PIHP CUSTOMER SERVICES HANDBOOK
REQUIRED STANDARD TOPICS

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

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

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

*Must use boilerplate language in templates (attached)

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

Other Required Topics (not necessarily in this order)

Access process
Access to out-of-network services

Affiliate [for Detroit-Wayne, the MCPNs] the names, addresses and phone numbers of the following personnel:

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

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

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

Template #1: Confidentiality and Family Access to Information

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

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

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

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

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

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

Template #2: Coordination of Care

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

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

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

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

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

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

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

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

Template #4: Glossary or Definition of Terms

GLOSSARY

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

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

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **72 hours** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **30 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **72 hours** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **90 calendar days** of the date of the request.

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

Appeal: A review of an adverse benefit determination.

Behavioral Health- Includes not only ways of promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also has as an aim preventing or intervening in substance abuse or other addictions. For the purposes of this handbook, behavioral health will include intellectual/developmental disabilities, mental illness in both adults and children and substance use disorders.

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

CMHSP: An acronym for Community Mental Health Services Program. There are 46 CMHSPs in Michigan that provide services in their local areas to people with mental

illness and developmental disabilities. May also be referred to as CMH.

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

Durable Medical Equipment: Any equipment that provides therapeutic benefits to a person in need because of certain medical conditions and/or illnesses. Durable Medical Equipment (DME) consists of items which:

- are primarily and customarily used to serve a medical purpose;
- are not useful to a person in the absence of illness, disability, or injury;
- are ordered or prescribed by a physician;
- are reusable;
- can stand repeated use, and
- are appropriate for use in the home.

Emergency Services/Care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical/behavioral emergency.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Flint 1115 Demonstration Waiver The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014 through a state-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act, and is effective as of March 3, 2016 the date of the signed approval through February 28, 2021. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the state plan. All such persons will have access to Targeted Case Management services under a fee for service contract between MDHHS and Genesee Health Systems (GHS). The fee for service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.

Grievance: Expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness or a provider or employee, or failure to respect beneficiary's rights regardless of whether remedial action is requested. Grievance includes a beneficiary's right to dispute an extension of time proposed by the PIHP to make an authorization decision.

Grievance and Appeal System: The processes the PIHP implements to handle the appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them

Habilitation Services and Devices: Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.

Health Insurance: Coverage that provides for the payments of benefits as a result of sickness or injury. It includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment.

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

Healthy Michigan Plan is an 1115 Demonstration project that provides health care benefits to individuals who are: aged 19-64 years; have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology; do not qualify or are not enrolled in Medicare or Medicaid; are not pregnant at the time of application; and are residents of the State of Michigan. Individuals meeting Health Michigan Plan eligibility requirements may also be eligible for behavioral health services. The Michigan Medicaid Provider Manual contains complete definitions of the available services as well as eligibility criteria and provider qualifications. The Manual may be accessed at:

http://www.michigan.gov/mdhhs/0,4612,7-132-2945_42542_42543_42546_42553-87572--,00.html

Customer Service staff can help you access the manual and/or information from it.

Home Health Care: Is supportive care provided in the home. Care may be provided by licensed healthcare professionals who provide medical treatment needs or by professional caregivers who provide daily assistance to ensure the activities of daily living (ADLs) are met.

Hospice Services: Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. The goal is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible.

Hospitalization: A term used when formally admitted to the hospital for skilled behavioral services. If not formally admitted, it might still be considered an outpatient instead of an inpatient even if an overnight stay is involved.

Hospital Outpatient Care: Is any type of care performed at a hospital when it is not expected there will be an overnight hospital stay.

Intellectual/Developmental Disability: Is defined by the Michigan Mental Health

code as either of the following: (a) If applied to a person older than five years, a severe chronic condition that is attributable to a mental or physical impairment or both, and is manifested before the age of 22 years; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration; (b) If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in a developmental disability.

Limited English proficient (LEP): Means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

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

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

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

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

Network: Is a list of the doctors, other health care providers, and hospitals that a plan has contracted with to provide medical care/services to its members.

Non-Participating Provider: A provider or facility that is not employed, owned, or operated by the PHIP/CMHSP and is not under contract to provide covered services to members.

Participating Provider: Is the general term used for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide health care services; medical

equipment; mental health, substance use disorder, intellectual/developmental disability, and long term supports and services. They are licensed or certified to provide health care services. They agree to work with the health plan, accept payment and not charge enrollees an extra amount. Participating providers are also called network providers.

Physician Services: Refers to the services provided by an individual licensed under state law to practice medicine or osteopathy.

PIHP: An acronym for Prepaid Inpatient Health Plan. A PIHP is an organization that manages the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic area under contract with the State. There are 10 PIHPs in Michigan and each one is organized as a Regional Entity or a Community Mental Health Services Program according to the Mental Health Code.

Preauthorization: Approval needed before certain services or drugs can be provided. Some network medical services are covered only if the doctor or other network provider gets prior authorization. Also called Prior Authorization.

Premium: An amount to be paid for an insurance policy, a sum added to an ordinary price or charge.

Prescription Drugs: Is a pharmaceutical drug that legally requires a medical prescription to be dispensed. In contrast, over-the-counter drugs can be obtained without a prescription.

Prescription Drug Coverage: Is a stand-alone insurance plan, covering only prescription drugs.

Primary Care Physician: A doctor who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.

Primary Care Provider: A health care professional (usually a physician) who is responsible for monitoring an individual's overall health care needs.

Provider: Is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.

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

Rehabilitation Services and Devices: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy and speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

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

SED: An acronym for Serious Emotional Disturbance, and as defined by the Michigan Mental Health Code, means a diagnosable mental, behavioral or emotional disorder affecting a child that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders; and has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

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

Skilled Nursing Care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A health care professional whose practice is limited to a particular area, such as a branch of medicine, surgery, or nursing; especially, one who by virtue of advanced training is certified by a specialty board as being qualified to so limit his or her practice.

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

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

Urgent Care: Care for a sudden illness, injury, or condition that is not an emergency but needs care right away. Urgently needed care can be obtained from out-of-

network providers when network providers are unavailable.

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

Template #5: Grievance and Appeals Processes

Grievances

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

Appeals

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

You may:

- Ask for a "Local Appeal" by contacting_____at_____.

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

State Fair Hearing

You must complete a local appeal before you can file a state fair hearing. However, if the PIHP fails to adhere to the notice and timing requirements, you will be deemed to have exhausted the local appeal process. You may request a State Fair Hearing at that time.

You can ask for a state fair hearing only after receiving notice that the service decision you appealed has been upheld. You can also ask for a state fair hearing if you were not provided your notice and decision regarding your appeal in the timeframe required. There are time limits on when you can file an appeal once you receive a decision about your local appeal.

*[Note to PIHPs: you may add detailed information about grievance and appeals to this template.]

Template #6: Language Assistance and Accommodations Language Assistance

If you are a person who does not speak English as your primary language and/or who has a limited ability to read, speak or understand English, you may be eligible to receive language assistance.

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

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

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

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

Accessibility and Accommodations

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

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

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

Template #7: Payment for Services

If you are enrolled in Medicaid and meet the criteria for the specialty behavioral health services the total cost of your authorized behavioral health treatment will be covered. No fees will be charged to you.
If you are a Medicaid beneficiary with a deductible ("spend-down"), as determined by the Michigan Department of Health and Human Services (MDHHS) you may be responsible for the cost of a portion of your services.

Should you lose your Medicaid coverage, your PIHP/provider may need to re-evaluate your eligibility for services. A different set of criteria may be applied to services that are covered by another funding source such as General Fund, Block Grant, or a third party payer.

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

Template #8: Person-Centered Planning

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

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

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

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

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

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

Topics Covered during Person-Centered Planning

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

Psychiatric Advance Directive

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

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

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

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

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

Template #9: Recipient Rights

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

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

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

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

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

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

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

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

Template #10: Recovery & Resiliency

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

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

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

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

Template #11: Service Array

MEDICAID SPECIALTY SUPPORTS AND SERVICES DESCRIPTIONS

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

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

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

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

Note: the Michigan Medicaid Provider Manual contains complete definitions of the following services as well as eligibility criteria and provider qualifications. The Manual may be accessed at:

http://www.michigan.gov/mdhhs/0,4612,7-132-2945_42542_42543_42546_42553-87572--,00.html

Customer Service staff can help you access the manual and/or information from it.

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

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

***Assistive Technology** includes adaptive devices and supplies that are not covered under the Medicaid Health Plan or by other community resources. These devices help

individuals to better take care of themselves, or to better interact in the places where they live, work, and play.

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

Behavioral Treatment Services/Applied Behavior Analysis are services for children under 21 years of age with Autism Spectrum Disorders (ASD).

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

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

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

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

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

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

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

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

Children's Waiver Program.

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

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

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

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

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

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) provide 24-hour intensive supervision, health and rehabilitative services and basic needs to persons with developmental disabilities.

Medication Administration is when a doctor, nurse, or other licensed medical provider gives an injection, or an oral medication or topical medication.

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

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

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

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

Partial Hospital Services include psychiatric, psychological, social, occupational, nursing, music therapy, and therapeutic recreational services in a hospital setting, under a doctor's

supervision. Partial hospital services are provided during the day – participants go home at night.

Peer-delivered and Peer Specialist Services. Peer-delivered services such as drop-in centers are entirely run by consumers of behavioral health services. They offer help with food, clothing, socialization, housing, and support to begin or maintain behavioral health treatment. Peer Specialist services are activities designed to help persons with serious mental illness in their individual recovery journey and are provided by individuals who are in recovery from serious mental illness. Peer mentors help people with developmental disabilities.

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

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

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

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

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

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

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

Supports Coordination or Targeted Case Management: A Supports Coordinator or Case Manager is a staff person who helps write an individual plan of service and makes sure the services are delivered. His or her role is to listen to a person's goals, and to help find the services and providers inside and outside the local community mental health services program that will help achieve the goals. A supports coordinator or case manager may also connect a person to resources in the community for employment, community living, education, public benefits, and recreational activities.

Supported/Integrated Employment Services provide initial and ongoing supports, services and training, usually provided at the job site, to help adults who are eligible for behavioral health services find and keep paid employment in the community.

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

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

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

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

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

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

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

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

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

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

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

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

Services for Persons with Substance Use Disorders

The Substance Abuse treatment services listed below are covered by Medicaid. These services are available through the PIHP.

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

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

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

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

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

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

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

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

Medicaid Health Plan Services

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

- Ambulance
- Chiropractic
- Doctor visits
- Family planning
- Health check ups
- Hearing aids
- Hearing and speech therapy
- Home Health Care
- Immunizations (shots)
- Lab and X-ray
- Nursing Home Care
- Medical supplies
- Medicine
- Mental health (limit of 20 outpatient visits)
- Physical and Occupational therapy
- Prenatal care and delivery
- Surgery
- Transportation to medical appointments
- Vision

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

[List of health plans and contact numbers]

Template #12: Service Authorization

Services you request must be authorized or approved by [the PIHP or its designee]. That agency may approve all, some or none of your requests. You will receive notice of a decision within 14 calendar days after you have requested the service during person-centered planning, or within 72 hours if the request requires a quick decision.

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

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

Template #13: Tag Lines

In order to establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each PIHP entity service area the list below is provided. Each PIHP must provide tag lines in the prevalent non-English languages in its particular service area included in the list below.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call

Albanian: KUJDES: Në qoftë se ju flisni anglisht, shërbimet e ndihmës gjuhësore, pa pagesë, janë në dispozicion për ty. Telefononi

Arabic: تنبيه: إذا كنت تتحدث العربية فإن خدمة الترجمة متوفرة لك مجاناً فقط إتصل على الرقم

Bengali: দৃষ্টি আকর্ষণ: আপনি ইংরেজি, ভাষা সহায়তা সেবা, নিখরচা কথা বলতে পারেন, আপনার জন্য উপলব্ধ. কল

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

German: Achtung: Wenn Sie Englisch sprechen, sind Sprache Assistance-Leistungen, unentgeltlich zur Verfügung. Rufen Sie .

Italian: Attenzione: Se si parla inglese, servizi di assistenza di lingua, gratuitamente, sono a vostra disposizione. Chiamare

Japanese: 注意: 英語を話す言語アシスタンス サービス、無料で、あなたに利用できま。を呼び出す)

Korean: 주의: 당신이 영어, 언어 지원 서비스를 무료로 사용할 수 있습니다 당신에 게. 전화.

Polish: UWAGI: Jeśli mówisz po angielsku, język pomocy usług, za darmo, są dostępne dla Ciebie. Wywołanie

Russian: ВНИМАНИЕ: Если вы говорите по-английски, языковой помощи, бесплатно предоставляются услуги для вас. Звоните

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (TTY- Telefon za osobe sa oštećenim govorom ili sluhom:).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al

Syriac: ܙܘܗܪܬܐ ܥܠ ܗܘܠܝ ܢܬܟܠܬܐ ܒܐܗܡܝܢܘܬܐ ܡܫܝܠܬܐ، ܐܝܟ ܠܟܬܒܐ ܡܠܘܬܐ، ܘܐܘܪܚ ܒܐܪܢܠ، ܐܘ ܒܣܦܪܐ ܐܟܐ ܒܟܠܬ ܡܬܢܡܘܬܐ ܐܘ ܒܠܥܢܝ ܒܠܟܝ ܠܫܢܐ ܢܬܪܐ. ܐܝܟ ܠܝ

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa

Vietnamese: Chú ý: Nếu bạn nói tiếng Anh, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi

Non-Discrimination and Accessibility

In providing behavioral healthcare services, [**PIHP Name Here]** complies with all applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. [**PIHP Name]** does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

[PIHP Name] provides free aids and services to people with disabilities to communicate effectively with us, such as:
Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, Braille)
[PIHP Name] provides free language services to people whose primary language is not English or have limited English skills, such as:
Qualified interpreters
Information written in other languages
If you need these services, contact **[Your Organization's Contact Person, Department, and Title,** at **Your Organization's Contact Number]**

If you believe that **[Your Organization]** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **[Your Organization's Contact Person** at **Your Organization's Address, Phone Number, Fax and Email.]**

If you are a person who is deaf or hard of hearing, you may contact **[Your Organization]** at **[Your Organization's TTY Number]** or MI Relay Service at 711 to request their assistance in connecting you to **[Your Organization]**. You can file a grievance in person or by mail, fax or email. If you need help in filing a grievance, **[Your Organization's Grievance Coordinator]** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You may also file a grievance electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Toll Free: 1-800-368-1019

GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT PIHP GRIEVANCE AND APPEAL SYSTEM FOR MEDICAID BENEFICIARIES

OCT. 2017

TABLE OF CONTENTS

PAGE

I. PURPOSE AND BACKGROUND 2

II. DEFINITIONS 2

III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS 5

IV. NOTICE OF ADVERSE BENEFIT DETERMINATION 5

V. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT 8

VI. PIHP APPEAL PROCESS (INTERNAL) 9

VII. LOCAL GRIEVANCE PROCESS 12

VIII. STATE FAIR HEARING APPEAL PROCESS 14

IX. RECORDKEEPING REQUIREMENTS 15

X. RECIPIENT RIGHTS COMPLAINT PROCESS 15

EXHIBIT A ADEQUATE NOTICE OF ADVERSE BENEFIT DETERMINATION (SAMPLE FORM) 16

EXHIBIT B ADVANCE NOTICE OF ADVERSE BENEFIT DETERMINATION. (SAMPLE FORM) 18

EXHIBIT C NOTICE OF APPEAL RESOLUTION (SAMPLE FORM) 21

EXHIBIT D NOTICE OF APPEAL DENIAL 25

I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with the Medicaid Enrollee Grievance and Appeal System requirements contained in Part 11, 6.3.1 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services (MDHHS). These requirements are applicable to all PIHPs, Community Mental Health Services Programs (CMHSPs) and their provider networks.

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

Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "due process" whenever their Medicaid benefits are denied, reduced or terminated. Due process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provides a process to help protect Medicaid Enrollee due process rights.

Consumers of mental health services who are Medicaid Enrollees eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care:

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

Medicaid Enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, Chapters 7,7A, 4 and 4A, including:

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

II. DEFINITIONS

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

Adverse Benefit Determination: A decision that adversely impacts a Medicaid Enrollee's claim for services due to: *(42 CFR 438.400)*

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. *42 CFR 438.400 (b)(1).*
- Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
- Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
- Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. *42 CFR 438.210(d)(1).*
- Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. *42 CFR 438.210(d)(2).*
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP. *42 CFR 438.400(b)(4).*
- Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*
- Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*
- Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*
- For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under *§ 438.52(b)(2)(ii)*, to obtain services outside the network. *42 CFR 438.400(b)(6).*
- Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. *42 CFR 438.400(b)(7).*

Adequate Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(2).*

Advance Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404(c)(1); 42 CFR 431.211.*

Appeal: A review at the local level by a PIHP of an Adverse Benefit Determination, as defined above. *42 CFR 438.400.*

Authorization of Services: The processing of requests for initial and continuing service delivery. *42 CFR 438.210(b).*

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

Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. *42 CFR 438.2.*

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, the PIHP must grant the request. *42 CFR 438.410(a).*

Grievance: Enrollee's expression of dissatisfaction about PIHP/CMHSP service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or an Enrollee's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. *42 CFR 438.400.*

Grievance Process: Impartial local level review of an Enrollee's Grievance.

Grievance and Appeal System: The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. *42 CFR 438.400.*

Medicaid Services: Services provided to an Enrollee under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Resolution: Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408.*

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

Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*

State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of an

adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

Federal regulation *(42 CFR 438.228)* requires the State to ensure through its contracts with PIHPs, that each PIHP has a grievance and appeal system in place for Enrollee's that complies with Subpart F of Part 438.

The Grievance and Appeal System must provide Enrollees:

- An Appeal process (one level, only) which enables Enrollees to challenge Adverse Benefit Determinations made by the PIHP or its agents.
- A Grievance Process.
- The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
- Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP level Appeal.
- Information that if the PIHP fails to adhere to notice and timing requirements as outlined in PHIP Appeal Process, the Enrollee is deemed to have exhausted the PIHP's appeals process. The Enrollee may initiate a State fair hearing.
- The right to request, and have, Medicaid covered benefits continued while a local PIHP Appeal and/or State Fair Hearing is pending.
- With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal or Grievance to the PIHP, or request a State Fair Hearing. The provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.

IV. NOTICE OF ADVERSE BENEFIT DETERMINATION

A PIHP is required to provide timely and "adequate" notice of any Adverse Benefit Determination. *42 CFR 438.404(a)*.

A. Content & Format: The notice of Adverse Benefit Determination must meet the following requirements: *(42 CFR 438.404(a)-(b))*

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "...manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency);

2. Notification that *42 CFR 440.230(d)* provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;

3. Description of Adverse Benefit Determination;

4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;

5. Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);

6. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;

7. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;

8. Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination";

9. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and

10. An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

B. Timing of Notice: *(42 CFR 438.404(c))*

1. Adequate Notice of Adverse Benefit Determination:

   a. For a denial of payment for services requested (not currently provided), notice must be provided to the Enrollee at the time of the action affecting the claim. *42 CFR 438.404(c)(2).*

   b. For a Service Authorization decision that denies or limits services notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an

expedited authorization decision. *42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3)&(6).*

c. For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. *42 CFR 438.404(c)(5).*
   - NOTE, however, that the PIHP may be able to extend the standard Service Authorization timeframe in certain circumstances *(42 CFR 438.210(d)(1)(ii)).* If so, the PIHP must: (i) provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4).*

2. Advance Notice of Adverse Benefit Determination:

   a. Required for reductions, suspensions or terminations of previously authorized/ currently provided Medicaid Services.

   b. Must be provided to the Enrollee at least ten (10) calendar days prior to the proposed effective date. *42 CFR 438.404(c)(1); 42 CFR 431.211.*

   c. Limited Exceptions: The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, IF *(42 CFR 431.213; 42 CFR 431.214)*

      i. The PIHP has factual information confirming the death of an Enrollee;

      ii. The PIHP receives a clear written statement signed by an Enrollee that he no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the Enrollee understands that this must be the result of supplying that information;

      iii. The Enrollee has been admitted to an institution where he is ineligible under the plan for further services;

      iv. The Enrollee's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address;

      v. The PIHP establishes that the Enrollee has been accepted

for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

vi. A change in the level of medical care is prescribed by the Enrollee's physician;

vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;

viii. The date of action will occur in less than 10 calendar days.

ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the Enrollee (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

C. Required Recipients of Notice of Adverse Benefit Determination:

1. The Enrollee must be provided written notice. *42 CFR 438.404(a); 42 CFR 438.210(c).*

2. The requesting provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing. *42 CFR 438.210(c).*

3. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an adverse benefit determination, and requires a written notice of action.

V. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

A. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: *42 CFR 438.420*

1. The Enrollee files the request for Appeal timely (within 60 calendar days from the date on the Adverse Benefit Determination Notice); *42 CFR 438.402(c)(2)(ii);*

2. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed

Adverse Benefit Determination). *42 CFR 438.420(a)*; and

3. The period covered by the original authorization has not expired.

B. Duration of Continued or Reinstated Benefits *(42 CFR 438.420(c))*. If the PIHP continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:

1. The Enrollee withdraws the Appeal or request for State Fair Hearing;

2. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal;

3. A State Fair Hearing office issues a decision adverse to the Enrollee.

C. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. *42 CFR 438.420(d)*.

D. If the Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.

E. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. *42 CFR 438.424(b)*

F. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)*.

VI. PIHP APPEAL PROCESS

A. Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:

1. The Enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal. *42 CFR 438.402(c)(2)(ii)*.

2. The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. *42 CFR 438.402(c)(3)(ii).*

   NOTE: Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). *42 CFR 438.406(b)(3).*

3. In the circumstances described above under the Section entitled "Continuation of Benefits," the PIHP will be required to continue/reinstate Medicaid Services until one of the events described in that section occurs.

B. PIHP Responsibilities when Enrollee Requests an Appeal:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of each Appeal. *42 CFR 438.406(b)(1).*

3. Maintain a record of appeals for review by the State as part of its quality strategy. *42 CFR 438.416.*

4. Ensure that the individual(s) who make the decisions on Appeals: *42* CFR 438.406(b)(2).

   a. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;

   b. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

   c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

5. Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing, and inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals; *42 CFR 438.406(b)(4).*

6. Provide the Enrollee and his/her representative the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. *42 CFR 438.406(b)(5).*

7. Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate; *42 CFR 438.406(b)(6)*.

8. Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

C. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed **30 calendar days** from the day the PIHP receives the Appeal.

2. Expedited Appeal Resolution (timing):

a. Available where the PIHP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee's behalf or supporting the Enrollee's request) that the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. *42 CFR 438.410(a).*

b. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an Enrollee's appeal. *42 CFR 438.410(b).*

c. If a request for expedited resolution is denied, the PIHP must:

i. Transfer the appeal to the timeframe for standard resolution. 42 CFR 438.410(c)(1).

ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial. *42 CFR 438.408(c)(2), 438.410(c)(2).*

iii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision. *42 CFR 438.408(c)(2), 438.410(c)(2).*

iv. Resolve the Appeal as expeditiously as the Enrollee's health condition requires but not to exceed 30 calendar days.

d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72-hours** after the PIHP receives the request for expedited resolution of the Appeal. *42 CFR 438.408.*

3. Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*

a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

ii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision.

iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.

4. Appeal Resolution Notice Format:

a. The PIHP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. *42 CFR 438.408(d)(2).*

b. Attached to this agreement are recommended notice templates for grievance and appeals. They are titled, Exhibit A "Notice of Adverse Benefit Determination", Exhibit B "Notice of Receipt of Appeal/Grievance", Exhibit C Notice of Appeal Approval", and Exhibit D "Notice of Appeal Denial". These templates incorporate the information needed to meet the requirement of grievance and appeal recordkeeping in 42 CFR 438.416. Specifically, 42 CFR 438.416 indicates the State must require the PIHP maintain records with (at minimum) the following information:

(1) A general description of the reason for the appeal or grievance.
(2) The date received.

(3) The date of each review or, if applicable, review meeting.
(4) Resolution at each level of the appeal or grievance if applicable.
(5) Date of resolution at each level, if applicable.
(6) Name of the covered person for whom the appeal or grievance was filed.

Further this recordkeeping must be "accurately maintained in a manner accessible to the state and available upon request to CMS."

IF the PIHP chooses not to use the recommended notice templates the alternatives used by the PIHP must include the required information under 42 CFR 438.416 as noted above.

c. Enrollee notice must meet the requirements of *42 CFR 438.10* (i.e., "...in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

5. Appeal Resolution Notice Content: *42 CFR 438.408(e)*

a. The notice of resolution must include the results of the resolution and the date it was completed.

b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:
   i. Right to request a state fair hearing, and how to do so;
   ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
   iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

VII. GRIEVANCE PROCESS

A. Federal regulations provide Enrollees the right to a grievance process to seek resolution to issues that are not Adverse Benefit Determinations. *(42 CFR 438.228)*

B. Generally:

1. Enrollees must file Grievances with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

2. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative. *42 CFR 438.402(c)(2)(i).*

3. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution

within **90 calendar days** of the date of the request. This constitutes an "Adverse Benefit Determination", and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

C. PIHP Responsibility when Enrollee Files a Grievance:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of the Grievance. *42 CFR 438.406(b)(1).*

3. Maintain a record of grievances for review by the State as part of its quality strategy.

4. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination. *42 CFR 434.32*

5. Ensure that the individual(s) who make the decisions on the Grievance:

   a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual. *42 CFR 438.406(b)(2)(i).*

   b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

   c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP received the Grievance.

2. Format and Content of Notice of Grievance Resolution:

   a. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "...in a manner and format that may be easily understood and is readily accessible by

such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

b. The notice of Grievance resolution must include:
   i. The results of the Grievance process;
   ii. The date the Grievance process was concluded;
   iii. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and
   iv. Instructions on how to access the State Fair Hearing process, if applicable .

VIII. STATE FAIR HEARING APPEAL PROCESS

A. Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:

1. After receiving notice that the PIHP is, after Appeal, upholding an Adverse Benefit Determination. *42 CFR 438.408(f)(1);*

2. When the PIHP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in *42 CFR 438.408. 42 CFR 438.408(f)(1)(i).*

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State and PIHP, and not extend any timeframes or disrupt continuation of benefits). *42 CFR 438.408(f)(1)(ii).*

C. The PIHP may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.

D. Enrollees are given **120 calendar days** from the date of the applicable notice of resolution to file a request for a State Fair Hearing. *42 CFR 438.408(f)(2).*

E. The PIHP is required to continue benefits, if the conditions described in Section V, MEDICAID SERVICES CONTINUATION OR REINSTATEMENT are satisfied, and for the durations described therein.

F. If the Enrollee's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the Adverse Benefit Determination.

G. The parties to the State Fair Hearing include the PIHP, the Enrollee and his or her representative, or the representative of a deceased Enrollee's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent

conflict of roles and responsibilities.

H. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:

www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html
OR

Department of Licensing and Regulatory Affairs
Michigan Administrative Hearing System Fair Hearing
http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html

IX. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain records of Enrollee Appeals and Grievances, which will be reviewed by the PIHP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy.

A PIHP's record of each Grievance or Appeal must contain, at a minimum:

A. A general description of the reason for the Grievance or Appeal;
B. The date received;
C. The date of each review, or if applicable, the review meeting;
D. The resolution at each level of the Appeal or Grievance, if applicable;
E. The date of the resolution at each level, if applicable;
F. Name of the covered person for whom the Grievance or Appeal was filed.

PIHPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.

X. RECIPIENT RIGHTS COMPLAINT PROCESS

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

Exhibit A

NOTICE OF ADVERSE BENEFIT DETERMINATION
<Health Plan/CMHSP-PIHP name/ MI Choice Waiver Agency name>

Important: This notice explains your internal appeal rights. Read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This is to tell you that the following action has been taken:

[Enter information regarding the adverse benefit determination taken to deny, reduce, suspend or terminate a covered benefit or payment with effective dates]

This action is based on the following:

[*Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our action, you have the right to an Internal Appeal

You have to ask <Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name> for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your doctor {provider} can send in your request that must include:

- Your Name
- Address
- Member number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters or other information that explains why you need the item or service. If you are asking for a fast appeal you will need a doctor's supporting statement. Call your doctor if you need this information.

Please keep a copy of everything you send us for your records.

There are 2 kinds of internal appeals:

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**. If you want to ask for an internal appeal, you can either call or send in a written request to:

<Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name>
Address
Phone Number TTY Phone Number
Fax Number

Expedited or Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. **We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request.** If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 calendar days. To ask for a Fast Appeal, you must call: {**Phone Number**} {**TTY Phone #**}

Continuation of services during an Internal Appeal

If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination <insert 10 calendar day date>, you may continue to

receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

> Your benefits for that service will continue if you request an internal appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: <number(s)> to learn how to name your representative. TTY users call <number>. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

What happens next?

- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing. [*Licensed health plans in Michigan must also insert*: You can also ask for an External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial Services (DIFS).]

- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] and how to file the request.

- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.

- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

- *[If applicable, insert other state or local aging/disability waiver resources contact information.]*

[Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]

Exhibit B

Notice of Receipt of Appeal/Grievance
<Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name>

Important: Read this notice carefully. If you need help, you can call one of the numbers listed on the next page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows: Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to a request that we received on <date received>.

☐ You Filed A Grievance

We received your grievance on <date received> about <subject of grievance>. We take your concerns seriously. Thank you for taking the time to bring this to our attention.

WHAT THIS MEANS

We will review your grievance by <date received plus 30 calendar days>. A letter will be mailed to you within two (2) calendar days after we complete our investigation telling you what we found and what (if any) action we will take, or have taken.

☐ You Filed An Internal Appeal

We received your request for an internal appeal on <date received>. You are appealing our decision to <description of subject of appeal>.

WHAT THIS MEANS

A decision on this appeal will be made by <date received plus thirty (30) days>. A letter will be mailed to you telling you what our decision is and why we made that decision.

<The appeal was received within ten (10) calendar days of the decision that you are appealing. Therefore, the service(s) you have been receiving may continue while the appeal is being reviewed.> You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

> Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

We may contact you for more information or if we have more questions. If you have any questions or additional information to provide please call <list an appeals specific phone number/fax number>.

FOR BOTH GRIEVANCES AND APPEALS

If you want someone to represent you

At any time during the process you may have another person act for you or help you. This person will be your representative. If you want someone to act for you, you must tell us that in writing.

If you already have someone to represent you, or if you have a legal guardian, power of attorney, or someone authorized to make health care decisions on your behalf, you do not have to do anything else.

Get help & more information

- {Health plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]

Exhibit C

Notice of Appeal Approval
<Health Plan/CMHSP-PIHP / MI Choice Waiver Agency name>

Important: This notice explains the results of your appeal. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows: Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to the internal appeal request that we received on <date appeal received>

Your appeal was approved

Your appeal was thoroughly considered. This is to inform you that we approved your appeal for the service/item listed below:

What this means:

Because your Level 1 Appeal decision was approved, you may receive the following services as of <date authorized>: [*List the services that were approved, including any applicable information about coverage amount, duration, etc. Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]

If you do not receive the services, or if the services are wrongly stopped or reduced, tell us immediately using the contact information below:

<Health Plan / CMHSP-PIHP / MI Choice Wavier Agency name>

<Name of Appeals/Grievance Department>
<Mailing Address for Appeals/Grievance Department>

Phone: <phone number> TTY: <TTY number>
Fax: <fax number>

Getting your case file

You can ask to see the medical records and other documents we reviewed during your appeal. You can also ask for a copy of the guidelines we used to make our decision. You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]

Exhibit D

Notice of Appeal Denial
<Health Plan/ CMHSP-PIHP / MI Choice Waiver Agency name>

Important: This notice explains your additional appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to the internal appeal request that we received on <date appeal received>.

Your internal appeal was denied

Your appeal was thoroughly considered. This is to inform you that we [*denied* or *partially denied*] your internal appeal for the service/item listed below:

Why did we deny your appeal?

We [*denied* or *partially denied*] your internal appeal for the service/item listed above because:
[*Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]

You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider requested coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our decision, you have the right to further appeal

You have the right to an External Appeal. The External Appeal is reviewed by an independent organization that is not connected to us. You can file an External Appeal yourself.

[*Health plans must insert:* There are two ways to make an External Appeal: 1) State Fair Hearing with the Michigan Administrative Hearing System (MAHS) and/or 2) External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial Services (DIFS).] [*PIHP and MI Choice Waiver Agency must insert:* You can do this by asking for a State Fair Hearing with the Michigan Administrative Hearing System (MAHS).]

Below is information on how to request a State Fair Hearing with MAHS [*Health Plans must insert:* and an External Review with DIFS].

How to ask for a State Fair Hearing with MAHS

To ask for a Medicaid State Fair Hearing you must follow the directions on the enclosed Request for State Fair Hearing form. You must ask for a State Fair Hearing within **120 calendar days** from the mailing date of this notice. If your request is not received at MAHS by <insert 120 calendar day date>, you will not be granted a hearing. If you need another copy of the form, you can ask for one by calling <Health Plan/ CMHSP-PIHP/ MI Choice Waiver Agency name> Member Services at <phone number> or the Michigan Department of Health and Human Services Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

What happens next?

MAHS will schedule a hearing. You will get a written "Notice of Hearing" telling you the date and time. Most hearings are held by telephone, but you can ask to have a hearing in person. During the hearing, you'll be asked to tell an Administrative Law Judge why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision within 90 calendar days from the date your Request for Hearing was received by MAHS. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) State Fair Hearing. Your request must be in writing and clearly state that you are asking for a fast State Fair Hearing. Your request can be mailed or faxed to MAHS (see the enclosed Request for Hearing form for the

address and fax number). If you qualify for a fast State Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions about the State Fair Hearings process, including the fast State Fair Hearing, you can call MAHS at 1-877-833-0870.

[PIHP and MI Choice are not subject to PRIRA and should therefore delete the following section on filing with DIFS.]

How to ask for an External Review with DIFS

To ask for an External Review under the Patient Right to Independent Review Act (PRIRA) from DIFS, you must complete the Health Care Request for External Review form. The form is included with this notice. You can also get a copy of the form by calling DIFS at 1-877-999-6442. Complete the form and send it with all supporting documentation to the address or fax number listed on the form. You must submit your request within **60 calendar days** of your receipt of this appeal decision notice. You have the right to request and receive benefits while the hearing is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

What happens next?

DIFS will review your request. If your case does not require medical record review, DIFS will issue a decision within 14 calendar days after your request is accepted. If your case involves issues of medical necessity or clinical review criteria, DIFS will issue a decision within 21 calendar days.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) External Review. To ask for a fast External Review, you can call DIFS at 1-877-999-6442. A fast External Review is completed within 72 hours after your request has been accepted.

Continuation of Services

If we previously approved coverage for a service but then decided to change or stop the service before the authorization ended, you can continue your benefits during External Appeals in some cases.

> Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

If your benefits are continued during your appeal, you can keep getting the service until one of the following happens: 1) you withdraw the External Appeal; or 2) all entities that got your appeal decide "no" to your request.

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.
- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
- [*If applicable, insert other state or local aging/disability resources contact information.*]

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]*

Technical Advisory for Estimated Cost of Services

Effective 10/1/14

Attachment P6.3.2.1.B.i is a template that can be used to provide cost information to Medicaid beneficiaries. The template and guidance were developed with a committee comprised of MDHHS, individuals receiving services, advocates and agency providers. The committee's recommendations are as follows:

1. The annual budget is directly related to goals in the individual plan of service (IPOS) developed through the person-centered planning process.

2. Specific services and supports are listed and separated out from bundled services.

3. The estimated annual budget is provided in conjunction with information on self-determination.

4. The document is described as an explanation of cost of services and is not a bill that requires payment.

5. The annual budget estimate is a good faith estimate.

6. Information provided is part of the electronic medical record with changes made as necessary and printed out at any time when requested by the beneficiary.

7. A new estimate is provided when the IPOS is changed, modified and/or addendums added.

8. Annual budgets do not include urgent or emergent services such as crisis or inpatient services, and is subject to change based on the needs of the individual.

9. The beneficiary signs the annual budget and a copy is retained in the records.

Estimated Cost of Services Template

TO:

As part of your individual plan of service that you completed through a person-centered planning process, listed below, is the cost for each service and support. The costs per month are an estimate. This is not a bill required to be paid. It is subject to change based on your needs.

Service/Support (Insert services in the spaces below Categories will be the ones listed in Cost of Service template, May 24, 2011. Categories are understood to be the categories in the MDHHS document "PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes")	**Total Estimated Annual Cost (Total cost of services in the category for the plan period.)**

For the goals that are in your individual plan of service you may receive mental health services and supports that have costs that are covered by public funds.

Goal number one, you are working on:
The services you receive are estimated at:

Goal number two, you are working on:
The services you receive are estimated at:

***Estimated cost of your services per year:**

If you have any questions about your individual plan of service and/or the estimated costs, please contact:

**This is an estimate cost of services and not a bill required to be paid. It is subject to change based on your needs.*

Technical Requirement for Explanation of Benefits

Effective 10/1/12

Attachment P 6.3.2.1.B.ii is a model for PIHP's to utilize for the Explanation of Benefits requirement in Section 6.3.3 of the Contract. The following guidelines were developed to assist PIHPs:

1. The PIHP must ensure that the most complete picture of services be provided to the Consumer.
2. For the "Service Description" – The intent of the EOB is not to use specific procedure or diagnosis codes but rather a description of the service that is understandable for the consumer.
3. The EOB would include all services over a select or standard date range. The list could include services from many providers on a single document. Some services would be limited to a specific date. Some services would cover a range of dates. Other services are individually provided as encounters but occur multiple times over the selected date range. These could be grouped together with a first and last date of service. The last column reflects the count of these services (unique dates of services – encounters).
4. The "Unique Dates of Services" column interprets the services in each line into a count of unique encounters. This is NOT a unit count. For example:
    a. Inpatient Community Hospital – Each stay is uniquely identified as a separate row in the EOB. The "Unique Dates of Services" will be the equivalent of the length of stay for that inpatient episode.
    b. Partial Hospitalization is typically referred over a date range but the actual encounters may not be contiguous. In this case the "Unique Dates of Services" would indicate the count of encounters.
    c. Specialized Residential – This would be the total count of days in Specialized residential over the time period.
    d. In the case of other common services, the "Unique Dates of Services" is a total of all of those encounters over the EOB time frame.
5. It is recommended that the PIHP coordinate the development of a cover sheet introducing the documents.

PIHP : _____

EXPLANATION OF BENEFITS

CONSUMER NAME ***STREET ADDRESS*** ***CITY, STATE ZIP CODE***	**Your Medicaid #** **Your Consumer ID:**

THIS IS NOT A BILL – KEEP this notice for your records

SERVICES PROVIDED FROM: **THROUGH:**

Service Provided By	Dates of Services	Service Description	Unique Dates of Service

General Information:
This list of services may not be a complete list as some services may not have been added to the chart prior to the running of this report.

You have the right to make a request in writing for an itemized statement which details each service you have received from your service provider. Please contact them directly, in writing, if you would like an itemized statement.

Compare the services you have received with those that appear on this Medicaid Summary Notice. If you have questions, call your service provider. If you feel further investigation is needed due to possible fraud and abuse, call the phone number in the Customer Service Information Box.

CUSTOMER SERVICE INFORMATION

If you have questions, please contact us at:
TTY for Hearing Impaired:

Or write to us at:

THIS IS NOT A BILL – KEEP this notice for your records

IMPORTANT INFORMATION ABOUT YOUR SERVICES

WHEN OTHER INSURANCE PAYS FIRST: All services are covered on the condition that you have no other insurance or your insurance will pay for the services first. Type of insurance that should pay first include Medicare, any health plans, no-fault insurance, automobile medical insurance, liability insurance and worker's compensation. Notify your provider right away if you have filed or could file a claim with your insurance.

HELP STOP MEDICAID FRAUD: Fraud is a false representation by a person or business to get Medicaid payments. Some examples of fraud include:

Offers of goods or money in exchange for your Medicaid Number.

Telephone or door-to-door offers for free medical services or items.

Claims for Medicaid services/items you did not receive.

If you think a person or business is involved in fraud, you should call the Customer Service telephone number listed in the "General Information" Section of this Summary of Services

MEDICAID SERVICES VERIFICATION – TECHNICAL REQUIREMENTS

I. SUMMARY

This guideline establishes operational policy; minimum procedures and reporting requirements for verification of Medicaid/Healthy Michigan claims/encounters provided to beneficiaries under this contract. Sampling Universe shall be in a fiscal year period of Medicaid/Healthy Michigan claims/encounters.

II. APPLICATION

Prepaid Inpatient Health Plans (PIHPs) and Medicaid/Healthy Michigan Programs only. It does not apply to Substance Use Disorder Block Grant and P.A. 2 funded services.

III. PROCEDURES

A. Verification procedures must be performed by qualified PIHP staff as determined by the PIHP or a qualified contract agency, including another PIHP as determined by the PIHP. Verification procedures may not be delegated to providers, Core Providers, CMHSPs, or MCPNs. PIHPs must perform or contract for this function for ALL Providers including those under contract to the agencies listed above.

- PIHP methodology must include a process for identifying staff or contracted agencies that may have a conflict of interest regarding the provider of services being verified.

- PIHP/CMHSP stand-alone agencies (counties of Wayne, Oakland, and Macomb) may have an inherent conflict of interest related to any of its staff and internally provided services. A qualified independent contractor, including a PIHP, must be selected to perform verification procedures in these circumstances.

B. Verification procedures must include testing of claims/encounters to determine validity.

- PIHP methodology must include data analytics to identify claims/encounters that cannot be valid or are more likely not valid.

  Examples: Multiple per diem inpatient claims/encounters on the same day, multiple providers providing the same service to the consumer in one day, individual clinicians providing an unexpectedly high daily volume.

- PIHP methodology must include testing data elements from individual claims/encounters to be validated against clinical records. The PIHP must include/test a) code is approved under this contract, b) eligibility of the beneficiary on the date of service, c) service is included in the beneficiaries

individual plan of service, d) the date/time of service, e) service provided by a qualified practitioner and falls within the scope of the code billed/paid, f) amount billed does not exceed the payer (PIHP or CMHSP) contracted amount, and g) amount paid does not exceed the payer (PIHP or CMHSP) contracted amount.

Note: The PIHPs are encouraged to include additional elements in this review to support the PIHP's quality improvement efforts around claims/encounters data.

C. Verification procedures must utilize statistically sound sampling methodology in accordance with OIG standards.

- PIHP methodology must identify and document the sampling methodology used to determine sampling and describe any tools used to assist in the sample determination process.

  Note: The OIG of HHS provides a tool to assist users in selecting random samples which can be obtained at https://oig.hhs.gov/compliance/rat-stats/index.asp. PIHPs are not required to utilize this tool.

- In general, minimum sample sizes for testing of claims/encounters must comply with the OIG standards. Alternative minimum sample sizes should be documented to indicate how an acceptable confidence level is achieved.

- Probe samples and claims verifications are to be used. In the event a probe sample result is less than 90% accurate, a larger sample with greater veracity shall occur, per HHS-OIG claims verification guidance.

D. Verification procedures must take into consideration significant variations in the source of the claims/encounters.

- Separate sampling and verification must be performed at each major provider in the PIHP network, as well as a single test encompassing all remaining providers. Major providers include ALL providers paid via a sub-capitation arrangement and any other providers that represent more than 25% of the PIHP claims/encounters in either unit volume or dollar value, whether direct contracted through the PIHP or subcontracted through a CMH, Core Provider, or MCPN.

- Separate sampling and verification must be performed for claims/encounters generated by a provider's employees and claims/encounters generated through subcontracts of the provider.

IV. CORRECTIVE ACTION AND RECOUPMENT

A. Corrective actions are required for providers who are found not to be in substantial compliance in their Medicaid Verification scores.

- PIHP methodology must describe the corrective action process, including method of communication, timeframes for correction and follow up review, penalties for inaction, and an appeals process.

B. Recoupment must be required and collected from providers whose claims/encounters are determined to be invalid.

- PIHP methodology must describe the recoupment process, including method of communication, timeframes for recovery of funds, any appeals process, and how the recoupment will be reflected as a credit against the MDHHS contract.

V. REPORTING

The PIHP is required to submit an annual report, due December 31, covering the claims/encounters verification process for the prior fiscal year. This report must encompass/include the following items:

- Cover letter on PIHP letterhead
- Describe the methodology used by the PIHP, including all required elements previously described.
- Summary of the results of procedures performed, including:
  - Population of providers
  - Number of providers tested
  - Number of providers put on corrective action plans
  - Number of providers on corrective action for repeat/continuing issues
  - Number of providers taken off corrective action plans
  - Population of claims/encounters tested (units & dollar value)
  - Claims/Encounters tested (units & value)
  - Invalid claims/encounters identified (units & dollar value)

VI. DOCUMENTATION

The PIHP must maintain all documentation supporting the verification process for 7 years.

Department of Health and Human Services
Behavioral Health and Developmental Disabilities Administration

CREDENTIALING AND RE-CREDENTIALING PROCESSES

A. Overview

This policy covers credentialing, temporary/provisional credentialing and re-credentialing processes for those individual and organizational providers directly or contractually employed by Prepaid Inpatient Health Plans (PIHPs), as it pertains to the rendering of specialty behavioral healthcare services within Michigan's Medicaid program. The policy does not establish the acceptable scope of practice for any of the identified providers, nor does it imply that any service delivered by the providers identified in the body of the policy is Medicaid billable or reimbursable. PIHPS are responsible for ensuring that each provider, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements. Please reference the applicable licensing statutes and standards, as well as the Medicaid Provider Manual should you have questions concerning scope of practice or whether Medicaid funds can be used to pay for a specific service.

Note: The individual practitioner and organizational provider credentialing process contains two primary components: initial credentialing and re-credentialing. MDHHS recognizes that PIHPs may have a process that permits initial credentialing on a provisional or temporary basis, while required documents are obtained or performance is assessed. The standards that govern these processes are in the sections that follow.

B. Credentialing Individual Practitioners

The PIHP must have a written system in place for credentialing and re-credentialing individual practitioners included in their provider network who are not operating as part of an organizational provider.

1. Credentialing and re-credentialing must be conducted and documented for at least the following health care professionals:
    a. Physicians (M.D.s and D.O.s)
    b. Physician's Assistants
    c. Psychologists (Licensed, Limited License, and Temporary License)
    d. Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers, and Registered Social Service Technicians
    e. Licensed Professional Counselors
    f. Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses
    g. Occupational Therapists and Occupational Therapist Assistants
    h. Physical Therapists and Physical Therapist Assistants
    i. Speech Pathologists

2. The PIHP must ensure:
    a. The credentialing and re-credentialing processes do not discriminate against:
        i. A health care professional, solely on the basis of license, registration or certification; or

ii. A health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid. A complete list of Centers for Medicare and Medicaid Services (CMS) sanctioned providers is available on their website at http://exclusions.oig.hhs.gov. A complete list of sanctioned providers is available on the Michigan Department of Health and Human Services website at www.michigan.gov/MDHHS. (Click on Providers, click on Information for Medicaid Providers, click on List of Sanctioned Providers)

3. If the PIHP delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this policy, it must retain the right to approve, suspend, or terminate from participation in the provision of Medicaid funded services a provider selected by that entity and meet all requirements associated with the delegation of PIHP functions. The PIHP is responsible for oversight regarding delegated credentialing or re-credentialing decisions.

4. Compliance with the standards outlined in this policy must be demonstrated through the PIHP's policies and procedures. Compliance will be assessed based on the PIHP's policies and standards in effect at the time of the credentialing/re-credentialing decision.

5. The PIHP's written credentialing policy must reflect the scope, criteria, timeliness and process for credentialing and re-credentialing providers. The policy must be approved by the PIHP's governing body, and
   a. Identify the PIHP administrative staff member and/or entity (e.g., credentialing committee) responsible for oversight and implementation of the process and delineate their role;
   b. Describe any use of participating providers in making credentialing decisions;
   c. Describe the methodology to be used by PIHP staff members or designees to provide documentation that each credentialing or re-credentialing file was complete and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation;
   d. Describe how the findings of the PIHP's Quality Assessment Performance Improvement Program are incorporated into the re-credentialing process.

6. PIHPs must ensure that an individual credentialing/re-credentialing file is maintained for each credentialed provider. Each file must include:
   a. The initial credentialing and all subsequent re-credentialing applications;
   b. Information gained through primary source verification; and
   c. Any other pertinent information used in determining whether or not the provider met the PIHP's credentialing and re-credentialing standards.

C. Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of the individual practitioners must require:

1. A written application that is completed, signed and dated by the provider and attests to the following elements:
    a. Lack of present illegal drug use.
    b. Any history of loss of license and/or felony convictions.
    c. Any history of loss or limitation of privileges or disciplinary action.
    d. Attestation by the applicant of the correctness and completeness of the application.

2. An evaluation of the provider's work history for the prior five years.

3. Verification from primary sources of:
    a. Licensure or certification.
    b. Board Certification, or highest level of credentials attained if applicable, or completion of any required internships/residency programs, or other postgraduate training.
    c. Documentation of graduation from an accredited school.
    d. National Practitioner Databank (NPDB)/ Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following must be verified:
        i. Minimum five-year history of professional liability claims resulting in a judgment or settlement;
        ii. Disciplinary status with regulatory board or agency; and
        iii. Medicare/Medicaid sanctions.
    e. If the individual practitioner undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (a), (b), and (c) above.

D. Temporary/Provisional Credentialing of Individual Practitioners

Temporary or provisional credentialing of individual practitioners is intended to increase the available network of providers in underserved areas, whether rural or urban. PIHPs must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of Medicaid Beneficiaries that providers be available to provide care prior to formal completion of the entire credentialing process. Temporary or provisional credentialing shall not exceed 150 days.

The PIHP shall have up to 31 days from receipt of a complete application, accompanied by the minimum documents identified below, within which to render a decision regarding temporary or provisional credentialing.

For consideration of temporary or provisional credentialing, at a minimum a provider must complete a signed application that must include the following items:

1. Lack of present illegal drug use.
2. History of loss of license, registration, or certification and/or felony convictions.
3. History of loss or limitation of privileges or disciplinary action.
4. A summary of the provider's work history for the prior five years.

5. Attestation by the applicant of the correctness and completeness of the application.

The PIHP must conduct primary source verification of the following:

1. Licensure or certification;
2. Board certification, if applicable, or the highest level of credential attained; and
3. Medicare/Medicaid sanctions.

The PIHP's designee must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification as outlined in this Section, should be completed.

E. Re-credentialing Individual Practitioners

At a minimum, the re-credentialing policies for physicians and other licensed, registered, or certified health care providers must identify procedures that address the re-credentialing process and include requirements for each of the following:

1. Re-credentialing at least every two years.

2. An update of information obtained during the initial credentialing.

3. A process for ongoing monitoring, and intervention if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider, which must include, at a minimum, review of:
    a. Medicare/Medicaid sanctions.
    b. State sanctions or limitations on licensure, registration or certification.
    c. Member concerns which include grievances (complaints) and appeals information.
    d. PIHP Quality issues.

F. Credentialing Organizational Providers

For organizational providers included in its network:

1. Each PIHP must validate, and re-validate at least every two years, that the organizational provider is licensed or certified as necessary to operate in the State, and has not been excluded from Medicaid or Medicare participation.

2. The PIHP must ensure that the contract between the PIHP and any organizational provider requires the organizational provider to credential and re-credential their directly employed and subcontract direct service providers in accordance with the PIHP's credentialing/re-credentialing policies and procedures (which must conform to MDHHS's credentialing process).

G. Deemed Status

Individual practitioners or organizational providers may deliver healthcare services to more than one PIHP. A PIHP may recognize and accept credentialing activities conducted by any other PIHP in lieu of completing their own credentialing activities. In those instances where a PIHP chooses to accept the credentialing decision of another PIHP, they must maintain copies of the credentialing PIHP's decisions in their administrative records.

H. Notification of Adverse Credentialing Decision

An individual practitioner or organizational provider that is denied credentialing or re-credentialing by the PIHP shall be informed of the reasons for the adverse credentialing decision in writing by the PIHP.

I. Appeal of Adverse Credentialing Decision

Each PIHP shall have an appeal process that is available when credentialing or re-credentialing is denied, suspended or terminated for any reason other than lack of need. The appeal process must be consistent with applicable federal and state requirements.

J. Reporting Requirements

The PIHP must have procedures for reporting improper known organizational provider or individual practitioner conduct that results in suspension or termination from the PIHP's provider network to appropriate authorities (i.e., MDHHS, the provider's regulatory board or agency, the Attorney General, etc.). Such procedures shall be consistent with current federal and state requirements, including those specified in the MDHHS Medicaid Managed Specialty Supports and Services Contract.

Definitions

National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB) The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. HRSA. They can be located on the Internet at www.npdb-hipdb.hrsa.gov/.

Organizational providers are entities that directly employ and/or contract with individuals to provide health care services. Examples of organizational providers include, but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units and partial hospitalization programs; substance abuse programs; and home health agencies.

PIHP is a Prepaid Inpatient Health Plan under contract with the Department of Health and Human Services to provide managed behavioral health services to eligible individuals.

Provider is any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.

PIHP-MHP Model Agreement

Coordinating Agreement Between <PIHP> and <MHP> For the county(ies) of: <X>

<DATE>

This agreement is made and entered into this ___ day of _____, in the year _____ by and between _____ (Health Plan) and _____ (PIHP) for the county(ies) of X, Y, Z.

RECITALS

Whereas, PIHPs are designated as providers of specialized mental health and developmental disability services under contract with the MDHHS consistent with the Mental Health Code; and

Whereas, PIHPs manage the Medicaid Specialty Services and Supports in a specified geographic region; and

Whereas, MHPs and PIHPs desire to coordinate and collaborate their efforts in order to protect and promote the health of the shared Medicaid-enrolled population;

Now, therefore, the MHP and the PIHP agree as follows.

A. Definitions

"MDHHS" means the Michigan Department of Health and Human Services.

"MHP" means Medicaid (Medical) Health Plan.

"PCP" means Primary Care Physician/Practitioner.

"PIHP" means Prepaid Inpatient Health Plan.

B. Roles and Responsibilities

The parties acknowledge that the primary guidance concerning their respective roles and responsibilities stem from the following, as applicable:

- Medicaid Waivers
- Medicaid State Plan and Amendments
- Medicaid Manual
- MDHHS, MHP and PIHP Contracts. See Attachment A for specific provisions of said contracts.
- Medical Services Administration (MSA) Medicaid *L-Letter 10-21* http://www.michigan.gov/documents/MDHHS/L_10-21_with_attachment_322809_7.pdf

C. Term of Agreement, Amendments and Cancellation

This Agreement is effective the date upon which the last party signs this Agreement until amended or cancelled. The Agreement is subject to amendment due to changes in the contracts between the MDHHS and the MHP or the PIHP. All Amendments shall be executed in writing. Either party may cancel the agreement upon thirty (30) days written notice.

D. Purpose, Administration and Point of Authority

The purpose of this Agreement is to address the integration of physical and mental health services provided by the MHP and PIHP for common Medicaid enrollees. Specifically, to improve Medicaid enrollee's health status, improve the Medicaid enrollee's experience of care, and to reduce unnecessary costs.

The MHP and PIHP designate below the respective persons who have authority to administer this Agreement on behalf of the MHP and PIHP:

<MHP Name, Address, Phone, Signatory, and Agreement Authority with contact information>

<PIHP Name, Address, Phone, Signatory, and Agreement Authority with contact information>

E. Areas of Shared Responsibility

1. Exchange of Information

   a. Each party shall inform the other of current contact information for their respective Medicaid enrollee Service Departments.

   b. MHP shall make electronically available to the PIHP its enrolled common/shared Medicaid enrollee list together with their enrolled Medicaid enrollee's PCP and PCP contact information, on a monthly basis.

c. The parties shall explore the prudence and cost-benefits of Medicaid enrollee information exchange efforts. If Protected and/or Confidential Medicaid enrollee Information are to be exchanged, such exchanges shall be in accordance with all applicable federal and state statutes and regulations.

d. The parties shall encourage and support their staff, PCPs and provider networks in maintaining integrative communication regarding mutually served Medicaid enrollees.

e. Prior to exchanging any Medicaid enrollee information, the parties shall obtain a release from the Medicaid enrollee, as required by federal and/or state law.

2. Referral Procedures

a. The PIHP shall exercise reasonable efforts to assist Medicaid enrollees in understanding the role of the MHP and how to contact the MHP. The PIHP shall exercise reasonable efforts to support Medicaid enrollees in selecting and seeing a Primary Care Practitioner (PCP).

b. The MHP shall exercise reasonable efforts to assist Medicaid enrollees in understanding the role of the PIHP and how to contact the PIHP. The MHP shall exercise reasonable efforts to support Medicaid enrollees in selecting and seeing a Primary Care Practitioner (PCP).

c. Each party shall exercise reasonable efforts to rapidly determine and provide the appropriate type, amount, scope and duration of medically necessary services as guided by the Medicaid Manual.

3. Medical and Care Coordination; Emergency Services; Pharmacy and Laboratory Services Coordination; Quality Assurance Coordination

a. Each party shall exercise reasonable efforts to support Medicaid enrollee and systemic coordination of care. The parties shall explore and consider the prudence and cost-benefits of systemic and Medicaid enrollee focused care coordination efforts. If care coordination efforts involve the exchange of Medicaid enrollees' health information, the exchange shall be in accordance with applicable federal and state statutes and regulations related thereto. Each shall make available to the other contact information for case level medical and care coordination.

b. Neither party shall withhold emergency services and each shall resolve payment disputes in good faith.

c. Each party shall take steps to reduce duplicative pharmacy and laboratory services and agree to abide by L-Letter 10-21 and other related guidance for payment purposes.

d. Each party agrees to consider and may implement by mutual agreement Quality Assurance Coordination efforts.

F. Grievance and Appeal Resolution

Each agrees to fulfill its Medicaid enrollee rights and protections grievance and appeal obligations with Medicaid enrollees, and to coordinate resolutions as necessary and appropriate.

G. Dispute Resolution

The parties specify below the steps that each shall follow to dispute a decision or action by the other party related to this Agreement:

1) Submission of a written request to the other party's Agreement Administrator for reconsideration of the disputed decision or action. The submission shall reference the applicable Agreement section(s), known related facts, argument(s) and proposed resolution/remedy; and

2) In the event this process does not resolve the dispute, either party may appeal to their applicable MDHHS Administration Contract Section representative.

Where the dispute affects a Medicaid enrollee's current care, good faith efforts will be made to resolve the dispute with all due haste and the receiving party shall respond in writing within three (3) business days.

Where the dispute is in regards to an administrative or retrospective matter the receiving party shall respond in writing within thirty (30) business days.

H. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all applicable federal, state, and local statutes and regulations. Where federal or state statute, regulation or policy is contrary to the terms and conditions herein, statute, regulation and policy shall prevail without necessity of amendment to this Agreement.

I. Merger and Integration

This Agreement expresses the final understanding of the parties regarding the obligations and commitments which are set forth herein, and supersedes all prior and contemporaneous negotiations, discussions, understandings, and agreements between them relating to the services, representations and duties which are articulated in this Agreement.

J. Notices

All notices or other communications authorized or required under this Agreement shall be given in writing, either by personal delivery or by certified mail (return receipt requested). A notice to the parties shall be deemed given upon delivery or by certified mail directed to the addresses shown below.

Address of the PIHP:

_____

_____

_____

Attention: _____

Address of the MHP:

_____

_____

_____

Attention: _____

K. Headings

The headings contained in this Agreement have been inserted and used solely for ease of reference and shall not be considered in the interpretation or construction of this Agreement.

L. Severability

In the event any provision of this Agreement, in whole or in part (or the application of any provision to a specific situation) is held to be invalid or unenforceable, such provision shall, if possible, be deemed written and revised in a manner which eliminates the offending language but maintains the overall intent of the Agreement. However, if that is not possible, the offending language shall be deemed removed with the Agreement otherwise remaining in effect, so long as

doing so would not result in substantial unfairness or injustice to either of the parties. Otherwise, the party adversely affected may terminate the Agreement immediately.

M. No Third Party Rights

Nothing in this Agreement, express or implied, is intended to or shall be construed to confer upon, or to give to, any person or organization other than the parties any right, remedy or claim under this Agreement as a third party beneficiary.

N. Assignment

This Agreement shall not be assigned by any party without the prior written consent of the other party.

O. Counterparts

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute the one in the same instrument.

P. Signatures

The parties by and through their duly authorized representatives have executed and delivered this Agreement. Each person signing this Agreement on behalf of a party represents that he or she has full authority to execute and deliver this Agreement on behalf of that party with the effect of binding the party.

IN WITNESS WHEREOF, the parties hereto have entered into, executed, and delivered this Agreement as of the day and year first written above.

PIHP

By: _____

Its: _____

Date: _____

MHP

By: _____

Its: _____

Date: _____

Coordination Agreement Outline of Required Elements

INTRODUCTION

A. Basis:

Current contract language requires that Prepaid Inpatient Health Plans (PIHPs) and Medicaid Health Plans (MHPs) "have a written, functioning coordination agreement with "plans serving any part of each organization's respective service area". The written coordination agreement shall describe the coordination arrangements, inclusive of but not limited to, the exchange of information, referral procedures, care coordination and dispute resolution. "At a minimum these arrangements must address the integration of physical and mental health services provided by the MHP and PIHP for the shared consumer base plans."[1]

A Coordination Agreement, currently exists and is in force between contractors (MHPs and PIHPs). The RFP issued by Michigan DHHS on May 8, 2015 to guide its Medicaid Health Plan re-procurement includes language specifying requirements for MHP and PIHP alignment that are expected to be included as contract language for both PIHPs and MHPs as of January 1, 2016. This includes the following: "Contractors must, in collaboration with Coordinating (PIHPs/MHPs), update the Coordinating Agreement to incorporate any necessary remedies to improve continuity of care, care management, and the provision of health care services, at least annually"[2].

Greater system integration across physical and behavioral health care delivery systems, as well as provision of community-based social support services, is a primary goal of Michigan's Medicaid and broad State Innovation Plan health care reforms. Fundamentally, operationalizing processes for streamlined care management and continuity of care will serve as the foundation by which this greater integration can be achieved. As illustrated in Figure 1, the end result will be a healthier Michigan population, served by an accountable, value-based health system for the state. Michigan's contracting MHPs and PIHPs recognize the value of continuing to update and enhance its Coordinating Agreement to reflect quality improvement efforts and incorporate provisions that will define and strengthen levels of streamlined collaboration.

This document serves as an attachment to the master Coordinating Agreement that must be updated on a regular and ongoing basis to further clarify, enhance and expand aspects of PIHP and MHP coordination that benefit Michigan Medicaid beneficiaries.

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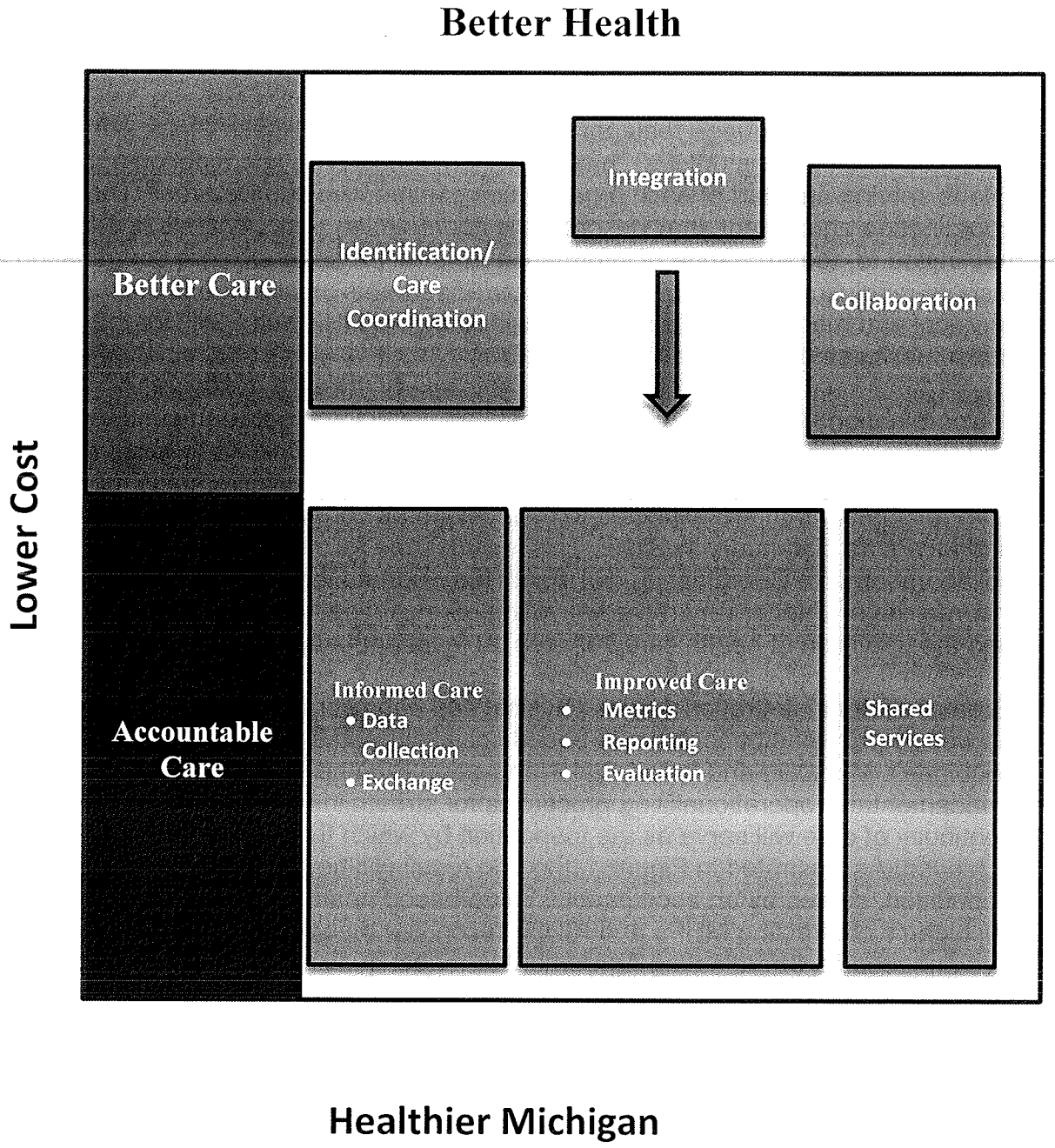
[1] PIHP Contract section 7.3

[2] MHP RFP Behavioral Health Integration Section I.C.1.c

Figure 1



3

[3] Based Upon Michigan Blueprint for Health Innovation 2014

B. Definitions

Continuity of Care:

"Continuity of care" means the quality of care over time, including both the patient's experience of a 'continuous caring relationship' with an identified health care professional and the delivery of a 'seamless service' through integration, coordination and the sharing of information between different providers.[4]

Care Management:

"Care Management" means the application of systems, science, incentives, and information to improve practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.[5]

Care Coordination:

"Care Coordination" means a set of activities designed to ensure needed, appropriate and cost effective care for beneficiaries. As a component of overall care management, care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between Responsible Plans. Major priorities for care coordination in the context of a care management plan include:

- Outreach and contacts/communication to support patient engagement,
- Conducting screening, record review and documentation as part of Evaluation and Assessment,
- Tracking and facilitating follow up on lab tests and referrals,
- Care Planning,
- Managing transitions of care activities to support continuity of care,
- Address social supports and making linkages to services addressing housing, food, etc., and
- Monitoring, Reporting and Documentation.

For purposes of this document, Care Coordination also refers to the levels of coordinated care management and care coordination activities carried out under the

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[4] Journal for Health Services Research and Policy. 2006 Oct;11 (4):248-50.**What is 'continuity of care'?**

[5] Center for Health Care Strategies: Care Management Definition and Framework, 2007

auspices of PIHP and MCO contractors.

"Contractors" means Medicaid Health Plans and Prepaid Inpatient Health Plans.

"Responsible Plans" means Contractors with responsibility for Medicaid beneficiaries within the shared service area.

Clarifying Operational Standards for MCO-PIHP Coordination

C. Population Identification and Stratification

Identification and stratification is necessary to align resources across Responsible Plans to those beneficiaries exhibiting the greatest needs.

Standards to Operationalize:

1) Contractors agree to work collaboratively with Responsible Plans serving shared Enrollees to meet the requirements in this section for identifying and coordinating the provision of services to Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.[6]

2) Contractor must work with the Responsible Plans to jointly create and implement a method for stratifying Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.[7]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting methodology

- Define responsibility and timing required to achieve the required action.
- Assess any existing capacity/methodology within responsible plans.
- Identify strengths and gaps of existing approaches, including availability of/access to needed data.
- Define and test methodology.
- Ensure evaluation/revision process is in place.
- Consider provider network (PIHP and MHP) input, impact.
- Determine how findings will be used collaboratively to align resources and improve population health.

D. Care Coordination:

[6] MHP RFP Behavioral Health Integration Section I.C.3.a

[7] MHP RFP Behavioral Health Integration Section I.C.3.b

Background: MHPs are required to arrange for a robust care management program that meet national best practice standards (i.e. NCQA and/or URAC accreditation standards) and all requirements in this section to all Enrollees requiring intensive care management.[8]

Standards to Operationalize:

1) Contractors must work to jointly develop care management standards for providing care management services to Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities based on patient needs and goals.[9]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting standards:

- Define responsibility and timing required to achieve the required action.
- Establish a process for drafting standards including stakeholder input, approval and adoption.
- Ensure compatibility w/ NCQA/URAC standards.
- Ensure compatibility w/ PIHP/CMHSP standards.
- Ensure compatibility w/ MHP standards.
- Ensure evaluation/revision process is in place.

2) Contractors must work to jointly develop and implement processes for providing coordinated complex care management services to Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.[10]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting processes:

- Define responsibility and timing required to achieve the required action.
- Establish a plan for developing a service description including stakeholder input, approval and adoption.
- Ensure compatibility w/ NCQA/URAC processes.
- Assess/Ensure compatibility w/ PIHP/CMHSP processes.
- Assess/Ensure compatibility w/ MHP processes.
- Ensure compatibility with Duals Pilot processes.
- Ensure evaluation/revision process is in place.

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[8] MHP RFP Behavioral Health Integration Section I.A.1.

[9] MHP RFP Behavioral Health Integration Section I.C.3.c

[10] MHP RFP Behavioral Health Integration Section I.C.3.d

3) Contractors must work to jointly create a care management tool used by staff from each organization to document a jointly created care plan and to track contacts, issues, and services regarding Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities.[11]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting tool:

- Define responsibility and timing required to achieve the required action.
- Define the process for selection/development, including stakeholder input, approval and adoption.
- Assess/Ensure compatibility w/ PIHP/CMHSP tools.
- Assess/Ensure compatibility w/ MHP tools.
- Ensure evaluation/revision process is in place.

4) Contractors' care managers must hold case reviews at least monthly during which the care managers and other team members, including community health workers, pharmacists, medical directors and behavioral health providers, must discuss Enrollees shared by both entities who have significant behavioral health issues and complex physical co-morbidities, and develop shared care management interventions.[12]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting process for case reviews:

- Plan for process development and adoption, including stakeholder input and timeline.
- Define process members and responsibilities.
- Assess/Ensure compatibility w/ PIHP/CMHSP processes.
- Assess/Ensure compatibility w/ MHP processes.
- Clarify process for documented accountability and monitoring of defined interventions.

E. Integration of Physical and Behavioral Health:

Integration of Physical and Behavioral Health improves the beneficiaries Continuity of Care and promotes improved health outcomes.

[11] MHP RFP Behavioral Health Integration Section I.C.3.e

[12] MHP RFP Behavioral Health Integration Section I.C.3.f

Standards to Operationalize:

1) Contractor must collaborate with Responsible Plans serving its Enrollees to improve integration of behavioral health and physical health services by meeting the following requirements:
   a) Facilitate the placement of primary care clinicians in community mental health centers (CMHC) to enable Enrollees to receive both primary care services and behavioral health services at the location where they are most comfortable and incorporate principles of shared decision-making.[13]

   b) Facilitate placement of behavioral health clinicians in primary care settings and providing training on treating patients in a holistic manner, using a single treatment plan that addresses both physical and mental health needs and taking into account unmet needs such as substance abuse treatment; and also helping the individual access his/her natural community supports based on his/her strengths and preferences;[14]

   c) Develop and implement initiatives to improve communication and collaboration between Contractors' provider networks (MHP network and PIHP's contracted CMHSPs and other behavioral health providers).[15]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting plan to facilitate placements and improve communication:
- Define responsibility and timing required to achieve the required action.
- Establish selection criteria for primary care clinician/ behavioral health clinician placements.
- Assess the strengths and weaknesses of current communication and coordination efforts to assure efficiency and effectiveness.
- Define how collaboration/coordination with provider networks will occur.
- Ensure evaluation/revision process is in place.

F. Collaboration:

Collaboration is based upon joint expectations, relationships and the ongoing exchange of information to address mutually agreed upon goals.

Standards to Operationalize:

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[13] MHP RFP Behavioral Health Integration Section I.C.4.a.1

[14] MHP RFP Behavioral Health Integration Section I.C.4.a.2

[15] MHP RFP Behavioral Health Integration Section I.C.4.a.3

1) Contractors must establish key contact personnel in each Responsible Plan and develop or jointly participate in a MDHHS-approved community-based public health initiative or project and report the project results to MDHHS.
   a) Responsible Plans must meet for this purpose at least quarterly.
   b) Responsible Plans must include, to the extent possible, key clinical leads at CMHSPs and other stakeholders.
   c) Responsible Plans must report projects and ongoing results to MDHHS at least annually.[16]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting plan to fulfill and report on public health initiatives:
- Identify Key Staff (if staff differ from contacts in Model Coordination Agreement).
- Establish quarterly meeting calendar and recommended agenda items.
- Define meeting participant roles and responsibilities.
- Assign responsibility for reporting to MDHHS as required.

2) Contractors must maintain an electronic bidirectional exchange of information with each Responsible Plan.[17]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process to ensure information exchange:
- Define responsibility and timing required to achieve the required action.
- Assess any existing capacity/methodology within responsible plans.
- Identify strengths and gaps of existing approaches, including availability of/access to needed data.
- Assess provider network (PIHP and MHP) input, impact.
- Define and test methodology.
- Ensure legal and compliance review.
- Ensure evaluation/revision process is in place.

G. Data Collection/Performance Reporting:

Informed, accountable care and management requires the collection, sharing, and reporting of actionable data. Performance Improvement requires the assessment, prioritization and development of strategies to address this data.

[16] MHP RFP Behavioral Health Integration Section I.C.1.d.i-iii

[17] MHP RFP Behavioral Health Integration Section I.C.2.b.

Standards to Operationalize:

1) Contractors must work collaboratively and with MDHHS to share data and develop a process to produce, at intervals designated by MDHHS, a list of Enrollees who have significant behavioral health issues and complex physical comorbidities.[18]
2) Contractors must separately track and report all grievances and appeals for Enrollees jointly served.[19]
3) Contractors must work collaboratively with primary care providers, and MDHHS to develop and implement performance improvement projects involving shared metrics and incentives for performance.[20]
4) Contractors agree to report to MDHHS the results of shared metric performance incentive programs in a manner determined by MDHHS.[21]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting a plan for joint performance improvement and reporting plan:

- Define responsibility and timing required to achieve the required action.
- Assess existing capacity/methodology within responsible plans.
- Identify strengths and gaps of existing approaches, including availability of/access to needed data.
- Assess provider network (PIHP and MHP) input, impact
- Draft collaborative performance improvement process and structure, including assignment of responsibility, and process for project selection.
- Identify required reports/metrics.
  - Recommend consideration of nationally normed and validated measures with existing data sources (e.g. hospital readmissions, ED utilization, primary care engagement)
- Jointly develop data definitions, test and implement the reporting processes.
- Ensure evaluation/revision process is in place.

H. Optional Services:

This section creates the opportunity to individualize arrangements between the responsible plans to more efficiently and effectively meet contractual standards. Potential areas/standards for additional agreements include:

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[18]MHP RFP Behavioral Health Integration Section I.A.2.

[19] MHP RFP Behavioral Health Integration Section I.C.1.b.

[20] MHP RFP Behavioral Health Integration Section I.C.3.g.

[21] MHP RFP Behavioral Health Integration Section I.C.3.h.

MHP Integration Requirements from RFP:

1) Contractor agrees to provide primary care training on evidence-based behavioral health service models for primary care providers, such as Screening, Brief Intervention and Referral to Treatment (SBIRT). [22]

2) Community Health Workers (CHWs) -
   - Contractor must provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to Enrollees who have significant behavioral health issues and complex physical co-morbidities who will engage with and benefit from CHW or peer-support specialist services. Examples of CHW services include but are not limited to:
     - Conduct home visits to assess barriers to healthy living and accessing health care
     - Set up medical and behavioral health office visits
     - Explain the importance of scheduled visits to clients
     - Remind clients of scheduled visits multiple times
     - Accompany clients to office visits, as necessary
     - Participate in office visits, as necessary
     - Advocate for clients with providers
     - Arrange for social services (such as housing and heating assistance) and surrounding support services
     - Track clients down when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care
     - Help boost clients' morale and sense of self-worth
     - Provide clients with training in self-management skills
     - Provide clients with someone they can trust by being reliable, non-judgmental, consistent, open, and accepting
     - Serve as a key knowledge source for services and information needed for clients to have healthier, more stable lives[23]

   - Contractor agrees to establish a reimbursement methodology for outreach, engagement, education and coordination services provided by community health workers or peer support specialists to promote behavioral health integration.[24]

Standards to Operationalize – PIHP Contract:

- The PIHP will initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid beneficiaries. These efforts will

[22] MHP RFP Behavioral Health Integration Section I.B.1.a.

[23] MHP RFP Behavioral Health Integration Section I.B.2.a.i-xiii

[24] MHP RFP Behavioral Health Integration Section I.B.2.b.

focus on persons that have a chronic condition such as a serious and persistent mental health illness, co-occurring substance use disorder or a developmental disability and have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports.

- The PIHP will implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the consumer's MHP as defined in 7.3.

- The PIHP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.[25]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process to assess and prioritize opportunities for shared services:
- Inclusive of, but not limited to, requirements above.
- Assessment of ability to more effectively and efficiently meet requirements.
- Prioritize and develop plan to implement prioritized opportunities.

I) Dispute Resolution Mechanisms:

Recommend: As defined in attachment 7.3.1., but consider opportunities to assign responsibility for problem solving prior to formal dispute to lead contacts from Responsible Parties.

J) Evaluation:

Evaluation is a key component to performance improvement and necessary to ensure the ongoing improvement of integration and coordination efforts.

Standards to Operationalize:

[25] PIHP Contract Section 7.4

- Contractors must collaboratively update the Coordinating Agreement to incorporate any necessary remedies to improve continuity of care, care management, and the provision of health care services, at least annually[26]

Recommended Steps: Engage identified Responsible Plans that will participate and agree on process and timeline for drafting and adopting process to evaluate each area, above, and agreement overall:

- Define responsibility and timing required to achieve the required action.
- Define Evaluation domains and process.
- Recommend initial evaluation at 3 and 6 months due to new requirements.
- Report results.
- Incorporate Evaluation into performance improvement processes.
- Identify improvements to evaluation process.
- Evaluate annually thereafter.

Do we need/want to add a Planning and Reporting format, instructions, and schedule?

[26] MHP RFP Behavioral Health Integration Section I.C.1.c.

Michigan Department of Health & Human Services
Prepaid Inpatient Health Plans
Specialty Mental Health and Substance Use Disorder Services and Supports
Network Management Reciprocity & Efficiency
Policy

POLICY

The Michigan Department Health and Human Services (MDHHS), along with its contracted statewide system of 10 (ten) regional PIHPs (Pre-Paid Inpatient Health Plans), is interested in promoting system efficiencies at all levels of service delivery and management. It is recognized that any subcontracting service providers connected to more than one regional PIHP system or more than one CMHSP (Community Mental Health Service Program) organization, greatly benefit from a statewide reciprocity expectation of MDHHS. PIHP systems benefit from reciprocity policies and procedures that create efficiencies for both the funding organizations and the service providers. Prevention of duplication of effort or unnecessary repetitive use of scarce public resources at all levels of management and operation of provider networks is desired.

MDHHS requires that certain network management functions be conducted to ensure compliance with state and federal regulations and mandates, and to ensure overall quality and consistency of provider management. PIHPs involved in the Michigan community mental health and substance use disorder programs, and engaged in the provision of various network management functions – including training, credentialing, procurement, contracting/subcontracting, provider monitoring and service delivery provision oversight - have finite resources to either conduct such functions or to create or accept alternatives that will fully meet MDHHS requirements. At the same time, MDHHS recognizes that each specific, responsible organization and/or system is structurally and operationally unique. MDHHS also recognizes that each unique organization bears the accountability for provider competency and network compliance as well as the risk for the actions of assigned individuals engaged in service and support provision with persons with disabilities.

This policy seeks to: 1) identify statewide standards for service provider reciprocity, 2) offer fairness to all service providers in areas of reciprocity, 3) address both internal and external reciprocity within and between PIHPs, and 4) allow flexibility for all systems in the methods for reciprocity actions.

APPLICATION

This policy and the contained standards are applicable to all MDHHS contracted PIHPs and their service provider networks in Michigan, comprising all contractors and subcontractors involved in the management and provision of specialty mental health and substance use disorder services and supports, including services directly provided by a PIHP or CMHSP. This policy does not apply to non-service contractors of PIHPs or CMHSPs.

It is understood that applicable BBA Standards and applicable national accreditation standards guide and supersede these requirements.

STANDARDS

1. GENERAL STANDARDS

A. MDHHS requires that each PIHP system demonstrate internal and external reciprocity efforts, as follows:

1) Written policy(ies) and procedure(s); reciprocity may be referenced content in other broader network management related policies.
2) Identified position(s) and/or processes to oversee and conduct reciprocity activities.
3) Proofs of the occurrence of reciprocity actions and activities where indicated.
4) Efforts to offer provider efficiencies within and for PIHP structures/regions, as well as between PIHP systems.

B. Each organization or system must have a means to collect, review and implement improvements in the areas of reciprocity and efficiencies as part of quality improvement efforts.

C. Each PIHP must adopt a common Provider Network Management function policy or policies to be used throughout the regional PIHP, consistently applicable to all service contractors and subcontractors.

D. Providers, including but not limited to those who are engaged in multi-CMHSP or multi-PIHP business, are encouraged to suggest or share useful examples of reciprocity practices at any time, however it is up to each PIHP system to develop and maintain their own methods to support reciprocity within and external to their regions, including PIHP delegation to CMHSPs.

E. Reciprocity is made available to service providers where applicable for the same provider/organization, the same individual staff or the same services. Where relevant provider differences occur, partial reciprocity or expedited processes will be offered when feasible. (For example, a provider who contracts for one service in one system and seeks to contract for another service in another system may be only offered partial reciprocity, given the difference in the type of services.)

2. PROCUREMENT

A. Providers will be offered efficiencies in purchasing processes within or between PIHP systems, which may include any of the following:

1) Readily available centralized provider application processes and procurement information, such as through PIHP websites and/or CMHSP website links.
2) CMHSP (or PIHP) cross sharing of provider application information or provision of common elements within PIHPs/between CMHSPs.
3) Publication of provider selection processes for the PIHP region.
4) Readily available PIHP or CMHSP contact information for specific provider contracting and selection procedures.
5) Readily available PIHP and/or CMHSP provider manual summary or complete content.
6) Uniform level of care or other standards wherever feasible.
7) References for providers in good standing will be readily given between PIHPs when providers seek to apply for new service arrangements; reference information provided will be shared with the applicable provider.

3. PROVIDER/PROGRAM MONITORING

A. It is recognized that each PIHP may have developed unique tools for provider performance and compliance oversight and monitoring, due to the decentralized service delivery and network management in the state.

B. For provider monitoring as required by MDHHS or other routine on-site compliance reviews or monitoring, PIHP systems or CMHSP organizations are expected to have a process, where at minimum, providers in good standing and/or at acceptable levels of performance are allowed a review waiver and/or modified/streamlined review experience at some regular interval. This may include verifying the existence of a comparable review report or summary verifying the provider's good standing with another comparable organization/system.

C. For purposes of this policy, it is recognized that service provider performance across a contracted provider system may vary from county to county or site to site, creating varied responses from PIHPs/CMHSPs on reasonable monitoring conditions and appropriate reciprocity. It is further recognized that this transparency of shared information about providers across PIHP systems may include the provision of both strengths and weaknesses of a provider's performance.

D. Expedited provider program/site reviews using reciprocal procedures could include any combination of the following:

1) PIHP/CMHSP sharing of recent review reports or outcomes conducted by another system.
2) Reduction of the depth of a review in any given cycle based on positive provider performance/compliance.
3) Verification of limited, priority only, review elements and/or conduction through a remote, off site process.

4) Simplified review protocols for programs which are located in the jurisdiction of another primary system or under contract for a larger volume of services, such as out of county consumer placements or off panel service purchases.
5) Joint or split system audits of provider program/sites coordinated by two or more systems/organizations which reduces more than one site visit to one site visit only
6) On-line audit processes and/or other methods which otherwise reduce the total amount of time spent by providers in such activities with funding CMHSPs and PIHPs.

E. PIHPs or CMHSP delegates will identify lead contact persons and/or share processes to help facilitate this provider monitoring reciprocity and readily share provider program or site review documents upon request in order to waive or conduct more limited reviews whenever possible.

F. This policy does not usurp the ability of the funding PIHP/CMHSP to conduct ad hoc audits or reviews of provider programs where needed or indicated at any time based on reported performance or as required by external entities.

G. MDHHS will accept use of shared or mutual PIHP or CMHSP reviews according to the PIHP/CMHSP procedure to meet annual provider site visit standards and/or ongoing monitoring needs as referenced in MDHHS contracts.

H. PIHPs/CMHSPs are expected to seek and consider routine provider feedback regarding on site review content and processes, such as through post review evaluation form completion.

I. PIHPs/CMHSPs are expected to include reference source(s) for specific monitoring or audit standards, as well as revise/streamline standards/protocols on a regular basis for necessity, value and efficiency.

J. PIHPs/CMHSPs, when adding new monitoring items to review processes, are expected to review the necessity of existing items, and whenever possible consider reducing or eliminating items of less value.

K. MDHHS expects to see meaningful consumer involvement in the monitoring activities of service providers.

4. TRAINING/CONTINUING EDUCATION

A. For mandatory required training, each responsible organization must have reasonable provisions for facilitating the acceptance of validated training - and where possible if indicated, offering expedited alternatives - for individuals for whom relevant, comparable training was provided by similar systems or sources. PIHP and/or CMHSP policy for acceptance may generally include any of the following considerations or combinations:

1) Length of time the individual worked in any prior similar role.

2) Length of time since the last validated training and/or work experience.
3) Comparableness of curriculum content elements, including detail and depth of content.
4) Employer recommendations relative to individual or program performance.
5) Partial training credit/validation for acceptable training content and/or proofs where possible.
6) Testing out for competency in relevant training areas.
7) Abbreviated training options (such as, refresher or renewal trainings) shorter in length of time required to demonstrate competency.
8) Self-study and/or on line (non-classroom based) trainings which the individual could complete on a flexible, individual schedule.
9) Conditions that might apply on a time-limited basis to all persons of a specific site or work program which may place limits on PIHP/CMHSP reciprocity considerations (such as, part of a state corrective plan, recipient rights finding response or other non-compliance, below-standard performance finding area(s)

B. Training reciprocity and efficiencies are made available to all levels of service providers and staff members, including those in professional and direct care roles.
C. Each PIHP/CMHSP will have a designated, qualified person assigned and/or a defined process for the oversight of reciprocal training approvals and to facilitate cross system training reciprocity related communications.

D. For trainings for which reciprocity applies, any organization responsible for conducting routine, required training programs, will have written protocols, which include:
   1) scope,
   2) content areas summaries,
   3) key objectives,
   4) length and mode(s) of training,
   5) competency testing process,
   6) intended audience(s),
   7) frequency offered,
   8) prerequisites (if any),
   9) trainer qualifications, and
   10) renewal requirements (if any)

E. Any organization which conducts training will issue or provide access to validated training proofs to participants on a routine and as needed basis, and directly to PIHPs/CMHSPs upon request.

F. PIHPs and CMHSPs will share training protocols/curriculums on a regular basis with other PIHPs/CMHSPs and all service providers upon request.

G. This policy does not usurp the ability of the PIHP/CMHSP system to conduct or require specific or new training programs unique to that regions need or priorities.

H. This policy does not usurp the ability of any specific employer/supervisor to require an individual staff member or group of staff to receive additional training in a certain area if needed or indicated.

I. PIHP/CMHSP systems/organizations will focus on efforts to help ensure demonstrated competency in training efforts, rather than other potentially arbitrary measures such as number of hours of training or classroom time.

J. It is recognized that for individuals who may move from one system to another, or who are engaged in service delivery for more than one organization or system simultaneously, the provision of training and reciprocity for prior training should be determined based on each individual's circumstance, so as to avoid duplication of effort and help to ensure most reasonable use of system resources.

K. For mandatory/core trainings commonly provided across systems, PIHPs/CMHSPs will seek to accept as many elements of comparable curriculum content as possible, and provide at least minimum levels of training reciprocity wherever feasible for providers.

L. The PIHP or CMHSP may reserve the right to require additional action if 'testing out' results are not satisfactory.

5. PROVIDER CONTRACTING

A. Contracts executed within PIHPs and/or CMHSPs and subcontractors within a region shall be consistent in terms of provider expectations, and have, at minimum, shared common elements or language to provide some consistency and efficiency for providers, although actual complete documents may differ among CMHSPs.

B. PHIPs/CMHSPs will have mechanisms for sharing application materials, provider monitoring/auditing reports, and provider training and credentialing when contracting with common providers within a region, and external to a region whenever feasible.

C. Integration of contracts will be pursued whenever feasible, such as a single contract for several or more services being purchased and/or when more than one population is being served.

D. New providers will be offered orientation to contracting requirements, with opportunities to ask questions at any time to support provider understanding of expectations and help promote strong compliance.

6. CREDENTIALING & BACKGROUND CHECKS

A. MDHHS recognizes that organizations may have credentialing reciprocity limitations due to direct source verification necessity and/or requirements. The importance of direct source verification of academic and/or licensing credentials and background checks is recognized by this policy, including pre-employment/pre contract needs, accrediting body standards, and other 'point-in-time' needs.

B. Each PIHP/CMHSP will have a mechanism available to providers to provide some level of reciprocity for credentials related to the provision of mental health and substance use disorder services and supports, including, required training, certifications, or completion of other requirements for the provision of a specific evidence-based model of treatment or intervention.

C. Where feasible to offer credentialing reciprocity, PIHPs/CMHSPs will seek and maintain validated records of accepted credentials for individuals and programs from other PIHPs/CMHSPs.

DEFINITIONS

Competency - Having the requisite or adequate abilities or qualities as well as the capacity to appropriately function and respond, as defined by demonstration, observation, checklist completion and/or testing.

Efficiencies - Reduction in or best use of staff time, cost or other resources.

Good Standing – Providers who are at a current acceptable level of performance and/or are in substantial compliance with PIHP/CMHSP requirements. (Examples of providers who may **not** be considered in good standing could include: those who have an active, written, formal sanction, those who are on 'probationary status', those who have an outstanding corrective action plan overdue, or those who have demonstrated current, chronic poor quality as documented by a PIHP and/or CMHSP. Providers who have minor or routine corrective actions in process as part of a regular quality review or monitoring schedule are considered to be in good standing.)

Reasonable - Non excessive, logical, moderate (expectations or standards); feasible, possible, practical, realistic, achievable.

Reciprocity - Process whereby corresponding status is mutually granted by one system to the other.

Validated - Directly verified as accurate and true with the originating/ issuing source. (Also often referred to as direct source verification.)

REFERENCES

Michigan Association of Community Mental Health Boards (MACMHB) – website: www: macmhb.org, member information.

Michigan Department of Community Health – PIHP/CMHSP contract language including attachments relevant to credentialing, procurement, contracting and provider network management areas; MDHHS Administrative Rules; MDHHS Application for Participation for Specialty Prepaid Inpatient Health Plans and Notice of Intent to Apply, 2013.

Michigan Department of Human Services – www.mi.gov/afchfa, direct care staff training information for certified specialized residential facilities

PIHP REPORTING REQUIREMENTS
Effective 10-1-18
Table of Contents

REPORTING REQUIREMENTS 2

FINANCIAL PLANNING, REPORTING AND SETTLEMENT 3

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS 5

BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS) COLLECTION/RECORDING AND REPORTING REQUIREMENTS 7

PROXY MEASURES FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES 11

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER BENEFICIARY 18

ENCOUNTER TIMELINESS CALCULATION 23

PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT 25

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM 25

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES 28

CONSUMER SATISFACTION SURVEY 29

CRITICAL INCIDENT REPORTING 29

EVENT NOTIFICATION 30

NOTIFICATION OF PROVIDER NETWORK CHANGES 31

FY 2019 MDHHS/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT

REPORTING REQUIREMENTS

Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2019 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs or substance use disorder 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 Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes. 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 The code list also includes 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, is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators.
- SUD Guidelines and instructions as found in the Agreement

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:

PIHP REPORTING REQUIREMENTS

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management
- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- External Quality Review
- 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 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 PIHP shall provide the financial reports to MDHHS as listed below. Forms, instructions and other reporting resources 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 Frequency	Report Period and Submittal Instructions
10/1/2018	SUD Budget Report	Projection/Initial	October 1 to September 30
12/3/2018	Risk Management Strategy	Annually	To cover the current fiscal year
12/31/2018	Medicaid Services Verification Report	Annually	October 1 to September 30
1/31/2019	SUD – Expenditure Report	Quarterly	October 1 to December 31
4/16/2019	SUD – Women's Specialty Services (WSS) Mid-Year Expenditure Status Report	Mid-Year	October 1 to March 31
4/30/2019	SUD – Expenditure Report	Quarterly	January 1 to March 31
5/15/2019	Program Integrity Activities	Quarterly	January 1 to March 31 using OIG's case tracking system
5/31/2019	Mid-Year Status Report	Mid-Year	October 1 to March 31
6/01/2019	SUD – Notice of Excess or Insufficient Funds	Projection	October 1 to September 30
7/31/2019	SUD – Expenditure Report	Quarterly	April 1 to June 30
8/15/2019	Program Integrity Activities	Quarterly	April 1 to June 30 using OIG's case tracking system
8/15/2019	SUD – Charitable Choice Report	Annually	October 1 to September 30
8/15/2019	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Projection (Use tab in FSR Bundle)	October 1 to September 30

PIHP REPORTING REQUIREMENTS

	• Medicaid – Shared Risk Calculation & Risk Financing	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Projection (Use tab in FSR Bundle)	October 1 to September 30
8/31/2019	Medicaid Unit Net Cost Report (MUNC)	Six month report	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
10/1/2019	Medicaid YEC Accrual	Final	October 1 to September 30
10/1/2019	SUD YEC Accrual	Final	October 1 to September 30
10/1/2019	SUD Budget Report	Projection	October 1 to September 30
11/10/2019	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Interim (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid – Shared Risk Calculation & Risk Financing	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Interim (Use tab in FSR Bundle)	October 1 to September 30
11/15/2019	• Program Integrity Activities	Quarterly	July 1 to September 30 using OIG's case tracking system
11/30/2019	SUD – Expenditure Report	Quarterly/Final	July 1 to September 30
12/31/2019	Medicaid Services Verification Report	Annually	October 1 to September 30
2/15/2019	Program Integrity Activities	Quarterly	October 1 to December 31 using OIG's case tracking system
2/28/2019	SUD – Primary Prevention Expenditures by Strategy Report	Annually	October 1to September 30
2/28/2019	SUD Budget Report	Final	October 1 to September 30
2/28/2019	SUD – Legislative Report/Section 408	Annually	October 1 to September 30
2/28/2019	SUD – Special Project Report: (Applies only to PIHP's with earmarked allocations for Flint Odyssey House Sacred Heart Rehab Center Saginaw Odyssey House)	Annually	October 1 to September 30
2/28/2019	PIHP Medicaid FSR Bundle – MA. HMP. Autism & SUD	Final (Use tab in FSR Bundle)	October 1 to September 30

PIHP REPORTING REQUIREMENTS

	Shared Risk Calculation & Risk Financing	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Final (Use tab in FSR Bundle)	October 1 to September 30
2/28/2019	• Medicaid Utilization and Cost Report (MUNC)	Final	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
2/28/2019	PIHP Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30
2/28/2019	Medical Loss Ratio	Annually	October 1 to September 30
3/31/2019	SUD - Maintenance of Effort (MOE) Report	Annually	October 1 to September 30
6/30/2019	SUD – Audit Report	Annually	October 1 to September 30 (Due 9 months after close of fiscal year)
30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov
30 Days after submission	Compliance exam and plan of correction	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS

The PIHP shall provide the following reports to MDHHS as listed below.

Due Date	**Report Title**	**Report Period**
10/31/2018	Recovery Policy & Practice Annual Survey Information Forms – Tables 3a & 3b	TBD See attachment P4.13.1
1/31/2019	Children Referral Report	October 1 to December 31
1/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 to December 31
2/19/2019	SUD Master Retail List	October 1 to September 30
03/31/2019	Performance Indicators	October 1 to December 31, 2018 Submit to: QMPMeasures@michigan.gov
4/30/2019	Children Referral Report	January 1 to March 31
4/30/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	January 1 to March 31
06/30/2019	Performance Indicators	January 1 to March 31, 2019 Submit to: QMPMeasures@michigan.gov
7/11/2019	Compliance Check Report (CCR) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov	Email OROSC backup to: ohs@michigan.gov and cc NordmannA@michigan.gov.

PIHP REPORTING REQUIREMENTS

07/11/2019	SUD – Tobacco/Formal Synar Inspections – To be reported in Youth Access to Tobacco (YAT) Compliance Checks Report	June 1 to 30 Coverage study activities should be conducted between Aug. 29 to Sept. 17, 2018
7/31/2019	Children Referral Report	April 1 to June 30
7/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	April 1 to June 30
08/31/2019	Consumer Satisfaction Survey raw data	Survey conducted in May
09/30/2019	Performance Indicators	April 1 to June 30, 2019 Submit to: QMPMeasures@michigan.gov
10/31/2019	Children Referral Report	July 1 to September 30
10/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	July 1 to September 30
10/31/2019	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30
Applicable in FY19	SUD – Synar Coverage Study Canvassing Forms	Next Synar Coverage Study occurs in 2019
11/30/2019	SUD – Communicable Disease (CD) Provider Information Report (Must be submitted only if PIHP funds CD services)	October 1 to September 30 (e-mail to mdhhs-BDDHA@michigan.gov)
11/30/2019	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2019	Performance Indicators	July 1 to September 30, 2019 Submit to: QMPMeasures@michigan.gov
2/28/2019	Recovery Policy & Practice Annual Reporting Matrice – Table 2	See attachment P4.13.1
Quarterly	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 – September 30 – Due end of month following the last month of the quarter.
Quarterly	Children Referral Report	October 1 – September 30 – Due end of month following the last month of the quarter.
Monthly (Last day of month following month in which exception occurred) Must submit even if no data to report	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30
Monthly (Last day each month)	SUD – Behavioral Health Treatment Episode Data Set (BH-TEDS)	October 1 to September 30 via DEG. Login at: https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly (Last day of month following the month in which the data was uploaded)	SUD - Michigan Prevention Data System (MPDS)	October 1 to September 30 Submit to: mdhhs.sudpds.com)

PIHP REPORTING REQUIREMENTS

Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 Submit via Login at: https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly*	Consumer level* a. Quality Improvement Encounter	October 1 to September 30 See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	Critical Incidents	Submit to PIHP Incident Warehouse at: https://mipihpwarehouse.org/MVC/Documentation
Annually (Same due date as Annual Plan)	b. SUD - Communicable Disease (CD) Provider Information Plan (Must be submitted only if PIHP funds CD services)	October 1 to September 30

*Consumer level data must be submitted-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.

NOTE: To submit via DEG to MDHHS/MIS Operations
Client Admission and Discharge client records must be sent electronically to:
Michigan Department of Health and Human Services
Michigan Department of Technology, Management & Budget
Data Exchange Gateway (DEG)
For admissions: put c:/4823 4823@dchbull
For discharges: put c:/4824 4824@dchbull

1. Send data to MDHHS MIS via DEG (see above)
2. Send data to MDHHS, BHDDA, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDHHS web site at www.michigan.gov/mdhhs/bhdda and click on Reporting Requirements

BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS)

PIHP REPORTING REQUIREMENTS

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 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

For FY19, the PIHPs 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 at: xxxxxxx

***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]

Disability Designation

***Developmental disability** (Individual meets the Mental Health Code Definition of Developmental Disability regardless of whether or not they receive services from the I/DD or MI services arrays) **(DD)**
1 = Yes
2 = No
3 = Not evaluated

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

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

***Date of birth* (DOB)**
Date of Birth - Year, month, and day of birth must be recorded in that order. Report in a string of eight characters, no punctuation: YYYYMMDD using leading zeros for days and

months when the number is less than 10. For example, January 1, 1945 would be reported as 19450101.

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

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

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

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

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff

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

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

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

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

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

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

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

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

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

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

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

Status of Family/Friend Support System (People with developmental disabilities only) **(SUPPSYS) 95% completeness and accuracy required**
Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

1= Care giver status is not at risk
2= Care giver is likely to reduce current level of help provided
3= Care giver is likely to cease providing help altogether
4= Family/friends do not currently provide care
5= Information unavailable
Blank = Missing

. *Support for Accommodating Challenging Behaviors (People with developmental disabilities only)* (BEHAV) 95% completeness and accuracy required
Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging behaviors" include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

1= No challenging behaviors, or no support needed
2= Limited Support, such as support up to once a month
3= Moderate Support, such as support once a week
4= Extensive Support, such as support several times a week
5= Total Support – Intermittent, such as support once or twice a day
6= Total Support – Continuous, such as full-time support
Blank = Missing

. *Presence of a Behavior Plan (People with developmental disabilities only)* (PLAN) 95% accuracy and completeness required
Indicate the presence of a behavior plan during the past 12 months.

1= No Behavior Plan
2= Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
3= Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
Blank = Missing

. *Use of Psychotropic Medications (People with developmental disabilities only)* 95% accuracy and completeness required
Fill in the number of anti-psychotic and other psychotrophic medications the individual is prescribed. See the codebook for further definition of "anti-psychotic" and "other psychotropic" and a list of the most common medications.

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

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

PIHP REPORTING REQUIREMENTS

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: xxxxxx

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	YYYYM MDD	36	43	Yes	Yes	

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER 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 PIHP 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.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837 includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
-
- Every behavioral health encounter record must have a corresponding Behavioral Health

Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

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

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

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

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

The following elements reported on the 837/5010 encounter format will be used by MDHHS Quality Management and Planning Division for its federal and state reporting, the Contracts Management Section and the state's actuary. The items with an ** are required by HIPAA, and when they are absent will result in rejection of a file. Items with an ** must have 100% of values recorded within the acceptable range of values. Failure to meet accuracy standards on these items will result in contract action.
Refer to HIPAA 837 transaction implementation guides for exact location of the elements. Please consult the HIPAA implementation guides, and clarification documents (on MDHHS's web site) for additional elements required of all 837/5010 encounter formats. The Supplemental Instructions contain field formats and specific instructions on how to submit encounter level data.

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

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

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

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

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

**5. *Diagnosis*
Enter the ICD-9 primary diagnosis of the consumer.

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

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

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

**9. *Procedure Code*
Enter procedure code from code list for service/support provided. The code list is located on the MDHHS web site. Do not use procedure codes that are not on the code list.

*10. *Procedure Modifier Code*
Enter modifier as required for Habilitation Supports Waiver services provided to enrollees; for 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 1/1/13)*:
Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial

Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

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

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

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

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

****16. *Billing Provider Name***
Enter the name of the Billing Provider for all encounters. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements). If the Billing Provider is a specialized licensed residential facility also report the LARA license facility number (See Instructions for Reporting Specialized Residential Facility Details at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements).

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

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

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

ENCOUNTER TIMELINESS CALCULATION

Requirements

1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service.
2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below).

Logic

Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month.

The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission.

These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse.

Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve.

The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019.

PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDHHS management of PIHP contracts and rate-setting by the actuary. In the case of a regional entity, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its CMHSP partners. This report includes Medicaid Substance Use Disorder services provided in the service area. The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries, **except** Children's Waiver beneficiaries. Refer to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual for the complete and specific requirements for coverage for the State Plan, Additional services provided under the authority of Section 1915(b)(3) of the Social Security Act, and the Habilitation Supports Waiver. All of the aforementioned Medicaid services and supports provided in the PIHP service area must be reported on this utilization and cost report. Instructions and current templates for completing and submitting the MUNC report may be found on the MDHHS web site at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html. Click on Behavioral Health and Substance Abuse, then Reporting Requirements. This report is due twice a year. One for the first six months of the fiscal year which will be due August 31st of the fiscal year a full year report due on February 28th following the end of the fiscal year. Templates for these reports will be made available at least 60 days prior to the due date.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0 FOR PIHPS

The purposes of the Michigan Mission Based Performance Indicator System (version 1.0) are:

- 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 PIHP contracts that would impact the quality of the service delivery system statewide.
- To the extent possible, facilitate the development and implementation of local quality improvement systems; and

- To link with existing health care planning efforts and to establish a foundation for future quality improvement monitoring within a managed health care system for the consumers of public mental health services in the state of Michigan.

All of the indicators here are measures of PIHP performance. Therefore, performance indicators should be reported by the PIHP for all the Medicaid beneficiaries for whom it is responsible. Medicaid beneficiaries who are not receiving specialty services and supports (1915(b)(c) waivers) but are provided outpatient services through contracts with Medicaid Health Plans, or sub-contracts with entities that contract with Medicaid Health Plans are not covered by the performance indicator requirements.

Due dates for indicators vary and can be found on the table following the list of indicators. Instructions and reporting tables are located in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by 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.

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**

2. The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SUD). **Standard = 95% in 14 days**.

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults, DD children, and Medicaid SUD) **Standard = 95% in 14 days**

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults (MI, DD) and all Medicaid SUD (sub-acute de-tox discharges) **Standard = 95% in seven days**

5. The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SUD)

ADEQUACY/APPROPRIATENESS

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

EFFICIENCY

7. The percent of total expenditures spent on managed care administrative functions for PIHPs.

OUTCOMES

8. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who are in competitive employment.

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who earn state minimum wage or more from employment activities (competitive, self-employment, or sheltered workshop).

10. The percent of children and adults with MI and DD readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.

12. The percent of adults with developmental disabilities served, who live in a private residence alone, or with spouse or non-relative.

13. The percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative.

14. The percent of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and respite.

Note: Indicators #2, 3, 4, and 5 include Medicaid beneficiaries who receive substance use disorder services managed by the PIHP.

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
5. Medicaid penetration*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
6. HSW services*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
7. Admin. Costs*	10/01 to 9/30	1/31							MDHHS
8. Competitive employment*	10/01 to 9/30								MDHHS
9. Minimum wage*	10/01 to 9/30								MDHHS
10. Readmissions	10/01 to 9/30	3/31	1/01 to 3/31	6/30	4-01 to 6-30	9/30	7/01 to 9/30	12/31	PIHPs
11. RR complaints	10/01 to 9/30	12/31							PIHPs
12. & 13. Living arrangements	10/1 to 9/30	N/A							MDHHS
14. Children with DD	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS

*Indicators with * mean MDHHS collects data from encounters, quality improvement or cost reports and calculates performance indicators

STATE LEVEL DATA COLLECTION

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 SUD, 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 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 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"

EVENT NOTIFICATION

The PIHP shall immediately notify MDHHS of the following events:

1. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:
    a. Name of beneficiary
    b. Beneficiary ID number (Medicaid, MiChild)
    c. Consumer I (CONID) if there is no beneficiary ID number
    d. Date, time and place of death (if a licensed foster care facility, include the license #)
    e. Preliminary cause of death
    f. Contact person's name and E-mail address
2. Relocation of a consumer's placement due to licensing suspension or revocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

Except for deaths, notification of the remaining events shall be made telephonically or other forms of communication within five (5) business days to contract management staff members in MDHHS's Behavioral Health and Developmental Disabilities Administration.

NOTIFICATION OF PROVIDER NETWORK CHANGES

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

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS FOR SPECIALTY PRE-PAID INPATIENT HEALTH PLANS

FY 2019

The State requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a quality assessment and performance improvement program (QAPIP) which meets the standards below. These standards are based upon the Guidelines for Internal Quality Assurance Programs as distributed by then Health Care Financing Administration's (HCFA) Medicaid Bureau in its guide to states in July of 1993; the Balanced Budget Act of 1997 (BBA), Public Law 105-33; and 42 Code of Federal Regulations (CFR) 438.358 of 2002. This document also reflects: concepts and standards more appropriate to the population of persons served under Michigan's current 1915(b) specialty services and supports waiver; Michigan state law; and existing requirements, processes and procedures implemented in Michigan.

Michigan Standards

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

II. The QAPIP must be accountable to a Governing Body that is a PIHP Regional Entity. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

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

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

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

   D. The Governing Body submits the written annual report to MDHHS following its review. The report will include a list of the members of the Governing Body.

III. There is a designated senior official responsible for the QAPIP implementation.

IV. There is active participation of providers and consumers in the QAPIP processes.

V. The PIHP measures its performance using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.

   A. PIHP must utilize performance measures established by the department in the areas of access, efficiency and outcome and report data to the state as established

in contract.

B. The PIHP may establish and monitor other performance indicators specific to its own program for the purpose of identifying process improvement projects.

VI. The PIHP utilizes its QAPIP to assure that it achieves minimum performance levels on performance indicators as established by the department and defined in the contract and analyzes the causes of negative statistical outliers when they occur.

VII. The PIHP's QAPIP includes affiliation-wide performance improvement projects that achieve through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction.

A. Performance improvement projects must address clinical and non-clinical aspects of care.

1. Clinical areas would include, but not be limited to, high-volume services, high-risk services, and continuity and coordination of care.

2. Non-clinical areas would include, but not be limited to, appeals, grievances and trends and patterns of substantiated Recipient Rights complaints; and access to, and availability of, services.

B. Project topics should be selected in a manner which takes into account the prevalence of a condition among, or need for a specific service by, the organization's consumers; consumer demographic characteristics and health risks; and the interest of consumers in the aspect of service to be addressed.

C. Performance improvement projects may be directed at state or PIHP-established aspects of care. Future state-directed projects will be selected by MDHHS with consultation from the Quality Improvement Council and will address performance issues identified through the external quality review, the Medicaid site reviews, or the performance indicator system.

D. PIHPs may collaborate with other PIHPs on projects, subject to the approval of the department.

E. The PIHP must engage in at least two projects during the waiver renewal period.

VIII. The QAPIP describes, and the PIHP implements or delegates, the process of the review and follow-up of sentinel events and other critical incidents and events that put people at risk of harm.

A. At a minimum, sentinel events as defined in the department's contract must be reviewed and acted upon as appropriate. The PIHP or its delegate has three business days after a critical incident occurred to determine if it is a sentinel event. If the critical incident is classified as a sentinel event, the PIHP or its delegate has two subsequent business days to commence a root cause analyses of

the event.

B. Persons involved in the review of sentinel events must have the appropriate credentials to review the scope of care. For example, sentinel events that involve client death, or other serious medical conditions, must involve a physician or nurse.

C. All unexpected* deaths of Medicaid beneficiaries, who at the time of their deaths were receiving specialty supports and services, must be reviewed and must include:

1. Screens of individual deaths with standard information (e.g., coroner's report, death certificate)
2. Involvement of medical personnel in the mortality reviews
3. Documentation of the mortality review process, findings, and recommendations
4. Use of mortality information to address quality of care
5. Aggregation of mortality data over time to identify possible trends.

* "Unexpected deaths" include those that resulted from suicide, homicide, an undiagnosed condition, were accidental, or were suspicious for possible abuse or neglect.

D. Following immediate event notification to MDHHS (See Section 6.1 of this contract) the PIHP will submit information on relevant events through the Critical Incident Reporting System described below.

E. Critical Incident Reporting System

The critical incident reporting system collects information on critical incidents that can be linked to specific service recipients. This critical incident reporting system became fully operational and contractually required October 1, 2011 (see Attachment 7.7.1.1).

The Critical Incident Reporting System captures information on five specific reportable events: suicide, non-suicide death, emergency medical treatment due to injury or medication error, hospitalization due to injury or medication error, and arrest of consumer. The population on which these events must be reported differs slightly by type of event.

The QAPIP must describe how the PIHP will analyze at least quarterly the critical incidents, sentinel events, and risk events (see below) to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits.

MDHHS has developed formal procedures for analyzing the event data submitted through this system. This includes criteria and processes for Department follow-up on individual events as well as processes for systemic data aggregation, analysis and follow-up with individual PIHPs.

F. Risk Events Management

The QAPIP has a process for analyzing additional critical incidents that put individuals (in the same population categories as the critical incidents above) at risk of harm. This analysis should be used to determine what action needs to be taken to remediate the problem or situation and to prevent the occurrence of additional events and incidents. MDHHS will request documentation of this process when performing site visits.

These events minimally include:

- Actions taken by individuals who receive services that cause harm to themselves
- Actions taken by individuals who receive services that cause harm to others
- Two or more unscheduled admissions to a medical hospital (not due to planned surgery or the natural course of a chronic illness, such as when an individual has a terminal illness) within a 12-month period

Following immediate event notification to MDHHS (See Section 6.1 of this contract Critical Incidents) the PIHP will submit to MDHHS, within 60 days after the month in which the death occurred, a written report of its review/analysis of the death of every Medicaid beneficiary whose death occurred within one year of the recipient's discharge from a state-operated service.

IX. The QAPIP quarterly reviews analyses of data from the behavior treatment review committee where intrusive or restrictive techniques have been approved for use with beneficiaries and where physical management or 911 calls to law enforcement have (see F above) been used in an emergency behavioral crisis. Only the techniques permitted by the Technical Requirement for Behavior Treatment Plans and that have been approved during person-centered planning by the beneficiary or his/her guardian, may be used with beneficiaries. Data shall include numbers of interventions and length of time the interventions were used per person.

X. The QAPIP includes periodic quantitative (e.g., surveys) and qualitative (e.g., focus groups) assessments of member experiences with its services. These assessments must be representative of the persons served and the services and supports offered.

A. The assessments must address the issues of the quality, availability, and accessibility of care.

B. As a result of the assessments, the organization:

1. Takes specific action on individual cases as appropriate;
2. Identifies and investigates sources of dissatisfaction;
3. Outlines systemic action steps to follow-up on the findings; and
4. Informs practitioners, providers, recipients of service and the governing body of assessment results.

C. The organization evaluates the effects of the above activities.

D. The organization insures the incorporation of consumers receiving long-term supports or services (e.g., persons receiving case management or supports

coordination) into the review and analysis of the information obtained from quantitative and qualitative methods.

XI. The QAPIP describes the process for the adoption, development, implementation and continuous monitoring and evaluation of practice guidelines when there are nationally accepted, or mutually agreed-upon (by MDHHS and the PIHPs) clinical standards, evidence-based practices, practice-based evidence, best practices and promising practices that are relevant to the persons served.

XII. The QAPIP contains written procedures to determine whether physicians and other health care professionals, who are licensed by the state and who are employees of the PIHP or under contract to the PIHP, are qualified to perform their services. The QAPIP also has written procedures to ensure that non-licensed providers of care or support are qualified to perform their jobs. The PIHP must have written policies and procedures for the credentialing process which are in compliance with MDHHS's Credentialing and Re-credentialing Processes, Attachment P.7.1.1, and includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or reappointment of practitioners. These procedures must describe how findings of the QAPIP are incorporated into this re-credentialing process.

The PIHP must also insure, regardless of funding mechanism (e.g., voucher):

1. Staff shall possess the appropriate qualifications as outlined in their job descriptions, including the qualifications for all the following:

    a. Educational background
    b. Relevant work experience
    c. Cultural competence
    d. Certification, registration, and licensure as required by law

2. A program shall train new personnel with regard to their responsibilities, program policy, and operating procedures.

3. A program shall identify staff training needs and provide in-service training, continuing education, and staff development activities.

XIII. The written description of the PIHP's QAPIP must address how it will verify whether services reimbursed by Medicaid were actually furnished to enrollees by affiliates (as applicable), providers and subcontractors.

1.The PIHP must submit to the state for approval its methodology for verification.

2.The PIHP must annually submit its findings from this process and provide any follow up actions that were taken as a result of the findings.

XIV. The organization operates a utilization management program.

A. Written Plan - Written utilization management program description that includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to identify and correct under-utilization as well as over-utilization.

C. Procedures - Prospective (preauthorization), concurrent and retrospective procedures are established and include:
   1. Review decisions are supervised by qualified medical professionals. Decisions to deny or reduce services are made by health care professionals who have the appropriate clinical expertise to treat the conditions.
   2. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate.
   3. The reasons for decisions are clearly documented and available to the member.
   4. There are well-publicized and readily-available appeals mechanisms for both providers and service recipients. Notification of denial is sent to both the beneficiary and the provider. Notification of a denial includes a description of how to file an appeal.
   5. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.
   6. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.
   7. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

XV. The PIHP annually monitors its provider network(s), including any affiliates or sub-contractors to which it has delegated managed care functions, including service and support provision. The PIHP shall review and follow-up on any provider network monitoring of its subcontractors.

XVI. The PIHPs, shall continually evaluate its oversight of "vulnerable" people in order to determine opportunities for improving oversight of their care and their outcomes. MDHHS will continue to work with PIHP to develop uniform methods for targeted monitoring of vulnerable people.

The PIHP shall review and approve plans of correction that result from identified areas of non-compliance and follow up on the implementation of the plans of correction at the appropriate interval. Reports of the annual monitoring and plans of correction shall be subject to MDHHS review.

INCLUSION PRACTICE GUIDELINE

I. SUMMARY

This guideline establishes policy and standards to be incorporated into the design and delivery of all public mental health services. Its purpose is to foster the inclusion and community integration of recipients of mental health service.

II. APPLICATION

a. Psychiatric hospitals operated by the Michigan Department of Health and Human Services (MDHHS).
b. Regional centers for developmental disabilities and community placement agencies operated by MDHHS.
c. Children's psychiatric hospitals operated by MDHHS.
d. Special facilities operated by MDHHS.
e. Prepaid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs) as specified in their contracts with MDHHS.

III. POLICY

It is the policy of the department to support inclusion of all recipients of public mental health services.

No matter where people live or what they do, all community members are entitled to fully exercise and enjoy the human, constitutional and civil rights which collectively are held in common. These rights are not conditional or situational; they are constant throughout our lives. Ideally they are also unaffected if a member receives services or supports from the public mental health system for a day, or over a lifetime. In addition, by virtue of an individual's membership in his or her community, he or she is entitled to fully share in all of the privileges and resources that the community has to offer.

IV. DEFINITIONS

Community: refers to both society in general, and the distinct cities, villages, townships and neighborhoods where people, under a local government structure, come together and establish a common identity, develop shared interests and share resources.

Inclusion: means recognizing and accepting people with mental health needs as valued members of their community.

Integration: means enabling mental health service recipients to become, or continue to be, participants and integral members of their community.