Contract Manager and Location Building:
Thomas J. Renwick – Lewis Cass Building, 320 S. Walnut
Contract Number#_____

Agreement Between
Michigan Department of Community Health
And
PIHP_____
For
MICHIGAN ABW NON-PREGNANT CHILDLESS ADULTS WAIVER (ADULT BENEFITS WAIVER) SECTION 1115 DEMONSTRATION

Period of Agreement:
This contract shall commence on October 1, 2012 and continue through September 30, 2013. This agreement is in full force and effect for the period specified.

Program Budget and Agreement Amount:
Total funding available for MICHIGAN ABW NON-PREGNANT CHILDLESS ADULTS WAIVER (ADULT BENEFITS WAIVER) SECTION 1115 DEMONSTRATION (ABW) is identified in the annual Legislative Appropriation for community mental health services programs. Payment to the PIHP will be paid based on the funding amount specified in Part II, Section 7.0 of this contract. The estimated value of this contract is contingent upon and subject to enactment of legislative appropriations and availability of funds.

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

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

Signature Section:

For the Michigan Department of Community Health

_____ _____
Kristi Broessel, Director Date
Grants and Purchasing Division

For the CONTRACTOR:

_____ _____
Name (print) Title (print)

_____ _____
Signature Date

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CONTRACT ATTACHMENTS *(following page 57)*

DEFINITIONS/EXPLANATION OF TERMS

1.0 DEFINITION OF TERMS

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

ABW Enrollee: Individual who has been determined to be eligible for ABW and who has been issued a MIHealth card. ABW eligibility is linked to certain coverages, services and benefits defined in the ABW Provider Manual, Adult Benefits Waiver Section. Because of the link between ABW eligibility and benefits, eligible individuals are also referred to in this agreement as "ABW beneficiaries."

ABW Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the ABW program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care. 42 CFR 455.2

ABW Fraud: The intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or another person. 42 CFR 455.2

Appropriations Act: The annual appropriations act adopted by the State Legislature that governs MDCH funding.

Beneficiary: An individual who is eligible for ABW and who is receiving or may qualify to receive services through the PIHP under this contract.

Capitated Payments: Monthly payments based on the Capitation Rate that are payable to the PIHP by the MDCH for the provision of ABW services and supports pursuant to Section 7.0 of this contract.

Capitation Rate: The fixed per person monthly rate payable to the PIHP by the MDCH for each ABW eligible person covered by ABW, regardless of whether or not the individual who is eligible for ABW receives covered ABW services during the month.

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

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

Cultural Competency: is 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 minority populations.

Customer: In this contract, customer includes all ABW eligible individuals located in the defined service area who are receiving or may potentially receive covered services and supports.

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 ABW 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.

Michigan Medicaid Provider Manual ABW Chapter: The Michigan Department of Community Health periodically issues notices of proposed policy for the ABW program. Once a policy is final, MDCH issues policy bulletins that explain the new policy and give its effective date. These documents represent official ABW policy and are included in the Michigan Medicaid Provider Manual – ABW section.

Per Eligible Per Month (PEPM): A fixed monthly rate per ABW eligible person payable to the PIHP by the MDCH for provision of ABW 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.

PIHP Mental Health and Substance Abuse Provider Network: The PIHP mental health and substance abuse provider network consists of Community Mental Health Services Programs (CMHSP) and Substance Abuse Coordinating Agencies and the Managed Care Provider Networks (MCPN) of the CMH/PIHP. The ABW benefit must be provided through the PIHPs, and their MCPNs, CMHSPs and CAs as required by the waiver.

Post-stabilization Services: Covered mental health ABW services specified in Section 2.0 that are related to an emergency medical condition and that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(2) to improve or resolve the beneficiary's condition.

Practice Guideline: MDCH-developed guidelines for PIHPs and CMHSPs for specific service, support or systems models of practice that are derived from empirical research and sound theoretical construction and are applied to the implementation of public policy.

Prepaid Inpatient Health Plan (PIHP): The organization that manages the ABW program including the mental health community inpatient psychiatric benefit on a prepaid, full risk basis, consistent with the PIHP requirements of 42 CFR part 401 et al June 14, 2002, regarding ABW managed care. (In ABW regulations, Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package).

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

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

PART I: CONTRACTUAL SERVICES TERMS AND CONDITIONS

1.0 PURPOSE

The Michigan Department of Community Health (MDCH) hereby enters into a contract with the specialty Prepaid Inpatient Health Plan (PIHP) identified on the signature page of this contract.

Under approval granted by the Centers for Medicare and Medicaid Services (CMS), MDCH operates an Adult Benefits Waiver section 1115 demonstration program. Under this waiver, selected ABW program services related to mental health and substance abuse services are provided to beneficiaries through a managed healthcare delivery system. .In Michigan, the ABW Program is managed on a full risk basis by specialty Prepaid Inpatient Health Plans (PIHPs),

The purpose of this contract is to obtain the services of the selected PIHP to manage the ABW Program in a designated services area and to provide mental health and substance abuse services and supports as indicated in this contract.

2.0 ISSUING OFFICE

This contract is issued by the Michigan Department of Community Health (MDCH). The MDCH is the sole point of contact regarding all procurement and contractual matters relating to the services described herein. 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 PIHP to the attention of the Director of MDCH's Bureau of Mental Health and Substance Abuse Services 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 Department of Community Health, subject to applicable provisions of this agreement regarding modifications, amendments, extensions or augmentations of the contract (Section 16.0). The Contract Administrator for this project is:

Elizabeth Knisely, Deputy Director
Bureau of Community Mental Health Services
Department of Community Health
5th 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, 2012 through September 30, 2013. The contract may be extended in increments no longer than 12 months, contingent upon mutual agreement to an amendment to the financial obligations reflected in Attachment P 7.0.1.2, and other changes required by the department. No more than three (3) one-year extensions after September 30, 2012 shall occur. Fiscal year payments are contingent upon and subject to enactment of legislative appropriations.

5.0 PAYMENT METHODOLOGY

The financing specifications are provided in Part II, Section 7.0 "Contract Financing" and capitation payments will be made based on the rates in Attachment P 7.0.1.2 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 PIHP prior to October 1, 2011. 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 PIHP under this contract shall be the responsibility of the PIHP, 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 the PIHP, its employees, officers or agent. Nothing herein shall be construed as a waiver of any governmental immunity for the county(ies), the PIHP, 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 PIHP 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 PIHP 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 PIHP's ability to continue service delivery at the current level. This includes actions filed in courts or by governmental regulatory agencies.

7.0 PIHP RESPONSIBILITIES

The PIHP shall be responsible for the operation of the ABW Program within its designated service area. The PIHP administration of the ABW Program must conform to regulations applicable to the ABW section 1115 demonstration waiver. The PIHP shall also be responsible for 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 PIHP elects to subcontract, except for sub-contracts with PIHPs, CMHSPs, and CAs, the PIHP shall comply with applicable provisions of federal procurement requirements, as specified in Attachment P 6.4.1.2. The PIHP is responsible for complying with all reporting requirements as specified in Part II, Section 6.5.1 of the contract and the finance reporting requirements specified in Part II, Section 7.8.

If required, performance objectives are identified in Attachment P7.0.2.2.

8.0 ACKNOWLEDGMENT OF MDCH FINANCIAL SUPPORT

The PIHP 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

MDCH funding obligated through this contract is ABW capitation payments. Detail regarding the MDCH financing obligation is specified in Part II, Section 7.0 of this contract and in Attachment P 7.0.1.2 to this contract.

11.0 LITIGATION

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

The MDCH and the PIHP 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 PIHP shall submit annual litigation reports providing the following detail for all civil litigation that the PIHP, subcontractor, or the PIHP's insurers or insurance agents are parties to. Reports must include the following details:

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 may cancel this contract for material default of the PIHP. Material default is defined as the substantial failure of the PIHP to fulfill the obligations of this contract, the standards promulgated by the department pursuant to P.A. 597 of the Public Acts of 2002 (MCL 330.1232b) or CMHSP Certification requirements as stated in the Michigan Mental Health Code (Section 232a). In case of material default by the PIHP, the MDCH may cancel this contract without further liability to the State, its departments, agencies, and employees, and procure services from other PIHPs.

In canceling this contract for material default, the MDCH shall provide written notification at least thirty (30) days prior to the cancellation date of the MDCH intent to cancel this contract to the PIHP and the relevant county(ies) Board of Commissioners. The PIHP may correct the problem during the thirty (30) day interval, in which case cancellation shall not occur. In the event that this contract is canceled, the PIHP 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. The transition plan shall set forth the process and time frame for the transition. The PIHP 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 MDCH. The PIHP will cooperate with 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 PIHP's responsibility to the new contractor.

If the Department takes action to cancel the contract under the provisions of MCL 330.1232b, it shall follow the applicable notice and hearing requirement described in MCL 330.1232b(6).

13.0 CLOSEOUT

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

A. Within 45 days (interim), and 90 days (final), following the end date imposed under Section 12.0, the PIHP shall provide to MDCH, all financial, performance, and other reports required by this contract.

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

C. Reconciliation of equipment with a value exceeding $5,000, purchased by the PIHP or its affiliates with funds provided under this contract, since May 1, 2010 will occur as part of settlement of this contract. The PIHP will submit to the MDCH an inventory of equipment meeting the above specifications within 45 days of the cancellation or non-renewal end date. The inventory listing must identify the current value and proportion of ABW funds used to purchase each item, and also whether or not the equipment is required by the PIHP as part of continued service provision to the continuing service population. MDCH will provide written notice within 90 days or less of any needed settlements concerning the portion of funds ending. If the PIHP disposes of the equipment, the appropriate portion of the value must be returned to MDCH (or used to offset costs in the final financial report).

D. All financial, administrative, and clinical records under the PIHP's responsibility must be retained for a period of seven years, unless these records are transferred to a successor organization or the PIHP is directed otherwise in writing by MDCH.

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

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

14.0 CONFIDENTIALITY

Both the MDCH and the PIHP shall assure that services and supports to, and information contained in the records of beneficiaries served under this agreement, or other such recorded information required to be held confidential by 45 CFR 160 and 164 and/or PA 258 of 1974 and PA 368 as amended, in connection with the provision of services or other activity under this agreement shall be privileged communication. Privileged communication shall be held confidential, and shall not be divulged without the written consent of either the recipient or a person responsible for the recipient, except as may be otherwise required by applicable law or regulation. Such information may be disclosed in summary, statistical, or other form, which does not directly or indirectly identify particular individuals.

15.0 ASSURANCES

The following assurances are hereby given to the MDCH:

15.1 Compliance with Applicable Laws

PIHPs will comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1973, and the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

15.2 Anti-Lobbying Act

The PIHP 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 PIHP shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

15.3 Non-Discrimination

In the performance of any contract or purchase order resulting here from, the PIHP 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 PIHP further agrees that every subcontract entered into for the performance of any contract or purchase order resulting here from will contain a provision requiring non-discrimination in employment, service delivery and access, as herein specified binding upon each subcontractor. 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 PIHP shall incorporate language in all contracts awarded: (1) prohibiting discrimination against minority-owned, women-owned, and handicapper-owned businesses in subcontracting; and (2) making discrimination a material breach of contract.

15.4 Debarment and Suspension

Assurance is hereby given to the MDCH that the PIHP 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 subcontractors:

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

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, and;

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.

15.6 Hatch Political Activity Act and Intergovernmental Personnel Act

The PIHP 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.

15.7 Limited English Proficiency

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

15.8 Health Insurance Portability and Accountability Act

To the extent that this act is pertinent to the services that the PIHP provides to the MDCH, the PIHP 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 time frames 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 PIHP from unauthorized disclosure as required by state and federal regulations. The PIHP must provide safeguards that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the contract.

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

In accordance with 45 CFR § 74, the Contractor shall comply with all of the following Federal regulations:

15.9 Byrd Anti-Lobbying Amendment

The PIHP shall comply with all applicable standards, orders, or requirements issued under 31 U.S.C. 1352 and 45 CFR Part 93. No appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

15.10 Davis-Bacon Act

(All contracts in excess of $2,000). (40 U.S.C. 276a to a-7) -- When required by Federal program legislation, all construction contracts awarded by the recipients and sub-recipients of more than $2,000 shall include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 276a to a-7) and as supplemented by Department of Labor regulations (29 CFR part 5), "Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction"). Under this act, contractors shall be required to pay wages to laborers and mechanics at a rate not less than the minimum wages specified in a wage determination made by the Secretary of Labor. In addition, contractors shall be required to pay wages not less than once a week. The recipient shall place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation and the award of a contract shall be conditioned upon the acceptance of the wage determination. The recipient shall report all suspected or reported violations to the federal awarding agency.

15.11 Contract Work Hours and Safety Standards

(All contracts in excess of $2,000 for construction and $2,500 employing mechanics or laborers). (40 U.S.C. 327 - 333) -- Where applicable, all contracts awarded by recipients in

excess of $2,000 for construction contracts and in excess of $2,500 for other contracts that involve the employment of mechanics or laborers shall include a provision for compliance with Section 102 and 107 of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327 - 333), as supplemented by Department of Labor regulations (29 CFR part 5). Under Section 102 of the Act, each contractor shall be required to compute the wages of every mechanic and laborer on the basis of a standard workweek of 40 hours. Work in excess of the standard workweek is permissible provided that the worker is compensated at a rate of not less than 1 and 1/2 times the basic rate of pay for all hours worked in excess of 40 hours in the workweek. Section 107 of the Act is applicable to construction work and provides that no laborer or mechanic shall be required to work in surroundings or under working conditions that are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

15.12 Rights to Inventions Made Under a Contract or Agreement

(All contracts containing experimental, developmental, or research work). Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and the recipient in any resulting invention in accordance with 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

15.13 Clean Air Act and Federal Water Pollution Control Act

(Contracts in excess of $100,000). Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended -- Contracts and subgrants of amounts in excess of $100,000 shall contain a provision that requires the recipient to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.). Violations shall be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

16.0 MODIFICATIONS, CONSENTS AND APPROVALS

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

17.0 Intentionally Left Blank

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 including attachments and appendices
C. Michigan Mental Health Code and Administrative Rules
D. Michigan Public Health Code and Administrative Rules
E. Approved ABW Waivers and corresponding CMS conditions, MDCH Appropriations Acts in effect during the contract period
F. Balanced Budget Act of 1997 (BBA) final rule effective 42 CFR 400, as revised.
H. All other pertinent Federal and State Statutes, Rules and Regulations
I. All final MDCH guidelines, and final technical requirements, as referenced in the contract. Additional guidelines and technical requirements must be added as provided for in Part 1, Section 16.0 of this contract
J. Michigan Medicaid Provider Manual: ABW Mental Health and Substance Abuse.

In the event of any conflict over the interpretation of the specifications, terms, and conditions indicated by the MDCH and those indicated by the PIHP, the dispute resolution process in included in section 19.0 of this contract shall be utilized.

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

19.0 DISPUTE RESOLUTION

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

In the event of the unsatisfactory resolution of a non-emergent contractual dispute or compliance/performance dispute, and if the PIHP desires to pursue the dispute, the PIHP shall request that the dispute be resolved through the dispute resolution process. This process shall involve a meeting between agents of the PIHP and the MDCH. The MDCH Deputy Director for Mental Health and Substance Abuse Services will identify the appropriate Deputy Director(s) or other department representatives to participate in the process for resolution, unless the MDCH Director has delegated these duties to the Administrative Tribunal.

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

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

In the event of an emergent compliance dispute, the dispute resolution process shall be initiated and completed within five (5) working days.

20.0 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.

21.0 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.

22.0 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 MDCH at the time of drafting. No inaccuracies in such data shall constitute a basis for legal recovery of damages, either real or punitive. MDCH will make corrections for identified inaccuracies to the extent feasible.

Captions and headings used in this contract are for information and organization purposes.

23.0 RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR)

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

24.0 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 and Section 3.0 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 (3rd) business day after being sent by U.S. mail, postage prepaid, return receipt requested; or (d) the next business day after being sent by a nationally recognized overnight express courier with a reliable tracking system. Either party may change its address where notices are to be sent by giving written notice in accordance with this section.

25.0 UNFAIR LABOR PRACTICES

Pursuant to 1980 PA 278, as amended, MCL 423.321 et seq., the State shall not award a contract or subcontract to an employer or any subcontractor, 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 PIHP as an employer, or the name of the subcontractor, manufacturer or supplier of the PIHP appears in the register.

26.0 SURVIVOR

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

27.0 GOVERNING LAW

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

29.0 ETHICAL CONDUCT

MDCH administration of this contract is subject to the State of Michigan State Ethics Act: Act 196 of 1973, "Standards of Conduct for Public Officers and Employees. Act 196 of 1973 prescribes standards of conduct for public officers and employees.

MDCH administration of this contract is subject to the State of Michigan Governor's Executive Order No: 2001-03, "Procurement of Goods and Services from Vendors."

PART II: STATEMENT OF WORK

1.0 SPECIFICATIONS

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

1.1 Targeted Geographical Area for Implementation

The PIHP directly or through sub-contracting with the PIHP Mental Health and Substance Abuse Provider Network shall manage the ABW Program under the terms of this agreement in the County(ies) of your geographic service area hereafter referred to as "service area" or exclusively as "ABW specialty service area."

1.2 Target Population

The PIHP directly or through sub-contracting with the PIHP Mental Health and Substance Abuse Provider Network shall serve all ABW beneficiaries, regardless of severity of disability in the service area described in 1.1 above who require the ABW mental health, substance abuse or developmental disabilities services included under the ABW Program.

1.3 Responsibility for Payment of Authorized Services

The PIHP directly or through sub-contracting with the PIHP Mental Health and Substance Abuse Provider Network shall be responsible for payment for services that the PIHP authorizes, including ABW mental health and substance abuse services. This provision presumes the PIHP and its agents are fulfilling their responsibility to individuals 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 PIHPs. In the event there is an unresolved dispute between PIHPs, either party may request MDCH involvement to resolve the dispute, and MDCH will make such determination. Likewise, services shall not be delayed or denied as a result of a dispute of payment responsibility between the PIHP and another agency.

The PIHP is financially responsible for ABW Program post-stabilization specialty care services obtained within or outside the PIHP catchment's area that are pre-approved by the PIHP or the plan provider if authorization is delegated to it by the PIHP.

The PIHP is also responsible for post-stabilization specialty care services when they are administered to maintain, improve, or resolve the beneficiary's stabilized condition when:

a) The PIHP does not respond to a request for pre-approval within 1 hour;
b) The PIHP cannot be contacted; or
c) The PIHP representative and the treating physician cannot reach an agreement concerning the beneficiary's care and a PIHP physician is not available for consultation. In this situation, the PIHP must give the treating physician the opportunity to consult with a PIHP physician and the treating physician may continue with care of the patient until a PIHP physician is reached or one of the criteria of 42 CFR 438.114 (2) is met.

1.4 Behavior Treatment Plan Review Committee

The PIHP directly or through sub-contracting with the PIHP Mental Health and Substance Abuse Provider Network shall use a specially-constituted committee, such as a behavior treatment plan review committee, to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. The Committee shall substantially incorporate the standards in Attachment P 1.4.1.2 Technical Requirement for Behavior Treatment Plans

2.0 SUPPORTS AND SERVICES

2.1 ABW Supports and Services

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in the Michigan ABW Provider Manual: Adult Benefits Waiver section, mental health and developmental disabilities services may also be provided in other locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness.

2.1.1.1 ABW Supports and Services

ABW Mental Health, Developmental Disabilities, and Substance Use Disorder Services for which ABW beneficiaries are entitled when medically necessary are listed in the Michigan Medicaid Provider Manual, Adult Benefits Waiver Section.

Optional ABW Supports and Services that PIHPs may offer in lieu of the ABW Supports and Services coverage as outlined in the Michigan Medicaid Provider Manual, Adult Benefits Waiver Section.

2.2 Service Requirements

The PIHP are to limit ABW services to those that are medically necessary and appropriate, and that conform to accepted standards of care. PIHPs must operate the provision of their ABW services consistent with the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the CMS/HCFA State Medicaid & State Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual: Adult Benefits Waiver section as applicable.

Criteria for medical necessity and utilization control procedures that are consistent with the medical necessity criteria specified by MDCH and based on practice standards may be used to place appropriate limits on a service (CFR 42 sec.440.230).

3.0 ACCESS ASSURANCE

3.1 Access Standards

The PIHP shall ensure timely access to ABW services in accordance with the Access Standards in Attachment P3.1.1.2 and the following timeliness standards, and report its performance on the standards in accordance with Attachment P 6.5.1.2, and shall locally monitor its performance and take action necessary to improve access for recipients.

A. Mental Health

1. At least 95% of all people who receive a pre-admission screening for psychiatric inpatient care have a disposition completed in three (3) hours.

2. At least 95% of all people receive a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (by sub-population).

3. At least 95% of all people start at least one ongoing service within 14 calendar days of a non-crisis (emergency) assessment with a professional.

B. Substance Abuse

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

2. 95% of people are admitted for treatment within 24 hours of assessment in urgent situations.

3. 95% of people receive an assessment for non-urgent situations within five days of referral or presentation.

4. 95% of people are admitted to treatment within seven (7) days following a non-urgent assessment.

C. The PIHP shall ensure geographic access to covered, alternative, and allowable 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 individual's primary service providers (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 individual'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 PIHP shall be responsible for outreach and ensuring adequate access to covered ABW services for beneficiaries. The PIHP shall assure that substance abuse screening/referral is available 24 hours, 7 days a week.

3.2 Medical Necessity

The definition of medical necessity for ABW services is included in the Michigan Medicaid Provider Manual: ABW Section.

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3.4 Other Access Requirements

3.4.1 Person-Centered Planning

The Michigan Mental Health Code establishes the right for all individuals to have an Individual Plan of Service (IPS) developed through a person-centered planning process (Section 712, added 1996). The PIHP shall implement person-centered planning in accordance with the MDCH Person-Centered Planning Practice Guideline (Attachment P 3.3.1.2). This provision is not currently a requirement for services provided through the ABW Substance Abuse capitation portion of this contract. MDCH will revisit the requirement for services provided in FY 11.

3.4.2 Cultural Competence

The supports and services provided by the PIHP (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 PIHP has five components in place: (1) a method of community assessment; (2) sufficient policy and procedure to reflect the PIHP's value and practice expectations; (3) a method of service assessment and monitoring; (4) ongoing training to assure that staff are aware of, and able to effectively implement, policy; and (5) the provision of supports and services within the cultural context of the recipient.

The PIHP shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

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3.4.4 Intentionally Left Blank

3.4.5 Choice

In accordance with 42 CFR 438.6(m), the PIHP must assure that the beneficiary is allowed to choose his or her health care professional, i.e., physician, therapist, etc. to the extent possible and appropriate.

3.4.6 Second Opinion

If the beneficiary requests, the PIHP must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the beneficiary to obtain one outside the network, at no cost to the beneficiary.

3.4.7 Out-of-Network Responsibility

If the PIHP is unable to provide necessary medical services covered under the contract to a particular beneficiary the PIHP must adequately and timely cover these services out of network for the beneficiary, for as long as the entity is unable to provide them within the network.

3.4.8 Denials By Qualified Professional

The PIHP must assure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition.

3.4.9 Utilization Management Incentives

The PIHP must assure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

5.0 OBSERVANCE OF FEDERAL, STATE AND LOCAL LAWS

The PIHP 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. The State must implement any changes in state or federal statutes, rules, or administrative procedures that become effective during the term of this contract. This includes laws and regulations regarding human subjects research and data projections set forth in 45 CFR and HIPAA.

5.2 Fiscal Soundness of the Risk-Based PIHP

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

5.3 Program Integrity

The PIHP must have administrative and management arrangements or procedures for compliance with 42 CFR 438.608. Such arrangements or procedures must identify any activities that will be delegated to affiliates and CA's on how the PIHP will monitor those activities.

(a) PIHP Ownership and Control Interests

In order to comply with 42 CFR 438.610, the PIHP may not have any of the following relationships with an individual who is excluded from participating in Federal health care programs:

1) Excluded individuals cannot be a director, officer, or partner of the PIHP;

2) Excluded individuals cannot have a beneficial ownership of five percent or more of the PIHP's equity; and

3) Excluded individuals cannot have an employment, consulting, or other arrangement with the PIHP for the provision of items or services that are significant and material to the PIHP's obligations under its contract with the State.

"Excluded" individuals or entities are individuals or entities that have been excluded from participating, but not reinstated, in the Medicare, ABW, or any other Federal health care programs. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance loans.

Federal regulations require PIHPs to disclose information about individuals with ownership or control interests in the PIHP. These regulations also require the PIHP to identify and report any additional ownership or control interests for those individuals in other entities, as well as identifying when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other.

The PIHP shall comply with the federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 C.F.R. §455.104-106. In addition, the PIHP shall ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment or services provided under the ABW agreement require compliance with 42 C.F.R. §455.104-106.

(b) PIHP Responsibilities for Monitoring Ownership and Control Interests Within Their Provider Networks

At the time of provider enrollment or re-enrollment in the PIHP's provider network, the PIHP must search the Office of Inspector General's (OIG) exclusions database to ensure that the provider entity, and any individuals with ownership or control interests in the provider entity (direct or indirect ownership of five percent or more or a managing employee), have not been excluded from participating in federal health care programs. Because these search activities must include determining whether any individuals with ownership or control interests in the provider entity appear on the OIG's exclusions database, the PIHP must mandate provider entity disclosure of ownership and control information at the time of provider enrollment, re-enrollment, or whenever a change in provider entity ownership or control takes place.

The PIHP must search the OIG exclusions database monthly to capture exclusions and reinstatements that have occurred since the last search, or at any time providers submit new disclosure information.
The PIHP must notify the Division of Program Development, Consultation and Contracts, Mental Health and Substance Abuse Administration in MDCH immediately if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in a provider entity are on the OIG exclusions database.

(c) PIHP Responsibility for Disclosing Criminal Convictions
PIHPs are required to promptly notify the Division of Program Development, Consultation and Contracts, Mental Health and Substance Abuse Administration in MDCH if:

1) any disclosures are made by providers with regard to the ownership or control by a person that has been convicted of a criminal offense described under

sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. (See 42 CFR 1001.1001(a)(1); or

2) any staff member, director, or manager of the PIHP, individual with beneficial ownership of five percent or more, or an individual with an employment, consulting, or other arrangement with the PIHP has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. (See 42 CFR 1001.1001(a)(1)

The PIHP's contract with each provider entity must contain language that requires the provider entity to disclose any such convictions to the PIHP.

(d) PIHP Responsibility for Notifying MDCH of Administrative Actions that Could Lead to Formal Exclusion

The PIHP must promptly notify the Division of Program Development, Consultation and Contracts, Mental Health and Substance Abuse Administration in MDCH if they have taken any administrative action that limits a provider's participation in the ABW program, including any provider entity conduct that results in suspension or termination from the PIHP's provider network.

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: http://exclusions.oig.hhs.gov. The state sanctioned list is at: www.michigan.gov/mdch, click on providers, click on Information for ABW Providers, click on List of Sanctioned Providers. Both lists must be regularly checked.

5.4 Public Health Reporting

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

5.5 ABW Policy

PIHPs shall comply with provisions of the Michigan Medicaid Provider Manual developed under the formal policy consultation and promulgation process, as established by the MDCH.

6.0 PIHP ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE SERVICES

6.1 Organizational Structure

The PIHP shall maintain an administrative and organizational structure that supports a high quality, comprehensive managed care program. The PIHP'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.

6.1.1 Event Notification

In addition to other reporting requirements outlined in this contract, the PIHP shall immediately notify MDCH of the following events:

1. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, liecensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, to QMPMeasures@michigan.gov and include the following information:

   a. Name of beneficiary
   b. Beneficiary ID number (Medicaid, ABW, MIChild)
   c. Consumer I (CONID) if there is not beneficiary ID number
   d. Date, time and place of death (if a licensed foster care facility, include the license #)
   e. Preliminary cause of death
   f. Contact person's name and e-mail address

2. Relocation of a consumer's placement due to licensing issues.

3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours

4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities

Except for deaths, notification of the remaining events shall be made telephonically or other forms of communication within five (5) business days to contract management staff members in MDCH's Mental Health and Substance Abuse Administration in time frames as specified by MDCH.

6.2 Administrative Personnel

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

position and responsibilities.

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

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

6.3 Customer Services

6.3.1 Customer Services: General

Customer services is an identifiable function that operates to enhance the relationship between the individual and the Prepaid Inpatient Health Plan (PIHP). This includes orienting new individuals to the services and benefits available including how to access them, helping individuals with all problems and questions regarding benefits, handling individual 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 individual has a need for help, and being able to help on the first contact in most situations. Key aspects of the customer service system are included in Section 3/6 of the Application for Participation. Standards for customer services are in Attachment P.6.3.1.2.

The PIHP must submit its customer services handbook to the MDCH for review and approval.

6.3.2 Recipient Rights and Grievance/Appeals

The PIHP shall adhere to the requirements stated in the MDCH Grievance and Appeal Technical Requirement, which is an attachment to this contract (Attachment P 6.3.2.2) in addition to provisions specified in 42 CFR 438.100.

Individuals enrolled in ABW must be informed of their right to an administrative hearing if dissatisfaction is expressed at any point during the rendering of state plan services. While PIHPs may attempt to resolve the dispute through their local processes, the local process must not supplant or replace the individual's right to file a hearing request with MDCH. The PIHP's grievance or complaint process may, and should, occur simultaneously with MDCH's administrative hearing process, as well as with the recipient rights process. The PIHP shall follow fair hearing guidelines and protocols issued by the MDCH.

The PIHP must maintain 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 PIHP must notify the requesting provider of any decision to deny a service

authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

The PIHPs must maintain records of grievances and appeals.

6.3.3 Information Requirements

A. Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services shall meet the following standards:

1. All such materials shall be written at the 4th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 4th grade level criteria).

2. All materials shall be available in the languages appropriate to the people served within the PIHP's area. Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002 Federal Register Vol. 65, August 16, 2002).

3. All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA). Beneficiaries shall be informed of how to access the alternative formats.

4. Material shall not contain false, confusing, and/or misleading information.

B. Additional Information Requirements

1. The PIHP must notify beneficiaries that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. The PIHP must also notify beneficiaries how to access alternative formats.

2. The PIHP must provide the following information to all beneficiaries:

   a. A listing of contracted providers that identifies provider name, locations, telephone numbers, any non-English languages spoken, and whether they are accepting new patients. This includes, at a minimum, information about primary service providers (e.g. case manager, psychiatrist, primary therapist, etc.) and any restrictions on the beneficiary's freedom of choice among network providers. A written copy of this listing bust be provided to each beneficiary annually, unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer service line is acceptable.

b. Their rights and protections, as specified in "Appeal and Grievance Resolution Processes Technical Requirement."
c. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled
d. Procedures for obtaining benefits, including authorization requirements.
e. The extent to which, and how, beneficiaries may obtain benefits and the extent to which, and how, after-hours crisis services are provided.
f: Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost to the PIHP of each covered support and service he/she is receiving.
g. MDCH will assemble a workgroup to develop a program integrity process which verifies claimed services were provided. This will include Explanation of Benefits reports for beneficiaries that will satisfy CMH audit requirements. Anticipated target date of April, 2011.

3. The PIHP must give each beneficiary written notice of a significant change in its provider network including the addition of new providers and planned termination of existing providers.

4. The PIHP will make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

5. The PIHP will provide information to beneficiaries about managed care and care coordination of the PIHP, including:

   a. Information on the structure and operation of the MCO or PIHP;
   b. Physician incentive plans in use by the PIHP or network providers as set forth in 42 CFR 438.6(h).

6.4 Provider Network Services

The PIHP is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract. The PIHP remains the accountable party for the Medicaid beneficiaries in its service area, regardless of the functions it has delegated to its CSSNs and its provider networks.

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

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

D. Provide a copy of the PIHP's grievance, appeal and fair hearing procedures and timeframes to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to those procedures or timeframes.

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

F. Notify MDCH within seven (7) days of any changes to the composition of the provider network organizations. PIHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDCH determines to negatively affect recipient access to covered services may be grounds for sanctions.

G. Assure that the provider network responds to the cultural, racial, and linguistic needs (including interpretive services as necessary) of the service area, and make oral interpretation services available free of charge to each potential beneficiary. This applies to all non-English languages not just those that the State identifies as prevalent. Each entity must notify its beneficiaries how to access oral interpretation services.

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

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

J. Annually monitors affiliates, as applicable, and provider networks who perform delegated functions to assure quality and performance in accordance with the standards in the Quality Assessment and Performance Improvement Technical Requirement (Attachment 6.7.1.2)

K. The PIHP shall assure HIPAA compliant access to information about persons receiving services in their contractual residential settings by individuals who have completed training and are working under the

auspices of the Dignified Lifestyles Community Connections program.

6.4.1 Provider Procurement

The PIHP 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 PIHP fulfills these responsibilities through subcontracts, they shall adhere to applicable provisions of federal procurement requirements as specified in Attachment P 6.4.1.2.

In complying with these requirements and in accordance with 42 CFR 438.12, the PIHP:

a. May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification;

b. Must give those providers not selected for inclusion in the network written notice of the reason for its decision;

Is not required to contract with providers beyond the number necessary to meet the needs of its beneficiaries, and is not precluded from using different practitioners in the same specialty. Nor is the PIHP prohibited from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to its beneficiaries. In addition, the PIHP's selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. Also, the PIHP must ensure that it does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

6.4.2 Subcontracting

The PIHP may subcontract for the provision of any of the services specified in this contract including contracts for administrative and financial management, and data processing. The PIHP shall be held solely and fully responsible to execute all provisions of this contract, whether or not said provisions are directly pursued by the PIHP, pursued by affiliated CMHSPs or CAs, or pursued by the PIHP through an MCPN or subcontract vendor. The PIHP shall ensure that all subcontract 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 PIHP.

Subcontracts entered into by the PIHP 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. Financing conditions consistent with this contract
I. Anti-delegation clause
J. Compliance with Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency"

K. In all contracts with health care professionals, the PIHP must comply with the requirements specified in the "Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans", Attachment P 6.7.1.2.: and require the provider to cooperate with the PIHP'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 PIHP's position or may not be covered by the PIHP.
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 ABW accessibility standards as established in ABW policy and this contract.

In accordance with 42 CFR 434.6(b), all subcontracts entered into by the PIHP must be in writing and fulfill the requirements of 42 CFR 434.6(a) and 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract. 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 PIHP intends to deliver services required under this contract, whether or not characterized as a subcontract, shall be subject to review by the MDCH at its discretion.

Subcontracts that contain provisions for a financial incentive, bonus, withhold, or sanctions, (including sub-capitations) must include provisions that protect individuals

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 422.208 and 422.210. The PIHP shall provide a copy of each contract that contains incentive, bonus, withhold, or sanction provisions (including sub-capitations) 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. The PIHP must provide information on its Provider Incentive Plan (PIP) to any ABW beneficiary upon request (this includes the right to adequate and timely information on a PIP).

The PIHP shall provide a listing of all subcontracts for administrative or financial management, or data processing services to the MDCH within 60 days of signing this contract. The listing shall include the name of the subcontractor, purpose, and amount of contract.

6.4.2.1 Contracts with PIHP Mental Health and Substance Abuse Provider Networks

PIHP contracts with CMHSP, CAs and MCPNSs for ABW Programs should include the following provisions:

a. Descriptions of the payment method of ABW funds to be used by the PIHP and assumptions used that such payments are at a level that will meet the needs of beneficiaries residing in that county(ies).
b. Define the model and methods of risk between the PIHP and the CMHSP affiliate.
c. Describe the PIHP oversight to assure that the CMHSP, CAs and MCPNS is managing the services and risk within the funding assumptions.
d. Describe the funding assumptions regarding the delegation of PIHP administrative activities and functions, and reporting of such activities and expenses to the PIHP.
e. Requirement and process for monitoring and tracking expenditures for ABW.

6.4.2.2 Agreements with Substance Abuse Coordinating Agencies (CA) for Substance Abuse Services

When the PIHP is one of several PIHPs contracting with the CA, the contract(s) between the PIHP and the CA(s), may also stipulate that the CA is able to use the funding from all of the PIHPs to maximize how it meets the needs of all beneficiaries within the CA region, to manage risk and savings across the CA region.

6.4.3 Provider Credentialing

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

6.4.4 Collaboration with Community Agencies

PIHPs 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.

The PIHP shall have a documented policy and set of procedures to assure that coordination regarding mutual recipients is occurring between the PIHP and/or its provider network, and primary care physicians. This policy shall minimally address all recipients of PIHP services for whom services 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.

6.4.6 Health Care Practitioner Discretions

The PIHP may not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a beneficiary who is receiving services under this contract:

A. For the beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
B. For any information the beneficiary needs in order to decide among all relevant treatment options
C. For the risks, benefits, and consequences of treatment or non-treatment
D. For the beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

6.5 Management Information Systems

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

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

- Monthly downloads of ABW eligible information
- Individual 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 MDCH
- Encounter and demographic data reporting
- Quality indicator reporting
- HIPAA compliance
- UBP compliance
- Individual access and satisfaction

6.5.1 Uniform Data and Information

To measure the PIHP'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 PIHP must provide the MDCH with uniform data and information as specified by MDCH as previously agreed, and such additional or different reporting requirements (with the exemption of those changes required by federal or state law and/or regulations) as the parties may agree upon from time to time. Any changes in the reporting requirements, required by state and federal law, will be communicated to the PIHP at least 90 days before they are effective unless state or federal law requires otherwise. Both parties must agree to other changes, beyond routine modifications, to the data reporting requirements.

The PIHP's timeliness in submitting required reports and their accuracy will be monitored by MDCH and will be considered by MDCH in measuring the performance of the PIHP. Regulations promulgated pursuant to the Balance Budget Act of 1997 (BBA) require that the CEO or designee certify the accuracy of the data.

The PIHP must cooperate with MDCH in carrying out validation of data provided by the PIHP by making available recipient records and a sample of its data and data collection protocols. PIHPs must certify that the data they submit are accurate, complete and truthful. An annual certification from and signed by the Chief Executive Officer or the Chief Financial Officer, or a designee who reports directly to either must be submitted annually. The certification must attest to the accuracy, completeness, and truthfulness of the information in each of the sets of data in this section.

The PIHP shall submit the information below to the MDCH consistent with the time frames and formats specified in Attachment P 6.5.1.2

Should additional statistical or management information from data currently collected

by the PIHP 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 PIHP shall submit encounter data containing detail for each recipient encounter reflecting all services provided by the PIHP. Encounter records shall be submitted monthly via electronic media in the HIPAA-compliant format specified by MDCH. Encounter level records must have a common identifier that will allow linkage between MDCH's and the PIHP's management information systems. Encounter data requirements are detailed in the PIHP Reporting Requirements Attachment P.6.5.1.2 to this contract.

6.6 Financial Management System

6.6.1 General

The PIHP shall maintain all pertinent financial and accounting records and evidence pertaining to this contract based on financial and statistical records that can be verified by qualified auditors. The PIHP will comply with generally accepted accounting principles (GAAP) for government units when preparing financial statements. The PIHP will use the principles and standards of OMB Circular A-87 for determining all costs related to the management and provision of ABW covered services under the ABW Program reported on the financial status report. The accounting and financial systems established by the PIHP shall be a double entry system having the capability to identify application of funds to specific funding streams participating in service costs for individuals. The accounting system must be capable of reporting the use of these specific fund sources by major population groups (MIA, DD and SA). In addition, cost accounting methodology used by the PIHP must ensure consistent treatment of costs across different funding sources and assure proper allocation to costs to the appropriate source.

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

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6.6.3 Claims Management System

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

A clean claim is a valid claim completed in the format and time frames specified by the PIHP 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. A valid claim is a claim for supports and services that the PIHP is responsible for under this contract. It includes services authorized by the PIHP, and those like Medicare co-pays and deductibles that the PIHP may be responsible for regardless of their authorization.

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

6.6.3.1 Post-payment Review

The PIHP may utilize a post-payment review methodology to assure claims have been paid appropriately. Regardless of method, the PIHP must have a process in place to verify that services were actually provided.

6.6.3.2 Total Payment

The PIHP 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 and/or policies. The PIHP's providers may not bill individuals for the difference between the provider's charge and the PIHP's payment for services. The providers shall not seek nor accept additional supplemental payment from the individual, his/her family, or representative, for services authorized by the PIHP. The providers shall not seek nor accept any additional payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if the PIHP provided the services directly.

6.6.3.3 Electronic Billing Capacity

The PIHP must be capable of accepting HIPAA compliant electronic billing for services billed to the PIHP, or the PIHP claims management agent, as stipulated in the Michigan ABW Manual. The PIHP may require its providers to meet the same standard as a condition for payment.

6.6.3.4 Third Party Resource Requirements

ABW is a payer of last resort. PIHPs are 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 PIHP shall collect any payments available from other health insurers including Medicare and private health insurance for services provided to its individuals 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.

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6.7 Quality Assessment and Performance Improvement Program Standards

6.7.1 Quality Assessment and Performance Improvement Program

The PIHP shall have a fully operational Quality Assessment and Performance Improvement Program in place that meets the conditions specified in the Quality Assessment and Performance Improvement Program Technical Requirement," Attachment P 6.7.1.2.

6.7.2 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 PIHP. The PIHP shall address the findings of the external review through its QAPIP. The PIHP must develop and implement performance improvement goals, objectives and activities in response to the external review findings as part of the PIHP'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 PIHP'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.

6.7.3 Annual Effectiveness Review

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

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6.8 Service and Utilization Management

The PIHP 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 practice guidelines. The PIHP 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.

6.8.1 Beneficiary Service Records

The PIHP shall establish and maintain a comprehensive individual service record system consistent with the provisions of MSA Policy Bulletins, and appropriate state and federal statutes. The PIHP 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 minimum 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 PIHP's provider agencies.

6.8.3 Coordination

The PIHP shall assure that services to each recipient are coordinated with primary health care providers', including County Health Plans, and other service agencies in the community that are serving the individual. In this regard, the PIHP will implement practices and agreements described in Section 6.4.4 of this contract.

6.8.6 Advance Directives

In accordance with 42 CFR 422.128, the PIHP shall maintain written policies and procedures for advance directives. The PIHP shall provide adult beneficiaries with written information on advance directive policies and a description of applicable state law and their rights under applicable laws. This information must be continuously updated to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective. The PIHP must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the Office of Recipient Rights.

6.9 Regulatory Management

The PIHP shall have an established process for carrying out corporate compliance activities across its service area. The process includes promulgation of policy that specifies procedures and standards of conduct that articulate the PIHP's commitment to comply with

all applicable Federal and State standards. The PIHP must designate an individual to be a compliance officer, and establish a committee that will coordinate analytic resources devoted to regulatory identification, comprehension, interpretation, and dissemination. The compliance officer, committee members, and PIHP employees shall be trained about the compliance policy and procedures. The PIHP shall establish ongoing internal monitoring and auditing to assure that the standards are enforced, to identify other high-risk compliance areas, and to identify where improvements must be made. There are procedures for prompt response to identified problems and development of corrective actions.

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 PIHP is included as Attachment P 7.0.1.2 to this contract.

The Department of Health and Human Services (HHS), United States Comptroller General or their representatives must have access to books, documents, etc., of the PIHP.

The rates included in attachment P7.0.1.2 are in effect with the initial contract. Rates may be revised without formal amendment of the contract when these revisions are actuarially certified, approved by CMS are necessary to comply with the requirements of an Executive Order or MDCH appropriations and are incorporated by reference in this contract when transmitted in writing to the PIHP.

7.4 MDCH Funding

MDCH funding includes ABW 1115 demonstration program funds for the mental health and substance abuse benefits. The financing in this contract is always contingent on the annual Appropriation Act.

7.4.1 ABW

The MDCH shall provide to the PIHP ABW funds as a capitated payment based upon a per eligible per month (PEPM) methodology for ABW-covered mental health and substance abuse services.

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

The ABW per eligible per month (PEPM) rates, are attached to this contract, Attachment P7.0.1.2.

7.4.1.1 ABW Rate Calculation

The ABW Rate Calculation is based on the actuarial documentation letter from Milliman USA. The capitation rates for FY 2011 are based on recipients with scope/coverage code 3G. The Milliman USA letter documents the calculation rate methodology and provides the required certification regarding actuarial soundness as required by the Balanced Budget Act Rules effective August 13, 2002. The chart of rates and factors contained in the actuarial documentation is included as Attachment P.7.0.1.2.

7.4.1.2 ABW Payments

MDCH will provide the Prepaid Inpatient Health Plan (PIHP) ABW Program managed care payments each month for the ABW covered services. The payment will be made on the fourth Thursday of the month. When applicable, additional payments may be scheduled (i.e. retro-rate implementation) after that date. HIPAA compliant 834 and 820 transactions will provide eligibility and remittance information.

7.5 Operating Practices

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

A. Generally Accepted Accounting Principles for Governmental Units.

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

C. OMB Circular A-87

7.6 Audits

The PIHP 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 PIHP at the end of the fiscal year. A copy of this audit report, along with the management letter and the PIHP's response to the management letter, shall be submitted to MDCH within 30 days of receipt of the audit report by the PIHP board of directors.

The PIHP shall ensure the completion of a fiscal year end Financial Statement Audit conducted in accordance with Generally Accepted Auditing Standards (GAAS); and a **contract end date of September 30.** Compliance Examination conducted in accordance with the American Institute of CPA's (AICPA's) Statements on Standards for Attestation Engagements (SSAE) 10 - Compliance Attestation, and the CMH Compliance Examination Guidelines in Attachment P.7.6.1.2.

The PIHP shall submit to the MDCH the Financial Statement Audit Report, the Compliance Examination Report, a Corrective Action Plan for any audit or examination findings that impact MDCH-funded programs, and management letter (if issued) with a response within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The PIHP or CMHSP must submit the reporting package by e-mail to MDCH at MDCH-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. MDCH reserves the right to request a hard copy of the compliance examination report materials if for any reason the electronic submission process is not successful.

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

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

The appeal process available to the PIHP relating to MDCH management decisions on Compliance Examination findings and disallowed costs is included in Attachment P.7.6.2.2.

7.7 Financial Planning

The PIHP shall bear the risk that actual PEPM amounts do not cover the expenses for Covered Services. This risk cannot be covered with the PIHP Specialty Medicaid Capitated funding under the concurrent 1915 (b)/(c) waiver.

The PIHP financial responsibility for liabilities for costs including cost over runs must be paid from the following sources: first, current year ABW revenue, then, local funds (or reserves) created for the purpose of managing ABW risk, then other local funds, and finally GF or State Agreement funds consistent with both the requirements of the GF/State Agreement respective contracts and a MDCH approved ABW risk management Strategy.

Unexpended ABW capitated payments may be used as local funds in the subsequent year.

7.7.1 Risk Management Strategy

Each PIHP must define the components of its risk management strategy that is consistent with general accounting principles as well as federal and state regulations.

7.7.2 PIHP Assurance of Financial Risk Protection

The PIHP must provide to MDCH upon request, documentation that demonstrates financial risk protections sufficient to cover the PIHP's determination of risk. The PIHP must update this documentation any time there is a change in the information.

The PIHP may use one or a combination of measures to assure financial risk protection, including pledged assets, reinsurance, and creation of an ISF.

The PIHP will submit a specific written Risk Management Strategy to the Department within sixty days of signing this contract and when known if the Strategy involves the use of GF funds. The Risk Management strategy will identify the amount of reserves, insurance and other revenues to be used by the PIHP to assure that its risk commitment is met. Whenever General Funds are included as one of the listed revenue sources, MDCH may disapprove the list of revenue sources, in whole or in part, after review of the information provided and a meeting with the PIHP. Such a meeting will be convened within 45 days after submission of the risk management strategy. If disapproval is not provided within 60 days following this meeting, the use of general funds will be considered to be allowed. Such disapproval will be provided in writing to the PIHP within 60 days of the first meeting between MDCH and the PIHP. Should circumstances change, the PIHP may submit a revision to its Risk Management Strategy at any time. MDCH will provide a response to this revision, when it changes the PIHPs intent to utilize General Funds to meet its risk commitment, within 30 days of submission.

7.8 Finance Planning, Reporting and Settlement

The PIHP shall provide financial reports to the MDCH as specified in this contract, and on forms and formats specified by the MDCH. Forms and instructions are posted to the DCH website at: http://www.michigan.gov./mdch/0,1607,7-132-2941_38765---,00.html (See attachment P7.8.1.2 Finance Planning, Reporting and Settlement)

7.9 Legal Expenses

The following legal expenses are ALLOWABLE:

1) Legal expenses required in the administration of the program on behalf of the State of Michigan or Federal Government.

2) Legal expenses relating to employer activities, labor negotiation, or in response to employment related issues or allegations, to the extent that the

engaged services or actions are not prohibited under federal principles of allowable costs.

3) Legal expenses incurred in the course of providing consumer care. The PIHP must maintain documentation to evidence that the legal expenses are allowable. Invoices with no detail regarding services provided will not be sufficient documentation.

The following legal expenses are UNALLOWABLE:

1) Where the Michigan Department of Community Health (MDCH) or the Centers for Medicare & ABW Services (CMS) takes action against the provider by initiating an enforcement action or issuing an audit finding, then the legal costs of responding to the action are unallowable except as noted in the following circumstances.

a) The PIHP prevails and the action is reversed.
Example: The audit finding is not upheld and the audit adjustment is reversed.

b) The PIHP prevails as defined by reduction of the contested audit finding(s) by 50 percent or more.
Example: An audit finding for an adjustment of $50,000 is reduced to $25,000. Or, in the case of several audit findings, a total adjustment of $100,000 is reduced to $50,000.

c) The PIHP enters into a settlement agreement with MDCH or CMS prior to any Hearing.

2) Legal expenses for the prosecution of claims against the State of Michigan or the Federal Government.

3) Legal expenses contingent upon recovery of costs from the State of Michigan or the Federal Government.

8.0 CONTRACT REMEDIES AND SANCTIONS

The state will utilize a variety of means to assure compliance with contract requirements in keeping with the provisions of Section 330, 1232(b) of Michigan's Mental Health Code. The state will pursue remedial actions and possibly sanctions as needed to resolve outstanding contract violations and performance concerns. The application of remedies and sanctions shall be a matter of public record.

The MDCH will utilize actions in the following order:

A. Notice of the contract violation and conditions will be issued to the PIHP with copies to the Board.

B Require a plan of correction and specified status reports that becomes a contract performance objective.

C. If previous items above have not worked, impose a direct dollar penalty and make it a non-matchable PIHP administrative expense and reduce earned savings from that fiscal year by the same dollar amount.

D. For sanctions related to reporting compliance issues, MDCH may delay up to 25% of scheduled payment amount to the PIHP until after compliance is achieved. MDCH may add time to the delay on subsequent uses of this provision. (Note: MDCH may apply this sanction in a subsequent payment cycle and will give prior written notice to the PIHP)

E. Initiate contract termination.

The implementation of any of these actions does not require a contract amendment to implement. The sanction notice to the PIHP is sufficient authority according to this provision. The use of remedies and sanctions will typically follow a progressive approach, but the MDCH reserves the right to deviate from the progression as needed to seek correction of serious, or repeated, or patterns of substantial non-compliance or performance problems. The PIHP can utilize the dispute resolution provision of the contract to dispute a contract compliance notice issued by the MDCH.

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

A. Reporting timeliness, quality and accuracy

B. Performance Indicator Standards

C. Repeated Site-Review non-compliance (repeated failure on same item)

D. Failure to complete or achieve contractual performance objectives

E. Substantial inappropriate denial of services required by this contract or substantial services not corresponding to condition. Substantial can be a pattern, large volume or small volume but severe impact.

F. Repeated failure to honor appeals/grievance assurances.

G. Substantial or repeated health and/or safety violations.

9.0 RESPONSIBILITIES OF THE DEPARTMENT OF COMMUNITY HEALTH

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

9.1 General Provisions

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

B. Provide the PIHP with HIPAA compliant 834 and 820 files identifying ABW beneficiaries and payment information.

C. Protect against fraud and abuse involving MDCH funds and recipients in cooperation with appropriate state and federal authorities.

D. Administer a ABW fair hearing process consistent with for ABW beneficiaries consistant with federal requirements.

E. Collaborate with the PIHP on quality improvement activities, fraud and abuse issues, and other activities that impact on the services provided to individuals.

F. Review PIHP marketing materials.

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

H. Monitor the operation of the PIHP to ensure access to quality care for all individuals in need of and qualifying for services.

I. Monitor quality of care provided to individuals who receive PIHP services and supports.

J. Refer local issues back to the PIHP.

K. Coordinate efforts with other state departments involved in services to the population.

L. When repeated health and welfare issues/emergencies are raised or concerns regarding timely implementation of medically necessary services the MDCH authority to take action is acknowledged by the PIHP.

9.2 Contract Financing

MDCH shall pay, to the PIHP, ABW funds as agreed to in the contract.

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

A. Action by the Michigan State Legislature or by the Center for Medicare and ABW Services 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's funding for specified services or that reduces the MDCH's funding level below that required to maintain services on a statewide basis.

C. A formal directive by the Governor, or the Michigan Department of Management and Budget (State Budget Office) on behalf of the Governor, requiring a reduction in expenditures.

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

9.3 Reviews and Audits

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

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

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

The MDCH may inspect and audit any financial records of the PIHP or its subcontractors.

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

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

Reviews and audits shall be conducted according to the protocols in section P.9.3.1.2, except when conditions appear to be severe and warrant deviation or when state or federal laws supersede these protocols.

9.3.1 MDCH Reviews

A. As used in this section, a review is an examination or inspection by the MDCH or its agent, of policies and practices, in an effort to verify compliance with requirements of this contract.

B. The MDCH will schedule reviews at mutually acceptable start dates to the extent possible, with the exception of those reviews for which advance announcement is prohibited by rule or federal regulation, or when the deputy director for the Health Care Administration determines that there is demonstrated threat to consumer health and welfare or substantial threats to access to care.

C. Except as precluded in 9.3.1 (A) above, the guideline, protocol and/or instrument to be used to review the PIHP, or a detailed agenda if no protocol exists, shall be provided to the PIHP at least 30 days prior to the review.

D. At the conclusion of the review, the MDCH shall conduct an exit interview with the PIHP. The purpose of the exit interview is to allow the MDCH to present the preliminary findings and recommendations.

E. Following the exit review, the MDCH shall generate a report within 45 days identifying the findings and recommendations that require a response by the PIHP.

1. The PIHP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The PIHP may also present new information to the MDCH that demonstrates it was in compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the exit interview and the POC). When access or care to individuals is a serious issue, the PIHP may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified in C above.

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

F. The PIHP can appeal findings reflected in review reports through the dispute resolution process identified in this contract.

9.3.2 MDCH Audits

A. The MDCH and/or federal agencies may inspect and audit any financial records of the entity or its subcontractors. As used in this section, an

audit is an examination of the PIHP's, its affiliates', and its contract service providers' financial records, policies, contracts, and financial management practices, conducted by the MDCH Office of Audit or its agent, or by a federal agency or its agent, to verify the PIHP's compliance with legal and contractual requirements.

B. The MDCH will schedule MDCH audits at mutually acceptable start dates to the extent possible. The MDCH will provide the PIHP with a list of documents to be audited at least 30 days prior to the date of the audit. An entrance meeting will be conducted with the PIHP to review the nature and scope of the audit.

C. MDCH audits of PIHPs will generally include the following (3) objectives (The MDCH may, however, modify their audit objectives as deemed necessary):

1. to assess the PIHP's effectiveness and efficiency in complying with the contract and establishing and implementing specific policies and procedures as required by the contract; and

2. to assess the PIHP's effectiveness and efficiency in reporting their financial activity to the MDCH in accordance with contractual requirements; applicable federal, state, and local statutory requirements; ABW regulations; and applicable accounting standards; and

3. to determine the MDCH's share of costs in accordance with applicable MDCH requirements and agreements, and any balance due to/from the PIHP.

To accomplish the above listed audit objectives, MDCH auditors will review PIHP documentation, interview PIHP staff members, and perform other audit procedures as deemed necessary.

D. The audit report and appeal process is identified in Attachment P9.3.2.2 and is a part of this contract.

As used in this section, an audit is an examination of the PIHP and their contract service providers' financial records, policies, contracts, and financial management practices, conducted by the MDCH Office of Audit or its agent, to verify the PIHP's compliance with legal and contractual requirements.

A. The MDCH will schedule audits at mutually acceptable start dates to the extent possible. The MDCH will provide the PIHP with a list of documents to be audited at least 30 days prior to the date of the audit. An entrance meeting will be conducted with the PIHP to review the nature and scope of the audit.

B. The MDCH audits of PIHPs will generally supplement the independent auditor's Compliance Examination and may include one or more of the following objectives:

1. To assess the PIHP's effectiveness and efficiency in complying with the contract, and establishing and implementing specific policies and procedures as required by the contract;
2. To assess the PIHP's effectiveness and efficiency in reporting their financial activity to the MDCH in accordance with contractual requirements; applicable federal, state, and local statutory requirements; ABW regulations; and applicable accounting standards; and
3. To determine the MDCH's share of costs in accordance with applicable MDCH requirements and agreements, and any balance due to/from the PIHP.

To accomplish the above listed audit objectives, MDCH auditors will review PIHP documentation, interview PIHP staff members, and perform other audit procedures as deemed necessary.

C. The audit report and appeal process is identified in Attachment P 9.3.2.2 and is a part of this contract.

10.0 RESPONSIBILITIES OF THE DEPARTMENT OF ATTORNEY GENERAL

The MDCH has responsibility and authority to make all fraud and/or abuse referrals to the Office of the Attorney General, Health Care Fraud Division. Contractors who have any suspicion or knowledge of fraud and/or abuse within any of the MDCH's programs must report directly to the MDCH by calling 866-428-0005 or by sending a memo to:

Program Investigations Section
Capitol Commons Center Building
400 S. Pine, 6th Floor
Lansing, MI 48909

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

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

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

In addition, the PIHP must report the following to the MDCH on an annual basis:

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

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

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION
Technical Requirement
For Behavior Treatment Plan Review Committees
Revision FY'12

Application:

Prepaid Inpatient Health Plans (PIHPs)
Community Mental Health Services Programs (CMHSPs)
Public mental health service providers

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

Preamble:

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

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

- Adheres to any legal psychiatric advance directive that is present for an adult with serious mental illness;
- Employs positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches;
- Considers other kinds of behavior treatment or interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions, if positive behavior supports and interventions are documented to be unsuccessful; or

- As a last resort, when there is documentation that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee.

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

I. POLICY

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

II. DEFINITIONS

Aversive Techniques: Those techniques that require the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or stimuli that would have a specific unpleasant effect on a particular person) to achieve the management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating target behavior. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g., exposure therapy for anxiety, masturbatory satiation for paraphilias) are not considered aversive for purposes of this technical requirement. Otherwise, use of aversive techniques is **prohibited.**

Consent: a written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.

Functional Behavioral Assessment (FBA): an approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a

particular behavior and guide the development of an effective and efficient behavior plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the behavior itself so that a new behavior or skill will be substituted to provide the same function or meet the identified need. Functional assessments should also identify situations and events that precede positive behavior to provide more information for a positive behavior support plan.

Emergency Interventions: There are only two emergency interventions approved by MDCH for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention. Each agency is shall have protocols specifying what physical management techniques are approved for use.

Imminent Risk: an event/action that is about to occur that will likely result in the potential harm to self or others.

Intrusive Techniques: Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage, control or extinguish an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. se of intrusive techniques as defined here requires the review and approval by the Committee.

Physical Management: A technique used by staff as an emergency intervention to restrict the movement of an individual by continued direct physical contact in spite of the individual's resistance in order to prevent him or her from physically harming himself, herself, or others. Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. The following are examples to further clarify the definition of physical management:

- Manually guiding down the hand/fists of an individual who is striking his or her own face repeatedly causing risk of harm IS considered physical management if he or she resists the physical contact and continues to try and strike him or herself. However, it IS NOT physical management if the individual stops the behavior without resistance.

- When a caregiver places his hands on an individual's biceps to prevent him or her from running out the door and the individual resists and continues to try and get out the door, it IS considered physical management. However, if the individual no longer attempts to run out the door, it is NOT considered physical management.

Physical management involving prone immobilization of an individual, as well as any physical management that restricts a person's respiratory process, for behavioral control purposes is **prohibited under any circumstances.** Prone immobilization is extended physical management of an individual in a prone (face down) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position.

Positive Behavior Support: A set of research-based strategies used to increase opportunities for an enhanced *quality of life* and decrease seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, property destruction, and pica. Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

Practice or Treatment Guidelines: Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.

Proactive Strategies in a Culture of Gentleness: strategies within a Positive Behavior Support Plan used to prevent seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm from occurring, or for reducing their frequency, intensity, or duration. Supporting individuals in a culture of gentleness is an ongoing process that requires patience and consistency. As such, no precise strategy can be applied to all situations. Some examples of proactive strategies include: unconditional valuing, precursor behaviors, redirection, stimulus control, and validating feelings. See the [prevention guide] for a full list of proactive strategies and definitions.

Reactive Strategies in a Culture of Gentleness: strategies within a Positive Behavior Support Plan used to respond when individuals begin feeling unsafe, insecure, anxious or frustrated. Some examples of reactive strategies include: reducing demanding interactions, increasing warm interactions, redirection, giving space, and blocking. See the [prevention guide] for a full list of reactive strategies and definitions.

Request for Law Enforcement Intervention: calling 911 and requesting law enforcement assistance as a result of an individual exhibiting a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance **only when**: caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

Restraint: the use of a physical or mechanical device to restrict an individual's movement at the order of a physician. The use of physical or mechanical devices used as restraint is **prohibited** except in a state-operated facility or a licensed hospital. This definition excludes:

- Anatomical or physical supports that are ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving an individual's physical functioning

- Protective devices which are defined as devices or physical barriers to prevent the individual from causing serious self-injury associated with documented and frequent incidents of the behavior and which are incorporated in the written individual plan of services through a behavior treatment plan which has been reviewed and approved by the Committee and received special consent from the individual or his/her legal representative.

- Medical restraint, i.e. the use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.

- Safety devices required by law, such as car seat belts or child car seats used while riding in vehicles.

Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm, include: limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.

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

Special Consent: Obtaining the written consent of the individual, the legal guardian, the parent with legal custody of a minor child, or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the individual, guardian or parent of a minor may only occur when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.

III. COMMITTEE STANDARDS

A. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. A psychiatric hospital, psychiatric unit or psychiatric partial hospitalization program licensed under 1974 PA 258, MCL 330.1137, that receives public funds under contract with the CMHSP and does not have its own Committee must also have access to and use of the services of the CMHSP Committee regarding a behavior treatment plan for an individual receiving services from that CMHSP. If the CMHSP delegates the functions of the Committee to a contracted mental health service provider, the CMHSP must monitor that Committee to assure compliance with this Technical Requirement.
B. The Committee shall be comprised of at least three individuals, one of whom shall be a licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Mental Health and Substance Abuse Chapter, with the specified training; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

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

D. The Committee shall meet as often as needed.

E. Expedited Review of Proposed Behavior Treatment Plans:

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

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

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

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

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

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

H. The functions of the Committee shall be to:
   1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
   2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques [see definitions].
   3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately

pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.

4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.5. Assure that inquiry has been made about any known medical, psychological or other factors that the individual has, which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.

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

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

I. On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
   1. Dates and numbers of interventions used.
   2. The settings (e.g., individual's home or work) where behaviors and interventions occurred
   3. Observations about any events, settings, or factors that may have triggered the behavior.
   4. Behaviors that initiated the techniques.
   5. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
   6. Description of positive behavioral supports used.

7. Behaviors that resulted in termination of the interventions.
8. Length of time of each intervention.
9. Staff development and training and supervisory guidance to reduce the use of these interventions.
10. Review and modification or development, if needed, of the individual's behavior plan.

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

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

IV. BEHAVIOR TREATMENT PLAN STANDARDS

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

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

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

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

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

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

Legal References

1997 federal Balanced Budget Act at 42 CFR 438.100
MCL 330.1712, Michigan Mental Health Code
MCL 330.1740, Michigan Mental Health Code
MCL 330.1742, Michigan Mental Health Code
MDCH Administrative Rule 7001(l)
MDCH Administrative Rule 7001(r)
Department of Community Health Administrative Rule 330.7199(2)(g)

PREPAID INPATIENT HEALTH PLANS AND COMMUNITY MENTAL HEALTH SERVICES PROGRAMS

ACCESS SYSTEM STANDARDS

Revised: October, 2011

Preamble

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

Functions

The key functions of an access system are to:

1. **Welcome** all individuals by demonstrating empathy and providing opportunity for the person presenting to describe situation, problems and functioning difficulties, exhibiting excellent customer service skills, and working with them in a non-judgmental way.
2. **Screen** individuals who approach the access system to determine whether they are in crisis and, if so, assure that they receive timely, appropriate attention.
3. **Determine** individuals' eligibility for Medicaid specialty services and supports, Adult Benefit Waiver (ABW), MIChild or, for those who do not have any of

these benefits as a person whose presenting needs for mental health services make them a priority to be served.

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

STANDARDS

These standards apply to all PIHPs and CMHSPs, whether the access system functions are directly provided by the PIHP or CMHSP, or are 'delegated' in whole or in part to a subcontract provider(s). Hereinafter, the above entities are referred to as "the organization." These standards provide the framework to address all populations that may seek out or request services of a PIHP or CMHSP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorder. For individuals with substance use disorders, the Access Management Standards for Substance Use Disorder Services shall apply for access to substance use disorder treatment. Access Management Standards for Substance Use Disorder Services can be found at:
http://www.michigan.gov/documents/mdch/Policy_Tx_07_AMS_183337_7.pdf

I. WELCOMING

a. The organization's access system services shall be available to all residents of the state of Michigan, regardless of where the person lives, or where he/she contacts the system. Staff shall be welcoming, accepting and helping with all applicants for service[1].
b. The access system shall operate or arrange for an access line that is available 24 hours per day, seven days per week; including in-person and by-telephone access for hearing impaired individuals. Telephone lines are toll-free; accommodate Limited English Proficiency (LEP); are accessible for individuals with hearing impairments; and have electronic caller identification, if locally available[2].
    i. Callers encounter no telephone "trees," and are not put on hold or sent to voicemail until they have spoken with a live representative from the access system and it is determined, following an

[1] MDCH Specialty Pre-Paid Health Plan 2002 Application for Participation (AFP), Section 3.1
[2] 42 CFR § 438.10 and 438.206. Michigan Mental Health Code, P.A. 258 of 1974 (MHC) §330.1206. MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.2. MDCH AFP, Section 3.1.8

empathetic opportunity for the caller to express their situation and circumstances, that their situation is not urgent or emergent.

ii. All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back.

iii. For non-emergent calls, a person's time on-hold awaiting a screening must not exceed **three minutes** without being offered an option for callback or talking with a non-professional in the interim.

iv. All non-emergent callbacks must occur within **one business day** of initial contact.

v. For organizations with decentralized access systems, there must be a mechanism in place to forward the call to the appropriate access portal without the individual having to re-dial.

c. The access system shall provide a timely, effective response to all individuals who walk in.

i. For individuals who walk in with urgent or emergent needs[3], an intervention shall be immediately initiated.

ii. Those individuals with routine needs must be screened or other arrangements made within **thirty minutes**.

iii. **It is expected that the Access Center/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.**

d. The access system shall maintain the capacity to immediately accommodate individuals who present with:

i. LEP and other linguistic needs

ii. Diverse cultural and demographic backgrounds

iii. Visual impairments

iv. Alternative needs for communication

v. Mobility challenges[4]

e. The access system shall address financial considerations, including county of financial responsibility as a secondary administrative concern, only after any urgent or emergent needs of the person are addressed. Access system screening and crisis intervention shall never require prior authorization; nor shall access system screening and referral ever require any financial contribution from the person being served[5].

f. The access system shall provide applicants with a summary of-their rights guaranteed by the Michigan Mental Health Code, including information about their rights to the person-centered planning process and assure that they have access to the pre-planning process as soon as the screening and coverage determination processes have been completed[6].

[3] For definition of emergent and urgent situations, see MHC §330.1100a and 1100d
[4] 42 CFR § 438.10. MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.2. MDCH AFP, Section 3.1.8
[5] 42 CFR §438.114
[6] MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.1 and Attachment 3.4.1.1; MCL 330.1706

II. SCREENING FOR CRISES

a. Access system staff shall first determine whether the presenting mental health need is urgent, emergent or routine and, if so, will address emergent and urgent need first. To assure understanding of the problem from the point of view of the person who is seeking help, methods for determining urgent or emergent situations must incorporate "caller or client-defined" crisis situations. Workers must be able to demonstrate empathy as a key customer service method.

b. The organization shall have emergency intervention services with sufficient capacity to provide clinical evaluation of the problem; to provide appropriate intervention; and to make timely disposition to admit to inpatient care or refer to outpatient services[7]. The organization may use: telephonic crisis intervention counseling, face-to-face crisis assessment, mobile crisis team, and dispatching staff to the emergency room, as appropriate. The access system shall perform or arrange for inpatient assessment and admission, or alternative hospital admissions placements, or immediate linkage to a crisis practitioner for stabilization, as applicable[8].

c. The access system shall inquire as to the existence of any established medical or psychiatric advance directives relevant to the provision of services[9].

d. The organization shall assure coverage and provision of post stabilization services for Medicaid beneficiaries once their crises are stabilized[10]. Individuals who are not Medicaid beneficiaries, but who need mental health services and supports following crisis stabilization, shall be referred back to the access system for assistance.

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

a. The organization shall ensure access to public mental health services in accordance with the MDCH/PIHP and MDCH/CMHSP contracts[11] and:

   i. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the individual is a Medicaid beneficiary.

   ii. The Adult Benefits Waiver (ABW) Chapter of the Medicaid Provider Manual, if the individual is an ABW beneficiary.

   iii. The MIChild Provider Manual if the individual is a MIChild beneficiary.

   iv. The Michigan Mental Health Code and the MDCH Administrative Rules, if the individual is not eligible for Medicaid, ABW or MIChild[12]. CMHSPs shall serve individuals with serious mental

[7] MDCH Administrative Rule 330.2006
[8] MHC § 330.1206 and 1409
[9] 42 CFR §438.6; MCL 700.5501 et seq
[10] 42 CFR §438.114. MDCH/PIHP Contract, Part I, Section 1
[11] MDCH/PIHP & CMHSP Contracts, Part II, Section 3
[12] MHC §330.1208

illness, serious emotional disturbance and developmental disabilities, giving priority to those with the most serious forms of illness and those in urgent and emergent situations. Once the needs of these individuals have been addressed, MDCH expects that individuals with other diagnoses of mental disorders with a diagnosis found in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM)[13], will be served based upon agency priorities and within the funding available..

b. The responsible organization shall ensure access to public substance abuse treatment services in accordance with the MDCH/PIHP and MDCH/Substance Abuse Coordinating Agency (CA) contracts[14] and:
    i. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the individual is a Medicaid beneficiary.
    ii. The Adult Benefits Waiver Chapter of the Medicaid Provider Manual, if the individual is an ABW beneficiary.
    iii. The MIChild Provider Manual if the individual is a MIChild beneficiary.
    iv. The priorities established in the Michigan Public Health Code, if the individual is not eligible for Medicaid, ABW or MIChild[15].
c. The organization shall ensure that screening tools and admission criteria are based on eligibility criteria in parts III.a. and III.b. above, and are valid, reliable, and uniformly administered[16].
d. The organization shall be capable of providing the Early Periodic Screening, Diagnostic and Treatment (EPSDT) corrective or ameliorative services that are required by the MDCH/PIHP specialty services and supports contract[17].
e. When clinical screening is conducted, the access system shall provide a written (hard copy or electronic) screening decision of the person's eligibility for admission based upon established admission criteria. The written decision shall include:
    i. Identification of presenting problem(s) and need for services and supports.
    ii. Initial identification of population group (DD, MI, SED, or SUD) that qualifies the person for public mental health and substance use disorder services and supports.
    iii. Legal eligibility and priority criteria (where applicable).
    iv. Documentation of any emergent or urgent needs and how they were immediately linked for crisis service.

[13] The **Diagnostic and Statistical Manual of Mental Disorders** (**DSM**) is an American handbook for mental health professionals that lists different categories of mental disorders and the criteria for diagnosing them, according to the publishing organization the American Psychiatric Association
[14] MDCH/CA contract, Attachment A, Statement of Work, and Attachment E, Methadone Enrollment Criteria and Access Management Policy
[15] Public Health Code P.A. 368 of 1978 §333.6100 and 6200 and MDCH Administrative Rule 325.14101
[16] MDCH AFP, Section 3.1.5
[17] MDCH/PIHP Contract, Part II, Section 3.4.3. Michigan Medicaid Provider Manual, Practitioner Chapter

v. Identification of screening disposition.
vi. Rationale for system admission or denial.

f. The access system shall identify and document any third-party payer source(s) for linkage to an appropriate referral source, either in network, or out-of-network.
g. The organization shall not deny an eligible individual a service because of individual/family income or third-party payer source[18].
h. The access system shall document the referral outcome and source, either in-network or out-of-network.
i. The access system shall document when a person with mental health needs, but who is not eligible for Medicaid, ABW or MIChild, is placed on a 'waiting list' and why[19].
j. The organization shall assure that an individual who has been discharged back into the community from outpatient services, and is requesting entrance back into the PIHP/CMHSP or provider, within one year, will not have to back through the duplicative screening process. They shall be triaged for presenting mental health needs per urgent, emergent or routine.

IV. COLLECTING INFORMATION

a. The access system shall avoid duplication of screening and assessments by using assessments already performed or by forwarding information gathered during the screening process to the provider receiving the referral, in accordance with applicable federal/state confidentiality guidelines (e.g. 42 CFR Part 2 for substance use disorders).
b. The access system shall have procedures for coordinating information between internal and external providers, including Medicaid Health Plans and primary care physicians[20].

V. REFERRAL TO PIHP or CMHSP PRACTITIONERS

a. The access system shall assure that applicants are offered appointments for assessments with mental health professionals of their choice within the MDCH/PIHP and CMHSP contract-required standard timeframes[21]. Staff follows up to ensure the appointment occurred.
b. The access system shall ensure that, at the completion of the screening and coverage determination process, individuals who are accepted for services have access to the person-centered planning process[22].
c. The access system shall ensure that the referral of individuals with co-occurring mental illness and substance use disorders to PIHP or CMHSP

[18] MHC §330.1208
[19] MHC §330.1226
[20] 42 CFR §438.208
[21] Choice of providers: 42 CFR §438.52. MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.4. Timeframes for access: Section 3.1
[22] MDCH AFP, Section 3.2. MDCH/PIHP & CMHSP Contracts, Part II, Section 3.4.1 and Attachment 3.4.1.1

or other practitioners must be in compliance with confidentiality requirements of 42 CFR.

VI. REFERRAL TO COMMUNITY RESOURCES

a. The access system shall refer Medicaid beneficiaries who request mental health services, but do not meet eligibility for specialty supports and services, to their Medicaid Health Plans[23] or Medicaid fee-for-service providers.
b. The access system shall refer individuals who request mental health or substance abuse services but who are neither eligible for Medicaid, ABW, or MIChild mental health and substance abuse services, nor who meet the priority population to be served criteria in the Michigan Mental Health Code or the Michigan Public Health Code for substance abuse services, to alternative mental health or substance abuse treatment services available in the community.
c. The access system shall provide information about other non-mental health community resources or services that are not the responsibility of the public mental health system to individuals who request it[24].

VII. INFORMING INDIVIDUALS

a. **General**
    i. The access system shall provide information about, and help people connect as needed with, the organization's Customer Services Unit, peer supports specialists and family advocates; and local community resources, such as: transportation services, prevention programs, local community advocacy groups, self-help groups, service recipient groups, and other avenues of support, as appropriate[25].
b. **Rights**
    i. The access system shall provide Medicaid, ABW and MIChild beneficiaries information about the local dispute resolution process and the state Medicaid Fair Hearing process[26]. When an individual is determined ineligible for Medicaid specialty service and supports, ABW or MIChild mental health services, he/she is notified both verbally and in-writing of the right to request a second opinion; and/or file an appeal through the local dispute resolution process; and/or request a state Fair Hearing.
    ii. The access system shall provide individuals with mental health needs or persons with co-occurring substance use/mental illness with information regarding the local community mental health Office of Recipient Rights (ORR)[27]. The access system shall

[23] 42 CFR §438.10
[24] MDCH AFP, Section 2.9
[25] MDCH AFP, Section 2.9
[26] 42 CFR § 438.10. MDCH/PIHP Contract, Part II, Section 6.3.2 and Attachment 6.3.2.1
[27] MHC §330.1706

provide individuals with substance use disorders, or persons with co-occurring substance use/mental illness with information regarding the local substance abuse coordinating Office of Recipient Rights[28].

iii. When an individual with mental health needs who is not a Medicaid beneficiary is denied community mental health services, for whatever reason, he/she is notified of the right under the Mental Health Code to request a second opinion and the local dispute resolution process[29].

iv. The access system shall schedule and provide for a timely second opinion, when requested, from a qualified health care professional within the network, or arrange for the person to obtain one outside the network at no cost. The person has the right to a face-to-face determination, if requested[30].

v. The access system shall ensure the person and any referral source (with the person's consent) are informed of the reasons for denial, and shall recommend alternative services and supports or disposition[31].

c. **Services and Providers Available**

i. The access system shall assure that applicants are provided comprehensive and up-to-date information about the mental health and substance abuse services that are available and the providers who deliver them[32].

ii. The access system shall assure that there are available alternative methods for providing the information to individuals who are unable to read or understand written material, or who have LEP[33].

VIII. ADMINISTRATIVE FUNCTIONS

a. The organization shall have written policies, procedures and plans that demonstrate the capability of its access system to meet the standards herein.

b. Community Outreach and Resources

i. The organization shall have an active outreach and education effort to ensure the network providers and the community are aware of the access system and how to use it.

ii. The organization shall have a regular and consistent outreach effort to commonly un-served or underserved populations who include children and families, older adults, homeless persons, members of

[28] MDCH Administrative Rule 325.14302
[29] MHC §330.1706, MDCH/CMHSP Contract, Part II, Attachment 6.3.2.1
[30] MDCH/PIHP & CMHSP Contract, Part II, Section 3.4.5
[31] 42 CFR § 438.10
[32] 42 CFR § 438.10, MDCH/PIHP Contract, Part II, Section 6.3.3. MDCH AFP, Section 3.1.1
[33] 42 CFR § 438.10, MDCH/PIHP Contract, Part II, Section 6.3.3

ethnic, racial, linguistic and culturally-diverse groups, persons with dementia, and pregnant women.[34]

iii. The organization shall assure that the access system staff are informed about, and routinely refer individuals to, community resources that not only include alternatives to public mental health or substance abuse treatment services, but also resources that may help them meet their other basic needs.

iv. The organization shall maintain linkages with the community's crisis/emergency system, liaison with local law enforcement, and have a protocol for jail diversion.

c. Oversight and Monitoring

i. The organization's Medical Director shall be involved in the review and oversight of access system policies and clinical practices.

ii. The organization shall assure that the access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, MIChild Provider Manual, the Michigan Mental Health Code, the Michigan Public Health Code, and this contract[35].

iii. The organization shall have mechanisms to prevent conflict of interest between the coverage determination function and access to, or authorization of, services.

iv. The organization shall monitor provider capacity to accept new individuals, and be aware of any provider organizations not accepting referrals at any point in time[36].

v. The organization shall routinely measure telephone answering rates, call abandonment rates and timeliness of appointments and referrals. Any resulting performance issues are addressed through the organization's Quality Improvement Plan.

vi. The organization shall assure that the access system maintains medical records in compliance with state and federal standards[37].

vii. The organization staff shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation[38].

d. Waiting Lists

i. The organization shall have policies and procedures for maintaining a waiting list for individuals not eligible for Medicaid, ABW or MIChild, and who request community mental health

[34] MDCH AFP, Section 3.1.2
[35] 42 CFR §438.214. MDCH/PIHP Contract, Part II, Attachment 6.7.1.1
[36] 42 CFR §438.10
[37] Michigan Medicaid Provider Manual, General Information Chapter, Section 13.1
[38] MDCH AFP, Section 3.1.10

services but cannot be immediately served[39]. The policies and procedures shall minimally assure:

1. No Medicaid, ABW and MIChild beneficiaries are placed on waiting lists for any medically necessary Medicaid, ABW or MIChild service.
2. A local waiting list shall be established and maintained when the CMHSP is unable to financially meet requests for public mental health services received from those who are not eligible for Medicaid, ABW, or MIChild[40]. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
3. Persons who are not eligible for Medicaid, ABW, or MIChild, who receive services on an interim basis that are other than those requested shall be retained on the waiting list for the specific requested program services. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
4. Use of a defined process, consistent with the Mental Health Code, to prioritize any service applicants and recipients on its waiting list.
5. Use of a defined process to contact and follow-up with any individual on a waiting list who is awaiting a mental health service.
6. Reporting, as applicable, of waiting list data to MDCH as part of its annual program plan submission report in accordance with the requirements of the Mental Health Code.

[39] MHC §330.1124
[40] MHC §330.1208

Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Person-Centered Planning Policy and Practice Guideline
3/15/2011

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

I. Introduction

A. Summary/Background

The purpose of the community mental health system is to support adults and children with developmental disabilities, adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance to live successfully in their communities—achieving community inclusion and participation, independence, and productivity. Person-centered planning (PCP) enables individuals to achieve their personally defined outcomes. As described below, PCP for minors (family-driven and youth-guided practice) accommodates the entire family.

Person-centered planning is a way for individuals to plan their lives with the support and input from those who care about them. The process is used for planning the life that the individual aspires to have—taking the individual's goals, hopes, strengths, and preferences and weaving them in plans for a life with meaning. PCP is used anytime an individual's goals, desires, circumstances, preferences, or needs change.

Through the PCP process, an individual and those who support him or her:

a. Focus on the individual's life goals, interests, desires, preferences, strengths and abilities as the foundation for the planning process.
b. Identify outcomes based on the individual's life goals, interests, strengths, abilities, desires and preferences.
c. Make plans for the individual to work toward and achieve identified outcomes.
d. Determine the services and supports the individual needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.

e. Develop an Individual Plan of Service (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

Meaningful PCP is at the heart of supporting individual choice and control. Person-centered planning focuses on the goals, interests, desires and preferences of the individual, while still exploring and addressing an individual's needs within an array of established life domains (including, but not limited to those listed in the Michigan Mental Health Code (the Code): the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation). As appropriate for the individual, the PCP process may involve other MDCH policies and initiatives including, but limited to, Recovery, Self-Determination, Culture of Gentleness, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning.

PCP focuses on services and supports necessary (including medically necessary services and supports funded by the CMHSP) for the individual to work toward and achieve their personal goals rather than being limited to authorizing the individual to receive existing programs.

For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach (see the MDCH Family-Driven and Youth-Guided Policy and Practice Guideline). A family-driven, youth-guided approach recognizes the importance of family in the lives of children and that supports and services impact the entire family. In the case of minor children, the child/family is the focus of planning and family members are integral to success of the planning process. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the individual reaches adulthood, his or her needs and goals become primary.

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

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

exclusion of parents shall be documented in the clinical record.

B. Michigan Mental Health Code—Definition

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

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

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

C. PCP Values and Principles

Person-centered planning is a highly individualized process designed to respond to the expressed needs/desires of the individual.

- Every individual is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community.

- Every individual has strengths, can express preferences, and can make choices.

- The individual's choices and preferences are honored and considered, if not always implemented.

- Every individual contributes to his or her community, and has the ability to choose how supports and services enable him or her to meaningfully participate and contribute.

- Through the person-centered planning process, an individual maximizes independence, creates community connections, and works towards achieving his or her chosen outcomes.

- An individual's cultural background is recognized and valued in the person-centered planning process.

D. Implementation of Person-Centered Planning

While the Code requires that PCP be used to develop an Individual Plan of Service (IPOS) that includes community mental health services and supports, the purpose of person-centered planning is a process for an individual to define the life that he or she wants and what components need to be in place for the individual to have, work toward or achieve that life. Depending on the individual, community mental health services and supports may play a small or large role in supporting an him or her in having the life he or she wants. When an individual is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life the he or she desires to have.

Individuals are going to be at different points in the process of achieving the life to which they aspire and the PCP process should be individualized to meet the needs of the individual for whom planning is done, e.g. meeting an individual where he or she is. Some people may be just beginning to define the life they want and initially the PCP process may be lengthy as the individual's goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once this initial work is completed, it does not need to be redone unless so desired by the individual. Once an IPOS is developed, subsequent use of the planning process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent that the IPOS is updated will be determined by the needs and desires of the individual. If and when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs and desires of the individual when he or she has them.

II. Essential Elements for Person-Centered Planning

The following characteristics are essential to the successful use of the PCP process with an individual and his/her allies.

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

2. **Person-Centered.** The planning process focuses on the individual, not the system or the individual's family, guardian, or friends. The individual's goals, interests, desires, and preferences are identified with an optimistic view of the future and plans for a satisfying life. The planning process is used whenever the individual wants or needs it, rather than viewed as an annual event.

3. **Outcome-Based.** Outcomes in pursuit of the individual's preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.

4. **Information, Support and Accommodations.** As needed, the individual receives comprehensive and unbiased information on the array of mental health services, community resources, and available providers. Support and accommodations to assist the individual to participate in the process are provided.

5. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process. See Section III below

6. **Pre-Planning.** The purpose of pre-planning is for the individual to gather all of the information and resources (e.g. people, agencies) necessary for effective person-centered planning and set the agenda for the process. Each individual (except for those individuals who receive short-term outpatient therapy only, medication only, or those who are incarcerated) is entitled to use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used

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

a. When and where the meeting will be held,
b. Who will be invited (including whether the individual has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support),
c. What will be discussed and not discussed,
d. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication),
e. Who will facilitate the meeting,
f. Who will record what is discussed at the meeting.

7. **Wellness and Well-Being.** Issues of wellness, well-being, health and primary care coordination or integration, supports needed for an individual to continue to live independently as he or she desires, and other concerns specific to the individual's personal health goals or support needed for the individual to live the way they want to live are discussed and plans to address them are developed. If so desired by the individual, these issues can be addressed outside of the PCP meeting.

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

III. Independent (External) Facilitation

In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator of the person-centered planning process, unless the individual is receiving short-term outpatient therapy or medication only. The CMHSP must make available a choice of at least two independent facilitators to individuals interested in using independent facilitation. The facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The facilitator helps the individual with the pre-planning activities and co-leads any PCP meeting(s) with the individual.

The independent facilitator must not have any other role within the CMHSP. The independent facilitator must personally know or get to know the individual who is the focus of the planning including what he or she likes and dislikes as well as personal preferences, goals, modes of communication, and who supports or is important to the individual. The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called "Treatment Planning" MPM MH&SAA Chapter, Section 3.25. If the independent facilitator is paid for the provision of these activities, the PIHP may report the service under the code H0032. It is advisable that the CMHSP support independent facilitators in obtaining training in PCP, regardless of whether the independent facilitator is paid or unpaid.

IV. Individual Plan of Service

The Code establishes the right for all individuals to develop individual plans of services (IPOS) through a person-centered planning process regardless of disability or residential setting. However, an IPOS needs to be more than the services and supports authorized by the community mental health system; it must include all of the components described below. The PCP process must be used at any time the individual wants or needs to use the process. The agenda for each PCP meeting should be set by the individual through the pre-planning process, not by agency or by the fields or categories in a form or an electronic medical record

Once an individual has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the individual's needs, changes in the individual's condition as determined through the PCP process or changes in the individual's preferences for support). Assessment may be used to inform the PCP process, but is not a substitute for the process.

The individual and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. An individual or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually through the PCP process to review progress toward goals and objectives and to assess beneficiary satisfaction. Reviews will work from the existing plan to amend or update it as circumstances, needs, preferences or goals change or to develop a completely new plan if so desired by the individual. Use of the PCP process in the review of the plan incorporates all of the Essential Elements as desired by the individual.

The individual decides who will take notes or minutes about what is discussed during the person-centered planning process. In addition, documentation maintained by the CMHSP within the Individual Plan of Service must include:

(1) A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports;
(2) The outcomes identified by the individual and how progress toward achieving those outcomes will be measured;
(3) The services and supports needed by the individual to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports;
(4) The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.
(5) The estimated/prospective cost of services and supports authorized by the community mental health system.
(6) The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.
(7) Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

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

V. Organizational Standards

The following characteristics are essential for organizations responsible for providing supports and services through PCP:

- Individual Awareness and Knowledge—The organization provides accessible and easily understood information, support and when necessary, training, to individuals using services and supports and those who assist them so that they are aware of their right to PCP, the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).
- Person-Centered Culture–The organization provides leadership, policy direction, and activities for implementing person-centered planning at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.

- Training—The organization has a process to identify and train staff at all levels on the philosophy of PCP. Staff who are directly involved in PCP are provided with additional training.
- Roles and Responsibilities—As an individualized process, PCP allows each individual to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.
- Quality Management—The QA/QM System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful person-centered planning. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and standards are in place to assure support the individual directs the PCP process and ensures that PCP is consistently done well.

VI. Dispute Resolution

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). Other options are available to all recipients of Michigan mental health services and supports. Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate dispute resolution processes.

ABW PIHP CUSTOMER SERVICES STANDARDS
Revised: October, 2012

Preamble

It is the function of the customer services unit to be the front door of the pre-paid inpatient health plan (PIHP), and to convey an atmosphere that is welcoming, helpful and informative*. *These standards apply to the PIHP and to any entity to which the PIHP has delegated the customer services function, including affiliate CMHSP(s), substance abuse coordinating agency (CA), or provider network.

Functions

A. Welcome and orient individuals to services and benefits available, and the provider network.
B. Provide information about how to access mental health, primary health, and other community services.
C. Provide information about how to access the various rights processes.
D. Help individuals with problems and inquiries regarding benefits.
E. Assist people with and oversee local complaint and grievance processes.
F. Track and report patterns of problem areas for the organization.

Standards

1. There shall be a designated unit called “Customer Services.”
2. There shall be at the PIHP a minimum of one FTE (full time equivalent) performing the customer services functions whether within the customer service unit or elsewhere within the PIHP. If the function is delegated, affiliate CMHSPs, substance abuse coordinating agencies and network providers, as applicable, shall have additional FTEs (or fractions thereof) as appropriate to sufficiently meet the needs of the people in the service area.
3. There shall be a designated toll-free customer services telephone line with access to alternative telephonic communication methods (such as Relays, TTY, etc). The customer services numbers shall be displayed in agency brochures and public information material.
4. Telephone calls to the customer services unit shall be answered by a live voice during business hours. Telephone menus are not acceptable. A variety of alternatives may be employed to triage high volumes of calls as long as there is response to each call within one business day.
5. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized. **It is expected that the customer services/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.**
6. The customer handbook shall contain the state-required topics (See P.6.3.1.1.A)
7. The Medicaid coverage name and the state’s description of each service shall be printed in the customer handbook.
8. The customer handbook shall contain a date of publication and revision(s).
9. Affiliate CMHSP, substance abuse coordinating agency, or network provider names, addresses, phone numbers, TTYs, E-mails, and web addresses, as well

as whether the provider speaks any non-English language and if they are accepting new patients, shall be contained in the customer handbook.

10. Information about how to contact the Medicaid Health Plans or Medicaid fee-for-service programs in the PIHP service area, including plan or program name, locations, and telephone numbers, shall be provided in the handbook.
11. Customer services unit shall maintain current listings of all providers, both organizations and practitioners, with whom the PIHP has contracts, the services they provide, any non-English languages they speak, any specialty for which they are known, and whether they are accepting new patients. This list must include independent PCP facilitators. Beneficiaries shall be given this list annually unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer services line is acceptable.
12. Customer services unit shall have access to information about the PIHP including each CMHSP affiliate annual report, current organizational chart, CMHSP board member list, meeting schedule and minutes. Customer services will provide this information in a timely manner to individuals upon their requests.
13. Upon request, the customer services unit shall assist beneficiaries with filing grievances and appeals, accessing local dispute resolution processes, and coordinate as appropriate with Fair Hearing Officers and the local Office of Recipient Rights.
14. Customer services staff shall be trained to welcome people to the public mental health system and to possess current working knowledge, or know where in the organization detailed information can be obtained in at least the following:
    a. *The populations served (serious mental illness, serious emotional disturbance, developmental disability and substance use disorder) and eligibility criteria for various benefits plans (e.g., Medicaid, Adult Benefit Waiver, MIChild)
    b. *Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services
    c. Person-centered planning
    d. Self-determination
    e. Recovery & Resiliency
    f. Peer Specialists
    g. *Grievance and appeals, Fair Hearings, local dispute resolution processes, and Recipient Rights
    h. Limited English Proficiency and cultural competency
    i. *Information and referral about Medicaid-covered services within the PIHP as well as outside to Medicaid Health Plans, Fee-for-Services practitioners, and Department of Human Services
    j. The organization of the Public Mental Health System
    k. Balanced Budget Act relative to the customer services functions and beneficiary rights and protections
    l. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies)
    m. Public Health Code (for substance abuse treatment recipients if not delegated to the substance abuse coordinating agency)

*Must have a working knowledge of these areas, as required by the Balanced Budget Act

PIHP CUSTOMER SERVICES HANDBOOK
REQUIRED STANDARD TOPICS
Revised: October 2012

Each pre-paid inpatient health plan (PIHP) must have a customer services handbook that is provided to Medicaid beneficiaries when they first come to service. Thereafter, PIHPs shall offer the most current version of the handbook annually at the time of person-centered planning, or sooner if substantial changes have been made to the handbook. The list below contains the topics that shall be in each PIHP's customer services handbook. The PIHP may determine the order of the topics as they appear in the handbook and may add more topics. In order that beneficiaries receive the same information no matter where they go in Michigan, the topics with asterisks (*) below must use the standard language templates contained in this requirement. PIHPs should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates. Information in the handbook should be easily understood, and accommodations available for helping beneficiaries understand the information. The information must be available in the prevalent non-English language(s) spoken in the PIHP's service area.

Per direction from the federal Centers for Medicare and Medicaid Services, MDCH must approve all customer services handbooks to assure compliance with the Balanced Budget Act. After initial approval, it is necessary to seek MDCH approval only when a PIHP makes significant changes (i.e., beyond new address or new providers) to the customer services handbook.

PIHP's are required to produce supplemental materials (inserts, stickers) to their handbooks if/when MDCH contractual requirements are updated so that a previously approved handbook continues to meet requirements. Supplemental materials must be provided to individuals with their copy of the customer services handbook.

*Must use boilerplate language in templates (attached)

<u>Topics Requiring Template Language</u> (not necessarily in this order)
*Confidentiality and family access to information
*Coordination of care
*Emergency and after-hours access to services
*Glossary
*Grievance and appeal
*Language accessibility/accommodation
*Payment for services
*Person-centered planning
*Recipient rights
*Recovery
*Service array, eligibility, medical necessity, & choice of providers in network
*Service authorization

<u>Other Required Topics</u> (not necessarily in this order)
Access process

Access to out-of-network services
Affiliate [for Detroit-Wayne, the MCPNs] the names, addresses and phone numbers of the following personnel:

- Executive director
- Medical director
- Recipient rights officer
- Customer services
- Emergency

Community resource list (and advocacy organizations)
Index
Right to information about PIHP operations (e.g., organizational chart, annual report)
Services not covered under contract
Welcome to PIHP
What is customer services and what it can do for the individual; hours of operation and process for obtaining customer assistance after hours?

Other Suggested Topics
Customer services phone number in the footer of each page
Safety information

Template #1: Confidentiality and Family Access to Information

You have the right to have information about your mental health treatment kept private. You also have the right to look at your own clinical records and add a formal statement about them if there is something with which you do not agree. Generally, information about you can only be given to others with your permission. However, there are times when your information is shared in order to coordinate your treatment or when it is required by law.

Family members have the right to provide information to [PIHP] about you. However, without a Release of Information signed by you, the [PIHP] may not give information about you to a family member. For minor children under the age of 18 years, parents/guardians are provided information about their child and must sign a release of information before information can be shared with others.

If you receive substance abuse services, you have rights related to confidentiality specific to substance abuse services.

> Under HIPAA (Health Insurance Portability and Accountability Act), you will be provided with an official Notice of Privacy Practices from your community mental health services program. This notice will tell you all the ways that information about you can be used or disclosed. It will also include a listing of your rights provided under HIPAA and how you can file a complaint if you feel your right to privacy has been violated.

If you feel your confidentiality rights have been violated, you can call the Recipient Rights Office where you get services.

[Note to PIHP: you may add additional information to this template]

Template #2: Coordination of Care

To improve the quality of services, [PIHP name] wants to coordinate your care with the medical provider who cares for your physical health. If you are also receiving substance abuse services, your mental health care should be coordinated with those services. Being able to coordinate with all providers involved in treating you improves your chances for recovery, relief of symptoms and improved functioning. Therefore, you are encouraged to sign a "Release of Information" so that information can be shared. If you do not have a medical doctor and need one, contact the [Customer Services Unit] and the staff will assist you in getting a medical provider.

[Note to PIHP: you may add additional information to this template]

Template #3: Emergency and After-Hours Access to Services

A "mental health emergency" is when a person is experiencing symptoms and behaviors that can reasonably be expected in the near future to lead him/her to harm self or another; or because of his/her inability to meet his/her basic needs he/she is at risk of harm; or the person's judgment is so impaired that he or she is unable to understand the need for treatment and that their condition is expected to result in harm to him/herself or another individual in the near future. You have the right to receive emergency services at any time, 24-hours a day, seven days a week, without prior authorization for payment of care.

If you have a mental health emergency, you should seek help right away. At any time during the day or night call:

[PIHP insert local emergency telephone numbers and place(s) to go for help]

Please **note: if you utilize a hospital emergency room, there may be health-care services provided** to you as part of the hospital treatment that you receive for which you may receive a bill and may be responsible for depending on your insurance status. These services may not be part of the PIHP emergency services you receive. Customer Services can answer questions about such bills.

Post-Stabilization Services
After you receive emergency mental health care and your condition is under control, you may receive mental health services to make sure your condition continues to stabilize and improve. Examples of post-stabilization services are crisis residential, case management, outpatient therapy, and/or medication reviews. Prior to the end of your emergency-level care, your local CMH will help you to coordinate your post-stabilization services.

Template #4: Glossary or Definition of Terms

MENTAL HEALTH GLOSSARY

Access: The entry point to the Prepaid Inpatient Health Plan (PIHP), sometimes called an "access center," where Medicaid beneficiaries call or go to request mental health services.

Adult Benefits Waiver: Michigan health care program for certain low-income adults who are not eligible for the Medicaid program. Contact the [Customer Services Unit] for more information. This is a narrowly defined benefit that does not entitle you to all of the services and supports described in this handbook. The ABW service array is specifically outlined later in this book.

Amount, Duration, and Scope: Terms to describe how much, how long, and in what ways the Medicaid services that are listed in a person's individual plan of service will be provided.

Beneficiary: An individual who is eligible for and enrolled in the Medicaid/ABWprogram in Michigan.

CA: An acronym for Substance Abuse Coordinating Agency. The CAs in Michigan manage services for people with substance use disorders.

CMHSP: An acronym for Community Mental Health Services Program. There are 46 CMHSPs in Michigan that provide services in their local areas to people with mental illness and developmental disabilities. May also be referred to as CMH.

Fair Hearing: A state level review of beneficiaries' disagreements with CMHSP, CA or PIHP denial, reduction, suspension or termination of Medicaid services. State administrative law judges who are independent of the Michigan Department of Community Health perform the reviews.

Deductible (or Spend-Down): A term used when individuals qualify for Medicaid coverage even though their countable incomes are higher than the usual Medicaid income standard. Under this process, the medical expenses that an individual incurs during a month are subtracted from the individual's income during that month. Once the individual's income has been reduced to a state-specified level, the individual qualifies for Medicaid benefits for the remainder of the month. Medicaid applications and deductible determinations are managed by the Michigan Department of Human Services – independent of the PIHP/CA service system.

Developmental Disability: Is defined by the Michigan Mental Health code as either of the following: (a) If applied to a person older than five years, a severe chronic condition that is attributable to a mental or physical impairment or both, and is manifested before the age of 22 years; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent

living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration; (b) 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 a developmental disability.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): This legislation is aimed, in part, at protecting the privacy and confidentially of patient information. “Patient” means any recipient of public or private health care, including mental health care, services.

MDCH: An acronym for Michigan Department of Community Health. This state department, located in Lansing, oversees public-funded services provided in local communities and state facilities to people with mental illness, developmental disabilities and substance use disorders.

Medically Necessary: A term used to describe one of the criteria that must be met in order for a beneficiary to receive Medicaid services. It means that the specific service is expected to help the beneficiary with his/her mental health, developmental disability or substance use (or any other medical) condition. Some services assess needs and some services help maintain or improve functioning. PIHP’s are unable to authorize (pay for) or provide services that are not determined as medically necessary for you.

Michigan Mental Health Code: The state law that governs public mental health services provided to adults and children with mental illness, serious emotional disturbance and developmental disabilities by local community mental health services programs and in state facilities.

MIChild: A Michigan health care program for low-income children who are not eligible for the Medicaid program. This is a limited benefit. Contact the [Customer Services Unit] for more information.

PIHP: An acronym for Prepaid Inpatient Health Plan. There are 18 PIHPs in Michigan that manage the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic areas. All 18 PIHPs are also community mental health services programs.

Recovery: A journey of healing and change allowing a person to live a meaningful life in a community of their choice, while working toward their full potential.

Resiliency: The ability to “bounce back.” This is a characteristic important to nurture in children with serious emotional disturbance and their families. It refers to the individual’s ability to become successful despite challenges they may face throughout their life.

Specialty Supports and Services: A term that means Medicaid-funded mental health, developmental disabilities and substance abuse supports and services that are managed by the Pre-Paid Inpatient Health Plans.

SED: An acronym for Serious Emotional Disturbance, and as defined by the Michigan Mental Health Code, means a diagnosable mental, behavioral or emotional disorder affecting a child 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; and has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

Serious Mental Illness: Is defined by the Michigan Mental Health Code to mean a diagnosable mental, behavioral or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders; and that has resulted in function impairment that substantially interferes with or limits one or more major life activities.

Substance Use Disorder (or substance abuse): Is defined in the Michigan Public Health Code to mean the taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

[Note to PIHP: you may add additional information to this template]

Template #5: Grievance and Appeals Processes

Grievances

You have the right to say that you are unhappy with your services or supports or the staff who provide them, by filing a "grievance." You can file a grievance *any time* by calling, visiting, or writing to the [Customer Services Office.] Assistance is available in the filing process by contacting _____. You will be given detailed information about grievance and appeal processes when you first start services and then again annually. You may ask for this information at any time by contacting the [Customer Services Office]. *

Appeals

You will be given notice when a decision is made that denies your request for services or reduces, suspends or terminates the services you already receive. You have the right to file an "appeal" when you do not agree with such a decision. There are two ways you can appeal these decisions. There are also time limits on when you can file an appeal once you receive a decision about your services.

You may:

- Ask for a "Local Appeal" by contacting _____ at _____. and/or
- You can ask at any time for a Medicaid Fair Hearing before an administrative law judge (a state appeal).

Your appeal will be completed quickly, and you will have the chance to provide information or have someone speak for you regarding the appeal. You may ask for assistance from [Customer Services] to file an appeal.

*[Note to PIHPs: you may add detailed information about grievance and appeals to this template. In that case, you may wish to modify this last sentence.]

Template #6: Language assistance and accommodations

Language Assistance

If you are a person who is deaf or hard of hearing, , you can utilize the Michigan Relay Center (MRC) to reach your PIHP, CMHSP or service provider. Please call 7-1-1 and ask MRC to connect you to the number you are trying to reach. If you prefer to use a TTY, please contact [customer services] at the following TTY phone number: (number).

If you need a sign language interpreter, contact the [customer services office] at (number) as soon as possible so that one will be made available. Sign language interpreters are available at no cost to you.

If you do not speak English, contact the [customer services office] at (number) so that arrangements can be made for an interpreter for you. Language interpreters are available at no cost to you.

[Note to PIHP: you should add in the handbook any other language assistance they have available]

Accessibility and Accommodations

In accordance with federal and state laws, all buildings and programs of the (PIHP name) are required to be physically accessible to individuals with all qualifying disabilities. Any individual who receives emotional, visual or mobility support from a qualified/trained and identified service animal such as a dog will be given access, along with the service animal, to all buildings and programs of the (PIHP name). If you need more information or if you have questions about accessibility or service/support animals, contact [customer services] at (phone number).

If you need to request an accommodation on behalf of yourself or a family member or a friend, you can contact [customer services] at (phone). You will be told how to request an accommodation (this can be done over the phone, in person and/or in writing) and you will be told who at the agency is responsible for handling accommodation requests.

[Note to PIHP: you may add additional information to this template. To accommodate multiple affiliates, CAs or provider networks, it is acceptable to format names and numbers in the most logical way]

Template #7: Payment for Services

If you are enrolled in Medicaid and meet the criteria for the specialty mental health and substance abuse services the total cost of your authorized mental health or substance abuse treatment will be covered. No fees will be charged to you.

If you are a Medicaid beneficiary with a deductible ("spend-down"), as determined by the Michigan Department of Human Services (DHS), or an Adult Benefit Waiver enrollee you may be responsible for the cost of a portion of your services.

[Note to PIHP: you may add additional information to this template]

Template #8: Person-Centered Planning

The process used to design your individual plan of mental health supports, service, or treatment is called "Person-centered Planning (PCP)." PCP is your right protected by the Michigan Mental Health Code.

The process begins when you determine whom, beside yourself, you would like at the person-centered planning meetings, such as family members or friends, and what staff from [name of PIHP] you would like to attend. You will also decide when and where the person-centered planning meetings will be held. Finally, you will decide what assistance you might need to help you participate in and understand the meetings.

During person-centered planning, you will be asked what are your hopes and dreams, and will be helped to develop goals or outcomes you want to achieve. The people attending this meeting will help you decide what supports, services or treatment you need, who you would like to provide this service, how often you need the service, and where it will be provided. You have the right, under federal and state laws, to a choice of providers.

After you begin receiving services, you will be asked from time to time how you feel about the supports, services or treatment you are receiving and whether changes need to be made. You have the right to ask at any time for a new person-centered planning meeting if you want to talk about changing your plan of service.

You have the right to "independent facilitation" of the person-centered planning process. This means that you may request that someone other than the [name of PIHP] staff conduct your planning meetings. You have the right to choose from available independent facilitators.

Children under the age of 18 with developmental disabilities or serious emotional disturbance also have the right to person-centered planning. However, person-centered planning must recognize the importance of the family and the fact that supports and services impact the entire family. The parent(s) or guardian(s) of the children will be involved in pre-planning and person-centered planning using "family-centered practice" in the delivery of supports, services and treatment to their children.

Topics Covered during Person-Centered Planning

During person-centered planning, you will be told about psychiatric advance directives, a crisis plan, and self-determination (see the descriptions below). You have the right to choose to develop any, all or none of these.

Psychiatric Advance Directive

Adults have the right, under Michigan law, to a **"psychiatric advance directive."** A psychiatric advance directive is a tool for making decisions before a crisis in which you may become unable to make a decision about the kind of treatment you want and the kind of treatment you do not want. This lets other people, including family, friends, and service providers, know what you want when you cannot speak for yourself.

If you do not believe you have received appropriate information regarding Psychiatric Advance Directives from your PIHP, please contact the customer services office to file a grievance.

Crisis Plan

You also have the right to develop a **"crisis plan."** A crisis plan is intended to give direct care if you begin to have problems in managing your life or you become unable to make decisions and care for yourself. The crisis plan would give information and direction to others about what you would like done in the time of crisis. Examples are friends or relatives to be called, preferred medicines, or care of children, pets, or bills.

Self-determination

Self-determination is an option for payment of medically necessary services you might request if you are an adult beneficiary receiving mental health services in Michigan. It is a process that would help you to design and exercise control over your own life by directing a fixed amount of dollars that will be spent on your authorized supports and services, often referred to as an "individual budget." You would also be supported in your management of providers, if you choose such control.

[Note to PIHP: you may add additional information to this template]

Template #9: Recipient Rights

Every person who receives public mental health services has certain rights. The Michigan Mental Health Code protects some rights. Some of your rights include:

- The right to be free from abuse and neglect
- The right to confidentiality
- The right to be treated with dignity and respect
- The right to treatment suited to condition

More information about your many rights is contained in the booklet titled "Your Rights." You will be given this booklet and have your rights explained to you when you first start services, and then once again every year. You can also ask for this booklet at any time.

You may file a Recipient Rights complaint *any time* if you think staff violated your rights. You can make a rights complaint either orally or in writing.

If you receive substance abuse services, you have rights protected by the Public Health Code. These rights will also be explained to you when you start services and then once again every year. You can find more information about your rights while getting substance abuse services in the "Know Your Rights" pamphlet.

You may contact your local community mental health services program to talk with a Recipient Rights Officer with any questions you may have about your rights or to get help to make a complaint. Customer Services can also help you make a complaint. You can contact the Office or Recipient Rights at: or Customer Services at: _____.

Freedom from Retaliation

If you use public mental health or substance abuse services, you are free to exercise your rights, and to use the rights protection system without fear of retaliation, harassment, or discrimination. In addition, under no circumstances will the public mental health system use seclusion or restraint as a means of coercion, discipline, convenience or retaliation.

[Note to PIHP: you may add additional information to this template]

Template #10: Recovery & Resiliency

"Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential."
Recovery is an individual journey that follows different paths and leads to different locations. Recovery is a process that we enter into and is a life long attitude. Recovery is unique to each individual and can truly only be defined by the individual themselves. What might be recovery for one person may be only part of the process for another. Recovery may also be defined as wellness. Mental health supports and services help people with mental illness in their recovery journeys. The person-centered planning process is used to identify the supports needed for individual recovery.

In recovery there may be relapses. A relapse is not a failure, rather a challenge. If a relapse is prepared for, and the tools and skills that have been learned throughout the recovery journey are used, a person can overcome and come out a stronger individual. It takes time, and that is why **Recovery** is a process that will lead to a future that holds days of pleasure and the energy to persevere through the trials of life.

Resiliency and development are the guiding principles for children with serious emotional disturbance. Resiliency is the ability to "bounce back" and is a characteristic important to nurture in children with serious emotional disturbance and their families. It refers to the individual's ability to become successful despite challenges they may face throughout their life.

[Note to PIHP: you may add additional information to this template]

Template #11: Service Array

MENTAL HEALTH MEDICAID SPECIALTY SUPPORTS AND SERVICES DESCRIPTIONS

Note: If you are a Medicaid beneficiary and have a serious mental illness, or serious emotional disturbance, or developmental disabilities, or substance use disorder, you may be eligible for some of the Mental Health Medicaid Specialty Supports and Services listed below.

Before services can be started, you will take part in an assessment to find out if you are eligible for services. It will also identify the services that can best meet your needs. You need to know that not all people who come to us are eligible, and not all services are available to everyone we serve. If a service cannot help you, your Community Mental Health will not pay for it. Medicaid will not pay for services that are otherwise available to you from other resources in the community.

During the person-centered planning process, you will be helped to figure out the medically necessary services that you need and the sufficient amount, scope and duration required to achieve the purpose of those services. You will also be able to choose who provides your supports and services. You will receive an individual plan of service that provides all of this information.

In addition to meeting medically necessary criteria, services listed below marked with an asterisk (*) require a doctor's prescription***.***

Note: the Michigan Medicaid Provider Manual contains complete definitions of the following services as well as eligibility criteria and provider qualifications. The Manual may be accessed at www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf. Customer Service staff can help you access the manual and/or information from it.

Assertive Community Treatment (ACT) provides basic services and supports essential for people with serious mental illness to maintain independence in the community. An ACT team will provide mental health therapy and help with medications. The team may also help access community resources and supports needed to maintain wellness and participate in social, educational and vocational activities. ACT may be provided daily for individuals who participate.

Assessment includes a comprehensive psychiatric evaluation, psychological testing, substance abuse screening, or other assessments conducted to determine a person's level of functioning and mental health treatment needs. Physical health assessments are not part of this PIHP service.

***Assistive Technology** includes adaptive devices and supplies that are not covered under the Medicaid Health Plan or by other community resources. These devices help individuals to better take care of themselves, or to better interact in the places where they live, work, and play.

Behavior Treatment Review: If a person's illness or disability involves behaviors that they or others who work with them want to change, their individual plan of services may include a plan that talks about the behavior. This plan is often called a "behavior treatment plan." The behavior management plan is developed during person-centered planning and then is approved and reviewed regularly by a team of specialists to make sure that it is effective and dignified, and continues to meet the person's needs.

Clubhouse Programs are programs where members (consumers) and staff work side by side to operate the clubhouse and to encourage participation in the greater community. Clubhouse programs focus on fostering recovery, competency, and social supports, as well as vocational skills and opportunities.

Community Inpatient Services are hospital services used to stabilize a mental health condition in the event of a significant change in symptoms, or in a mental health emergency. Community hospital services are provided in licensed psychiatric hospitals and in licensed psychiatric units of general hospitals.

Community Living Supports (CLS) are activities provided by paid staff that help adults with either serious mental illness or developmental disabilities live independently and participate actively in the community. Community Living Supports may also help families who have children with special needs (such as developmental disabilities or serious emotional disturbance).

Crisis Interventions are unscheduled individual or group services aimed at reducing or eliminating the impact of unexpected events on mental health and well-being.

Crisis Residential Services are short-term alternatives to inpatient hospitalization provided in a licensed residential setting.

***Enhanced Pharmacy** includes doctor-ordered nonprescription or over-the-counter items (such as vitamins or cough syrup) necessary to manage your health condition(s) when a person's Medicaid Health Plan does not cover these items.

***Environmental Modifications** are physical changes to a person's home, car, or work environment that are of direct medical or remedial benefit to the person. Modifications ensure access, protect health and safety, or enable greater independence for a person with physical disabilities. Note that all other sources of funding must be explored first, before using Medicaid funds for environmental modifications.

Family Support and Training provides family-focused assistance to family members relating to and caring for a relative with serious mental illness, serious emotional disturbance, or developmental disabilities. "Family Skills Training" is education and training for families who live with and or care for a family member who is eligible for the Children's Waiver Program.

Fiscal Intermediary Services help individuals manage their service and supports budget and pay providers if they are using a "self-determination" approach.

Health Services include assessment, treatment, and professional monitoring of health conditions that are related to or impacted by a person's mental health condition. A person's primary doctor will treat any other health conditions they may have.

Home-Based Services for Children and Families are provided in the family home or in another community setting. Services are designed individually for each family, and can include things like mental health therapy, crisis intervention, service coordination, or other supports to the family.

Housing Assistance is assistance with short-term, transitional, or one-time-only expenses in an individual's own home that his/her resources and other community resources could not cover.

Intensive Crisis Stabilization is another short-term alternative to inpatient hospitalization. Intensive crisis stabilization services are structured treatment and support activities provided by a mental health crisis team in the person's home or in another community setting.

Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) provide 24-hour intensive supervision, health and rehabilitative services and basic needs to persons with developmental disabilities. **Medication Administration** is when a doctor, nurse, or other licensed medical provider gives an injection, or an oral medication or topical medication.

Medication Review is the evaluation and monitoring of medicines used to treat a person's mental health condition, their effects, and the need for continuing or changing their medicines.

Mental Health Therapy and Counseling for Adults, Children and Families includes therapy or counseling designed to help improve functioning and relationships with other people.

Nursing Home Mental Health Assessment and Monitoring includes a review of a nursing home resident's need for and response to mental health treatment, along with consultations with nursing home staff.

***Occupational Therapy** includes the evaluation by an occupational therapist of an individuals' ability to do things in order to take care of themselves every day, and treatments to help increase these abilities.

Partial Hospital Services include psychiatric, psychological, social, occupational, nursing, music therapy, and therapeutic recreational services in a hospital setting, under a doctor's supervision. Partial hospital services are provided during the day – participants go home at night.

Peer-delivered and Peer Specialist Services. Peer-delivered services such as drop-in centers are entirely run by consumers of mental health services. They offer help with

food, clothing, socialization, housing, and support to begin or maintain mental health treatment. Peer Specialist services are activities designed to help persons with serious mental illness in their individual recovery journey and are provided by individuals who are in recovery from serious mental illness. Peer mentors help people with developmental disabilities.

Personal Care in Specialized Residential Settings assists an adult with mental illness or developmental disabilities with activities of daily living, self-care and basic needs, while they are living in a specialized residential setting in the community.

***Physical Therapy** includes the evaluation by a physical therapist of a person's physical abilities (such as the ways they move, use their arms or hands, or hold their body), and treatments to help improve their physical abilities.

Prevention Service Models (such as Infant Mental Health, School Success, etc.) use both individual and group interventions designed to reduce the likelihood that individuals will need treatment from the public mental health system.

Respite Care Services provide short-term relief to the unpaid primary caregivers of people eligible for specialty services. Respite provides temporary alternative care, either in the family home, or in another community setting chosen by the family.

Skill-Building Assistance includes supports, services and training to help a person participate actively at school, work, volunteer, or community settings, or to learn social skills they may need to support themselves or to get around in the community.

***Speech and Language Therapy** includes the evaluation by a speech therapist of a person's ability to use and understand language and communicate with others or to manage swallowing or related conditions, and treatments to help enhance speech, communication or swallowing.

Substance Abuse Treatment Services (descriptions follow the mental health services)

Supports Coordination or Targeted Case Management: A Supports Coordinator or Case Manager is a staff person who helps write an individual plan of service and makes sure the services are delivered. His or her role is to listen to a person's goals, and to help find the services and providers inside and outside the local community mental health services program that will help achieve the goals. A supports coordinator or case manager may also connect a person to resources in the community for employment, community living, education, public benefits, and recreational activities.
Supported/Integrated Employment Services provide initial and ongoing supports, services and training, usually provided at the job site, to help adults who are eligible for mental health services find and keep paid employment in the community.

Transportation may be provided to and from a person's home in order for them to take part in a non-medical Medicaid-covered service.

Treatment Planning assists the person and those of his/her choosing in the development and periodic review of the individual plan of services.

Wraparound Services for Children and Adolescents with serious emotional disturbance and their families that include treatment and supports necessary to maintain the child in the family home.

Services for Only Habilitation Supports Waiver (HSW) and Children's Waiver Participants

Some Medicaid beneficiaries are eligible for special services that help them avoid having to go to an institution for people with developmental disabilities or nursing home. These special services are called the Habilitation Supports Waiver and the Children's Waiver. In order to receive these services, people with developmental disabilities need to be enrolled in either of these "waivers." The availability of these waivers is very limited. People enrolled in the waivers have access to the services listed above as well as those listed here:

Goods and Services (for HSW enrollees) is a non-staff service that replaces the assistance that staff would be hired to provide. This service, used in conjunctions with a self-determination arrangement, provides assistance to increase independence, facilitate productivity, or promote community inclusion.

Non-Family Training (for Children's Waiver enrollees) is customized training for the paid in-home support staff who provide care for a child enrolled in the Waiver.

Out-of-home Non-Vocational Supports and Services (for HSW enrollees) is assistance to gain, retain or improve in self-help, socialization or adaptive skills.

Personal Emergency Response devices (for HSW enrollees) help a person maintain independence and safety, in their own home or in a community setting. These are devices that are used to call for help in an emergency.

Prevocational Services (for HSW enrollees) include supports, services and training to prepare a person for paid employment or community volunteer work.

Private Duty Nursing (for HSW enrollees) is individualized nursing service provided in the home, as necessary to meet specialized health needs.

Specialty Services (for Children's Waiver enrollees) are music, recreation, art, or massage therapies that may be provided to help reduce or manage the symptoms of a child's mental health condition or developmental disability. Specialty services might also include specialized child and family training, coaching, staff supervision, or monitoring of program goals.

Services for Persons with Substance Use Disorders

The Substance Abuse treatment services listed below are covered by Medicaid. These services are available through [PIHP or SA Coordinating Agency]

Access, Assessment and Referral (AAR) determines the need for substance abuse services and will assist in getting to the right services and providers.

Outpatient Treatment includes therapy/counseling for the individual, and family and group therapy in an office setting.

Intensive/Enhanced Outpatient (IOP or EOP) is a service that provides more frequent and longer counseling sessions each week and may include day or evening programs.

Methadone and LAAM Treatment is provided to people who have heroin or other opiate dependence. The treatment consists of opiate substitution monitored by a doctor as well as nursing services and lab tests. This treatment is usually provided along with other substance abuse outpatient treatment.

Sub-Acute Detoxification is medical care in a residential setting for people who are withdrawing from alcohol or other drugs.

Residential Treatment is intensive therapuetic services which include overnight stays in a staffed licensed facility.

If you receive Medicaid, you may be entitled to other medical services not listed above. Services necessary to maintain your physical health are provided or ordered by your primary care doctor. If you receive Community Mental Health services, your local community mental health services program will work with your primary care doctor to coordinate your physical and mental health services. If you do not have a primary care doctor, your local community mental health services program will help you find one.

Note: **Home Help Program** is another service available to Medicaid beneficiaries who require in-home assistance with activities of daily living, and household chores. In order to learn more about this service, you may call the local Michigan Department of Human Services' number below or contact the [Customer Services Office] for assistance.
[Name and phone number of the local MDHS]

Mental Health and Substance Abuse Services for Adult Benefits Waiver Enrollees

Individuals enrolled in the Adult Benefits Waiver (ABW) may be eligible for mental health and substance abuse services such as those listed below. An assessment will determine the medical necessity for the services. The ABW enrollee may be required to pay a co-pay for these services. ***Note: the Michigan Medicaid Provider Manual contains complete definitions of the following services as well as eligibility criteria and provider qualifications. The Manual may be accessed at*** www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf. Customer Service staff can help you access the manual and/or information from it.

Mental Health Services

☐ Crisis interventions for mental health-related emergency situations and/or conditions.

☐ Identification, assessment and diagnostic evaluation to determine the beneficiary's mental health status, condition and specific needs.

☐ Inpatient hospital psychiatric care for mentally ill beneficiaries who require care in a 24-hour medically-structured and supervised licensed facility.

☐ Other medically necessary mental health services:

☐ Psychotherapy or counseling (individual, family, group) when indicated;

☐ Interpretation or explanation of results of psychiatric examination, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the beneficiary;

☐ Pharmacological management, including prescription, administration, and review of medication use and effects; or

☐ Specialized community mental health clinical and rehabilitation services, including case management, psychosocial interventions and other community supports, as medically necessary, and when utilized as an approved alternative to more restrictive care or placement.

Substance Abuse Services

Initial assessment, diagnostic evaluation, referral and patient placement;

☐ Outpatient Treatment;

☐ Federal Food and Drug Administration (FDA) approved pharmacological supports for Levo-Alpha-Acetyl-Methadol (LAAM) and Methadone only; or

☐ Other substance abuse services that may be provided, at the discretion of the PIHP, to enhance outcomes.

Medicaid Health Plan Services

If you are enrolled in a Medicaid Health Plan, the following kinds of health care services are available to you when your medical condition requires them.

- Ambulance
- Chiropractic
- Doctor visits
- Family planning
- Health check ups
- Hearing aids
- Hearing and speech therapy
- Home Health Care
- Immunizations (shots)
- Lab and X-ray
- Nursing Home Care
- Medical supplies
- Medicine
- Mental health (limit of 20 outpatient visits)

- Physical and Occupational therapy
- Prenatal care and delivery
- Surgery
- Transportation to medical appointments
- Vision

If you already are enrolled in one of the health plans [listed below] you can contact the health plan directly for more information about the services listed above. If you are not enrolled in a health plan or do not know the name of your health plan, you can contact the [Customer Services Office] for assistance.
[List of health plans and contact numbers

Template #12: Service Authorization

Services you request must be authorized or approved by [the PIHP or its designee]. That agency may approve all, some or none of your requests. You will receive notice of a decision within 14 calendar days after you have requested the service during person-centered planning, or within 3 business days if the request requires a quick decision

Any decision that denies a service you request or denies the amount, scope or duration of the service that you request will be made by a health care professional who has appropriate clinical expertise in treating your condition. Authorizations are made according to medical necessity. If you do not agree with a decision that denies, reduces, suspends or terminates a service, you may file an appeal.

[Note to PIHP: you may add additional information to this template]

GRIEVANCE AND APPEAL TECHNICAL REQUI REMENT
PIHP GRIEVANCE SYSTEM FOR MEDICAID BENEFICIARIES

July 2004

TABLE OF CONTENTS

I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with Medicaid Beneficiary Grievance System requirements for grievances and appeals contained in Part 11, 6.3.2 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Community Health (DCH). These requirements are applicable to all PIHPs, affiliate Community Mental Health Services Programs (CMHSPs), Substance Abuse Coordinating Agencies (CAs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance System processes required for Medicaid beneficiaries, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

The term "Grievance system," as used in the federal regulations refers to the overall system for Medicaid beneficiary grievances and appeals, required in the Medicaid managed care context. Conceptually, the grievance system divides beneficiary complaints into two categories, those challenging an action, as defined in this document, and those challenging anything else. A challenge to an action is called an **appeal.** Any other type of complaint is considered a **grievance.**

The Due Process Clause of the U.S. Constitution guarantees that Medicaid beneficiaries must receive "due process" whenever benefits are denied, reduced or terminated. Due Process includes: (1) prior written notice of the adverse action (2) a fair hearing before an impartial decision maker (3) continued benefits pending a final decision and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements.

Consumers of mental health services who are Medicaid beneficiaries eligible for Speciality Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care. Grievance and appeal process requirements for Medicaid beneficiaries were significantly expanded through federal regulations implementing the Balanced Budget Act (BBA) of 1997.

Medicaid beneficiaries have rights and dispute resolution protections under federal authority of the Social Security Act, including:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- Local appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Beneficiaries, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, (hereafter referred to as the 'Code") Chapters 7,7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.)
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705)

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

Action: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including the type or level of service.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **three (3) working days** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **45 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **three (3) working days** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **60 calendar days** of the date of the request.

Note: The term "action" is also referred to as an "adverse action" in this document.

Additional Mental Health Services: Supports and services available to Medicaid beneficiaries who meet the criteria for specialty services and supports, under the authority of Section 1915(b)(3) of the Social Security Act. Also referred to as **"B3"** waiver services.

Adequate Notice of Action: Written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid **services requested.** Notice is provided to the Medicaid beneficiary **on the same date** the action takes effect, or at the time of the signing of the individual plan of services/supports.

Advance Notice of Action: Written statement advising the beneficiary of a decision to reduce, suspend or terminate Medicaid services **currently provided.** Notice to be provided/mailed to the Medicaid beneficiary at least **12 calendar days prior** to the proposed date the action is to take effect.

Appeal: Request for a review of an 'action" as defined above.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Beneficiary: An individual who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through a PIHP/CMHSP.

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Expedited Appeal: The expeditious review of an action, requested by a beneficiary or the beneficiary's provider, when the time necessary for the normal appeal review process could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP must grant the request.

Fair Hearing: Impartial state level review of a Medicaid beneficiary's appeal of an action presided over by a DCH Administrative Law Judge. Also referred to as "Administrative Hearing".

Grievance: Medicaid Beneficiary's expression of dissatisfaction about PIHP/CMHSP service issues, **other than an action.** Possible subjects for grievances include, but are not limited to, quality of care or services provided and aspects of interpersonal relationships between a service provider and the beneficiary.

Grievance Process: Impartial local level review of a Medicaid Beneficiary's grievance (expression of dissatisfaction) about PIHP/CMHSP service issues **other than an action.**

Grievance System: Federal terminology for the overall local system of grievance and appeals required for Medicaid beneficiaries in the managed care context, including access to the state fair hearing process.

Local Appeal Process: Impartial local level PIHP review of a Medicaid beneficiary's appeal of an action presided over by individuals not involved with decision-making or previous level of review.

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, Habilitation Services and Support waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Disposition: Written statement of the PIHP decision for each local appeal and/or grievance, provided to the beneficiary.

Recipient Rights Complaint: Written or verbal statement by a consumer, or anyone acting on behalf of the consumer, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

111. GRIEVANCE SYSTEM GENERAL REQUIREMENTS

Federal regulation (42 CFR 438.228) requires the state to ensure through its contracts with PIHPs, that each PIHP has an overall grievance system in place for Medicaid beneficiaries that complies with Subpart F of Part 438.

The grievance system must provide Medicaid beneficiaries:

- A local PIHP appeal process for challenging an "action" taken by the PIHP or one of its agents.
- Access to the state level fair hearing process for an appeal of an "action".
- A local PIHP grievance process for expressions of dissatisfaction about any matter other than those that meet the definition of an 'action".
- The right to **concurrently** file a PIHP level appeal of an action, **and** request a State fair hearing on an action, **and** file a PIHP level grievance regarding other service complaints.
- The right to request a State fair hearing **before exhausting** the PIHP level appeal of an 'action".
- The right to request, and have, Medicaid benefits continued while a local PIHP appeal and/or state fair hearing is pending.
- The right to have a provider, acting on the beneficiary's behalf and with the beneficiary's written consent, file an appeal to the PIHP. The provider may file a grievance or request for a state fair hearing on behalf of the beneficiary **only if** the State permits the provider to act as the beneficiary's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the beneficiary's behalf with the beneficiary's written consent to do so.

IV. SERVICE AUTHORIZATION DECISIONS

When a Medicaid service authorization is processed (initial request or continuation of service delivery) the PIHP **must provide** the beneficiary written service authorization decision within specified timeframes and as expeditiously as the beneficiary's health condition requires. The service authorization must meet the requirements for either **standard** authorization or **expedited** authorization:

- **Standard Authorization:** Notice of the authorization decision must be provided as expeditiously as the beneficiary's health condition requires, and **no later than 14 calendar days** following receipt of a request for service.

  If the beneficiary or provider requests an extension **OR** if the PIHP justifies (to the state agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the **14 calendar** day time period by up to **14 additional calendar days.**

  Expedited authorization: In cases in which a provider indicates, or the PIHP determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, the PIHP must make an expedited authorization decision and provide notice of the decision as expeditiously as the beneficiary's health condition requires, and **no later than three (3) working days** after receipt of the request for service.

  If the beneficiary requests an extension, or if the PIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest; the PIHP may extend the three (3) working day time period by up to **14 calendar days.**

When a **standard or expedited** authorization of services decision is extended, the PIHP must give the beneficiary written notice of the reason for the decision to extend the timeframe, and inform the beneficiary of the right to file an appeal if he or she disagrees with that decision. The PIHP must issue and carry out its determination as expeditiously as the enrollee's beneficiary's health condition requires and no later than the date the extension expires.

V. NOTICE OF ACTION

A Notice of Action must be provided to a Medicaid beneficiary when a service authorization decision constitutes an **"action"** by authorizing a service in amount, duration or scope@ than requested or less than currently authorized, or the service authorization is not made timely. In these situations, the PIHP **must** provide a notice of action containing additional information to inform the beneficiary of the basis for the action the PIHP has taken, or intends to take and the process available to appeal the decision.

PIHP Notice of Action requirements include:

The notice of action to the beneficiary must be in writing and meet language format needs of the individual to understand the content (i.e. the format meets the needs of those with limited English proficiency and or limited reading proficiency).

- The requesting provider, in addition to the beneficiary, must be provided notice of any decision by the PIHP to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice of action to the provider is not required to be in writing.
- **If** the beneficiary or representative requests a local appeal or a fair hearing not more than **12 calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the appeal.
- **If** the beneficiary's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.
- **If** the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an action, **and requires** a written notice of action.

The notice of action must be either Adequate or Advance:

- **Adequate notice:** is a written notice provided to the beneficiary **at the time of EACH** action. The individual plan of service, developed through a person-centered planning process and finalized with the beneficiary, must include, or have attached, the adequate notice provisions.
- **Advance notice:** is a written notice required when an action is being taken to reduce, suspend or terminate services that the beneficiary is currently receiving. The advance notice must be mailed **12 calendar days** before the intended action takes effect.

The content of both adequate and advance notices must include an explanation of:

What action the PIHP has taken or intends to take,

- The reason(s) for the action,
- 42 CFR 440.230(d) is the basic legal authority for an action to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,
- The beneficiary's or provider's right to file a PIHP appeal, and instructions for doing so,
- The beneficiary's right to request a State fair hearing, and instructions for doing so,
- The circumstances under which expedited resolution can be requested, and instructions for doing so,
- An explanation that the beneficiary may represent himself or use legal counsel, a relative, a friend or other spokesman.

The content of an advance notice must also include an explanation of:

The circumstances under which services will be continued pending resolution of the appeal,

- How to request that benefits be continued, and
- The circumstances under which the beneficiary may be required to pay the costs of these services.

NOTE: Examples of adequate and advance notices containing required content are in Exhibits A and B at the end of this document.

There are limited exceptions to the advance notice requirement. The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, **IF:**

- The PIHP has factual information confirming the death of the beneficiary.
- The PIHP receives a clear written statement signed by the beneficiary that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
- The beneficiary has been admitted to an institution where he/she is ineligible under Medicaid for further services.
- The beneficiary's whereabouts are unknown and the post office returns PIHP mail directed to him/her indicating no forwarding address.
- The PIHP establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
- A change in the level of medical care is prescribed by the beneficiary's physician
- The date of the action will occur in less than **10 calendar days.**

The Notice of Action must be mailed within the following timeframes:

- **At least 12 calendar days before** the date of an action to terminate suspend or reduce previously authorized Medicaid covered services(s) (Advance)
- **At the time of the decision** to deny payment for a service (Adequate)
- **Within 14 calendar days** of the request for a standard service authorization decision to deny or limit services (Adequate).
- **Within 3 working days** of the request for an expedited service authorization decision to deny or limit services (Adequate).

If the PIHP is unable to complete either a standard or expedited service authorization to deny or limit services within the timeframe requirement, the timeframe may be **extended up to an additional 14 calendar days.**

If the PIHP extends the timeframe, it must:

- Give the beneficiary written notice, no later than the date the current timeframe expires, of the reason for the decision to extend the timeframe and inform the

beneficiary of the right to file an appeal if he or she disagrees with that decision; and

- Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

VI. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

The PIHP **must** continue Medicaid services previously authorized while the PIHP appeal and/or State fair hearing are pending **if:**

- The Beneficiary specifically requests to have the services continued, and
- The Beneficiary or provider files the appeal timely; and
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, and
- The services were ordered by an authorized provider, and
- The original period covered by the original authorization has not expired.

When the PIHP continues or reinstates the beneficiary's services while the appeal is pending, the services must be continued until one of the following occurs:

- The beneficiary withdraws the appeal.
- **Twelve calendar** days pass after the PIHP mails the notice of disposition providing the resolution of the appeal against the beneficiary, **unless** the beneficiary, within the **12 day** timeframe, has requested a State fair hearing with continuation of services until a State fair hearing decision is reached.
- A State fair hearing office issues a hearing decision adverse to the beneficiary. The time period or service limits of the previously authorized service has been met.

If the PIHP, or the DCH fair hearing administrative law judge **reverses a decision** to deny authorization of services, and the beneficiary **received the disputed services** while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations.

If the PIHP, or the DCH fair hearing administrative law judge **reverses a decision** to deny, limit, or delay services that were **not furnished** while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires.

VII. STATE FAIR HEARING APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to an impartial review (fair hearing) by a state level administrative law judge, of a decision (action) made by the local agency or its agent.

- A Medicaid beneficiary has the right to request a fair hearing when the PIHP or its contractor takes an "action", or a grievance request is not acted upon within **60 calendar days.** The beneficiary does not have to exhaust local appeals before he/she can request a fair hearing.
- The agency must issue a written notice of action to the affected beneficiary. (See section VI above for Notice information.)
- The agency may not limit or interfere with the beneficiary's freedom to make a request for a fair hearing.
- Beneficiaries are given **90 calendar days** from the date of the notice to file a request for a fair hearing.
- If the beneficiary, or representative, requests a fair hearing not more than 12 **calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing by the administrative law judge.
- If the beneficiary's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the action.
- The parties to the state fair hearing include the PIHP, the beneficiary and his or her representative, or the representative of a deceased beneficiary's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.
- Expedited hearings are available.

Detailed information and instructions for the Fair Hearing process can be found in the DCH Administrative Tribunal Policy and Procedures Manual online at:

www.michigan.gov/documents/mdch/ADMN_HEARING_PAMPLET_MARCH_2008_227657_7.pdf

VIII. LOCAL APPEAL PROCESS

Federal regulations provide a Medicaid beneficiary the right to a local level appeal of an action. PIHP appeals, like those for fair hearings, are initiated by an "action". The beneficiary may request a local appeal under the following conditions:

- The beneficiary has **45 calendar days** from the date of the notice of action to request a local appeal.
- An oral request for a local appeal of an action is treated as an appeal to establish the earliest possible filing date for appeal. The oral request must be confirmed in writing unless the beneficiary requests expedited resolution.
  The beneficiary may file an appeal with the PIHP organizational unit approved and administratively responsible for facilitating local appeals.
- If the beneficiary, or representative, requests a local appeal not more than 12 **calendar days** from the date of the notice of action, the PIHP must reinstate the Medicaid services until disposition of the hearing.

When a beneficiary requests a local appeal, the PIHP is required to:

- Give beneficiaries reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. Acknowledge receipt of each appeal.
- Maintain a log of all requests for appeal to allow reporting to the PIHP Quality Improvement Program. Ensure that the individuals who make the decisions on appeal were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on appeal are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease when the appeal is of a denial based on lack of medical necessity or involves other clinical issues.
- Provide the beneficiary, or representative with:
  - o Reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;
  - o Opportunity, before and during the appeals process, to examine the beneficiary's case file, including medical records and any other documents or records considered during the appeals process;
  - o Opportunity to include as parties to the appeal the beneficiary and his or her representative or the legal representative of a deceased beneficiary's estate;
  - o Information regarding the right to a fair hearing and the process to be used to request the hearing.

Notice of Disposition requirements:

- The PIHP must provide written notice of the disposition of the appeal, and must also make reasonable efforts to provide oral notice of an expedited resolution. The content of a notice of disposition must include an explanation of the results of the resolution and the date it was completed.
- When the appeal is not resolved wholly in favor of the beneficiary, the notice of disposition must also include:
  - o The right to request a state fair hearing, and how to do so;
  - o The right to request to receive benefits while the state fair hearing is pending, if requested within 12 days of the PIHP mailing the notice of disposition, and how to make the request; and
  - o That the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the PIHP's action.

The Notice of Disposition must be provided within the following timeframes:

- **Standard Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties as expeditiously as the beneficiary's health condition requires, but not to exceed **45 calendar days** from the day the PIHP receives the appeal.

- **Expedited Resolution:** The PIHP must resolve the appeal and provide notice of disposition to the affected parties no longer than **three** (3) **working** days after the PIHP receives the request for expedited resolution of the appeal. An expedited resolution is required when the PIHP determines (for a request from the beneficiary) or the provider indicates (in making the request on behalf of, or in support of the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.
- The PIHP may extend the notice of disposition timeframe by up to **14 calendar days** if the beneficiary requests an extension, or if the PIHP shows to the satisfaction of the state that there is a need for additional information and how the delay is in the beneficiary's interest.
- I f the PIHP denies a request for expedited resolution of an appeal, it must:

    o Transfer the appeal to the timeframe for standard resolution or no longer than 45 days from the date the PIHP receives the appeal;
    o Make reasonable efforts to give the beneficiary **prompt oral notice** of the denial, and
    o Give the beneficiary follow up **written notice** within **two (2) calendar days.**

IX. LOCAL GRIEVANCE PROCESS

Federal regulations provide Medicaid beneficiaries the right to a local grievance process for **issues that are not "actions".**

Beneficiary grievances:

- Shall be filed with the PIHP/CMHSP organizational unit approved and administratively responsible for facilitating resolution of the grievance.
- May be filed at any time by the beneficiary, guardian, or parent of a minor child or his/her legal representative.
- **Do not** have access to the state fair hearing process **unless,** the PIHP fails to respond to the grievance **within 60 calendar days.** This constitutes an 'action", and can be appealed for fair hearing to the DCH Administrative Tribunal.

For each grievance filed by a beneficiary, the PIHP is required to:

- Give the beneficiary reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability
- Acknowledge receipt of the grievance;
- Log the grievance for reporting to the PIHP/CMHSP Quality Improvement Program.

- Ensure that the individual(s) who make the decisions on the grievance were not involved in the previous level review or decision-making.
- Ensure that the individual(s) who make the decisions on the grievance are health care professionals with appropriate clinical expertise in treating the beneficiary's condition or disease if the grievance:
  - Involves clinical issues, or
  - Involves the denial of an expedited resolution of an appeal (of an action).
- Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
- Provide the beneficiary a written **notice of disposition** not to exceed **60 calendar days** from the day PIHP received the grievance/complaint. The content of the notice of disposition must include:
  - The results of the grievance process
  - The date the grievance process was concluded.
  - The beneficiary's right to request a fair hearing if the notice of disposition is more than 60 days from the date of the request for a grievance and
  - How to access the fair hearing process.

X. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain Grievance System records of beneficiary appeals and grievances for review by State staff as part of the State quality strategy.

PIHP Grievance System records should contain sufficient information to accurately reflect:

- The process in place to track requests for Medicaid services denied by the PIHP or any of its providers.
  The volume of denied claims for services in the most recent year.

XI. RECIPIENT RIGHTS COMPLAINT PROCESS

Medicaid beneficiaries, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.

EXHIBIT A ADEQUATE NOTICE OF ACTION (SAMPLE FORM)

ADEQUATE ACTION NOTICE

Date
Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear

Following a review of the mental health services for which you have applied, it has been determined that the following service(s) shall not be authorized.

Service(s)	Effective Date

The reason for this action is <reason> . The legal basis for this decision is 42 CFR 440.2301d).

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the "Request for Hearing" form, and return it in the enclosed pre-addressed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30195
LANSING, MI 48909-7695

ADEQUATE ACTION NOTICE
Page 2

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

I f you do not agree with this action, you may request a local appeal, either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number - Voice>
<Phone Number - **FAX>**

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:
Hearing Request Form
Return Envelope

EXHIBIT B ADVANCE NOTICE OF ACTION (SAMPLE FORM)

ADVANCE ACTION NOTICE

Date

Name
Address
City, State, Zip

RE: Beneficiary's Name:
Beneficiary's Medicaid ID Number:

Dear

Following a review of mental health services and supports that you are currently receiving, it has been determined that the following service(s) shall be <reduced, terminated or suspended> effective <date>.

Service(s)	Effective Date

The reason for this action is <reason>. The legal basis for this decision is 42 CFR 440.230(d).

If you do not agree with this action, you may request a Michigan Department of Community Health fair hearing within 90 calendar days of the date of this notice. Hearing requests must be made in writing and signed by you or an authorized person.

To request a fair hearing, complete the enclosed "Request for Hearing" form, and return it in the enclosed pre-addressed envelope, or mail to:

ADMINISTRATIVE TRIBUNAL
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
P.O. BOX 30195
LANSING, MICHIGAN 48909-7695

You have a right to an expedited hearing if waiting for the standard time for a hearing would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited hearing, you must call, toll-free, 877-833-0870.

ADVANCE ACTION NOTICE
Page 2

You will continue to receive the affected services until the hearing decision is rendered **if** your request for a fair hearing is received prior to the effective date of action.

If you continue to receive benefits because you requested a fair hearing you may be required to repay the benefits. This may occur if:

- The proposed termination or denial of benefits is upheld in the hearing decision.
- You withdraw your hearing request.
- You or the person you asked to represent you does not attend the hearing.

If you do not agree with this action, **you may also request a local appeal,** either orally or in writing, with your Prepaid Inpatient Health Plan (PIHP) within 45 calendar days of the date of this notice by contacting:

<Name of PIHP office/individual responsible for local appeal process>
<Address>
<City, State ZIP>
<Phone Number - Voice>
<Phone Number - **FAX>**

You have a right to an expedited local appeal if waiting for the standard time for a local appeal would seriously jeopardize your life or health or would jeopardize your ability to attain, maintain, or regain maximum function. To request an expedited local appeal, you must call your PIHP.

You may request both a fair hearing and a local appeal. The fair hearing and local appeal processes may occur at the same time. You may contact the Administrative Tribunal, toll free, at 877-833-0870 or the PIHP if you have further questions.

Enclosures:
Hearing Request Form
Return Envelope

PROCUREMENT TECHNICAL REQUIREMENT

PROCUREMENT AND SELECTIVE CONTRACTING UNDER MANAGED CARE

Introduction

The assumption of managed care responsibilities for specialized Medicaid mental health, developmental disabilities and or substance abuse services has implications for the procurement and selective contracting activities of Community Mental Health Service Programs (CMHSPs) and Regional Substance Abuse Coordinating Agencies (RSACAs). Soliciting providers and programs for the service delivery system, acquiring claims processing capabilities, enhancements to management information system capacity, or obtaining general management's services to assist in the administration of the managed care program, must be done with due deliberation and sensitivity to procurement and contracting issues.

Procurement of Automatic Data Processing Services and Comprehensive Administrative or Management Services –

The Michigan Department of Community Health's (MDCH) plan to make sole source "sub-awards" for the administration and provision of Medicaid mental health, developmental disability and substance abuse services raises questions about the applicability of federal procurement regulations to CMHSP and RSACA procurement and contracting activities. Federal regulations regarding procurement are described in the Code of Federal Regulations, (45 CFR Part 74; 42 CFR 5 434), Office of Management and Budget Circular A-110, and State Medicaid Manual Part 2 (Sections 2083 through 2087).

In general, these regulations and requirements give the State fairly wide latitude in determining the procedural aspects and applicable circumstances for procurement processes. However, the MDCH's preliminary interpretation of these regulations suggests that procurement for significant automatic data processing services related to the operation of the ABW program, and contracts for comprehensive management services (so-called MSO or ASO arrangements) must be conducted in compliance with federal procurement requirements outlined in the documents listed above.

Procurement and Contracting for Service Providers

CMHSPs and RSACAs will also be soliciting providers to furnish programs, services and/or supports for Medicaid recipients needing mental health, developmental disability or substance abuse services. When soliciting providers, it should be the objective of each CMHSP or RSACA to acquire needed services and supports at fair and economical prices, with appropriate attention to quality of care and maintenance of exiting-care relationships and service networks currently used by Medicaid recipients. Procurement processes should be used to solicit such services. Depending on the circumstances (e.g., local area market conditions, kind or quantity of services needed, etc.) various methods for selecting providers may be used including:

1. Procurement for Selective Contracting [1]

   The CMHSP or RSACA (as the managing entity) purchases services from a limited number of providers who agree to fulfill contractual obligations for an agreed upon price. The managing entity identifies the specific services to be provided, seeks proposals price bids, and awards contracts to the best bidders. Contracts are let only with a sufficient number of providers to assure adequate access to services. The prospect of increased volume induces providers to bid lower prices.

2. Procurement to Obtain Best Prices Without Selective Contracting

   Under an "any willing and qualified provider" process, bids can be solicited and used to set prices for a service, and then contracts or provider agreements can be offered to any qualified provider that is willing to fulfill the contract and meet the bid price.

(NOTE: A procurement process must be used when the managing entity is planning to restrict or otherwise limit the number of providers who can participate in the program.)

3. Non-Competitive Solicitation and/or Selection of Providers

   Under certain circumstances, the managing entity may select providers without a competitive procurement process. These circumstances are:

   - The service is available only from a single source;
   - There is a public exigency or emergency, and the urgency for obtaining the service does not permit a delay incident to competitive solicitation;
   - After solicitation of a number of sources, competition is determined inadequate;
   - The services involved are professional services (e.g., psychological testing) of limited quantity or duration;
   - The services are unique (e.g., financial intermediaries for consumers using vouchers or personal service budgets) and/or the selection of the service provider has been delegated to the consumer under a self-determination program; and

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[1] Competitive procurement is usually pursued through either a COMPETITIVE SEALED BIDDING method (the process of publicizing government needs, inviting bids, conducting public bid openings, and awarding a contract to the lowest responsive and responsible bidder) or a COMPETITIVE SEALED PROPOSAL process (method of publicizing government needs, requesting proposals, evaluating proposals received, negotiating proposals with acceptable or potentially acceptable offerors, and awarding the contract after consideration of evaluation factors in the RFP and the price offered).

- Existing residential service systems, where continuity of care arrangements are of paramount concern.

In these situations, the managing entity may employ noncompetitive negotiation to secure the needed services. The single- or limited-source procurement process involves soliciting interest and negotiating with a single or limit set of providers. Again, this may be used where competition for a service is deemed inadequate or when the uniqueness of the services or other considerations limits competitive procurement possibilities.

Whether a competitive procurement or noncompetitive solicitation process is used, the managing entity must ensure that organizations or individuals selected and offered contracts have not been previously sanctioned by the Medicaid program resulting in prohibition of their participation in the program.

Checklists for Procurement
(adapted from Section 2087 of the State Medicaid Manual)

This checklist is provided as a guide for planning procurement activities. Use is not mandatory.

1. Planning Checklist

* Has an analysis been conducted to determine if a procurement process should be initiated (need for services, available providers, likelihood of cost savings, etc.)? Have consumers and family members been involved in this analysis?

* If a procurement process is warranted, what form should it take?

    * Automatic data processing (ADP) services, significant management information system enhancements, comprehensive management support functions

    * Full Compliance with CFR regulations, OMB Circulars and HCFA State Medicaid Manual

* Acquisition of Service Provider Capacity - Network Participation

    * Competitive Sealed Bids

    * Competitive Negotiation

    * Non-Competitive Negotiations (if solicitation falls under the exception criteria listed above)

2. Request for Proposals Checklist (Competitive Procurement for Providers)

    * Have consumers and families been involved in developing the request for proposals?

* Are the major time frames of the RFP for response by competitors, evaluation period, award, contract negotiation, implementation and contract start-up time adequate to assure interested contractors a sufficient period to prepare a proposal and assume operations in an orderly manner?

* Does the RFP contain a detailed and clear description of the scope of work to be contracted?

* Does the RFP provide for:

* Answering written questions from a prospective bidder about the RFP?
* Acceptance of a late or alternate proposal or withdrawal of a proposal?

* Evidence of adequate financial stability of the bidder and of any parent organization?
* Performance standards?
* A time-frame requirement for guarantee of all prices quoted in the proposal?
* Acceptance by a bidder of any reduction in payments for nonperformance?
* A bidders' conference?
* The general overall evaluation criteria, including maximum points available by category?
* A reference to applicable code requirements, administrative rules, board policies, and managed care program stipulations?

* Does the RFP provide for open solicitation of all technically competent contractors?

* Does the RFP list procedures for handling changes to the RFP that occur after some proposals are submitted, identify who will be notified of the changes, and describe how they will be made?

* Are there any requirements in the RFP that would unduly or unfairly restrict or limit competition among prospective bidders?

* Does the RFP include a copy of the Managing Entity's proposed contract?

3. Proposal Evaluation Plan (PEP) Checklist

* Does the PEP consider the following in the evaluation of proposals?

* Contractor Capability Staff qualifications and general experience; Experience with Title XIX or similar programs; Experience in service to the target populations; Contractor stability (including financial stability and reputation in the field); Evaluation by previous clients.

* Technical Approach Understanding of the scope, objectives, and requirements; Proper emphasis on various job elements; Responsiveness to specifications; Clarity of statement of implementation plan.

* Financial Aspects Realism of total cost estimate and cost breakdown; Realism of estimated hours of staff time; Hourly rate structure; Reasonableness of implementation costs; Reasonableness of turnover costs.

`

4. Report of the Selection Committee Checklist

* Are consumers and family members included on the proposal evaluation team?

* If a contractor that did not submit the lowest offer was selected, was its selection justified as being most advantageous to the CMHSP or RSACA?

* Is the selection committee's tabulation of proposal scores complete and accurate?

* Is the evaluation process free of bias?

* Is a meeting for debriefing of unsuccessful bidders offered after the announcement of the contract award?

* Did the evaluation committee substantiate reasons a prospective bidder was determined to be non-responsive?

* Did the evaluation committee document valid reasons for not awarding the maximum points in each category and or the reasons for awarding bonus points?

Attachment P6.4.3.2

Department of Community Health
Mental Health and Substance Abuse Administration

CREDENTIALING AND RE-CREDENTIALING PROCESSES

A. Overview

This policy covers credentialing, temporary/provisional credentialing and re-credentialing processes for those individual and organizational providers directly or contractually employed by Prepaid Inpatient Health Plans (PIHPs), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Adult Benefits Waiver (ABW) and Medicaid programs. The policy does not establish the acceptable scope of practice for any of the identified providers, nor does it imply that any service delivered by the providers identified in the body of the policy is billable or reimbursable. PIHPs are responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual, ABW and Medicaid Provider Manual requirements. Please reference the applicable licensing statutes and standards, as well as the Medicaid Provider Manual should you have questions concerning scope of practice or whether ABW or Medicaid funds can be used to pay for a specific service.

Note: The individual practitioner and organizational provider credentialing process contains two primary components: initial credentialing and re-credentialing. MDCH recognizes that PIHPs may have a process that permits initial credentialing on a provisional or temporary basis, while required documents are obtained or performance is assessed. The standards that govern these processes are in the sections that follow.

B. Credentialing Individual Practitioners

The PIHP must have a written system in place for credentialing and re-credentialing individual practitioners included in their provider network who are not operating as part of an organizational provider.

1. Credentialing and re-credentialing must be conducted and documented for at least the following health care professionals:

    a. Physicians (M.D.s and D.O.s)

    b. Physician's Assistants

    c. Psychologists (Licensed, Limited License, and Temporary License)

    d. Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians

e. Licensed Professional Counselors

f. Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses

g. Occupational Therapists and Occupational Therapist Assistants

h. Physical Therapists and Physical Therapist Assistants

i. Speech Pathologists

2. The PIHP must ensure:

a. The credentialing and re-credentialing processes do not discriminate against:

(1) A health care professional, solely on the basis of license, registration or certification; or

(2) A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available on their website at http://exclusions.oig.hhs.gov. A complete list of sanctioned providers is available on the Michigan Department of Community Health website at www.michigan.gov/mdch. (Click on Providers, click on Information for Medicaid Providers, click on List of Sanctioned Providers)

3. If the PIHP delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this policy, it must retain the right to approve, suspend, or terminate from participation in the provision of ABW or Medicaid funded services a provider selected by that entity and meet all requirements associated with the delegation of PIHP functions. The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions.

4. Compliance with the standards outlined in this policy must be demonstrated through the PIHP's policies and procedures. Compliance will be assessed based on the PIHP's policies and standards in effect at the time of the credentialing/re-credentialing decision.

5. The PIHP's written credentialing policy must reflect the scope, criteria, timeliness and process for credentialing and re-credentialing providers. The policy must be approved by the PIHP's governing body, and

   a. Identify the PIHP administrative staff member and/or entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineate their role;

   b. Describe any use of participating providers in making credentialing decisions;

   c. Describe the methodology to be used by PIHP staff members or designees to provide documentation that each credentialing or re-credentialing file was complete and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation;

   d. Describe how the findings of the PIHP's Quality Assessment Performance Improvement Program are incorporated into the re-credentialing process.

6. PIHPs must ensure that an individual credentialing/re-credentialing file is maintained for each credentialed provider. Each file must include:

   a. The initial credentialing and all subsequent re-credentialing applications;

   b. Information gained through primary source verification; and

   c. Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and re-credentialing standards.

C. Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of the individual practitioners must require:

1. A written application that is completed, signed and dated by the provider and attests to the following elements:

   a. Lack of present illegal drug use.

   b. Any history of loss of license and/or felony convictions.

   c. Any history of loss or limitation of privileges or disciplinary action.

   d. Attestation by the applicant of the correctness and completeness of the application.

2. An evaluation of the provider's work history for the prior five years.

3. Verification from primary sources of:

   a. Licensure or certification.

   b. Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.

   c. Documentation of graduation from an accredited school.

   d. National Practitioner Databank (NPDB)/ Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:

      (1) Minimum five-year history of professional liability claims resulting in a judgment or settlement;

      (2) Disciplinary status with regulatory board or agency; and

      (3) Medicare/Medicaid sanctions.

   e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a), (b), and (c) above.

D. Temporary/Provisional Credentialing of Individual Practitioners

Temporary or provisional credentialing of individual practitioners is intended to increase the available network of providers in underserved areas, whether rural or urban. PIHPs must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of ABW or Medicaid Beneficiaries that providers be available to provide care prior to formal completion of the entire credentialing process. Temporary or provisional credentialing shall not exceed 150 days.

The PIHP shall have up to 31 days from receipt of a complete application, accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.

For consideration of temporary or provisional credentialing, at a minimum a provider must complete a signed application that must include the following items:

1. Lack of present illegal drug use.

2. History of loss of license, registration, or certification and/or felony convictions.

3. History of loss or limitation of privileges or disciplinary action.

4. A summary of the provider's work history for the prior five years.

5. Attestation by the applicant of the correctness and completeness of the application.

The PIHP must conduct primary source verification of the following:

1. Licensure or certification;

2. Board certification, if applicable, or the highest level of credential attained; and

3. Medicare/Medicaid sanctions.

The PIHP's designee must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification as outlined in this Section, should be completed.

E. Re-credentialing Individual Practitioners

At a minimum, the re-credentialing policies for physicians and other licensed, registered, or certified health care providers must identify procedures that address the re-credentialing process and include requirements for each of the following:

1. Re-credentialing at least every two years.

2. An update of information obtained during the initial credentialing.

3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:

a. Medicare/Medicaid sanctions.

b. State sanctions or limitations on licensure, registration or certification.

c. Member concerns which include grievances (complaints) and appeals information.

d. PIHP Quality issues.

F. Credentialing Organizational Providers

For organizational providers included in its network:

1. Each PIHP must validate, and re-validate at least every two years, that the organizational provider is licensed or certified as necessary to operate in the State, and has not been excluded from Medicaid or Medicare participation.

2. The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and re-credential their directly employed and subcontract direct service providers in accordance with the PIHP's credentialing/re-credentialing policies and procedures (which must conform to MDCH's credentialing process).

G. Deemed Status

Individual practitioners or organizational providers may deliver healthcare services to more than one PIHP. A PIHP may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where a PIHP chooses to accept the credentialing decision of another PIHP, they must maintain copies of the credentialing PIHP's decisions in their administrative records.

H. Notification of Adverse Credentialing Decision

An individual practitioner or organizational provider that is denied credentialing or re-credentialing by the PIHP shall be informed of the reasons for the adverse credentialing decision in writing by the PIHP.

I. Appeal of Adverse Credentialing Decision

Each PIHP shall have an appeal process that is available when credentialing or re-credentialing is denied, suspended or terminated for any reason other than lack of need. The appeal process must be consistent with applicable federal and state requirements.

J. Reporting Requirements

The PIHP must have procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from the PIHP's provider network to appropriate authorities (i.e., DCH, the provider's regulatory board or agency, the Attorney General, etc.). Such procedures shall be consistent with current federal and state requirements, including those specified in the DCH Michigan Medicaid Non-Pregnant Childless Adults Waiver (Adults Benefits Waiver) Section 1115 Demonstration contract.

Definitions

National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB) The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. HRSA. They can be located on the Internet at www.npdb-hipdb.hrsa.gov/.

Organizational providers are entities that directly employ and/or contract with individuals to provide health care services. Examples of organizational providers include, but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units and partial hospitalization programs; substance abuse programs; and home health agencies.

PIHPs is a Prepaid Inpatient Health Plan under contract with the Department of Community Health to provide managed behavioral health services to ABW and Medicaid eligible individuals.

Provider is any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.

PIHP REPORTING REQUIREMENTS FOR MEDICAID SPECIALTY SUPPORTS AND SERVICES BENEFICIARIES

Effective 10/1/12

Table of Contents

FY 2012 MDCH/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
MENTAL HEALTH REPORTING REQUIREMENTS

Introduction

The Michigan Department of Community Health reporting requirements for the FY2013 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs or Substance Abuse Coordinating Agencies (CAs). These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

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

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

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

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

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

Where accuracy standards for collecting and reporting QI data are noted in the contract, it is expected that PIHPs will meet those standards.

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

FY 2013 DATA REPORT DUE DATES

	Nov11	Dec	Jan12	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec12	Jan13
1. Consumer level** a. Quality Improvement (monthly)[1] b. Encounter (monthly)[1]	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2.PIHP level a. Medicaid Utilization and Net Cost Report: annually)[2]				√											
b. Performance indicators (quarterly)[2]					√			√			√			√	
c. Consumer Satisfaction (annually) [2]										√					
d. CAFAS [3]													√		
e. Critical incidents (monthly)[3]															

NOTES:

1. Send data to MDCH MIS via DEG
2. Send data to MDCH, Mental Health and Substance Abuse Administration, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDCH web site at: www.michigan.gov/mhsa Click on "Reporting Requirements"

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

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

QUALITY IMPROVEMENT DATA

Demographic or "quality improvement" (QI) data is required to be reported for each consumer for whom an encounter data record or fee-for service claim (for Children's Waiver) is being submitted. Encounter data is reported within 30 days after the claim for the service is adjudicated, or in cases where claims payment is not part of the PIHP's business practice, within 30 days following the end of the month in which services were delivered. QI data is reported year-to-date. The first report for the fiscal year will contain records for all consumers whose claims were adjudicated the first month, the next month's report will contain records of all consumers whose claims were adjudicated in month one and month two, etc. Corrective QI file updates are allowed from the PIHP to replace a rejected file, or a file that contained rejected records.

Method for submission: The QI data is to be submitted in a delimited format, with the columns identified by the delimiter, rather then by column "from" and "to" indicators.

Due dates: The first QI data should be submitted during the same month the first encounter data is submitted. Encounter and QI data are due 30 days after a claim is adjudicated or services were rendered (see above note). Reporting adjudicated claims will enable the PIHP to accurately report on the amount paid for the service and on third party reimbursements.

Who to report: Report on each consumer who received a service from the PIHP, and from each CMHSP in the case of an affiliation, regardless of funding stream. The exception is when a PIHP or CMHSP contracts with another PIHP or CMHSP; when a Medicaid Health Plan contracts with a PIHP or CMHSP to provide its mental health outpatient benefit; or when a PIHP or CMHSP, through a sub-contract arrangement, provides the Medicaid Health Plan mental health outpatient benefit. In those cases, the PIHP or CMHSP that delivers the service does not report the encounter. Reporting QI data for all other consumers who are seen for a one-time-only assessment, crisis intervention, or prevention service, or received face-toface non-specialty mental health services in such settings as Federally Qualified Health Centers, county health plans, homeless shelters, primary care offices, or schools, requires only those data elements with a **. The encounter and QI file will be rejected if those data elements are not present.

Who submits consumer-level data: The PIHP must report the encounter and QI data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area for all services provided under MDCH benefit plans. The PIHP must report the encounter data for all substance abuse Medicaid beneficiaries in its service area. QI data for Medicaid beneficiaries receiving services from the Substance Abuse Coordinating Agencies (CAs) are not required to be reported by the PIHP. Some PIHPs may choose, however, to collect QI data from the CAs and forward it to MDCH.

Notes:

1. Demographic Information must be updated at least annually, such as at the time of annual planning. **A consumer demographic record must be submitted for each month the consumer receives services, and for which an encounter record or fee-for-service claim**

(Children's Waiver) is being submitted. Failure to meet this standard may result in rejection of a file and contract action.

2. Numbers missing from the sequence of options represent items deleted from previous reporting requirements.
3. Items with an * require that 95% of records contain a value in that field and that the values be within acceptable ranges (see each item for the ranges). Items with ** require that 100% of the records contain a value in the field, and the values are in the proper format and within acceptable ranges. Failure to meet the 100% standard will result in rejection of the file or record.
4. A "Supplemental Instructions for Encounter and Quality Improvement Data Submissions" issued by MDCH should be used for file layouts.
5. Some demographic items are reported on both the 837 Health Care Claim transaction and the QI data report for ease of calculating population numbers during the year.

The following is a description of the individual consumer demographic elements for which data is required of Community Mental Health Services Programs.

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

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

****2.a.** ***PIHP Payer Identification Number*** **(PIHPID)**

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

2.b. ***CMHSP Payer Identification Number*** **(CMHID)**

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

****3.** ***Consumer Unique ID*** **(CONID)**

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

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4. ***Social Security Number*** **(SSNO)**

The nine-digit integer must be recorded, if available.
Blank = Unreported [Leave nine blanks]

5.a** ***Medicaid ID Number **(MCIDNO)**

Enter the ten-digit integer for consumers with a Medicaid number, or ABW number.
Blank = Unreported [Leave ten blanks]

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

6. Leave blank beginning with FY'06 service reporting

7. ***Corrections Related Status*** **(CORSTAT)**

For persons under the jurisdiction of a corrections or law enforcement program during treatment, indicate the location/jurisdiction involved at the time of annual update

1 = In prison
2 = In jail
3 = Paroled from prison
4 = Probation from jail
5 = Juvenile detention center
6 = Court supervision
7 = Not under the jurisdiction of a corrections or law enforcement program
8 = Awaiting trial
9 = Awaiting sentencing
10= Consumer refused to provide information
11= Minor (under age 18) who was referred by the court
12= Arrested and booked
13= Diverted from arrest or booking
Blank = Unknown

****8.*** ***Residential Living Arrangement*** **(RESID)**

Indicate the consumer's residential situation or arrangement at the time of intake if it occurred during the reporting period, or at the time of annual update of consumer information during the period. Reporting categories are as follows:

1 = Homeless on the street or in a shelter for the homeless
2 = Living in a private residence with natural or adoptive family member(s). "Family member" means parent, stepparent, sibling, child, or grandparent of the primary consumer; or an individual upon whom the primary consumer is dependent for at least 50% of his or her financial support.
3 = Living in a private residence not owned by the PIHP, CMHSP or the contracted provider, alone or with spouse or non-relative(s).
5 = Foster family home (Include all foster family arrangements regardless of number of beds)
6= Specialized residential home - Includes any adult foster care facility certified to provide a specialized program per DMH Administrative Rules, 3/9/96, R 330.1801 (Include all specialized residential, regardless of number of beds); or a licensed Children's Therapeutic Group Home
8 = General residential home (Include all general residential regardless of number of beds)

"General residential home" means a licensed foster care facility not certified to provide specialized program (per the DMH Administrative Rules)

10 = Prison/jail/juvenile detention center

11 = Deleted (AIS/MR)

12= Nursing Care Facility

13= Institutional setting (congregate care facility, boarding schools, Child Caring Institutions, state facilities)

16 = Living in a private residence that is owned by the PIHP, CMHSP or the contracted provider, alone or with spouse or non-relative.

Blank = Unreported

9.** ***Total Annual Income **(TOTINC)**

Indicate the total amount of gross income of the individual consumer if he/she is single; or that of the consumer and his/her spouse if married; or that of the parent(s) of a minor consumer at the time of service initiation or most recent plan review. "Income" is defined as income that is identified as taxable personal income in section 30 of Act No. 281 of the Public Acts of 1967, as amended, being 206.30 of the Michigan Compiled Laws, and non-taxable income, which can be expected to be available to the individual and spouse not more than 2 years subsequent to the determination of liability.

1= Income is below $10,000

2= Income is $10,001 to $20,000

3= Income is $20,001 to $30,000

4= Income is $30,001 to $40,000

5= Income is $40,001 to $60,000

6= Income is more than $60,000

Blank = Income was not reported

10.** ***Number of Dependents **(NUMDEP)**

Enter the number of dependents claimed in determining ability-to-pay. "Dependents" means those individuals who are allowed as exemptions pursuant to section 30 of Act No. 281 of the Public Acts of 1967, as amended, being 206.30 of the Michigan Compiled Laws. Single individuals living in an AFC or independently are considered one exemption, therefore enter "1" for number of dependents.

# of dependents =_ _ Blank = Unreported

11.** ***Employment Status **(EMPLOY)**

Indicate current employment status as it relates to <u>principal</u> employment for consumers age 18 and over. Reporting categories are as follows:

1= Employed full time (30 hours or more per week) competitively.

2= Employed part time (less than 30 hours per week) competitively.

3= Unemployed – looking for work, and/or layoff from job.

4= Deleted.

5= Deleted.
6= Deleted.
7= Participates in sheltered workshop or facility-based work.
8= Deleted.
9= Deleted.
10= Deleted.
11= In unpaid work (e.g., volunteering, internship, community service).
12= Self-employed (e.g., micro-enterprise).
13= In enclaves/mobile crews, agency-owned transitional employment.
14= Participates in facility-based activity program where an array of specialty supports and services are provided to assist an individual in achieving his/her non-work related goals.
15= Not in the competitive labor force-includes homemaker, child, student age 18 and over, retire from work, resident of an institution (including nursing home), or incarcerated.

Note: "Competitive Employment" " is work for which anyone may apply, that occurs in an integrated setting, with or without supports, for which the individual is paid at or above minimum wage, but not less than the customary wage and benefit level for all workers in that setting. This status includes persons employed as Peer Support Specialists and Peer Mentors.

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12. ***Education*** **(EDUC)**

Indicate the level attained at the time of the most recent admission or annual update. For children attending pre-school that is not special education, use "blank=unreported." Reporting categories are as follows:

1 = Completed less than high school
2 = Completed special education, high school, or GED
3 = In school - Kindergarten through 12th grade
4 = In training program
6 = In Special Education
7 = Attended or is attending undergraduate college
8 = College graduate
Blank = Unreported

Items 13 through 16 intentionally left blank

****17.*** ***Disability Designation***

Enter yes for <u>all</u> that apply, enter no for all that do not apply. To meet standard at least one field must have a "1."

17.01: Developmental disability (Individual meets the 1996 Mental Health Code Definition of Developmental Disability regardless of whether or not they receive services from the DD or MI services arrays) **(DD)**

1 = Yes
2 = No
3 = Not evaluated

17.02: Mental Illness or Serious Emotional Disturbance (Has DSM-IV diagnosis, exclusive of mental retardation, developmental disability, or substance abuse disorder) **(MI)**

1 = Yes
2 = No
3 = Not evaluated

17.03: Substance Abuse Disorder/SUD (as defined in Section 6107 of the public health code. Act 368 of the Public Health Acts of 1978, being section 333.6107 of the MCL)**.** Indicate the appropriate substance use disorder related status at the time of intake, and subsequently at annual update. **(SA)**.

2= No, individual does not have an SUD
3= Not evaluated for SUD (e.g., person is an infant, in crisis situation, etc.)
4 = Individual has one or more DSM-IV substance use disorder(s), diagnosis codes 291xx, 292xx, 303xx, 304xx, 305xx, with at least one disorder either active or in partial remission (use within past year).
5 = Individual has one or more DSM-IV substance use disorder(s), diagnosis codes 291xx, 292xx, 303xx, 304xx, 305xx, and all coded substance use disorders are in full remission (no use for one year). This includes cases where the disorder is in full remission and the consumer is on agonist therapy or is in a controlled environment.
6 = Results from a screening or assessment suggest substance use disorder. This includes indications, provisional diagnoses, or "rule-out diagnoses.

17.04: Individual received an assessment only, and was found to meet none of the disabilities listed above (NA).

1 = Yes
2 = No

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18. **Reporting element deleted in FY'03-04**

Leave blank beginning with FY'04 service reporting

Items 19-24 should be left blank beginning October 1, 2011.

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25. ***Gender (GENDER)***

Identify consumer as male or female.
M = Male
F = Female

****26.*** ***Program Eligibility*** **(PE)**

Indicate ALL programs or plans in which the individual is enrolled and/or from which funding is received directly by the individual/family or on his/her/family's behalf.
Every item MUST have a response of "1" or "2" to meet standard.

26.1 Reporting element deleted in FY'03-04

26.2 Adoption Subsidy **(PE_ASUB)**
1 = Yes
2 = No

26.3 Commercial Health Insurance or Service Contract (EAP, HMO) **(PE_COM)**
1 = Yes
2 = No

26.4 Program or plan is not listed above **(PE_OTH)**
1= Yes
2= No

26.5 Individual is not enrolled in or eligible for a program or plan **(PE_INELG)**
1= Yes
2= No

26.6 Individual is enrolled in Medicare (PE_MCARE
1= Yes
2 = No

26.7 SDA, SSI, SSDI (**PE_SSI**)
1= Yes
2= No

***27. Parental Status* (PARSTAT)**

Indicate if the consumer (no matter what age) is the natural or adoptive parent of a minor child (under 18 years old)

1= Yes
2= No
Blank = Unreported

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28. Children Served by Department of Human Services

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

28.01 Child served by DHS for abuse and neglect (FIA_AN)
1= Yes
2= No
Blank = Unreported

28.02 Child served by another DHS program (FIA_OT)
1= Yes
2= No

Blank = Unreported

***29. Children Enrolled in Early On* (CHILDEOP)**

Indicate whether minor child is enrolled in the Early On program. If the consumer is an adult or if the consumer is a child not enrolled in the Early On program, enter 2=No.

1= Yes
2= No
Blank = Unreported

****30. Date of birth* (DOB)**

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

***31.* Intentionally Left Blank**

****32. Hispanic* (HIS)**

Indicate whether the person is Hispanic or Latino or not, or their ethnicity is unknown. Must use one these codes:

1. Hispanic or Latino
2. Not Hispanic or Latino
3. Unknown

****33. Race 1, Race 2, Race3* (RACE1, RACE2, RACE3)**

There are three separate fields for race, each one character long. RACE1 is required for individuals with service dates after 9/30/2005. RACE2 and RACE3 are for individuals who report more than one race. Report one race in each field. RACE2 and RACE3 are optional, but please use a blank to hold the place if there is no value for either.

Use these codes:

a. White - A person having origins in any of the original peoples of Europe
b. Black or African American - A person having origins in any of the Black racial groups of Africa.
c. American Indian or Alaskan Native - American Indian, Eskimo, and Aleut, having origins in any of the native peoples of North America
d. Asian - A person having origins in any of the original peoples of the far East, Southeast Asia, or the Indian subcontinent.
e. Native Hawaiian or other Pacific Islander
f. Some other race
g. Unknown Race
h. Consumer refused to provide

***34. Minimum Wage* (MINW)**

Indicate if the consumer is currently earning minimum wage or more.

1 = Yes
2 = No
3 = Not Applicable (e.g., person is not working)
Blank = Unreported

***35.* Foster Care Facility License Number**

The Foster Care Facility License Number (eleven alpha-numeric characters) must be entered when the consumer resides in one of the following living arrangement reported in #8 RESID:

Foster family home (#5)
Specialized residential home (#6)
General residential home (#8)

Blank = Not Applicable (the individual does not live in a licensed foster care facility)

HEALTH AND OTHER CONDITIONS FOR ALL POPULATIONS

The following three elements should be collected for all populations. These are conditions that affect all people served by the public mental health system and impact the success of the specialty services and supports they receive. The information is obtained from the individual's record and/or observation. Complete when an individual begins receiving public mental health services for the first time and update at least annually. Information can be gathered as part of the person-centered planning process. PIHPs and CMHSPs should be aware of these conditions and assure that care for them is being provided. MDCH is collecting this data in order to have more complete information about people served by the public mental health system who are more vulnerable.

39. Hearing 95% accuracy and completeness required

39.1: Ability to hear (with hearing appliance normally used) **(HEARING)**

1 = Adequate—No difficulty in normal conversation, social interaction, listening to TV
2 = Minimal difficulty—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
3 = Moderate difficulty—Problem hearing normal conversation, requires quiet setting to hear well
4 = Severe difficulty—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
5 = No hearing
Blank = Missing

39.2: Hearing aid used **(HEARAID)**

1 = Yes
2 = No
Blank = Missing

40. Vision 95% accuracy and completeness required

40.1: Ability to see in adequate light (with glasses or with other visual appliance normally used) **(VISION)**

1 = Adequate—Sees fine detail, including regular print in newspapers/books or small items in pictures
2 = Minimal difficulty—Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures
3 = Moderate difficulty—Limited vision; not able to see newspaper headlines or small items in pictures, but can identify objects in his/her environment
4 = Severe difficulty—Object identification in question, but the person's eyes appear to follow objects, or the person sees only light, colors, shapes
5 = No vision—eyes do not appear to follow objects; absence of sight
Blank = Missing

40. 2: Visual appliance used **(VISAPP)**

1= Yes

2 = No
Blank = Missing

***41. Health Conditions* 95% accuracy and completeness required**

Indicate whether or not the individual had the presence of each of the following health conditions, as reported by the individual, a health care professional or family member, in the past 12 months.

41.1: Pneumonia (2 or more times within past 12 months) – including Aspiration Pneumonia **(PNEUM)**
1 = Never present
2 = History of condition, but not treated for the condition within the past 12 months
3 = Treated for the condition within the past 12 months
4 = Information unavailable
Blank = Missing

41.2: Asthma **(ASTHMA)**
1 = Never present
2 = History of condition, but not treated for the condition within the past 12 months
3 = Treated for the condition within the past 12 months
4 = Information unavailable
Blank = Missing

41.3: Upper Respiratory Infections (3 or more times within past 12 months) **(RESP)**
1 = Never present
2 = History of condition, but not treated for the condition within the past 12 months
3 = Treated for the condition within the past 12 months
4 = Information unavailable
Blank = Missing

41.4: Gastroesophageal Reflux, or GERD **(GERD)**
1 = Never present
2 = History of condition, but not treated for the condition within the past 12 months
3 = Treated for the condition within the past 12 months
4 = Information unavailable
Blank = Missing

41.5: Chronic Bowel Impactions **(BOWEL)**
1 = Never present
2 = History of condition, but not treated for the condition within the past 12 months
3 = Treated for the condition within the past 12 months
4 = Information unavailable
Blank = Missing

41.6: Seizure disorder or Epilepsy **(SEIZURE)**

1 = Never present
2 = History of condition, but not treated for the condition within the past 12 months
3 = Treated for the condition within the past 12 months and seizure free
4 = Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)
5 = Treated for the condition within the past 12 months, but still experience frequent seizures
6 = Information unavailable
Blank = Missing

41.7: Progressive neurological disease, e.g., Alzheimer's **(NEURO)**
1 = Not present
2 = Treated for the condition within the past 12 months
3 = Information unavailable
Blank = Missing

41.8: Diabetes **(DIABETES)**
1 = Never present
2 = History of condition, but not treated for the condition within the past 12 months
3 = Treated for the condition within the past 12 months
4 = Information unavailable
Blank = Missing

41.9: Hypertension **(HYPERTEN)**
1 = Never present
2 = History of condition, but not treated for the condition within the past 12 months
3 = Treated for condition within the past 12 months and blood pressure is stable
4 = Treated for condition within the past 12 months, but blood pressure remains high or unstable
5 = Information is unavailable
Blank = Missing

41.10: Obesity **(OBESITY)**
1 = Not present
2 = Medical diagnosis of obesity present or Body Mass Index (BMI) > 30
Blank = Missing

PROXY MEASURES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

The following 11 elements are proxy measures for people with developmental disabilities. The information is obtained from the individual's record and/or observation. Complete when an individual begins receiving public mental health services for the first time and update at least annually. Information can be gathered as part of the person-centered planning process.

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

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

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

Indicate from the list below how the individual communicates **most of the time**:

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

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

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff

1 = Always Understood – Expresses self without difficulty
2 = Usually Understood – Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
3 = Often Understood – Difficulty communicating AND prompting usually required
4 = Sometimes Understood - Ability is limited to making concrete requests or understood only by a very limited number of people
5 = Rarely or Never Understood – Understanding is limited to interpretation of very

person-specific sounds or body language
Blank = Missing

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

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

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

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

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

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score a "2" to reflect the overall average ability. The person may or may not use assistive devices like shower

or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

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

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

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

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

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

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

1 = Care giver status is not at risk
2 = Care giver is likely to reduce current level of help provided
3 = Care giver is likely to cease providing help altogether
4 = Family/friends do not currently provide care
5 = Information unavailable
Blank = Missing

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

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

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

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

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

Fill in the number of anti-psychotic and other psychotrophic medications the individual is prescribed. See the codebook for further definition of "anti-psychotic" and "other psychotropic" and a list of the most common medications.
51.1: Number of Anti-Psychotic Medications **(AP)** ___
Blank = Missing
51.2: Number of Other Psychotropic Medications **(OTHPSYCH)** ___
Blank = Missing

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

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

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

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

DATA REPORT

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

Encounters per Beneficiary

Encounter data is collected and reported for every beneficiary for which a claim was adjudicated or service rendered during the month by the PIHP (directly or via contract) regardless of payment source or funding stream. Every MH/DD encounter record reported must have a corresponding quality improvement (QI) or demographic record reported at the same time. Failure to report both an encounter record and a QI record for a consumer receiving services will result in contract action. SA encounter records do not require a corresponding quality improvement (QI) or demographic record to be reported by the PIHP. * PIHP's and CMHSPs that contract with another PIHP or CMHSP to provide mental health services should include that consumer in the encounter and QI data sets. In those cases the PIHP or CMHSP that provides the service via a contract should not report the consumer in this data set. Likewise, PIHPs or CMHSPs that contract directly with a Medicaid Health Plan, or sub-contract via another entity that contracts with a Medicaid Health Plan to provide the Medicaid mental health outpatient benefit, should not report the consumer in this data set.

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all consumer level data reported after October 16, 2002 must be compliant with the transaction standards. Beginning January 1, 2012, all health care providers, billing agents and clearinghouses currently submitting version 4010A1 electronic transactions will need to convert to the version 5010, including the approved errata version. Version 4010A1 will be used for production transactions submitted through ~~12/31/2011~~ 3/31/2012 and Version 5010 must be used for all transactions submitted ~~41~~/1/2012 and after.

A summary of the relevant requirements is:

- Encounter data (service use) is to be submitted electronically on a Health Care Claim 4010A1 or 5010 as appropriate.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837/4010A includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
- The remaining demographic data, in HIPAA parlance called "Quality Improvement" data, shall be submitted in a separate file to CHAMPs and must be accompanied by required headers and trailers.

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

Data that is uploaded to CHAMPS must follow the HIPAA-prescribed formats for the 837/4010A1 and 5010 (institutional and professional) and MDCH-prescribed formats for QI data. The 837/4010A1 and 5010 includes header and trailer information that identifies the sender and receiver and the type of information being submitted. If data does not follow the formats, entire files could be rejected by the electronic system.

HIPAA also requires that procedure codes, revenue codes and modifiers approved by the CMS be used for reporting encounters. Those codes are found in the Current Procedural Terminology (CPT) Manual, Fifth Edition, published by the American Medical Associations, the Health Care Financing Administration Common Procedure Coding System (HCPCS), the National Drug Codes (NDC), the Code on Dental Procedures and Nomenclature (CDPN), the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), and the Michigan Uniform Billing Manual. The procedure codes in these coding systems require standard units that must be used in reporting on the 837/4010A1 and 5010.

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

The following elements reported on the 837/4010A1 and 5010 encounter format will be used by MDCH Quality Management and Planning Division for its federal and state reporting, the Contracts Management Section and the state's actuary. The items with an ** are required by HIPAA, and when they are absent will result in rejection of a file. Items with an ** must have 100% of values recorded within the acceptable range of values. Failure to meet accuracy standards on these items will result in contract action.

Refer to HIPAA 837 transaction implementation guides for exact location of the elements. Please consult the HIPAA implementation guides, and clarification documents (on MDCH's web site) for additional elements required of all 837/4010A1and 5010 encounter formats. The Supplemental Instructions contain field formats and specific instructions on how to submit encounter level data.

****1.a.** ***PIHP Plan Identification Number*** **(PIHPID)**
The MDCH-assigned 7-digit payer identification number must be used to identify the PIHP with all data transactions.

1.b. ***CMHSP Plan Identification Number*** **(CMHID)**
The MDCH-assigned 7-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

1.c. ***CA Plan Identification Number (CAID)***
The MDCH-assigned 7-digit payer identification number must be used to identify the Substance Abuse Coordinating Agency with all Substance Abuse data transactions

****2**. ***Identification Code/Subscriber Primary Identifier (please see the details in the submitter's manual)***
Ten-digit Medicaid number must be entered for a **Medicaid, ABW or MIChild** beneficiary. If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.
If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID.**

****3.** ***Identification Code/Other Subscriber Primary Identifier (please see the details in the submitter's manual)***
Enter the consumer's unique identification number (**CONID**) assigned by the CMHSP **regardless** of whether it has been used above**.**

****4.** ***Date of birth***
Enter the date of birth of the beneficiary/consumer.

*****5.*** ***Diagnosis***
Enter the ICD-9 primary diagnosis of the consumer.

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

***7. Encounter Data Identifier**
Enter specified code indicating this file is an encounter file.

***8. Line Counter Assigned Number**
A number that uniquely identifies each of up to 50 service lines per claim.

***9. Procedure Code**
Enter procedure code from code list for service/support provided. The code list is located on the MDCH web site. Do not use procedure codes that are not on the code list.

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

11. Monetary Amount (effective 10/1/12):
Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines

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

***13. Place of Service Code**
Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc.

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

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

PIHP REPORTING REQUIREMENTS

FY'13 PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDCH management of PIHP contracts and rate-setting by the actuary. In the case of an affiliation, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its affiliates. Medicaid Substance Abuse services provided by Substance Abuse Coordinating Agencies are now included in this report, effective 10/1/06. The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries, **except** Children's Waiver beneficiaries. Refer to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual for the complete and specific requirements for coverage for the State Plan, Additional services provided under the authority of Section 1915(b)(3) of the Social Security Act, and the Habilitation Supports Waiver. All of the aforementioned Medicaid services and supports provided in the PIHP service area (affiliation, if applicable) must be reported on this utilization and cost report. Instructions and current templates for completing and submitting the MUNC report may be found on the MDCH web site at www.michigan.gov/mdch. Click on Mental Health and Substance Abuse, then Reporting Requirements.

PIHP REPORTING REQUIREMENTS

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0 FOR PIHPS

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

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

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

PIHP REPORTING REQUIREMENTS

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM, VERSION 6.0 FOR PIHPS

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**

2. The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SA). **Standard = 95% in 14 day**s.

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults, DD children, and Medicaid SA) **Standard = 95% in 14 days**

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults (MI, DD) and all Medicaid SA (sub-acute de-tox discharges)

5. The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SA)

ADEQUACY/APPROPRIATENESS

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

EFFICIENCY

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

OUTCOMES

8. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who are in competitive employment.

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who earn state

minimum wage or more from employment activities (competitive, self employment, or sheltered workshop).

10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.

12. The percent of adults with developmental disabilities served, who live in a private residence alone, or with spouse or non-relative.

13. The percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative.

14. The percent of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and respite.

Note: Indicators #2, 3, 4, and 5 include Medicaid beneficiaries who receive substance abuse services managed by the Substance Abuse Coordinating Agencies.

PIHP REPORTING REQUIREMENTS

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
5. Medicaid penetration*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDCH
6. HSW services*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDCH
7. Admin. Costs*	10/01 to 9/30	1/31							MDCH
8. Competitive employment*	10/01 to 9/30								MDCH
9. Minimum wage*	10/01 to 9/30								MDCH
10. Readmissions	10/01 to 9/30	3/31	1/01 to 3/31	6/30	4-01 to 6-30	9/30	7/01 to 9/30	12/31	PIHPs
11. RR complaints	10/01 to 9/30	12/31							PIHPs
12. & 13. Living arrangements	10/1 to 9/30	N/A							MDCH
14. Children with DD	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDCH

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

PIHP REPORTING REQUIREMENTS

STATE LEVEL DATA COLLECTION

CAFAS:

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

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

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

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

-An annual survey using MHSIP 44 items for adults with MI and substance use disorder, and MHSIP Youth and Family survey for families of children with SED will be conducted. Surveys are available on the MHSIP web site and have been translated into several languages. See www.mhsip.org/surveylink.htm
-The PIHPs will conduct the survey in the month of May for all people (regardless of medical assistance eligibility) currently receiving services in specific programs.
-Programs to be selected annually by QIC based on volume of units, expenditures, complaints and site review information.
-The raw data is due August 31st to MDCH each year on an Excel template to be provided by MDCH.

Critical Incident Reporting

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

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30

days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.

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

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

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PRE-PAID INPATIENT HEALTH PLANS

FY 2013

The State require**s** that each specialty Prepaid Inpatient Health Plan (PIHP) 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 then Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002. This document also reflects: concepts and standards more appropriate to the population of persons served under Michigan's current 1915(b) specialty services and supports waiver; Michigan state law; and existing requirements, processes and procedures implemented in Michigan.

Michigan Standards

I. The PIHP 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 improvement.

II. The QAPIP must be accountable to a Governing Body that is a Community Mental Health Services Program Board of Directors. 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.

D. The Governing Body submits the written annual report to MDCH following its review. The report will include a list of the members of the Governing Body

III. There is a designated senior official responsible for the QAPIP implementation.

IV. There is active participation of providers and consumers in the QAPIP processes.

V. The PIHP measures its performance using standardized indicators based upon the

systematic, ongoing collection and analysis of valid and reliable data.

A. PIHP 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 PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.

VI. The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur.

VII. The PIHP's QAPIP includes affiliation-wide 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 trends and patterns of substantiated Recipient Rights 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 consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.

C. Performance improvement projects may be directed at state or PIHP-established aspects of care. Future state-directed projects will be selected by MDCH with consultation from the Mental Health Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.

D. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department.

E. The PIHP must engage in at least two projects during the waiver renewal period.

VIII. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put people at risk of harm.

A. At a minimum, sentinel events as defined in the department's contract must be

reviewed and acted upon as appropriate. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of the event.

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.

C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
2. Involvement of medical personnel in the mortality reviews
3. Documentation of the mortality review process, findings, and recommendations
4. Use of mortality information to address quality of care
5. Aggregation of mortality data over time to identify possible trends.

* "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

D. Following immediate event notification to MDCH (See Section 6.1.1 of this contract) the PIHP will submit information on relevant events through the Critical Incident Reporting System described below.

E. Critical Incident Reporting System

The critical incident reporting system collects information on critical incidents that can be linked to specific service recipients. This critical incident reporting system became fully operational and contractually required October 1, 2011 (see Attachment 6.5.1.1)

The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. The population on which these events must be reported differs slightly by type of event.

The QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events (see below) to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDCH will request documentation of this process when performing site visits.

MDCH has developed formal procedures for analyzing the event data submitted through this system. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up with individual PIHPs.

F. Risk Events Management

The QAPIP has a process for analyzing additional critical events that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDCH will request documentation of this process when performing site visits.

These events minimally include:

- Actions taken by individuals who receive services that cause harm to themselves
- Actions taken by individuals who receive services that cause harm to others
- Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period

Following immediate event notification to MDCH (See Section 6.1.1 of this contract) the PIHP will submit to MDCH, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service

IX. The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have (see F above) been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plan Review Committees and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. 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 consumers receiving long-term supports or services (e.g., persons receiving case management or supports coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. 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 (by MDCH and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served.

XII. 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 PIHP or under contract to the PIHP, 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 PIHP must have written policies and procedures for the credentialing process which are in compliance with MDCH's Credentialing and Re-credentialing Processes, January 2007, Attachment P.6.4.3.1, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also insure, regardless of funding mechanism (e.g., voucher):

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.

XIII. The written description of the PIHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates (as applicable**),** providers and subcontractors.

A. The PIHP must submit to the state for approval its methodology for verification.
B. The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.

XIV. 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. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.
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 service recipients. Notification of denial is sent to both the beneficiary and the provider. 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.

XV. The PIHP annually monitors its provider network(s), including any affiliates or sub-contractors to which it has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any provider network monitoring of its subcontractors.

XVI. The PIHPs, shall continually evaluate its oversight of “vulnerable” people in order to determine opportunities for improving oversight of their care and their outcomes. MDCH will continue to work with PIHP to develop uniform methods for targeted monitoring of vulnerable people.

The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDCH review.

CONSUMERISM PRACTICE GUIDELINE

I. SUMMARY

This guideline sets policy and standards for consumer inclusion in the service delivery design and delivery process for all public mental health services. This guideline ensures the goals of a consumer-driven system which gives consumers choices, decision-making roles. It is based on the active participation by primary consumers, family members and advocates in gathering consumer responses to meet these goals.

This participation by consumers, family members and advocates is the basis of a provider's evaluation. Evaluation also includes how this information guides improvements.

II. APPLICATION

A. Psychiatric hospitals operated by the Michigan Department of Community Health (MDCH).

B. Centers for persons with developmental disabilities and community placement agencies operated by the MDCH..

C. Special facilities operated by MDCH.

D. Prepaid Inpatient Health Plans (PIHPs) under contract with MDCH.

E. Community Mental Health Services Programs (CMHSPs) under contract with MDCH.

F. All providers of mental health services who receive public funds, either directly or by contract, grant, third party payers, including managed care organizations or other reimbursements.

III. POLICY

This policy supports services that advocate for and promote the needs, interests, and well-being of primary consumers. It is essential that consumers become partners in creating and evaluating these programs and services. Involvement in treatment planning is also essential.

Services need to be consumer-driven and may also be consumer-run. This policy supports the broadest range of options and choices for consumers in services. It also supports consumer-run programs which empower consumers in decision-making of their own services.

All consumers need opportunities and choices to reach their fullest potential and live independently. They also have the rights to be included and involved in all aspects of society.

Accommodations shall be made available and tailored to the needs of consumers as specified by consumers for their full and active participation as required by this guideline.

IV. DEFINITIONS

Informed Choice: means that an individual receives information and understands his or her options.

Primary Consumer: means an individual who receives services from the Michigan Department of Community Health or a Community Mental Health Services Program. It also means a person who has received the equivalent mental health services from the private sector.

Consumerism: means active promotion of the interests, service needs, and rights of mental health consumers.

Consumer-Driven: means any program or service focused and directed by participation from consumers.

Consumer-Run: refers to any program or service operated and controlled exclusively by consumers.

Family Member: means a parent, stepparent, spouse, sibling, child, or grandparent of a primary consumer. It is also any individual upon whom a primary consumer depends for 50 percent or more of his or her financial support.

Person-Centered Planning: means the process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life. It honors the individual's preferences, choices, and abilities.

Person-First Language: refers to a person first before any description of disability.

Recovery: means the process of personal change in developing a life of purpose, hope, and contribution. The emphasis is on abilities and potentials. Recovery includes positive expectations for all consumers. Learning self-responsibility is a major element to recovery.

V. STANDARDS

A. All services shall be designed to include ways to accomplish each of the standards.

1. "Person-first language" shall be utilized in all publications, formal communications, and daily discussions.

2. Provide informed choice through information about available options.

3. Respond to an individual's ethnic and cultural diversities. This includes the availability of staff and services that reflect the ethnic and cultural makeup of the service area. Interpreters needed in communicating with non-English and limited-English-speaking persons shall be provided.

4. Promote the efforts and achievements of consumers through special recognition of consumers.

5. Through customer satisfaction surveys and other appropriate consumer related methods, gather ideas and responses from consumers concerning their experiences with services.

6. Involve consumers and family members in evaluating the quality and effectiveness of service. Administrative mechanisms used to establish service must also be evaluated. The evaluation is based upon what is important to consumers, as reported in customer satisfaction surveys.

7. Advance the employment of consumers within the mental health system and in the community at all levels of positions, including mental health service provision roles.

B. Services, programs, and contracts concerning persons with mental illness and related disorders shall actively strive to accomplish these goals.

1. Provide information to reduce the stigma of mental illness that exists within communities, service agencies, and among consumers.

2. Create environments for all consumers in which the process of "recovery" can occur. This is shown by an expressed awareness of recovery by consumers and staff.

3. Provide basic information about mental illness, recovery, and wellness to consumers and the public.

C. Services, programs, and contracts concerning persons with developmental disabilities shall be based upon these elements.

1. Provide personal preferences and meaningful choices with consumers in control over the choice of services and supports.

2. Through educational strategies: promote inclusion, both personal and in the community; strive to relieve disabling circumstances; actively work to prevent occurrence of increased disability; and promote individuals in exercising their abilities to their highest potentials.

3. Provide roles for consumers to make decisions in polices, programs, and services that affect their lives including person-centered planning processes.

E. Consumer-run programs shall receive the same consideration as all other providers of mental health services. This includes these considerations:

1. Clear contract performance standards.

2. Fiscal resources to meet performance expectations.

3 A contract liaison person to address the concerns of either party.

4. Inclusion in provider coordination meeting and planning processes.

5. Access to information and supports to ensure sound business decisions.

F. Current and former consumers, family members, and advocates must be invited to participate in implementing this guideline. Provider organizations must develop collaborative approaches for ensuring continued participation.

Organizations' compliance with this guideline shall be locally and statewide evaluated. Foremost, this must involve consumers, family members and advocates. Providers, professionals, and administrators must be also included. The PIHP/CMHSP shall provide technical assistance. Evaluation methods shall provide constructive feedback about improving the use of this guideline. This guideline requires that it be part of the organizations' Continuous Quality Improvement.

VI. REFERENCES AND LEGAL AUTHORITY

Act 258, Section 116(e), Public Acts of 1974 as amended, being MCL 330.1116, 1704, 1708.

INCLUSION PRACTICE GUIDELINE

NOTE: Replicated from the MDCH Inclusion Guideline as included in the Public Mental Health Manual, Volume II, Section 1116(j), Subject GL-01, Chapter 01-C, Dated 2/13/95.

I. SUMMARY

This guideline establishes policy and standards to be incorporated into the design and delivery of all public mental health services. Its purpose is to foster the inclusion and community integration of recipients of mental health service.

II. APPLICATION

A. Psychiatric hospitals operated by the Michigan Department of Community Health (MDCH).

B. Regional centers for developmental disabilities and community placement agencies operated by MDCH.

C. Special facilities operated by MDCH.

D. Prepaid Inpatient Health Plans (PIHPs) under contract with MDCH.

E. Community Mental Health Services Programs (CMHSPs) under contract with MDCH.

III. POLICY

It is the policy of the department to support inclusion of all recipients of public mental health services.

No matter where people live or what they do, all community members are entitled to fully exercise and enjoy the human, constitutional and civil rights, which collectively are held in common. These rights are not conditional or situational; they are constant throughout our lives. Ideally they are also unaffected if a member receives services or supports from the public mental health system for a day, or over a lifetime. In addition, by virtue of an individual's membership in his or her community, he or she is entitled to fully share in all of the privileges and resources that the community has to offer.

IV DEFINITIONS

Community: refers to both society in general, and the distinct cities, villages, townships and neighborhoods where people, under a local government structure, come together and establish a common identity, develop shared interests and share resources.

Inclusion: means recognizing and accepting people with mental health needs as valued members of their community.

Integration: means enabling mental health service recipients to become, or continue to be, participants and integral members of their community.

Normalization: means rendering services in an environment and under conditions that are culturally normative. This approach not only maximizes an individual's opportunities to learn, grow and function within generally accepted patterns of human behavior but it also serves to mitigate social stigma and foster inclusion.

Self-determination: means the right of a recipient to exercise his or her own free will in deciding to accept or reject, in whole or in part, the services, which are being offered. Individuals cannot develop a sense of dignity unless they are afforded the freedom and respect that comes from exercising opportunities for self-determination.

Self-representation: means encouraging recipients, including those who have guardians or employ the services of advocates, to express their own point of view and have input regarding the services that are being planned or provided by the RMHA.

V. STANDARDS

A. Responsible Mental Health Agencies (RMHAs) shall design their programs and services to be congruent with the norms of their community.

This includes giving first consideration to using a community's established conventional resources before attempting to develop new ones that exclusively or predominantly serve only mental health recipients.

Some of the resources which can be used to foster inclusion, integration and acceptance include the use of the community's public transportation services, leisure and recreation facilities, general health care services, employment opportunities (real work for real pay), and traditional housing resources.

B. RMHA's shall organizationally promote inclusion by establishing internal mechanisms that:

1. assure all recipients of mental health services will be treated with dignity and respect.

2. assure all recipients, including those who have advocates or guardians, have genuine opportunities for consumer choice and self-representation.

3. provide for a review of recipient outcomes.

4. provide opportunities for representation and membership on planning committees, work groups, and agency service evaluation committees.

5. invite and encourage recipient participation in sponsored events and activities of their choice.

C. RMHAs shall establish policies and procedures that support the principle of normalization through delivery of clinical services and supports that:

1. address the social, chronological, cultural, and ethnic aspects of services and outcomes of treatment.

2. help recipients gain social integration skills and become more self-reliant.

3. encourage and assist adult recipients to obtain and maintain integrated, remunerative employment in the labor market(s) of their communities, irrespective of their disabilities. Such assistance may include but is not limited to helping them develop relationships with co-workers both at work and in non-work situations. It also includes making use of assistive technology to obtain or maintain employment.

4. assist adult recipients to obtain/ maintain permanent, individual housing integrated in residential neighborhoods.

5. help families develop and utilize both informal interpersonal and community based networks of supports and resources.

D. RMHAs shall establish procedures and mechanisms to provide recipients with the information and counsel they need to make informed treatment choices. This includes helping recipients examine and weigh their treatment and support options, financial resources, housing options, education and employment options.

In some instances, this may also include helping recipients:

1. learn how to make their own decisions and take responsibility for them.

2. understand his or her social obligations

VI. REFERENCES AND LEGAL AUTHORITY

MCL330.116, et.seq.
MCL330.1704, et.seq.

VII. EXHIBITS

None

Attachment C.7.0.1.2

MDCH Funding

Milliman letter with ABW capitation rates for the period of October 1, 2012 to September 30, 2013 will be sent at a later date.

Community Mental Health

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Community Health

Fiscal Year End September 30, 2013

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INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Community Health (MDCH) to assist independent audit personnel, Prepaid Inpatient Health Plan (PIHP) personnel, and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDCH and PIHPs or CMHSPs, and to assure examinations are completed in a consistent and equitable manner.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDCH to manage the Concurrent 1915(b)/(c) Medicaid Program (hereinafter referred to as "Medicaid Program"), contracts between PIHPs and MDCH to manage the Michigan Medicaid Non-Pregnant Childless Adults Waiver (hereinafter referred to as "ABW Program") Section 1115 Demonstration Program, contracts between CMHSPs and MDCH to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208 (hereinafter referred to as "GF Program"), and, in certain circumstances, contracts between CMHSPs and MDCH to manage the Community Mental Health Services Block Grant Program (hereinafter referred to as "CMHS Block Grant Program"). These CMH Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a PIHP or CMHSP expends $500,000 or more in federal awards[1], the PIHP or CMHSP must obtain a Single Audit.

PIHPs are ultimately responsible for the Medicaid funds received from MDCH, and are responsible for monitoring the activities of affiliated CMHSPs as necessary to ensure expenditures of Medicaid Program funds are for authorized purposes in compliance with laws, regulations, and the provisions of contracts. Therefore, PIHPs must either require their independent auditor to examine compliance issues related to the Medicaid funds awarded to the affiliated CMHSPs, or require the affiliated CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 8, 9, & 10).

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2013 and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

Failure to meet the requirements contained in these CMH Compliance Examination Guidelines may result in the withholding of current funds or the denial of future awards.

[1] Medicaid payments to PIHPs and CMHSPs for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended for the purposes of determining Single Audit requirements.

RESPONSIBILITIES

MDCH Responsibilities

MDCH must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code, and federal and state audit requirements; and to ensure the **COMPLIANCE REQUIREMENTS** contained in the CMH Compliance Examination Guidelines are complete and accurately represent requirements of PIHPs and CMHSPs; and distribute revised CMH Compliance Examination Guidelines to PIHPs and CMHSPs.
2. Review the examination reporting packages submitted by PIHPs and CMHSPs to ensure completeness and adequacy within six months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination reporting package within eight months after the receipt of a complete and final reporting package.
4. Monitor the activities of PIHPs and CMHSPs as necessary to ensure the Medicaid Program, ABW Program, GF Program, and CMHS Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDCH will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Program, ABW Program, and GF Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDCH will rely on PIHP or CMHSP Single Audits or the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure CMHSP Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDCH may, however, determine it is necessary to also perform a limited scope compliance examination or review of selected areas. Any additional reviews or examinations shall be planned and performed in such a way as to build upon work performed by other auditors. The following are some examples of situations that may trigger an MDCH examination or review:
    a. Significant changes from one year to the next in reported line items on the FSR.
    b. A PIHP entering the MDCH risk corridor.
    c. A large percentage or amount of ABW program funding converting to local.
    d. A large addition to an ISF per the cost settlement schedules.
    e. A material non-compliance issue identified by the independent auditor.
    f. The CPA that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.
    g. The CPA issued an adverse opinion on compliance due to their inability to draw conclusions because of the condition of the agency's records.

PIHP Responsibilities

PIHPs must:

1. Maintain internal control over the Medicaid Program and ABW Program that provides reasonable assurance that the PIHP is managing the programs in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the programs.
2. Comply with laws, regulations, and the provisions of contracts related to the Medicaid Program and ABW Program. Examples of these would include, but not be limited to: the Medicaid Managed Specialty Supports & Services Concurrent 1915(b)(c) Waiver Program Contract (Medicaid Program Contract), the Adult Benefits Waiver Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), OMB Circular A-87 (Cost Principles for State, Local, and Indian Tribal Governments located at 2 CFR Part 225), OMB Circular A-102 (Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments found at 45 CFR 92), the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines is properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the PIHP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The PIHP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDCH and the PIHP will be notified of any required action in the management decision.
8. Monitor the activities of affiliated CMHSPs as necessary to ensure the Medicaid Program and ABW Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. PIHPs must either (a.) require the PIHP's independent auditor (as part of the PIHP's examination engagement) to examine the records of the affiliated CMHSP for compliance with the Medicaid Program and ABW Program provisions, or (b.) require the affiliated CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Program and ABW Program. If the latter is chosen, the PIHP must incorporate the examination requirement in the PIHP/CMHSP contract and develop Compliance Examination Guidelines specific to their PIHP/CMHSP contract. Additionally, if the latter is chosen, the CMHSP examination must be

completed in sufficient time so that the PIHP auditor may rely on the CMHSP examination when completing their examination of the PIHP if they choose to.

9. If requiring an examination of the affiliated CMHSP, review the examination reporting packages submitted by affiliated CMHSPs to ensure completeness and adequacy.
10. If requiring an examination of the affiliated CMHSP, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in affiliated CMHSP's examination reporting packages.

CMHSP Responsibilities

(as a recipient of Medicaid and ABW funds from PIHP and a recipient of GF funds from MDCH and a recipient of CMHS Block Grant funds from MDCH)

CMHSPs must:

1. Maintain internal control over the Medicaid, ABW, GF, and CMHS Block Grant Programs that provides reasonable assurance that the CMHSP is managing the Medicaid, ABW, GF, and CMHS Block Grant Programs in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid, ABW, GF, and CMHS Block Grant Programs.
2. Comply with laws, regulations, and the provisions of contracts related to the Medicaid, ABW, GF, and CMHS Block Grant Programs. Examples of these would include, but not be limited to: the Medicaid Managed Specialty Supports & Services Concurrent 1915(b)(c) Waiver Program Contract (Medicaid Contract), the Managed Mental Health Supports and Services Contract (General Fund Contract), the Adult Benefits Waiver Contract, the CMHS Block Grant Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), OMB Circular A-87 (Cost Principles for State, Local, and Indian Tribal Governments located at 2 CFR Part 225), OMB Circular A-102 (Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments found at 45 CFR 92), the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines, and any examination required by the PIHP from which the CMHSP receives Medicaid and/or ABW funds are properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The CMHSP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDCH, and the CMHSP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

PIHPs under contract with MDCH to manage the Medicaid Program and ABW Program, and CMHSPs under contract with MDCH to manage the GF Program are required to contract annually with a certified public accountant in the practice of public accounting (hereinafter referred to as a practitioner) to examine the PIHP's or CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 10 – Compliance Attestation – AT 601 (Codified Section of AICPA Professional Standards) (hereinafter referred to as an examination engagement). The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Additionally, CMHSPs under contract with MDCH to provide CMHS Block Grant Program services with a contract amount of greater than $100,000 are required to ensure the above referenced examination engagement includes an examination of compliance with specified requirements related to the CMHS Block Grant Program **IF** the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program. The specified requirements and specified criteria related to the CMHS Block Grant Program are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Practitioner Selection

In procuring examination services, PIHPs and CMHSPs must engage an independent practitioner, and must follow the procurement standards prescribed by the Grants Management Common Rule (A-102 Common Rule). The codified common rule for PIHPs and CMHSPs is located at 45 CFR 92, Uniform Administrative Requirements for Grants and Cooperative Agreements to State, Local, and Tribal Governments. Procurement standards are addressed in Section 92.36. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, and price. When possible, PIHPs and CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the PIHP's or CMHSP's compliance with specified requirements is to express an opinion on the PIHP's or CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain

reasonable assurance that the PIHP or CMHSP complied, in all material respects, based on the specified criteria.

Practitioner Requirements

The practitioner should exercise due care in planning, performing, and evaluating the results of his or her examination procedures; and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected. The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements." In the examination of the PIHP's or CMHSP's compliance with specified requirements, the practitioner should:

1. Obtain an understanding of the specified compliance requirements (See AT 601.40).
2. Plan the engagement (See AT 601.41 through 601.44).
3. Consider the relevant portions of the PIHP's or CMHSP's internal control over compliance (See AT 601.45 through 601.47).
4. Obtain sufficient evidence including testing compliance with specified requirements (See AT 601.48 through 601.49).
5. Consider subsequent events (See AT 601.50 through 601.52).
6. Form an opinion about whether the entity complied, in all material respects with specified requirements based on the specified criteria (See AT 601.53).

Practitioner's Report

The practitioner's examination report on compliance should include the information detailed in AT 601.55 and 601.56, which includes the practitioner's opinion on whether the entity complied, in all material respects, with specified requirements based on the specified criteria. When an examination of the PIHP's or CMHSP's compliance with specified requirements discloses noncompliance with the applicable requirements that the practitioner believes have a material effect on the entity's compliance, the practitioner should modify the report as detailed in AT 601.64 through AT 601.67.

In addition to the above examination report standards, the practitioner must prepare:

1. A Schedule of Findings **including the applicable finding detail[2] listed in OMB Circular A-133, Section 510(b)** that includes the following:

[2] Finding detail must be presented in sufficient detail for the PIHP or CMHSP to prepare a corrective action plan and for MDCH to arrive at a management decision. The following specific information must be included, as applicable, in findings:

a. The criteria or specific requirement upon which the finding is based including statutory, regulatory, contractual, or other citation. The Compliance Examination Guidelines should NOT be used as criterion.

b. The condition found, including facts that support the deficiency identified in the finding.

   a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid, ABW, GF, and/or CMHS Block Grant Program(s).
   b. Material noncompliance with the provisions of laws, regulations, or contracts related to the Medicaid, ABW, GF, and/or CMHS Block Grant Program(s).
   c. Known fraud affecting the Medicaid, ABW, GF, and/or CMHS Block Grant Program(s).
2. A schedule showing final reported Financial Status Report (FSR) amounts, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below)], and examined FSR amounts. All examination adjustments must be explained and must have a corresponding finding or comment. This schedule is called the "Examined FSR Schedule." Note that Medicaid and ABW FSRs must be provided for PIHPs. All applicable FSRs must be included in the practitioner's report regardless of the lack of any examination adjustments.
3. A schedule showing a revised cost settlement for the PIHP or CMHSP based on the Examined FSR Schedule. This schedule is called the "Examined Cost Settlement Schedule." This must be included in the practitioner's report regardless of the lack of any examination adjustments.
4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid, ABW, GF, and/or CMHS Block Grant program(s), and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency. The list of details required for findings (a. through j. in footnote 2.) must also be provided for the comments.

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c. Identification of applicable examination adjustments and how they were computed.
d. Information to provide proper perspective regarding prevalence and consequences.
e. The possible asserted effect.
f. Recommendations to prevent future occurrences of the deficiency(ies) noted in the finding.
g. Views of responsible officials of the PIHP/CMHSP when there is a disagreement with the finding.
h. Planned corrective actions.
i. Responsible party(ies) for the corrective action.
j. Anticipated completion date.

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDCH within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The PIHP or CMHSP must submit the reporting package by e-mail to MDCH at MDCH-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. MDCH reserves the right to request a hard copy of the compliance examination report materials if for any reason the electronic submission process is not successful.

Examination Reporting Package

The reporting package includes the following:

1. Practitioner's report as described above;
2. Corrective action plan prepared by the PIHP or CMHSP.

Penalty

If the PIHP or CMHSP fails to submit the required examination reporting package by June 30th following the contract year end and an extension has not been granted by MDCH, MDCH may withhold from current funding five percent of the examination year's grant funding (not to exceed $200,000) until the required reporting package is received. MDCH may retain the withheld amount if the reporting package is delinquent more than 120 days from the due date and MDCH has not granted an extension.

Incomplete or Inadequate Examinations

If MDCH determines the examination reporting package is incomplete or inadequate, the PIHP or CMHSP, and possibly its independent auditor will be informed of the reason of inadequacy and its impact in writing. The recommendations and expected time frame for resubmitting the corrected reporting package will be indicated.

Management Decision

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

If there are no findings, comments, and/or questioned costs, MDCH will notify the PIHP or CMHSP when the review of the examination reporting package is complete and the results of the review.

COMPLIANCE REQUIREMENTS

The practitioner must examine the PIHP's or CMHSP's compliance with the A-K specified requirements based on the specified criteria stated below. If the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the L-N specified requirements based on the specified criteria stated below that specifically relate to the CMHS Block Grant, but only if the CMHSP's contract amount for the CMHS Block Grant is greater than $100,000.

COMPLIANCE REQUIREMENTS A-J
(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

The final FSR complies with contractual provisions as follows:

a. FSR agrees with agency financial records (general ledger) (Contract, Section 6.6.1).
b. FSR includes only allowable costs as specified in OMB Circular A-87 (located at 2 CFR Part 225); and the Mental Health Code, Sections 240, 241, and 242 (Contract, Section 6.6.1).
c. FSR includes revenues and expenditures in proper categories and according to reporting instructions (Contract, Sections 6.6.1 and 7.8, and Attachment 7.8.1).

Differences between the general ledger and FSR should be adequately explained and justified. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule." Any reported expenditures that do not comply with the OMB Circular A-87 cost principles, the Code, or contract provisions must be shown on the auditor's "Examined FSR Schedule."

The following items should be considered in determining allowable costs:

OMB Circular A-87 cost principles (2 CFR Part 225, Appendix A, Section C. 1.) require that for costs to be allowable they must meet the following general criteria:

a. Be necessary and reasonable for proper and efficient performance and administration of the grant.
b. Be allocable to the grant under the provisions of the applicable OMB Circular.
c. Be authorized or not prohibited under State or local laws or regulations.

d. Conform to any limitations or exclusions set forth in the applicable OMB Circular, other applicable laws and regulations, or terms and conditions of the grant and agreement.
e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
f. Be accorded consistent treatment.
g. Be determined in accordance with generally accepted accounting principles.
h. Not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period.
i. Be the net of all applicable credits.
j. Be adequately documented.

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (OMB Circular A-87, Appendix A, Section C.1.j.). Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness criteria of OMB Circular A-87, Appendix A, Section C.1.a., was met. If subcontractors are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation (OMB Circular A-87, Appendix A, Section C.1.j.). When the PIHP pays FQHCs and RHCs for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported rental costs for **less-than-arms-length transactions** must be limited to underlying cost (OMB Circular A-87, Appendix B, Section 37.c.). For example, the agency may rent their office building from the agency's board member/members, but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in OMB Circular A-87.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost (OMB Circular A-87, Appendix B, Section 37.b.).

Capital asset purchases that cost greater than $5,000 must be capitalized and depreciated over the useful life of the asset rather than expensing it in the year of purchase (OMB Circular A-87, Appendix B, Sections 11. and 15.). All invoices for a remodeling or renovation project must be accumulated for a total project cost when

determining capitalization requirements; individual invoices should not simply be expensed because they are less than $5,000.

Costs must be allocated to programs in accordance with relative benefits received. Accordingly, **Medicaid costs must be charged to the Medicaid Program, Adult Benefits Waiver Costs must be charged to the Adult Benefits Waiver, and GF costs must be charged to the GF Program**. Additionally, **administrative/indirect costs** must be distributed to programs on bases that will produce an equitable result in consideration of relative benefits derived in accordance with OMB Circular A-87, Appendix A, Sections C. and F., provisions.

Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported by personnel activity reports that meet the standards listed in OMB Circular A-87, Appendix B, Section 8.h.(4.).

B. CRCS Reporting

The final CRCS complies with reporting instructions contained in the contract (Contract, Section 7.8, and Attachment 7.8.1).

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (OMB Circular A-87, Appendix A, Section C.1.j.). For subcontractors paid on a net cost basis, adequate supporting documentation on costs include cost reporting by the subcontractor and documented evidence that the PIHP/CMHSP monitored the subcontractor and verified costs. Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness criteria of OMB Circular A-87, Appendix A, Section C.1.a., was met. When the PIHP pays Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services.

C. Real Property Disposition

The PIHP's or CMHSP's real property disposition (for property acquired with Federal funds) complied with the requirements contained in the A-102 Common Rule, or 45 CFR 92.31. Specifically, the following are required:

1. The PIHP or CMHSP must have prior consent of MDCH to dispose of or encumber the title to real property acquired with Federal funds.

2. For sales of real property, the PIHP or CMHSP must ensure sales procedures provide for competition to the extent practicable and result in the highest possible return.

3. The PIHP or CMHSP must obtain disposition instructions from MDCH.

4. The PIHP or CMHSP must comply with the disposition instructions obtained from MDCH. The disposition instructions will likely require a remittance to MDCH of the Federal portion (based on the Federal participation in the project) of the net sales proceeds. If the property is retained, but no longer needed to support the program, the PIHP or CMHSP will likely be required to compensate MDCH for the Federal portion of the current fair market value of the property. If the title to the property is transferred, the PIHP or CMHSP will likely be required to compensate MDCH for the Federal portion of the current fair market value of the property.

D. Administration Cost Report

The most recently completed PIHP's or CMHSP's Administration Cost Report complies with the applicable CMHSP/PIHP Administration Cost Reporting Instructions and the applicable standards in ESTABLISHING ADMINISTRATIVE COSTS WITHIN AND ACROSS THE CMHSP SYSTEM and contract provisions.

E. Procurement

The PIHP or CMHSP followed the procurement requirements contained in 45 CFR 92.36 (b) – (i), and ensured that organizations or individuals selected and offered contracts have not been debarred or suspended or otherwise excluded from or ineligible for participation in Federal assistance programs as required by 45 CFR 92.35.

F. Ability to Pay

The PIHP/CMHSP determined responsible parties' insurance coverage and ability to pay before, or as soon as practical after, the start of services as required by MCL 330.1817. Also, the PIHP/CMHSP annually determine the insurance coverage and ability to pay of individuals who continue to receive services and of any additional responsible party as required by MCL 330.1828. Also, the PIHP/CMHSP complete a new determination if informed of a significant change in a responsible party's ability to pay as required by MCL 330.1828.

It should be noted that Medicaid eligible consumers are deemed to have zero ability to pay. So there is no need to determine their ability to pay. The one exception is during the period when a Medicaid eligible consumer has a deductible. In that case an ability to pay determination does apply.

The PIHP's or CMHSP's charges for services represent the lesser of ability to pay determinations or cost of services according to MCL 330.1804. Cost of services means the total operating and capital costs incurred according to MCL 330.1800.

In the comparison of coast to ability to pay the practitioner may consider a cost based rate sheet or other documentation that is supported by cost records as evidence of costs of services.

G. Internal Service Fund (ISF)

The PIHP's Internal Service Fund complies with the Internal Service Fund Technical Requirement contained in Contract Attachment P 7.7.4.1 with respect to funding and maintenance.

H. Medicaid Savings and General Fund Carryforward

The PIHP's Medicaid Savings was expended in accordance with the PIHP's reinvestment strategy as required by Sections 7.7.2.2 and 7.7.2.3 of the Contract. The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1 of the contract. .

I. Match Requirement

The PIHP or CMHSP met the local match requirement, and all items considered as local match actually qualify as local match according to Section 7.2 of the Contract. Some examples of funds that do NOT qualify as local match are: (a.) revenues (such as workers' compensation refunds) that should be offset against related expenditures, (b.) interest earned from ISF accounts, (c.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (d.) donations of funds from subcontractors of the PIHP or CMHSP, (e.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSP's actual costs, and (f) donations of items that would not be an item generally provided by the PIHP or CMHSP in providing plan services.

If the PIHP or CMHSP does not comply with the match requirement in the Mental Health Code, Section 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

J. Consumer Fund Review

The PIHP or CMHSP has policies and procedures that address residents' property and funds as required by MCL 330.1752. The policies and procedures should address the proper handling of consumer funds by the agency, if applicable, and any applicable service provider; and require PIHP/CMHSP monitoring of resident funds and valuables for compliance with the Licensing Rules for Adult Foster Care Small Group Homes (R 400.14315). Consumer funds must be maintained separate from other agency funds, revenues and expenditures must be properly tracked, consumer's funds cannot be commingled and used for each others' expenses, and sufficient controls must exist to protect the consumers' funds. The auditor should verify that the PIHP or CMSHP performed monitoring of their employees and/or service providers for compliance with the Licensing Rules for Adult Foster Care Small Group Homes (R 400.14315).

COMPLIANCE REQUIREMENTS K-M

(APPLICABLE TO CMHSPs WITH A CMHS BLOCK GRANT OF GREATER THAN $100,000 THAT DID NOT HAVE A SINGLE AUDIT OR THE CMHS BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

K. Activities Allowed or Unallowed

The CMHSP expended CMHS Block Grant (CFDA 93.958) funds only on allowable activities in accordance with the OMB Circular A-133 Compliance Supplement and the Grant Agreement between MDCH and the CMHSP. CMHS Block Grant funds were NOT expended to supplant existing mental health funding; fund Medicaid-approved services; purchase medications; purchase or lease vehicles; purchase vehicle insurance; pay for administrative or indirect expenses; provide inpatient hospital services; make cash payments to recipients of health services; purchase or improve land; purchase, construct, or permanently improve any building; purchase major medical equipment; provide matching funds for other Federal funding; or provide financial assistance to any entity other than a public or non-profit entity.

L. Cash Management

The CMHSP complied with the applicable cash management compliance requirements that are contained in the OMB Circular A-133 Compliance Supplement. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by CMHSP funds before reimbursement is requested from MDCH.

M. Sub-recipient Monitoring

If the CMHSP contracts with other sub-recipients ("sub-recipient" per the OMB Circular A-133 definition) to carry out the Federal CMHS Block Grant Program, the CMHSP complied with the following requirements of OMB Circular A-133, Section .400 (d):

1. properly identified Federal award information and compliance requirements to the subrecipient, and approved only allowable activities in the award documents;
2. monitored subrecipient activities to provide reasonable assurance that the subrecipient administered Federal awards in compliance with Federal requirements;
3. ensured required audits are performed, issued a management decision on audit findings within 6 months after receipt of the sub-recipient's audit report, and ensured that the subrecipient took timely and appropriate corrective action on all audit findings; and
4. took appropriate action using sanctions if a subrecipient had a continued inability or unwillingness to have the required audits performed.

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDCH. Also, PIHPs are required to keep affiliate CMHSP's reports on file for three years from date of receipt. All examination working papers must be accessible and are subject to review by representatives of the Michigan Department of Community Health, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and affiliate CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDCH CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2012/2013 examinations. Any questions relating to these guidelines should be directed to:

Debra S. Hallenbeck, Manager
Quality Assurance and Review, Office of Audit
Michigan Department of Community Health
Capital Commons Center
400 S. Pine Street
Lansing, Michigan 48933
hallenbeckd@michigan.gov
Phone: (517) 241-7598 Fax: (517) 241-7122

GLOSSARY OF ACRONYMS AND TERMS

AICPA.....American Institute of Certified Public Accountants.

CMHS Block Grant Program.The program managed by CMHSPs under contract with MDCH to provide Community Mental Health Services Block Grant program services under CFDA 93.958.

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

Examination Engagement.....A PIHP or CMHSP's engagement with a practitioner to examine the entity's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 10 – Compliance Attestation – AT 601 (Codified Section of AICPA Professional Standards).

GF Program.....The program managed by CMHSPs under contract with MDCH to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.

MDCH.....Michigan Department of Community Health

Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program managed by PIHPs under contract with MDCH.

Adult Benefits Waiver .....The Michigan Medicaid Non-Pregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration Program managed by PIHPs under contract with MDCH

PIHP.....Prepaid Inpatient Health Plan. An organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, and manages services under the state's approved Michigan Medicaid Non-Pregnant Childless Adults Waiver (Adult Benefits Waiver) Section 1115 Demonstration Program.

Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.

SSAE.....AICPA's Statements on Standards for Attestation Engagements.

APPEAL PROCESS FOR COMPLIANCE EXAMINATION MANAGMENT DECISIONS

The following process shall be used to appeal MDCH management decisions relating to the Compliance Examinations that are required in Section 7.6 of the Master Contract.

STEP 1: MANAGEMENT DECISION

MDCH Office of Audit	Within eight months after the receipt of a complete and final Compliance Examination, MDCH shall issue to the PIHP/CMHSP a management decision on findings and questioned costs contained in the PIHP/CMHSP examination report. The management decision will include whether or not the examination finding is sustained; the reasons for the decision; the expected PIHP/CMHSP action to repay disallowed costs, make financial adjustments, or take other action; and a description of the appeal process available to the PIHP/CMHSP.

STEP 2: SETTLEMENT AND DISPUTE OF FINDINGS AND QUESTIONED COSTS

PIHP/CMHSP	1. Within 30 days of receipt of the management decision: A. Submits payment to MDCH for amounts due other than amounts resulting from disputed items; and B. If disputing items: i. Requests a conference with the Director of the MDCH Operations Administration, or his or her designee, to attempt to reach resolution on the audit findings, or submits to the MDCH Administrative Tribunal & Appeals Division a request for the Medicaid Provider Reviews and Hearings Process pursuant to MCL 400.1, et seq. and MAC R 400.3401, et seq. As specified in ii below. Any resolution as a result of of a conference with the Director of the MDCH Operations

	Administration would not be binding upon either party unless both parties agree to the resolution reached through these discussions. If the parties agree to a resolution the terms will be reduced to a written settlement agreement and signed by both parties. If no resolution is reached then there will be no obligation on the part of MDCH to produce a report of the conference process. Matters that remain unresolved, after these discussions, would move to the Administrative Hearing process, at the discretion of the CMHSP/PIHP. Administrative Hearing process ii. Submits to the MDCH Administrative Tribunal & Appeals Division a request for the Medicaid Provider Reviews and Hearings Process pursuant to MCL 400.1, et seq. and MAC R 400.3401, et seq. This process will be used for all PIHP/CMHSP disputes involving Compliance Examinations whether they involve Medicaid funds or not. Requests must identify the specific item(s) under dispute, explain the reason(s) for the disagreement, and state the dollar amount(s) involved, if any. The request must also include any substantive documentary evidence to support the position. Requests must specifically identify whether the agency is seeking a preliminary conference, a bureau conference or an administrative hearing. If MDCH does not receive a request for a preliminary conference, a bureau conference or an administrative hearing within 30 days of the date of the management decision, the management decision will constitute MDCH's Final Determination Notice according to MAC R 400.3405. C. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDCH Office of Audit, MDCH Contract Management, and

	MDCH Accounting.
MDCH Accounting	2. If the PIHP/CMHSP has not requested a conference with the Director of Operations Administration or the Medicaid Provider Reviews and Hearings Process within the timeframe specified, implements the adjustments as outlined in the management decision. If repayment is not made, recovers funds by withholding future payments.
MDCH Contract Management Unit	3. Ensures audited PIHP/CMHSP resolves all findings in a satisfactory manner. Works with the audited PIHP/CMHSP on developing performance objectives, as necessary.

STEP 3. MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS

MDCH Administrative Tribunal & Appeals Division	Follows the rules contained in MAC R 400.3401, et seq., and various internal procedures regarding meetings, notifications, documentation, and decisions.

ABW contract attachment 7.8.1.2 Finance Planning, Reporting and Settlement

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

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

Due Date	Report Title	Report Period
5/31/2013	Mid-Year Status Report	October 1 to March 31
8/15/2013	Financial Status Report – ABW/Medicaid	October 1 to June 30
8/15/2013	Medicaid – Shared Risk Calculation & Risk Financing	October 1 to June 30
8/15/2013	Medicaid – Internal Service Fund	October 1 to June 30
8/15/2013	Projection Financial Status Report – ABW/Medicaid	October 1 to September 30
8/15/2013	Projection Medicaid – Shared Risk Calculation & Risk Financing	October 1 to September 30
8/15/2013	Projection Medicaid – Internal Service Fund	October 1 to September 30
8/15/2013	Projection Medicaid Contract Settlement Worksheet	October 1 to September 30
8/15/2013	Projection Medicaid Contract Reconciliation & Cash Settlement	October 1 to September 30
10/15/2013	Medicaid Year End Accrual Schedule	October 1 to September 30
11/10/2013	Interim Financial Status Report – ABW/Medicaid	October 1 to September 30
11/10/2013	Interim Medicaid – Shared Risk Calculation & Risk Financing	October 1 to September 30
11/10/2013	Interim Medicaid – Internal Service Fund	October 1 to September 30
11/10/2013	Interim Medicaid Contract Settlement Worksheet	October 1 to September 30
11/10/2013	Interim Medicaid Contract Reconciliation & Cash Settlement	October 1 to September 30
1/31/2014	Annual Report on Fraud and Abuse Complaints	October 1 to September 30
2/28/2014	Final Financial Status Report – ABW/Medicaid	October 1 to September 30
2/28/2014	Final Shared Risk Calculation & Risk Financing	October 1 to September 30
2/28/2014	Final Medicaid – Internal Service Fund	October 1 to September 30
2/28/2014	Final Medicaid Contract Settlement Worksheet	October 1 to September 30
2/28/2014	Final Medicaid Contract Reconciliation & Cash Settlement	October 1 to September 30

2/28/2014	ABW/Medicaid Utilization and Cost Report (MUNC)	See Attachment P 6.5.1.1 Submit report to: QMPMeasures@michigan.gov
2/28/2014	Medicaid Community Inpatient Psychiatric Services Expenditure Report	FY 13 expenditures
3/31/2014	Administrative Cost Report	For the fiscal year ending October 1 to September 30, 2013
30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter. Compliance exam and plan of correction	October 1 to September 30 Submit reports to: MDCHAuditReports@michigan.gov

MDCH AUDIT REPORT AND APPEAL PROCESS

The following process shall be used to issue audit reports, and appeal audit findings and recommendations. Established timeframes may be extended by mutual agreement of parties involved.

STEP 1. AUDIT / PRELIMINARY ANALYSIS / RESPONSE	
MDCH Office of Audit	1. Completes audit of PIHP and holds an exit conference with PIHP management.
	2. Issues a preliminary analysis within 60 days of the exit conference. The preliminary analysis is a working document and is not subject to Freedom of Information Act requests.
Audited PIHP	3. Within 10 days of receipt of the preliminary analysis, requests a meeting with the MDCH Office of Audit to discuss disputed audit findings and conclusions in the preliminary analysis. Since the preliminary analysis serves as the basis for the final report, the PIHP shall take advantage of this opportunity to ensure that any factual disagreements or wording changes are considered before the final report is issued.
MDCH Office of Audit	4. <u>If a meeting is requested</u>, convenes a meeting to discuss concerns regarding the preliminary analysis.
Audited PIHP	5. Within 14 days of the meeting with the MDCH Office of Audit to discuss the preliminary analysis, submits to the MDCH Office of Audit any additional evidence to support its arguments.
MDCH Office of Audit	6. Within 30 Days of either the meeting to discuss the preliminary analysis, or receipt of additional information from the PIHP, whichever is later, revises and issues the preliminary analysis as appropriate based on factual information submitted at the meeting or other supporting documentation provided subsequent to the meeting.
Audited PIHP	7. Within 30 days of receipt of the revised preliminary analysis, submits a brief written response indicating agreement or disagreement with each finding and recommendation. If there is disagreement, the response shall explain the basis or rationale for the disagreement and shall include additional

	documentation if appropriate. If there is agreement, the response shall briefly describe the actions to be taken to correct the deficiency and an expected completion date. Include responses on the Corrective Action Plan Forms included in the preliminary analysis. 8. If a meeting is not requested, within 30 days of receipt of the preliminary analysis, submits a brief written response to each finding and recommendation as described in STEP 1. 7. above.

STEP 2. FINAL AUDIT REPORT

MDCH Office of Audit	1. Within 30 days of receipt of the PIHPs response to the preliminary analysis prepares and issues final audit report incorporating paraphrased PIHP's responses, and Office of Audit responses where deemed necessary.
	2. Forwards final audit report to audited PIHP and other relevant parties. The letter bound with the final audit report describes the audited PIHP's appeal rights.

STEP 3. SETTLEMENT AND DISPUTE OF FINDINGS

Audited PIHP	1. Within 30 days of receipt of the final audit report: a. Submits payment to MDCH for amounts due other than amounts resulting from disputed findings; and b. If disputing findings, submits to the MDCH Administrative Tribunal & Appeals Division a request for the Medicaid Provider Reviews and Hearings Process pursuant to MCL 400.1 et seq. and MAC R 400.3401, et seq. This process will be used for all CMHSP audits regarding the Specialty Service Contract whether they involve Medicaid funds or not. Requests must identify the specific audit adjustment(s) under dispute, explain the reason(s) for the disagreement, and state the dollar amount(s) involved, if any. The request must also include any substantive documentary evidence to support the position. Requests must specifically identify whether the agency is seeking a preliminary conference, a

	bureau conference or an administrative hearing. If MDCH does not receive a request for a preliminary conference, a bureau conference or an administrative hearing within 30 days of the date of the letter transmitting the final audit report, the letter will constitute MDCH's Final Determination Notice according to MAC R 400.3405. c. Provides copies of the request for the Medicaid Provider Reviews and Hearings Process to the MDCH Office of Audit, MDCH Contract Management, and MDCH Accounting.
MDCH Accounting	2. If the PIHP has not requested the Medicaid Provider Reviews and Hearings Process within the timeframe specified, implements the adjustments as outlined in the final report. If repayment is not made, recovers funds by withholding future payments.
MDCH Contract Management Unit	3. Ensures audited PIHP resolves all findings in a satisfactory manner. Works with the audited PIHP on developing performance objectives, as necessary.

STEP 4. MEDICAID PROVIDER REVIEWS AND HEARINGS PROCESS

MDCH Administrative Tribunal & Appeals Division	Follows the rules contained in MAC R 400.3401, et seq., and various internal procedures regarding meetings, notifications, documentation, and decisions.