FEIN# 46-3351818

DUNS# 079148120

Contract Manager and Location Building:
John P. Duvendeck– Lewis Cass Building, 320 S. Walnut
Contract Number# 20170111-00

Agreement Between
Michigan Department of Health & Human Services
And
CMHSP Detroit Wayne MH Authority
For
Managed Mental Health Supports and Services

Period of Agreement:
This contract shall commence on October 1, 2016 and continue through September 30, 2017. This agreement is in full force and effect for the period specified.

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

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

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 Health & Human Services

Kim Stephen — 9-21-16
Kim Stephen, Director — Date
Bureau of Purchasing

For the CONTRACTOR:

Tom Watkins — CEO
Name (print) — Title (print)

Tom Watkins — 8-23-16
Signature — Date

Executive Summary
MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration
Changes to the FY 17 contract between MDHHS and the CMHSPs

Additions and changes to the contract between the Michigan Community Mental Health Service Plans for Managed Mental Health Supports and Services Contract and MDHHS.

I. Contract effective date: October 1, 2016 through September 30, 2017

II. New sections to the contract boilerplate as follows: Part II Statement of Work:

6.3.2.3B Recipient Rights Training Standards for CMHSP Staff
The CMHSP shall conduct training standards in accordance with Attachment C 6.3.2.3.B.

6.5.3 Level of Care Utilization System (LOCUS)
In order to ensure the MDHHS has the ability to use the LOCUS assessment for all individuals served by CMHSP the LOCUS is required to be included in the assessment of all non-Medicaid individuals.

The CMHSP will:

1. Ensure that the LOCUS is incorporated into the initial assessment process for all Non-Medicaid eligible individuals 18 and older seeking supports and services for a severe mental illness using one of the three department approved methods for scoring the tool. Approved methods:
    a. Paper and pencil scoring;
    b. Use of the online scoring system, through Deerfield Behavioral Health, with cost covered by BHDDA through Mental Health and Wellness Commission funding; or
    c. Use of software purchased through Deerfield Behavioral Health with costs covered by BHDDA through Mental Health and Wellness Commission funding.
2. Ensure that each Non-Medicaid eligible individual 18 years and older with a severe mental illness, who is receiving services as of October 1, 2016, has a LOCUS completed as part of any re-assessment process during the current fiscal year.
3. Collaborate with BHDDA for ongoing fidelity monitoring on the use of the tool.
4. Provide the composite score for each LOCUS that is completed in accord with the established reporting guidelines.

6.9.9 CMHSP Trauma Policy
The CMHSPs, through their direct service operations and their network providers, shall develop a trauma-informed system for all ages and across the services spectrum in accordance with attachment C6.9.9.1 Trauma Policy.

7.8.1 Executive Expenditures Survey for Sec. 904 (2)(k)
The CMHSP shall report expenditures that includes a breakout of the salary, benefits, and pension of each executive level staff and shall include the director, chief executive, and chief operating officers and other members identified as executive staff.

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

III. List of changes to the following contract sections. Additions are included in **"bold"** and deletion in "~~strikeout~~."

Part I: CONTRACTUAL SERVICES TERMS AND CONDITIONS

No changes made to existing boilerplate language for this section.

Part II: STATEMENT OF WORK

No changes made to existing boilerplate language for this section.

IV. The following attachment(s) are new to the Contract:

C6.3.2.3.B Recipient Rights Training Standards for CMH and Provider Staff Technical Requirements

V. The following attachments to the Contract are updated or revised:

C4.5.1 PASARR Agreement
C4.7.2 Technical Requirement for SED Children
C6.3.2.3A CEU Requirements for Recipient Rights Staff
C6.3.2.4 Recipient Rights Appeal Process
C6.5.1.1 CMHSP Reporting Requirements
C6.9.6.1 School to Community Transition Guideline
C6.9.9.1 CMHSP Trauma Policy

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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 Health & Human Services

_____ _____
Kim Stephen, Director Date
Bureau of Budget and Purchasing

For the CONTRACTOR:

_____ _____
Name (print) Title (print)

_____ _____
Signature Date

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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. Any reference to Medicaid, CMS or medical necessity is limited in application to the Children's Waiver and SED Waiver programs administered by the CMHSP as part of this contract.

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

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

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

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

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

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

Developmental Disability: Means either of the following:

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

disciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

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

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

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

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

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

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

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

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

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

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

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

Policy Manuals of the Medical Assistance Program: The Michigan Department of Health & Human Services periodically issues notices of proposed policy for the Medicaid program. Once a policy is final, MDHHS issues policy bulletins that explain the new policy and give its effective date. These documents represent official Medicaid policy and are included in the policy manual of the Medical Assistance Program. The Medicaid manual is referenced in this contract when a particular policy is intended to be followed for non-Medicaid individuals served in the Children's Waiver, and MI Child.

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

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

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

Serious Mental Illness: Diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and

dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness. The following disorders are included only if they occur in conjunction with another diagnosable serious mental illness:

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

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

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

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

PART I: CONTRACTUAL SERVICES TERMS AND CONDITIONS

1.0 PURPOSE

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

2.0 ISSUING OFFICE

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

3.0 CONTRACT ADMINISTRATOR

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

~~Cynthia Kelly~~Thomas J. Renwick, Director
Bureau of ~~State Hospitals & Behavioral Heath Administrative Operations~~Community Based Services
Department of Health & Human Services
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, 2016 through September 30, 2017. The contract may be extended in increments no longer than 12 months, contingent upon mutual agreement to an amendment to the financial obligations reflected in Attachment C 7.0.1 and other changes agreed upon by the parties for no more than three (3) one-year extensions after September 30, 2016. Fiscal year payments are contingent upon and subject to enactment of legislative appropriations.

5.0 PAYMENT METHODOLOGY

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

6.0 LIABILITY

6.1 Cost Liability

The MDHHS assumes no responsibility or liability for costs under this contract incurred by the CMHSP prior to October 1, 2015. Total liability of the MDHHS is limited to the terms and conditions of this contract.

6.2 Contract Liability

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

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

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

7.0 CMHSP RESPONSIBILITIES

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

7.1 MDHHS Standard Consent Form

It is the intent of the parties to promote the use and acceptance of the standard release form that was created by MDHHS under Public Act 129 of 2014. Accordingly, the CMHSPs have the opportunity to participate in the Department's annual review of the DCH-3927 and to submit comments to the Department regarding challenges and successes with using DCH-3927.

There are remaining issues to be addressed before the standard consent form can be used to support electronic Health Information Exchange. However, for all non-electronic Health Information Exchange environments, the CMHSP shall implement a written policy that requires the CMHSP and its provider network to use, accept, and honor the standard release form that was created by MDHHS under Public Act 129 of 2014.

8.0 ACKNOWLEDGMENT OF MDHHS FINANCIAL SUPPORT

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

9.0 DISCLOSURE

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

10.0 CONTRACT INVOICING AND PAYMENT

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

11.0 LITIGATION

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

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

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

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

12.0 CANCELLATION

Material Default

The MDHHS may cancel this contract for material default of the CMHSP. Material default is defined as the substantial failure of the CMHSP to meet CMHSP certification requirements as stated in the Michigan Mental Health Code (Section 232a) or other Mental Health Code mandated provisions. In case of material default by the CMHSP, the MDHHS may cancel

this contract without further liability to the state, its departments, agencies, or employees and procure services from other CMHSPs or other providers of mental health services that the department has determined can operate in compliance with applicable standards and are capable of maintaining the delivery of services within the county or counties.

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

13.0 CLOSEOUT

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

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

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

C. The portion of all reserve accounts maintained by the CMHSP that were funded with MDHHS funds and related interest are owed to the MDHHS within 90 days, less amounts needed to cover outstanding claims or liabilities unless otherwise directed in writing by the MDHHS.

D. Reconciliation of equipment with a value exceeding $5,000, purchased by the CMHSP within the last two fiscal years, will occur as part of settlement of this contract. The CMHSP will submit to the MDHHS an inventory of equipment meeting the above specifications within 45 days of the end date. The inventory listing must identify the current value and proportion of GF funds used to purchase each item, and also whether or not the equipment is required by the CMHSP as part of continued service provision to the continuing service population. The MDHHS will provide written notice within 90 days or less of any needed settlements concerning the portion of funds ending. If the CMHSP disposes of the equipment, the appropriate portion of the value must be returned to the MDHHS (or used to offset costs in the final financial report).

E. All earned carry-forward funds and savings from prior fiscal years that remain unspent as of the end date, must be returned to the MDHHS within 90 days. No carry-forward funds or savings as provided in Part II, Section 7.7.1 and 7.7.1.1, can be earned during the year this contract ends, unless specifically authorized in writing by the MDHHS.

F. All financial, administrative and clinical records under the CMHSP's responsibility must be retained according to the retention schedules in place by the Department of Management and Budget's (DTMB) General Schedule #20 at: http://michigan.gov/dmb/0,4568,7-150-9141_21738_31548-56101--,00.html unless directed otherwise in writing by the MDHHS.

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

14.0 CONFIDENTIALITY

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

15.0 ASSURANCES

The following assurances are hereby given to the MDHHS:

15.1 Compliance with Applicable Laws

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

15.2 Anti-Lobbying Act

With regard to any federal funds received or utilized under this agreement, the CMHSP will comply with the Anti-Lobbying Act, 31 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 CMHSP shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including sub-contracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

15.3 Non-Discrimination

In the performance of any contract or purchase order resulting here from, the CMHSP agrees not to discriminate against any employee or applicant for employment or service delivery and access, with respect to their hire, tenure, terms, conditions or privileges of employment, programs and services provided or any matter directly or indirectly related to employment,

because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. The CMHSP further agrees that every sub-contract entered into for the performance of any contract or purchase order resulting here from will contain a provision requiring non-discrimination in employment, service delivery and access, as herein specified binding upon each sub-contractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 P.A. 453, as amended, MCL 37.2201 et seq, and the Persons with Disabilities Civil Rights Act, 1976 P.A. 220, as amended, MCL 37.1101 et seq, and Section 504 of the Federal Rehabilitation Act 1973, 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 MDHHS that pro-active efforts will be made to identify and encourage the participation of minority-owned, women-owned, and handicapper-owned businesses in contract solicitations. The CMHSP shall incorporate language in all contracts awarded: (1) prohibiting discrimination against minority-owned, women-owned, and handicapper-owned businesses in sub-contracting; and (2) making discrimination a material breach of contract.

15.4 Debarment and Suspension

With regard to any federal funds received or utilized under this agreement, assurance is hereby given to the MDHHS that the CMHSP will comply with Federal Regulation 45 CFR Part 76 and certifies to the best of its knowledge and belief that it, including its employees and sub-contractors:

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

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.

15.5 Federal Requirement: Pro-Children Act

Assurance is hereby given to the MDHHS that the CMHSP will comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or

contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The CMHSP also assures that this language will be included in any sub-awards, which contain provisions for children's services.

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

15.8 Health Insurance Portability and Accountability Act
To the extent that this act is pertinent to the services that the CMHSP provides to the MDHHS, the CMHSP 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 CMHSP from unauthorized disclosure as required by state and federal regulations. The CMHSP must provide safeguards that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the contract.

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

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

17.0 ENTIRE AGREEMENT

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

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

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

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

18.0 DISPUTE RESOLUTION

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

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

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

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

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

19.0 NO WAIVER OF DEFAULT

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

20.0 SEVERABILITY

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

21.0 DISCLAIMER

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

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

22.0 RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR)

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

23.0 NOTICES

Any notice given to a party under this contract must be written and shall be deemed effective, if addressed to such party at the address indicated on the signature page of this contract upon (a) delivery, if hand delivered; (b) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this section; (c) the third (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.

24.0 UNFAIR LABOR PRACTICES

Pursuant to 1980 P.A. 278, as amended, MCL 423.321 et seq., the state shall not award a contract or sub-contract to an employer or any sub-contractor, manufacturer or supplier of the employer,

whose name appears in the current register compiled by the Michigan Department of Consumer and Industry Services. The state may void any contract if, subsequent to award of the contract, the name of the CMHSP as an employer, or the name of the sub-contractor, manufacturer of supplier of the CMHSP appears in the register.

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

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

PART II: STATEMENT OF WORK

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

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

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

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

1. to provide services that are not covered under the 1915(b) and 1915(c) Medicaid Habilitation Supports waiver to Medicaid beneficiaries who are individuals with serious mental illness, serious emotional disturbances or developmental disabilities; or

2. to underwrite a portion of the cost of covered services to these beneficiaries if Medicaid payment for services to the PIHP is exhausted; and
3. for CMHSPs that are under subcontract with the PIHP, when the contract with the PIHP stipulates conditions regarding such use of General Funds. MDHHS reserves the right to disallow such use of General funds if it believes that the PIHP-CMHSP contract conditions were not met

1.3 Responsibility for Payment of Authorized Services

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

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

2.0 SUPPORTS AND SERVICES

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

2.1 Availability of Services

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

3.0 ACCESS ASSURANCE

3.1 Access Standards

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

A. Mental Health

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

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

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

C. The CMHSP shall be responsible for outreach and ensuring adequate access to services to the priority populations.

D. In addition, the CMHSP shall assure access according to the following standard, and shall report its performance on the standard in accordance with Attachment C 6.5.1.1.

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

3.2 Medical Necessity

The CMHSP may implement the medical necessity criteria specified by the MDHHS. Medical necessity is commonly defined as a determination that a specific service is medically (clinically) appropriate, necessary to meet the person's mental health needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical industry standards of care. In addition, the CMHSP must also consider social services and community supports that are crucial for full participation in community life, must apply person-centered

planning for individuals with mental health needs, and must consider environmental factors and other available resources that might address the situation. The criteria are intended to ensure appropriate access to care, to protect the rights of recipients and to facilitate an appropriate matching of supports and services to individual needs for the priority populations, consistent with the resources (general fund allocation) available to the CMHSP to serve these individuals. The level and scope of such services are contingent on available funding, and services provided through the use of general funds are not an entitlement to any individual recipient.

3.3 Other Access Requirements

3.3.1 Person-Centered Planning

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

3.3.2 Limited English Proficiency

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

3.3.3 Cultural Competence

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

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

3.3.4 Self-Determination Policy and Practice Guideline

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

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

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

3.3.5 Recovery Policy

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

4.0 SPECIAL COVERAGE PROVISIONS

If funds are appropriated the following sub-sections describe special considerations, services, and/or funding arrangements required by this contract. The parties recognize that some persons served under these special considerations, services or arrangements may be Medicaid beneficiaries, and that the CMHSP may discharge its obligations and service provision responsibilities specified below to such individuals using both general funds dollars and available Medicaid specialty service benefits and coverages.

4.1 Nursing Home Placements

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

4.2 Nursing Home Mental Health Services

All designated state funds that the MDHHS has authorized to the CMHSP for nursing home mental health and/or developmental disability-related services shall continue to be used for

this purpose until such time that MDHHS approves an alternative. Residents of nursing homes with mental health needs shall be given the same opportunity for access to CMHSP services as other individuals covered by this contract.

4.3 Prevention Services

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

4.4 Categorical Funding

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

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

4.5 OBRA Pre-Admission Screening and Annual Resident Review

The CMHSP shall be responsible for the completion of Pre-Admission Screenings and Annual Resident Reviews (PASARR) for individuals who are located in the CMHSP service area presenting for nursing home admission, or who are currently a resident of a nursing

home located in the CMHSP service area. A copy of the MDHHS/CMHSP PASARR Agreement is attached (Attachment C 4.5.1).

4.6 Long Term Care

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

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

4.7 SED Waiver

The intent of this program is to provide 1915 (c) Home and Community Based Waiver Services, as approved by Centers for Medicare and Medicaid Services (CMS) for children with Serious Emotional Disturbances, along with state plan services in accordance with the Medicaid Provider Manual. (See attachment C 4.7.1 1915 (c) Home and Community Based Waiver Services and State Plan Services to Children with Serious Emotional Disturbance (SEDW)).

Within the SEDW, there are two funding streams that constitute the match to the federal Medicaid funding. The Community Mental Health Services Program (CMHSP) provides the match to the federal Medicaid funding for children not funded by the Michigan Department of Health & Human Services (MDHHS). For the (MDHHS) SEDW Project, the match to the federal Medicaid funding is provided by MDHHS. Attachment C 4.7.2 1915 (c) Home and Community Based Waiver for Children with Serious Emotional Disturbance (SEDW) outlines CMHSP responsibilities related to the two distinct funding streams.

A. The CMHSP shall assess eligibility for the SEDW and submit applications to the MDHHS for those children the CMHSP determines are eligible. For children determined ineligible for the SEDW, the CMHSP, on behalf of MDHHS, informs the family of its right to request a fair hearing by providing written adequate notice of denial of the SEDW to the family.

B. The CMHSP shall carry out administrative and operational functions delegated by MDHHS to the CMHSPs as specified in the CMS approved (c) waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.

C. The CMHSP shall assure that services are provided in amount, scope and duration as specified in the approved plan of service. Wraparound is a required service for all participants in the SEDW and CMHSPs must assure sufficient service capacity to meet the needs of SEDW recipients.

D. The CMHSP shall comply with credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by the CMHSPs, as it pertains to the rendering of services within the SEDW. CMHSPs are responsible for ensuring that each provider, directly or contractually employed, credentialed or non-credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and requirements.

E. The CMHSP shall bill Medicaid in a timely manner on a fee-for-service basis for covered services delivered in accordance with the most recent Medicaid Provider Manual. Billings must represent the actual direct cost of providing the services. The actual direct cost of providing the services includes amounts paid to contractors for providing services, and the costs incurred by the CMHSP in providing the services as determined in accordance with2 CFR 200 Subpart E Cost Principles. Benefit plan administrative costs are not to be included in the billings. Benefit plan administrative costs related to providing the services must be covered by general fund or local revenue, and while reported with program costs they must be covered by redirects of non-federal funds on the FSR.

F. The CMHSP Office of Recipient Rights shall assure that the semi-annual and annual recipient rights data reports required by MCL 330.1755(5)(j) and MCL 330.1755(6) are submitted to the PIHP Quality Assessment and Performance Improvement Program (QAPIP) in addition to other entities and individuals specified in law. The CMHSPs shall ensure that there is a signed agreement between the CMHSP Office of Recipient Rights, the MDHHS Bureau of Child and Adult Licensing (BCAL) and MDHHS Children's Protective Services (CPS) regarding reporting and investigation of suspected abuse, neglect, and exploitation in programs operated or contracted with the CMHSP.

G. Medicaid fee for service funds paid to the CMHSP under the SEDW may be utilized for the implementation of, or continuing participation in, locally established multi-agency shared funding arrangements developed to address the needs of beneficiaries served through multiple public systems. Local interagency agreements and/or memoranda of understanding will stipulate the amount and source of local funding. Medicaid is to be billed on a fee-for-service basis for services to children enrolled in the SEDW when the service is: 1) a covered service for the SEDW; 2) determined to be medically necessary; 3) not covered or paid by from other sources. Monitoring safeguards and relevant documents must be in place to ensure compliance.

H. As allowed under the MDHHS/CMHSP master contract, a CMHSP may use State General Funds to cover those costs (indirect administrative costs, direct program costs, and/or direct service cost which exceed the Medicaid fee-for-service reimbursement rate.)

I. The CMHSP and its partner agencies may elect to use excess local contributions to fund the 1915(c) Waiver for Children with Serious Emotional Disturbance (SED) to pay for the cost of products or services that do not qualify as allowable under this waiver. The CMHSP shall separately report this use of excess local contributions as specified in the FSR.

J. Through the Event Reporting System (ERS), the CMHSP will report the following

incidents for children on the SEDW: Suicide; Non suicide Death; Arrest of Consumer; Emergency Medical Treatment Due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions; Hospitalization due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions.

4.8 – Disaster Behavioral Health CMHSP Responsibilities

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

1. Designate a primary and alternate emergency preparedness coordinator (EPC).
    a. Participate in local emergency management disaster planning and exercises in collaboration with local health department, regional healthcare coalitions, and jurisdictionally appropriate emergency manager(s).
    b. Attend/host trainings geared toward disaster mental/behavioral health planning, response, and recovery.
2. Provide emergency response support, including memoranda of agreement (MOA) both formal and informal, in collaboration with private sector or mental/behavioral health service providers and Non-governmental organizations (NGOs) such as the American Red Cross, Regional Health Care Coalitions and/or Michigan Crisis Response Association.
    a. Coordinate local community assessments of disaster behavioral health to determine the psychological impact of a disaster on survivors and disaster response personnel.
    b. Provide psychological triage of individuals as appropriate (example, PsySTART triage).
    c. According to the time frames recommended for the application of each intervention, provide appropriate disaster behavioral health services, including, but not limited to:
        i. Psychological First Aid
        ii. Crisis intervention/stabilization
        iii. Grief/bereavement counseling
        iv. Critical Incident Stress Management (CISM)
        v. Post-Traumatic Stress Disorder Counseling
        vi. Substance use disorder counseling
        vii. Provide community outreach activities as needed

viii. Advise local Public Information Officer (PIO) of appropriate disaster behavioral health messaging

ix. Request additional disaster behavioral health resources according to pre-established emergency management channels

3. Develop and maintain formal and informal mutual aid agreements (MUA) with other agencies outside of their jurisdiction. The number and type should be individualized by need but at least one (1) MUA should be developed.

4.9 Mental Health Court Pilot Projects

The mental health court pilot projects are specialized court dockets that use a problem solving approach to reduce contacts with the criminal justice system and to facilitate a participation in mental health and substance use treatment services for those identified as mentally ill. Cross system collaboration between the criminal justice system and the mental health community is critical to successful programs. CMHSPs where a mental health court exists will be required to provide detail on mental health court participants. The following reporting requirements apply: (1) CMHSPs must be able to identify MH Court participants and all associated encounters; (2) CMHSPS must provide a HIPAA compliant list of consumer unique IDs to MDHHS upon request so that mental health court participant data can be drawn from the state data warehouse; (3) CMHSPs may be requested to provide detail or summary information about services provided to MH Court participants. Additionally, the Department or its designee is permitted to visit and, or to make an evaluation of the project. CMHSPs will be required to participate in MDHHS funded evaluation activities. (See attachment C4.9.1 Mental Health Court Pilot Projects)

4.10 Pooled Funding Arrangements

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

5.0 OBSERVANCE OF FEDERAL, STATE AND LOCAL LAWS

The CMHSP agrees that it will comply with all state and federal statutes, accompanying regulations, and administrative procedures that are in effect, or that become effective during the term of this contract. The state must implement any changes in state or federal statutes, rules, or administrative procedures that become effective during the term of this contract. Federal statutes and regulations pertaining to the Medicaid program are applicable to the operation of the Children's Waiver. This includes laws and regulations regarding human subjects research and data projections set forth in 45 CFR and HIPAA.

5.1 Fiscal Soundness of the CMHSP

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

5.2 Suspended Providers

Federal regulations and state law preclude reimbursement for any services ordered,

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

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

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

5.3 Public Health Reporting

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

6.0 CMHSP ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE SERVICES

6.1 Organizational Structure

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

6.2 Administrative Personnel

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

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

- Administrator (Chief Executive Officer)

- Medical Director
- Recipient Rights Officer

6.3 Customer Services

6.3.1 Customer Services: General

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

6.3.2 Recipient Rights and Grievance/Appeals

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

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

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

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

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

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

6.3.2.1 CMHSP Local Dispute Resolution Process
The CMHSP shall conduct CMHSP local dispute resolution processes in accordance with Attachment C 6.3.2.1.

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

6.3.2.3 Continuing Education Requirements for Recipient Rights Staff
The CMHSP shall conduct continuing education activities in accordance with Attachment C 6.3.2.3.A.

6.3.2.3B Recipient Rights Training Standards for CMHSP Staff
The CMHSP shall conduct training standards in accordance with Attachment C 6.3.2.3.B.

6.3.2.4 Recipient Rights Appeal Process
The CMHSP shall conduct recipient rights appeals processes in accordance with Attachment C 6.3.2.4.

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

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

Marketing materials shall be available to the MDHHS for review of consistency with these standards.

6.4 Provider Network Services

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

In this regard, the CMHSP agrees to:

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

6.4.1 Provider Contracts

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

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

and therefore not a party to any employer/employee relationship with the sub-contractor of the CMHSP.

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

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

In addition, sub-contracts shall:

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

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

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

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

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

This is applicable to any staff training area. This includes the required staff training in the areas of abuse and neglect (recipient rights), person-centered planning: HIPAA

security, and certificates earned from specific clinical training in evidence-based, best and promising practices such as ACT, DBT, PMTO, FPE, and motivational interviewing.

6.4.2 Provider Credentialing

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

6.4.3 Collaboration with Community Agencies

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

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

6.5 Management Information Systems

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

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

- Recipient registration and demographic information
- Provider enrollment

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

6.5.1 Uniform Data and Information

To measure the CMHSP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures, the CMHSP must provide the MDHHS with uniform data and information as specified in this contract, and other such additional or different reporting requirements or data elements as the parties may agree upon from time to time. Any changes in the reporting requirements required by state or federal law will be communicated to the CMHSP at least 90 days before they are effective unless state or federal law requires otherwise. Other changes beyond routine modifications to the data reporting requirements must be agreed to by both parties.

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

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

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

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

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

C. The CMHSP shall submit a written review of death for every recipient whose death occurred within six (6) months of the recipient's discharge from a state-operated service. The review shall include:
   1. Recipient's name
   2. Gender
   3. Date of birth
   4. Date, time, place of death
   5. Diagnoses (mental and physical)
   6. Cause of death
   7. Recent changes in medical or psychiatric status, including notation of most recent hospitalization
   8. Summary of condition and treatment (programs and services being provided to the recipient) preceding death
   9. Any other relevant history
   10. Autopsy findings if one was performed and available
   11. Any action taken as a result of the death

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

Reporting Requirements for the period October 1, 2016 to September 30, 2017 are included in Attachment C 6.5.1.1

6.5.2 Encounter Data Reporting

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

6.5.3 Level of Care Utilization System (LOCUS)

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

The CMHSP will:

1. Ensure that the LOCUS is incorporated into the initial assessment process for all Non-Medicaid eligible individuals 18 and older seeking supports and services for a severe mental illness using one of the three department approved methods for scoring the tool. Approved methods:
    a. Paper and pencil scoring;
    b. Use of the online scoring system, through Deerfield Behavioral Health, with cost covered by BHDDA through Mental Health and Wellness Commission funding; or
    c. Use of software purchased through Deerfield Behavioral Health with costs covered by BHDDA through Mental Health and Wellness Commission funding.
2. Ensure that each Non-Medicaid eligible individual 18 years and older with a severe mental illness, who is receiving services as of October 1, 2016, has a LOCUS completed as part of any re-assessment process during the current fiscal year.
3. Collaborate with BHDDA for ongoing fidelity monitoring on the use of the tool.
4. Provide the composite score for each LOCUS that is completed in accord with the established reporting guidelines.

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6.6 Financial Management System

6.6.1 General

The CMHSP shall maintain all pertinent financial and accounting records and evidence pertaining to this contract based on financial and statistical records that can be verified by qualified auditors. The CMHSP will comply with generally accepted accounting principles (GAAP) for governmental units when preparing financial statements. The CMHSP will use the principles and standards of 2 CFR 200 Subpart E Cost Principles for determining all costs reported on the financial status report, except for a) local funds, not obligated to meet local match requirements nor required as reserve against possible obligations or liabilities; b) selected items of allowable cost – agreed upon by the CMHSP and MDHHS – where state law or county regulations differ from federal policy as outlined in 2 CFR 200 Subpart E Cost Principles and requires adherence to different principles or a different methodology for cost allocation, distribution or estimation, c) earned revenue not encumbered to satisfy local match obligations, nor required as an adjustment or credit or distribution to offset or reduce expense items allocated to a federal award or to state general fund allocation; d) other grants or awards where the grantor requires principles and standards other than those described in2 CFR

200 Subpart E Cost Principles. Expenditures of General Fund Formula Funds reported on the financial status report must comply with Sections 240 241 and 242 of the Mental Health Code. Cost settlement of the General Fund Formula Funding to the CMHSP will be based upon costs reported on the financial status report. If a conflict exists between 2 CFR 200 Subpart E Cost Principles and Section 242 of the Mental Health Code regarding expenditures the more restrictive sections of Section 242 of Mental Health Code will prevail.

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

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

6.6.3 Claims Management System

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

A clean claim is a valid claim completed in the format and time frames specified by the CMHSP and that can be processed without obtaining additional information from the provider of service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity (Children's Waiver and SEDW only). A valid claim is a claim for supports and services that the CMHSP is responsible for under this contract.

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

6.6.3.1 Post-payment Review

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

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

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

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

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

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

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

6.6.3.6 Payment of State-Delivered Services

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

6.7 State Lease Expiration

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

6.8 Quality Assessment and Performance Improvement Program Standards

6.8.1 General

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

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

6.8.2 Annual Effectiveness Review

The CMHSP shall annually conduct an effectiveness review of its QAPIP. The effectiveness review must include analysis of whether there have been improvements

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

6.8.3 Behavior Treatment Plan Review Committee

The CMHSP shall use a specially-constituted committee, such as a behavior treatment plan review committee, to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. The Committee shall substantially incorporate the standards in Attachment C 6.8.3.1 Technical Requirement for Behavior Treatment Plans.

6.9 Service and Utilization Management

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

6.9.1 State Managed Services

A. The CMHSP shall authorize inpatient care in advance for all admissions in those instances where there is no community inpatient alternative. The CMHSP shall review treatment at intervals determined jointly between the authorizing CMHSP and the State Facility and authorize continued stay. The application of this provision to NGRI and IST cases requires additional clarification stemming from the conditions specified in Chapter 10 of the Michigan Mental Health Code. The clarification and requirements are specified in the NGRI Protocol, Attachment C 6.9.1.1. The provisions of Chapter 10 shall apply to all authorizations.

B. The MDHHS and CMHSP agree that admissions must meet the criteria specified in the Michigan Mental Health Code for adults and children with mental illness, or that the criteria for judicial or administrative admission of a person with developmental disabilities must be met, and that inpatient care in a state hospital/center must be the most appropriate level of care available. The parties further agree that continued stay will be authorized, as long as the criteria for continued stays is met.

C. The CMHSP's authorization of admission and of continued treatment shall be the basis on which the CMHSP will reimburse the MDHHS for the state cost of inpatient services provided in a state-managed hospital/center. The CMHSP's obligation for the local match cost of such services shall not be affected by this section. Service authorizations shall be conveyed in writing to the hospital/center. The MDHHS contract manager shall be notified by the CMHSP within seven (7) days of the decision when the CMHSP determines that continued inpatient care is no longer warranted based on the criteria stated in the above item B, but the hospital/center did not discharge the recipient according to the recognized placement plan developed according to Sections 209(a) and 209(b) of the Michigan Mental Health Code. The CMHSP shall not be liable for any inpatient services that have not been authorized by the CMHSP in this circumstance. Likewise, the MDHHS contract manager shall be notified by the hospital/center whenever an authorization of continued stay by the CMHSP is clinically unwarranted in the judgment of the hospital/center. Such notification shall initiate a process for resolution of the differences.

D. The CMHSP shall comply with the requirements of attachment C 6.9.1.2 of this contract.

6.9.2 Individual Service Records

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

6.9.3 Other Service Requirements

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

A. Housing Practice Guideline (Attachment C 6.9.3 1)
B. Inclusion Practice Guideline (Attachment C 6.9.3.2)
C. Consumerism Practice Guideline (Attachment C 6.9.3.3)

6.9.4 Coordination

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

described in Part II, Section 6.4.3 of this contract.

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

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

6.9.7 Children's Waiver

A. The CMHSP shall identify children who meet the eligibility criteria for the Children's Waiver Program and submit to MDHHS prescreens for those children.
B. The CMHSP shall carry out administrative and operational functions delegated by MDHHS to the CMHSPs as specified in the CMS approved (c) waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.
C. The CMHSP shall determine the appropriate Category of Care/Intensity of Care and the amount of publicly funded hourly care for each Children's Waiver Program recipient per the Medicaid Provider Manual.
D. The CMHSP shall assure that services are provided in amount, scope, and duration as specified in the approved plan.
E. The CMHSP shall comply with policy covering credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by the CMHSPs, as it pertains to the rendering of services within the Children's Waiver Program. CMHSPs are responsible for ensuring that each provider, directly or contractually employed, credentialed or non–credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and 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 Medicaid funds can be used to pay for a specific service.
F. The CMHSP shall bill Medicaid in a timely manner on a fee-for-service basis for all covered services delivered, in accordance with the most recent Medicaid manual. Billings must represent the actual direct cost of providing the services. The actual direct cost of providing the services include amounts paid to contractors for providing services, and the costs incurred by the

CMHSP in providing the services as determined in accordance with2 CFR 200 Subpart E Cost Principles. Benefit plan administrative costs are not to be included in the billings. Benefit plan administrative costs related to providing the services must be covered by general fund or local revenue, and while reported with program costs they must be covered by redirects of non-federal funds on the FSR.

G. The CMHSP Office of Recipient Rights shall assure that the semi-annual and annual recipient rights data reports required by MCL 330.1755(5)(j) and MCL 330.1755(6) are submitted to the PIHP Quality Assessment and Performance Improvement Program (QAPIP) in addition to other entities and individuals specified in law. The CMHSPs shall ensure that there is a signed agreement between the CMHSP Office of Recipient Rights, the MDHHS Bureau of Child and Adult Licensing (BCAL) and MDHHS Children's Protective Services (CPS) regarding reporting and investigation of suspected abuse, neglect, and exploitation in programs operated or contracted with the CMHSP.
H. Through the Critical Incident Reporting System, the CMHSP will report the following incidents for children on the CWP: Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions; Hospitalization due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions.

6.9.9 CMHSP Trauma Policy
The CMHSPs, through their direct service operations and their network providers, shall develop a trauma-informed system for all ages and across the services spectrum in accordance with attachment 5.6.9.1 Trauma Policy.

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7.0 CONTRACT FINANCING

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

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

7.1 Local Obligation

The CMHSP shall provide the local financial obligation for services requiring local match, as stipulated by the Mental Health Code. In the event a CMHSP is unable to provide the required local obligation, the CMHSP shall notify the MDHHS immediately. This may result in MDHHS reducing the state portion of total financing available through this contract. The

state obligation shall continue to be at the reduced level in the subsequent year unless the CMHSP provides the MDHHS with a plan and assurances that the local obligation shortfall has been rectified.

7.2 Revenue Sources for Local Obligation

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

7.2.1 County Appropriations

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

7.2.2 Other Appropriations and Service Revenues

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

7.2.3 Gifts and Contributions

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

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

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

7.2.4 Special Fund Account

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

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

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

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

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

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

7.2.5 Investment Interest
Interest earned on funds deposited or invested by or on behalf of the CMHSP, except as otherwise restricted by GAAP or2 CFR 200 Subpart E Cost Principles. Also, interest earned on MDHHS funds by contract agencies and/or network providers as specified in its contracts with the CMHSP.

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

7.3 Local Obligations - Requirement Exceptions

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

A. Residential programs as defined in Section 309 of the Michigan Mental Health Code. Specialized residential services, as defined in Section 100d (6) of the Michigan Mental Health Code, includes mental health services that are expressly designed to provide rehabilitation and therapy to a recipient, that are provided in the residency of the recipient, and that are part of a comprehensive individual plan of services.
B. Services provided to people whose residency is transferred according to the provisions in Section 307 of the Michigan Mental Health Code.
C. Programs for which responsibility is transferred to the CMHSP and the state is responsible for 100% of the cost of the program, consistent with the Michigan Constitution.
D. Services provided to an individual under criminal sentence to a state prison.

7.4 MDHHS Funding

MDHHS funding includes both state and federal funds (Children's Waiver and federal block grants), which the state is responsible to manage. MDHHS financial

responsibility is specified in Chapter 3 of the Michigan Mental Health Code (P.A. 258 of the Public Acts of 1974, as amended) and the level of funding contained in the current year state legislative Appropriations Act. The financing in this contract is always contingent on the annual Appropriations Act.

7.4.1 State Mental Health General Fund Formula Funding

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

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

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

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

7.4.1.1 GF Formula Funds Calculation

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

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

7.4.2 Special and/or Designated Funds: Exclusions

Special and/or Designated Funds (including categorical and earned revenue funds) are those funds that are earmarked by the MDHHS for a specific purpose, project, and/or target population and are not included in the GF formula funding.

These funds and programs may be authorized through separate contractual arrangements between the CMHSP and the MDHHS. These agreements typically include performance and outcome expectations, reporting requirements, and finance-

related specifications. The CMHSP shall identify the revenues and expenditures associated with these projects as part of financial reporting required by this contract.

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

7.4.3 Fee-for-Service

The Children's Waiver is a fee-for-service Medicaid program. The MDHHS shall reimburse the CMHSP, in accordance with MDHHS-approved budgets and Medicaid reimbursement policies, for billings submitted by the CMHSP for each beneficiary with a MDHHS approved Children's Waiver. The CMHSP will be reimbursed based on the billings submitted, as this program shall not be pre-paid.

7.4.5 Implementation of Current Year Appropriation Act

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

The CMHSP agrees to provide local funds to the MDHHS through the PIHP. The CMHSP agrees to provide local funds, in the amount stipulated in Attachment C 7.0.1, to the MDHHS through the PIHP. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a CMHSP or an affiliation of CMHSPs. In the event that a CMHSP fails to meet this obligation and the PIHP has not made available other bona fide local funds to offset this obligation, MDHHS will reduce the CMHSP State Mental Health General Fund authorization/payment to the CMHSP by an equivalent amount.

7.5 Operating Practices

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

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

7.6 Audits

The CMHSP shall ensure the completion of a fiscal year end Financial Statement Audit

conducted in accordance with Generally Accepted Auditing Standards (GAAS); and a fiscal year end Compliance Examination conducted in accordance with the American Institute of CPA's (AICPA's) Statements on Standards for Attestation Engagements (SSAE) 10 - Compliance Attestation, (as amended by SSAE 11, 12 and 14) and the CMH Compliance Examination Guidelines in Attachment C 7.6.1.)

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

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

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

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

7.7 Financial Planning

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

7.7.1 Savings Carry Forward

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

7.7.1.1 General Fund Carry Forward

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

7.7.2 Expenditures to Retire Unfunded Pension Liabilities

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

7.8 Finance Planning, Reporting and Settlement

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

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

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

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

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7.9 Legal Expenses

The following legal expenses are ALLOWABLE:

1) Legal expenses required in the administration of the program on behalf of the State of Michigan or Federal Government.
2) Legal expenses relating to employer activities, labor negotiation, or in response to employment related issues or allegations, to the extent that the engaged services or actions are not prohibited under federal principles of allowable costs.
3) Legal expenses incurred in the course of providing consumer care.

The CMHSP must maintain documentation to evidence that the legal expenses are allowable. Invoices with no detail regarding services provided will not be sufficient documentation.

8.0 CONTRACT REMEDIES AND SANCTIONS

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

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

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

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

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

9.0 RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES

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

9.1 General Provisions

A. Notify the CMHSP of changes in contractual services or conditions of providing contractual services.
B. Protect against fraud and abuse involving MDHHS funds and recipients in cooperation with appropriate state and federal authorities.
C. Administer an alternative dispute resolution process for recipients not Medicaid eligible to consider issues regarding suspension, termination or reduction of services and supports defined in the Grievance and Appeal Technical Requirement.
D. Collaborate with the CMHSP on quality improvement activities, fraud and abuse issues, and other activities that impact on the services provided to recipients.
E. Conduct a recipient quality of life survey and publish the results.
F. Review CMHSP marketing materials.
G. Apply contract remedies necessary to assure compliance with contract requirements.
H. Monitor the operation of the CMHSP to ensure access to quality care for all individuals in need of and qualifying for services.
I. Monitor quality of care provided to recipients of CMHSP services and supports.
J. Refer local issues back to the CMHSP.
K. Coordinate efforts with other state departments involved in services to these populations.
L. Administer the Children's Waiver Program.
M. Administer the PASARR Program.
N. When repeated health and welfare issues/emergencies are raised or concerns regarding timely implementation of medically necessary (Children's Waiver and SEDW only) services the MDHHS authority to take action is acknowledged by the CMHSP.

9.2 Contract Financing

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

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

A. Action by the Michigan state legislature that removes any MDHHS funding for, or authority to provide for, specified services.
B. Action by the Governor pursuant to Const. 1963, Art. 5, 320 that removes the MDHHS's funding for specified services or that reduces the MDHHS's funding level below that required to maintain services on a statewide basis.

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

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

9.3 State Facilities

The MDHHS agrees:

A. To supply to the CMHSP, at the time of completion, copies of the State Facilities' ability-to-pay determination on each county resident admitted to a state facility, to inform the CMHSP of any claims on the financial assets of recipients and their families, and of any appeals by recipients or their families.
B. To pursue all possible first- and third-party reimbursements.
C. To provide the CMHSP with rates for state-managed services no later than October 1 of each fiscal year. Rates shall be issued that include the net state rate paid by the CMHSP and the gross rate on which the local share of facility billings is based.
D. The protection and investigation of the rights of recipients while on inpatient status at the state hospital or center shall be the responsibility of the MDHHS Office of Recipient Rights. When requested, the MDHHS Office of Recipient Rights shall share appropriate information on investigations related to the CMHSP's residents in accordance with the confidentiality provisions of the Michigan Mental Health Code (P.A. 258 of 1974 as amended, Section 748).
E. To comply with the NGRI Protocol C 6.9.1.1.
F. To comply with attachment C 6.9.1.2.

9.4 Reviews and Audits

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

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

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

9.4.1 MDHHS Reviews

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

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

9.4.2 MDHHS Audits

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

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

    To accomplish the above listed audit objectives, MDHHS auditors will review CMHSP documentation, interview CMHSP staff members, and perform other audit procedures as deemed necessary.
D. The audit report and appeal process is identified in Attachment C 9.3.2.1 and is a part of this contract.

10.0 RESPONSIBILITIES OF THE DEPARTMENT OF ATTORNEY GENERAL

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

Office of Inspector General
Michigan Department of Health & Human Services

P. O. Box 30062
Lansing, MI 48909

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

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

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

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

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

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

PASARR AGREEMENT

I. PURPOSE

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

II. REQUIREMENTS

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

1. ~~Medical Services Administration (MSA) Bulletin 03-11.~~Medicaid Provider Manual Nursing Section ~~(~~ if the individual is a Medicaid beneficiary.

2. Federal Register/Vol 57, No. 230/Monday, November 30, 1992/Rules and Regulations/Subpart C -- Pre-admission Screening and Annual Resident Review of Mentally Ill and Mentally Retarded Individuals. These are operationalized in the OBRA Manual (5-04).

3. The CMHSP must ensure that all new employees, ~~along with current staff~~ who administer PASARR, are trained ~~annually~~ on the policies and procedures with respect to the OBRA/PASARR process through Improving MI Practices website at: www.improvingmipractices.org.

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

PRE-ADMISSION SCREENING

B. The CMHSP will provide evaluations and assessments for all individuals located in the CMHSP's service area who are presented for admission to a nursing ~~home~~ facility regardless of the location of the admitting facility and for whom a Level I Pre-admission Screening procedure (DCH Form 3877) has identified the possible presence of a mental illness or a developmental disability ~~or related condition~~. This evaluation and assessment will be completed and an appropriate determination made prior to admission

of the individual to a nursing ~~home~~facility. This evaluation and assessment will be completed utilizing criteria specified in Paragraph A. above by OBRA electronic application ~~with~~ or paper system requirements.

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

~~D. In the event that a Pre-admission Telephone Authorization is necessary, because hospital discharge will occur within forty-eight (48) hours and a nursing home bed is available, the CMHSP may obtain a telephone authorization from the DEPARTMENT's OBRA office. When requesting a telephone authorization, the CMHSP will have completed all evaluations and assessments as specified in Paragraph A. above and will verbally provide all necessary information for the DEPARTMENT to make the required determinations. Following the approval or denial of the placement, the CMHSP will submit the completed evaluation, in writing, to the Department within four (4) working days of the referral as specified in Paragraph C. above. Upon review of the submitted documents, the decision related to admission and to the level of service may be altered if the information does not match the information provided during the telephone approval.~~

ANNUAL RESIDENT REVIEW

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

~~F~~E. The CMHSP agrees that Annual Resident Reviews will be completed and required documentation submitted to the DEPARTMENT within fourteen (14) calendar days of receipt by the CMHSP of an appropriately completed DCH Form 3877 from the nursing facility(ies). In the case of Annual Resident Reviews of persons who have been admitted to a nursing facility without a Pre-admission screening as an exempted hospital discharge, the CMHSP will complete a review and submit required documentation to the DEPARTMENT within ~~seven~~ fourteen (~~7~~14) calendar days of referral. In either situation, if a CMHSP is unable to comply with this requirement in a particular case, the CMHSP will notify the DEPARTMENT.

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III. RECORDS, BILLINGS, AND REIMBURSEMENT

A. The CMHSP will maintain all documentation and records concerning services provided, client treatment recommendations and treatment plans, and verification

of compliance with standards for subsequent audit, and actual cost documentation for a period of seven (7) years and assure that all such documentations will be accessible for audit by appropriate DEPARTMENT staff and other authorized agencies.

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

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

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

IV. DEPARTMENT RESPONSIBILITIES

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

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

C. The DEPARTMENT will hold the CMHSP financially harmless where the CMHSP has followed procedures as outlined in Federal Office of Management and Budget ~~Circular A-87~~ 2 CFR Part 200, Subpart E – Cost Principles, and has documentation as to the services performed. The Federal Office of Management and Budget, ~~Circular A-87~~ 2 CFR Part 200, Subpart E – Cost Principles, is included in the MDHHS Technical Manual. The CMHSP will be responsible where procedures related to these identified evaluations are not followed or where documentation is lacking.

V. TERMINATION

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

DETAIL OF SERVICES BILLED

~~Nursing Home~~Nursing Facility Evaluations

CMH Board Name:_____ **Month/Year:**_____

Name of Resident	Date of Birth	*Type of Screening	MI or DD	Date of Service
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				

18.				
19.				
20.				

***Indicate PAS or ARR**

SUMMARY BILLING FOR ~~FY 2006 and FY 2007~~ PRE-ADMISSION SCREENING and ANNUAL RESIDENT REVIEWS (PASARR)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CMH BOARD_____ TELEPHONE NUMBER _____
PERSON COMPLETING FORM:_____
MONTH ENDING:_____ DATE SUBMITTED _____
NUMBER of Reviews: DD_____ MI_____ TOTAL_____

I. DIRECT COSTS TOTAL

A. Direct labor(excluding overtime, shift or holiday premiums and fringe benefits) $_____

B. Other Labor(overtimes, shift or holiday premiums and fringe benefits). $_____

C. Other Direct Costs(contractual services, supplies/materials, travel, equipment, telephone, office space, etc.) $_____

D. Subtotal Direct Costs: $_____

II. INDIRECT COSTS

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

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

IV. FEDERAL REIMBURSEMENT
(Total Costs ..III Above) Total Costs_____ x .75 = $_____

CMHSP CERTIFICATION

The CMHSP has reported all costs at actual and in conformance with Federal OMB ~~Circular A-87~~ 2 CFR Part 200, Subpart E – Cost Principles. The CMHSP acknowledges that all costs are subject to audit for federal reimbursement purposes and assumes full responsibility and proper documentation.

COMMUNITY MENTAL HEALTH SERVICES PROGRAMS DIRECTOR **DATE**

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

MDHHS Authorized Staff **DATE**

CERTIFICATE OF INDIRECT COSTS

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

1. All costs included in this proposal, dated _____, to establish billing or final indirect costs rates for fiscal year _____, are allowable in accordance with the requirements of the Federal Award to which they apply and OMB ~~Circular A-87, "Cost Principles for State, and Local Governments."~~ 2 CFR Part 200, Subpart E – Cost Principles. Unallowable costs have been adjusted for in allocating costs as indicated in the cost allocation plan.

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

I declare that the foregoing is true and correct.

Community Mental Health Agency:

Name: _____

Signature: _____

Title: _____

Date: _____

STATE OF MICHIGAN

JOHN ENGLER, Governor

DEPARTMENT OF COMMUNITY HEALTH

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

October 2, 1996

TO: Executive Directors
Community Mental Health Services Programs

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

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

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

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

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

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

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

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

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

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

WJA:SOH:eed
Attachments

c. David Verseput
David Viele
Richard Miles

TECHNICAL REQUIREMENT FOR SED CHILDREN
~~FINAL~~ **REVISED** ~~April 10, 2012~~May 2, 2016

REGARDING: 1) MEDICAID ELIGIBILITY CRITERIA FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE; AND 2) ESTABLISHING GENERAL FUND PRIORITY FOR MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

General Considerations:

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

A key feature of the ~~Medicaid eligibility criteria and~~ general fund priority framework in the Technical Requirement is that diagnosis alone is not sufficient to determine eligibility for ~~Medicaid specialty mental health services, nor~~ general fund priority for services. This means that the practice of using a defined or limited set of diagnoses to determine ~~Medicaid eligibility, or~~ general fund priority for services should cease. As stated in the Mental Health Code, any diagnosis in the DSM can be used (with the exception of developmental disorder, substance abuse disorder or "V" codes unless these disorders occur in conjunction with another diagnosable serious emotional disorder), and should be coupled with functional impairment and duration criteria for determination of serious emotional disturbance in a child.

The ~~Medicaid eligibility criteria and~~ general fund priority framework delineated in this document is intended to: (1) assist Community Mental Health Services Programs (CMHSPs) in determining severity, complexity and duration that would indicate a need for specialty mental health services and supports ~~for Medicaid children and~~ for non-Medicaid children to establish priority for service under the Michigan Mental Health Code, and (2) bring more uniformity to these decisions for children across the system. Children meeting the criteria delineated in this document are considered to have a serious emotional disturbance, as defined in the Mental Health Code.

Selection of Services

For Non-Medicaid children, once an eligibility determination has been made based on the criteria delineated in this document, selection of services is determined based on priority of general funds and person-centered planning and family-centered practice. Selection of services should also be made based on medical necessity criteria, and, where applicable, the service-specific criteria, coverage policy and decision parameters contained in the most recent version of the Medical Services Administration's Medicaid Policy Manual. However, decisions regarding access/eligibility should not be based on medical necessity criteria or service-specific criteria since these decisions are a separate and subsequent process to eligibility determinations.

Special Note: For Direct Prevention Services Models (CCEP, School Success Program, Infant Mental Health, Parent Education) with a family or child care provider regarding an individual child, the service should be noted in the child's plan of services as "medically necessary" and should be reported using the child's beneficiary identification number. PIHPCMHSPs typically use "unspecified" diagnosis codes found in the ICD-910 for infants, young children and individuals who receive one-time crisis intervention.

Definition of Child with Serious Emotional Disturbance 7 through 17 Years

The definition of SED for children 7 through 17 years delineated below is based on the Mental Health Code, Section 330.1100d. In addition, extensive reviews and examinations of Child and Adolescent Functional Assessment Scale (CAFAS) data submitted by CMHSPs for the children served were undertaken to establish functioning criteria consistent with the Michigan Mental Health Code definition of serious emotional disturbance.[1] The parameters delineated below do not preclude the diagnosis of and the provision of services to an adult beneficiary who is a parent and who has diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance.

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

Diagnosis

[1] The recommendations for the CAFAS scores as detailed under the functioning dimension described in this document is estimated to capture about 84.2% of the children currently being served by CMHSPs.

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

Degree of Disability/Functional Impairment

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

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

Duration/History

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

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

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

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

However, as with infants and toddlers (birth through age three years), assessment must be sensitive to the critical indicators of

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

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

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

The child shall meet each of the following:

Diagnosis

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

Degree of Disability/Functional Impairment

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

Area I:

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

Internalized Behaviors:

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

Externalized Behaviors:

- frequent tantrums or aggressiveness toward others, self and animals
- inflexibility and low frustration tolerance
- severe reaction to changes in routine
- disorganized behaviors or play
- shows inappropriate emotions for situation
- reckless behavior
- danger to self, including self-mutilation
- need for constant supervision
- impulsive or danger seeking
- sexualized behaviors inappropriate for developmental age
- developmentally inappropriate ability to comply with adult requests
- refuses to attend child care and/or school
- deliberately damages property
- fire starting
- stealing

Area II:

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

- bed wetting

- sleep disorders
- eating disorders
- encopresis
- somatic complaints

Area III:

Disturbances of thought, as indicated by the following behaviors:

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

Area IV:

Difficulty with social relationships as indicated by:

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

Area V:

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

- a chaotic household/constantly changing care-giving environments
- parental expectations are inappropriate considering the developmental age of the young child

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

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

Duration/History

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

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

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

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

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

- the magnitude and speed of developmental changes through pregnancy and infancy and early childhood;
- the limited capacity of the very young to symptomatically present underlying disturbances;

- the extreme dependence of infants and toddlers upon caregivers for their survival and well-being; and
- the vulnerability of the very young to relationship and environmental factors.

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

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

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

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

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

The child shall meet each of the following:

Diagnosis

An infant or toddler has a mental, behavioral, or emotional disturbance sufficient to meet the diagnostic criteria specified in the most recent diagnostic and statistical manual of mental disorders published by the American Psychiatric Association consistent with the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition* (see attached crosswalk) that has resulted in functional impairment as indicated below. The following disorders are included only if they occur in conjunction with

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

Degree of Disability/Functional Impairment

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

Area I:

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

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

Area II:

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

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

Area III:

Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of infant/toddler,

parent/caregiver and environmental characteristics. Indicators in the infant or toddler are:

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

The standardized ~~An~~ assessment tool specifically targeting social-emotional functioning for infants is the Devereaux Early Childhood Assessment (Infant, Toddler or Clinical Version) ~~toddlers and assessment of the relationship between primary caregiver(s) will be determined based on field testing of recommended assessment tools.~~

Duration/History

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

(1) The infant or toddler's disorder(s) is affected by persistent multiple barriers to normal development (inconsistent parenting or care-giving, chaotic environment, etc.); or
(2) The infant or toddler has been observed to exhibit the functional impairments for more days than not for a minimum

of two weeks (see Areas I-III above); or

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

Infants and Toddlers (birth to 47 months) who Require Specialty Services and Supports
Crosswalk between DC 0-3R and ICD-10 and DSM-IV-TR

DC 0-3 R	ICD-10	ICD-10 Diagnostic Category Description	DSM-IV	DSM-IV-TR
100 Post-Traumatic Stress Disorder	F43.0	Acute stress reaction	308.3	Acute stress reaction
	F43.1	Post traumatic stress disorder	309.81	Post traumatic Stress Disorder
	F43.2x	Adjustment disorders specify clinical form with 5th character: F43.20 – Brief depressive reaction F43.21 – Prolonged depressive reaction F43.22 – Mixed anxiety and depressive reaction F43.23 – With predominant disturbance of other emotions F43.24 – With predominant disturbance of conduct		
	F44.0	Dissociative amnesia		
150 Deprivation/ Maltreatment Disorder	T74.0	Neglect or abandonment	313.89	Reactive Attachment Disorder
	T74.8	Other Maltreatment Syndromes		
	T74.9	Maltreatment syndrome, specified		

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DC 0-3 R	ICD 10	ICD 10 Diagnostic Category Description	DSM-IV	DSM-IV-TR
	F94.1	Reactive attachment disorder of childhood		
	F94.2	Disinhibited attachment disorder of childhood		
200 Disorder of Affect				
210 Prolonged Bereavement/Grief Reaction	F43.22	Adjustment disorder with mixed anxiety and depressive reaction	309.0	Adjustment Disorder with Depressed Mood
	F43.23	Adjustment disorder with predominant disturbance of other emotions		
220 Anxiety Disorder				
221 Separation Anxiety	F93.0	Separation anxiety disorder of childhood	309.21	Separation Anxiety Disorder
222 Specific Phobia	F93.1	Phobic anxiety disorder of childhood	300.01	Panic disorder w/o Agoraphobia
223 Social Anxiety Disorder	F93.2	Social anxiety disorder of childhood	300.23	Social Phobia
224 Generalized Anxiety Disorder	F41.1	Generalized anxiety disorder	300.02	Generalized Anxiety Disorder
225 Anxiety Disorder NOS	F41.9	Anxiety disorder, unspecified	300.00	Anxiety Disorder NOS
230 Depression of Infancy and Early Childhood				
231 Type I Major Depression	F32.2	Severe depressive episode without psychotic symptoms	296.20	Major Depressive Disorder, Single Episode, Unspecified
	F32.3	Severe depressive episode with psychotic symptoms		

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DC 0-3 R	ICD-10	ICD-10 Diagnostic Category Description	DSM-IV	DSM-IV-TR
	F32.1	Moderate depressive episode	300.4	Dysthymic Disorder
	F33.x	Recurrent depressive disorder 4th digit specifies severity (as with F32.x above) 0 – current episode mild 1 – current episode moderate 2 – current episode severe, without psychotic symptoms 3 – current episode severe, with psychotic symptom	296.30	Major Depressive Disorder, Recurrent, Unspecified
	F33.9	Recurrent depressive disorder, unspecified	296.30	Major Depressive Disorder, Recurrent, Unspecified
232 Type II Depressive Disorder NOS	F32.0	Mild depressive episode	311	Depressive Disorder NOS
	F32.9	Depressive episode, unspecified		
240 Mixed disorder of emotional expressiveness	F92.9	Mixed disorder of conduct and emotions, unspecified	313.9	Disorder of Infancy, Childhood, or Adolescence NOS
300 Adjustment Disorder	F43.2	Adjustment disorders	309.9	Adjustment Disorder, Unspecified
	F43.0	Acute stress reaction		
400 Regulation Disorders of Sensory Processing			313.9	Disorder of Infancy, Childhood, or Adolescence NOS
410 Hypersensitive		(see codes for subtypes)		
411 Type A – fearful/cautious	F41.8	Other specific anxiety disorder		
412 Type B – Negative/Defiant	F92.8	Other mixed disorder of conduct and emotions		

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DC 0-3 R	ICD 10	ICD 10 Diagnostic Category Description	DSM-IV	DSM-IV-TR
420 Hyposensitive/ Underresponsive	F90.0	Disturbance of activity and attention		
430 Sensory stimulations-seeking/Impulsive	F90.1	Hyperkenetic conduct disorder		
500 Sleep Behavior Disorder			307.47	Dyssomnia NOS or Parasomnia NOS
510 Sleep onset disorder	G47.0	Disorders of initiating and maintaining sleep		
520 Night waking disorder	G47.2	Disorders of sleep-wake cycle		
	G 47.9	Sleep disorder , unspecified		
	F51.3	Sleep walking		
	F51.4	Sleep terrors (night terrors)		
	F51.9	Nonorganic sleep disorder, unspecified		
600 Feeding Behavior Disorders			307.59	Feeding Disorder of Infancy or Early Childhood
601 Feeding Disorder of State Regulation	P92.9	Feeding problem of newborn, unspecified		
602 Feeding Disorder of Caregiver-Infant Reciprocity	R63.6	Feeding difficulties and mismanagement		
603 Infantile Anorexia	R63.0	Anorexia, loss of appetite		
604 Sensory Food Aversions	F98.2	Feeding disorder of infancy and childhood		
605 Feeding Disorder associated with concurrent medical conditions	F98.2	Feeding disorder of infancy and childhood		

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DC 0-3 R	ICD 10	ICD 10 Diagnostic Category Description	DSM-IV	DSM-IV-TR
606 Feeding disorder associated with insults to gastrointestinal tract	F50.9	Eating disorder, unspecified		
	F98.2	Feeding disorder of infancy and childhood		
	F50.9	Eating disorder, unspecified		
700 Disorders of Relating and Communicating		If 2 or older, use ICD codes for Pervasive developmental disorders See block F84	299.00	Autistic Disorder
If under age 2				
710 Multisystem developmental disorder	F84.9	Pervasive developmental disorder, unspecified	299.80	Pervasive developmental disorder NOS
AXIS II: Relationship Classification	From Illinois Crosswalk: For Axis II, relational disorders of any degree of severity, a psychosocial stressor must, by definition, also be present. When a relationship disorder or an interaction disorder seems to be the diagnosis of choice in the DC: 0-3R system, the very least that can be used in the DSM and ICD systems is the diagnosis of Adjustment disorder (to the psychosocial stressor).			
900 Relationship Disorder	F43.25	Adjustment disorder with predominant disturbance of emotions and conduct	309.4 Adjustment Disorder With Mixed Disturbance of Emotions and Conduct	
	F41.2	Mixed anxiety and depressive disorder		

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Introduction

This diagnostic thinking process includes a crosswalk that is intended to help overcome the limited applicability of classification systems such as DSM and ICD for assessment and diagnostic formulation with clients in the birth through 5 age range. The assessment framework imbedded in the DC: 0-3R promotes diagnostic thinking that identifies contributions of constitutional (physical health), medical/developmental, relational, psychosocial and functional social-emotional factors to clinical understanding of the child's presentation of challenges and competencies. Each axis supports assessment of significant features of a young child's symptoms and history. For example, a child's difficulties may be diagnosed as issues that focus on interaction processes, relationship challenges, and/or functional developmental challenges highlighting the importance of including functional developmental processes (Axis V) and relationship dynamics (Axis II). Use of all DC: 0-3R axes promotes a thorough assessment process that is a foundation for clinical formulation of the factors that are contributing to overall child functioning and capacity to successfully cope with the challenges of daily life. Integration of the data represented by the axes helps to establish a strong connection between diagnostic formulation and treatment planning. Furthermore, this assessment framework supports identification of risks/stresses that threaten to derail overall developmental and social-emotional progress or contribute to significant deterioration in areas of life functioning or adaptive capacity. This breadth of perspective highlights limitations of DSM and ICD Axis I for diagnostic formulation in work with young children and their families.

This crosswalk invites the clinician to work through a comprehensive set of assessment questions to guide a two-step process of a) DC:0-3R diagnostic formulation of primary presenting problems, then b) crosswalk to DSM-5 billable diagnosis. Two caveats: **Do not start with Axis I; Evaluate all axes.** Choose the diagnosis/diagnoses that characterize the focus of treatment.

Overview of assessment framework:

Part 1: Are the presenting problems primarily or substantially reactions to severe stress or related to issues of coping with psychosocial stressors that are affecting the family, undermining the caregivers' capacities, and challenging the child's adaptive capacities? Have these stressors undermined the caregiver's capacity to be protective? The presenting problems may indicate stresses or cumulative risk (Axis IV). Is the presentation of symptoms related to stress or risk a focus of treatment?

Part 2: What is the role of physical health (constitutional), medical diagnoses, health care needs, or developmental factors (disorders) in determining the child's difficulties (Axis III). Is the child struggling with daily tasks due to health or developmental problems? Note that developmental disorder diagnoses are included on DC: 0-3R Axis III - diagnoses used by developmental specialists (e.g., speech/language, OT, PT, special education)

Part 3: Does the child demonstrate age level emotional and social functioning across the routines and settings of daily life and in interactions with all caregivers? Does the child struggle with maintaining functional levels of competencies in interactions with only some caregivers? With all caregivers? Are there difficulties with specific developmental skills that undermine functional competency and limit the child's capacity to adapt successfully to solve the problems of his/her daily life (See Axis III, disorders in language, motor, cognition)? Are these functional competency challenges a focus of treatment?

Part 4: What is the role/contribution of relational dynamics: are there patterns of rigidity in parent-child interactions, tension, conflict that tends to be unresolvable? Do these relational factors contribute to undermining the child's functional competencies, and possibly impact the child's

developmental trajectory; the caregiver's functioning? Axis II describes problems that appear to be specific to a relationship. Is the relational dynamic a focus of treatment?

Part 5: Are the child's difficulties pervasive, occurring across settings and across relationships? This overarching question of pervasiveness (severity, duration, impairment) guides assessment questions that will help to distinguish DC:0-3R Axis I diagnoses from difficulties that occur only in certain circumstances or in relation to a particular person. Does the symptom pattern meet criteria for a diagnosis on Axis I of the DC: 0-3 R? How will that diagnosis guide the focus of treatment? For example, has the child experienced major traumatic events that contribute to a pervasive presentation of symptoms?

In absence of a primary Axis I diagnosis, are the presenting symptoms adequately captured and characterized by clinical formulation of risk/stress (Axis IV), physical and developmental health (Axis III), dynamics specific to a relationship (Axis II), and/or functional competencies (Axis V)?

Part 1

For risks, cumulative, or chronic stress, consider the context for enduring and significant adjustment challenges. A child's behavioral difficulties may be an indication of the child's struggles to cope with the impact of stresses affecting daily life with family/caregivers.

Develop full DC:0-3R formulation (reviewing each axis for salient assessment findings)	Select DSM crosswalk diagnosis for billing purposes	
DC 0-3 R	DSM-5 Code	DSM-5
Psychosocial Risk/Stressors	Note: Axis IV Checklist in DC: 0-3R does not focus exclusively on risk factors that have been identified in risk/resiliency research as factors in cumulative risk. Many check list items are more specific stress factors in family life. Cumulative daily stress can be a significant risk factor.	
Risk, cumulative risk, imminent risk- Distinguish history from chronic and current stressors.	309.9	Adjustment Disorder, Unspecified (Unspecified Trauma- and Stressor-Related Disorder) • New dx criteria E: *Once the stressors or its consequences have terminated*, the symptoms do not persist for more than an additional 6 months.
300 Adjustment Disorder	309.xx 309.9	Adjustment Disorder, (specify) 309.0 With depressed mood 309.24 With anxiety 309.28 With anxiety and depressed mood Adjustment Disorder, Unspecified (309.3 RESERVED –this code is reserved for 240 Mixed Disorder of Emotional Expressiveness- Axis I) (309.4 RESERVED - this code is reserved for Axis II, Relationship Disorder)

If traumatic events meet DC: 0-3R Axis I criteria and child's symptom presentation is pervasive across situations and relationships, evaluate:		From DSM-5 Trauma and Stressor Related Disorders
100 Post Traumatic Stress Disorder	309.81	Post-Traumatic Stress Disorder
150 Deprivation/Maltreatment Disorder	313.89	Reactive Attachment Disorder
	313.89	Disinhibited Social Engagement Disorder
	308.3	Acute Stress Disorder

Part 2

The presence of specific physical health (constitutional), developmental or learning challenges undermines a child's functional competencies, strains capacities for coping, and contributes to a context of chronic adjustment challenges that undermine developmental trajectory. Many psychiatric conditions may be indications of (co-occurring) medical conditions that may also undermine a child's capacity for successful adjustment.

AXIS III Medical and Developmental Disorders and Conditions		
DC:0-3 R – Developmental, Health/Medical disorders are recorded on Axis III	**DSM-5 Code**	**DSM-5**
For a primary diagnosis, crosswalk to:	309.9	Adjustment Disorder, Unspecified
	315.9	Unspecified Neurodevelopmental Disorder
If needed for secondary diagnosis		Crosswalk to DSM-5 Axis I and record as Secondary Diagnosis 307.9 Unspecified Communication Disorder 315.39 Social (Pragmatic) Communication Disorder 315.9 Unspecified Neurodevelopmental Disorder 315.4 Developmental Coordination Disorder 315.8 Global Developmental Delay (under age 5) 319 Unspecified Intellectual Disability
Codes are not needed for health/medical conditions. Provide descriptive information about medical/ health issues. Distinguish history, chronic conditions and current issues. Identify names of specific current and chronic medical diagnoses, e.g. asthma; obesity; ear infections; prematurity; genetic syndromes such as Fragile X, Prader Willis; sleep apnea.		

AXIS III Medical and Developmental Disorders and Conditions		
DC:0-3 R - Developmental, Health/Medical disorders are recorded on Axis III	DSM-5 Code	DSM-5

Part 3

Consider the child's capacity to participate in meaningful everyday family routines and interactions.
Does this child demonstrate functional limitations in capacities to integrate emotional, cognitive, communicative competencies to meet emotionally meaningful goals, to "problem solve" effectively, to express wants, needs, likes, dislikes? Does this child use age level developmental skills in daily life routines with each of the important persons in his daily life?

AXIS V – Functional Social-Emotional Capacities	Functional competency may differ significantly from standardized test performance. Functional competency may differ in unstructured contexts that allow child to be in lead compared to structured contexts in which child is expected to follow another's ideas or respond to directions. Challenges presented in a child's functional competencies may involve many factors. If the child's functional competencies are not at age level, then the child does not have age level expected capacities for "problem-solving" responses to challenges of daily life, will need special supports, and will face ongoing challenges to adjustment	
DC: 0-3R	DSM-5 Code	DSM-5
IF not at age-level in any one or more of the capacities:	309.9	Adjustment Disorder, Unspecified (Unspecified Trauma and Stressor Related Disorder)
	315.9	Unspecified Neurodevelopmental Disorder
Treatment planning requires assessment to identify contribution of the factors undermining child's functional competency. Child's functional challenges may be context specific vulnerabilities, immaturity, selective deficit, and may reflect constitutional issues. In addition, functional difficulties may, in turn, contribute to regulatory problems, anxieties, relationship problems. For treatment planning, specify the developmental processes that are not at age level and identify factors that are involved in or affected by functional competencies, e.g., specific developmental delays or disorders, relational dynamics, or health issues. See Axis IV, III above and Axis II below.		

Part 4

What are the patterns of flexibility, tension and conflict in the interactions of this child with each of the important persons in his/her daily life (PIR-GAS rating)? Do these patterns of difficult interactions affect more than one or two of the routines of daily life If possible, determine when these patterns were first established. How long have features of distress/conflict affected multiple daily routines? Is the relationship context of conflicted interactions a primary contributor to the child's difficulties with developmental progress, functioning in daily routines, adjustment?

DC: 0-3R Axis II Relationship Classification	If a specific relationship is characterized by patterns of difficult interactions between child and this adult, (lack of flexibility, tension, and unresolvable conflict) then the child's behavioral problems may reflect the presence of ongoing challenges to the child's adjustment. Undermining of Axis V functional competencies may be specific to a relationship. Difficulties in interaction may also create a context of risk or features of disorder that may indicate increased risk of developing a relationship disorder or other problems.	
	DSM-5 Code	DSM-5
900 Relationship Disorder – If PIR-GAS of 40 or below, dx of relationship disorder	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct; Chronic
If PIR-GAS of 41- 80 - Features of Disorder Difficulties may not yet be ingrained. Interventions may be focused on addressing risks of deterioration in child's adaptive functioning or development.	309.4	Adjustment Disorder With Mixed Disturbance of Emotions and Conduct; Chronic
		Note: Specific relationship disorder may co-occur with other diagnoses.

Part 5

Is (some part of) the child's problem/symptom presentation pervasive, that is, across relationships and across settings, instead of specific to a relationship or selectively expressed in only some contexts?

In addition to difficulties identified above, is there a DC:0-3 R Axis I diagnosis	DSM-5 Codes	DSM-5
DC:0-R Clinical Disorders		
100 Post Traumatic Stress Disorder	309.81	Post Traumatic Stress Disorder
150 Deprivation/Maltreatment Disorder	313.89	Reactive Attachment Disorder
	313.89	Disinhibited Social Engagement Disorder
	308.3	Acute Stress Disorder
DC: 0-3R 200 Disorders of Affect		
210 Prolonged Bereavement/Grief Reaction	309.0	Adjustment Disorder with Depressed Mood
	309.9	Adjustment Disorder, Unspecified (Unspecified Trauma and Stressor Related Disorder)
220 Anxiety Disorders		
221 Separation Anxiety	309.21	Separation Anxiety Disorder
222 Specific Phobia	300.01	Panic disorder
223 Social Anxiety Disorder	300.23	Social Anxiety Disorder (Social Phobia)
224 Generalized Anxiety Disorder	300.02	Generalized Anxiety Disorder
225 Anxiety Disorder NOS	300.00	Unspecified Anxiety Disorder
230 Depression of Infancy and Early Childhood		
231 Type I Major Depression	296.99	Disruptive Mood Dysregulation Disorder
	296.20	Major Depressive Disorder, Single Episode, Unspecified
232 Type II Depressive Disorder NOS	311	Unspecified Depressive Disorder
240 Mixed disorder of emotional expressiveness	309.3	Adjustment Disorder with disturbance of conduct

DC:0-3R 300 Adjustment Disorder	309.xx 309.9	Adjustment Disorder, (specify) 309.0 With depressed mood 309.24 With anxiety 309.28 With anxiety and depressed mood Adjustment Disorder, Unspecified (309.3 RESERVED –this code is reserved for 240 Mixed Disorder of Emotional Expressiveness-above) (309.4 RESERVED - this code is reserved for Axis II, Relationship Disorder)
400 Regulation Disorders of Sensory Processing 410 Hypersensitive 411 Type A – Fearful/cautious 412 Type B – Negative/Defiant 420 Hyposensitive/Underresponsive 430 Sensory stimulations-seeking/Impulsive	315.9	Same DSM-5 code for all subtypes Unspecified Neurodevelopmental Disorder
500 Sleep Behavior Disorder Note: *IF primary diagnosis, the Sleep Disorder is not a symptom related to or secondary to other problems.*		NOTE: Medicaid rules exclude Sleep Disorders as primary diagnosis. Can Sleep Disorder be a Secondary Diagnosis?– yes
510 Sleep onset disorder 520 Night-waking disorder	309.9	Adjustment Disorder, Unspecified
If needed for Secondary diagnosis	780.52 780.59	Insomnia Disorder Unspecified Sleep-Wake Disorder
600 Feeding Behavior Disorder 601 Feeding Disorder of State Regulation 602 Feeding Disorder of Caregiver-Infant Reciprocity (this dx is specific to feeding interactions so is less pervasive than a relationship disorder)	307.59	(Same DSM-5 Code for all DC:0-3R subtypes) Unspecified Feeding or Eating Disorder Note: *IF primary diagnosis, the Feeding Disorder is not a symptom related to or secondary to other problems.*

603 Infantile Anorexia		
604 Sensory Food Aversions		
605 Feeding Disorder associated with concurrent medical conditions		
606 Feeding disorder associated with insults to gastrointestinal tract		
700 Disorders of Relating and Communicating (Referred to as PDD in the DSM classification.)		NOTE: A mental health diagnosis for a child who also suffers from a Disorder of Relating and Communicating (PDD) may focus treatment on related symptoms, e.g., anxieties, interaction problems with family members, functional competencies, etc. Autism (299.00) may be a secondary diagnosis within mental health.
DC:0 3R guides clinicians to diagnose differently for children age 2 and over and those under age 2. 710 Multisystem Developmental Disorder is limited to under age 2.		DC:0-3R age distinctions do not apply in crosswalk.
710 Multisystem Developmental Disorder (MSDD)	299.80	Pervasive developmental disorder NOS – can be primary dx
	300.00	Unspecified Anxiety Disorder
	315.9	Unspecified Neurodevelopmental Disorder
For Secondary Diagnosis if needed This may be important for advocacy work with other service providers, agencies.		299.00 Autistic Disorder Can be Secondary Diagnosis, but not a primary diagnosis. Specify severity: Level 3 -Requiring very substantial support Level 2- Requiring substantial support Level 1- Requiring support
800 Other Disorders -- Not relevant to Medicaid billing crosswalk		This code would be used to include diagnostic codes from the ICD, DSM or other classifications into a DC: 0-3R formulation; in that context, the DC:0-3R would serve as the primary system for diagnostic classification & no crosswalk would be needed.
If a DC: 0-3R Axis I Diagnosis has not been identified - First, re-consider assessment areas above	This crosswalk includes directions for all DC:0-3R axes to ICD-9 Axis I Codes. See Above.	
If no DC:0-3R Axis I diagnosis but significant concerns that indicate need for monitoring or further assessment, then for eligibility, consider these diagnoses and develop a plan for further assessment activities.		

	315.9	Unspecified neurodevelopmental disorder
	309.9	Adjustment Disorder, Unspecified
	309.9	Unspecified Trauma- and Stressor-Related Disorder

Diagnostic Thinking Process

Assessment Framework: All Axis Crosswalk between DC: 0-3R and ICD-10 CM

October, 2015

Introduction

This diagnostic thinking process includes a crosswalk that is intended to help overcome the limited applicability of classification systems such as DSM and ICD for assessment and diagnostic formulation with clients in the birth through 5 age range. The assessment framework imbedded in the DC: 0-3R promotes diagnostic thinking that identifies contributions of constitutional (physical health), medical/developmental, relational, psychosocial and functional social-emotional factors to clinical understanding of the child's presentation of challenges and competencies. Each axis supports assessment of significant features of a young child's symptoms and history. For example, a child's difficulties may be diagnosed as issues that focus on interaction processes, relationship challenges, and/or functional developmental challenges highlighting the importance of including functional developmental processes (Axis V) and relationship dynamics (Axis II). Use of all DC:0-3R axes promotes a thorough assessment process that is a foundation for clinical formulation of the factors that are contributing to overall child functioning and capacity to successfully cope with the challenges of daily life. Integration of the data represented by the axes helps to establish a strong connection between diagnostic formulation and treatment planning. Furthermore, this assessment framework supports identification of risks/stresses that threaten to derail overall developmental and social-emotional progress or contribute to significant deterioration in areas of life functioning or adaptive capacity. This breadth of perspective highlights limitations of DSM and ICD Axis I for diagnostic formulation in work with young children and their families.

This crosswalk invites the clinician to work through a comprehensive set of assessment questions to guide a two-step process of a) DC: 0-3R diagnostic formulation of primary presenting problems, then b) crosswalk to ICD-10 billable diagnosis. Two caveats: Do not start with Axis I; Evaluate all axes. Choose the diagnosis/diagnoses that characterize the focus of treatment:

Overview of assessment framework:

Part 1: Are the presenting problems primarily or substantially reactions to severe stress or related to issues of coping with psychosocial stressors that are affecting the family, undermining the caregivers' capacities, and challenging the child's adaptive capacities? Have these stressors weakened the caregiver's capacity to be protective? The presenting problems may indicate risk or cumulative stress (Axis IV). Is the presentation of risk a focus of treatment?

Part 2: What is the role of physical health (constitutional), medical diagnoses, health care needs, or developmental factors (disorders) in determining the child's difficulties (Axis III). Is the child struggling with daily tasks due to health or developmental problems? Note that

developmental disorder diagnoses are included on DV: 0-3R Axis III - diagnoses used by developmental specialists, e.g., speech/language, OT, PT, special education)

Part 3: Does the child demonstrate age level emotional and social functioning across the routines and settings of daily life and in interactions with all caregivers? Does the child struggle with maintaining functional levels of competencies in interactions with only some caregivers? With all caregivers? Are there difficulties with specific developmental skills that undermine functional competency and limit the child's capacity to adapt successfully to solve the problems of his/her daily life (See Axis III, disorders in language, motor, cognition)? Are these functional competency challenges a focus of treatment?

Part 4: What is the role/contribution of relational dynamics: are there patterns of rigidity in parent-child interactions, tension, conflict that tends to be unresolvable? Do these relational factors contribute to undermining the child's functional competencies, and possibly impact the child's developmental trajectory; the caregiver's functioning? Axis II describes problems that appear to be specific to a relationship. Is the relational dynamic a focus of treatment?

Part 5: Are the child's difficulties pervasive, occurring across settings and across relationships? This overarching question of pervasiveness (severity, duration, impairment) guides assessment questions that will help to distinguish DC:0-3R Axis I diagnoses from difficulties that occur only in certain circumstances or in relation to a particular person. Does the symptom pattern meet criteria for a diagnosis on Axis I of the DC: 0-3 R? How will that diagnosis guide the focus of treatment? For example, has the child experienced major traumatic events that contribute to a pervasive presentation of symptoms?

In absence of a primary Axis I diagnosis, are the presenting symptoms adequately captured and characterized by clinical formulation of risk/stress (Axis IV), physical and developmental health (Axis III), dynamics specific to a relationship (Axis II), and/or functional competencies (Axis V)?

Part 1

For risks, cumulative or chronic stress, consider the context for enduring and significant adjustment challenges. A child's behavioral difficulties may be an indication of the child's struggles to cope with the impact of stresses affecting daily life with family/caregivers.

Develop full DC0-3R formulation (reviewing each axis for salient assessment findings)	Select ICD-10 crosswalk diagnosis for billing purposes	
DC 0-3 R	ICD-10 Code	ICD-10
Psychosocial Risk/Stressors	Note: Axis IV Checklist in DC: 0-3R does not focus exclusively on Risk factors that have been identified in risk/resiliency research as factors in cumulative risk. Many check list items are "daily hassles." Cumulative daily stress can be a significant risk factor.	
Risk, cumulative risk, imminent risk- Distinguish history from chronic and current stressors.	F43.9	Reaction to severe stress, unspecified.

300 Adjustment Disorder	F43.20 F43.21 F43.22 F43.23	Adjustment disorder, unspecified with depressed mood with anxiety with mixed anxiety and depressed mood (F43.24 RESERVED— this code is reserved for 240 Mixed Disorder of Emotional Disturbance – Axis I) (F43.25 RESERVED- that code is reserved for Axis II, Relationship Disorder-See Axis II Relationship Disorder)
If stress/risk events meet DC: 0-3R Axis I criteria, and child's symptom presentation is pervasive across situations and relationships, evaluate:		
100 Post Traumatic Stress Disorder	F43.10	Post traumatic stress disorder, unspecified F43.11 acute F43.12 chronic
150 Deprivation/Maltreatment Disorder	F94.1	Reactive attachment disorder of childhood (inhibited form)
	F94.2	Reactive attachment disorder of childhood (disinhibited form)
		NOTE: These two diagnoses (94.1 and 94.2) are mutually exclusive – i.e., cannot co-occur

Part 2

The presence of specific physical health (constitutional), developmental or learning challenges undermines a child's functional competencies, strains capacities for coping, and contributes to a context of chronic adjustment challenges that undermine developmental trajectory. Many psychiatric conditions may be indications of (co-occurring) medical conditions that may also undermine a child's capacity for successful adjustment.

AXIS III Medical and Developmental Disorders and Conditions		
DC: 0-3 R - Developmental, Health/Medical disorders are recorded on Axis III	ICD-10 Code	ICD-10
For a primary diagnosis, crosswalk to:	F43.20	Adjustment disorder, unspecified

AXIS III Medical and Developmental Disorders and Conditions		
DC: 0-3 R - Developmental, Health/Medical disorders are recorded on Axis III	ICD-10 Code	ICD-10
	F93.9	Childhood emotional disorder, unspecified
If needed for secondary diagnosis		For Secondary Diagnosis: F80.1 Expressive language disorder F80.2 Mixed expressive-receptive language disorder F80.9 Development disorder of speech and language, unspecified F81.9 Developmental disorder of scholastic skills, unspecified F82 Specific developmental disorder of motor function F79 Unspecified intellectual disabilities
ICD-10 codes are not needed for physical health/medical conditions. Provide descriptive information about medical/ health issues. Distinguish history, chronic conditions and current issues. Identify names of specific current and chronic medical diagnoses, e.g. asthma; obesity; ear infections; prematurity; genetic syndromes such as Fragile X, Prader Willis; sleep apnea		

Part 3

Consider the child's capacity to participate in meaningful everyday family routines and interactions.
Does this child demonstrate functional limitations in capacities to integrate emotional, cognitive, communicative competencies to meet emotionally meaningful goals, to "problem solve" effectively, to express wants, needs, likes, dislikes? Does this child use age level developmental skills in daily life routines with each of the important persons in his daily life?

AXIS V – Functional Social-Emotional Capacities	Functional competency may differ significantly from standardized test performance. Functional competency may differ in unstructured contexts that allow child to be in lead compared to structured contexts in which child is expected to follow another's ideas or respond to directions. Challenges presented in a child's functional competencies may involve many factors. If the child's functional competencies are not at age level, then the child does not have age level expected capacities for "problem-solving" responses to challenges of daily life, will need special supports, and will face ongoing challenges to adjustment.	
DC: 0-3R	ICD-10 Code	ICD-10
If not at age-level in any one or more of the capacities:	F94.9	Childhood disorder of social functioning
	F99	Not otherwise specified
Treatment planning requires assessment to identify the contributing factors undermining a child's functional competency. Standardized testing may be indicated. Child's functional challenges may be context specific vulnerabilities, immaturity, selective deficit, and may reflect constitutional /physical health issues. In addition, functional difficulties may, in turn, contribute to regulatory problems, anxieties, relationship problems. For treatment planning, specify the developmental processes that are not at age level and identify factors that are involved in or affected by functional competencies, e.g., specific developmental delays or disorders, relational dynamics, or health issues. See Axis IV, III above and Axis II below.		

Part 4

What are the patterns of flexibility, tension and conflict in the interactions of this child with each of the important persons in his/her daily life (PIR-GAS rating)? Do these patterns of difficult interactions affect more than one or two of the routines of daily life If possible, determine when these patterns were first established. How long have features of distress/conflict affected multiple daily routines? Is the relationship context of conflicted interactions a primary contributor to the child's difficulties with developmental progress, functioning in daily routines, adjustment?

DC: 0-3R Axis II Relationship Classification	If a specific relationship is characterized by patterns of difficult interactions between child and this adult, (lack of flexibility, tension, and unresolvable conflict) then the child's behavioral problems may reflect the presence of ongoing challenges to the child's adjustment. Undermining of Axis V functional competencies may be specific to a relationship. Difficulties in interaction may also create a context of risk or features of disorder that may indicate increased risk of developing a relationship disorder or other problems.	
DC: 0-3R	ICD-10 Code	ICD-10
900 Relationship Disorder – If PIR-GAS of 40 or below, dx of relationship disorder	F43.25	Adjustment disorder with mixed disturbance of emotions and conduct
If PIR-GAS of 41- 80 - Features of Disorder Difficulties may not yet be ingrained. Interventions may be focused on addressing risks of deterioration in child's adaptive functioning or development.	F43.25	Adjustment disorder with mixed disturbance of emotions and conduct
		Note: Specific relationship disorder may co-occur with other diagnoses.

Part 5

Is (some part of) the child's problem/symptom presentation pervasive, that is, across relationships and across settings, instead of specific to a relationship or selectively expressed in only some contexts?

DC: 0-3 R	ICD-10 Code	ICD-10
In addition to difficulties identified above, is there a DC: 0-3 R Axis I diagnosis		
DC:0-3 Clinical Disorders		
100 Post Traumatic Stress Disorder	F43.10	Post traumatic stress disorder, unspecified F43.11 acute F43.12 chronic
150 Deprivation/Maltreatment Disorder	F94.1	Reactive attachment disorder of childhood (inhibited form)
	F94.2	Reactive attachment disorder of childhood (disinhibited form)
		NOTE: These two diagnoses (94.1 and 94.2) are mutually exclusive – i.e., cannot co-occur
200 Disorders of Affect		
210 Prolonged Bereavement/Grief Reaction	F43.20	Adjustment disorder, unspecified
	F43.9	Reaction to severe stress, unspecified
220 Anxiety Disorders		
221 Separation Anxiety	F93.0	Separation anxiety disorder of childhood
222 Specific Phobia	F40.9	Phobic anxiety disorder, unspecified
223 Social Anxiety Disorder	F40.10	Social phobia, unspecified
224 Generalized Anxiety Disorder	F41.1	Generalized anxiety disorder
225 Anxiety Disorder NOS	F41.9	Anxiety disorder, unspecified
230 Depression of Infancy and Early Childhood		

DC: 0-3 R	ICD-10 Code	ICD-10
231 Type I Major Depression	F32.9	Major depressive disorder, single episode, unspecified
	F33.9	Major depressive disorder, recurrent, unspecified
232 Type II Depressive Disorder NOS	F34.9	Persistent mood (affective) disorder, unspecified
240 Mixed disorder of emotional expressiveness	F43.24	Adjustment disorder with disturbance of conduct
300 Adjustment Disorder		See Axis IV Above
400 Regulation Disorders of Sensory Processing	F41.9	Anxiety disorder, unspecified
410 Hypersensitive		
411 Type A – Fearful/cautious		
412 Type B – Negative/Defiant		
420 Hyposensitive/Under-responsive		
430 Sensory stimulations-seeking/Impulsive		
500 Sleep Behavior Disorder Note: *the Sleep difficulties are not symptoms related to or secondary to other problems.*	F43.20	Adjustment disorder, unspecified
NOTE: Medicaid rules exclude Sleep Disorders as primary diagnosis.		
If needed for secondary diagnosis:		Can Sleep Disorder be a Secondary Diagnosis?– yes
510 Sleep onset disorder		G47.50 Parasomnia, unspecified
520 Night waking disorder		G47.9 Sleep disorder, unspecified
		F51.4 Sleep terrors (night terrors)
600 Feeding Behavior Disorder		(Same ICD-10 Code for all DC:0-3R subtypes)
601 Feeding Disorder of State Regulation		

DC: 0-3 R	ICD-10 Code	ICD-10
602 Feeding Disorder of Caregiver-Infant Reciprocity (this dx is specific to feeding interactions so is less pervasive than a relationship disorder)	F98.2	Other feeding disorders of infancy and early childhood Note: *IF primary diagnosis, the feeding difficulties are not a symptom related to or secondary to other problems.*
603 Infantile Anorexia		
604 Sensory Food Aversions		
605 Feeding Disorder associated with concurrent medical conditions		
606 Feeding disorder associated with insults to gastrointestinal tract		
700 Disorders of Relating and Communicating (Referred to as PDD in the ICD-10 classification.)		NOTE: A mental health diagnosis for a child who also suffers from a Disorder of Relating and Communicating (PDD) may focus treatment on related symptoms, e.g., anxieties, interaction problems with family members, functional competencies, etc. Autism (F84.0) may be a secondary diagnosis within mental health.
DC:0-3R guides clinicians to diagnose differently for children age 2 and over and those under age 2. 710 Multisystem Developmental Disorder is limited to under age 2.		DC: 0-3R age distinctions do not apply in crosswalk.
710 Multisystem Developmental Disorder (MSDD)	F84.9	Pervasive developmental disorder , unspecified Note: *can be primary diagnosis*
	F41.9	Anxiety disorder, unspecified
For Secondary Diagnosis if needed This may be important for advocacy work with other service providers, agencies.		F84.0 Autistic disorder Note: Can be Secondary Diagnosis, but not a primary diagnosis.
800 Other Disorders	Not relevant to Medicaid billing crosswalk	This code would be used to include diagnostic codes from the ICD, DSM or other classifications into a DC: 0-3R formulation; in that context, the DC:0-3R would serve as the primary system for diagnostic classification and no crosswalk would be needed.

DC: 0-3 R	ICD-10 Code	ICD-10
If a DC:0-3R Axis I Diagnosis has not been identified - First, re-consider assessment areas above		This crosswalk includes directions for all DC:0-3R axes to ICD-**10** Axis I Codes. See Above.
If no DC:0-3R Axis I diagnosis but significant concerns that indicate need for monitoring or further assessment, then for eligibility, consider these diagnoses and develop a plan for further assessment activities.		
	F99	Unspecified mental disorder
	F93.9	Childhood emotional disorder, unspecified
	F94.9	Childhood disorder of social functioning, unspecified

Continuing Education Requirements for Recipient Rights Staff
Technical Advisory
~~**October 2015**~~

Background/Regulatory Overview

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

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

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

MDHHS/CMHSP Managed Mental Health Supports and Services Contract: ~~FY 16~~
The Community Mental Health Services Program (CMHSP) shall assure that, within the first three months (90 days) of employment, the Recipient Rights Office Director, and all Rights Office staff (excluding clerical staff) shall attend and successfully complete the Basic Skills Training programs offered by the Department's Office of Recipient Rights. In addition, within every three (3) year period subsequent to their completion of Basic Skills, the Recipient Rights Office Director and all Rights Office staff (excluding clerical staff) must comply with the requirements specified in Attachment C6.3.2.3A "Continuing Education Requirements for Recipient Rights Staff".

Definitions

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

2. Category I Credits: Operations
   This category includes programs that support and enhance the fundamental scope of responsibilities and effective work of recipient rights staff. These may be directly related to prevention, complaint resolution, and monitoring and education that support the fundamental scope of a Rights Office's operations. Examples include:
   Rights Office Operations Techniques
   Enhancing Investigative Skills

Inpatient Rights
Out-of-catchment rights protection
Writing effective rights-related contract language
Conducting effective site visits
How to protect rights in a dual rights protection system

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

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

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

6. CMHSP: Community Mental Health Services Program~~rovider~~

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

8. Department: Michigan Department of Health and Human Services (MDHHS)

9. LPH/U: Licensed Private Hospital/Unit

Standards

A. Basic Requirements

1. All staff of the Department, a community mental health services program (CMHSP), or a licensed private
Hospital (LPH/U), employed for the purpose of providing recipient rights services shall, within the first 90 days of employment, attend, and successfully complete, the Basic Skills Training curriculum as determined by the Michigan Department of Health and Human Services Office of Recipient Rights. The Basic Skills curriculum shall consist of the following classes:
Basic Skills – Part 1
Basic Skills – Part 2
NOTE: THIS IS CLARIFICATION NOT A CHANGE

~~2. A person who does not successfully complete the Basic Skills curriculum will not be allowed to conduct investigations or training.~~

B. Continuing Education Requirements

1. All staff employed or contracted to provide recipient rights services shall receive education and training oriented toward maintenance, improvement or enhancement of the skills required to effectively perform the functions as rights staff.
2. A minimum of 36 contact hours of education or training shall be required over a three (3) year period subsequent to the completion of the Basic Skills requirements, and in every three (3) year period thereafter.
3. The 36 contact hours obtained must be in rights-related activities and must fall within one or more of the categories identified in the definitions above.
4. A minimum of 12 contact hours must be obtained in programs classified as Category I or II.
5. No more than 12 credits in a 3 year period may be earned through the use of online learning resources.

~~6. All rights staff must attend a "Basic Skills Update Training" as required by the Department once every five years after they have successfully completed the Basic Skills Course. Attendance at this course will count for required contact hours.~~

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~~7.~~6. CEU's may be received by attending programs or conferences developed by the Department, other rights-related organizations, organizations that have applied to the Office of Recipient Rights Training Division for approval of their programs or through online training.

~~8.~~7. Rights staff may request approval for other educational programs by utilizing the established approval process.

~~9.~~8. Recipient rights staff should retain documentation of meeting the CEU requirements for a period

of four (4) years from the date of attendance. It is suggested that the following information be kept on file:

a. The title of the course or program and any identification number assigned to it by the education provider. The number of CEU hours completed.
b. The provider's name and identifying number.
c. Verification of your attendance by the provider.
d. The date and location of the course.

9. Reviews will be conducted by the MDHHS Office of Recipient Rights Assessment Unit staff at each assessment of a recipient rights program to determine if all rights staff have met both the basic and continuing education requirements.
10. CMHSPs who contract with Licensed Private Hospitals/Units shall mandate compliance with the standards in this Technical Advisory by the Recipient Rights Office staff of those entities.

C. Procedures for Training approval

1. Training that is automatically approved for CEU credits:

   a) MDHHS ORR training *excluding Basic Skills*
   b) Sessions at the MDCH ORR Annual Conference, including the Pre-Conference session
   c) Training provided by, or sponsored by, MDHHS Office of Recipient Rights

2. Training that may be approved for CEU credits, if meeting the criteria above and with the submission of the necessary documents by the applicant:

   a) RROAM sponsored training
   b) CMH/LPH/U sponsored training
   c) Training provided by other agencies, entities, or professionals—law enforcement, mental health or physical health professionals, accreditation bodies, risk management, corporation counsel/lawyer, etc.
   d) Training provided to the Rights Officer/Advisor for their own profession's licensure.
   e) Other training in the community at large, including on-line training, if requirements as detailed above are met.

~~3. Application Review, Approval and Notification~~

~~a) Applications from organizations outside the Department, or applications from individuals who have attended, or plan to attend training programs shall be reviewed and approved or rejected by the Continuing Education Committee.~~

43. CEU Documentation and Notification

   a) Application

   To apply for CEU credits for a training, complete the MDHHS ORR Continuing Education Course Summary (Exhibit A) form and send by email, mail or FAX, at least 30 calendar days prior to the date of the event, to:

MDHHS ORR Education and Training Unit
18471 Haggerty Road
Northville, MI 48168
FAX: 248-348-9963
Email: MDHHS-ORR-Training@michigan.gov

b) Verification of attendance.

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

c) Notification

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

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d) Application Review, Approval and Appeal

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

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Exhibit A: APPLICATION FOR RECIPIENT RIGHTS CEU CREDIT

OFFICE OF RECIPIENT RIGHTS
APPLICATION FOR RECIPIENT RIGHTS CEU CREDIT

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

Please attach a detailed agenda.

~~MDHHS/CMHSP Managed Mental Health Supports and Services Contract FY17 Attachment C6.3.2.3B~~

Recipient Rights Training Standards for CMH and Provider Staff
Technical Requirement NEW
~~October 2015~~

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

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

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

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

Definitions
Core Competencies:
The Core Competencies are a consensus set of skills necessary for an understanding of the rights of mental health recipients. The Core Competencies reflect foundational knowledge that professionals and paraprofessionals engaging in the provision of services to public mental health recipients must have in order to provide services in accordance with Chapter 7 of the Michigan Mental Health Code. These competencies are organized into thirteen domains, reflecting skill areas identified by Chapter 7.

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

Resident: an individual who receives services in either a state operated facility, a licensed psychiatric hospital or unit or an adult foster care facility.

STANDARDS:

1. Training for newly hired agency and provider staff shall encompass the entirety of the core competencies identified in Exhibit A.
2. Annual rights training may focus on any or all of the competencies.

Exhibit A – Areas to be covered in Training

	Board of Directors	Administration	Clinical Staff - Non-Residential	Clinical Staff - Specialized Residential	Direct Care Staff - Specialized Residential	Direct Care Staff - Non Residential	Outpatient Clinic - All Staff	Recipients (not required)	Volunteers	Advisory Committee	Appeals Committee
Abuse and Neglect	*	*	*	*	*	*	*	*	*	*	*
Advisory Committee	*	*							*	*	
Appeals Process	*	*							*	*	*
Confidentiality	*	*	*	*	*	*	*	*	*	*	*
Dignity & Respect	*	*	*	*	*	*	*	*	*	*	
Employee Rights		*	*	*	*	*	*				
Family Rights	*	*	*	*	*	*	*	*	*	*	
ORR Investigative Process	*	*	*	*	*	*	*	*	*	*	*
Overview of the Rights System	*	*	*	*	*	*	*	*	*	*	*
Reporting Requirements	*	*	*	*	*	*	*	*	*	*	
Responsibilities of the Board of Directors	*	*								*	*
Responsibilities of the Agency Director	*	*								*	*
RESIDENTIAL RIGHTS (inpatient, group home)											
Civil Rights		*		*	*	*	*	*	*		
Communications and Visits		*		*	*				*		
Financial Issues		*		*	*				*		
Freedom of Movement		*		*	*				*		
Limitations/Restrictions		*	*	*	*	*	*	*	*		
Medication Rights		*		*	*				*		
Person Centered Planning		*	*	*	*	*	*	*	*		
Personal Property		*		*	*				*		
Photographs, Fingerprints, Taping		*		*	*				*		
Safe, Sanitary, Humane Environment		*	*	*	*	*	*	*	*		
Seclusion/Restraint		*		*	*				*		

Exhibit B – Core Competencies

Code Citation and Title
MHC 330.1722 ABUSE AND NEGLECT

Code Language

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

COMPETENCIES:

- We have a zero-tolerance stance regarding abuse and neglect
- Abuse is defined as:
  - An act (or provocation of another to act) by an employee, volunteer or agent of the provider that causes or contributes to a recipient's death, sexual abuse, serious or non-serious physical harm or emotional harm.
  - The use of unreasonable force on a recipient with or without apparent harm;
  - An action taken on behalf of a recipient by a provider, who assumes the recipient is incompetent, which results in substantial economic, material, or emotional harm to the recipient;
  - An action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient
  - The use of language or other means of communication by an employee, volunteer, or agent of a provider to degrade, threaten, or sexually harass a recipient.
- Agents of the Provider: people who work for agencies that contract with the Department, a CMHSP or PIHP, or a LPH/U
- Neglect is defined as:
  - Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service:
    1. that caused or contributed to the death, sexual abuse of, serious, or non- serious physical harm or emotional harm to a recipient, or
    2. that placed, or could have placed, a recipient at risk of physical harm or sexual abuse.
  - The failure to report apparent or suspected abuse or neglect of a recipient.
- "Bodily function" means the usual action of any region or organ of the body.
- "Emotional harm" means impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.
- "Non-serious physical harm" means physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or registered nurse determines could not have caused, or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his or her bodily functions.
- "Physical management" means a technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself, or others.
- "Serious physical harm" means physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
- "Sexual abuse" means any of the following:
  - Criminal sexual conduct as defined by section 520b to 520e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient.

  - Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a department operated hospital or center, a facility licensed by the department under section 137 of the act or an adult foster care facility and a recipient.
  - Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.
- "Sexual contact" means the intentional touching of the recipient's or employee's intimate parts or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following:
  - Revenge.
  - To inflict humiliation.
  - Out of anger.

- "Sexual harassment" means sexual advances to a recipient, requests for sexual favors from a recipient, or other conduct or communication of a sexual nature toward a recipient.
- "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.
- "Time out" means a voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.
- "Unreasonable force" means physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances:
  - There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others.
  - The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.
  - The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service.
  - The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force

Code Citation and Title	
MHC 330.1704	CIVIL RIGHTS
AR 330.7009	CIVIL RIGHTS

Code Language

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

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

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

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

COMPETENCIES:

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

Code Citation and Title
MHC 330.1748 CONFIDENTIALITY

Code Language

- *Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and shall not be open to public inspection.*
- *If information made confidential by this section is disclosed, the identity of the individual to whom it pertains shall be protected and shall not be disclosed unless it is germane to the authorized purpose for which disclosure was sought; and, when practicable, no other information shall be disclosed unless it is germane to the authorized purpose for which disclosure was sought.*
- *Individuals receiving information made confidential by this section shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained.*
- *For case record entries made subsequent to March 28, 1996, information made confidential by this section shall be disclosed to an adult recipient, upon the recipient's request, if the recipient does not have a guardian and has not been adjudicated legally incompetent*

COMPETENCIES:

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

Code Citation and Title
MHC 330.1708 DIGNITY AND RESPECT

Code Language

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

COMPETENCIES:
Showing respect for recipients shall include:

- Calling a person by his or her preferred name
- Knocking on a closed door before entering
- Using positive language
- Encouraging the person to make choices instead of making assumptions about what he or she wants
- Taking the person's opinion seriously, including the person in conversations; allowing the person to do things independently or to try new things.
- Provide definitions of dignity and respect (Use agency's definition if different)

  Dignity: To be treated with esteem, honor, politeness; to be addressed in a manner that is not patronizing, condescending or demeaning; to be treated as an equal; to be treated the way any individual would like to be treated.

  Respect: To show deferential regard for; to be treated with esteem, concern, consideration or appreciation; to protect the individual's privacy; to be sensitive to cultural differences; to allow an individual to make choices.

Code Citation and Title

MHC 330.1711 RIGHTS OF FAMILY MEMBERS

Code Language

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

COMPETENCIES:

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

Code Citation and Title

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

Code Language

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

COMPETENCIES:

- Prior written consent from the recipient, the recipient's guardian or a parent with legal and physical custody of a minor recipient must be obtained before fingerprinting, photographing, audio-recording, or viewing through one-way glass.
- The procedures above shall only be utilized in order to provide services (including research) to identify, s recipient, or for education and training purposes.
- Photographs include still pictures, motion pictures and videotapes.
- Photographs may to be taken for purely personal or social purposes and must be treated as the recipient's personal property. Photographs must not be taken for this purpose if the recipient has objected.
- Fingerprints, photographs and audio-recordings and any copies of these are to be made part of the recipient record and are to be destroyed or returned to the recipient when no longer essential or upon discharge, whichever occurs first.
- If fingerprints, photographs or audio-recordings are done and sent out to others to help determine the name of the recipient, the individual receiving the items must be informed that return is required for inclusion in the recipient record.
- Restrictions may be put in place if the recipient is receiving services pursuant to the criminal provisions of Chapter 10 of the Mental Health Code – Incompetent to Stand Trial, Not Guilty by Reason of Insanity, recipient of the Department of Corrections Mental Health Services Program
- Video surveillance may be conducted in a psychiatric hospital for purposes of safety, security, and quality improvement.
- Video surveillance may only be conducted in common areas such as hallways, nursing station areas, and social activity areas within the psychiatric unit. Video surveillance recordings taken in common areas shall not be used for treatment or therapeutic purposes. Before implementation of video surveillance, the psychiatric hospital shall establish written policies and procedures that address, at a minimum, all of the following:
    - Identification of locations where video surveillance images will be recorded and saved.
    - Mechanisms by which recipients and visitors will be advised of the video surveillance.
    - Security provisions that assure that only authorized staff members have access to view recorded surveillance video. The security provisions shall include all of the following:
        - Who may authorize viewing of recorded surveillance ~~video.~~video?
        - Circumstances under which recorded surveillance video may be viewed.
        - Who may view recorded surveillance video with proper authorization.
        - Safeguards to prevent and detect unauthorized viewing of recorded surveillance video.
        - Circumstances under which recorded surveillance video may be duplicated and what steps will be taken to prevent unauthorized distribution of the duplicate.
    - Documentation required to be maintained for each instance of authorized access, viewing duplication, or distribution of any recorded surveillance videos.
    - Process to assure retrieval of distributed recorded surveillance video when the purpose for which the video was distributed no longer exists.
    - Archived footage of video surveillance recordings for up to 30 days unless notice is received that an incident requires investigation by the department's office of recipient rights, the licensing division of the bureau of health systems, law enforcement, licensed psychiatric hospital or unit office of recipient rights, and the United States department of health and human services centers for

Medicaid and Medicare services. In that case, archived footage of video surveillance recordings may be retained for the duration of the investigation.

- Recorded video surveillance images shall not be maintained as part of a recipient's clinical record

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

Code Language

Mental health services shall be offered in the least restrictive setting that is appropriate and available. Every recipient has the right to move about his or her residence, environment and community.

COMPETENCIES:

- Mental health services shall be offered in the least restrictive setting that is appropriate and available.
- The freedom of movement of a recipient shall not be restricted more than necessary to provide mental health services, to prevent injury to himself, herself or others, or to prevent substantial property damage
- House rules may restrict freedom of movement only by general restrictions:
  - From areas that could cause health or safety or problems
  - Temporary restrictions from areas for reasonable unforeseeable activities including repair or maintenance
  - For emergencies in case of fire, tornadoes, floods, etc.
- Seclusion and restraint are prohibited except in a MDHHS operated or licensed hospital. Every patient in one of those settings has the right not to be secluded or restrained unless it is essential to prevent the patient from physically harming himself, herself or others.
- Time out, defined as a VOLUNTARY response to a therapeutic suggestion to a recipient to remove himself or herself from a stressful situation to another area to regain control. (AR 330.7001[x])
- Physical management, defined as a techniques used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from harming himself, herself or others. (AR 330.7001[m])
- Physical management may only be used when a recipient is presenting an imminent risk of serious or non-serious physical harm to himself, herself or others and lesser restrictive interventions have been unsuccessful in reducing or eliminating an imminent risk of serious or non-serious physical harm.
- Physical management must not be included as a component of a behavior treatment plan
- Prone immobilization of a recipient for the purpose of behavioral control is prohibited (by agency policy) or (implementation of physical management techniques other than prone immobilization is medically contraindicated and documented in the recipient's record) (AR 330. 7243 [11][i][ii])
- This right can be limited but only as allowed in the individual plan of service (IPOS) following review and approval by the Behavior Treatment Plan Review Committee (CMH only) and the special consent of the 47

Code Citation and Title
MHC 330.1712 INDIVIDUALIZED WRITTEN PLAN OF SERVICES
AR 330.7199

MDHHS PRACTICE GUIDELINE
TECHNICAL REQUIREMENT FOR BEHAVIOR TREATMENT REVIEW COMMITTEES

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

COMPETENCIES:

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

Code Citation and Title
MCL 330. 1708 (1) (2) AR 330.7171 SAFE, SANITARY, HUMANE,TREATMENT ENVIRONMENT

Code Language
Every resident is entitled to mental health services in a safe, sanitary and humane treatment environment.

COMPETENCIES:

- Mental Health Code requires safe, sanitary, humane treatment environment
- Does not define what this means so we use Adult Foster Care Licensing Rules (400.14401 – 14403) to determine if the residential setting was safe, sanitary or humane.
    - Assure pressurized hot and cold water
    - Hot water temp no more than 105 degrees to 120 degrees at the faucet
    - Assure all sewage is disposed of in a public sewer system or as approved by the health department
    - Maintain an insect, rodent or pest control program

- Store and safeguard poisons, caustics and other dangerous materials in non-resident and non-food reparation storage areas
- Assure adequate preparation and storage of food items.
- Assure premises are constructed, arranged and maintained to adequately provide for the health, safety and well-being of occupants

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

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Code Citation and Title
VARIOUS

Code Language

330.1706 Notice of rights.

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

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

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

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

COMPETENCIES:

- What is the Rights Office, Who is in it?
- What are the various roles: Prevention, Monitoring, Education, Complaints
- What is your (staff) role in complaints (1776)?
- What happens when there is a complaint? The complaint process
- Employee Rights (retaliation/harassment (1755 3),Whistleblowers (Civil Action), Bullard-Plawecki (by HR or waived): emphasis on non-retaliation & disciplinary action)
- Basics of rights appeals - What do staff need to know and be able to explain about appeals? (1784)
- Other Key Points: Access by ORR, Preponderance of Evidence standard

Code Citation and Title
SUITABLE SERVICES – INFORMED CONSENT

Code Language

330.1100a Definitions; A to E. (19) "Consent" means a written agreement executed by a recipient, a minor recipient's parent, or a recipient's legal representative with authority to execute a consent, or a verbal agreement of a recipient that is witnessed and documented by an individual other than the individual providing treatment.

R 330.7003 Informed consent.

COMPETENCIES:

(1) All of the following are elements of informed consent:
(a) Legal competency. An individual shall be presumed to be legally competent. This presumption may be rebutted only by a court appointment of a guardian or exercise by a court of guardianship powers and only to the extent of the scope and duration of the guardianship. An individual shall be presumed legally competent regarding matters that are not within the scope and authority of the guardianship.
(b) Knowledge. To consent, a recipient or legal representative must have basic information about the procedure, risks, other related consequences, and other relevant information. The standard governing required disclosure by a doctor is what a reasonable patient needs to know in order to make an informed decision. Other relevant information includes all of the following:
(i) The purpose of the procedures.
(ii) A description of the attendant discomforts, risks, and benefits that can reasonably be expected.
(iii) A disclosure of appropriate alternatives advantageous to the recipient.
(iv) An offer to answer further inquiries.
(c) Comprehension. An individual must be able to understand what the personal implications of providing consent will be based upon the information provided under subdivision (b)
(d) Voluntariness. There shall be free power of choice without the intervention of an element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion, including promises or assurances of privileges or freedom. There shall be an instruction that an individual is free to withdraw consent and to discontinue participation or activity at any time without prejudice to the recipient.

Code Citation and Title
SUITABLE SERVICES – FAMILY PLANNING

R 330.7029 Family planning and health information.
The individual in charge of the recipient's written plan of service shall provide recipients, their guardians, and parents of minor recipients with notice of the availability of family planning, and health information services and, upon request, provide referral assistance to providers of such services. The notice shall include a statement that receiving mental health services does not depend in any way on requesting or not requesting family planning or health information services.

Code Citation and Title
SUITABLE SERVICES – TREATMENT BY SPIRITUAL MEANS

R 330.7135 Treatment by spiritual means.
A provider shall permit a recipient to have access to treatment by spiritual means upon the request of the recipient, a guardian, if any, or a parent of a minor recipient.

Code Citation and Title
SUITABLE SERVICES – MENTAL HEALTH SERVICES SUITED TO CONDITION

330.1708 Suitable services; treatment environment; setting; rights.
A recipient shall receive mental health services suited to his or her condition.

Code Citation and Title

SUITABLE SERVICES – CHOICE OF PHYSICIAN/MHP

330.1713 Choice of physician or mental health professional.

A recipient shall be given a choice of physician or other mental health professional in accordance with the policies of the community mental health services program, licensed hospital, or service provider under contract with the community mental health services program, or licensed hospital providing services and within the limits of available staff in the community mental health services program, licensed hospital, or service provider under contract with the community mental health services program, or licensed hospital

Code Citation and Title

SUITABLE SERVICES – NOTICE OF CLINICAL STATUS

330.1714 Informing resident of clinical status and progress.

A recipient shall be informed orally and in writing of his or her clinical status and progress at reasonable intervals established in the individual plan of services in a manner appropriate to his or her clinical condition.

ADDITIONAL RIGHTS GRANTED TO RESIDENTS OF SPECIALIZED RESIDENTIAL FACILITIES

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Code Citation and Title

MHC 330.1726 COMMUNICATIONS

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Code Language

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

COMPETENCIES:

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

  The communications are between a resident and his/her attorney or a court, or between a resident and any other individuals when the communication involves legal matters or may be the subject of legal inquiry.

Code Citation and Title

AR 330.7139 ENTERTAINMENT MATERIALS, INFORMATION AND NEWS

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Code Language

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

~~*NOTE: A resident is an individual who receives services in either a state operated facility, a licensed psychiatric hospital or unit or an adult foster care facility.*~~

COMPETENCIES:

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

Code Citation and Title
MHC 330.1726 VISITS

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Code Language

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

TRAINING POINTS:

- Residents must be allowed the ability to visit with persons of their choice
- If house rules are to be established regarding visits, these must be reasonable and support the right as indicated above.
- House rules (limitations) must be posted in conspicuous areas for residents, guardians, visitors and others to see.
- Restrictions can be made on these rights for individuals but only as allowed in the individual plan of service (IPOS) following review and approval by the Behavior Treatment Plan Review Committee and the special consent of the resident or his/her legal representative.
- The ability to have visitors at any time shall not be limited if the communications are between a resident and his/her attorney or a court, or between a resident and any other individuals when the communication involves legal matters or may be the subject of legal inquiry.

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

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330.1715 Services of mental health professional.

If a resident is able to secure the services of a mental health professional, he or she shall be allowed to see the professional at any reasonable time.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
RECIPIENT RIGHTS APPEAL PROCESS

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

I. Definitions

A. Appeals Committee: A committee appointed by the MDHHS Director or by the board of a community mental health services program (CMHSP). The governing board of a licensed private psychiatric hospital/unit (LPH/U) shall designate the appeals committee of the CMHSP to hear appeals brought by or on behalf of a recipient of that CMHSP. For non-CMHSP recipients, the LPH/U, may appoint its own Appeals Committee in compliance with section 774(4)(a) of the Code or, by agreement with MDHHS, designate the MDHHS Appeals Committee to hear appeals against the LPH/U under section 774(4)(b) of the Code.

B. Appellant: The complainant or, if different than the complainant, the recipient or his/her legal guardian, if any, who seeks review by an appeals committee or the MDHHS pursuant to sections 784 and 786 of the Code.

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

D. Legal Guardian: A judicially appointed guardian or parent with legal custody of a minor recipient.

E. Office: Any of the following:

1. With respect to a rights complaint involving services provided directly by the MDHHS, the state Office of Recipient Rights created under section 754 of the Code.

2. With respect to a rights complaint involving services provided directly or under contract to a community mental health services program, the office of recipient rights created by the community mental health services program under section 755 of the Code.

3. With respect to a rights complaint involving services provided directly or under contract to a licensed private psychiatric hospital/unit, the office of recipient rights created by the licensed hospital under section 755 of the Code.

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

G. Responsible Mental Health Agency (RMHA): A MDHHS hospital or center; a community mental health services program; a licensed private psychiatric hospital or unit.

II. Procedure – Appeals Committee

A. The office of recipient rights with the MDHHS, a CMHSP, or an LPH/U shall assure that training is provided to the Appeals Committee, as required by Section 755(2)(a) of the Code. ~~Topics shall include the following:~~

~~1. Categories of rights violations~~
~~2. The complaint investigation process~~
~~3. Types and weighing of evidence~~
~~4. Explanation of the preponderance of the evidence standard used by the rights office in determining whether a rights violation has occurred~~
~~5. Statutory definition of "appropriate remedial action"~~
~~6. Agency disciplinary guidelines~~
~~7. Agency policy/procedures on the appeal process and functions of the Appeals Committee~~

B. Every complainant, recipient if different than the complainant, and the recipient's legal guardian, if any, shall be informed in the Summary Report issued by the MDHHS facility director, executive director of a CMHSP or the director of an LPH/U of the right to appeal to the designated Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 784(2), the time frame for submission of the appeal, advocacy organizations that may assist with filing the written appeal, and an offer of assistance by the office of recipient rights in the absence of assistance from an advocacy organization.

C. Not later than 45 calendar days after receipt of the Summary Report under section 782 of the Code, the appellant may file a written appeal with the Appeals Committee having jurisdiction to act upon it.

D. ~~1)~~ If the Summary report contains a plan of action, the office of recipient rights is provided written notice and evidence of the completion of the plan.

If the Summary report contains a plan of action, and the completed action is different than that proposed, the MDHHS facility director, CMHSP executive director or director of the LPH/U shall assure that the office of recipient rights, the complainant, recipient if different than the complainant, his/her legal guardian, if any, shall be provided written notice including specific information as to the action that was taken and the date that it occurred. The complainant, recipient, if different that the complainant, and his/her legal guardian, if any, shall be afforded 45 days after receipt of the notice to appeal the appropriate Appeals Committee on the grounds of inadequate action taken to remedy a rights violations.

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~~If the Summary report contains a plan of action to be completed in the future, the MDHHS facility director, CMHSP executive director or director of the LPH/U shall assure that the complainant, recipient if different than the complainant, his/her legal guardian, if any, and the office are provided written notice of the completion of the plan. The notice shall include specific information as to the action that was taken and the date that it occurred, if it is different than that proposed. The complainant, recipient if different that the complainant and his/her legal guardian, if any, shall be afforded 45 calendar days from the date of the mailing of the notice to appeal the appropriate Appeals Committee on the grounds of inadequate action taken to remedy a right's violations.~~

E. Grounds for appeal to the Appeals Committee shall be as follows:

1. The investigative findings of the office are not consistent with the facts or with law, rules, policies or guidelines
2. The action taken or plan of action proposed by the respondent does not provide an adequate remedy
3. An investigation was not initiated or completed on a timely basis

F. Within 5 business days of receipt of the appeal, members of the appeals committee shall review the appeal to determine if it meets the criteria stated above. This review may be conducted by the full Committee or by an individual member or subcommittee designated by the full Committee to fulfill this responsibility. The Committee shall maintain a log of all appeals received and the disposition of each.

G. Within 5 business days of receipt of the appeal, written notice that the appeal has been accepted shall be provided to the appellant and a copy of the appeal shall be provided to the respondent and RMHA. The appellant shall also be informed within the same time frame if the appeal has not been accepted as it did not meet the criteria set forth in E. above.

H. Within 30 calendar days after receipt of a written appeal that is found to state one or more of the grounds cited in E. above, the Appeals Committee shall meet in closed session and review the facts as stated in all complaint investigation documents. Any member of the Appeals Committee who has a personal or professional relationship with an individual involved in the appeal shall abstain from participating in that appeal. The Committee shall not consider additional allegations that were not part of the original complaint at issue on appeal but shall inform appellant of his/her right to file the complaint with the office.

I. At the meeting in H. preceding, the Appeals Committee shall do one of the following:

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

2. Return the investigation to the office and direct that it be reopened or reinvestigated;

3. Uphold the investigative findings of the office but direct that the respondent take additional or different action to remedy the violation;

4. If the Committee confirms that the investigation was not initiated or completed in a timely manner, recommend that the MDHHS-ORR director, executive director of the CMHSP or director of the LPH/U take appropriate supervisory action with the investigating rights officer/advisor;

5. If the RMHA is a CMHSP or an LPH/U, recommend that the board or governing body request an external investigation by MDHHS-Office of Recipient Rights.

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

K. If the Appeals Committee directs that the office reopen or reinvestigate the complaint, the office shall submit another investigative report in compliance with section 778(5) within 45 calendar days of receipt of the written decision of the Committee to the MDHHS facility directors, CMHSP executive director or the director of the LPH/U. The 45 calendar day time frame may be extended at the discretion of the Appeals Committee upon a showing of good cause by the office. At no time shall the time frame exceed 90 days.

1. Within 10 business days of receipt of the reinvestigate report, the MDHHS facility director, executive director of the CMHSP or the director of the LPH/U shall issue another Summary Report in compliance with section 782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the office and the Appeals Committee.

2. If the findings of the office remain unsubstantiated upon reinvestigation, the appellant may file a further appeal to the MDHHS-APPEALS - Level 2 Appeal, if the appellant continues to assert that the investigative findings of the office are not consistent with the facts or with law, rules, policies or guidelines. The Summary Report shall contain information regarding the appellant's right to further appeal, the time frame for the appeal and the ground for appeal. The report shall also inform the appellant of advocacy organizations that may assist in filing the written appeal or offer the assistance of the office in the absence from an advocacy organization.

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

L. If the Appeals Committee upholds the findings of the office and directs that the respondent take additional or different action, that direction shall be based on the fact that appropriate remedial action has not been taken in compliance with section 780 of the Code.

1. The Appeals Committee shall base its determination upon any or all of the following:
   a. Action taken or proposed did not correct or remedy the rights violation.
   b. Action taken or proposed was/will not be taken in a timely manner.
   c. Action taken or proposed did not/will not prevent a future recurrence of the violation.

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

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

4. If the action taken by the respondent is determined by the Appeals Committee and/or the appellant still to be inadequate to remedy the violation, the appellant shall be informed by the Appeals Committee of his/her right to file a recipient rights complaint against the RMHA, i.e., MDHHS facility director, executive director of a CMHSP or the director of an LPH/U for violation of section 754(3)(c) or 755(3)(b) of the Code.

M. If the Appeals Committee recommends that the board or governing body of the RMHA (a CMHSP or a LPH/U), request an external investigation by MDHHS-Office of Recipient Rights, the Board of Directors may make the request to MDHHS-ORR, in writing, within 5 business days of receipt of the request from the Appeals Committee.

1. Within 10 business days of receipt of the investigative report from MDHHS-ORR, the executive director of the CMHSP or the director of the LPH/U shall issue a Summary Report in compliance with section 782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the office and the Appeals Committee.

2. The complainant, recipient if different than the complainant, and the recipient's legal guardian, if any, shall be informed in the Summary Report issued by the executive director of a CMHSP or the director of an LPH/U of the right to appeal to the MDHHS Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 784(2), the time frame for submission of the appeal, advocacy organizations that may assist

with filing the written appeal, and an offer of assistance by the office of recipient rights in the absence of assistance from an advocacy organization.

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

4. If the Summary report contains a plan of action, the office of recipient rights is provided written notice and evidence of the completion of the plan. If the Summary report contains a plan of action, and the completed action is different than that proposed, the CMHSP executive director or director of the LPH/U shall assure that the office of recipient rights, the complainant, recipient if different than the complainant, his/her legal guardian, if any, shall be provided written notice including specific information as to the action that was taken and the date that it occurred. The complainant, recipient if different that the complainant and his/her legal guardian, if any, shall be afforded 45 calendar days after receipt of the notice to appeal the appropriate Appeals Committee on the grounds of inadequate action taken to remedy a rights violations.

III. MDHHS Appeals

A. An appeal to MDHHS Appeals may be taken only upon the ground that the investigative finding of the office were inconsistent with the facts or with law, rules, policies or guidelines; and only after a decision on an appeal has been made by the appropriate Appeals Committee to uphold the findings of an investigation, or, upon reinvestigation, the findings of the office remain unsubstantiated.

B. Within 45 calendar days after receiving written notice of the decision of the Appeals Committee under section II. I. 1. or the Summary Report in II. K. 2., the appellant may file a written appeal with MDHHS appeals. The written appeal shall be mailed to:

MDHHS-APPEALS
Level 2 Appeal
Lewis Cass Building, 1st floor
P.O. Box 30807
Lansing, MI 48909

FAX: (517) 241-7973

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

D. MDHHS-APPEALS shall review the record generated by the local appeal. It shall not consider additional evidence or information that was not available during the local appeal.

E. Within 30 calendar days after receiving the appeal, MDHHS-APPEALS shall review the appeal and do one of the following:

1. Uphold the findings of the office.
2. Affirm the decision of the Appeals Committee.
3. Return the matter to the director of the department's Office of Recipient Rights, the executive director of the CMHSP or the director of the LPH/U with instruction for additional investigation or consideration.

F. MDHHS-APPEALS shall provide copies of its action to the respondent, the appellant, recipient if different than appellant, the recipient's legal guardian, if any, the board of a CMHSP, the governing body of the LPH/U and the local office of recipient rights holding the record. If the appeal involves the findings of a MDHHS-ORR rights advisor, the MDHHS-ORR director shall also be provided copies of the action. If MDHHS-APPEALS upholds the findings of the office, notice shall be provided to the appellant of his/her legal right to seek redress through the circuit court.

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

H. Within 10 business days of the receipt of the investigative report, the facility director, executive director of the CMHSP, or the director of the LPH/U shall issue a Summary Report in compliance with section 782 of the Code to the department, appellant, recipient if different than appellant and the recipient's legal representative, if any.

1. If the findings of the additional investigation remain the same as those appealed, the department shall inform appellant, recipient if different than appellant and the recipient's legal guardian, if any, in writing of the right to seek redress through the circuit court.
Copies of this notice will be provided to the deputy director of the MDHHS Mental Health/Substance Abuse Services (if the investigation was conducted by staff of the MDHHS-ORR) the director of MDHHS Quality Management and Service Innovation (if the investigation was conducted by a CMHSP) or the Licensing Officer with the Psychiatric Licensure Unit of the MDHHS Division of Health Facility Licensing and Certification (if the investigation was conducted by an LPH/U).

2. If the additional investigation results in the substantiation of previously unsubstantiated violation but the appellant, recipient if different than the appellant and/or the recipient's legal guardian, if any, disagrees with the adequacy of the action taken or plan of action proposed to remedy the violation, the department shall inform the individual(s) of the right to appeal this to the local Appeals Committee.

MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
FY17 REPORTING REQUIREMENTS
Effective 10/1/16

Table of Contents

MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT FY17 REPORTING REQUIREMENTS

Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2016 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

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

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

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

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

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

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

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

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

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

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

Due Date	Report Title	Report Period
1/31/20167	1Q Special Fund Account – Section 226a, PA of the MHC	October 1 to December 31
4/30/20167	2Q Special Fund Account – Section 226a, PA of the MHC	October 1 to March 31
5/31/20167	Mid-Year Status Report	October 1 to March 31
6/30/2017	Semi-annual Recipient Rights Data Report	October 1 to March 31. Section I only. See section "Recipient Rights Data Report" for additional information in this attachment.
8/15/20167	3Q Special Fund Account – Section 226a, PA of the MHC	October 1 to June 30
8/15/20167	Projection Financial Status Report – All Non-Medicaid,	October 1 to September 30
8/15/20167	Projection State Services Utilization, Reconciliation & Cash Analysis	October 1 to September 30
8/15/20167	Projection General Fund Contract Settlement Worksheet	October 1 to September 30
8/15/20167	Projection General Fund Reconciliation and Cash Settlement	October 1 to September 30
10/1/20167	General Fund – Year End Accrual Schedule	October 1 to September 30
FY17 Monthly	PASARR Agreement Monthly Billing	Only one (1) bill will be considered for payment per month, and should be submitted for payment to the DEPARTMENT within forty-five (45) days after the end of the month in

		which the service was provided, except for the September bill which shall be submitted within fifteen (15) days after the end of the month.
11/10/2016	Interim Financial Status Report – All Non-Medicaid,	October 1 to September 30
11/10/2016	Interim State Services Utilization, Reconciliation & Cash Analysis	October 1 to September 30
11/10/2016	Interim Special Fund Account – Section 226a, PA of the MHC	October 1 to September 30
11/10/2016	Interim General Fund Contract Settlement Worksheet	October 1 to September 30
11/10/2016	Interim General Fund Reconciliation and Cash Settlement	October 1 to September 30
11/10/2016	Categorical Funding – Multi-cultural Annual Report	October 1 to September 30
12/30/2017	Annual Recipient Rights Data Report	October 1 to September 30. Sections I, II, III & IV. See section "Recipient Rights Data Report" for additional information in this attachment.
1/31/2017	Annual Report on Fraud and Abuse Complaints	October 1 to September 30
2/28/2017	Final Financial Status Report – All Non-Medicaid	October 1 to September 30
2/28/2017	Final State Services Utilization, Reconciliation & Cash Analysis	October 1 to September 30
2/28/2017	Final Special Fund Account – Section 226a, PA of the MHC	October 1 to September 30
2/28/2017	Final General Fund Reconciliation and Cash Settlement	October 1 to September 30
2/28/2017	Final General Fund Contract Settlement Worksheet	October 1 to September 30
2/28/2017	Sub-Element Cost Report	See Attachment 6.5.1.1 Submit report to: QMPMeasures@michigan.gov
2/28/2017	Annual Submission Requirement Form – Estimated FTE Equivalents	For the fiscal year ending October 1 to September 30, 2016
2/28/2017	Annual Submission Requirement Form – Requests for Services and Disposition of Requests	For the fiscal year ending October 1 to September 30,2016
2/28/2017	Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 1	For the fiscal year ending October 1 to September 30, 2016
2/28/2017	Annual Submission Requirement Form – Summary of Current Contracts for MH Services Delivery – Form 2	For the fiscal year ending October 1 to September 30, 2016
2/28/2017	Annual Submission Requirement Form – Waiting List	For the fiscal year ending October 1 to September 30, 2016
2/28/2017	Annual Submission Requirement Form – Specialized Residential	For the fiscal year ending October 1 to September 30, 2016
2/28/2017	Annual Submission Requirement Form – Community Needs Assessment	For the fiscal year ending October 1 to September 30, 2016
2/28/2017	CMHSP Administrative Cost Report	For the fiscal year ending October 1 to September 30, 2016

2/28/2017~~8~~	Executive Administrative Expenditures Survey for Sec. 904(2)(k)	October 1 to September 30, 201~~6~~7
30 days after receipt, but no later than June 30, 201~~6~~7	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter. Compliance exam and plan of correction	October 1 to September 30th Submit reports to: MDHHS-AuditReports@michigan.gov

FY 2017 DATA REPORT DUE DATES

	Nov14	Dec	Jan15	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec15	Jan16
1. Consumer level** Demographic BHTEDS (monthly)[1] b. Encounter (monthly)[1]	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2.PIHP level a. Medicaid Utilization and Net Cost Report: annually)[2]				√											
b. Performance indicators (quarterly)[2]					√			√			√			√	
c. Consumer Satisfaction (annually) [2]										√					
d. CAFAS [3]													√		
e. Critical incidents (monthly)[3]															

NOTES:

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

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

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

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

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

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

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

A. Basis of Data Reporting

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

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

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

3 Legislative boilerplate annual reporting and semi-annual updates

B. Policies and Requirements Regarding Data

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

Policy:

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

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

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

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

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

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

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

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

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

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

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

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

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

PROXY MEASURES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

For FY16, the CMHSPs are required to report a limited set of data items in the Quality Improvement (QI) file for consumers with an intellectual or developmental disability. The required items and instructions are shown below. Detailed file specifications are (will be) available on the MDHHS web site.

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

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

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

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

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* ***Reporting Period*** **(REPORTPD)**

The last day of the month in which the consumer data is being updated. Report year, month, day: yyyymmdd.

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

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

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

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

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

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

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

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

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

Indicate from the list below how the individual communicates **most of the time**:

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

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

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

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

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

and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day

Blank = Missing

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

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

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

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

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

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

Indicate whether or not the individual has "natural supports" defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.
1 = Extensive involvement, such as daily emotional support/companionship
2 = Moderate involvement, such as several times a month up to several times a week
3 = Limited involvement, such as intermittent or up to once a month
4 = Involved in planning or decision-making, but does not provide emotional support/companionship
5 = No involvement
Blank = Missing

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

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

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

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

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

Indicate the presence of a behavior plan during the past 12 months.
1 = No Behavior Plan

2 = Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
3 = Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
Blank = Missing

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

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

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

51.2: Number of Other Psychotropic Medications **(OTHPSYCH)** ___
Blank = Missing

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

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

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

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

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

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

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

Data Record

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

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

DATA REPORT

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

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

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

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

of service, and amount paid for the service is required.

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

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

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

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

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

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

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

1.a. ***PIHP Plan Identification Number* **(PIHPID) or PIHP CA Function ID
The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transactions.

1.b. ***CMHSP Plan Identification Number* **(CMHID)
The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

**2. ***Identification Code/Subscriber Primary Identifier (please see the details in the submitter's manual)*
Ten-digit Medicaid number must be entered for a **Medicaid, or MIChild** beneficiary.
If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.
If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID.**

**3. ***Identification Code/Other Subscriber Primary Identifier (please see the details in the submitter's manual)*
Enter the consumer's unique identification number (**CONID**) assigned by the CMHSP **regardless** of whether it has been used above.

**4. ***Date of birth*
Enter the date of birth of the beneficiary/consumer.

**5. ***Diagnosis*
Enter the ICD-10 primary diagnosis of the consumer.

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

**7. ***Encounter Data Identifier*
Enter specified code indicating this file is an encounter file.

**8. ***Line Counter Assigned Number*
A number that uniquely identifies each of up to 50 service lines per claim.

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

*10. ***Procedure Modifier Code***
Enter modifiers as required for Habilitation Supports Waiver services provided to enrollees; for Autism Benefit services under 1915 iSPA; for Community Living Supports and Personal Care levels of need; for Nursing Home Monitoring; and for evidence-based

practices. See Costing per Code List.

*11. ***Monetary Amount (effective 10/1/13)***:
Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

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

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

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

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

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

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

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

FY'16 SUB-ELEMENT COST REPORT

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

Instructions and reporting templates can be found at:

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

FY17 CMHSP GENERAL FUND COST REPORT

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

Instructions and reporting templates can be found at:

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

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM
VERSION 6.0
FOR CMHSPS

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

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

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

CMHSP PERFORMANCE INDICATOR SYSTEM

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

ACCESS

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

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

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

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

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

6. The percent of Section 705 second opinions that result in services. (MI and DD) (Old Indicator #7)

a. Quarterly report
b. CMHSP
c. Scope: all MI/DD consumers

EFFICIENCY

*7. The percent of total expenditures spent on administrative functions for CMHSPs. (Old Indicator #9)

a. Annual report (MDHHS calculates from cost reports)
b. PIHP for Medicaid administrative expenditures
c. CMHSP for all administrative expenditures

OUTCOMES

*8. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by CMHSP who are in competitive employment. (Old Indicator #10)

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

*9. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop). (Old Indicator #11)

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge. (Old Indicator #12)

a. Standard = 15% or less within 30 days
b. Quarterly report
c. PIHP for all Medicaid beneficiaries
c. CMHSP
d. Scope: All MI and DD children and adults - Do not include dual eligibles (Medicare/Medicaid) in these counts.

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

*13. The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

*14. The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

CMHSP PERFORMANCE INDICATOR REPORTING DUE DATES

FY 2017 Due Dates

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screening	10/01 to 12/31	3/31/167	1/01 to 3/31	6/30/167	4/01 to 6/30	9/30/167	7/01 to 9/30	12/31/167	CMHSPs
2. 1st request	10/01 to 12/31	3/31/167	1/01 to 3/31	6/30/167	4/01 to 6/30	9/30/167	7/01 to 9/30	12/31/167	CMHSPs
3. 1st service	10/01 to 12/31	3/31/167	1/01 to 3/31	6/30/167	4/01 to 6/30	9/30/167	7/01 to 9/30	12/31/167	CMHSPs
4. Follow-up	10/01 to 12/31	3/31/167	1/01 to 3/31	6/30/167	4/01 to 6/30	9/30/167	7/01 to 9/30	12/31/167	CMHSPs
5. Denials	10/01 to 12/31	3/31/167	1/01 to 3/31	6/30/167	4/01 to 6/30	9/30/167	7/01 to 9/30	12/31/167	CMHSPs
6. 2nd Opinions	10/01 to 12/31	3/31/167	1/01to 3/31	6/30/167	4/01 to 6/30	9/30/167	7/01 to 9/30	12/31/167	CMHSPs
7. Admin Costs*	10/01 to 9/30	2/27/178							CMHSPs
8. Competitive employment*	10/01 to 9/30	N/A							MDHHS
9. Minimum wage*	10/01 to 9/30	N/A							MDHHS
10. Readmissions	10/01 to 12/31	3/31/167	1/01 to 3/31	6/30/167	4-01 to 6-30	9/30/167	7/01 to 9/30	12/31/167	CMHSPs
11. RR complaints	10/01 to 9/30	12/31/167							CMHSPs
13. Residence (DD)*	10/01 to 9/30	N/A							MDHHS
14. Residence (MI)*	10/01 to 9/30	N/A							MDHHS

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

STATE LEVEL DATA COLLECTION

CAFAS

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

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

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

DECA

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

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

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

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

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

-Programs to be selected annually by QIC based on volume of units, expenditures, complaints and site review information.
-The raw data is due August 31st to MDHHS each year on an Excel template to be provided by MDHHS.

Critical Incident Reporting

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

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- **Non-suicide death** for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.
- **Emergency Medical treatment due to Injury or Medication Error** for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.
- **Hospitalization due to Injury or Medication Error** for individuals who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- **Arrest of Consumer** for individuals who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

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

RECIPIENT RIGHTS DATA REPORT

INSTRUCTIONS FOR COMPLETING THE RECIPIENT RIGHTS DATA REPORT

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

Demographic Data

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

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

Service Site Information

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

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

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

Staffing Information:

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

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

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

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

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

Appeal Information

CMHSPs and LPH/Us without an agreement with MDHHS:

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

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

Complaint Data:

Section 1: Complaint Data Summary

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

Part A: Totals

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

20 **COMPLAINT SOURCE**

Recipient	
Staff	
ORR	
Guardian/Family	
Anonymous	
Community/General Public	
Total Complaints Received	**0**

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

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

Part B: Aggregate Summary of Allegations by Category

For each sub-category, insert the following:

-
- Number of allegations involved
- Number of these in which some **intervention** ** was conducted
- Number of allegations substantiated by investigation.
- Number of these **investigated** *
- Number of allegations substantiated by intervention.

In each subcategory: If "0", enter 0 in ALL appropriate boxes of the row where an allegation is received

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

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

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

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

Part C: Remediation of Substantiated Rights Violations:

For each allegation, which, through investigation **or intervention,** it was established that a recipient's right was violated indicate (from the drop down):

- The category name
- The Specific Provider type (see table)
- The Specific remedial action taken (be sure to list 1 action per column)
- The number of the type of population

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

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

SEDW

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

DD- CWP

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

HSW

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

THE FOLLOWING SECTION IS REQUIRED FOR THE ANNUAL REPORT ONLY

Section II: Training Activity

Part A: Training Received by Rights Office Staff

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

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

Part B: Training Provided by Rights Office

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

Indicate the name of the training provided during the period, the length of the session, the number of

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

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

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

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

Section III: Desired Outcomes for the Office

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

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

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

General Information:

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

REPORT DATES:

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

Hospital	Director
To "the department" & Advisory Committee	To "the department" & Board of CMHSP or governing board of licensed hospital
Due at MDHHS: June 30	Due at MDHHS: December 30

Special Education-to-Community Transition Planning Policy

Statement of Purpose

The purpose of this policy is to underscore the BHDDA/MDHHS's expectation of CMHSPs to support schools with students with disabilities to transition to full community inclusion. Such services are required by the Michigan Mental Health Code Section 330.1227, School-to-Community Transition Services.

> *"Each community mental health services program shall participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. This planning and development shall be done in conjunction with the individual's local school district or intermediate school district as appropriate and shall begin not later than the school year in which the individual student reaches 16 years of age. These services shall be individualized. This section is not intended to increase or decrease the fiscal responsibility of school districts, community mental health services programs, or any other agency or organization with respect to individuals described in this section."*

In other words, this does not usurp the primary responsibility of DOE for school to community transition. ← **Formatted:** Indent: Left: 0"

Furthermore; Section 330.1100d(11) of the Michigan Mental Health Code states:

> *"Transition services" means a coordinated set of activities for a special education student designed within an outcome-oriented process that promotes movement from school to post-school activities, including postsecondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult services, independent living, or community participation."*

Although this policy focuses only on special education to community transition, it is important to note CMHSP responsibilities described in Section 208 of the Mental Health Code:

> *"(1) Services provided by a community mental health service program shall be directed to individuals who have a serious mental illness, serious emotional disturbance, or developmental disability.*
> *(2) Priority shall be given to the provision of services to persons with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability."* In addition, any Medicaid recipient requiring medically necessary services must also be served.

Children meeting the criteria described above, but not in special education, also face issues of transition to adult life. These may include sub-populations of youth such as:

- Runaway/Homeless youth
- Children with emotional disturbance at risk of expulsion from school
- Youth who "age out" of:
    1. The DSM diagnosis for which they are receiving mental health services; who do not qualify for adult service or criteria for SMI/ID/DD;
    2. Children's Waiver;
    3. Children's Special Health Care Services plan;
    4. Foster care placement, making them at risk for being homeless.
- Children/Youth involved in multiple systems – Child Welfare/Juvenile Justice/Substance Use Disorder, etc.

MDHHS/CMHSP MANAGED ~~SPECIALTY~~ MENTAL HEALTH SUPPORTS AND SERVICES CONTRACT FY17: Attachment C6.9.6.1

Summary:
The effectiveness of primary and secondary school programming for students with disabilities; inclusive of behavioral health challenges or needs, directly affects services and financial planning of CMHSPs. Schools that best prepare students with disabilities to live, learn, and work in the community and to access generic community services such as transportation and recreation create fewer demands on the adult services system including CMHSPs and foster better community participation and integration for individuals with disabilities. CMHSPs have a responsibility to grow community partnerships and provide information about eligibility requirements, types of services, and person-centered planning in the public mental health system to ~~students, families, caregivers, and~~ school systems initially and update as needed and to student, parents or legal guardians when requested..
Recognizing limited resources and funding for such transition efforts, it is imperative that CMHSPs begin this process ~~at least by the each school~~as the school identifies those ~~year-like~~ student reaching 16 years of age. The intent of this policy is to:

1. Ensure ~~young adults teenage~~ students and their families are fully informed about CMHSP services and supports in partnership with the school.
2. Maximize young adult outcomes, including participation in employment, access to natural supports, and access to needed adult support services.
3. With the school, identify the number of likely students to be eligible for CMHSP services after the student reaches 18 years of age to allow CMHSPs to anticipate future service needs and ideally lower long-term support costs by assisting the student to smoothly transition into community with as many natural supports as possible.
4. Ensure collaboration between CMHSPs, schools, and other local partners.

~~The effectiveness of primary and secondary school programming for students with disabilities directly affects services and financial planning by CMHSPs.~~ CMHSPs should actively participate with schools and other community services providers to effectively braid resources ~~and that~~ best assure the student transitions to the community as independently as possible.

> *NOTE: It is allowable to braid resources from community partners to support individuals seeking to obtain, return to competitive employment, or increase their employment objectives. This service can be used concurrently to supplement/complement services to help individuals achieve their desired employment outcomes **as long as there is no duplication of resources for the same service element(s) at the same time.** Documentation is maintained that same service is not presently available under a program funded under WIOA, Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

It remains imperative that CMHSPs jointly promote:

- Implementing the values of Individuals with Disabilities Education Act (IDEA) with particular focus on community inclusion in the least restrictive environment, keenly focused on vocational exploration, work experiences, and ideally paid work.
- Becoming more knowledgeable of school practices better preparing youth for adult life.

CMHSPs need to ensure that schools, students, families, caregivers, and community partners have basic knowledge of what CMHSPs can provide to youth/adults with disabilities, and eligibility criteria for these services through a family-centered/youth guided process and plan. This information should be distributed to applicable schools and also available on-line.

CMHSPs shall ~~provide schools, young adults and families with~~ make available the following information through the CMHSP customer services efforts:

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1. Values governing public mental health services including:
   a. Recovery
   b. Self-determination
   c. Full community inclusion
   d. Person-centered planning
2. Eligibility criteria:
   a. Michigan Mental Health Code priority populations
   ~~b. Medicaid~~
   ~~c.~~b. Specialty ~~medically necessary services~~ behavioral health (including the boundary with the Qualified Health Plans)
   ~~Children's Model Waiver~~
   ~~d.~~c. Local service selection guidelines/protocols/etc.
3. Local service array for child, youth, and adult service providers, including ~~the name and telephone number for a CMHSP liaison~~ contact information at the CMHSP to the school for systemic service related issues.

Additionally, CMHSPs have the responsibility to provide information to appropriate local school ~~staff~~ administrators about specific conditions which would indicate the likelihood that a student would need assessment and/or service from the CMHSP upon turning 18 years of age including:

- Students classified under the school system as Severe Multiple Impairments (SXI), Severe Cognitive Impairment (SCI), Moderate Cognitive Impairment (MoCI), and/or Mild Cognitive Impairment (MiCI) are generally eligible for CMHSP services.
- Other student classifications would indicate a closer look by CMHSPs to determine eligibility for adult services from the CMHSP.
- The classification of Autism Spectrum Disorder (ASD) covers students with a very broad range of skills and abilities often necessitating further assessment to determine eligibility for CMHSP services.
- Students classified as Emotional Impairment (EI) would have to be assessed for eligibility for adult services from the CMHSP. In the public mental health system, Serious Emotional Disturbance (SED), by definition, ends at the age of 18. Students classified as SED as well as Specific Learning Disabled (SLD) and Physical Impairment (PI) or Otherwise Health Impaired (OHI) would need to be assessed with consent for an appropriate developmental disability or mental illness diagnosis.
- ~~Where the school diagnosis is not appropriate, it is the responsibility of~~ When the legal guardian is considering CMHSP services, the CMHSP ~~to provide~~ will provide a screening and possibly an assessment. CMHSPs ~~must~~ will look at ~~other~~ factors ~~in addition to diagnosis. These other factors~~ that include: risk for expulsion from school, need for assistance in multiple life domains, or absence of a stable natural support network.

Essential elements with ~~suggested~~ required tracking, and ~~suggested~~ activities, and measurement criteria are outlined in the following table:

Essential elements:	~~Suggested~~ Tracking:	~~Suggested~~ Activities:	Measurement Criteria:
Coordinated planning and development with student's local school district or Intermediate School District (ISD) at least by 16th year to shape least restrictive community opportunities	-Documentation of a local agreement noting responsibilities of each party - A work plan that details specific action plans for outreach to and communication with	-Track number of youth likely to be CMHSP eligible at age 18 and beyond - Establish or participate in a local transition planning or coordination council	- Annual documentation of number of youth likely to be eligible for services -Documentation of local participation

for independence, employment and post school education.	schools, young adults and families	- Development of local transition guides that address supports and resources	
Outreach and communication to young adults and families	- Participation in Individualized Education Program (IEP) meetings that address transition	-At least annual group presentations about potential eligibility to youth, parents/guardians, and school staff - Participation in local transition fairs -Upon determination of likely eligibility, participate in at least 1 annual student IEP meeting for each likely eligible student	-Documentation of at least annual presentation -Documentation of participation in IEPs for likely eligible youth at the youth's invitation
Increased focus on integrated residential/community-based living	Track: -Number of pre age 18 students with integrated living as a goal in transition plan -Integrated? -Non-integrated -Number of post age 18 students with integrated residential living as a goal in transition plan	-Track growth in integrated living	- Number of post-age 18 students seeking integrated residential living
Increase focus on integrated employment	Track: -Number of pre age 18 students with work as a goal in transition plan -Integrated? -Non-integrated -Number of post age 18 students with competitive, integrated work as a goal in transition plan	-Track growth in competitive, integrated work goals	Number of post-age 18 students seeking competitive integrated employment

Data tracked during the fiscal year is to be submitted on an annual basis by December 1st following the end of the fiscal year and will be outlined in a corresponding attachment. ~~as outlined in Attachment (INSERT APPROPRIATE ATTACHMENT FOR REPORTING REQUIREMENTS/WHERE SENT)~~ The attachment will ~~to~~ be developed by a workgroup of MDHHS and CMHSP representatives, ~~W~~with the goal to complete the attachment during FY 17.

Michigan Department of Health & Human Services
Behavioral Health and Developmental Disabilities Administration

TRAUMA POLICY

The purpose of the policy is to address the trauma in the lives of the people served by the public behavioral health system. The policy is promulgated to promote the understanding of trauma and its impact, ensure the development of a trauma informed system and the availability of trauma specific services for all populations served. Trauma is defined as:

> *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.*[1]

Policy

It is the policy of Michigan Department of Health and Human Services – Behavioral Health And Developmental Disabilities Administration (MDHHS - BHDDA) that Community Mental Health Service Programs (CMHSPs), through their direct service operations and their network providers, shall develop a trauma-informed system for all ages and across the services spectrum and shall ensure that the following essential elements are provided:

I. Adoption of trauma informed culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization.
II. Engagement in organizational self-assessment of trauma informed care
III. Adoption of approaches that prevent and address secondary trauma of staff (See Exhibit A)
IV. Screening for trauma exposure and related symptoms for each population
V. Trauma-specific assessment for each population
VI. Trauma-specific services for each population using evidence based practice(s) (EBPs); or evidence informed practice(s) are provided in addition to EBPs
VII. CMHSPs through their direct service operations and their network providers shall join with other community organizations to support the development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders[2] [3]

Standards

To ensure a trauma informed behavioral health system, the following standards are required to meet the stated policy.

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[1] Substance Abuse Mental Health Services Administration (SAMHSA), http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx
[2] Substance Abuse and Mental Health Services Administration, Leading Change: SAMHSA's Role and Actions 2011-2012.
[3] SAMHSA's Initiatives, Preventing Substance Abuse and Mental Illness, 2010.

	Policy	Standards - Requirements
I.	**Adoption of trauma informed Culture: values, principles and development of a trauma informed system of care ensuring safety and preventing re-traumatization.**	(a.) The CMHSP shall, through its direct service operations and its network providers, develop and support a Quality Improvement committee with representatives from children, adult, SUD, I/DD services and consumers. The committee's primary focus is to ensure the building and maintaining of trauma informed care within the CMHSP's direct service operations and its network providers. (b.) The CMHSP, through its direct services operations and its network providers, shall ensure that all staff, including direct care staff, are trained/has ongoing training in trauma informed care (online module, *Creating Cultures of Trauma Informed Care* with Roger Fallot, Ph.D. of Community Connections, Washington, DC is available at http://improvingmipractice.org). Training needs to be updated on a regular basis due to changes in the research and/or evidence based approaches. Staff trained in trauma informed care should (1.) understand what trauma is and the principles of trauma informed care; (2.) know the impact of trauma on a child's and/or adult's life; (3.) know strategies to mitigate the impact of the trauma(s); and (4) understand re-traumatization and its impact. (c.) Policies and procedures shall ensure a trauma informed system of care is supported and that the policies address trauma issues, re-traumatization and secondary trauma of staff. ~~(d.)~~
II.	**Engagement in organizational self-assessment of trauma informed care**	(a.) The CMHSP Quality Improvement committee conducts an organizational self-assessment to evaluate the extent to which current agency's policies are trauma-informed, identify organizational strengths and barriers, including an environmental scan to ensure that the environment/building(s) do(es) not re-traumatize (online module available to assist the committee in their orientation to self-assessment. The module, *Creating Cultures of Trauma-Informed Care: Assessing your Agency* with Roger Fallot, Ph.D. & Lori L. Beyer, LICSW, Community Connections, Washington, DC is available at http://improvingmipractice.org). The self-assessment is updated every three (3) years.

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	Policy	Standards - Requirements
III.	**Adoption of approaches that prevent and address Secondary Trauma of staff**	(a.) The CMHSP, through direct services operations and its network providers, adopt approaches that prevent and address secondary traumatic stress of all staff, including, but not limited to: • Opportunity for supervision • Trauma-specific incident debriefing • Training • Self-care • Other organizational support (e.g., employee assistance program).
IV.	**Screening for trauma exposure and related symptoms for each population**	(a.) CMHSP, through direct service operations and provider network, shall use a culturally competent, standardized and validated screening tool appropriate for each population during the intake process and other points as clinically appropriate. Examples of standardized, validated screening tools are provided in the trauma section of the website, www.improvingMIpractices.org.
V.	**Trauma –specific assessment for each population**	(a.) CMHSP shall, through direct service operations and provider network, use a culturally competent, standardized and validated assessment instrument appropriate for each population. Trauma assessment is administered based on the outcome of the trauma screening. Examples of assessment tools are provided in the trauma section of the website, www.improvingMIpractices.org.
VI.	**Trauma-specific services for each population using EBP(s) or evidence informed practices are provided in addition to EBPs**	(a.) The CMHSP, through its direct service operations and network providers, shall use evidence based trauma-specific services for each population in sufficient capacity to meet the need. The services are delivered within a trauma informed environment. Examples of trauma-specific services are provided in the trauma section of the website, www.improvingMIpractices.org.
VII.	**CMHSP through its direct service operations and its network providers, shall join with other community**	(a.) CMHSP and its network providers shall join with community organizations, agencies, community collaboratives (i.e., MPCBs) and community coalitions (i.e., Substance Abuse Coalitions, Child Abuse and Neglect Councils, Great Start Collaboratives, neighborhood coalitions, etc.) to support the development of a trauma

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	Policy	Standards - Requirements
	organizations to support the development of a trauma informed community that promotes behavioral health and reduces the likelihood of mental illness and substance use disorders.	informed community that promotes healthy environments for children, adults and their families. (b.) Education on recovery and the reduction of stigma are approaches supported in a trauma informed community. (c.) Substance abuse prevention programming is provided using a SAMHSA approved, evidence based and trauma informed approach.

~~Exhibit A~~

Exhibit A **Source is the** National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary Traumatic Stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms captures elements of this definition but are not all interchangeable with it.

Compassion fatigue, a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with the term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material.

Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

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