review

Site reviews will be used to validate the responses in the application. The applicant must be prepared to participate in, and accommodate, a MDCH site review at any time during March and early April 2002. Site reviews may last a week for each applicant (including affiliates). If the desired components are present within the application but the application failed to clearly describe the facts, the applicant's score could be increased. If the required components of items marked with an "X," or the information in the appendices and insertions submitted with the application are not consistent with the findings of the site review, the applicant's score would be decreased by up to twice the variation points. For example, if an applicant claimed a capacity that upon review did not exist and the particular subsection was valued at 1.5 points, up to 3.0 points could be deducted from the overall points.

MDCH DECISIONS

The review of applications, scoring, and site visits will result in one of three decisions below that will be announced by the department following the conclusion of these activities:

1. Award without conditions means that the department will contract with the applicant without changes required in the application. This action will be announced in early May. Contracts will be signed in September, with a start date of October 1, 2002.

2. Award with conditions means that the department requires that certain improvements must be completed or plans of correction approved before it will contract with the applicant. This action will be announced in early May. Conditions must be met by a date specified in the award announcement. Following the MDCH acceptance of improvements or plans of correction, contracts will be signed in September, with a start date of October 1, 2002.

3. Unsuccessful application means one of the following:
   a. The application was received after the deadline and will be returned to the sender immediately.
   b. The application did not pass Section 1.0, Organizational Status and Configuration, and was not considered for scoring. Notification of failure to pass Section 1.0 will be made within one week of receipt of the application by the MDCH.
   c. The application did not meet the scoring threshold. Notification of such a situation will be made within one week following the scoring of the application (approximately three weeks after the due date).
   d. The site review findings resulted in the scores to be lowered beneath the scoring threshold. Notification will be made by mid-April.

Applicants may appeal the decisions in number three above by delivering or faxing a letter requesting reconsideration, within two days of receipt of the notifications listed, to:

Terry Geiger, Deputy Director
Michigan Department of Community Health
Lewis Cass Building, Sixth Floor
320 S. Walnut Street
Lansing, Michigan 48913
FAX (517) 373-4288

THE APPLICATION

1.0 Organizational Status and Configuration

This section will receive a pass or fail determination. If any one item receives a fail determination, it will stop the application from further consideration. A fail determination will result from an answer of either **"no" without sufficient justifiable narrative included** or **an answer of n/a (not applicable) for an application consisting of an affiliation of CMHSPs**. Failed applicants will be notified within one week of the application due date.

Instructions: *Insert an"X" directly in the electronic version of the document in the appropriate box. This document is actually one very large electronic form, please use the mouse to "click" on the box to either add or remove an "X" Insert any explanation directly below each item. If for some reason the item is not applicable, that should be entered as the explanation, along with why the item is not applicable. All items not marked with an "X" must have an explanation. Tables, diagrams, and Artwork must be labeled with the section number they support (i.e., 2.9.9) and inserted electronically and sequentially directly following the section. Appendices should be labeled with the appropriate number and inserted electronically and sequentially in the Appendix section.*

The department's Revised Plan for Procurement affords initial consideration for specialty prepaid health plan designation to qualified CMHSPs. Therefore, the first and most basic requirement is that the organization submitting an application, and affiliated member organizations as part of a consolidated application, be legally established and operating as a CMHSP pursuant to Section 204 or 205 of Act 258 of the Public Acts of 1974, as amended in the Mental Health Code.

1.0.1 ☐ Applicant is a CMHSP.

1.0.2 ☐ Affiliate members are all CMHSPs.

For affiliations, specify which legal arrangement is being utilized for the applicant. Current permissive legal arrangements for affiliation include the Intergovernmental Contracts Between Municipal Corporations Act (ICA), the Intergovernmental Transfer of Functions and Responsibilities Act (ITFRA), and the Urban Cooperation Act (UCA).

1.1 ☐ One of the three items below has an "X".

- ☐ ICA
- ☐ ITFRA
- ☐ UCA

An application for an affiliation must provide, in Appendix A, of the hard copies of the application only, a copy of the legal documents that establish or validate that the entity making application has status as a CMHSP under the Mental Health Code and, where applicable, has the legal basis to enter into a contractual commitment with the department for a consolidated application for multiple CMHSP service areas. *(These items need not be scanned and submitted electronically. They must, however, be appropriately labeled with suitable cover sheets and inserted into the two required hard copies of the application.)* Where an application is being made by a single CMHSP, appropriate documentation is currently on file with the department.

The legal document(s) should address the following. Insert an "X" in the box next to each item that is addressed in the submitted documentation.

- ☐ the relationship between the parties
- ☐ the roles of each party to the agreement
- ☐ the rights of each party to the agreement
- ☐ governance arrangements and conditions
- ☐ functional consolidation* of administrative activities
- ☐ assurances that all affiliate members will comply with federal and state standards and regulation and what processes exist to address non-compliance
- ☐ the financial arrangements and interests of each party to the agreement including, but not limited to: cost-sharing, cost-allocations, local match obligations related to Medicaid funds, fund transfers, re-purchase (contracting back) arrangements, resource/asset claims, liability obligations, risk obligations, risk management, contingencies, areas of limitations, and areas of exclusions
- ☐ established dispute resolution mechanism(s) between the affiliates
- ☐ identification of the designated CMHSP to act as the prepaid health plan

* Functional consolidation - the combining and merging of staff functions and activities in an effort to increase efficiency.

1.2 ☐ Document(s) submitted for this item, in Appendix A, have been determined by the applicant's legal counsel to provide a legal basis for entering into a Medicaid contract for the specified service area.

For all CMHSP boards represented in the application, attach a list of board member categories with the number of members currently serving in each category and any vacancies labeled Appendix 1.3. This list should confirm compliance with Sections 212, 214, 216, 219, and/or 222 of the Mental Health Code regarding board membership participation and composition. Additionally, for a consolidated application, identify in the legal document submitted any specific reference to an affiliated member's board and how this board's composition meets Section 222(1) of the Mental Health Code criteria. If no affiliated member's board will be constituted, state this fact.

1.3 ☐ Board composition of applicant meets Mental Health Code requirements.

The department shall review the applicant's, and affiliate(s), status regarding compliance with certification criteria, Section 232 of the Mental Health Code. Consolidated applications will be reviewed to assure all CMHSPs within the consolidated application meet the criteria. To be referred for scoring of the proposal, applicants must have substantial or provisional certification for each participant CMHSP within the consolidated application at the time of application.

1.4 ☐ Substantial or provisional certification met.

The department shall review the applicant's status regarding MCLA 330.1232a(6); Recipient Rights System. Consolidated applications will be reviewed to assure all CMHSPs within the consolidated application have overall assessment scores of substantial compliance. To be referred for scoring of the proposal, applicants must be determined to have scores of substantial compliance with Recipient Rights System standards.

1.5 ☐ Assessment scores meet substantial compliance.

1.6 The department's calculation of the number of Medicaid-covered lives in each county is in Attachment A of this document. Consistent with the Implementation Guide (10/11/01, page 8) a minimum covered lives criterion of 20,000 Medicaid beneficiaries must be met by each prepaid health plan. Applicable contiguity criteria (Public Act 60 of the Public Acts of 2001) will be applied to the geographic region.

1.6.1 ☐ Applicant service area has minimum 20,000 lives.

1.6.2 ☐ Applicant attests to meeting the contiguity requirements.

Include a statement, as Appendix 1.7, signed by those involved, attesting to their involvement in the development of the application as primary individuals, family members, and/or advocates representing each service area of the affiliation, if applicable, and all populations served, i.e., adults with serious mental illness, children with serious emotional disturbance, children and adults with developmental disabilities, and children and adults with substance use disorders.

1.7 ☐ Statement attached attesting to consumer/stakeholder involvement.

1.8 ☐ If the applicant is submitting the application under an assumed name (doing business as, or DBA), documentation on the DBA allowing the department to verify registration is included as Appendix 1.8.

Submit a narrative in Appendix 1.9, three pages or less, defining the vision and values of the stand-alone applicant, or of the affiliation. Include within the narrative a description of how the affiliation arrangement will actualize this vision and build upon the existing strengths of member CMHSPs. Explain how the prepaid health plan will bring any affiliates or providers with deficits up to standard or acceptable performance. Also indicate how functional integration* has been achieved and provide a plan for any further integration with corresponding time frames.

* Functional integration - the unification of agency functions to create a harmonious relationship among affiliate members in a consolidated application to allow the PHP entity to operate efficiently.

1.9 ☐ A narrative is enclosed in Appendix 1.9 and it meets the requirements spelled out above.

In Appendix 1.10, provide an administrative organizational chart with names and titles that reflects structure and reporting responsibilities for the applicant. Be sure that all affiliates and other subcontractors fulfilling managed care administrative responsibilities of the prepaid health plan are identified and included. See Figure 1 in the Implementation Guide for managed care administrative categories to which the organizational chart should refer.

1.10 ☐ An organizational chart meeting the criteria is included.

As Appendix 1.11, provide a curriculum vitae for the executive director of the applicant organization that verifies the following:

1.11 ☐ The executive director of the applicant organization meets the qualifications of an executive director as specified in Section 226(1)(k) of the Mental Health Code.

1.12 ☐ All appendices required throughout the application are included in the Application for Participation response.

Provider Sponsored Specialty Networks

(Responses 1.13.1 through 1.13.4 apply to applicants with more than 100,000 covered lives in the service area.)

1.13.1 ☐ The applicant has a written plan for the development and implementation of at least two provider-sponsored specialty networks to provide an array of specialty services and supports. These networks will be fully operational not later than 10/01/02. The plan includes the competitive procurement methodology which

assures best value, and may exempt certain highly-specialized or cultural-specific services in order to assure access to unique providers.

1.13.2 ☐ A written plan describes the structure and functions of the provider-sponsored services networks, their entity status, governance, individual and family representations, administrative responsibilities, service delivery and coordination of care responsibility, legal and liability issues, delegation, risk sharing arrangement, and other elements. The is plan is available for review. This plan has already been reviewed by:

- the applicant's legal counsel
- the applicant's financial advisor
- groups representing individuals, families, and advocates

1.13.3 ☐ The plan includes policies and procedures that allow individuals the opportunity to choose and move between and among provider-sponsored services networks.

1.13.4 ☐ The applicant has identified the specialty services and supports that will be provided by its own organization and therein kept out of the responsibility of the provider-sponsored services networks. The applicant has examined the effects of this decision on care coordination, quality, cost, and availability. The applicant has also examined the implications of this decision for apparent or real conflicts of interest and has adjusted its policies and procedures as needed to minimize conflict.

Table, Diagrams, and Artwork Supporting

Section One

(Insert any tables, diagrams, or artwork pertaining to Section One after this page. Please make sure the text typed immediately after the numbered subsection clearly refers to the fact that artwork has been placed here and that the artwork is clearly labeled as to which subsection it supports. The artwork must be readable as entered, without enlargement. Insertions should be sequential by number.)

2.0 Public Policy Management and Public Interest Considerations

This part of the application will be scored. The MDCH expectations and standards for delivery of specialty mental health, developmental disabilities, and substance abuse services are contained in the numbered items in each section. The term "applicant" refers to the applying entity and includes any applicable affiliates. If the statement in each section is true, insert an "X" directly in the electronic version of the document in the appropriate box by using the mouse to "click" on the box to either add or remove an "X." If the applicant, or any of its affiliates, does not meet an expectation or standard, do not place a mark in the box. Insert any explanation directly below each item. If for some reason the item is not applicable, that should be entered as the explanation, along with why the item is not applicable. All items not marked with an "X" must have an explanation. Tables, diagrams, and artwork must be labeled with the section number they support (i.e., 2.9.9) and inserted electronically and sequentially directly following the section. Appendices should be labeled with the appropriate number and inserted electronically and sequentially in the Appendix section. If an item is not marked, it requires 1) an explanation for why the applicant does not meet the expectation or standard; and 2) a plan for compliance (whichever is appropriate to the item) that includes: action steps, measurable objectives, time frames for completing each step, and person(s) responsible for execution of the plan. Insert the explanation and plan in the text box provided directly following the item. Documentation and evidence of meeting expectations and standards, and any explanations with plans, will be verified during a readiness site visit.

2.1 Stakeholder and Community Input

The applicant must be value-based and community-focused. Consumer and family participation on governing boards is already significant in the current CMHSP system; however, progressive organizations in the current milieu go beyond this level of participation and directly seek out stakeholder input and community concerns. This can be accomplished through "town-meetings," advocacy forums, advisory groups and other participatory mechanisms. In addition, while it is not a requirement of the Mental Health Code that consumer members of CMHSP boards self-disclose their disability, CHMSPs are encouraged to recruit consumers who will do so. Disclosure helps to fight stigma, provides an obvious consumer voice during board deliberations, and serves as a resource to other persons in the community.

The applicant will be responsible for obtaining, absorbing, applying and implementing stakeholder recommendations. The case for the MDCH preferential contracting with CMHSPs rests upon their commitment to particular public policy objectives and outcomes (e.g., effective freedom), and upon their unique role in the community as an "integrator" of services for individuals with mental health needs or substance use disorders.

2.1.1 ☐ Opportunities for stakeholder and community input and their involvement in policy formulation and implementation are available through:

- existing advisory boards
- scheduled community meetings
- local press coverage of services and activities

- self-disclosure by consumer members of CMHSP board and other advisory committees

2.1.2 ☐ Stakeholder involvement represents the scope and diversity of the community.

2.1.3 ☐ The names of key local individual advocates and advocacy groups providing stakeholder input are available upon request.

2.1.4 ☐ Stakeholder input is used to improve policy and operations

2.1.5 ☐ *Bonus Item:* Describe, in a maximum of three pages inserted below, the innovative methods the applicant has employed to obtain stakeholder and community input. Include the policies, procedures or practices for which input has been sought, and the number and diversity of the stakeholders and community members who provided the input. Also provide information on how feedback is provided to stakeholders in the utilization of their input to improve policy and operations.

2.2 Person-Centered Planning Policy Implementation

Person-centered planning has been a requirement in the Mental Health Code since 1996. The MDCH has revised practice guidelines which are located in Attachment E. Person-centered planning is not a current legislative requirement for individuals with substance use disorders.

Person-centered planning is required for persons with mental illness, developmental disabilities and substance use disorders, and for children with serious emotional disturbance. It is an ongoing process that recognizes that each individual has gifts and contributions to offer to the community and has the ability to choose how supports, services and/or treatment may help utilize his/her gifts and make contributions to community life. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate in the planning meetings and to assist the individual with his/her dreams, goals and desires. In person-centered planning with minors, the child/family is the focus of service planning and family members are integral to the planning process and its success. Throughout the person-centered planning process, the individual, and/or family for the minor child, is provided with ongoing opportunities to express his/her needs, desires and preferences and to make choices. Health and safety needs are identified in the process and supports are provided to address the areas identified.

2.2.1 ☐ The applicant has a person-centered planning policy in operation which was approved by the department between 10/1/98 and 9/30/01.

2.2.2 ☐ The applicant has integrated person-centered planning for persons with mental illness, serious emotional disturbance, developmental disabilities or co-occurring mental health and substance use disorders into the organization. Evidence that the service delivery system is driven by the person-centered planning process is found in organizational policy and procedures that assure person-centered plans are implemented, staff memos, informational brochures, and consumer satisfaction surveys.

2.2.3 ☐ *Bonus Item:* Identify, in a maximum of three pages inserted below, the person-centered planning training that has taken place between 10/1/98 and 9/30/01, including the frequency of training events, agendas, number of persons trained, and target training audience (e.g., case managers, support staff, secretaries, board members, families, individuals).

2.3 Care Management

Persons with serious mental illness, developmental disabilities, serious emotional disturbance and substance use disorders often have significant impairments and capacity limitations. Sustaining and accommodating these individuals in the community requires an array of care management activities, specialized treatments, rehabilitative services, and on-going supports. The spectrum of necessary services and supports must be configured into a coherent and coordinated system of care to meet the multiple and changing needs of individuals with these conditions.

2.3.1 ☐ The applicant has prepared an analysis of the number, demographics and community placement needs of persons in the service area currently residing in state mental health hospitals and developmental disabilities centers. The analysis identifies placement needs and service implementation time lines for each individual. This analysis is on file and will be made available upon request.

2.3.2 ☐ The applicant identifies, through the Omnibus Budget Reconciliation Act, Pre-Admission Screening Annual Resident Review (PASARR) process, those individuals who do not require nursing home placement; and has prepared an analysis which identifies placement needs and service implementation time lines. This analysis is on file and will be made available upon request.

2.3.3 ☐ The applicant has a written policy in place that assures consistency across the applicant's service area in the provision of supports coordination and case management options for individuals. This policy is on file and will be made available upon request. [Note: Case management is not a covered substance abuse service.]

2.3.4 ☐ The applicant has a written plan in place assuring that individuals in each part of the service area have:

- increased use of flexible options
- choice of consumer-operated and consumer-directed services
- increased choice in the service array
- availability of self-determination arrangements
  [Note: Self-determination is not required for persons receiving substance abuse treatment services.]
- increased opportunities for independent living
- increased opportunities for employment

The plan includes current capacity across the applicant's service area and implementation plans for increased opportunities with specified time lines. The written plan is provided as Appendix 2.3.4.

2.4 Employment

Michigan has encouraged a viable role for individuals with disabilities* in the public mental health system so that they are active, informed, and protected. Employing individuals with disabilities can help organizations improve their service delivery systems. To be credible and effective, the prepaid health plan must include meaningful involvement of these individuals in the delivery and evaluation of services and supports provided. The prepaid health plan must integrate individual and informal caregivers (family members) into its customer services operations, with specific attention to employment of individuals and family members to provide beneficiary services. Michigan has also identified employment as a critical outcome of services and supports for individuals with developmental disabilities and serious mental illness and has included employment in the Performance Indicator System for mental health and developmental disabilities.

2.4.1 ☐ Affirmative efforts are in place to increase agency and subcontractor employment of individuals with disabilities including recruitment, placement and development of pay scales including fringe benefits and training.

2.4.2 ☐ The applicant currently has individuals with disabilities on staff.

2.4.3 ☐ An organizational unit specifically dedicated to consumer interests and staffed by individuals with disabilities and/or family members is in place.

2.4.4 ☐ The applicant has demonstrated improvements in performance in employment of individuals with disabilities as measured by Performance Indicator reports for the period 10/1/99 to 9/30/01.

2.4.5 ☐ *Bonus Item:* Provide, in a maximum of three pages inserted below, the number of persons with mental illness, developmental disabilities, and substance use disorders employed by the applicant in each of the last two years, their work status (full-time or part-time), pay scales, fringe benefits, and a brief job description for each consumer employed by the applicant.

*For purposes of this section, "disabilities" include mental illness, developmental disabilities and substance use disorders.

2.5 Accommodations

To accommodate access and assure an individual's full participation and receipt of maximum benefit from the services being offered, the services must be provided in a manner that recognizes and takes into consideration the individual's ethnicity, cultural differences, language proficiency, communication and physical limitations. Recognizing and accommodating these differences is cost-effective for the prepaid health plan, adds customer value to the services being provided, and is fundamental to customer satisfaction.

Staff at all levels of the organization need to be sensitive to, and appreciate, how important accommodation is to effective service delivery. Creating an atmosphere of staff sensitivity to diversity and recognition of the need for accommodation requires a physical plant environment that is designed to be accessible, ongoing staff training, and policies, procedures, and practices which promote such sensitivity.

2.5.1 ☐ The applicant developed and implemented policy that ensures access and accommodation of persons with limited-English proficiency.

2.5.2 ☐ The applicant developed and implemented policy that assures sensitivity and accommodation of diverse ethnic cultural backgrounds.

2.5.3 ☐ The applicant developed and implemented policy to accommodate individuals with communication impairments (including persons who do not use verbal language to communicate or who use alternate forms of communication).

2.5.4 ☐ The applicant developed and implemented policy that better assures accommodation for persons with visual impairments or mobility challenges.

2.5.5 ☐ The applicant has informational posters, pamphlets and other materials used to describe various services and appeals/grievance mechanisms in formats that take into account the ethnicity, cultural diversity, limited-English proficiency, reading abilities, and sensory impairments of the general community available for MDCH review.

2.6 Rights

The applicant is expected to have clearly defined, easily accessible and responsive systems for protecting the rights of individuals receiving mental health and substance abuse services. Staff at all levels and at all service delivery sites of the applicant must have a basic working knowledge of the applicant's recipient rights policies and procedures for assuring this mandated protection mechanism is in place.

Procedurally, individuals shall be presented with basic information as to what their rights are and what appeal mechanisms exist to resolve rights-related disputes. This includes information about how to access rights protection system services, describes the process of assisting individuals filing formal complaints, and tracking and reporting patterns of service delivery problems within the organization.

2.6.1 ☐ The applicant employs at least one person who has a working knowledge of the applicant's service delivery system and is skilled in understanding the recipient rights protections that are afforded to individuals receiving mental health and substance abuse services under state and federal law.

2.6.2 ☐ The applicant has written mental health and substance abuse recipient rights polices and procedures that are in keeping with Michigan's public health and mental health codes. These policies and procedures are applied throughout the service area.

2.6.3 ☐ The applicant maintains a recipient rights data base and uses the information to train staff, track complaints and improve its service delivery, in addition to complying with MDCH reporting requirements.

2.6.4 ☐ The applicant maintains satisfactory compliance with MDCH rights standards for CMHSP certification, and all citations from the most recent state Office of Recipient Rights reviews have been corrected and accepted by that office.

2.6.5 ☐ *Bonus Item:* Describe, in a maximum of three pages inserted below, how individuals with limited-English proficiency and sensory impairments are assisted with understanding their rights, and with exercising those rights when they have a concern.

2.7 Health and Safety

It is essential that the applicant has clearly defined administrative policies and procedures for reporting, reviewing, and analyzing critical health and safety issues and sentinel events* that pose a risk for individuals. The applicant must have established processes which demonstrate that they effectively:

- identify and report the occurrence of critical health and safety incidents
- evaluate the factors involved in allowing critical health and safety incidents to occur
- identify and implement actions to eliminate or lessen the risk that critical health and safety incidents will occur

2.7.1 ☐ The applicant has an administrative policy and procedure for the reporting, review, root cause analysis**, follow-up of sentinel events, and documentation that this policy and procedure was implemented.

2.7.2 ☐ The applicant has an administrative policy and procedure that specifies how critical health and safety incidents are to be reported, reviewed, analyzed, and documented.

*Sentinel event - an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

**Root cause analysis - a structured and process-focused framework for identifying and evaluating the basis or causal factors involved in producing a sentinel event. The analysis should include the development of an action plan that identifies the steps that will be implemented to lessen the risk that similar events would happen again.

2.8 Public Interest

Whether managing particular categorical/population-specific services, or collaborating with other agencies to address community problems, local governance entities shoulder broad public interest responsibilities within their jurisdictions. Public interest considerations include protection of basic rights, promotion of inclusion and integration, equitable representation, public involvement and open proceedings, recognition of diversity, preservation of public safety, jail diversion*, provision of certain "public goods" (e.g., emergency services) and essential safety-net services available to all, comprehensive planning and needs assessment, prevention, and consultation efforts to promote community health and well-being, and outreach activities to vulnerable populations.

2.8.1 ☐ The applicant has provisions for crisis stabilization and response, pre-admission screening, initial assessments for substance use disorders, and MDCH certified/approved children's diagnostic and treatment programs that assure individuals receive timely service.

2.8.2 ☐ The applicant has jail diversion policies and programs in place, including:

- a clearly described mechanism or process for screening individuals at pre-and post-booking for the presence of a serious mental illness, a serious emotional disturbance, a developmental disability or a co-occurring mental health disorder and linking eligible individuals to the array of community-based mental health and substance abuse services
- signed coordination agreements with the criminal and juvenile justice system and routine cross-training is available

2.8.3 ☐ Information, in a maximum of three pages inserted below, is provided on jail diversion activities for the period 10/1/98 to 9/30/01 that includes the number of persons diverted by diagnosis and age with a brief description of the impact of these interventions.

* Jail diversion - a collaborative, integrated program utilizing a community's resources to divert a person with serious mental illness, serious emotional disturbance or developmental disability from possible jail incarceration when appropriate.

2.9 Coordination and Collaboration

The prepaid health plans are expected to cultivate partnerships among community agencies. Partnerships are necessary to forge linkages for care coordination and to develop cooperative solutions to complex community problems. Community direction, participation, and voice are accentuated and public interest considerations are explicitly promoted through community coordination and collaboration.

Examples of efforts to foster collaboration include: structures, such as Multi-Purpose Collaborative Bodies, that facilitate local coordination, promote early intervention, and explore methods for pooling resources; efforts to focus on substance abuse issues as a thread running through multiple community problems; collaborative efforts to address needs of older adults, individuals with dementia and their caregivers; the mental health/corrections systems interface; and the coordination of specialty services with local physical health care organizations.

Specialty mental health services for children and adolescents are regarded as part of a broader community "child and family services system," which includes education, child welfare, juvenile justice, and other community agencies. Collaborative planning between these agencies is heavily promoted, and the urgent need for expanded inter-agency efforts to address targeting sub-populations is a continuous theme in contemporary public policy.

2.9.1 ☐ The applicant has evidence of participation in local Multi-Purpose Collaborative Bodies, including attendance records. The director, or his/her designee who is able to make commitments for the organization, attends at least 80 percent of the Multi-Purpose Collaborative Body meetings.

2.9.2 ☐ The applicant is involved in other collaborative enterprises involving children such as Early-On and Strong Families/Safe Children. The applicant has evidence of participation in these enterprises, including attendance records. The director, or his/her designee who is able to make commitments for the organization, attends at least 80 percent of the meetings.

2.9.3 ☐ The applicant has formal linkages in place with each of the following:

- the family courts/juvenile justice system
- child welfare system
- local education system
- local district health offices

2.9.4 ☐ The applicant is involved in organized, ongoing collaborative efforts that involve individuals who require services from multiple systems, such as

those who have co-occurring disorders, are homeless, reside in nursing homes, are involved in the criminal justice system, or are older adults. A description of the efforts and the target population(s) is available for review.

2.9.5 ☐ Pooled funding arrangements or joint-service ventures with other community agencies across the service area are in place. Target populations and joint venture arrangements are described as Appendix 2.9.5.

2.9.6 ☐ A working relationship between the applicant and the local coordinating agency assures continuity of services, as evidenced by:

- subcontracting arrangements for Medicaid funds are in place
- mechanisms for coordination of services are in place so that services appear integrated to the individual
- joint efforts to address co-occurring disorders are ongoing
- the applicant has the capacity to serve individuals with co-occurring disorders (a listing of service sites that have this capacity is available and is used by the mental health and substance abuse service systems)
- described changes are located in section 3.12 Substance Abuse

2.9.7 ☐ The applicant has required signed agreements in place with all Medicaid health plans, the Michigan Rehabilitation Services office, and nursing homes.

2.9.8 ☐ The applicant assures coordination with primary health care and dental services for individuals that includes:

- identification of medical conditions requiring treatment
- referrals to appropriate providers
- follow-up to assess whether Medicaid treatment has been received
- services and supports provided are coordinated with primary care

2.9.9 ☐ The applicant assures coordination of benefits for children enrolled in the MIChild Program.

2.10 Agency Practices

Over the past 30 years, a consensus has emerged - established in law, preserved by judicial review, and reflected in policy - that unjustified isolation or segregation of individuals with disabilities in institutions is discriminatory and unwarranted. Thus, the contemporary specialty services system affirms the principles of community inclusion, integration, participation, and accommodation. The system recognizes that persons with serious mental illness, developmental disabilities, children with serious emotional disturbance, and persons with substance use disorders have certain attributes, impairments, limitations, or circumstances that constrain their functional capabilities, personal autonomy, life choices, and achievement opportunities. To reduce or minimize these constraints, prepaid health plans and their affiliates are expected to provide treatments, interventions, services, supports, and accommodations that: maximize community alternatives to more restrictive care; involve individuals in system governance; address cultural diversity in service planning and care decisions; promote choice wherever possible; seek support arrangements that facilitate independence, personal responsibility, involvement in community life, and promote wellness.

In fostering inclusion, participation and involvement, the system acknowledges an affirmative obligation to counter stigma and limit stereotypes applied to persons with these disabilities and disorders. The Revised Plan for Procurement and this Application for Participation endorse, and are constructed around, four major goals or purposes for managed specialty care. These goals are freedom, community, accountability, and efficiency.

In order to address these values, the applicant must demonstrate agency philosophy and practices related to services for persons with serious mental illness, serious emotional disturbances, developmental disabilities and substance use disorders that embody the principles of recovery and self-determination, support community linkages, work aggressively to prevent relapse, promote effective freedom throughout agency practices; and for children, provide individualized services which promote and support children to live with their families and achieve improved functioning in home, school, and community.

Insert a brief (one page) description of each of the following policies and practices of the prepaid health plan:

2.10.1 ☐ Foster recovery - description has been entered below.

2.10.2 ☐ Prevent relapse - description has been entered below.

2.10.3 ☐ Promote effective freedom - description has been entered below.

2.10.4 ☐ Promote and support children to live with their families and achieve improved functioning in home, school, and community – description has been entered below.

2.10.5 ☐ Evidence is available for demonstrating that the applicant routinely uses all of the following mechanisms to promote community inclusion, integration, participation, and accommodation:

- information and education
- consultation
- prevention (indirect models)
- outreach
- early intervention
- other community benefit activities

2.11 Self-Determination Policy and Practice Development

The Mental Health Code, Section 226 (2)(a)(i), provides the CMHSP executive director with the authority to: "Issue a voucher to a recipient in accordance with the recipient's plan of services developed by the community mental health services program." This code language, added in the 1996 Mental Health Code amendments, provides an opportunity for a CMHSP to partner with individuals in supporting their opportunities to choose and direct the provision of services and supports as agreed to in their plan of services that is developed using a person-centered planning process. With this authority in mind, the MDCH created an initiative to support and develop arrangements through CMHSPs that support an individual's capacity to self-determine the nature and circumstances of needed services and supports. While this option has not yet been a system-wide requirement, it is recognized that several CMHSPs have pursued the development of self-determination as a policy direction, and have diligently worked to assure that formalized learning about the principles and practices of self-determination has received priority in their local system. See Attachment J of this document for additional information. [Note: Self-determination policy specifically addresses persons with mental illness and persons with developmental disabilities only.]

2.11.1 ☐ The applicant has available for review, written polices and procedures that guide self determination arrangements for the individuals served.

2.11.2 ☐ The applicant has available for review, a list in tabular form, of significant formal training activities provided by external experts for the applicant, and each affiliate if applicable, identifying the training dates, events, presenters, and participants.

2.11.3 ☐ *Bonus Item:* Describe, in a maximum of three pages inserted below, the applicant's self-determination capacity in the service area. Identify the successes and challenges associated with developing self-determination as a policy and a set of practices. Describe how the applicant will involve primary consumers in the development of its policy and practice guidelines for self-determination, and how the applicant will use the experiences of individuals already active in self-determination, whether in its own area or other parts of the state, in this development. Reflect the implementation of the policy by identifying the number of individuals operating within the self-determination framework, the number on a waiting list to do so, and the number who have been offered but rejected the offer at this time.

Table, Diagrams, and Artwork Supporting

Section Two

(Insert any tables, diagrams, or artwork pertaining to Section Two after this page. Please make sure the text typed immediately after the numbered subsection clearly refers to the fact that artwork has been placed here and that the artwork is clearly labeled as to which subsection it supports. The artwork must be readable as entered, without enlargement. Insertions should be sequential by number.)

3.0 Administrative Capabilities and Management

This part of the application will be scored. The MDCH expectations and standards for delivery of specialty mental health, developmental disabilities, and substance abuse services are contained in the numbered items in each section. The term "applicant" refers to the applying entity and includes any applicable affiliates. If the statement in each section is true, insert an "X" directly in the electronic version of the document in the appropriate box by using the mouse to "click" on the box to either add or remove an "X." If the applicant, or any of its affiliates, does not meet an expectation or standard, do not place a mark in the box. Insert any explanation directly below each item. If for some reason the item is not applicable, that should be entered as the explanation, along with why the item is not applicable. All items not marked with an "X" must have an explanation. Tables, diagrams, and artwork must be labeled with the section number they support (i.e., 2.9.9) and inserted electronically and sequentially directly following the section. Appendices should be labeled with the appropriate number and inserted electronically and sequentially in the Appendix section. If an item is not marked, it requires 1) an explanation for why the applicant does not meet the expectation or standard; and 2) a plan for compliance (whichever is appropriate to the item) that includes: action steps, measurable objectives, time frames for completing each step, and person(s) responsible for execution of the plan. Insert the explanation and plan in the text box provided directly following the item. Documentation and evidence of meeting expectations and standards, and any explanations with plans, will be verified during a readiness site visit.

3.1 Access to Care

Prompt and easy access to services is a critical component of a managed care system. Access to services must be ensured to all individuals who are Medicaid-eligible and/or meet the Mental Health Code definition of priority population. Individuals who rely on public sector systems often lack resources to obtain services from complex systems and their mental health disabilities and/or substance use disorders affect their ability to pursue access. These individuals may require specialized supports to access the services they need.

Persons eligible for services, as well as staff of the applicant, any affiliates, and providers, require comprehensive and up-to-date information about the services that are available and how to access them. Information must be conveyed in an easily understood manner. Written materials must be at a basic reading level* and be available in the languages primarily spoken in the community. Alternatives for those who cannot read must be in place.

* Basic reading level – the reading level at which an individual is able to understand the overall meaning of what they read.

Outreach is needed to support access for under-served and hard-to-reach populations, including persons under 18, over 65, and members of ethnic, racial, linguistic, and culturally-diverse groups. It involves developing a responsive presence in emergency rooms, homeless shelters, women's shelters, senior centers, nursing homes, primary care clinics, and other places where

persons in need of services are likely to be found, for the purpose of encouraging them to enter treatment. Outreach for children involves establishing contacts with early childhood providers (Early On, Head Start), schools, Family Independence Agency (abuse and neglect services, adoption), family court, and juvenile justice services.

Promptness in access is necessary to maximize opportunities to address crises and to initiate treatment when it is needed. Time standards related to crisis response, pre-admission screening, assessment, and entry to ongoing services have been established. Access systems must accommodate the needs of all persons, including those from different cultural backgrounds and with limited-English proficiency, as well as persons with mobility impairments. Services must be available within a reasonable distance of an individual's residence.

The applicant must have a system to determine clinical eligibility for services and supports. This includes arrangements with Medicaid health plans for seamless access between the health plan and the specialty services system. The applicant must assure that individuals are given an informed choice of providers of mental health and substance abuse services.

3.1.1 ☐ Up-to-date and comprehensive information on available services and how to use them is readily available to the general public, persons eligible for services, and to families of eligible children.

3.1.2 ☐ Outreach is regularly and consistently conducted to the following commonly under-served populations who may be in need of mental health, developmental disability, or co-occurring mental health and substance abuse services:

- children and families
- older adults
- homeless persons
- members of ethnic, racial, linguistic, and culturally-diverse groups
- persons with dementia
- pregnant women

3.1.3 ☐ The applicant has formal procedures in place to assure that individuals are not inappropriately denied access during the screening, initial assessment, or access process, including Medicaid-eligibles, persons with a dementia diagnosis or co-occurring mental health and substance use disorder, persons under 18, and persons in nursing homes with mental health needs (including persons with severe mental illness, persons with developmental disabilities, and persons with dementia).

3.1.4 ☐ Transportation to programs is facilitated by the applicant via handicap accessible public transportation, Family Independence Agency, or other arrangements.

3.1.5 ☐ There is documentation that defensible methods are used to establish clinical eligibility for services for individuals entering services, and periodically for continuing individuals (assessments, diagnostic tests, medical necessity criteria, American Society of Addiction Medicine Patient Placement criteria for substance use disorders, etc.).

3.1.6 ☐ For any MDCH site review citations of partial or non-compliance received by the applicant in the dimension of customer services since 10/1/98, improvements have been made and all are now in full compliance in that area.

3.1.7 ☐ The applicant has service penetration rates for persons under 18 and for those over 65 equal to or greater than the representation of those groups in the service area population. If either rate has been an extreme negative statistical outlier for the two quarters ending 9/30/01, describe below what has been done to assess why this situation exists and what problems have been identified. Include specific plans with time frames that are in place to ensure improvement. This item is not applicable to penetration rates for substance abuse services.

3.1.8 ☐ Accommodations are available to address all of the following:

- limited-English proficiency and linguistically appropriate needs, including the availability of language assistance services, such as American Sign Language interpreters, bilingual staff and/or interpreters at no cost to individuals when requested; and written materials and signs are available in the languages of commonly encountered groups in the community
- cultural and demographic needs of the community
- visual impairments, e.g., written materials and signs translated into Braille, are available in buildings, accommodations for service animals
- alternative needs for communication, including the availability of an augmentative communication specialist, if needed
- mobility challenges, e.g., buildings are accessible (entrances ramped, restrooms wheelchair accessible, automatic door openers, elevators in multi-story buildings), parking lots have sufficient designated parking for vehicles with handicap permits

3.1.9 ☐ The applicant has developed staff (including employees, contract staff, and volunteers) competencies and assures that training is continuously provided in:

- limited-English proficiency and linguistically-appropriate services
- cultural competence
- accommodations for visual, communication, and mobility impairments

3.1.10 ☐ *Bonus Item:* Provide, in a maximum of three pages inserted below, a description of how the applicant routinely meets with individuals/families/ stakeholders to identify any barriers to access, and to discuss strategies for improving access.

3.2 Person-Centered Planning Practices

Person-centered planning has been a requirement in the Mental Health Code since 1996. The MDCH has recently revised practice guidelines which are located in Attachment E. It is not mandated for individuals with substance use disorders.

Person-centered planning is required for all persons receiving public mental health system services. It is an ongoing process that recognizes that each individual has gifts and contributions to offer to the community and has the ability to choose how supports, services and/or treatment may help utilize his/her gifts and make contributions to community life. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate in the planning meetings and to assist the individual with his/her dreams, goals and desires. In person-centered planning with minors, the child/family is the focus of service planning and family members are integral to the planning process and its success. Throughout the person-centered process, the individual, and/or family for the minor child, is provided with ongoing opportunities to express his/her needs, desires and preferences and to make choices. Health and safety needs are identified in the process and supports are provided to address the areas identified. This section addresses implementation of person-centered planning practices.

3.2.1 ☐ The applicant received no citations in the MDCH site review process during the review conducted in FY 00/01 for the 17 essential elements of person-centered planning.

3.2.2 ☐ Needed improvements in person-centered planning practice identified through the post-MDCH site review process, internal reviews, consumer satisfaction surveys or other information, have been made by the applicant.

3.2.3 ☐ Training on person-centered planning has been provided to, or arranged for, individuals, staff, contract providers, families, and guardians, and there are plans for continuation that are available for review.

3.2.4 ☐ The applicant has a plan for developing the option of independent facilitation of the person-centered planning process in the service area. The plan must be developed with the involvement of consumers, families and stakeholders, with at least 50 percent being primary consumers. The plan must include how individuals involve their families, friends, and allies to develop their own person-centered plan. This option must be available for all individuals except those receiving short-term outpatient services or medication only. The plan to obtain facilitators must be in place by 10/1/02, and must specifically address the following:

- how the applicant will obtain a group of independent facilitators, including what the experience and/or training requirements will be to assure that independent facilitators have an understanding of the person-centered planning process, including facilitation
- how the applicant will describe the function of the independent facilitator
- how individuals will be made aware that they have the option of an independent facilitator
- strategies to maximize opportunities for individuals to obtain an independent facilitator (with the exception of those receiving short-term outpatient services or medication only) to facilitate their own plans
- how individuals who choose independent facilitation will be assured choices among facilitators
- how the applicant will assure that independent facilitators are free rom conflicts of interest (principal-agent conflicts)
- how the applicant will assure that independent facilitators are supported through opportunities for networking and continued development
- the issue of compensation for independent facilitators and how this may affect individuals with or without individual budgets
- how the applicant will evaluate the performance of each independent facilitator, including the use of feedback, and how it will make this information available to individuals
- how the applicant will assure that the person-centered planning experience is not delayed for individuals because they desire to obtain and utilize an independent facilitator
- how, and in what time frames, a person-centered plan developed with independent facilitation will be approved, including funding commitments, by the applicant

3.3 Service Authorization

A key aspect of utilization management is service authorization. Service authorization is a process designed to help assure that planned services meet medical necessity criteria, and are appropriate to the conditions, needs, and desires of the individual. Authorization can occur before services are delivered (pre-authorized), at some point(s) during service delivery, or can occur after services have been delivered based on a retrospective review. Some services may be exempt from authorization, up to specified limits.

3.3.1 ☐ The applicant has policies and procedures that define the use of service authorization throughout the service area and include all of the following:

- the purpose of service authorization
- the services that require authorization, and the necessary staff qualifications
- the method of service authorization used for each service, including decision-making criteria
- methodology that assures that receipt of needed services and appropriate services are not delayed by the authorization process
- how service authorization relates to claims management to assure that unauthorized services are not paid, and authorized services are not rejected by claims management
- how the service authorization process addresses person-centered planning outcomes
- published mechanisms to resolve differences or disputes between person-centered planning outcomes and service authorization decisions
- mechanisms for providers to appeal decisions rendered by the service authorization process

3.3.2 ☐ The applicant has mechanisms in place and described in policy for reviewing the operation and impacts of service authorization throughout the service area on a regular basis. These mechanisms include the use of individuals and advocates in the review of, and deliberation on, findings.

3.4 Case Management and Supports Coordination

Case management and supports coordination programs assist individuals who are eligible to receive case management services in gaining access to needed mental health, substance abuse, medical, pharmacological, social, educational, and other services. The essential elements of case management and supports coordination include, but are not limited to: assessment; linking and coordinating services; and follow-up and monitoring service effectiveness. Case management and supports coordination services may be provided in any settings or locations that the individual prefers. The intensity of these services varies according to individual desires and needs.

3.4.1 ☐ The applicant has available for review a description, in table format, of the availability of case management services which describes:

- the number of case management providers
- whether the provider is direct or contractually- operated
- the populations served (persons with mental illness, persons with developmental disabilities, children with serious emotional disturbance, and persons with substance use disorders)
- the case manager/supports coordinator-to-individual ratio for each provider

3.4.2 ☐ The applicant has implemented procedures that assure all eligible individuals are aware of options related to case management arrangements.

3.4.3 ☐ The applicant has evidence to show that all individuals eligible for services are offered a choice of case management and supports coordination provider agency, as well as an informed choice of case manager.

3.4.4 ☐ Processes and incentives are in place to assure case management staff and supports coordinators are supported, and not limited, in the information they provide about the availability of, and access to, the full array of services and supports available to individuals.

3.4.5 ☐ The applicant assures an organizational culture that promotes familiarity with the existence of, and eligibility requirements for, those services and supports available to meet the individual's desires and needs. This includes all of the following:

- documentation which identifies and routinely updates those resources available in the community, including formal and informal supports, that can assist individuals in meeting their needs
- formal mechanisms in place to assess the technical assistance and training needs for case management providers
- documentation which demonstrates the provision of formal technical assistance and training activities provided to case management and supports coordination providers
- evidence that technical assistance was given to all providers who needed it relative to case management and supports coordination requirements

3.4.6 ☐ The applicant was in full compliance with the MDCH mental health site review standards on Case Management (B.7. - B.7.5.3.of the site review protocols) for the visit conducted during FY 01.

3.5 Service Array

To assure service availability and structural integrity, the applicant must provide assurance that specific covered services alternative services and allowable services are available throughout the service area and meet state established "structural integrity" and "model fidelity" criteria as outlined in Chapter III of the Medicaid Bulletin and the MDCH contract. Program enrollment is maintained as verification of integrity and fidelity, and site visits confirm that program criteria are being met.

3.5.1 ☐ The applicant has available for review an annual evaluation of the likely demand for care that includes:

- the expected utilization of all services specified in the MDCH contract and technical advisory
- the numbers and types of providers and provider organizations necessary to meet demand and utilization predictions
- highly specialized providers necessary to address:
  - special needs (such as age-appropriate)
  - cultural diversity
  - other unique conditions or situations of the populations served

3.5.2 ☐ All mental health and developmental disability covered and alternative services and allowable substance abuse treatment services included in the MDCH contract are available in the applicant's service area to eligible individuals as necessary and authorized. The availability of these services meets the geographic standard. A comprehensive description of the size, scope, and capacity of all services, and how these services are provided in a culturally and age appropriate and competent manner to individuals requiring such accommodation is available. These descriptions are on file and will be made available upon request.

3.5.3 ☐ The applicant is in compliance with the requirements of the service array that meet criteria outlined in Chapter III of the Medicaid Bulletin and the MDCH contract. In the case of mergers or affiliations among CMHSPs, the consolidation has not resulted in a reduction in the availability of services from those that were available in FY 01.

3.5.4 ☐ EPSDT specialty services to correct or ameliorate a qualifying condition discovered through the EPSDT screening process are available to individuals referred by a primary EPSDT screener. These services are available in the applicant's service area.

3.5.5 ☐ The applicant has a process in place to assist individuals in obtaining necessary transportation for EPSDT participants through the individual's Medicaid health plan or through the Family Independence Agency.

3.5.6 ☐ The applicant has a process in place to foster the growth and development of consumer-run and consumer-operated services that is available for state review.

3.6 Customer Services

Customer services is an identifiable function that operates to enhance the relationship between the community and applicant, as well as between the individual and the applicant. As such, it must interact with essentially all other aspects of the operations. Customer services include orienting new individuals to the services and benefits available, including how to access services, rights protections processes, helping individuals with problems and inquiries regarding benefits, assisting individuals with, and overseeing complaint and grievance processes, and tracking and reporting patterns of problem areas for the organization. This requires a system that is available to assist at the time the individual has a need for help, and being able to assist on the first contact if at all possible.

General Customer Services Operations

3.6.1 ☐ The customer services operation is clearly identified and facilitates:

- phone access by the community and service recipients throughout normal business hours (voice mail and answering machines are not considered phone access)
- that persons contacting the customer services operation speak with staff who have up-to-date knowledge regarding benefits, the provider network, applicant and network policies/procedures regarding access, service authorization, grievance/appeal procedures, and are skilled in customer relations
- a documented process whereby service or process improvement suggestions from individuals are routed in a timely manner to the appropriate part of the operation
- integration of individuals and family members into customer services operations including orienting new individuals and their families, creating special project work groups and councils, community awareness outreach initiatives, providing or facilitating arrangements for advocacy when requested, mentoring, developing informational material, and customer satisfaction inquiries.

3.6.2 ☐ Customer services staff are knowledgeable regarding referral systems to assist individuals in accessing transportation services necessary for medically-necessary services (including specialty services identified by EPSDT).

3.6.3 ☐ A range of methods are used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the applicant network.

3.6.4 ☐ Customer services performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the applicant.

3.6.5 ☐ The focus of customer services is customer satisfaction and problem avoidance, as reflected in policy and practice.

3.6.6 ☐ Customer services is managed in a way that assures timely access to customer services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities, hearing and/or vision impairments, limited-English proficiency, and alternative forms of communication.

3.6.7 ☐ The relationship of customer services to required grievance and appeals, and recipient rights processes is clearly defined organizationally and managerially in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations.

Grievance and Appeal Operations

It is incumbent upon the applicant to have a clearly defined, easily-accessible and responsive system for handling customer appeals and grievances. Staff at all levels and at all service delivery sites of the applicant must have a basic working knowledge of the applicant's policies and procedures for managing grievances and appeals.

Procedurally, each individual shall be presented with basic information as to what their appeal and grievance rights are and what procedural options exist to resolve service delivery disputes. This includes information about how to access services, helping individuals with problems and inquiries regarding benefits, assisting individuals with complaint and grievance processes, and tracking and reporting patterns of service delivery problems within the organization.

It is important to note that if the applicant is part of an affiliation, the plans must reflect the system that will be in place on 10/1/02 to serve the affiliation's entire service area.

3.6.8 ☐ The applicant employs at least one person skilled in customer relations who is responsible for coordinating all grievances and appeals, and advising individuals of their rights and dispute resolution options.

3.6.9 ☐ The grievance and appeal coordinator has a working knowledge of the applicant's service delivery system and plan benefits.

3.6.10 ☐ Posters and/or brochures in alternative formats notifying individuals of their grievance and appeal rights, including mediation, shall prominently include the name and telephone number of the applicant's appeal and grievance coordinator.

3.6.11 ☐ All persons experiencing the need to complain or pursue a grievance or appeal regarding some aspect of their experience with services/treatment which are the responsibility of the applicant, and needing assistance to advance their complaint or grievance, obtain sufficient assistance from customer services staff to succeed in having their concern addressed through the desired process.

3.7 Self-Determination Policy Implementation Planning

Self-determination, as a means for achieving an individual's plan of services and supports, has evolved from a change in the philosophy, vision and methods defining the relationship between individuals and the service delivery system. This direction has been guided by a set of concepts and values which underscore a core belief that people who require support from the public mental health system as a result of a disability should be able to define what they need in terms of the life they seek, should have access to meaningful choices, and should have control over their lives. The Mental Health Code, Section 226 (2)(a)(i), provides an option for a CMHSP executive director to issue a voucher to a recipient, based upon their plan of services. The MDCH has issued a Self-Determination Policy and Practice Guideline that is to govern the actions of applicant development of local policy, practice and methodologies which can assure that services and supports for individuals are not only person-centered, but person-defined and person-controlled. The department's intent is that the applicant achieve full compliance with the Self-Determination Policy and Practice Guideline during FY 03. Achieving compliance with the policy requires development of written local policy and assuring that there is local practice guidance available. More importantly, it requires that the applicant and members design and pursue a strategy for building an organizational environment that truly supports the principles and practices of self-determination for individuals who desire that option. Self-determination is not required for substance abuse treatment services.

3.7.1 ☐ The applicant has on file, and will make available upon request, a written plan with a timetable of specific actions and deadlines for achieving compliance with the MDCH Self-Determination Policy and Practice Guideline. This plan must include provisions to achieve full compliance by the conclusion of FY 03, and to begin offering self-determination as an option no later than 10/1/02. The plan must include identification of the deadline for the promulgation of official applicant policy governing the application of self-determination and consumer-directed care options, and all of the following:

- describe the method that will be applied across the applicant's service area and its direct-operated and contracted providers, to orient and assure understanding of the principles of self-determination
- specify the method by which the applicant will assure leadership within each affiliate for the emerging self-determination direction, in terms of designated staff and percent of time devoted to leadership/coordination of self-determination
- describe how the applicant will share knowledge to make it feasible for the applicant and any affiliates to achieve compliance with the Self-Determination Policy and Practice Guideline
- describe the methods by which the applicant will gauge compliance with the Self-Determination Policy and Practice Guideline, and how it will ascertain and manage quality and efficiency of local self-determination arrangements across any

affiliates, including how this process will meaningfully involve individuals and family members

- the applicant has submitted a summary of the plan outlined above as Appendix 3.7.1 to the application

3.8 Provider Network Configuration, Selection and Management

This section outlines minimum requirements related to the capacity, characteristics, selection, and management of a provider network for all applicants.

Provider Network Configuration

3.8.1 ☐ The applicant assures that its provider network has all the following characteristics:

- the capacity to provide each specialty service and support is equal to or greater than the demand for each service and support, in relation to geographical standards
- meets the minimum qualifications and legal and program requirements to provide the services it is contracted to provide
- includes, in urban areas, qualified Native American providers that offer specialty mental health and substance abuse services to Native American populations. (see Attachment 6)
- assures an individual's informed choice of providers
- assures compliance with limited-English proficiency, cultural competence, and accommodation of physical and communication limitations
- reflects input of individual/family/stakeholder group(s)
- all identified network providers have reviewed proposed or final provisions of the FY 02/03 provider master contract(s), as Appendix 3.8.1, and have expressed in writing their agreement to participate in the provider network

Provider Network Selection

3.8.2 ☐ The procurement methods and criteria used to select and procure network providers are provided, as Appendix 3.8.2. The applicant must provide information on payment rates for all services, in tabular format.

In column 1 of the table, list each covered, alternative, and allowable service that will be made available in the service area as of 10/1/02.

In column 2, indicate the payment rate(s) for each service, effective 10/1/02. The rates may be reimbursement rates paid to providers or costs determined by the applicant and any affiliates for services they provide directly. For each rate, indicate the type of unit that applies, such as unit of service, case rate, cost settlement, sub-capitation, or other (must specify). If a range of rates has been established for a given service, indicate the range. If affiliates will use different rate structures than the applicant, the rate structure for each affiliate must be entered separately.

Some services are not rate specific, indicate these in some manner with a short notation.

In column 3, indicate the method for establishing each rate. The method may be one or more of the following: customary charge, competitive price bid, negotiated rate, actuarial basis for sub-capitation, or other (specify if other). If all rates were established through the same means, this may be indicated. If different methods were used for different rates, or if the applicant and affiliates used different methods to establish rates, these differences must be indicated. The applicant is advised that documentation concerning rate methodologies must be available for department review upon request.

In column 4, indicate the fiscal year in which each rate was established or was last updated, whichever is more recent. Where work is in process to define rates, indicate this and include a notation for the service, planned completion date, and who is responsible for achieving this activity.
The methods and criteria:

- are consistent with requirements in the department's contract for Medicaid specialty services and supports
- involvement of individual/family/stakeholder group(s) in the process
- provider selection and contracting include a "best value" process, where appropriate, and will result in improved administrative efficiencies, access, choice, and quality of services and supports

3.8.3 ☐ The applicant's plan for network development and management, provided as Appendix 3.8.3, contains strategies to assure that:

- a provider network will be in place to assure a full array of services by 10/1/02
- training and orientation on contract requirements and network policies and procedures for all network providers are completed not later than 9/1/02
- there is a designated single point of responsibility within the applicant for overseeing contract development and execution
- there is a designated single point of responsibility within the applicant for on-going contract and network management
- there are explicit and specific measures to be implemented to avoid conflicts of interest concerning the selection, management and monitoring of any provider that is part of the network

3.8.4 ☐ The applicant has adopted common policies and procedures concerning assessment and service provision for individuals with co-occurring mental

health and substance use disorders. These policies and procedures are applicable throughout the network, and encompass all of the following:

- access centers/units in the service area routinely screen for co-occurring disorders
- all access centers/units in the service area have professional staff who are cross-trained in performing assessments for co-occurring disorders
- developed criteria for selecting providers who deliver services to individuals with co-occurring disorders
- service area has reasonable access (30 miles or 30 minutes in urban areas, or 60 miles or 60 minutes in rural areas) to specialized services for co-occurring disorders
- assurances that services (mental health and substance abuse) for this population are provided concurrently, continuously, and/or integrated as appropriate
- coordination of benefits

Managing the Network

3.8.5 ☐ The applicant has adopted (common) policies and procedures for managing networks, described as follows:

- individuals, families and advocates participated in development of provider network policies and procedures prior to their adoption
- policies and procedures, for use throughout the service area, include those that are specific to services to children, services to individuals with substance use disorders, and services to older adults
- all network providers must demonstrate compliance with policies and procedures as a condition of initial contract award and of continued contract award and payments
- methodologies employed to perform criminal background checks on potential employees

3.8.6 ☐ The provider contract(s), as Appendix 3.8.1, contains the following:

- payment rates for all services being purchased
- specifications for submitting clean claims/invoices
- payment schedule(s), including the applicant's responsibility for payment timeliness
- providers' financial risk (if any)
- first and third party liability and provider responsibility for collections (including provision that Medicaid beneficiaries have no first-party liability)
- incentive systems (if any)

- requirements concerning Medicare/Medicaid dual eligibles
- maximum lag between service date and claims submission date
- all reporting requirements
- sanctions

3.8.7 ☐ The applicant has policy and business practice procedures to assure regular monitoring and reporting on the performance of each network provider, as well as actions to assure improvement and compliance with all stated requirements. These mechanisms include:

- operations for prompt review and analysis of data and finance reports from providers
- on-site review of each provider once a year and as needed
- integration of utilization management and other practice information, including customer service reports
- individual/family/stakeholder group(s) involvement in the monitoring/ management process
- remedies to be used for compliance and performance problems.
- how the above mechanisms are applied to network providers

3.8.8 ☐ The applicant has conducted performance reviews annually or more often for all providers in the provider network since 10/1/98. These reports, and any provider comments, are contained in files available for review. Written reports of findings are prepared and shared with providers for comments, and plans of corrections are submitted by the providers as necessary. Provider performance reports are available for review by individuals, families, advocates, and the public.

3.8.9 ☐ *Bonus Item:* Describe, in a maximum of three pages inserted below, the role individuals/families/stakeholders play in monitoring the performance of network providers. Identify the number of persons involved, the nature and frequency of their monitoring activities, the portions of the network they do or do not monitor, and how their findings are utilized by the applicant.

3.9 Quality Management

Michigan's quality management system for CMHSPs has been described as having prospective, concurrent, and retrospective elements that assess the CMHSP's performance in providing quality supports and services. Included in "prospective" elements are the requirements that the CMHSP is certified by the MDCH including a recipient rights system that is in compliance with standards; that its specialized residential programs are certified by the Michigan Department of Consumer and Industry Services; that its Children's Diagnostic and Treatment Services Program is certified; and that all foster care programs used by individuals served by CMHSPs are licensed by Consumer and Industry Services. "Concurrent" elements are primarily the annual reviews of CMHSPs and their contractors conducted by MDCH staff to determine if programs are meeting the standards of Chapter III of the Medicaid Bulletin, the Mental Health Code, and agreed-upon contract specifications. "Retrospective" elements include the Michigan Mission-Based Performance Indicator System, the annual report of costs, statewide quality of life and consumer satisfaction surveys, the encounter data system, and the independent assessments.

Quality management for substance abuse services also has prospective, concurrent and retrospective elements. All service programs are licensed by Consumer and Industry Services, and all treatment programs are required to be accredited by a national organization for substance abuse standards of practice. Annual reviews include the Annual Action Plan process used in funding and contract requirements, as well as annual substance abuse coordinating agency site reviews by MDCH staff. Substance abuse performance indicators, the annual legislative report on costs and services, consumer satisfaction surveys, encounter and other data reporting, and independent assessments are also in place.

The applicant must have an internal quality management system that meets the requirements of the federal Quality Improvement Systems for Managed Care. The applicant's quality management system monitors its own performance, as well as that of its affiliates, if applicable, and the provider network, and compares the performance to state standards and the performance of other prepaid health plans. In order to be effective, the quality management system must integrate and analyze information from multiple units and functions within the organization such as customer services, access, recipient rights office, and programs; as well as from external sources (e.g., individuals and community, MDCH, Consumer and Industry Services, primary care providers, etc.). A health information system is essential to an effective quality management system.

<u>Internal Quality Management System</u>

3.9.1 ☐ One unit has responsibility for the quality management system and is identifiable on the applicant's organizational chart.

3.9.2 ☐ The quality management system uses data from internal units and external sources (MDCH, advocates, providers, community) to:

- assess performance of the applicant and their provider networks
- analyze the applicant's performance in relation to statewide and affiliation or regional performance as reported by the MDCH
- integrate network providers into the applicant's quality management system (e.g. participation on quality management committees, receive consultation, training or technical assistance from Quality Management staff, receive prepaid health plan and state reports on quality management activities).

MDCH Site Reviews

3.9.3 ☐ The state selection panel will review the reports from site visits conducted through the period 10/1/98-9/30/01. The applicant has available for on-site review, evidence that plans of correction were implemented on all standards that received scores of partial or non-compliance for both of the last two years.

3.9.4 ☐ Site review reports from the MDCH are annually shared with the CMHSP board(s) of directors, as well as consumer advisory groups, councils, or committees.

Quality Management Reporting

Note: The state selection panel will review reports of data submitted for FY 00/01 by the CMHSP (or multiple CMHSPs if an affiliation) and coordinating agencies and published by the MDCH on performance indicators, sub-element costs, legislative report for substance abuse, consumer level demographic and service use, sentinel events, and deaths. Criteria for scoring (up to 10 points) include:

- Did the CMHSP (or multiple CMHSPs in an affiliation) and coordinating agencies meet standards, where applicable, for the four quarters of FY 00/01?
- Were the CMHSP(s) and coordinating agencies negative statistical outliers on performance indicators for two or more consecutive quarters during the fiscal year?
- Where applicable, was improvement in performance observed during the period?
- Was data complete and reported on time?

3.9.5 ☐ The applicant has available for on-site review evidence that the data submitted to the state is accurate.

3.9.6 ☐ The applicant has available for on-site review evidence that performance improvement measures have been put in place where performance was substandard and improvement is not evident in the reports submitted to the MDCH.

Quality Assessment and Performance Improvement Program

3.9.7 ☐ The applicant has a Quality Assessment and Performance Improvement Program that meets the approved Michigan Standards contained in the 1915(b) waiver renewal (Appendix C.1.a (2) and is in Attachment D of this document.

3.9.8 ☐ The applicant is implementing the mandatory performance improvement project on person-centered planning, and the second project as assigned (if applicable) for the current waiver period.

3.9.9 ☐ The applicant conducts annual assessments of satisfaction of at least a sample of all target populations receiving services using a standardized or a credible locally-designed instrument(s) or methodology.

3.9.10 ☐ The applicant routinely makes available to individuals, advocacy groups, and the general public reports in plain language and alternative formats to meet the needs of individuals of its performance in the areas of access, quality, appropriateness, and outcomes.

3.9.11 ☐ *Bonus Item:* Provide, in a maximum of three pages inserted below, a description of the elements of the quality management system in which individuals, family members (of both adults and children), and community are involved throughout the applicant's service area (e.g. review of results from the performance indicator system, site reviews, consumer satisfaction surveys) and the frequency and types of methods for involving them (meetings, forums, mailings). Include numbers of individuals receiving services, family members, and interested parties involved and their demographics (e.g., age, disabilities, cultural backgrounds) in table format; and how the individuals receiving services and family members are recruited, trained or oriented, and provided ongoing support for participation in the quality management activities.

3.10 Information System

The applicant must have an information management system that supports the core administrative activities of the organization/affiliation, including:

- integration of clinical, financial, utilization, authorization
- retrieval/access on-line, real time
- capability of identifying costs and revenues for different organization and service components
- methods for detecting and correcting errors

3.10.1 ☐ There is currently in place an information management system and data processing capabilities sufficient for collection, storage, retrieval, and reporting of all required data for the applicant, including demographic, service encounter, sub-element cost, and performance indicators as evidenced by:

- all required data reports to the MDCH have been submitted on time for at least the four quarters preceding this application
- a plan is available for review detailing how data collected from affiliates and vendors is tested for accuracy

3.10.2 ☐ The information management system supports authorization, utilization management, and claims processing activities as evidenced by:

- the capacity for linking authorizations, utilization, and claims processing across its provider network and affiliation
- an information flow chart detailing the authorization process is provided as Appendix 3.10.2. Identify how data is collected, how it is aligned with utilization data, and summarize reports available to management.

3.10.3 ☐ The information management system ensures timely reimbursement for approved services as evidenced by:

- a specifically-defined review process identifying claims payment rates at least by affiliate and by vendor
- the process is documented and a history of process utilization is available for review

3.10.4 ☐ The information management system supports other critical administrative, care management, quality assessment, compliance monitoring, and fiscal functions of the applicant as evidenced by:

- an active internal quality improvement process for the information management system with regularly scheduled meetings and meeting minutes available for review; must identify how any

affiliates will be incorporated into the process
- the organizational chart in Appendix 1.10 identifies the information management system staff and their reporting linkage to the agency director; chart must identify how any affiliate information systems teams will be incorporated
- there is evidence that the results of internal statistical review of data is used for process improvement

3.10.5 ☐ The information management system interfaces with provider subsystems to ensure efficient collection and reporting of data as evidenced by:
- a plan is in place and available for review detailing how information held by the applicant will be synchronized with data held by any affiliates, vendors, or providers to support record security
- a plan is in place and available for review detailing how beneficiary information held by the applicant will be synchronized with data held by any affiliates, vendors, or providers to support system management by the applicant

3.10.6 ☐ The information management system has protection and security features to ensure confidentiality and safeguard against data loss or corruption as evidenced by:
- a plan and procedures are in place to prevent unauthorized access from outside the network to individual level data and documentation to verify compliance with the plan
- a plan and procedures are in place to prevent unauthorized access from inside the network to individual level data and documentation to verify compliance with the plan
- use of anti-virus software, anti-virus signature files are updated on at least weekly, and documentation exists to verify this
- off-site back-up data storage (off-site would include any storage in a building physically separated from the building housing the computers being backed up)

3.10.7 ☐ The information management system can demonstrate at least a twelve month history of unpacking and reviewing the Medicaid eligibility files as supplied in the 4396/4397 file formats downloaded from the DEG system. This includes use of the data for eligibility determination and both revenue and service population projections.

3.10.8 ☐ The information management system has a plan for complying with current Health Insurance Portability and Accountability Act (HIPAA)

requirements for code and transaction sets, and applicable regulations for privacy and security as evidenced by:

- will be in full compliance with the HIPAA transaction standards by 7/1/02
- will be in full compliance with the HIPAA privacy standards prior to 3/1/03, as determined by the federal Department of Health and Human Services

3.10.9 ☐ The information management system is in compliance with the current phase of the MDCH Uniform Billing Project for Medicaid.

3.10.10 ☐ *Bonus Item:* Provide an information flow diagram and a descriptive narrative explaining how individual level information is collected, stored, and used for compiled MDCH-mandated quality management reports. This should specifically include how demographic data are extracted for MDCH reports. It should also clearly identify any data not stored in the information system, and any points at which data is not exchanged by electronic data interchange.

3.11 Financial Management

The applicant needs to have a thorough and efficient financial management system to assure success in meeting the service delivery and administrative requirements of the specialty supports and services contract. The MDCH is agreeing to participate with successful applicants on a shared risk basis. Since the MDCH assumes full financial risk above 110 percent, and the purpose of the contract is to assure medically-necessary services to vulnerable populations, the state is requiring various documents and assurances from the applicant to enable an assessment of the strength and integrity of the financial management system.

It is important to note that if the applicant is part of an affiliation of CMHSPs, the application must reflect the status for the entire service area, not just the applicant CMHSP. Examples of policies and procedures, methodologies, reports, etc., from one member of the affiliation can be reflected in the application if they reflect the requirements, process, and parameters that will be required for the affiliation as a whole, and this is clearly stated in the application.

3.11.1 ☐ The applicant operates from a financial management plan that assures proper internal controls throughout the operation in accord with state, federal, and professional requirements. The plan addresses the following internal control elements:

a) a plan of organization that provides separation of duties and responsibilities among employees;
b) a plan that limits access to resources to authorized personnel whose use is required within the scope of their assigned duties;
c) a system of authorization and record keeping procedures to control assets, liabilities, revenues, and expenditures;
d) a system of practices to be followed in the performance of duties and functions;
e) qualified personnel that maintain a level of competence; and
f) internal control techniques that are effective and efficient.

3.11.2. ☐ Financial data is integrated with the information system in a way that reconciles the determination of care costs by unit, episode, population, provider, and administrative cost distribution.

3.11.3 ☐ Financial management reports are provided on a frequency that assures early identification of potential problem areas, and has systems in place to assure timely analysis and follow-up action called for by the information. Provide three examples of reports utilized during the fiscal year ending September 2001 that reflect practices (type of reports) that will be utilized throughout the service area effective 10/1/02. As Appendix 3.11.3, include a description/documentation that reflects system changes stemming from the implications of these reports.

3.11.4 ☐ Financial statements are generated and published at the following frequency each fiscal year and distributed to the board of directors and administrative management staff: (mark one that best applies or provide and explanation)

- ☐ Once a Year
- ☐ Monthly
- ☐ Quarterly

3.11.5 ☐ Mechanisms are in place that assure timely receipt of invoices from network providers.

3.11.6 ☐ Data is collected and monitored to assure that 90 percent of all clean claims are processed within 30 days of receipt, and 99 percent within 90 days of receipt. A clean claim is a claim that is completed in the format 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 or abuse, or a claim under review for medical necessity.

3.11.7 ☐ Mechanisms are in place that assure all available third party revenues are identified and actively pursued.

3.11.8 ☐ The applicant is fully prepared for MDCH Uniform Billing changes taking effect during fiscal year ending September 2002 , including acceptance and processing of electronic invoices submitted by vendors.

3.11.9 ☐ Improvements have been made in the financial management system during the past two fiscal years using quality improvement methodology.

3.11.10 ☐ Mechanisms are in place to assure sufficient local match financing as specified in Chapter 3 of the Mental Health Code to enable the full use of authorized MDCH funds.

3.11.11 ☐ Expenditures are recorded in a way that enables identification of managed care administrative costs as distinct from other costs, including the costs to administer direct service operations. Provide copies of the managed care administrative cost detail for fiscal year ending September 2001 as

Appendix 3.11.11. Managed care administrative cost includes administrative management, customer services including recipient reports and grievance/ appeal processes, provider network management, information system, governing body, financial management including claims management, quality improvement, access, and utilization management. The CMHSP may add costs related to additional managed care administration functions they incur so long as the functions are clearly described. Describe how these costs will change effective 10/1/02.

3.11.12 ☐ A financial risk protection plan is in place that assures protection of the risk exposure determined actuarially or through recent history.

3.11.13 ☐ Mechanisms are in place to assure coordination of benefits for Medicaid eligibles needing non-covered services, and for persons that cycle in and out of Medicaid eligibility. These mechanisms enable individuals to continue receiving needed specialty supports and services without interruption.

3.11.14 ☐ Provide a calculation of working capital (current assets less current liabilities) as of 9/30/99, and 9/30/00 as Appendix 3.11.14.

3.11.15 ☐ Provide a calculation of net worth (total assets less total liabilities) as of 9/30/99 and 9/30/00 as Appendix 3.11.15.

3.11.16 ☐ Provide copies of annual audit reports and corresponding management letters for fiscal years ending September 1999, and September 2000, in Appendix C of the hard copies of the application only. *(These items need not be scanned and submitted electronically. They must, however, be appropriately labeled with suitable cover sheets and inserted into the two required hard copies of the application.)*

3.11.17 ☐ An organizational plan has been developed to achieve administrative and perhaps service delivery efficiencies across the service area, and has determined and calculated administrative efficiencies already realized over the course of fiscal years ending September 2000, and September 2001. Provide a copy of this plan and documentation of efficiencies gained as Appendix 3.11.17.

3.11.18 ☐ *Bonus Item:* Provide, in a maximum of three pages inserted below, an explanation on the applicant's plan to comply with Governmental Accounting Standards Board Statement 10.

3.12 Substance Abuse

This section of the Application for Participation is designed to reflect the applicant's qualifications and plans concerning the management of substance abuse services for Medicaid beneficiaries. The application devotes separate consideration to this for several reasons, assuming that most CMHSP applicants do not have direct or extensive experience in managing these services. Separate consideration does not indicate that the department necessarily expects substance abuse to be managed separately from other specialty services. The department continues to desire that substance abuse services be managed within an overall integrated management system for specialty services and supports.

Items 3.12.1, 3.12.4, and 3.12.5 must be completed by all applicants. Items 3.12.2 and 3.12.3 must be completed by those applicants where management responsibility for substance abuse will not be handled by a current coordinating agency(ies). This would include all applicants that did not select one of the first three responses to item 3.12.1 below.

3.12.1 ☐ With respect to the applicant's plan for the management of specialty substance abuse services, at least one of the following is true. [Mark the most appropriate box.]

- ☐ The applicant is currently a designated substance abuse coordinating agency, and will administer substance abuse services under the prepaid health plan.
- ☐ The applicant will seek MDCH designation as a coordinating agency, effective no later than 10/1/02, with support from all existing agencies in the service area. Existing coordinating agency personnel will have significant responsibility for the management of applicant substance abuse services.
- ☐ The applicant will contract with the current coordinating agencies in the service area for the management of prepaid health plan substance abuse services.
- ☐ The applicant will assume management responsibility for substance abuse services in the service area. The current coordinating agencies will not have management responsibilities under the prepaid health plan.

3.12.2 ☐ The applicant has sufficient experience and knowledge to manage specialty substance abuse services. [See Memorandum Regarding Coordinating Agency Designation (5/17/01), Attachment F.] The applicant has had direct responsibility for managing prepaid health plan substance abuse services on a shared risk basis. [Note: The experience gained by a current CMHSP in contracting with the department for Medicaid substance abuse services is expected to be helpful in this context, but is not considered sufficient in itself to qualify as direct

management responsibility, except for CMHSPs that are also coordinating agencies.] The applicant has hired qualified and experienced personnel (staff or consultants) to participate in substance abuse services management. The applicant intends to assign responsibility for on-going substance abuse services management after 9/30/02 to qualified and experienced personnel.

3.12.3 ☐ The applicant has a written plan for managing substance abuse services effective 10/1/02. The plan specifies current status of preparation (what has been accomplished to date); a time line with key steps and dates leading to 10/1/02; an estimate of the funds needed for preparation, and source(s) of funds; and the person(s) with principal direct responsibility for preparation. The plan includes all of the following:

- consideration for procurement of a provider network to provide all covered and allowable services, that affords choice of provider for each covered service, that meets minimum Public Health Code and department contractual requirements, that is geographically-accessible, that is experienced in providing each covered service and that has sufficient capacity to meet expected demand for each covered substance abuse service
- identification of providers that will comprise the network
- identification of any current Medicaid substance abuse providers in the service area that will not be part of the prepaid health plan provider network
- assumption of all access functions, including screening, assessment, authorization/re-authorization, referral and follow up
- protection of confidentiality as required by federal statute
- implementation of, or confirmation that, financial systems that are consistent with requirements of the current department contract (e.g., accounting and first- and third-party reimbursements)
- development of data collection, management, and reporting capabilities sufficient to meet contractual requirements
- establishment of linkages with referral sources (including courts, corrections, health care, employers, Family Independence Agency) and with sources of ancillary care and supports for individuals in addiction treatment (including health care, public health agencies, child care, self-help recovery groups)

3.12.4 ☐ The applicant will be required to assure coordination and continuity between prepaid health plan-managed substance abuse services and substance abuse services managed by coordinating agencies through their direct contracts with the department. The applicant has a written plan for coordination and continuity with all current coordinating agencies in the service area that includes the following (no plan required if the applicant is

the coordinating agency for the entire service area):

- protection of confidential information
- payment for allowable services
- screening, assessment, authorization and referral
- data collection and reporting
- financial records and reporting
- case management
- co-occurring disorders
- exchange of pertinent clinical and related information regarding individuals receiving care through the prepaid health plan and coordinating agency networks
- assuring continuation of care through the same providers for individuals receiving care through the coordinating agency networks on 10/01/02 and who require further care
- assuring that the prepaid health plan and coordinating agency provider networks contain the same providers
- assuring care continuity for individuals whose Medicaid eligibility changes over time
- assuring care continuity when the composition of the provider network changes
- coordination of benefits

3.12.5 ☐ The applicant plans to notify the following audiences of all pertinent changes in referral procedures, gatekeeping criteria and procedures, access to the provider network and access entities, provider network composition, and other system changes that are of importance to each audience:

- current coordinating agencies (if the applicant is not an agency)
- current Medicaid providers in the service area for substance abuse services
- referral sources
- providers of ancillary and supportive services
- the general public
- individuals currently receiving care through the existing coordinating agency networks
- MDCH

Table, Diagrams, and Artwork Supporting

Section Three

(Insert any tables, diagrams, or artwork pertaining to Section Three after this page. Please make sure the text typed immediately after the numbered subsection clearly refers to the fact that artwork has been placed here and that the artwork is clearly labeled as to which subsection it supports. The artwork must be readable as entered, without enlargement. Insertions should be sequential by number.)

4.0 Regulatory Management

This part of the application will be scored. The MDCH expectations and standards for delivery of specialty mental health, developmental disabilities, and substance abuse services are contained in the numbered items in each section. The term "applican
entity and includes any applicable affiliates. If the statement in each section is true, insert an "X" directly in the electronic version of the document in the appropriate box by using the mouse
dd or remove an "X." If the applicant, or any of its affiliates, does not meet an expectation or standard, do not place a mark in the box. Insert any explanation directly below each item. If for some reason the item is not applicable, that should be entered as the explanation, along with why the item is not applicable. All items not marked with an "X" must have an explanation. Tables, diagrams, and artwork must be labeled with the section number they support (i.e., 2.9.9) and inserted electronically and sequentially directly following the section. Appendices should be labeled with the appropriate number and inserted electronically and sequentially in the Appendix section. If an item is not marked, it requires 1) an explanation for why the applicant does not meet the expectation or standard; and 2) a plan for compliance (whichever is appropriate to the item) that includes: action steps, measurable objectives, time frames for completing each step, and person(s) responsible for execution of the plan. Insert the explanation and plan in the text box provided directly following the item. Documentation and evidence of meeting expectations and standards, and any explanations with plans, will be verified during a readiness site visit.

Regulatory management is a pro-active, preventive approach to identifying, monitoring, and controlling risks associated with complex duties, obligations, rules, regulations, and requirements. The prepaid health plan must have established processes and practices for ensuring regulatory compliance.

Two major regulations are expected to go into effect during the next fiscal year: the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997.

The **Health Insurance Portability and Accountability Act** has three parts: transaction standards, privacy rules, and security rules.

Transaction standards, which go into effect in October 2002, require that every part of a health care transaction be standardized and use federally-approved codes. The MDCH has determined that these standards affect claims processing, billing third party payers and the Medical Service Administration, and reporting encounter data to the MDCH.

Privacy rules go into effect in March 2003, and will impact any handling of consumer health care information. The MDCH has determined that privacy rules impact where information is stored (hard copy or electronic), who has access, and protections from casual or unauthorized access.

Security rules have not yet been promulgated. The rules will likely impact the security of electronic transmission of consumer health care information.

The Health Insurance Portability and Accountability Act transaction standard implementation guides and links to other rules have been placed on the Michigan Association of Community Mental Health Boards' web site: www.macmhb.org.

The **Balanced Budget Act** expands existing regulatory beneficiary protections provided to enrollees in Medicaid prepaid health plans. The proposed rules were published 8/20/01. It is expected that they will go into effect in 2002. The major requirements of the Balanced Budget Act as proposed include the following:

General Contract Requirements, addressing enrollment discrimination prohibition, compliance with federal and state laws pertaining to individual rights, inspection and audit of financial records, physician incentive plans, advanced directives, subcontracts, choice of health professionals, and provider discrimination prohibition.

Information Requirements that include non-English language, format for written information, information to potential enrollees, and information to all enrollees.

Enrollee Rights and Protections including written policies for enrollee rights, identification of specific rights, compliance with state and federal laws, provider-enrollee communications, and marketing activities.

Quality Assessment and Performance Improvement that addresses access standards, structure and operation standards, and measurement and improvement standards.

Grievance System that includes grievance processes, appeals processes, and access to the state's fair hearing system.

Certifications and Program Integrity Provisions addressing administrative and management procedures to guard against fraud and abuse.

To view the proposed rule in its entirety, go to http://www.access.gpo.gov/nara/index.html., select year 2001, August 20, 2001, Centers for Medicare and Medicaid Services, Proposed Rules, Medicaid: Managed Care.

4.1 ☐ There is an established process, coordinated across the affiliation if applicable, for carrying out the regulatory management activities. There are identifiable unit(s) where the responsibilities for regulatory management are located. Responsibilities include coordination of analytic resources devoted to regulatory identification, comprehension, interpretation, and dissemination. The process identifies various tools for promoting regulatory compliance by the applicant and the provider network(s) including information dissemination, technical assistance, surveys, voluntary commitment to compliance, review teams and compliance audits, enforcement (sanctions) activities.

4.2 ☐ The applicant has identified high risk compliance areas and has a plan in place to address them.

4.3 ☐ The applicant has a plan with tasks, time frames, and persons responsible for achieving compliance with the Health Insurance Portability and Accountability Act transaction standards by October 2002.

4.4 ☐ The applicant has a plan with tasks, time frames, and persons responsible for achieving compliance with the Health Insurance Portability and Accountability Act privacy standards by approximately February 2003.

4.5 ☐ The applicant has analyzed the requirements of the proposed rule of the Balanced Budget Act and has determined that requirements are already being met, and any that are not currently being met. With respect to requirements not being met, the applicant has prepared a preliminary analysis of what steps would be required to come into compliance.

Table, Diagrams, and Artwork Supporting

Section Four

(Insert any tables, diagrams, or artwork pertaining to Section Four after this page. Please make sure the text typed immediately after the numbered subsection clearly refers to the fact that artwork has been placed here and that the artwork is clearly labeled as to which subsection it supports. The artwork must be readable as entered, without enlargement. Insertions should be sequential by number.)

Appendices

(Insert appendices after this page. Appendices are required as indicated in the Application for Participation. Please make sure all appendices are clearly labeled and inserted sequentially by number.)

Attachments

Attachme nt A

Medicaid Covered Lives

County Code	County Name	Eligible Recipients	County Code	County Name	Eligible Recipients
01	Alcona	1,536	43	Lake	2,398
02	Alger	1,163	44	Lapeer	6,228
03	Allegan	9,109	45	Leelanau	1,704
04	Alpena	4,983	46	Lenawee	9,083
05	Antrim	2,473	47	Livingston	5,010
06	Arenac	2,786	48	Luce	1,547
07	Baraga	1,155	49	Mackinac	1,109
08	Barry	4,365	50	Macomb	47,853
09	Bay	13,498	51	Manistee	3,446
10	Benzie	1,877	52	Marquette	6,742
11	Berrien	25,210	53	Mason	4,062
12	Branch	5,323	54	Mecosta	5,707
13	Calhoun	19,907	55	Menominee	2,728
14	Cass	6,236	56	Midland	7,391
15	Charlevoix	2,660	57	Missaukee	42
16	Cheboygan	3,843	58	Monroe	10,801
17	Chippewa	4,848	59	Montcalm	7,429
18	Clare	5,781	60	Montmorency	1,689
19	Clinton	3,499	61	Muskegon	26,939
20	Crawford	2,258	62	Newaygo	6,524
21	Delta	5,363	63	Oakland	67,815
22	Dickinson	3,027	64	Oceana	5,534
23	Eaton	7,111	65	Ogemaw	4,040
24	Emmet	3,004	66	Ontonagon	1,176
25	Genesee	70,974	67	Osceola	3,558
26	Gladwin	3,652	68	Oscoda	1,637
27	Gogebic	2,782	69	Otsego	2,845
28	Grand Traverse	6,322	70	Ottawa	12,886
29	Gratiot	4,960	71	Presque Isle	1,654
30	Hillsdale	5,082	72	Roscommon	4,128
31	Houghton	4,697	73	Saginaw	34,846
32	Huron	4,192	74	St. Clair	15,358
33	Ingham	34,019	75	St. Joseph	7,936
34	Ionia	5,913	76	Sanilac	5,243
35	Iosco	3,921	77	Schoolcraft	1,555
36	Iron	2,021	78	Shiawassee	7,317
37	Isabella	5,900	79	Tuscola	6,477
38	Jackson	18,360	80	Van Buren	13,011
39	Kalamazoo	25,745	81	Washtenaw	18,707
40	Kalkaska	2,380	82	Wayne	375,587
41	Kent	61,464	83	Wexford	6,440
42	Keweenaw	298			

Attachment B

Glossary of Terms

Administrative Efficiencies - The ability to produce a desired effect with a minimum of effort, expense, or waste as applied to management functions of the organization.

Affiliates - CMHSPs that are participating in a consolidated application with a "lead" CMHSP that has submitted the application and who will serve at the prepaid health plan.

Beneficiary - Persons who are Medicaid-eligible.

Best Value - A process used in competitive negotiated contracting to select the most advantageous offer by evaluating and comparing factors in addition to cost or price.

Co-Occurring Disorders - When used in the context of substance abuse, this term refers to co-occurring psychiatric and substance use disorders.

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 toward better meeting the needs of the minority populations. The cultural competency of an organization is demonstrated by its policies and practices.

Individual - Persons with mental illness, developmental disabilities, or substance use disorders (or a combination of disabilities). For the purpose of this application, includes persons who are Medicaid-eligible, as well as other mental health and substance abuse specialty services recipients who may be indigent, are self-pay, or have private insurance coverage.

Initial Assessment - Term used in substance abuse services. It is a process that collects sufficient information to determine a level of care based on at least the six dimensions of the American Society of Addiction Medicine Patient Placement Criteria. This initial assessment process also gathers enough information to determine an initial diagnostic impression using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.

Effective Freedom - The realization of social citizenship and full community membership. Citizens are able to build upon basic freedoms - to effectively unlock the potential of liberty - by making choices, pursing personal goals, engaging in productive activity, establishing a wide range of associations and relationships, participating in community events, and living in real homes.

Limited-English Proficiency - Persons who cannot speak, write, read, or understand the English language in a manner that permits them to interact effectively with health care providers and social services agencies.

Linguistically Appropriate Services - Provided in the language best understood by the consumer through bi-lingual staff and the use of qualified interpreters, including American Sign Language, to individuals with limited-English proficiency. These services are a core element of cultural competency and reflect an understanding, acceptance, and respect for the cultural values, beliefs, and practices of the community of individuals with limited-English proficiency. Linguistically appropriate services must be available at the point of entry into the system and throughout the course of treatment, and must be available at no cost to the consumer.

Outreach - Efforts to extend services to those persons who are under-served or hard-to-reach that often require seeking individuals in places where they are most likely to be found, including hospital emergency rooms, homeless shelters, women's shelters, senior centers, nursing homes, primary care clinics and similar locations.

Provider-Sponsored Specialty Networks - Vertically integrated, comprehensive service entities that are organized and operated by affiliated groups of service providers that offer relatively complete "systems of care" for beneficiaries with particular service needs.

Reasonable Access (geographic access standard) - Services are available within 30 miles or 30 minutes in urban areas, or within 60 miles or 60 minutes in rural areas.

Recovery - The overarching message of recovery is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.

Stakeholder - An individual or entity that has an interest, investment or involvement in the operations of a prepaid health plan or affiliate. Stakeholders can include individuals (see definition above) and their families, advocacy organizations, and other members of the community that are affected by the prepaid health plan and the supports and services it offers.

Substance Use Disorders - Substance use disorders include Substance Dependence and Substance Abuse, according to *selected* specific diagnostic criteria given in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Specific DSM IV diagnoses are found in Attachment 7.0.1.1 of the department's contract with CMHSPs.

Attachment C

EXPECTED CONTRACT REQUIREMENTS

BEGINNING OCTOBER 1, 2002

MANAGED SPECIALTY SUPPORTS AND SERVICES

(Second Draft – Released January 3, 2002)

Michigan Department of Community Health

MDCH

John Engler, Governor
James K. Haveman, Jr., Director

Modifications will be required for changes driven by state and federal regulations, waiver requirements, CMS review and issues identified during the procurement process. Requirements described in practice guidelines, technical requirements, and other attachments are not included in this version. Those documents will be identical or very similar to those in the current contract and those attached to the Application for Participation.

TABLE OF CONTENTS

Part II

STATEMENT OF WORK

DEFINITIONS/EXPLANATION OF TERMS

DEFINITIONS

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.

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. As stated in the FY 02 State Appropriation Act (P.A. 60), a clean claim that is not paid within 45 days after receipt shall bear simple interest at a rate of 12% per annum.

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, a potential recipient, which includes all people located in the defined service area.

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, inter-disciplinary, 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.

Emergency 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 or herself, or another individual, either intentionally or unintentionally.

2. The individual is unable to provide himself or herself 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.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) to eligible Medicaid beneficiaries under 21 years of age. The intent is to find and treat problems early so they do not become more serious and costly.

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

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

HIPAA mandates that the following must be implemented:
1. Guard data integrity, confidentiality, and availability
2. Access control (user-based, role-based, context-based)
3. Audit controls (user-based, role-based)
4. Data authentication (automatic log-off, unique user ID, password, PIN, biometrics, token, or telephone callback)
5. Guard against unauthorized access

6. Communications/network controls (access controls, encryption, integrity controls or message authentication)
7. Network (alarm, audit trail, entity authentication, event reporting, user-based, role-based, or context-based access)

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

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

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

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

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

Prepaid Health Plan (PHP): Organization that manages specialty health care services under the Michigan Medicaid Waiver Program for Specialty Services.

Recipient: Individual who is currently receiving services and/or supports financed in part or completely through this contract.

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 MDCH, and that has resulted in functional impairment that substantially interferes with or limits the minor's role or functioning in family, school, or community activities. The following disorders are included only if they occur in conjunction with another diagnosable serious emotional disturbance:

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

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

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

Substance Use Disorders: Include Substance Dependence and Substance Abuse, according to *selected* specific diagnostic criteria given in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Specific DSM IV diagnoses are found in Attachment 7.0.1.1 of the department's contract with CMHSPs.

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

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

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

Part I

CONTRACTUAL SERVICES TERMS AND CONDITIONS

1.0 PURPOSE

The Michigan Department of Community Health (MDCH), hereby enters into a contract with the PHP identified on the signature cover page of this contract.

The purpose of this contract is to obtain the services of the PHP to manage and provide a comprehensive array of specialty mental health and substance abuse services and supports as indicated in this contract. All contract provisions as written apply to both mental health and substance abuse management unless otherwise indicated.

1.1 Value Purchasing

The creation of the MDCH, through Executive Order 1996-1, brought together policy, programs and resources to enable the State to become a more effective purchaser of health care services, including mental health services, services for people with developmental disabilities, and substance abuse services for the Medicaid population and other priority populations. As the single state agency responsible for health policy and purchasing of health care services using state-appropriated and federal matching funds, MDCH intends to get better value while ensuring quality and access. MDCH will focus on "value purchasing." Value purchasing involves aligning financing incentives to stimulate appropriate changes in the health delivery system that will:

- bring organization and accountability for the full range of benefits
- provide greater flexibility in the range of services
- improve access to and quality of care
- achieve greater cost efficiency
- link performance of PHPs to improvements in the lives of people receiving services

1.2 Managed Care Direction

Under the Managed Specialty Supports and Services Program (MSSSP), the state selectively contracts with PHPs who will accept shared financial risk for managing comprehensive specialty supports and services through a performance contract. The focus will be on quality of care, accessibility, and cost-effectiveness.

Within this context, MDCH believes that a managed system of supports and services operated through the public mental health and substance abuse systems must be based on values that reflect person-centered planning. This system must support individuals to be:

- empowered to exercise choice and control over all aspects of their lives
- involved in meaningful relationships with family and friends

- supported to live with family while children, and independently as adults
- engaged in daily activities that are meaningful, such as school, work, social recreation and volunteering
- fully included in community life and activities

2.0 ISSUING OFFICE

This contract is issued by the MDCH. The MDCH is the sole point of contact regarding all procurement and contractual matters relating to the services described herein. The MDCH is the only entity authorized to change, modify, amend, clarify, or otherwise alter the specifications, terms, and conditions of this contract. Inquiries and requests concerning the terms and conditions of this contract, including requests for amendment, shall be directed by the PHP to the attention of the MDCH Division of Community Services/Mental Health and by the MDCH to the contracting organization's executive director.

3.0 CONTRACT ADMINISTRATOR

The person named below is authorized to administer the contract on a day-to-day basis during the term of the contract. However, administration of this contract implies no authority to modify, amend, or otherwise alter the payment methodology, terms, conditions, and specifications of the contract. That authority is retained by the MDCH. The contract administrator for this project is:

Director, Bureau of Community Services
Department of Community Health
6th Floor – Lewis Cass Building
320 South Walnut
Lansing, Michigan 48913

4.0 TERM OF CONTRACT

The term of this contract shall be from October 1, 2002, through September 30, 2004. The contract may be extended for no more than three one-year extensions after September 30, 2004. 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 8.0 "Contract Financing" and estimated payments are described in Attachment A to this contract.

6.0 LIABILITY

6.1 Cost Liability

The MDCH assumes no responsibility or liability for costs under this contract incurred by the PHP prior to October 1, 2001. Total liability of the MDCH is limited to the terms and conditions of this contract.

6.2 Contract Liability

A. All liability, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out pursuant to the obligation of the PHP under this contract shall be the responsibility of the PHP, and not the responsibility of the MDCH, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the part of PHP, its employees, officers or agent. Nothing herein shall be construed as a waiver of any governmental immunity for the county(ies), the PHP, its agencies or employees as provided by statute or modified by court decisions.

B. All liability, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out pursuant to the obligations of the MDCH under this contract shall be the responsibility of the MDCH and not the responsibility of the PHP if the liability, loss, or damage is caused by, or arises out of, the action or failure to act on the part of MDCH, its employees, or officers. Nothing herein shall be construed as a waiver of any governmental immunity for the state, the MDCH, its agencies or employees or as provided by statute or modified by court decisions.

C. The PHP and MDCH agree that written notification shall take place immediately of pending legal action that may result in an action naming the other or that may result in a judgment that would limit the PHP's ability to continue service delivery at the current level. This includes actions filed in courts or governmental regulatory agencies.

7.0 PHP RESPONSIBILITIES

The PHP 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. If the PHP elects to subcontract, the PHP shall comply with federal procurement requirements. The PHP is responsible for complying with all reporting requirements as specified by the MDCH. Data reporting requirements are specified in Section 7.5.1 of the contract and Attachment B, "Managed Specialty Supports and Services Contract Reporting Requirements." Finance reporting requirements are specified in Part II, Section 8.8.

8.0 ACKNOWLEDGMENT OF MDCH FINANCIAL SUPPORT

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

9.0 DISCLOSURE

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

10.0 CONTRACT INVOICING AND PAYMENT

The MDCH funding obligated through this contract includes both state and federal funds, which the state is responsible for managing. Detail regarding the MDCH financing obligation is specified in Part II, Section 8.0, and in Attachment A, to this contract. Invoicing for PASARR is addressed in Attachment C, the PASARR Agreement.

11.0 LITIGATION

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

The MDCH and the PHP 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 PHP shall submit annual litigation reports in a format established by the MDCH, providing the following detail for all civil litigation that the PHP, subcontractor, or the PHPs insurers or insurance agents are parties to:

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

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

12.0 CANCELLATION

The MDCH will utilize a variety of means to assure compliance with contract requirements and will pursue remedial actions or improvement plans that the PHP can implement to resolve outstanding requirements. Contract remedies are described in Part II, Section 9.0, "Contract Remedies." Contract cancellation is a decision by the MDCH to cancel, terminate or end this contract; a decision by the PHP to cancel, terminate or end this contract; or a joint decision by the MDCH and the PHP to cancel, terminate or end this contract.

The MDCH may cancel this contract for material default of the PHP. Material default is defined as the material failure of the PHP to fulfill the obligations of this contract or PHP certification requirements as stated in the Michigan Mental Health Code (Section 232a). In case of material default by the PHP, the MDCH may cancel this contract without further liability to the state, its departments, agencies, and employees, and procure services from other PHPs.

In canceling this contract, the MDCH shall provide written notification at least 30 days prior to

the cancellation date of the MDCH intent to cancel this contract to the PHP and the relevant County(ies) Board of Commissioners. The PHP may correct the problem during the 30-day interval, in which case cancellation shall not occur. In the event that this contract is canceled, the PHP shall cooperate with the MDCH to implement a transition plan for recipients. The MDCH shall have the sole authority for approving the adequacy of the transition plan, including providing for the financing of said plan, with the PHP responsible for providing the required local match funding. The transition plan shall set forth the process and time frame for the transition. The PHP 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 MDCH. The PHP will cooperate with the MDCH in developing a transition plan for the provision of services during the transition period following the end of this contract, including the systematic transfer of each recipient and clinical records from the PHP'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), of the end date, the PHP shall provide to the MDCH, all financial, performance and other reports required by this contract.

B. Payment for any and all valid claims for covered services rendered to covered recipients prior to the effective end date shall be the PHP's responsibility, and not the responsibility of the MDCH.

C. The portion of all reserve accounts maintained by the PHP that were financed in whole or in part by MDCH funds are owed to MDCH within 90 days, unless otherwise directed in writing by the MDCH.

D. Title to equipment with a purchase value exceeding $30,000, purchased by the PHP within the last two fiscal years and financed in whole or in part with MDCH funds, may be assumed by MDCH within 120 days of the end date. The PHP will submit a complete inventory of equipment purchased during the previous two years including the ending year, to MDCH within 30 days of the end date. The MDCH will provide written notice within 90 days to the PHP, of items to be assumed by the MDCH. The PHP is responsible to facilitate the assumption of said equipment by the MDCH, and costs of taking possession, including payment of local share value, are the responsibility of MDCH.

E. All earned carry-forward funds and savings from prior fiscal years that remain unspent as of the end date, must be returned to MDCH within 90 days. No carry-forward funds or savings, as provided in section 8.7.1, can be earned during the year this contract ends, unless specifically authorized in writing by the MDCH.

F. All financial, administrative and clinical records under the PHP's responsibility must be retained for a period of seven years, unless directed otherwise in writing by

MDCH.

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

Should additional statistical or management information be required by the MDCH when this contract ends or is canceled, at least 45 days notice shall be provided to the PHP.

14.0 CONFIDENTIALITY

Both the MDCH and the PHP 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 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

To the extent that this act is pertinent to the services that the PHP provides to the MDCH, the PHP assures that it is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements currently in effect and will be in compliance by the timeframes specified in the HIPAA regulations for portions not yet in effect.

All recipient information, medical records, data and data elements collected, maintained, or used in the administration of this contract shall be protected by the PHP from unauthorized disclosure as required by state and federal regulations. The PHP must provide safeguards that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the contract.

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

16.0 ASSURANCES

The following assurances are hereby given to the MDCH:

16.1 Compliance with Applicable Laws

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

16.2 Anti-Lobbying Act

The PHP will comply with the Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq, and Section 503 of the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act (Public Law 104-208). Further, the PHP shall 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 sub-recipients shall certify and disclose accordingly.

16.3 Non-Discrimination

In the performance of any contract or purchase order resulting herefrom, the PHP 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 PHP further agrees that every sub-contract entered into for the performance of any contract or purchase order resulting herefrom 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 PA 220, as amended, MCL 37.1101 et seq, and Section 504 of the Federal Rehabilitation Act 1973, PL 93-112, 87 Stat. 394, and any breach thereof may be regarded as a material breach of the contract or purchase order.

Additionally, assurance is given to the MDCH that pro-active efforts will be made to identify and encourage the participation of minority-owned, women-owned, and handicapper-owned businesses in contract solicitations. The PHP shall 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.

16.4 Debarment and Suspension

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

A. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded fom covered transactions by any federal department or PHP.

B. Have not within a three-year period preceding this agreement been convicted of

or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.

C. Are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in section B.

D. Have not within a three-year period preceding this agreement had one or more public transactions (federal, state or local) terminated for cause or default.

16.5 Federal Requirement: Pro-Children Act

Assurance is hereby given to the MDCH that the PHP will comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by the PHP 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 PHP also assures that this language will be included in any sub-awards which contain provisions for children's services.

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

16.6 Hatch Political Activity Act and Inter-governmental Personnel Act

The PHP will comply with the Hatch Political Activity Act, 5 USC 1501-1508, and the Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, Public Law 95-454, 42 USC 4728. Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration

of federally-assisted programs.

16.7 Limited English Proficiency

The PHP 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.

17.0 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.

18.0 ENTIRE AGREEMENT

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

A. This contract and any addenda thereto
B. The Application for Participation (AFP) submitted to the MDCH and any stated conditions, as reflected in the MDCH approval of the AFP
C. Michigan Mental Health Code and Administrative Rules
D. Michigan Public Health Code and Administrative Rules
E. Approved Medicaid Waivers and corresponding CMS conditions, including 1915 (b) and (c) waivers, and Children's Waiver
F. MDCH Appropriations Act in effect during the contract period
G. All other pertinent Federal and State Statutes, Rules and Regulations
H. All MDCH guidelines, technical requirements, policy, reporting forms, formats and instructions, as referenced in the contract

In the event of any conflict over the interpretation of the specifications, terms, and conditions indicated by the MDCH and those indicated by the PHP, those of the MDCH take precedence.

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

19.0 NO WAIVER OF DEFAULT

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

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 the MDCH at the time of drafting. No inaccuracies in such data shall constitute a basis for legal recovery of damages, either real or punitive. The MDCH 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 MDCH and the PHP is that of client and independent contractor. No agent, employee, or servant of the PHP or any of its sub-contractors shall be deemed to be an employee, agent or servant of the state for any reason. The PHP 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 the address where notices are to be sent by giving written notice in accordance with this Section.

24.0 UNFAIR LABOR PRACTICES

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

25.0 SURVIVOR

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

26.0 GOVERNING LAW

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

27.0 YEAR 2000 COMPATIBILITY

The PHP must ensure year 2000 compatibility for any software purchases related to this agreement. This shall include, but is not limited to: data structures (databases, data files, etc.) that provide four-digit date century; stored data that contain date century recognition, including but not limited to, data stored in databases and hardware device internal system dates; calculations and program logic (e.g., sort algorithms, calendar generation, event recognition, and all processing actions that use or produce date values) that accommodates same century and multi-century formulas and date values; interfaces that supply data to and receive data from other systems or organizations that prevent non-compliant dates and data from entering any state system; user interfaces (i.e., screens, reports, etc.) that accurately show four-digit years; and assurance that the year 2000 shall be correctly treated as a leap year within all calculation and calendar logic.

Part II

STATEMENT OF WORK

1.0 SPECIFICATIONS

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

1.1 Targeted Geographical Area for Implementation

The PHP shall provide Medicaid Specialty mental health and developmental disability (MH/DD) services and supports in the county(ies) of NAME OF COUNTY(IES), hereafter referred to as "service area" or exclusively "MH/DD service area." The PHP shall provide MH/DD supports and services to the non-Medicaid priority population, in the county(ies) of NAME OF COUNTY(IES), hereafter referred to as "service area" or exclusively "MH/DD service area." The PHP shall provide Medicaid Substance Abuse (MASA) services in the county(ies) of NAME OF COUNTIES, hereafter referred to as "service area" or exclusively "MASA service area."

1.2 Target Population

The PHP shall serve all Medicaid-eligible individuals in the service area, people located in the service area defined as priority populations in Section 208 of the Michigan Mental Health Code. The PHP shall also provide mental health services to children enrolled in the MIChild program.

1.3 Responsibility for Payment of Authorized Services

The PHP shall be responsible for payment of services that the PHP authorizes, including MASA services. This provision presumes the PHP and its agents are fulfilling their responsibility to recipients and 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 PHPs. In the event there is an unresolved dispute between PHPs, either party may request MDCH involvement to resolve the dispute, and the MDCH will make such determination. Likewise, services shall not be delayed or denied as a result of a dispute of payment responsibility between the PHP and another agency.

Regarding MH/DD services, the PHP will be financially responsible for serving people located outside the defined service area as follows:

A. When the PHP assumes responsibility for serving an individual from the service area, and at any point in time arranges for services to be delivered outside of the service area through a contractual arrangement, the PHP retains responsibility for meeting the service needs of that person until: (1) the responsibility is expressly and knowingly assumed by another PHP, (e.g., Section 307 transfer, or other arrangement that involves agreement of both PHPs); or (2) the recipient expressly relocates to another state or service area by choice.

B. When the PHP assumes responsibility for providing services for any recipient needing urgent/emergent care and who is located in their service area, but the recipient resides in, and intends to return to, their home service area. The PHP retains responsibility until: (1) the PHP notifies the home PHP and the responsibility is transferred back to the home PHP. The home PHP is responsible for transitioning the recipient back to the home service area at the point urgent care is no longer required, or at an earlier point in the episode, if clinically appropriate. (2) If the PHPs have a standing agreement covering these situations, that agreement takes precedence.

C. When the Family Independence Agency (FIA) office in the PHP's service area places a child outside of the service area on a non-permanent basis and the child needs specialty supports and services.

The PHP retains responsibility for services unless the family relocates to another service area, in which case responsibility transfers to the PHP where the family has relocated.

The FIA Medicaid county of residence should not be confused with PHP service responsibility. In most cases, they are the same. However, FIA modification of the Medicaid county of residence is not by itself a condition that alters PHP responsibility in the above and related situations. The PHPs can, and must, try to make arrangements for capitation payments to be applied against costs when the capitation payment is going to a PHP that is not the PHP responsible for payment of services. This is typically done through contractual agreements.

2.0 SPECIALTY SUPPORTS AND SERVICES

The supports and services as described in the current MDCH Medical Services Administration (MSA) policy for PHPs shall be available to both the Medicaid-eligible individual and the priority population. The PHP may limit services to those that are medically necessary and appropriate, and that conform to professionally-accepted standards of care. The PHPs must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations. If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the PHP must implement the changes consistent with state policy. The PHP also must have available alternative and allowable services. A general description of those supports and services, for reporting purposes, are located in the Technical Requirement on Alternative Specialty Services.

2.1 Sufficiency Standard

The PHP shall provide services in the amount, for the duration, and with a scope that is appropriate to reasonably achieve the purpose of the service for the recipient. Consistent with 42 CFR 440.210 and 42 CFR 440.220, services to recipients shall not be reduced arbitrarily. Criteria for medical necessity and utilization control procedures based on best practice standards may be used to place appropriate limits on a service.

2.2 Medicaid Services

A. Required Covered Services (see Chapter III for service definitions)

1. Mental Health and Developmental Disabilities Services
   - Community Inpatient
   - State Hospital Services
   - Specialized Residential
   - Crisis Residential
   - Supported Independent Housing
   - Outpatient Partial Hospitalization Services
   - Clubhouse Programs
   - Day Programs
   - Assessment and Evaluation
   - Mental Health Therapy and Counseling
   - Occupational Therapy
   - Speech and Language Therapy
   - Physical Therapy
   - Medication Administration
   - Person-centered Planning
   - Private Duty Nursing (DD)
   - Emergency Services (MI)
   - ACT
   - Intensive Crisis Stabilization Services
   - Case Management
   - Home-Based Services
   - Supported/Integrated Employment Services

2. Substance Abuse Services
   - Outpatient
   - Intensive Outpatient
   - Methadone/LAAM
   - Screening, assessment, referral and follow-up

B. Alternative MH/DD Services and Substance Abuse Allowable Services

1. Alternative MH/DD Services

- Support and Service Coordination (DD)
- Family Skills Development
- Respite Care Services
- Community Living-Support Staff (DD)
- Community Living Training and Support (MI)
- Durable Medical Equipment (DD)
- Medical Supplies (DD)
- Environmental Modifications (DD)
- Housing Assistance
- Skill-Building Assistance
- Enhanced Pharmacy (DD)
- Enhanced Dental Services (DD)
- Assistance for Challenging Behaviors (DD)
- Extended Observation Beds (MI)
- Wraparound Services
- Peer-Delivered/-Operated Support Services
- Prevention-Direct Service Models
- Prevention-Other or Indirect Service Models
- Enhanced Health Services
- Crisis Stabilization and Response (DD)

2. Allowable Substance Abuse Services

- Residential
- Residential detox

2.3 Excluded Services

A. Room and board is not a Medicaid-covered service.

B. Medicaid services funded outside this plan (e.g., Comprehensive Health Plan Services, etc.)

C. Acute detoxification - This is a hospital provided service, billed directly to MSA by the hospital.

D. Laboratory services - Laboratory services related to substance abuse (with the exception of lab services required for Methadone and LAAM) should be billed directly to MSA by the laboratory.

E. Pharmacy services - Medications prescribed as a support to mental health and/or substance abuse treatment are paid for either on a fee-for-service basis by MSA (for recipients who are not in a Medicaid Health Plan [MHP]) or through the recipient's MHP (with prior authorization from the MHP).

F. Emergency medical care - This is a primary health care benefit. For MHP recipients, services are the responsibility of the MHP.

G. Emergency Service transportation - This is a primary health care benefit. For MHP recipients, services are the responsibility of the MHP.

H. Substance abuse prevention and mental health and treatment that occurs routinely in the context of providing primary health care.

I. Routine transportation - Routine transportation to substance abuse treatment services is the responsibility of the local FIA.

3.0 ACCESS ASSURANCE

3.1 Access Standards

The PHP 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 B, and shall locally monitor its performance and take action necessary to improve access for recipients.

A. Mental Health

1. The percentage of people receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed in three hours. (Standard: 95%)

2. The percentage of people receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (by sub-population). (Standard: 95%)

3. Percentage of people starting any needed on-going service within 14 calendar days of a non-emergent assessment with a professional (by sub-population). (Standard: 95%)

B. Substance Abuse

1. The percentage of people receiving an assessment within 24 hours of referral or presentation for urgent situations. (Standard: 95%)

2. The percentage of people admitted for treatment within 24 hours of assessment in urgent situations. (Standard: 95%)

3. The percentage of people receiving an assessment for non-urgent situations within five days of referral or presentation. (Standard: 95%)

4. The percentage of people admitted to treatment within seven days following a non-urgent assessment. (Standard: 95%)

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

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

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

D. The PHP shall be responsible for outreach and ensuring adequate access to services to the priority populations (Medicaid eligibles and Michigan Mental Health Code-mandated priority populations). The PHP shall assure that substance abuse screening/referral is available 24 hours, seven days a week.

E. In addition, the PHP shall assure access according to the following standard, and shall report its performance on the standard in accordance with Attachment B.

1. The percentage of people who met the OBRA Level II Assessment criteria for specialized mental health services for people residing in nursing homes, as determined by the MDCH, who received PHP managed mental health services. (Standard: 100%)

3.2 Medical Necessity: Mental Illness and/or Substance Abuse

The PHP will implement the medical necessity criteria specified. Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet the person's mental health/substance abuse 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 standards of care. In addition, the PHP must also consider social services and community supports that are crucial for full participation in community life, must apply person-centered planning for recipients 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 recipient needs.

3.3 Service Selection Guidelines

The PHP shall utilize the Service Selection Guidelines for Mental Health and Substance Abuse Services, and Services to People with a Developmental Disability.

3.4 Other Access Requirements

3.4.1 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 PHP shall implement person-centered planning in accordance with the MDCH Person-Centered Planning Practice Guideline. This provision is not currently a requirement for services provided through the Medicaid Substance Abuse capitation portion of this contract.

3.4.2 Limited English Proficiency

The PHP shall assure equal access for people with diverse cultural background and/or 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.

3.4.3 Cultural Competence

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

3.4.4 Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Under Michigan's specialty service waiver and this agreement, the PHP is responsible

for the provision of certain Medicaid benefits, and must make these benefits available to beneficiaries referred by a primary EPSDT screener, to correct or ameliorate a qualifying condition discovered through the screening process.

While transportation to EPSDT corrective or ameliorative specialty services is not a covered service under this Waiver, the PHP must assist beneficiaries in obtaining necessary transportation either through the FIA or through the beneficiary's Medicaid Health Plan.

4.0 SPECIAL COVERAGE PROVISIONS

The following subsections describe special considerations, services, and/or funding arrangements required by this contract.

4.1 Nursing Home Placements

All designated state funds that the MDCH has authorized to the PHP 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 PHP is notified in writing by the MDCH that the MDCHs 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 MDCH has authorized to the PHP for nursing home mental health and/or developmental disability related services shall continue to be used for this purpose until such time that MDCH approves an alternative. Residents of nursing homes with mental health needs shall be given the same opportunity for access to PHP 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 Multi-cultural Services

Funds categorically defined for multi-cultural supports and services shall be used for the specified purpose only.

4.5 Continuation and Transfer of Demonstration Projects

The transfer of projects from special funding to the PHP state mental health general funds shall be made if:

A. The MDCH determines that the performance and evaluation criteria that were specified have been met; and

B. The PHP commits to continue the project for a minimum of three years and to submit an annual report to the MDCH on the implementation and progress of the project.

4.6 Grants for Older Adults with Dementia

Pursuant to Section 208 of the Michigan Mental Health Code, resources that have been specifically designated to PHPs for services to people with dementia shall be utilized for that specific purpose.

4.7 OBRA Pre-Admission Screening and Annual Resident Review

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

4.8 Long Term Care

The PHP shall assume responsibility for people who are verified to meet the Michigan Mental Health Code eligibility criteria and who are determined by the MDCH through the PASARR 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 PHP and Long Term Care agent. The MDCH shall be notified in the event of a local dispute and the MDCH shall determine the responsibility of the PHP and the Long Term Care agent in these disputes.

4.9 MIChild

The Per Enrolled Child Per Month (PECPM) funding specified in this contract is a full financial risk capitated payment for medically necessary MIChild mental health covered services including inpatient, outpatient, alternative treatment, case management, and prescription medications and laboratory services as authorized by the PHP.

4.10 Capitated Payments and Other Pooled Funding Arrangements

Funding for the purpose of implementing or continuing 1915a capitated projects or other MDCH approved funding arrangements, at the PHP discretion, shall be placed into a pooled funding arrangement limited to that purpose.

5.0 OBSERVANCE OF FEDERAL, STATE AND LOCAL LAWS

The PHP agrees that it will comply with all state and federal statutes, regulations, and administrative procedures that are in effect, or that become effective during the term of this contract. Federal regulations governing contracts with risk-based managed care plans are specified in Section 1903(m) of the Social Security Act and 42 CFR Part 434, and will govern the Medicaid portions of this contract. Pertinent State statutes (Public Health, Mental Health Michigan Department of Management and Budget, Treasury, Family Independence Agency) will govern this contract except for the preceding reference. The state is not precluded from implementing any changes in state or federal statutes, rules, or administrative procedures that become effective during the term of this contract.

5.1 Special Waiver Provisions for MSSSP

The MDCH waiver renewal application to the CMS under the auspices of Section 1915(b)(1) and (4), requesting that Section 1902(a)(10)(B) of the Social Security Act pertaining to Amount, Duration and Scope of Services, and Section 1902(a)(23) pertaining to Freedom of Choice, has been approved. The renewal was approved by the CMS for the period through March 27, 2002. In addition, the MDCH has received approval for its Waiver application to CMS regarding Section 1915(c) of the Social Security Act. This Waiver is referred to as the Home and Community Based Waiver, serving people with a developmental disability. Under these waivers, beneficiaries are entitled to medically necessary specialty supports and services from the PHP. Federal approval of the waiver is required prior to commitment of the federal financing share of funds under this contract. No other waiver is necessary to implement the Medicaid portions of this contract.

5.2 Fiscal Soundness of the Risk-Based PHP

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

5.3 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 Medicaid funds may be used. The MDCH publishes a list of providers who are terminated, suspended or otherwise excluded from participation in the program. The PHP must ensure that its provider networks do not include these providers.

Pursuant to Section 1932(d)(1) of the Social Security Act, a PHP may not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity who is currently debarred or suspended by any federal agency. The

PHPs 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 PHP'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.

5.4 Public Health Reporting

State law requires that health professionals comply with specified reporting requirements for communicable disease and other health indicators. The PHP agrees to ensure compliance with all such reporting requirements through its provider contracts.

5.5 Medicaid Policy

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

6.0 PHP ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE SERVICES

6.1 Organizational Structure

The PHP shall maintain an administrative and organizational structure that supports a high quality, comprehensive managed care program. The PHP'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 PHP shall have sufficient administrative staff and organizational components to comply with the responsibilities reflected in this contract. The PHP shall ensure that all staff have training, education, experience, licensing, or certification appropriate to their position and responsibilities.

The PHP will provide written notification to the MDCH of any vacancies and changes in the following senior management positions within seven days:

- Administrator (Chief Executive Officer)
- Chief Operating Officer
- Medical Director and Clinical/Program Director(s)
- Chief Financial Officer
- Management Information System Director

- Customer Services Director and 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 Prepaid Health Plan (PHP). 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 being able to help on the first contact in most situations. Key aspects of the customer service system shall include:

A. Customer services staff are skilled in customer relations and have up-to-date knowledge and resources regarding benefits, provider network, access, and related policies/procedures.

B. Referral systems to assist recipients in accessing transportation services for medically necessary services, including those stemming from an EPSDT referral.

C. Customer services staff have ready access to pertinent up-to-date, automated information.

D. Recipients and the community have phone access to a customer services representative throughout normal business hours. The customer service phone number is a published number.

E. Customer service performance standards are documented and periodic reports of performance are monitored by the Quality Assurance/Performance Improvement Program (QAPIP).

F. The customer services focus is customer satisfaction and problem avoidance.

G. All voice, electronic and paper communications are logged, tracked, stored, and reflected in performance reports.

All customer services must address the need for culturally-appropriate interventions. Consideration shall be given to multiple language and alternative forms of communication in order to present information in an understandable manner to the recipient(s). Reasonable accommodation must be made for recipients with physical disabilities and hearing and/or vision impairments.

Customer services may offer health/wellness promotion programs periodically.

Customer services shall routinely inform recipients of opportunities for involvement on various boards, councils and work groups managed and utilized by the PHP; and include recipients and family members in providing assistance to new service recipients.

6.3.2 Recipient Rights and Grievance/Appeals

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

The PHP shall adhere to the requirements stated in the MDCH Grievance and Appeal Technical Requirement.

Recipients enrolled in Medicaid must be told of their right to an administrative hearing if dissatisfaction is expressed at any point during the rendering of supports and services. While PHPs may attempt to resolve the dispute through their grievance or complaint process, this process must not supplant or replace the recipient's right to file a hearing request with the MDCH. The PHP's grievance or complaint process may, and should, occur simultaneously with the MDCH administrative hearing process, as well as with the recipient rights process. The PHP shall follow fair hearing guidelines and protocols issued by the MDCH.

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 covered 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.

B. All materials shall be available in the languages appropriate to the people served within the PHP's area. Such materials shall be available in any language alternative to English when an alternative language-related population comprises one percent of the PHP service area as determined by the most recent U.S. Census update.

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 MDCH for review of consistency with these standards.

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

6.4 Provider Network Services

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

In this regard, the PHP 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 mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.

C. Provide a copy of the PHP's prior authorization policies to the provider when the provider joins the PHPs provider network. The PHP must notify providers of any changes to prior authorization policies as changes are made.

D. Provide to the MDCH in the format specified by the MDCH, provider information profiles that contain a complete listing and description of the provider network available to recipients in the service area.

E. Notify the MDCH within seven days of any changes to the composition of the provider network. The PHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that the MDCH determines to negatively affect recipient access to covered services may be grounds for sanctions.

F. Assure that the provider network responds to the cultural, racial and linguistic needs (including interpretive services as necessary) of the service area.

G. Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility.

H. Assure that primary supports and services including hospital services will be available to recipients within 30 minutes or 30 miles travel in urban areas, and 60 minutes or 60 miles travel in rural areas. Exceptions to this standard may be granted if the PHP documents that no other network or non-network provider is

accessible within the specified travel time or distance.

I. Assure that network providers do not segregate PHPs recipients in any way from other people receiving their services.

6.4.1 Provider Contracts and Procurement

The PHP is responsible for the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract. Where the PHP and affiliated PHPs fulfill these responsibilities through sub-contracts with providers, they shall adhere to federal procurement requirements.

6.4.2 Sub-contracting

The PHP may sub-contract for the provision of any of the services specified in this contract. The PHP shall be held solely and fully responsible to execute all provisions of this contract, whether or not said provisions are directly pursued by the PHP, pursued by affiliated PHPs, or pursued by the PHP through a subcontract vendor. The PHP shall ensure that sub-contract arrangements clearly specify the type of services being purchased. Subcontracts shall ensure that the MDCH is not a party to the contract and therefore not a party to any employer/employee relationship with the subcontractor of the PHP. Subcontracts entered into by the PHP shall address the following:

A. Duty to treat and accept referrals
B. Prior authorization requirements
C. Access standards and treatment time lines
D. Relationship with other providers
E. Reporting requirements and time frames
F. QA/QI Systems
G. Payment arrangements (including coordination of benefits) and solvency requirements
H. Anti-delegation clause
I. Compliance with Office of Civil Right Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency
J. EPSDT requirements

In addition, subcontracts shall:

K. Require the provider to cooperate with the PHP'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. Not prohibit a provider from discussing treatment options with a recipient that may not reflect the PHP's position or may not be covered by the PHP.
N. Not prohibit a provider from advocating on behalf of the recipient in any grievance or utilization review process, or individual authorization

process to obtain necessary health care services.

O. Require providers to meet Medicaid accessibility standards as established in Medicaid policy and this contract.

In accordance with 42 CFR 434.6(b), all subcontracts entered into by the PHP must be in writing and fulfill the requirements of 42 CFR 434.6(a) that are appropriate to the service or activity delegated under the sub-contract. All subcontracts must be in compliance with all State of Michigan statutes and will be subject to the provisions thereof. All subcontracts must fulfill the requirements of this contract that are appropriate to the services or activities delegated under the subcontract.

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

Sub-contracts that contain provisions for a financial incentive, bonus, withhold, or sanctions (including subcapitations) must include provisions that protect recipients from practices that result in the withholding of services that would otherwise be provided according to medical necessity criteria and best practice standards, consistent with 42 CFR 417.479, Subpart L. The PHP shall provide a copy of each contract that contains incentive, bonus, withhold, or sanction provisions (including subcapitations) to the MDCH at the time the contract is issued to the provider. MDCH reserves the right to disallow such contracts if the provisions appear to increase the risk to MDCH, or to jeopardize individuals' access to services.

6.4.3 Provider Credentialing

The PHP shall have written credentialing and recredentialing (at least every two years) policies and procedures for ensuring quality of care and ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services throughout the life of the contract. The PHP must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state. The PHP also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the PHP's standards.

6.4.4 Collaboration with Community Agencies

The PHPs must work closely with local public and private community-based organizations and providers to address prevalent human conditions and issues that relate to a shared customer base. Such agencies and organizations include local health departments, Medicaid Health Plans (MHPs), local FIA offices, Substance Abuse Coordinating Agencies, community and migrant health centers, nursing homes, Area Agency and Commissions on Aging, Medicaid Waiver agents for the HCBW program, school systems, and Michigan Rehabilitation Services. Local

coordination and collaboration with these entities will make a wider range of essential supports and services available to the PHP's recipients. PHPs are encouraged to coordinate with these entities through participation in multi-purpose human services collaborative bodies, and other similar community groups. The PHP shall have a written coordination agreement with each of the pertinent agencies noted above describing the coordination arrangements agreed to and how disputes between the agencies will be resolved. To ensure that the services provided by these agencies are available to all PHPs, an individual contractor shall not require an exclusive contract as a condition of participation with the PHP.

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

6.4.5 Medicaid Health Plan (MHP) Agreements

Most Medicaid beneficiaries receiving services from the PHP will be enrolled in a MHP for their health care services. The MHP is responsible for non-specialty level mental health services. It is therefore essential that the PHP have a written, functioning coordination agreement with each MHP serving any part of the PHP's service area.

PHPs must ensure that local agreements address the following issues:

- Emergency services
- Pharmacy and laboratory service coordination
- Medical coordination
- Data and reporting requirements
- Quality assurance coordination
- Grievance and complaint resolution
- Dispute resolution

6.5 Management Information Systems

The PHP shall have and maintain a Management Information System and related practices that reflect sufficient capacity to fulfill the obligations of this contract. Management information systems capabilities are necessary for at least the following areas:

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

Note that PHPs managing the Medicaid Substance Abuse benefit are not required to collect and submit client and service data for the fiscal year ending September 30, 2003. That requirement will, however, commence for all PHPs beginning October 1, 2003. The Coordinating Agencies remain responsible for this information during the current fiscal year, through their contract with the department.

6.5.1 Uniform Data and Information

To measure the PHP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates, the PHP must provide the MDCH with uniform data and information as specified by the MDCH. Any changes in the reporting requirements will be communicated to the PHP at least 90 days before they are effective unless state or federal law requires otherwise.

The PHP's timeliness in submitting required reports and their accuracy will be monitored by the MDCH and will be considered by the MDCH in measuring the performance of the PHP.

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

The PHP shall submit the information below to the MDCH consistent with the time frames and formats specified in Attachment B. 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 Severe 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. Report of Deaths

4. Office of Recipient Rights
5. Sentinel Events

C. The PHP shall submit a written review of death for every recipient whose death occurred within six 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 PHP be required by the MDCH, at least 45 days written notice shall be provided. The written request shall identify who is making the request and the purpose of the request. The MDCH shall make earnest efforts not to request additional information (above and/or beyond what is required in this contract and/or any modification of the contract informational requirements). Particular exceptions include additional informational requirements issued by funding and regulatory sources and/or resulting from legislative action.

6.5.2 Encounter Data Reporting

In order to assess quality of care, determine utilization patterns and access to care for various health care services, affirm capitation rate calculations and estimates, the PHP shall submit encounter data containing detail for each recipient encounter reflecting all services provided by the PHP. Encounter records shall be submitted monthly via electronic media in the format specified by the MDCH. Encounter level records must have a common identifier that will allow linkage between the MDCH and the PHP management information systems.

6.6 Financial Management System

6.6.1 General

The PHP 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. Financial reporting shall be in accordance with Generally Accepted Accounting Principles (GAAP) applicable to state and local governments, as promulgated by the Governmental Accounting Standards Board (GASB). Within this context, the contract requires that aside from P.A. 423 funds, all revenues and expenditures will be reported on a full accrual basis of accounting, and will reflect depreciation of capital expenditures as required by OMB Circular A-87, and sections 241 and 242 of the Mental Health Code. When a deviation from GAAP is desired, the PHP shall obtain prior written instructions for the deviation from the MDCH, and follow other specified procedures by the State of Michigan.

The accounting and financial systems established by the PHP 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 capitated payments, state general funds, MIChild, 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 100 percent state funding. The accounting system must be capable of reporting the use of these specific fund sources by major population groups (MIA, MIC, DD and SA).

The PHP shall submit financial reports as indicated in Section 8.8 of the contract.

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

6.6.2 Financial Reporting

The PHP shall provide financial reports to the MDCH as specified in Section 8.8 and at the times and in the formats specified.

6.6.3 Claims Management System

The PHP shall make timely payments to all providers for covered services rendered to recipients covered by this contract. This includes payment at 90 percent or higher of all clean claims from affiliates and network subcontractors within 30 days of receipt, and at least 99 percent 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 one completed in the format specified by the PHP and that can be processed without obtaining additional information from the provider of service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. As stated in the State Appropriation Act (Section 242), a clean claim that is not paid within 45 days after receipt shall bear simple interest at a rate of 12 percent per annum.

The PHP shall have an effective provider appeal process to promptly resolve provider billing disputes, as well as other matters of dispute.

6.6.3.1 Post-payment Review

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

6.6.3.2 Total Payment

The PHP 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 PHP's providers may not bill recipients for the difference between the provider's charge and the PHP's payment for covered services. The providers shall not seek nor accept additional supplemental payment from the recipient, his/her family, or representative in addition to the amount paid by the PHP, even when the recipient has signed an agreement to do so.

6.6.3.3 Electronic Billing Capacity

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

6.6.3.4 Third Party Resource Requirements

PHPs 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., Medicare) that has liability for all or part of a recipient's covered benefit. The PHP shall collect any payments available from other health insurers including Medicare and private health insurance for services provided to its recipients in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, and the Michigan Mental Health Code and Public Health Code as applicable. The PHP shall be responsible for identifying and collecting third party liability information and may retain third party collections, as provided for in Section 226a of the Michigan Mental Health Code.

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

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 PHP that specifies credentialing and utilization review requirements. Voucher rates for such services shall be predetermined by the PHP using the 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 Section 7.4.1 (Provider Contracts and Procurement) and Section 7.4.2 (Sub-contracting) of this contract.

6.6.3.6 Payment of State-Delivered Services

A. The PHP shall authorize payment, within 30 days of receiving the bill, for the actual number of PHP 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 based upon a bill that identifies the individuals served and the days of care provided at a fixed net State cost per day. The PHP's payment for days of care shall cover days provided to those specified individuals for whom service has been authorized by the PHP as described in this contract.

C. The PHP 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. Authorization of undisputed bills shall be made within 30 days of receipt of the billing. The PHP shall identify to the MDCH disputes concerning bills on a case-by-case basis within 30 days of the bill and shall work with the MDCH in resolving these disputes on a timely basis. The MDCH may refer to the Michigan Department of Treasury (MDT) for collection of all bills that are

both undisputed and overdue.

D. The mechanisms and procedures for disputing the MDCH billings for state-delivered services are described in the State Service Billing Dispute document.

6.7 State Lease Expiration

The MDCH shall notify the PHP, 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 PHP shall be responsible for any lease costs it causes the MDCH 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 PHP shall have a Quality Assessment and Performance Improvement Program (QAPIP) that meets the requirements outlined in the Quality Assessment and Performance Improvement Program Requirements, Appendix C.1.a (2) of Michigan's approved 1915(b) Waiver renewal and 42 CFR 434.34. The PHP must have a written description, available for the MDCH review of its QAPIP that specifies how appropriate administration and evaluation of the QAPIP will be accomplished. This description must include the components and activities of the QAPIP; the role of recipients of service; and how process and outcome improvements will be adopted and communicated. The QAPIP must have a designated senior official responsible for implementation, active participation by providers and service recipients, and management by a governing body. Evidence of this would include documentation that the governing body has approved the overall QAPIP and an annual quality improvement plan, and that the governing body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken, and the results of those actions. The annual plan and evidence of action taken and outcomes of the action must be available for MDCH review.

A. The essential elements of a QAPIP include:
   1. Performance measurement using standardized indicators, including those established by the MDCH, in the areas of access, efficiency and outcome. Reports are shared with the governing body, and where required, sent to the MDCH.

   2. Assurance that the PHP achieves acceptable performance levels on performance indicators as established by the MDCH and defined in Attachment B.

   3. Performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained

improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and recipient satisfaction. The PHP is required to participate, along with all other PHPs, in a performance improvement project on the implementation of person-centered planning directed by the MDCH. The PHP may be required to engage in another performance improvement project directed by the MDCH targeting an area of continued or repeated non-compliance with performance standards. Notification of this MDCH assigned project will be provided to the PHP. Methodology for implementing the PCP project and the second project must be submitted to, and approved by, the MDCH prior to commencement of the projects.

4. A process for the review and follow-up of sentinel events.

5. Periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of recipient experiences with the PHP's services. These assessments must be representative of the people served and the services and supports offered, and address issues affecting the quality, availability, and accessibility of supports and services.

6. A process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted or mutually agreed upon clinical standards that are relevant to the people served.

7. Written procedures to determine whether physicians, health care professionals, and other providers of care or support who are employees of the PHP or under contract with the PHP, possess the qualifications outlined in their job descriptions and are qualified to perform their services.

8. A methodology for verifying whether services reimbursed by Medicaid were actually furnished to recipients by providers and sub-contractors.

The PHP must maintain a Quality Improvement Council (QIC) for purposes of reviewing the QAPIP, its results and activities, and recommending changes on an ongoing basis. The QIC must be comprised of PHP staff, including but not limited to the quality improvement director and other key management staff, as well as health professionals providing care to recipients.

The PHP's QAPIP shall be capable of identifying opportunities to improve the provision of health care services and the outcomes of such care for recipients. In addition, the PHP's QAPIP shall incorporate and address findings of site

reviews by the 'MDCH, external independent reviews, and statewide focused studies. The PHPs QAPIP must also develop or adopt performance improvement goals, objectives and activities or interventions as required by the MDCH to improve service delivery or outcomes for recipients.

The PHP shall have a written plan for the QAPIP that includes a statement of the PHP's performance goals and objectives, lines of authority and accountability including data responsibilities, evaluation tools, and performance improvement activities.

B. The written plan must also describe how the PHP will:

1. Analyze both the processes and outcomes of care using currently accepted standards from recognized authorities, including focused review of individual cases as appropriate, and to discern the causes of variation in the provision of care to recipients.

2. Establish clinical and non-clinical priority areas and indicators for assessment and performance improvement.

3. Use measures to analyze the delivery of services and quality of care, over- and under-utilization of services, disease management strategies, and outcomes of care. The PHP is expected to collect and use data from multiple sources such as medical records, encounter data, HEDIS, claims processing, grievances, utilization review, and recipient satisfaction instruments in this activity.

4. Compare QAPIP findings with past performance and with established program goals and available external standards.

5. Measure the performance of PHP providers and conduct peer review activities such as: identification of practices that do not meet PHP standards, recommendation of appropriate action to correct deficiencies, and monitoring of corrective action by providers.

6. Measure provider performance through the inclusion of medical record audits to be performed at least twice annually on a statistically valid sample of PHP providers.

7. Provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the PHP.

8. Develop and/or adopt clinically appropriate practice parameters and protocols/guidelines and give the PHP's providers enough information about the protocols to enable them to meet the established standards.

9. Evaluate access to care for recipients according to the established standards and those developed by the CAC and PHP's QIC, and implement a process for ensuring that network providers meet and maintain the standards. The evaluation should include an analysis of the accessibility of services to recipients with disabilities.

10. Perform a recipient satisfaction survey annually in collaboration with the MDCH, and distribute results to providers, recipients, and the MDCH.

11. Implement improvement strategies related to program findings and evaluate progress periodically, but at least annually.

12. Maintain the written plan for the PHP's QAPIP that will be available to the MDCH upon request.

C. Performance Objectives

At a minimum, the PHP shall include performance objectives for the delivery of services to recipients in the written plan for its QAPIP. The PHP's performance on these objectives will be monitored by the MDCH.

6.8.2 External Quality Review

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

6.8.3 Annual Effectiveness Review

The PHP 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 PHP. The analysis should take into consideration trends in service delivery and health outcomes over time and include the monitoring of progress on performance goals and objectives. Information on the effectiveness of the PHP's QAPIP must be provided annually to network providers and to recipients upon request. Information on the effectiveness of the PHP's QAPIP must be

provided to the MDCH upon request.

6.9 Service and Utilization Management

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

6.9.1 State Managed Services

A. The PHP shall authorize medically necessary inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. The PHP shall review treatment at intervals and authorize medically necessary 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 NGRI Protocol. The authority and responsibility of the PHP regarding hospital admissions is always a shared responsibility to a degree, and Chapter 10 requires some unique applications related to authorization of state services.

Mechanisms/procedures for implementation of this single entry responsibility shall be contained in an operating/service agreement between the PHP and each admitting hospital/center.

B. The MDCH and PHP agree that admissions must be medically necessary, that criteria specified in the Michigan Mental Health Code must be met 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 requirements for medical necessity are met and the PHP cannot offer an alternative at the appropriate level of care.

C. The PHP's authorization of admission and of continued treatment shall be the basis on which the PHP will reimburse the MDCH for the state cost of inpatient services provided in a state-managed hospital/center. The PHP's obligation for the local match cost of such services shall not be affected by this section. Authorizations shall be conveyed in writing to the hospital/center. The MDCH contract manager shall be notified by the PHP within seven days of the decision when the PHP 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 PHP shall not be liable for any inpatient services that have not been authorized by the PHP in this circumstance. Likewise, the MDCH contract manager shall be notified by the hospital/center whenever an authorization of continued stay by the PHP is clinically unwarranted in the judgment of the hospital/center. Such notification shall initiate a process for resolution of the differences.

6.9.2 Recipient Service Records

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

6.9.3 Other Service Requirements

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

A. Inclusion Best Practice Guideline
B. Housing Best Practice Guideline
C. Consumerism Best Practice Guideline
D. Personal Care in Non-Specialized Home Guideline
E. Substance Abuse Practice Guideline

6.9.4 Coordination

The PHP shall assure that services to each recipient are coordinated with primary health care providers, including Medicaid Health Plans, and other service agencies in the community that are serving the recipient. In this regard, the PHP will implement practices and agreements described in Section 7.4.3 of this contract.

6.9.5 Jail Diversion

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

6.9.6 School-to-Community Transition

The PHP shall participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. Participation shall be consistent with the MDCH School-to-Community Transition Guideline.

6.9.7 Children's Waiver

The PHP shall be responsible for pursuing and managing Children's Waiver services for people who meet the criteria for the waiver services. This includes the following:

A. Develop the IPS and accompanying materials for waiver applicants, according to waiver instructions issued by the MDCH. Where specified in the instructions, the PHP shall also provide appeals and verification of IPS for waiver applicants.

B. Determine the appropriate program category for the waiver recipient and the amount of publicly-funded hourly care following the instructions issued in the most recent Medicaid Manual.

C. Develop subcontract arrangements with appropriate agencies to meet the service needs reflected in the plan of service, and assure that services are provided at levels specified in the approved plans.

D. Bill Medicaid on a fee-for-service basis for all covered services delivered, in accordance with the most recent Medicaid Manual, and in a timely manner.

E. Provide access and submit required reports for the purpose of monitoring by the CMS and the MDCH.

6.9.8 Utilization Management

The PHP shall have and maintain utilization management (UM) practices that are adequate to fulfill the obligations of this contract. The major components of the PHP utilization management plan must encompass, at a minimum, the following:

A. A written plan describing the Utilization Management operations and detailing prospective, concurrent and retrospective utilization management practices.

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B. The Utilization Management function is under the direction of a senior PHP administrator to oversee the utilization review process and assure appropriate follow-up.

C. An Information System that supports the Utilization Management function through timely and accurate utilization and cost information.

D. An annual review and report of utilization review activities and outcomes.

The PHP may establish and use a prior approval procedure for utilization management purposes provided that it does not use such procedures to avoid providing medically necessary services within the coverages established under the contract. Providers and recipients must be made aware of prior approval procedures prior to their implementation. The utilization management activities of the PHP must be integrated with the PHP's quality assessment and performance improvement program.

7.0 CONTRACT FINANCING

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

7.1 Local Obligation

The PHP shall provide the local financial obligation for services requiring local match, as required by state statute. In the event a PHP is unable to provide the required local obligation, the PHP shall notify the MDCH immediately. This may result in the MDCH 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 PHP provides the MDCH with a plan and assurances that the local obligation shortfall has been rectified.

7.2 Revenue Sources for Local Obligation

The following subsections describe potential revenue sources for the PHP's local obligation:

7.2.1 County Appropriations

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

7.2.2 Other Appropriations and Service Revenues

Appropriations of funds to the PHP 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 PHP, 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.

7.2.4 Special Fund Account

Funds of participating PHPs from the Community Mental Health Grant Fund consistent with Section 226a of the Michigan Mental Health Code.

7.2.5 Investment Interest

Interest earned on funds deposited or invested by or on behalf of the PHP. Also, interest earned on the MDCH funds by contract agencies and/or network providers as specified in its contracts with the PHP to provide mental health services.

7.2.6 Other Revenues for Mental Health Services

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

7.2.7 Other Revenues

Revenues in excess of expenses for PHP mental health and non-mental health services provided by persons other than recipients, to agencies/businesses other than those identified in Section 8.2.6 above, as long as federal or the MDCH state funds are not paid to and/or used by the PHP to pay for any costs, including administrative costs of those mental health services.

7.2.8 Grants or Gifts Exclusions

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

An exception may be made, where the PHP 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 PHP payments to the contract agency that are claimed as matchable expenses for the purpose of state financing.

7.3 Local Obligations - Requirement Exceptions

The following services shall not require the PHP 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 PHP and the state is responsible for 100 percent of the cost of the program, consistent with the Michigan Constitution.

D. Community hospital-based psychiatric services (inpatient, partial hospitalization, and related physician services) expenditures incurred for services to people who are Medicaid eligibles.

E. Services provided to an individual under criminal sentence to a state prison.

7.4 MDCH Funding

The MDCH funding includes both state and federal funds, which the state is responsible to manage. The MDCH financial responsibility is specified in Chapter 3 of the Michigan Mental Health Code and the level of funding contained in the current year state legislative appropriations.

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

7.4.1 Medicaid

The MDCH shall provide to the PHP both the state and federal share of Medicaid funds as a capitated payment based upon a per eligible per month (PEPM) methodology. The MDCH will provide access to an electronic copy of the names of the Medicaid eligible people for whom a capitation payment is made. A PEPM is determined for each of the populations covered by this contract, which includes services for people with a developmental disability, a mental illness or emotional disturbance, and may include people with a substance use disorder as reflected in Section 2.1 of this contract.

The Medicaid per eligible per month (PEPM) rates and the annual estimate of current year payments are attached to this contract. The actual number of Medicaid eligibles

shall be determined monthly and the PHP shall be notified of the eligibles in their service area via the pre-payment process. Also, PEPM rates shall be recalculated if the PHP has individuals entering or exiting a state center for persons with developmental disabilities.

Beginning with the first month of this contract, the PHP shall receive a pre-payment equal to one month. The pre-payment shall be issued on the first Wednesday of each month.

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

7.4.1.1 Medicaid Rate Calculation

The Medicaid financing strategy used by the MDCH, and stated in the 1915(b) Waiver, is to contain the growth of Medicaid expenditures, not to create savings. The Medicaid rates reflected in this contract are derived from the original 1998 methodology reflected in the 1915(b) Waiver. Those rates are adjusted as of April 2001 to remove retro-eligibles from the monthly eligibles formula, and adjust the rates up to the level supported by the state legislative appropriation. This level of financing has been determined to remain within the upper payment limit as specified in the approved 1915(b) and (c) Waivers.

Two groups of Medicaid eligibles are excluded from the capitation methodology/payments. These are the eligibles enrolled in the Children's Waiver (approximately 400 people) and people residing in a state center for developmental disabilities who remain in ICF-MR Medicaid funding.

The PEPM continues to be determined by three variables: (a) a statewide capitation rate for each of three Medicaid-eligible defined groups (Disabled P/E; DAB, and TANF/Other), (b) an intensity factor for each PHP for each of three Medicaid-eligible defined groups (Disabled P/E; DAB, and TANF/Other), and (c) the number of Medicaid eligibles per month by Medicaid group. These variables are factored in a matrix across six age categories (0-17, 18-25, 26-39, 40-49, 50-64 and 65 and over). The eligibles included in the PEPM calculation are Scope/Coverage 1F, 2F, 1E, 2E, 2B, 4, P, T, U, V and Program Code: A, B, C, E, I, J, R, L, M, N, O, P, and Q.

The Social Security Act (SSA) precludes states from paying risk-based health plans more than a reasonable estimate of what would have been paid for the same set of services had the eligibles remained in the fee-for-service system. The rates in this contract comply with this requirement as the capitation rates fall within the test of cost effectiveness for the upper payment limit as approved by the CMS. The upper payment limit and capitation rates include funds to cover the federal Medicaid match for Section 1915(c) "Habilitation Supports Waiver" services/supports to individuals enrolled in the C-Waiver program.

The approved upper payment limit also provides for federal funds to be made available for people exiting state centers for people with developmental disabilities. Section 8.4.1 provides contractual language for the financial adjustments to Medicaid payments to a PHP for people exiting from or entering state DD Centers.

Additional description and detail regarding the PEPM rates and calculations are included in Attachment A to this contract.

7.4.2 State Mental Health General Fund Formula Funding

The MDCH shall provide the PHP 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 full year GF formula funds authorized for this contract year is reflected in Attachment A.

Beginning with the first month of this contract, the MDCH shall provide the PHP an amount equal to one month's payment. The pre-payment shall be issued on the first Wednesday of each month.

7.4.2.1 GF Formula Funds Calculation

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

This funding is based upon the prior year full-year authorizations, including state facility funding, together with adjustments for transfers and other program/policy requirements, including adjustments for trade-offs earned in the prior year and changes in current year state facility rates, plus any current year appropriation changes. The MDCH has redistributed some of these formula funds across PHPs in prior years, and may do so again to further reduce identified financing inequities. Prior notice will be given to the PHP in the event of a redistribution. $2.4 million of this GF formula funding is set aside to meet the intent of Section 8.4.4. The calculation for this set aside is a pro-rata distribution across all PHPs.

7.4.3 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 MDCH for a specific purpose, project, and/or target population and are not included in the PEPM or GF formula funding.

These funds and programs may be authorized through separate contractual arrangements between the PHP and the MDCH. These agreements typically include performance and outcome expectations, reporting requirements, and finance-related specifications. The PHP 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 MDCH for a specific purpose, project, and/or target population. The categorical funding authorized through this contract is specified in Attachment A. Funding for any special and/or designated funds shall not be redirected by the PHP without prior approval of the MDCH.

7.4.4 Special and/or Designated Funds: Inclusions

The Medicaid PEPM financing as well as state GF formula funds may include funds that were previously earmarked as special and/or designated funds. These funds shall continue to be expended for the purpose that they were earmarked and may not be redirected for any other use without prior approval from the MDCH. These funds are identified as Maintenance of Effort.

7.4.5 Maintenance of Effort

A. The following categories of funding are identified as each individually requiring a financing Maintenance of Effort (MOE):

   1. Funds identified as "Ethnic Population" for FY 85/86 through FY 90/91 (inclusive).

   2. Funds supporting OBRA Active Treatment and OBRA Residential placement.

   3. Funds identified as "Direct Care Wage (DCW) Increase," as reflected in the Appropriations Act.

B. The PHP shall be responsible for the following:

   1. Developing and submitting to the MDCH, for approval, an expenditure budget reflecting the total state and federal Medicaid and non-Medicaid funding for each category of MOE funding. This shall be done for each new MOE initiative.

   2. Maintain expenditures for each individual MOE budget at a minimum of 95 percent of the approved budget. The exception to the 95 percent requirement is the DCW Wage Increase. The DCW Wage Increase is required to be maintained at 100 percent of the

MOE budget identified in the contract.

3. Returning any funds to the MDCH that fall below the expenditure expectations. This shall take place as part of the contract settlement process to occur at the end of each fiscal year. The MDCH may reduce the PHP funding for each individual MOE budget that falls below the expenditure expectations. The PHP may request continuation of full funding.

7.4.6 Fee-for-Service

The Children's Waiver is a fee-for-service Medicaid program. The MDCH Medical Services Administration shall reimburse the PHP in accordance with MDCH-approved budgets and Medicaid reimbursement billings submitted by the PHP for each beneficiary with a MDCH approved Children's Waiver. The PHP will be reimbursed based on the billings submitted, as this program shall not be prepaid.

7.4.7 MIChild

The MDCH shall provide to the PHP the federal share of MIChild funds as a capitated payment based upon a per enrolled child per month (PECPM) methodology for MIChild covered mental health services. Included with these funds shall be an electronic copy of the names of the MIChild enrolled people forming the basis of these calculations. See Attachment A for the PECPM rates.

Beginning with the first month of this contract, the PHP shall receive a MIChild prepayment. The prepayment shall be issued on the first Wednesday of each month. Unexpended MIChild capitated payments may be used as local funds.

7.5 Operating Practices

The PHP shall adhere to Generally Accepted Accounting Principles and other federal and state regulations. The final expenditure report shall reflect incurred but not paid claims. The following documents shall guide program accounting procedures:

A. Generally Accepted Accounting Principles for Governmental Units.

B. Audits of State and Local Governmental Units, issued by the American Institute of Certified Public Accountants (current edition).

C. OMB A-87

7.6 Audits

The PHP shall ensure the completion of an annual independent financial audit for each fiscal year that will clearly indicate the operating results for the reporting period and the

financial position of the PHP at the end of the fiscal year. A copy of this audit report, along with the management letter and the PHP's response to the management letter, shall be submitted to the MDCH within six months of the end of the reporting period.

7.7 Financial Planning

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

7.7.1 Risk Corridor

The shared risk arrangement shall cover all Medicaid capitation payments and state mental health general fund formula funds, with the exception of funds identified as MOE earmarked for specific services or supports. Funds identified as MOE shall be subject to the PHP financial responsibility described in items C and D below. However, such funding may be considered for carry forward in the shared risk arrangement only if the funds within each MOE expenditure budget have been expended as defined in Section 8.4.5. Funding identified as categorical, all fee-for-service, and the PECPM MIChild payments are completely excluded from the shared risk arrangement, as the PHP assumes full risk of operating within the boundaries of the approved expenditure and revenue budgets of each of these funding arrangements.

Within each fiscal year, the boundaries of the shared risk arrangement are defined within the risk corridor as follows:

A. The PHP shall return unexpended risk corridor-related funds to the MDCH between 0 percent and 95 percent of said funds contracted.

B. The PHP may retain all risk corridor-related operating budget funds between 95 percent and 100 percent of said funds contracted, except as specified in Part I, Section 13 "Closeout."

C. The PHP shall be fully financially responsible for liabilities incurred for expenses above the risk corridor-related operating budget between 100 percent and 105 percent of said funds contracted.

D. The PHP shall be responsible for 50 percent of the full financial liabilities for expenses above the risk-corridor-related operating budget between 105 percent and 110 percent of said funds contracted.

E. The PHP shall not be financially responsible for liabilities incurred for expenses above the risk corridor-related operating budget over 110 percent of said funds contracted.

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

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

7.7.2 Savings and Reinvestment

Provisions regarding the carry forward of state mental health general funds, Medicaid savings, and the PHP reinvestment strategy are included in the following subsections. Note that these provisions may be limited or canceled by the closeout provision in Part I, Section 13 (E).

7.7.2.1 General Fund Carry Forward

At the conclusion of the fiscal year ending in 2002, the PHP may carry forward up to five percent of unexpended 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 PHP planned expenditure in the subsequent year. All carry-forward funds unexpended in the subsequent year shall be returned to the MDCH.

7.7.2.2 Medicaid Savings

At the conclusion of the fiscal year, the PHP may retain unexpended Medicaid funds up to five percent of the Medicaid pre-payment authorization. These funds shall be treated as Medicaid funds and shall be included in the PHP reinvestment strategy as described below. All Medicaid savings funds unexpended at the end of two fiscal years from the period earned shall be returned to the MDCH. In addition, the PHP cannot accumulate Medicaid savings above seven percent. Any earned savings above seven percent of the most recent Medicaid prepayment authorization will be reclaimed by the MDCH. Substance abuse earned savings must be reinvested in the substance abuse program and mental health earned savings must be reinvested in the mental health program.

7.7.2.3 Reinvestment Strategy - Medicaid Savings

The PHP shall develop and implement a reinvestment strategy for all Medicaid savings realized. The PHP reinvestment strategy shall be directed to the Medicaid population and shall financially support one or more of the following:

A. Development of new treatment, support and/or service models

B. Expansion of existing treatment, support and/or service models to address projected demand increases

C. Community education, prevention and/or early intervention initiatives

D. Treatment, support and/or service model research and evaluation

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

F. Identified benefit stabilization purposes. Benefit stabilization is designed to enable maintenance of contracted state plan benefits under conditions of changing economic conditions and payment modifications. This enables the PHP to retain savings for one year to help meet unavoidable costs, and thereby continue to provide full benefits in the following year. The reinvestment strategy must indicate the conditions that justify the use of this option.

The PHP reinvestment strategy must receive approval by the PHP board and a copy provided to the MDCH upon board approval. The reinvestment strategy becomes a contractual performance objective. The PHP shall be required to document the expenditures that implement the reinvestment plan according to approved plans for audit purposes. Also note that capital costs must be financed according to provisions in the Mental Health Code and OMB Circular A-87.

7.7.3 Risk Management Strategy

The PHP shall be responsible for developing and implementing a comprehensive risk management strategy that has been approved by the MDCH as a contractual performance objective. The risk management strategy shall minimally consider the following:

A. Tracking and determining trends in the number of Medicaid eligibles and the total population of the PHP's service area as related to risk.

B. Tracking of penetration rates relative to current expectations of penetration rates based upon a reliable methodology.

C. The PHP ability to accurately predict need using a sound methodology.

D. The PHP ability to competently and comprehensively maintain a system of access, authorization, claims management, utilization management, real time data collection and analysis, and QI practices.

E. The PHP board strategic plan consistent with the vision and mission of the organization.

F. The PHP's provider network, including an assessment of the competencies and sufficient resources, to ensure choice, quality and market competition.

G. The PHP's relationship with other community organizations and resources to promote efficiencies and access to recipient-entitled and/or naturally available resources.

H. Historical and current financial performance and viability as evidenced in routine fiscal practices including the timeliness and accuracy of tracking revenues and expenditures, and in projections of revenues and expenditures.

7.7.4 PHP Assurance of Financial Risk Protection

The PHP must provide to MDCH upon request, documentation that demonstrates financial risk protections sufficient to cover the PHP's determination of risk. The PHP must update this documentation any time there is a change in the information. The PHP may use one or a combination of measures to assure financial risk protection, including pledged assets, stop-loss reinsurance, and creation of an ISF. The use of an ISF in this regard must adhere to guidelines published by the MDCH, and must be reported to the MDCH as required by the financial reporting requirements of this contract.

7.8 Finance Planning, Reporting and Settlement

The PHP shall provide financial reports to the MDCH as specified in this contract, and on forms and formats specified by the MDCH.

Financial reporting will require that the PHP utilize Generally Accepted Accounting Principles in reporting revenues and expenditures, except P.A. 423 funds, which are to be reported on a cash basis of accounting. Reporting of revenues and expenditures must be on a full accrual basis of accounting, and will be made in relation to the PHP's spending plan. The full year spending plan is to be updated by the PHP on a quarterly basis to reflect full-

year impacts of year-to-date experiences. Claims payment reports shall also be part of financial reporting under this contract. The PHPs that maintain an ISF Risk Reserve Account, and any form of reserve account are required to report on the status of these accounts on a quarterly basis, as well as post year periods. The MDCH will use information from these reports in making determinations and judgments regarding the PHP's performance, including implications for the risk corridors.

Required reports and time frames are listed below. Note that the MDCH may require more frequent reporting if information reflective of the PHP's performance warrants it. Such a change in frequency will be communicated to the PHP in writing, with at least 30 days advance notice. Reports are due at MDCH 30 days following the end of the reporting period, except the interim and final reports. The final report is due 90 days from the end of the state fiscal year. The interim report for the year ending September 30, 2002,is due on or before November 8, 2002.

Note that the final FSR will require reporting expenditures by major population groups (MIA, MIC, and DD, other services and administration). Also, the substance abuse reports are required only for those PHPs managing the Medicaid SA benefit.

Financial Reports

Four Quarterlies, Interim & Final Report	MH Financial Status Report - Exp. & Rev.
Four Quarterlies, Interim & Final Report	MH State Facility Utilization
Four Quarterlies, Interim & Final Report	ISF & Other Reserve Accounts (MH/SA, separate)
Interim & Final Report	MH Contract Reconciliation & Cash Settlement Summary
Four Quarterlies and Final Report	Special Fund Report (226a of the Code);for PHPs participating in P.A. 423 fund.
Four Quarterlies and Final Report	Claims Aging Report - MH/SA, separate
Four Quarterlies and Final Report	Financial trial balance - MH/SA, separate
See Attachment B	Sub-Element Cost Report
Four Quarterlies, Interim & Final Report	MASA Financial Status Report
Interim & Final Report	MASA Year-end Closeout of Medicaid
Due no later than six months from end of fiscal year	Annual Audit Report, Management Letter, and PHP Response to the Management Letter

8.0 CONTRACT REMEDIES

The state will utilize a variety of means to assure compliance with contract requirements. The state will pursue remedial actions that the PHP can implement to resolve outstanding requirements. If remedial actions are not appropriate or are not successful, contract remedies

including, but not limited to, capitation withholds or financial penalties may be implemented. The application of remedies shall be a matter of public record.

The use of intermediate sanctions for non-compliance is described in Section 1932(e) of the Social Security Act as enacted in the Balanced Budget Act, Section 4707(e). This provision states that a hearing must be afforded to PHPs before termination of a contract under this Section can occur.

The MDCH may utilize any of the following remedies:

A. Sanction letter identifying the problem (use with all remedies)
B. Sanction letter identifying the problem with copies to commissioners and board members
C. Require a plan of correction that becomes a contract performance objective
D. Require a plan of correction with frequent status reporting (e.g., every 14 days)
E. For sanction related to reporting issues, increase the frequency or nature of reports for a specified period of time
F. Impact the opportunity for savings reinvestment
    1. Reduce administration opportunity by 20 percent for each remedial action.
    2. Reduce total available savings opportunity by 10 percent for each occurrence
G. Delay scheduled payment to the PHP
H. Impose a direct dollar penalty and make it a non-matchable PHP expense
I. Initiate contract termination

The use of sanctions will typically follow a progressive approach, but MDCH has the right to deviate from the progression as needed to seek correction of serious, or repeated, or patterns of compliance or performance problems.

9.0 RESPONSIBILITIES OF THE DEPARTMENT OF COMMUNITY HEALTH

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

9.1 General Provisions

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

B. Provide the PHP with information related to known third-party resources and any subsequent changes as the department becomes aware of said information. Notify the PHP of changes in covered services or conditions of providing covered services.

C. Protect against fraud and abuse involving MDCH funds and recipients in

cooperation with appropriate state and federal authorities.

D. Administer a Medicaid fair hearing process consistent with federal requirements.

E. 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.

F. Collaborate with the PHP on quality improvement activities, fraud and abuse issues, and other activities that impact on the services provided to recipients.

G. Conduct a recipient quality of life survey and publish the results.

H. Review PHP marketing materials.

I. Apply contract remedies necessary to assure compliance with contract requirements.

J. Monitor the operation of the PHP to ensure access to quality care for all recipients.

K. Monitor quality of care provided to recipients of PHP services and supports.

9.2 Contract Financing

The MDCH shall pay Medicaid funds, state general funds, MIChild funds, and Title XX replacement funds, as agreed to in the contract, to the PHP.

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

A. Action by the Michigan State Legislature that removes any MDCH funding for, or authority to provide for, specified services.

B. Action by the Governor pursuant to Const. 1963, Art. 5, 320 that removes the MDCH funding for specified services or that reduces the MDCH 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 D occur, the MDCH shall issue an amendment to this contract reflective of the above condition.

9.3 State Facilities

The MDCH agrees:

A. To supply to the PHP 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 PHP 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. To provide the PHP with rates for state-managed services no later than October 1st of each fiscal year. Rates shall be issued that include the net state rate paid by the PHP and the gross rate on which the local share of facility billings is based.

D. 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 MDCH Office of Recipient Rights. When requested, the MDCH Office of Recipient Rights shall share appropriate information on investigations related to the PHP's residents in accordance with the confidentiality provisions of the Michigan Mental Health Code (PA 258 of 1974 as amended, Section 748).

9.4 Reviews and Audits

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

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

Reviews and audits shall be conducted according to the protocols, except when conditions appear to be severe and warrant deviation. Also, MDCH audits will utilize the MDCH Administrative Directive on Audits:

A. MDCH will schedule reviews/audits at mutually acceptable start dates to the extent possible, with the exception of those reviews for which advance notice is prohibited by rule or federal regulation.

B. The guideline, protocol and/or instrument to be used to review/audit the PHP, or a detailed agenda if no protocol exists, shall be provided to the PHP at least 30 days prior to the review, unless prohibited by rule or federal regulation.

C. At the conclusion of the reviews/audits, the MDCH shall conduct an exit interview with the PHP. The purpose of the exit interview is to allow the MDCH to present the preliminary findings and recommendations.

D. Following the exit review, the MDCH shall generate a report identifying the findings and recommendations that require follow up action by the PHP, as follows:

1. The PHP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance, unless extended for up to 30 days by mutual agreement of both parties. The PHP may also present new information to MDCH staff that indicates 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).

2. MDCH will review the POC, seek clarifying or additional information from the PHP as needed, and issue an approval of the POC within 30 days of having required information from the PHP. The MDCH will take steps to monitor the PHP's implementation of the POC as part of performance monitoring.

3. The MDCH shall protect the confidentiality of the records, data and knowledge collected for or by individuals or committees assigned a peer review function in planning the process of review and in preparing the review or audit report for public release.

10.0 RESPONSIBILITIES OF THE DEPARTMENT OF ATTORNEY GENERAL

The Health Care Fraud Division of the Department of Attorney General (Medicaid Fraud Control Unit) is the state agency responsible for the investigation of fraud in the state Medicaid program. The PHPs shall immediately report to the Michigan Medicaid Fraud Control Unit any suspicion or knowledge of fraud, including but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return monies allowed or paid on claims known to be false or fraudulent. The reporting entity shall not attempt to investigate or resolve the reported suspicion, knowledge, or action without informing the Michigan Medicaid Fraud Control Unit and must cooperate fully in any investigation by the Medicaid Fraud Control Unit and any subsequent legal action that may result from such investigation.

PHPs and their health care providers participating in the state Medicaid program shall, upon request, make available to the Medicaid Fraud Control Unit, any and all administrative, financial and medical records relating to the delivery of items or services for which State Medicaid program funds are expended. In addition, the Medicaid Fraud Control Unit must be allowed access to the place of business and to all records of any managed care organization or health care providers or any sub-contractors during normal business hours, except under special circumstances when after-hour admission shall be allowed. Special circumstances shall be determined by the Medicaid Fraud Control Unit.

Attachment D

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PREPAID HEALTH PLANS

The State will require that each specialty Prepaid Health Plan (PHP) have a quality assessment and performance improvement program (QAPIP) which meets the standards below. These standards are based upon the Guidelines for Internal Quality Assurance Programs as distributed by the Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in Standards and Guidelines for Review of Medicare and Medicaid Managed Care Organizations (December 22, 1997), and HCFA's Medicaid Managed Care; Proposed Rules (September 29, 1998). 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

I. The PHP must have a written description of its QAPIP which specifies 1) an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPIP; 2) the components and activities of the QAPIP, including those as required below; 3) the role for recipients of service in the QAPIP; and 4) the mechanisms or procedures to be used for adopting and communicating process and outcome improvements.

II. The QAPIP must be accountable to the Governing Body - Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

   A. Oversight of QAPIP - There is documentation that the Governing Body has approved the overall QAPIP and an annual QI plan.

   B. QAPIP progress reports - The Governing Body routinely receives written reports from the QAPIP describing performance improvement projects undertaken, the actions taken and the results of those actions.

   C. Annual QAPIP review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the operation of the QAPIP.

III. There is a designated senior official responsible for the QAPIP implementation.

IV. There is active participation of providers and individuals in the QAPIP.

V. The PHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

A. PHP must utilize performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as established in contract.

B. The PHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.

VI. The PHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in contract.

VII. The PHP's QAPIP includes performance improvement projects that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction.

A. Performance improvement projects must address clinical and non-clinical aspects of care.
   1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.
   2. Non-clinical areas would include, but not be limited to, appeals, grievances and complaints; and access to, and availability of, services.

B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's individuals; individual demographic characteristics and health risks; and the interest of individuals in the aspect of service to be addressed.

C. Performance improvement projects may be directed at state or PHP-established aspects of care.

D. PHPs may collaborate with other PHPs on projects, subject to the approval of the department.

E. The PHP must engage in at least two projects during the waiver renewal period.

VIII. The QAPIP describes the process of the review and follow-up of sentinel events.

A. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate.

B. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

IX. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and accessibility of care.

B. As a result of the assessments, the organization:
1. Takes specific action on individual cases as appropriate;
2. Identifies and investigates sources of dissatisfaction;
3. Outlines systemic action steps to follow-up on the findings; and
4. Informs practitioners, providers, recipients of service and the governing body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization insures the incorporation of individuals 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.

X. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted or mutually agreed-upon clinical standards that are relevant to the persons served.

XI. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the CMHSP or under contract to the CMHSP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs.

The CMHSP must have written policies and procedures for the credentialing process which includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP 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.

XII. The written description of the PHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors.

A. The PHP must submit to the state for approval its methodology for verification.

B. The PHP must submit its findings from this process and provide any follow up actions that were taken as a result of the findings.

XIII. The organization operates a utilization management program.

A. Written Plan - Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to identify and correct under utilization as well as over utilization.

C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:
   1. Review decisions are supervised by qualified medical professionals.
   2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
   3. The reasons for decisions are clearly documented and available to the member.
   4. There are well-publicized and readily-available appeals mechanisms for both providers and patients. Notification of 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.

Attachment E

PERSON-CENTERED PLANNING REVISED PRACTICE GUIDELINE January 2002

I. SUMMARY/BACKGROUND

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

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

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

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

II. VALUES AND PRINCIPLES UNDERLYING PERSON-CENTERED PLANNING

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

A. Each individual has strengths, and the ability to express preferences and to make choices.

B. The individual's choices and preferences shall always be honored and considered, if not always granted.

C. Each individual has gifts and contributions to offer to the community, and has the ability to choose how supports, services and/or treatment may help them utilize their gifts and make contributions to community life.

D. Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals and desires.

E. A person's cultural background shall be recognized and valued in the decision-making process.

III. PCP PRACTICE GUIDELINES

A. Essential Elements

1. Person-centered planning is a process in which the individual is provided with opportunities to reconvene any or all of the planning processes whenever he/she wants or needs.

2. The process encourages strengthening and developing natural supports by inviting family, friends and allies to participate in the planning meeting(s) to assist the individual with his/her dreams, goals and desires.

3. The development of natural supports shall be viewed as an equal responsibility of the CMHSP and the individual. The CMHSP, in partnership with the person, is expected to develop, initiate, strengthen, and maintain community connections and friendships through the person-centered process.

4. The individual is provided with options of who facilitates his/her meeting(s).

5. Before a person-centered planning meeting is initiated, a pre-planning meeting occurs. In pre-planning the individual chooses:

   a. dreams, goals, desires and any topics about which he/she would like to talk
   b. topics he/she does not want discussed at the meeting
   c. who to invite

d. where and when the meeting will be held
e. who will facilitate
f. who will record

6. Potential support and/or treatment options to meet the expressed needs and desires of the individual are identified and discussed with the individual.

   a. Health and safety needs are identified in partnership with the individual. The plan coordinates and integrates services with primary health care.

7. The individual has ongoing opportunities to express his/her needs and desires, preferences**,** and to make choices. This includes:

   a. Accommodations for communication, with choices and options clearly explained, shall be made.
   b. To the extent possible, the individual shall be given the opportunity for experiencing the options available prior to making a choice/decision. This is particularly critical for individuals who have limited life experiences in the community with respect to housing, work and other domains.
   c. Individuals who have court-appointed legal guardians shall participate in person-centered planning and make decisions that are not delegated to the guardian in the Guardianship Letters of Authority.
   d. Service delivery shall concentrate on the child as a member of a family, with the wants and needs of the child and family integral to the plan developed. Parents and family members of minors shall participate in the person-centered planning process unless:

      (1) The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Mental Health Code;
      (2) The minor is emancipated; or
      (3) The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process as stated in the Mental Health Code. Justification of the exclusion of parents shall be documented in the clinical record.

8. Individuals are provided with ongoing opportunities to provide feedback on how they feel about the service, support and/or treatment they are receiving, and their progress toward attaining valued outcomes. Information is collected and changes are made in response to the individual's feedback.

   a. Each individual is provided with a copy of his/her person-centered plan within 15 business days after their meeting.

B. Illustrations of Individual Needs

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

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

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

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

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

   A life domain could be any of the following:
   a. Daily activities
   b. Social relationships
   c. Finances
   d. Work
   e. School
   f. Legal and safety
   g. Health
   h. Family relationships, etc.

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

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

ELEMENTS/STRATEGIES	*URGENT/ EMERGENT*	*SHORT DURATION*	*EXTENDED DURATION*
The individual expresses his/her needs and/or desires. Accommodations for communication will be made to maximize his/her ability for expression.	X	X	X
The individual's preferences, choices and abilities are respected.	X	X	X
Potential issues of health and safety are explored and discussed. Supports to address health and safety needs are included in the person-centered plan.	X	X	X
As a result of health or safety concerns or court-ordered treatment, limitations may exist for individual choice. However, opportunities for individuals to express their perceived needs can occur and opportunities to make choices among limited options can be given.	X	X	X
Person-centered planning includes pre-planning activities. These activities result in the determination of whether in-depth treatment or support planning is necessary, and if so, to determine and identify the persons and information that need to be assembled for successful planning to take place.		X	X
In short-term/outpatient service areas, the individual is provided with information on person-centered planning, including pre-planning at or before the initial visit. Individuals are encouraged to invite persons to the session where the plan is developed.		X	
In collaboration with the CMHSP, the individual identifies strategies and supports, services and/or treatment needed to achieve desired outcomes.		X	X

ELEMENTS/STRATEGIES	*URGENT/ EMERGENT*	*SHORT DURATION*	*EXTENDED DURATION*

Exploration of the potential resources for supports and services to be included in the individual's plan are to be considered in this order:
• The individual.
• Family, friends, guardian, and significant others.
• Resources in the neighborhood and community.
  • Publicly-funded supports and services available for all citizens.
  • Publicly-funded supports and services provided under the auspices of the Department of Community Health and Community Mental Health Services Programs.
		X	X

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

IV. ASSURANCES AND INDICATORS OF PERSON-CENTERED PLANNING IMPLEMENTATION

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

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

1. The CMHSP has a policy or practice guideline that delineates how person-centered planning will be implemented.

2. Evidence that the CMHSP informs individuals of their right to person-centered planning and associated appeal mechanisms, investigates complaints in this area, and documents outcomes.

3. Evidence that the CMHSP's quality improvement system actively seeks feedback from individuals receiving services, support and/or treatment regarding their satisfaction, providing opportunities to express needs and preferences and the ability to make choices.

4. The CMHSP's staff development plan includes efforts to ensure that staff involved in managing, planning and delivering support and/or treatment services are trained in the philosophy and methods of person-centered planning.

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

1. Evidence the individual was provided with information of his/her right to person-centered planning.

2. Evidence that the individual chose whether or not other persons should be involved, and those identified were involved in the planning process and in the implementation of the Individual Plan of Service.

3. Evidence that the individual chose the places and times to meet, convenient to the individual and to the persons he/she wanted present.

4. Evidence that the individual had choice in the selection of treatment or support services and staff.

5. Evidence that the individual's preferences and choices were considered, or a description of the dispute/appeal process and the resulting outcome.

6. Evidence that the progress made toward the valued outcomes identified by the individual was reviewed and discussed for the purpose of modifying the strategies and techniques employed to achieve these outcomes.

V. DISPUTE RESOLUTION/APPEAL MECHANISMS

A. If, in the judgment of the person representing the CMHSP, an individual requests inpatient treatment, or a specific mental health support or service where appropriate alternatives for the individual exist that are of equal or greater effectiveness and equal or lower cost, the CMHSP should**:**

1. Identify and discuss the underlying reasons for the request/preference;
2. Identify and discuss alternatives with the individual;
3. Negotiate toward a mutually acceptable support, service and/or treatment.

In the event that a mutually acceptable alternative cannot be reached, the person representing the CMHSP should:

4. Document the individual's preference, the support, service and/or treatment the CMHSP is offering, and the reason for not accepting that preference;
5. Inform the individual of their right to appeal the decision as permitted in the Grievance and Appeal Technical Requirement attachment to the MDCH/CMHSP Managed Specialty Supports and Services Contract. This includes:

    a. His/her right to contact the recipient rights office for consultation, mediation or intervention in response to their request for a specific mental health support or service.
    b. His/her right to request a second opinion as referenced in the Mental Health Code, if requesting inpatient treatment.
    c. His/her right to a Fair Hearing, if a Medicaid recipient.

B. If, in the judgment of the CMHSP, an individual's choice or preference for the inclusion or exclusion of a planning participant, meeting location or specific provider poses an issue of health or safety, or exceeds reasonable expectations of resource consumption, the CMHSP should discuss and identify the individual's underlying reason for that specific choice or preference and negotiate toward a mutually acceptable alternative that meets the outcomes intended.

C. If an individual is not satisfied with his/her Individual Plan of Service, the Michigan Mental Health Code allows the individual to 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. In addition, the individual has access to the appeal processes as defined in the Grievance and Appeal Technical Requirement of the MDCH/CMHSP Managed Specialty Supports and Services Contract.

D. If the individual believes that the opportunity for person-centered planning is not provided as specified in the manner above, it is the responsibility of the CMHSP to inform the individual of his/her right to consult with the recipient rights office.

E. When there is a disagreement between an individual and the legal guardian or responsible parent, the CMHSP staff should attempt to mediate between the two parties in order to provide an outcome that is acceptable to both parties.

VI. DEFINITIONS

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

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

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

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

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

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

Minor - An individual under the age of 18 years.

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

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

VII. LEGAL REFERENCES:

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

Mental Health Code Act, 258 MI. §§ 700-g (1974 & Supp. 1996).

Mental Health Code Act, 258 MI. §§ 707-1-5 (1974 & Supp. 1996).

Mental Health Code Act, 258 MI. §§ 712-1-3 (1974 & Supp. 1996).

VIII. RELATED REFERENCES:

Allen, W.T. (1989). Read my lips, it's my choice. St. Paul, MN: (Governor's Planning Council on Developmental Disabilities State Planning Agency).

Amado, A.N. & Lyon, P. (1992). Listen, lady, this is my life: A book of stories about personal futures planning in Minnesota, St. Paul, MN: (Governor's Planning Council on Developmental Disabilities State Planning Agency).

Butterworth, J., Hagner, D., Heikkinen, B., DeMello, S., & McDonough, K. (1993). Whole life planning: A guide for organizers and facilitators. Boston, MA: Children's Hospital, Institute for Community Inclusion.

Chamberlain, J. (1978). On our own: Patient-controlled alternatives to the mental health system. New York, NY: Hawthorn Books.

Cnaan, R.A., Blankertz, L., Messinger, K.W., & Gardner, J.R. (1988). Psychosocial rehabilitation: Toward a definition. Psychosocial Rehabilitation Journal, 11(4), 61-77.

Hagner, D., Helm, D.T., & Butterworth, S. (1996). This is your meeting: A qualitative study of person-centered planning. Mental Retardation, 34, 159-171.

Joyce, S. (1992). Gathering together: A collective approach to personal planning with people who have been labeled. (3rd edition). London, Ontario, Canada: Realizations.

Kiernan, W., Schalock, R., Butterworth, J., & Sailor, W. (1993). Enhancing the use of natural supports for people with severe disabilities. Boston, MA: Children's Hospital Training and Research Institute for People with Disabilities.

Lovett, H. (1991). Empowerment and choices. In L.H. Meyer, C.A. Peck, & L. Brown (Eds.), Critical issues in the lives of people with severe disabilities. Baltimore, MD: Paul Brookes Publishing Co.

Mallet, P., Mirenda, P., Kandborg, T., Jones, P., Bunz, T., & Rogow, S. (1992). Application of a lifestyle development process for person with severe intellectual disabilities: A case study report. The Journal of the Association for Persons With Severe Handicaps, 179-191.

Meyer, L.H., Peck, C.A., & Brown, L. (1991). Critical issues in the lives of people with severe disabilities. Baltimore, MD: Paul Brookes Publishing Co.

Mount, B., & Zwernick, K. (1988). It's never too early, it's never too late: An overview of personal futures planning. St Paul, MN: (Governor's Planning Council on Developmental Disabilities State Planning Agency).

Mount, B. (1990). Imperfect change: Embracing the tensions of person-centered work Manchester, CT: Communitas.

Mount, B. (1991). Dare to dream: An analysis of the conditions leading to personal change for people with disabilities. Manchester, CT: Communitas.

Mount, B., Ducharmenm, G., & Beeman, P. (1991). Person-centered development: A journey in learning to listen to people with disabilities. Manchester, CT: Communitas.

Mount, B. (1992). Personal futures planning: Promises and precautions. New York, NY: Graphic Futures.

Mount, B. (1994). Benefits and limitations of personal futures planning. In V. Bradley, J. Ashbaugh, B. Blaney (Eds.), Creating individual supports for people with developmental disabilities (pp.97-108). Baltimore, MD: Paul Brookes Publishing Co.

O'Brien, J. (1987). A guide to lifestyle planning. In B. Wilcox & T. Bellamy. (Eds.), A comprehensive guide to activities catalog. Baltimore, MD: Paul Brookes Publishing Co.

O'Brien, J., & Mount, B. (1991). Telling new stories: The search for capacity among people with severe handicaps. In L.H. Meyer, C.A. Peck, & L. Brown. (Eds.), Critical issues in the lives of people with severe disabilities. Baltimore, MD: Paul Brookes Publishing Co.

O'Brien, J., & Lovett, H. (1992) Everyday Lives: The contribution of person centered planning. Pennsylvania Department of Public Welfare, Office of Mental Retardation.

Perske, R. (1988). Circles of friends. Nashville, TN: Abingdon Press.

Pearpoint, J., & Forest, M. (1995). The Inclusion Papers: Strategies to make inclusion happen. Toronto, Ontario, Canada: Inclusion Press.

Pearpoint, J., O'Brien, J., & Forest, M. (1995) Path: A workbook for planning positive possible futures. (2nd edition). Toronto, Ontario, Canada: Inclusion Press.

Smull, M.W., & Harrison, S.B., (1992). Supporting people with severe reputations in the community. Alexandria, VA: National Association of State Mental Retardation Program Directors, Inc.

Snow, J. (1995). What's really worth doing & how to do it!. Toronto, Ontario, Canada: Inclusion Press.

Stineman, R., Morningstar, M., Bishop, B., & Turnbull, H. R. (1993). Role of families in transition planning for young adults with disabilities: Toward a method of person-centered planning. Journal of Vocational Rehabilitation, 3, 52-61.

Taylor, S. J. & Racino, J.A. (1991). Community living: Lessons for today. In L.H. Meyer, C.A.

Peck & L. Brown, (Eds.), Critical issues in the lives of people with severe disabilities. Baltimore, MD: Paul Brookes Publishing Co.

Uditsky, B. (1993). Natural pathways to friendships. In A. Amado (Ed.), Friendships and Community Connections Between People With and Without Developmental Disabilities (pp. 85-96). Baltimore, MD: Paul Brookes Publishing Co.

Vandercook, T., York, J., & Forest, M. (1989). The McGill Action Planning System (MAPS): A strategy for building the vision. Journal of the Association of Severe Handicaps, 14, 205-215.

Wieck, C. & Strully, J.L. (1991). What's wrong with the continuum? A metaphorical analysis. In L.H. Meyer, C.A. Peck, & L. Brown. Critical issues in the lives of people with severe disabilities. Baltimore, MD: Paul Brookes Publishing Co.

Attachment F

MEMORANDUM

May 17, 2001

TO: Executive Directors of Community Mental Health Services Programs

FROM: Jeff Patton, Deputy Director
Mental Health and Substance Abuse Services

SUBJECT: Requests for Designation of Substance Abuse Coordinating Agencies

This memorandum is in response to several inquiries from Community Mental Health Services Programs (CMHSPs) regarding their desire to be designated as Substance Abuse Coordinating Agencies (CA) for their region or "combined alliance region" as early as October 1, 2001. Department staff have been involved in reviewing or discussing these proposals and conclude that a time frame for readiness to undertake these responsibilities is not attainable until October 1, 2002 or later. One of the reasons for this is that key Department staff who would otherwise be available to provide necessary technical assistance and consultation for this endeavor, are devoting most of their time towards planning and preparing the Application for Participation (AFP) Concept Paper and Test AFP to be issued in June and October, respectively. They will also be involved during late summer in statewide training activities relative to these documents. This fall these same staff will be heavily involved in preparing the formal AFP to be issued in January, 2002.

Technical assistance that I referred to above would focus on federal/state substance abuse requirements including, but not limited, to financing issues, organizational structure and relationships, data system requirements, provider panel development and quality, continuum of care and program capacity, treatment access systems, prevention, and evaluation of the CMHSP's readiness to provide technical assistance to contracted agencies on substance abuse federal block grant requirements. We are committed, however, to providing guidance over the next twelve to eighteen months to CMHSPs and their respective County Boards of Commissioners who have expressed interest in pursuing CA designation. In this regard, we have enclosed two files containing information which was created, and continues to be updated, as a basis for evaluating readiness for CMHSPs to acquire CA designation.

Our primary concern and responsibility is to assure that individuals will have uninterrupted access to substance abuse services, should there be a change in CA managing entities. This requires careful and well thought out planning with provider agencies. Given the very short time frame for issuing the AFP in January, 2002 (approximately eight months), a CA designation of a CMHSP prior to October 1, 2002, would be unduly disruptive to affected individuals and programs, particularly if a CMHSP is later found to have unsuccessfully met the AFP specifications and is not selected as a Prepaid Health Plan (PHP) for the October 1, 2002 contract year.

Therefore, the Department will not approve CA designations to CMHSPs until fiscal years beginning October 1, 2002 and beyond. We will, however, provide guidance over the next twelve to eighteen months and establish a structured process to transition CA designation, including mergers of CMHSPs and Substance Abuse Coordinating Agencies. This will provide additional time to plan and transition CA designation with minimal impact on the existing public substance abuse services system.

Should you have questions regarding this memorandum, please contact Gary VanNorman, Director of Community Services/Substance Abuse Division, at (517) 241-2595 or E-mail him at vannormang@state.mi.us. Mr. VanNorman's division will take the lead in scheduling technical assistance and substance abuse overviews as requests are received from CMHSPs regarding designation changes.

JP:jp

Enclosures

c: Patrick Barrie
Gary VanNorman
Irene Kazieczko
Substance Abuse Coordinating Agencies

CA Statutory Responsibilities and Associated Review Criteria
May 1, 2001

P.A. 368 of 1978 statutory provisions

A. Develop comprehensive plans for s/a treatment and rehabilitations services and prevention services consistent with guidelines established by the office.
- Is there a budget that addresses the functions for administration of the agency within the constraints of the administrative efficiencies task force report?
- Is there knowledge and experience in the areas of prevention services, women's specialty services, federal block grant requirements?
- Is there a provider network or at least a completed assessment and understanding of the need for programming, locations, waiting lists, priority admissions, etc?
- Is there cultural competencies demonstrated or addressed?
- Are linkages addressed with agencies for; primary health, community agencies, criminal justice, Family Independence Agency, etc?

B. Review and comment to the office on applications for licenses submitted by local treatment, rehabilitation, and prevention organizations.
- Is there a demonstrated understanding of the Administrative Rules for Substance Abuse Service Programs in Michigan?

C. Provide technical assistance for local substance abuse service organizations.
- Do staff exist that have the expertise in areas of: accounting, data, prevention, all aspects of treatment (see below)?
- Recipient rights knowledge and experience for s/a
- Confidentiality knowledge and experience for s/a
- Communicable disease knowledge and experience
- Methadone knowledge and experience
- Patient placement knowledge and experience related to ASAM criteria
- Financial expertise related to establishing rates, program viability, reimbursement processes, and audit requirements

D. Collect and transfer data and financial information from local organizations to the office.
- What is the agency's demonstrated ability to meet data submission criteria/standards?
- What is the agency's ability to address financial requirements regarding accounting for federal and state earmarks and restrictions?
- Are the management information systems (financial system and client system) have linkages?

E. Submit an annual budget request to the office for use of state administered funds for its city, county or region for s/a treatment and rehabilitation services and prevention services in accordance with guidelines established by the administrator. (Refer also to A)
- How are planning and start-up costs being addressed? What is the source of funding to cover the pre-designation and contract related costs?

- What are the projected administrative costs and proposed funding source(s) for the costs for the first three years?

F. Make contracts necessary and incidental to the performance of the agency's functions.
- Compliance with Match Rules
- Compliance with procurement standards
- Compliance with contract requirements such as: contract types, continuum of care, sliding fee scale, access, reporting, etc
- Compliance with P.A. 2 requirements
- Compliance with Licensing Rules (Is the proposed entity a provider of s/a treatment services, other than assessment and referral?) If yes, how is Rule 325.14213 addressed?
- Is contract monitoring, deficient performance, corrective action process addressed?

G. Annually evaluate and assess substance abuse services in the city, county, or region in accordance with guidelines established by the administrator.
- Need for a plan to address how this will be completed, who will be involved, and what will be done with the product once completed.

Readiness Review Considerations on separate document

The department's rigor in requiring evidence of readiness will be based in part on the general history of the proposed parent entity (administrative and financial performance, organizational stability, degree of local support, etc.) and the track record and experience (if any) of the proposed CA in administering a substance abuse system.

CA READINESS INDICATORS AND REVIEW CRITERIA

Six months or more prior to proposed start date
Minimum conditions for department receptivity to a proposed designation (approval or contingent approval):

1. Specific evidence must be presented to show that designation of the proposed CA would add net value to the public substance abuse system compared to current arrangements. Value may be construed in terms of cost savings, cost efficiency, quality of CA performance, quantity or quality of direct services, or other important dimensions.

1. The proposed CA is an established, competent entity and this entity would assume full responsibility and accountability for CA functions. The department is not receptive to designating a newly-established or to-be-established entity as a CA. This does not preclude a new CMH affiliation from developing a designation proposal, as long as a qualified affiliation member is the proposed designee.

2. The size (population, geographic range) and county composition (including county contiguity) of the proposed CA region meets AFP minimum size criteria and is conducive to administrative efficiency, client choice of providers, the availability of a full continuum of care, coordination with primary care, and other factors.

3. County Commissions have requested the proposed designation or have expressed willingness to approve.

4. If designation would have the effect of breaking up or changing the composition of one or more existing CA regions, the proposal must demonstrate probable net benefit for the new and existing regions. That is, the department is not receptive to designating a new CA if the indirect negative consequences for other counties would outweigh the likely value of the proposed CA.

5. The proposed designee must submit a readiness plan, consistent with department requirements (see below), for preparing to assume CA responsibilities. The plan must be realistic and feasible given the time and resources available prior to the proposed effective date of designation. It is the responsibility of the proposing entity to demonstrate that the plan is realistic and feasible.

6. The proposed designee must submit a business and operations plan for the new CA, consistent with department requirements (see below).

7. The proposal must provide for integrated responsibility for all department-administered

substance abuse programs, including Medicaid, Community Grant, MIChild, TANF, and any others. Proposals calling for partial or nonintegrated responsibility will not be considered.

8. The effective date of designation (start-up) must be at the start of a state fiscal year.

Readiness Plan Requirements

The readiness plan must describe all major steps that the proposing entity will take to prepare to assume CA responsibilities. The department will monitor progress in implementing the plan as necessary to determine that progress is satisfactory. The department will provide a copy of its readiness review monitoring criteria upon request. The plan must include:

1. A realistic budget covering all proposed readiness (preparation) activities and components, including personnel, facilities, equipment, and any other foreseeable costs. Funds sources must be identified. The budget must not call for new department funding support, and must not involve displacement of funds necessary for current operations or services.

2. A task timetable showing all major tasks and products.

3. Identification of key persons participating in the readiness process, including the qualifications and estimated time (in hours or percent FTE) of each. The person responsible for overall leadership of the process must be identified.

4. Identification of permanent CA staff who will be engaged and assigned positions prior to start-up, at what FTEs. Minimum staff positions must include a CA director, recipient rights coordinator, prevention coordinator, finance manager (or equivalent), and IS manager (or equivalent). Qualifications of each person must be described. The CA director must be on board at least 60 days prior to start-up.

5. A plan (subplan) for the timely procurement of a qualified panel of prevention and treatment providers with sufficient capacity to meet projected demand. The prevention panel must be capable of providing services consistent with federal SAPT Block Grant and department requirements. The treatment panel must be capable of providing services consistent with Block Grant, Medicaid, MIChild and department requirements, including specialized services. The treatment panel must meet requirements concerning client choice of provider and geographic accessibility. Needs of special populations, including needs related to disability, gender, age, limited English proficiency, and other factors must be addressed. As necessary, procurement of HIV/AIDS Early Intervention Program and Training providers must be addressed. This plan must address all factors that may be important to timely, successful start-up of a provider panel, including reimbursement rates, client fee scale requirements, qualifications of provider personnel, etc. Provider contracts must be signed, and provider training and orientation must be provided, not less than 45 days prior to start-up.

6. A system for assessing client need, referral to clinically appropriate care, and authorization of initial and continuing care. Key personnel and their qualifications must be identified. It

must show how all required functions will be organized and handled. The system must be capable of meeting assessment and treatment access timeliness standards. Applicable standards concerning client confidentiality, notices of rights to appeal and grieve CA and provider decisions, and client-centered care decisions must be met. This system must be fully operational at least 30 days prior to start-up.

7. Implementation of a financial management system capable of separate budgeting, tracking expenditures and incurred claims, and accounting of substance abuse funds, and integrated with a competent financial risk management system.

8. Implementation of a provider payment system that meets required timeliness standards and is linked to the authorization and risk management components. Must be operational at least 30 days prior to start-up.

9. A data system capable of meeting requirements for the prevention Minimum Data Set, and a system capable of handling all treatment client data collection, management and reporting requirements. These systems must be operational at least 30 days prior to start-up.

10. An integrated information management system and related practices with adequate capacity to fulfill all management responsibilities, including reporting, quality assurance, risk management, care authorization and utilization, provider claims, etc.

11. Submission to the department of an acceptable Annual Action Plan for the initial fiscal year of designation, by the department's established due date.

12. A transition plan enabling a structured transition of functions and responsibilities from the current CA(s) to the proposed CA. This component must address:

    a. Financial advances provided by the department to the current CA(s);
    b. Financial closeouts for the fiscal year preceding start-up;
    c. Reports due to the department in the first year of designation that cover activities of the prior year, including legislative report, audit reports, client data reports, and others;
    d. Assurance of continuity of care for clients in treatment at start-up, with special attention to clients receiving care from providers that will not be empaneled by the proposed CA;
    e. Continuity of any continuing prevention services or programs;
    f. Description of the role and involvement of the current CA(s) in the transition process.
    g. Disposition of any Medicaid substance abuse carry-forward savings applicable to the affected counties (the counties that would be part of the proposed new CA), not expended by the end of the fiscal year prior to start-up.
    h. Disposition of any local funds (including PA 2 funds) allocated to the current CA(s) by the affected counties not expended by the end of the fiscal year prior to start-up.

13. Review of current and new year (if available) contracts between the department and CAs, and the department's Medicaid substance abuse requirements. The proposing entity must provide the department with a statement of intent to sign (agree to) these requirements, or

must identify any factors that present barriers to agreement, at least 90 days prior to start-up. Contracts with the department must be signed by authorized local person(s) at least 45 days prior to start-up.

14. Formation of a Substance Abuse Advisory Council consistent with department requirements. Members must be selected at least 30 days prior to start up. The first Council meeting must be held not less than 30 days after start-up.

15. Identification of all major current and potential treatment referral sources, and development of written referral agreements, not less than 45 days prior to start-up.

16. Identification of care coordination partners (such as primary care, SAMI co-occurring disorders, FIA, etc.) and execution of coordination agreements at least 30 days prior to start-up.

Business/Operations Plan Requirements

The business/operations plan must present a comprehensive description of the organization, operations, and functions of the proposed CA. This plan will overlap with the readiness plan, and must be consistent with it. Some components of the readiness plan may be incorporated into the business/operations plan. The plan must be consistent with and meet the requirements of all applicable federal and state laws, rules and contract requirements, and must clearly show how the proposed CA will carry out all required functions and responsibilities, beginning at start-up. In particular, note that business/operations plan must:

1. Be submitted to the department not less than 90 days prior to start-up.

2. Meet with the approval of the proposed CA entity's current governing board, and have the approval of the governing board of the affiliation (or like organization) that the entity is a part of.

3. Include a budget for anticipated first-year annual operating costs and costs of purchasing all services, indicating sources for all funds.

4. Describe the proposed organization structure and lines of responsibility, authority and oversight for the proposed CA. Show how the proposed CA will fit into the proposing entity's organization and into the organization of any affiliation (or equivalent) as applicable.

5. Present a staffing plan calling for all key personnel to be engaged (hired, assigned) by or before start-up (see readiness plan requirements). Minimum qualifications of each must be described.

6. Describe how CA utilization management and review functions will be conducted.

7. Describe provisions for internal oversight and management review.

8. Present a quality management and improvement plan for direct services, including monitoring of providers for compliance and quality.

Attachment G

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES ADMINISTRATION

MANAGED SPECIALIZED SERVICES PROGRAM
TECHNICAL ISSUES ADVISORY

SERVICES TO NATIVE AMERICAN BENEFICIARIES

In approving Michigan's submission for renewal of the 1915(b) Managed Specialty Services waiver, the Centers for Medicare and Medicaid Services (CMS) indicated that its approval of the waiver renewal was contingent upon a number of conditions. One of these conditions was that the Michigan Department of Community Health (MDCH) issue written direction to Community Mental Health Services Programs (CMHSPs) regarding services for Native-American beneficiaries served by Indian Health Service (IHS) and Tribal Health Center (THC) facilities. CMS indicated that this written guidance should also address the special circumstances of urban providers who provide culturally specific services to Native-American beneficiaries residing in urban areas, and should describe contracting opportunities for IHS and THC facilities that offer specialty services to non-Native-American beneficiaries. In its acceptance letter to CMS, the MDCH consented to this stipulation, as well as to the other conditions associated with waiver approval.

SERVICES THROUGH INDIAN HEALTH SERVICE AND TRIBAL HEALTH CENTER FACILITIES

Michigan's waiver application specifically indicates that Native-American beneficiaries may obtain mental health and substance abuse services outside of the 1915(b) specialty services waiver directly from Indian Health Service (IHS) and Tribal Health Centers (THC) facilities. The THCs, referred to as Tribal 638 facilities, are owned and operated by American Indian and Alaska Native (AI/AN) Tribes and tribal organizations, with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638). Mental health and substance abuse services provided by IHS or THC facilities to Native-American beneficiaries are not included in the waiver and are paid for separately by the MDCH, under specific arrangements with the IHS and Tribal 638 facilities.

Mental health and substance abuse services provided by IHS and THC facilities to non-Native-American beneficiaries do not fall under the aforementioned special arrangement with the MDCH. If an IHS of THC facility wishes to provide waiver specialty services to non-Native-American beneficiaries, they must apply to participate in CMHSP provider networks for specialty services, and must meet applicable qualifications and contractual requirements. All specialty services under the waiver for non-Native-American beneficiaries are authorized and reimbursed through CMHSPs.

NATIVE AMERICAN BENEFICIARIES AND CMHSPS

Although Native-American beneficiaries may elect to receive mental health and substance abuse

services outside of (and reimbursed separately from) the waiver through IHS and THC facilities, they are not precluded from seeking waiver specialty services from CMHSPs, if they require such services. Native-American beneficiaries who require specialty services covered under the waiver may, just as any other Medicaid beneficiary, obtain these services through the local CMHSP.

URBAN INDIAN PROGRAMS

Although Native-American beneficiaries may elect to receive mental health and substance abuse services outside of (and reimbursed separately from) the waiver through IHS and THC facilities, they are not precluded from seeking waiver specialty services from CMHSPs, if they require such services. Native-American beneficiaries who require specialty services covered under the waiver may, just as any other Medicaid beneficiary, obtain these services through the local CMHSP. The CMHSP may not deny medically necessary covered waiver benefits to a Native-American beneficiary who elects to receive those services through the CMHSP.

CMHSPs are reminded of their obligation to provide culturally appropriate and culturally competent services to all beneficiaries, including Native-American beneficiaries.

Native-American beneficiaries who reside in urban areas often seek services, when available, from urban Indian health programs. Unlike THC facilities, urban Indian health programs (including those offering mental health and substance abuse services) are not "Tribal 638 facilities" and hence, these programs do not receive any direct reimbursement from the MDCH for mental health or substance abuse services they provide to Native-American beneficiaries.

Urban Indian health programs have a long-standing relationship with Native-American beneficiaries in urban areas, and have valuable experience and expertise in offering culturally competent services to this beneficiary population.

In order to provide culturally competent specialty services to Native-American beneficiaries in urban areas, CMHSPs are required to include, within their provider networks, qualified urban Indian programs that offer specialty mental health or substance abuse services for this population. Moreover, CMHSPs with urban Indian specialty programs within their service areas must offer technical assistance to these programs to help them meet network participation standards.

Attachment H

STATE MANAGED SERVICES AND FINANCIAL LIABILITY FOR PERSONS ACQUITTED OF A CRIMINAL CHARGE BY REASON OF INSANITY

Purpose of Protocol

Section 6.1 of the MDCH/CMHSP Managed Specialty 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 review treatment at intervals (at least annually) and authorize medically necessary continued stay. However, Section 6.1 of the contract states that, "This part shall not apply to the Forensic Center Admissions nor to continued stay in state-managed services when a (criminal) court order of NGRI or IST is applicable and limits the authority and responsibility of the CMHSP described herein." It is important to note that this is not an exemption from all provisions of Section 6.1. Regardless of where the person is served, if they have been acquitted of the criminal charges and subsequently, civilly committed under a probate court order, their inpatient care must be authorized by the responsible CMHSP.

Section 302 of the Mental Health Code states that "...a county is financially liable for l0% of the net cost of any service that is provided by the department, directly or by contract, to a resident of that county." This Section does not apply to (1) an individual under a criminal sentence to a state prison; (2) a criminal defendant determined incompetent to stand trial under Section 1031 of the Mental Health Code; or (3) an individual acquitted of a criminal charge by reason of insanity, *during the initial 60-day period of evaluation* [italics added] provided for in Section 1015 of the Mental Health Code. However, CMHSPs are financially liable for 10% of the net cost of any service that is provided by the department, directly or by contract to a resident of that county who the criminal courts have acquitted or found not guilty by reason of insanity (NGRI), and committed under a civil (probate) court order to the custody of the Center for Forensic Psychiatry (hereinafter referred to as the Forensic Center) *after the initial 60-day period of evaluation* [italics added].[1]

The purpose of this protocol is to provide clarification and additional guidance in applying the *State Managed Services* provisions described in Section 6.1 of the MDCH/CMHSP Managed Specialty Supports and Services Contract for persons on NGRI status after the initial 60-day criminally ordered period of evaluation at the Forensic Center, and to establish a procedure for waiving financial liability in those instances when a court order or decision of the NGRI committee, the hospital or department limits the legal or contractual authority of CMHSPs.

[1]This refers to criminal acquittees or those who committed crimes but were found not guilty by reason of insanity (NGRI). Included are those who a criminal court has ordered under Section 1050 to be examined for up to 60 days at the Center for Forensic Psychiatry to determine whether they meet criteria as persons requiring mental health treatment under Section 401 or 515 of the Mental Health Code.

PROTOCOL
CMHSP Authorization for Medically Necessary Inpatient State Managed Services
For Persons Acquitted of a Criminal Charge by Reason of Insanity (NGRI)

Initial Commitment or Judicial Admission Orders from a Probate Court

In instances where a defendant is acquitted of a criminal charge because they were found to be not guilty by reason of insanity (NGRI), the court will take steps to involuntarily commit the acquittee under a criminal order to the Forensic Center for a diagnostic period of sixty days. Within this time frame, the Forensic Center shall:

- notify the responsible CMHSP that a possible probate court ordered admission may be pending.
- examine the acquittee's mental condition in order to form an opinion as to whether the acquittee meets the civil involuntary treatment criteria set forth in Section 401 or 515 of the Mental Health Code.
- complete their examination and submit a report with the court setting forth its opinion as to whether the acquittee meets the criteria of a person requiring treatment or judicial admission as defined by Section 401 or 515 of the Mental Health Code. If in their opinion, the acquittee meets criteria, it shall make recommendation to the court for admission of the person to the Forensic Center or other state-operated hospital or center. A number of factors will be considered in this order, including the security risks posed by the person.

If the criminal court agrees with the recommendation of the Forensic Center, it may direct the prosecutor to petition the probate court for a civil commitment or judicial admission.

It is at that point in the process that CMHSP will be formally notified by the probate court of its intent to hold an initial hearing to determine whether the person requires involuntary treatment at the Forensic Center or one of the other state hospitals or center.

At the hearing, the CMHSP will have an opportunity to either concur with the recommendation to hospitalize or admit the person to the Forensic Center, state hospital or center, or present arguments that it has a comprehensive plan of services and supports which it is prepared to implement as an alternative to involuntary admission.

If the community based alternative presented by the CMHSP is determined to be appropriate to meet the needs of the person, the Court may issue an alternative or combined alternative treatment order. Otherwise, the Court will proceed to commit the person to the Forensic Center or one of the other state operated hospitals or the state D.D. Center. It is at that point that the CMHSP becomes financially liable for the provision of state operated services.

Usually it will be the Forensic Center that will be requesting an authorization from the responsible CMHSP to provide medically necessary inpatient care in accordance with provisions described in Section 6.1 of the MDCH/CMHSP Managed Specialty Supports and Services

Contract.[2] To better identify and track individuals who have been admitted in this matter, the department clerically and clinically identifies such patients or residents as recipients on NGRI status with the Department. Public Safety and minimum level of required custody are factors used in determining which state operated program is capable of complying with the terms and conditions of the court orders.

If the person is admitted to the Forensic Center, the CMHSP shall be financially liable for only the 10% share of the net cost of services provided by the Center. If the person is later transferred from the Forensic Center and admitted to another state-operated hospital or center, the CMHSP shall be financially liable for the full net cost of state-provided services.

Second and One Year Continuing Treatment Orders

At any point after issuance of the initial probate court commitment order, the CMHSP may either:

1. Authorize hospitalization or judicial admission to the Forensic Center, or another state-operated hospital or center.

2. Deny authorization for hospitalization or judicial admission to the Forensic Center, or another state-operated hospital or center, on the basis that it has a community alternative and is fully prepared to implement a pre-release plan for community placement and aftercare services, which addresses the person's treatment and placement needs, and security risks.

3. Approve authorization of admission for hospitalization to the Forensic Center, but deny authorization of a subsequent transfer from the Forensic Center to another state operated hospital or center for hospitalization or judicial admission, on the basis that it has a community alternative and is fully prepared to implement a pre-release plan for community placement and aftercare services which addresses the person's treatment and placement needs, and security risks.

   If the CMHSP does not authorize admission for hospitalization to the Forensic Center or transfer of a person on NGRI status from the Forensic Center to another state-operated hospital or center, the CMHSP shall submit a copy of its pre-release plan for community placement and aftercare services to the Forensic Center's NGRI Committee and MDCH Division of Mental Health Community Services for review. (See attached submission requirements)

[2] Section 6.1 of the MDCH/CMHSP Specialty Supports and Services Contract states that the CMHSP shall authorize medically necessary inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. The MDCH and CMHSP agree that admissions must be medically necessary; that criteria specified in the Michigan Mental Health Code must be met for adults and children with mental illness or that the criteria for judicial or administrative admissions 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 so long as the requirements for medical necessity are met and the CMHSP cannot offer an alternative at the appropriate level of care.

If the NGRI Committee is in agreement that the CMHSP's comprehensive service and placement plan addresses treatment needs and security risks, and the CMHSP is prepared to make a clinically appropriate community placement, the probate court will be notified and the person on NGRI status will be discharged to the CMHSP. Upon discharge, the CMHSP shall not incur financial liability for state-provided services.

[Note: The only exception to these conditions is if the person was found not guilty by reason of insanity for the crime of murder. Under such circumstances, the Director of the Department of Community Health may exercise discretionary judgment to overrule the decisions of all parties and admit and maintain the person on NGRI status to a state-operated hospital or center. If this decision is made, the CMHSP will be held liable for only the 10% share of the net cost of any service provided by the Department.[3]]

If the NGRI Committee makes a determination that a person on NGRI status should remain at the Forensic Center or transfer to another state-operated hospital or center, because in their opinion the CMHSP plan does not comprehensively address placement and treatment needs, and security risks, or that the CMHSP is not prepared to fully implement a pre-release plan for community placement and aftercare services, the CMHSP will be held financially liable for the state services provided. Under such circumstances, the CMHSP can appeal the hospital decision to Department's Division of Mental Health Community Services in keeping with the terms of its contract

If the CMHSP fails to submit copies of its pre-release plan for community placement and aftercare services, or the Forensic Center's NGRI Committee and the MDCH Division of Mental Health Community Services both determine the CMHSP's plan falls short of addressing the needs of the person on NGRI status, the person shall not be discharged, and the CMHSP will continue to be held financially liable for only the 10% share of the net cost of services provided to the person at the Forensic Center following its initial 60-day evaluation period, and the full net cost of the services provided by another state-operated hospital or center. The CMHSP may appeal this determination in keeping with the terms of its contact with the department.

If a person on NGRI status is to be transferred from the Forensic Center to another state operated hospital or center, the Forensic Center must provide the appropriate CMHSP with notice of transfer at least seven days before the proposed transfer date. This notice is needed to give the CMHSP time to determine if an appropriate community placement plan can be developed or finalized in lieu of transfer. If the Forensic Center does not provide the seven day notice, the CMHSP shall not be liable for the 90% share of net cost for each

[3] The Department of Community Health Administrative Directive 10-C-1050-AD states that, "...Any person found NGRI for the crime of murder, recommended by the NGRI Committee for release must be reviewed by the Director/designee of the Department of Community Health for final authorization."

day that the person is served at the receiving hospital or center until seven days after the CMHSP has been notified of the transfer.

CMHSP Continued Stay Reviews, Pre-Release and Community Placement Planning

The CMHSP may present a pre-release plan for community placement and aftercare services at any time following the admission of a person under a probate court order on NGRI status to the Forensic Center or another state-operated hospital and center. (A description of the submission requirements is attached to this protocol.)

When the CMHSP determines it can serve the person in a community setting, the CMHSP will develop and submit a pre-release plan for community placement and aftercare services to the Forensic Center or another state-operated hospital or center, and the Forensic Center's NGRI Committee for review and approval. The plan must address the person's placement and service needs, and security risks. It should also include a proposed placement date and a description of the specific placement options considered for the person.

If the Forensic Center, or another state-operated hospital or center, and the Forensic Center's NGRI Committee approve the CMHSP's pre-release plan for community placement and aftercare services, the person will be discharged. For purposes of determining financial liability, the CMHSP shall not be financially liable for state-provided services when the person is on authorized leave, or upon discharge.

[Note: There may be circumstances when a person on NGRI status will be determined clinically suitable for discharge, but the probate court may order that the person not be discharged but be placed under the clinical supervision of the Forensic Center or another state-operated hospital or center. In addition to implementing an approved pre-release plan for community placement and aftercare services, the CMHSP shall comply with provisions of the court order and reporting requirements of the Forensic Center's NGRI Committee, Forensic Center or another state-operated hospital and center. Similar to the standard discharge provisions, the CMHSP shall not be financially liable for state-provided services after a person on NGRI status is released on Authorized Leave status.]

If the Forensic Center, or another state-operated hospital or center, and the Forensic Center's NGRI Committee do not approve the CMHSP's pre-release plan for community placement and aftercare services, the reason/s for that decision will be communicated to the CMHSP in writing. Under such circumstances, the CMHSP may appeal the decision in keeping with the terms of its contact with the department.

If the CMHSP's pre-release plan for community placement and aftercare services is not approved by the Forensic Center or another state-operated hospital or center, and the Forensic Center's NGRI Committee within 30 days of initial submission, the CMHSP may submit a copy of its plans to the MDCH Division of Mental Health Community Services as evidence that it has demonstrated a "good faith effort" to implement a pre-release plan for community placement and aftercare services.

If the MDCH Division of Mental Health Community Services does not believe that the CMHSP has demonstrated a "good faith effort" to implement a pre-release plan for community placement and aftercare services address the person's placement and treatment needs, and security risks, the reason/s for that decision will be communicated to the CMHSP in writing and the CMHSP shall remain financially liable for the 10% share of the net cost of state-provided services if the person is maintained at the Forensic Center, and the full net cost of state-provided services, if those services are provided at another state-operated hospital or center.

However, if the MDCH Division of Mental Health Community Services determines that the CMHSP has demonstrated a "good faith effort" to implement a comprehensive placement and service plan, the person on NGRI status will remain in the hospital or center, but the CMHSP will be financially liable for only the 10% share of the net cost of state-provided services.

The Director of the Department of Community Health retains final authority over all discharge decisions involving persons on NGRI status for the crime of murder and are being considered for discharge. In those instances where the Director overrules the decision of the Forensic Center, or another hospital and center, the Forensic Center's NGRI Committee, and/or the MDCH Division of Mental Health Community Services, to approve the CMHSP pre-release plan for community placement and aftercare services, the CMHSP shall be financially liable for only the 10% share of the net cost of state-provided services.

All CMHSP community placement and service plans that have been determined by the MDCH Division of Mental Health Community Services to not meet the "good faith effort" standard may be appealed in accordance with the provisions described in Section 3.1 of the MDCH/CMHSP Specialty Managed Supports and Services Contract.

When the Department waives the CMHSP financial liability based on the "good faith effort" principle described above, the CMH should continue to periodically monitor and update their placement plans. This means that the CMHSP needs to engage in pre-release planning for community placement and aftercare services at least every 12 months in order to keep the waiver active. An exception to this waiver period requirement involves decisions made by the Director of Community Health to maintain a person on NGRI status for the crime of murder on active inpatient status.[4]

When a waiver of financial liability is given in such a case, it is active for up to a three-year period, and waives all but the 10% share of the state hospital's, or center's, net cost.

> [Note: The references to the "good faith effort" and the CMHSPs liability being limited to only 10% of the net cost of care when there is an appropriate plan and the hospitalized person is not released, also applies when the Forensic Center or other state-operated hospital or center decides not to grant an "authorized leave" for a trial placement.]

[4] The Department of Community Health Administrative Directive 10-C-1050-AD states that, "...Any person found NGRI for the crime of murder, recommended by the NGRI Committee for release must be reviewed by the Director/designee of the Department of Community Health for final authorization."

CONTRACTUAL REQUIREMENTS
MDCH/CMHSP
Managed Specialty Supports and Services Contract
Section 6.1, *State Managed Services*

6.1 STATE-MANAGED SERVICES

1. The CMHSP shall authorize medically necessary inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. The CMHSP shall review treatment at intervals and authorize medically necessary continued stay. This part shall not apply to the Forensic Center Admissions, nor to continued stay in state-managed services when a court order of NGRI or IST is applicable and limits the authority and responsibility of the CMHSP described herein.

   Mechanisms/procedures for implementation of this single entry responsibility shall be contained in the operating/services agreement between the CMHSP and each admitting hospital/center.

2. The MDCH and CMHSP agree that admissions must be medically necessary, that criteria specified in the Michigan Mental Health Code must be met for adults and children with mental illness or that the criteria for judicial or administrative admissions 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 so long as the requirements for medical necessity are met and the CMHSP cannot offer an alternative at the appropriate level of care.

3. The CMHSP's authorization of admissions and of continued treatment shall be the basis on which the CMHSP will reimburse the Department 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. The MDCH 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 #2, but the hospital/center did not discharge the individual. The CMHSP shall not be liable for any inpatient services that have not been authorized by the CMHSP. Likewise, the MDCH Contract Manager will 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 will initiate a process for resolution of the differences. The CMHSP's obligation for the local match cost of such services shall not be affected by this Section.

4. The CMHSP shall authorize payment, within sixty (60) days of receiving the bill, for the actual number of CMHSP authorized days of care provided to its consumers in state facilities.

5. Payment for state-operated services shall be made at the net state billing in effect on October 1 of each fiscal year based upon a bill that identifies the individuals served and the

days of care provided at a fixed net state cost per day.

The CMHSP's payment for days of care shall cover days provided to those specified individuals for whom service has been authorized by the CMHSP as described in this contract.

6. The CMHSP shall authorize payment of the county match portion of the net cost of services provided to persons who are residents as defined by Section 306 and Section 307 of the Mental Health Code. Authorization of undisputed bills shall be made within sixty (60) days of receipt of the billing. The CMHSP shall identify to MDCH disputes concerning bills on a case-by-case basis within sixty (60) days of the bill and to work with the MDCH in resolving these disputes on a timely basis. MDCH may refer to the Michigan Department of Treasury (MDT) for collection of all bills that are both undisputed and overdue.

Attachment #1

STATUTORY REQUIREMENTS
Michigan Mental Health Code (1996)
Chapter 10, §330.2050
Disposition of Persons Found Not Guilty by Reason of Insanity
Section 1050

The court shall immediately commit any person who is acquitted of a criminal charge by reason of insanity to the custody of the center for forensic psychiatry, for a period not to exceed 60 days. The court shall forward to the center a full report, in the form of a settled record, of the fact concerning the crime which the patient was found to have committed, but which he was acquitted by reason of insanity. The center shall thoroughly examine and evaluate the present mental condition of the person in order to reach an opinion on whether the person meets the criteria of a person requiring treatment or for judicial admission set forth in section 401 or 515.

Within the 60-day period the center shall file a report with the court, prosecuting attorney, and defense counsel. The report shall contain a summary of the crime which the patient committed but of which he was acquitted by reason of insanity and an opinion as to whether the person meets the criteria of a person requiring treatment or for judicial admission as defined by Section 401 or 515, and the facts upon which the opinion is based. If the opinion stated is that the person is a person requiring treatment, the report shall be accompanied by certificates from 2 physicians, at least 1 of whom shall be a psychiatrist, which conform to the requirements of section 400(j).

After receipt of the report, the court may direct the prosecuting attorney to file a petition pursuant to Section 434 or 516 for an order of hospitalization or an order of admission to a facility with the probate court of the person's county of residence or of the county in which the criminal trial was held. Any certificates that accompanied the report of the center may be filed with the petition, and shall be sufficient to cause a hearing to be held pursuant to section 451 even if they were not executed within 72 hours of the filing of the petition. The report from the court containing the facts concerning the crime for which he was acquitted by reason of insanity shall be admissible in the hearings.

If the report states the opinion that the person meets the criteria of a person requiring treatment or for judicial admission, and if a petition is to be filed pursuant to subsection (3), the center may retain the person pending a hearing on the petition. If a petition is not to be filed, the prosecutor shall notify the center in writing. The center, upon receipt of the notification, shall cause the person to be discharged.

The release provisions of sections 476 to 479 of this act shall apply to a person found to have committed a crime by a court or jury, but who is acquitted by reason of insanity, except that a person shall not be discharged or placed on leave without first being evaluated and recommended for discharge or leave by the department's program for forensic psychiatry, and authorized leave or absence from the hospital may be extended for a period of 5 years.

Attachment #2

DEPARTMENT OF COMMUNITY HEALTH
ADMINISTRATIVE DIRECTIVE 10-C-1050-AD

On September 9, 1996, Department of Community Health Director James K. Haveman, Jr., issued Administrative Directive 10-C-1050-AD to have immediate effect. The Directive concerned the subject of persons committed under legal status of not guilty by reason of insanity. The Directive provides the following:

> It is the policy of the Department of Community Health that all patients/residents under the legal status of "not guilty by reason of insanity" who have improved to the point, wherein release from hospitalization or transfer between facilities is being considered, shall have their treatment plan and recommendations reviewed by the "NGRI" Committee for Forensic Psychiatry.
>
> All recommendations to the (probate) court for release from hospitalization, transfer between facilities, or alternative treatment, shall be reviewed by the NGRI Committee prior to filing and/or appearance. Petitions and/or recommendations shall be accompanied by the written recommendations of the NGRI Committee and disclosed during testimony. Referrals to the NGRI Committee for review shall be made by the hospital/center director/designee. Any delay in referring or filing necessary papers in a timely manner that would result in not renewing the order will be considered a violation of this policy.
>
> Any person found NGRI for the crime of murder recommended by the NGRI Committee for release must also be reviewed by the Director/designee of the Department of Community Health for final authorization.

Attachment #3

CMHSP REQUIREMENTS
FOR A
"GOOD FAITH EFFORT" SUBMISSION

The submission shall include:

- The individual's name and basic identifying information.

- A description of both the individual's strengths and his or her placement, and service needs in major life domains (health, legal and safety, finances, housing, daily activities, work/school, social relationships, family relationships, etc.)

- A description of the security risks posed by the individual if placed in the community.

- A summary of the CMHSP response and reasons for disagreement with the decision of the Center for Forensic Center NGRI committee regarding placement.

- A copy of the CMHSP's pre-release plan for the individual that includes a detailed description of:

    - the specific placement option that has been arranged for the individual and the scheduled date for placement,
    - -the specific services and supports that CMHSP has arranged to address the individual's treatment needs, and
    - the measures that the CMHSP has taken to address the particular security risks posed by the individual.

December 14, 2001

Attachment I

Best Value

Definition

Best value is a process used in competitive negotiated contracting to select the most advantageous offer by evaluating and comparing factors in addition to cost or price.

Applicants are expected to:

- use best value when it is essential to evaluate and compare factors in addition to cost in order to identify and select the most advantageous offer
- include factors such as stakeholder preferences, increasing choice and quality
- always include cost or price as an evaluation factor
- include the bidder's relevant past performance as an evaluation factor unless it would clearly serve no useful purpose
- structure evaluation criteria and their relative order of importance to clearly reflect the need to comply with requirements of the specialty services health plan

Attachment J

DRAFT

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

INTRODUCTION

Self-determination incorporates a set of concepts and values underscoring a core belief that people who require support through the public mental health system must have the freedom to define the life they seek, and obtain assistance to achieve that life. They need to have access to meaningful choices, and to be assured of control over the course of their lives. Arrangements that support self-determination must be sponsored by the public mental health system, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.

Person-centered planning (PCP) is a central element of self-determination. The principles of self-determination recognize the rights of people supported by the mental health system to have a life with freedom, and to access needed supports that assist in the pursuit of their life, with responsible citizenship.

The methods applicable to self-determination provide a route for the person to engage in activities that accompany a meaningful life. Activities that promote deep community connections, the opportunity for real work, ways to contribute to one=s community, and participation in chosen experiences must be among the purposes of supports the person may need. These supports function best when they build upon natural community experiences and opportunities. The person determines and manages needed supports in close association with chosen friends, family, neighbors, and co-workers as a part of an ordinary community life.

Person-centered planning and self-determination underscore a commitment in Michigan to move away from traditional service approaches for consumers of the public mental health system. In Michigan, the flexibility of the Mental Health and Substance Abuse Services Freedom of Choice waiver and the requirements of person-centered planning have reoriented organizations to respond in new and more meaningful ways. Recognition has increased among providers and professionals that many consumers do not need, want, nor benefit from a clinical regimen, especially when imposed without clear choice. Many provider agencies are learning ways to better support the consumer to choose, participate in, and accomplish a life with personal meaning. This has meant, for example, reconstitution of segregated programs into non-segregated intervention options that connect better with community life. But the move away from predefined programmatic approaches has many barriers. Conflicts of interest abound among many who manage the current system. They have obligations and underlying values that support the right of choice and control. Yet, they also have long-standing investments in existing programs and services, including their investments in capital and personnel resources. Even when options are expanded, the choices currently available seldom dissolve the isolation of

people with disabilities, reduce the segregation, nor necessarily promote participation in life and community as a first-class citizen.

The Department of Community Health is supportive of the desire of people who use the services of the public mental health system to have a full and meaningful role in controlling and directing their services and supports arrangements. This policy is intended to clarify the essential aspects of arrangements that promote opportunity for self-determination, and define required aspects of these arrangements.

PURPOSE

I. To provide policy direction that defines and guides the practice of self-determination for the public mental health system in order to assure that it makes self-determination available as a means for achieving consumer-designed plans of services and supports.

CORE ELEMENTS

I. Consumers shall have access to the tools and mechanisms supportive of self-determination, upon request. Self-determination shall be effective when the CMHSP and the consumer reach an agreement on a plan of services and supports, the amount of mental health and other public resources needed to accomplish the plan, and the arrangements through which resource use will be controlled and accounted for.

II. CMHSPs shall ensure that their services planning and delivery processes are designed to encourage and support consumers to decide and control their own lives. The CMHSP shall offer and support easily accessed methods for consumers to control and direct an individual budget. This includes providing them with methods to authorize and direct the delivery of services and supports from qualified providers selected by the consumer.

III. Consumers of services of the public mental health system shall direct the use of resources to choose meaningful services and supports in accordance with their plan as developed through a person-centered planning process.

IV. Fiscal responsibility and the wise use of public funds shall guide the consumer and the CMHSP in reaching an agreement on the allotment and use of funds comprising an individual budget. Accountability for the use of public funds must be a shared responsibility of the CMHSP and the consumer.

V. Self-determination arrangements are partnerships between the CMHSP and the consumer. They require the active commitment of the CMHSP to provide a range of options for consumer choice and control of personalized provider relationships within an overall environment of person-centered supports.

VI. Issues of health, safety and well-being are central to assuring successful accomplishment of a consumer=s plan of services and supports. These issues must be addressed and resolved using the person-centered planning process. Resolutions should be guided by

the consumer=s preferences and needs, implemented in ways that maintain the greatest opportunity for consumer control and direction.

VII. Self-determination requires recognition that there may be strong inherent conflicts of interest between the consumer=s choices and current methods of planning, managing and delivering services and supports. The CMHSP must watch for and seek to minimize or eliminate either potential or actual conflicts of interest between itself and its provider systems, and the processes and outcomes sought by the consumer.

VIII. Self-determination arrangements must be developed and operated within the requirements of the Prepaid Health Plan contract between the CMHSP and the State of Michigan. Involvement in self-determination does not change a consumer=s eligibility for particular services and supports.

POLICY

I. Self-determination shall be available in each Community Mental Health Services Program, for adults with developmental disabilities and adults with mental illness. Each CMHSP shall make a set of methods available that provide opportunities for the consumer to control and direct their services and supports arrangements.

A. Participation in self-determination shall be a voluntary option on the part of the consumer.

B. Consumers shall have the authority to select, control and direct their own services and supports arrangements through authority over the resources allotted in an individual budget.

C. A CMHSP shall assure that full and complete information about self-determination and the manner in which it may be accessed and applied is provided to each consumer. This shall include specific examples of alternative ways that a consumer may use to control and direct an individual budget, and the obligations associated with doing this properly and successfully.

D. Self-determination shall not serve as a method for a CMHSP to reduce its obligations to the consumer, or to avoid the provision of needed services and supports.

E. A CMHSP shall actively support and facilitate a consumer=s application of the principles of self-determination in the accomplishment of his/her plan of services.

II. Self-determination shall be available to each consumer who requests the opportunity to participate, and for whom an agreement on a plan of services and supports, along with an acceptable individual budget, can be reached.

A. Development of an individual budget shall be done in conjunction with development of a plan of services and supports, using a person-centered planning process.

B. The individual budget represents the expected or estimated costs of a concrete approach to accomplishing the consumer=s plan.

C. The amount of the individual budget shall be formally agreed to by both the consumer and the CMHSP before it may be authorized for use by the consumer. A copy of the individual budget must be provided to the consumer prior to the onset of a self-determination arrangement.

D. Proper use of an individual budget is of mutual concern to the CMHSP and the consumer.

1. Mental Health funds included in an individual budget are the property and responsibility of the CMHSP. Authority over their direction is delegated to the consumer, for the purpose of achieving the goals and outcomes contained in the consumer=s plan.

2. An agreement shall be made in writing between the CMHSP and the consumer delineating the responsibility and the authority of both parties in the application of the individual budget, including how communication will occur about its use. The agreement shall include a copy of the consumer=s plan and individual budget.

3. An individual budget, once authorized, shall accompany the consumer=s plan of service. It shall be in effect for a defined period of time, typically one year. Since the budget is based upon the consumer=s plan of services and supports, when the plan needs to change, the budget may need to be reconsidered as well. In accordance with the Person-Centered Planning Practice Guidelines, the plan may be reopened and reconsidered whenever the consumer, or the agency, feels it needs to be reconsidered.

4. An individual budget shall be flexible in its use.

   a. The consumer may adjust the specific application of funds within the budget between budgetary line items and/or categories in order to adjust his/her services and supports arrangements as he or she deems necessary to accomplish his/her plan.

   b. Unless the adjustment deviates from the goals and objectives in the consumer=s plan, the consumer does not need to seek permission from the CMHSP nor be required to provide advance notification of an intended adjustment.

c. When a consumer makes adjustments in the application of funds in an individual budget, these should be communicated to the CMHSP.

d. The funds aggregated and used to finance an individual budget may be controlled by more than one funding source. Flexibility in the use of these funds is therefore constrained by the specific limitations of funding sources (e.g., Home Help, Vocational Rehabilitation, etc.)

5. Either party -- the CMHSP or the consumer -- may terminate a self-determination agreement, and therefore, the self-determination arrangement. Prior to the CMHSP terminating an agreement, and unless it is not feasible, the CMHSP shall inform the consumer of the issues that have led to considering termination and provide an opportunity for problem resolution. Typically this will be conducted using the person-centered planning process, with termination being the option of choice if other mutually agreeable solutions cannot be found. If necessary, the local process for dispute resolution may be used to address and resolve these issues.

6. Termination of a self-determination agreement shall not, by itself, change the consumer=s plan of services, nor eliminate the obligation of the CMHSP to assure services and supports required in the plan.

III. A CMHSP shall design and implement alternative approaches that will be available for the consumer to use in applying their individual budget to obtain consumer-selected and -directed provider arrangements.

A. A consumer shall be able to access any willing and qualified provider entity who is available to provide needed services and supports.

B. Approaches shall provide for a range of control options up to and including the direct retention of consumer-preferred providers through purchase of services agreements between the consumer and the provider. Options shall include, upon the consumer=s request and in line with their preferences:

1. Services/supports to be provided by an entity or individual currently operated by or under contract with the CMHSP.

2. Services/supports to be provided by a qualified provider chosen by the consumer, with the CMHSP agreeing to enter into a contract with that provider.

3. Services/supports to be provided by a consumer-selected provider with whom the consumer executes a direct purchase-of-services agreement.

a. Consumers shall be responsible for assuring those individuals and entities selected and retained meet applicable provider qualifications. Methods that lead to consistency and success must be developed and supported by the CMHSP.

b. Consumers shall assure that written agreements are developed with each provider entity or individual that specify the type of service or support, the rate to be paid, and the requirements incumbent upon the provider.

c. Copies of all agreements shall be kept current, and shall be made available by the consumer, for review by authorized representatives of the CMHSP.

d. Consumers shall act as careful purchasers of services and supports necessary to accomplish their plan. Arrangements for purchasing services shall not be excessive in cost. Existing personal and community resources shall be given first consideration before using public mental health system resources.

e. Fees and rates paid to providers with a direct purchase-of-services agreement with the consumer shall be negotiated by the consumer, within the boundaries of the consumer=s authorized individual budget. The CMHSP may provide guidance as to the range of applicable rates, including maximum amounts that a consumer may spend to pay specific providers.

4. A consumer shall be able to access alternative methods to choose, control and direct personnel necessary to provide direct support, including:

a. Acting as the employer of record of personnel.

b. Access to a provider entity that can serve as employer of record for personnel selected by the consumer.

c. CMHSP contractual language with provider entities that assures consumer selection of personnel, and removal or reassignment of personnel who fail to meet consumer preferences.

d. Use of CMHSP-employed direct support personnel, as selected and retained by the consumer.

5. A consumer participating in self-determination shall not be required to utilize CMHSP-employed direct support personnel or a CMHSP-operated or -contracted program/service.

6. All individuals selected by the consumer, whether she or he is acting as employer of record or not, shall meet applicable provider requirements for direct support personnel, or the requirements pertinent to the particular professional services offered by the provider.

7. A consumer shall not be required to select and direct needed provider entities or his/her direct support personnel if she or he does not desire to do so.

IV. A CMHSP shall assist a consumer participating in self-determination to select, employ, and direct his/her support personnel, to select and retain chosen qualified provider entities, and shall make reasonably available access to alternative methods for directing and managing support personnel.

A. A CMHSP shall select and make available qualified third-party entities that may serve as fiscal intermediaries to perform payroll agent functions and provide other employer supports, in order to support the consumer in the use of the Choice Voucher System.

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

1. Payroll agent for direct support personnel employed by the consumer (or chosen representative), including acting as an employer agent for IRS and other public authorities requiring payroll withholding and employee insurances payments.

2. Payment agent for consumer-held purchase-of-services and consultant agreements with providers of services and supports.

3. Provision of periodic (not less than monthly) financial status reports concerning the individual budget, to both the CMHSP and the consumer. Reports made to the consumer shall be in a format that is useful to the consumer in tracking and managing the funds making up the individual budget.

4. Provision of an accounting to the CMHSP for the funds transferred to it and used to finance the costs of authorized individual budgets under its management.

5. Assuring timely service activity and cost reporting to the CMHSP for services and supports provided by individuals and entities that have a direct agreement with the consumer.

6. Other supportive services that strengthen the role of the consumer as an employer, or assist with the use of other agreements directly involving the consumer in the process of securing needed services.

C. A CMHSP shall assure that fiscal intermediary entities are oriented to and supportive of the principles of self-determination, and able to work with a range of consumer styles and characteristics.

D. An entity acting as a fiscal intermediary shall be free from other relationships involving the CMHSP or the consumer that would have the effect of creating a conflict of interest for the fiscal intermediary in relationship to its role of supporting consumer-determined services/ supports transactions. This typically would include the provision of direct services to the consumer.

E. A CMHSP shall collaborate with and guide the fiscal intermediary and each consumer involved in self-determination to assure compliance with various state and federal requirements, and to assist the consumer in meeting his/her obligations to follow applicable requirements.

DEFINITIONS

Fiscal Intermediary
A Fiscal Intermediary is an independent legal entity that acts as a fiscal agent under contract with a CMHSP or its designated sub-contractor. The purpose of the fiscal intermediary is to receive funds making up a consumer=s individual budget, and make payments as authorized by the consumer to providers and other parties to whom a consumer using the individual budget may be obligated. A fiscal intermediary may provide a variety of supportive services that assist the consumer in selecting, employing and directing individual and agency providers. Examples of entities that might serve in the role of a fiscal intermediary include: bookkeeping or accounting firms; local ARC or other advocacy organizations; a subsidiary of a service provider entity.

Qualified Provider
A qualified provider is a provider of services or supports that can demonstrate compliance with the requirements contained in the contract between the Department of Community Health and the CMHSP, including applicable requirements that accompany specific funding sources, such as Medicaid. Where additional requirements are to apply, they should be derived directly from the consumer=s person-centered planning process, and should be specified in the consumer=s plan, or result from a process developed locally to assure the health and well-being of consumers, conducted with the full input and involvement of local consumers and advocates.

Consumer
For the purposes of this policy, Aconsumer@ means the adult consumer of direct services or his/her selected representative. That is, the consumer may select a representative to enter into the self-determination agreement and for other agreements that may be necessary for the consumer to participate in consumer-directed supports and services arrangements. Where the

consumer has a guardian, the role of the guardian shall be as the consumer=s representative, if the guardianship arrangement so requires. A person selected as the representative of the consumer shall not supplant the role of the consumer in the process of person-centered planning, in accordance with the Mental Health Code and the requirements of the contract between the CMHSP and the Department of Community Health. Where a consumer has been deemed to require a legal guardian, there is an extra obligation on the part of the CMHSP and those close to the consumer to assure that it is the consumer=s preferences and dreams that drive the use of self-determination arrangements, and that the best interests of the consumer are primary. It is not the obligation of the CMHSP to afford direct control arrangements to a guardian when the planned or actual use of those arrangements by that guardian are in conflict with the expressed goals and outcomes of the consumer.

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

CMHSP
For the purposes of this policy, a Community Mental Health Services Program or an entity under contract with the CMHSP and authorized to act on its behalf in providing access to, planning for, and authorization of services and supports for people eligible for mental health services.

Choice Voucher System
The Choice Voucher System is a term describing a set of arrangements whereby a consumer served by the public mental health system may be authorized to use an individual budget to directly procure one or more of the services and supports required to accomplish the consumer=s plan of services. The system supports ways to apply these resources to the costs of services and supports obtained from qualified providers as chosen by the consumer. The system supports the consumer to be a direct employer of personal assistants, the contractor for services/supports with qualified providers, and therefore in a lead role concerning how, where, and by whom needed services and supports are provided. A key aspect of the system is the use of an independent fiscal intermediary to handle the funds making up the consumer's budget, and to assure compliance with tax and labor law requirements. Use of the Choice Voucher System derives from the authority provided to the CMHSP to issue a voucher to a consumer in accordance with their plan of services and supports as provided for in the Mental Health Code. The Choice Voucher System requires the CMHSP to assist and support its use through development of the proper set of agreements and contracts, linking qualified providers to the consumer, and assuring that provider agreements fit with pertinent local, state and Federal requirements. Included in this is the use of agreements between each provider and the CMHSP that assure provider compliance with requirements associated with the use of Medicaid funds.

Self-Determination

Self-determination incorporates a set of concepts and values that underscore a core belief that people who require support from the public mental health system as a result of a disability should be able to define what they need in terms of the life they seek, have access to meaningful choices, and have control over their lives. Within Michigan=s public mental health system, self-determination involves accomplishing system change to assure that services and supports for people are not only person-centered, but person-defined and person-controlled. Self-determination is based in four principles. These principles are:

FREEDOM: The ability for individuals, with assistance from significant others (e.g., chosen family and/or friends), to plan a life based on acquiring necessary supports in desirable ways, rather than purchasing a program. This includes the **freedom** to choose where and with whom one lives, who and how to connect to in one=s community, the opportunity to contribute in one=s own ways, and the development of a personal lifestyle.

AUTHORITY: The assurance for a person with a disability to control a certain sum of dollars in order to purchase these supports, with the backing of their significant others, as needed. It is the **authority** to control resources.

SUPPORT: The arranging of resources and personnel--both formal and informal--to assist the person in living his/her desired life in the community, rich in community associations and contributions. It is the **support** to develop a life dream and reach toward that dream.

RESPONSIBILITY: The acceptance of a valued role by the person in the community through employment, affiliations, spiritual development, and caring for others, as well as accountability for spending public dollars in ways that are life-enhancing. This includes the **responsibility** to use public funds efficiently and to contribute to the community through the expression of responsible citizenship.

A hallmark of self-determination is assuring a person the opportunity to direct a fixed amount of resources, which is derived from the person-centered planning process and called an individual budget. The person controls the use of the resources in his/her individual budget, determining, with the assistance of chosen allies, which services and supports he or she will purchase, from whom, and under what circumstances. Through this process they possess power to make meaningful choices in how they live their life.

Attachment K

Resources

The following resources are available on the MDCH web site: www.mdch.mi.us

- Plan for Procurement, September 2000
- Implementation Guide, October 11, 2001
- 1915(b) Waiver Renewal Application and Approval Letter from Centers for Medicare and Medicaid Services (with terms and conditions)
- Self-determination Guideline
- Choice Voucher
- All Guidelines
- Legal Arrangements for Organization (web links)
- 42CFR.434 (web link)

The following resources are available on the Michigan Association of Community Mental Health Boards web site: www.macmhb.org.

- Limited English Proficiency Guidance from the federal Office of Civil Rights, and U.S. Census estimates by county of persons who are unable to use English to communicate with a service provider
- Balanced Budget Act of 1997, Proposed Rules of 2001
- Health Insurance Portability and Accountability Act of 1996, Transaction Standards Implementation Guides