PART II: STATEMENT OF WORK

1.0 SPECIFICATIONS

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

1.1 Targeted Geographical Area for Implementation

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

1.2 Target Population

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

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

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

1.3 Responsibility for Payment of Authorized Services

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

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

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

2.0 SUPPORTS AND SERVICES

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

2.1 Availability of Services

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

3.0 ACCESS ASSURANCE

3.1 Access Standards

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

A. Mental Health
   1. At least 95% of all people receive a pre-admission screening for psychiatric inpatient care for whom the disposition was completed in three hours.

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

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

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

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

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

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

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

REQUIREMENTS FOR DENIAL OF HOSPITALIZATION

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

APPEAL OF DENIAL PROCESS FOR NON-MEDICAID RECIPIENTS

A. Background

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

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

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

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

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

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

3.2 Medical Necessity

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

3.3 Other Access Requirements

3.3.1 Person-Centered Planning

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

3.3.2 Limited English Proficiency

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

3.3.3 Cultural Competence

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

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

3.3.4 Self-Determination Policy and Practice Guideline

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

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

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

3.3.5 Recovery Policy

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

4.0 SPECIAL COVERAGE PROVISIONS

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

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

4.1 Nursing Home Placements

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

4.2 Nursing Home Mental Health Services

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

4.3 Prevention Services

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

4.4 Categorical Funding

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

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

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

4.5 OBRA Pre-Admission Screening and Annual Resident Review

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

4.6 Long Term Care

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

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

4.7 Disaster Behavioral Health CMHSP Responsibilities

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

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

PsySTART triage).

c. According to the time frames recommended for the application of each intervention, provide appropriate disaster behavioral health services, including, but not limited to:
   i. Psychological First Aid
   ii. Crisis intervention/stabilization
   iii. Grief/bereavement counseling
   iv. Critical Incident Stress Management (CISM)
   v. Post-Traumatic Stress Disorder Counseling
   vi. Substance use disorder counseling
   vii. Provide community outreach activities as needed
   viii. Advise local Public Information Officer (PIO) of appropriate disaster behavioral health messaging
   ix. Request additional disaster behavioral health resources according to pre-established emergency management channels

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

4.8 RESERVED

4.9 Pooled Funding Arrangements

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

4.10 Guardian Reimbursement

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

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

5.0 OBSERVANCE OF FEDERAL, STATE AND LOCAL LAWS

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

5.1 Fiscal Soundness of the CMHSP

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

5.2 Suspended Providers

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

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

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

5.3 Public Health Reporting

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

6.0 CMHSP ORGANIZATIONAL STRUCTURE AND ADMINISTRATIVE SERVICES

6.1 Organizational Structure

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

6.2 Administrative Personnel

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

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

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

6.3 Customer Services

6.3.1 Customer Services: General

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

6.3.2 Recipient Rights and Grievance/Appeals

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

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

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

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

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

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

6.3.2.1 CMHSP Local Dispute Resolution Process

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

6.3.2.1B Mediation in Mental Health Dispute Resolution

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

6.3.2.2 Family Support Subsidy Appeals

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

6.3.2.3 Continuing Education Requirements for Recipient Rights Staff

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

6.3.2.3B Recipient Rights Training Standards for CMHSP Staff

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

6.3.2.4 Recipient Rights Appeal Process

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

6.3.3 Marketing

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

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

Marketing materials shall be available to the MDHHS for review of

consistency with these standards.

6.4 Provider Network Services

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

In this regard, the CMHSP agrees to:

A. Maintain a regular means of communicating and providing information on changes in policies and procedures to its providers. This may include guidelines for answering written correspondence to providers, offering provider-dedicated phone lines, and a regular provider newsletter.

B. Have clear written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.

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

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

E. Notify MDHHS within seven (7) days of any changes to the composition of the provider network organizations that negatively affect access to care. CMHSPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network organization and/or composition that the MDHHS determines to negatively affect the CMHSP's ability to meet its service obligations under MCL 330.1206(1) to priority populations (MCL 330.1208) may be grounds for sanctions.

F. Assure that network providers do not segregate the CMHSP's recipients in any way from other people receiving their services.

G. The CMHSP shall assure HIPAA compliant access to information about persons receiving services in their contractual residential settings by individuals who have completed training and are working under the auspices of the Dignified Lifestyles Community Connections program.

6.4.1 Provider Contracts

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

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

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

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

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

In addition, sub-contracts shall:

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

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

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

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

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

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

6.4.2 Provider Credentialing

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

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

6.4.3 Collaboration with Community Agencies

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

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

6.5 Management Information Systems

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

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

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

6.5.1 Uniform Data and Information

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

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

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

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

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

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

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

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

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

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

6.5.2 Encounter Data Reporting

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

6.5.3 Level of Care Utilization System (LOCUS)

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

The CMHSP will:

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

6.5.4 State of Michigan Systems with Confidential Information

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

6.6 Financial Management System

6.6.1 General

The CMHSP shall maintain all pertinent financial and accounting records and evidence pertaining to this contract based on financial and statistical records that can be verified by qualified auditors. The CMHSP will comply with generally accepted accounting principles (GAAP) for governmental units when preparing financial statements. The CMHSP will use the principles and standards of 2 CFR 200 Subpart E Cost Principles for determining all costs reported on the financial status report, except for a) local funds, not obligated to meet local match requirements nor required as reserve against possible obligations or liabilities; b) selected items of allowable cost – agreed upon by the CMHSP and MDHHS – where state law or county regulations differ from federal policy as outlined in 2 CFR 200 Subpart E Cost Principles and requires adherence to different principles or a different methodology for cost allocation, distribution or estimation, c) earned revenue not encumbered to satisfy local match obligations, nor required as an adjustment or credit or distribution to offset or reduce expense items allocated to a federal award or to state general fund allocation; d) other grants or awards where the grantor requires principles and standards other than those described in2 CFR 200 Subpart E Cost Principles. Expenditures of General Fund Formula Funds reported on the financial status report must comply with Sections 240 241 and 242 of the Mental Health Code. Cost settlement of the General Fund Formula Funding to the CMHSP will be based upon costs reported on the financial status report. If a conflict exists between 2 CFR 200 Subpart E Cost Principles and Section 242 of the Mental Health Code regarding expenditures the more restrictive sections of Section 242 of Mental Health Code will prevail.

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

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

6.6.2 Claims Management System

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

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

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

6.6.3.1 Post-payment Review

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

6.6.3.2 Total Payment

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

6.6.3.3 Electronic Billing Capacity

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

6.6.3.4 Third Party Resource Requirements

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

6.6.3.5 Vouchers

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

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

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

6.6.3.6 Payment of State-Delivered Services

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

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

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

6.7 State Lease Expiration

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

6.8 Quality Assessment and Performance Improvement Program Standards

6.8.1 General

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

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

6.8.2 Annual Effectiveness Review

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

6.8.3 Behavior Treatment Plan Review Committee

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

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

6.9 Service and Utilization Management

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

6.9.1 State Managed Services

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

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

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

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

E. MDHHS Community Transition Program - While placed by MDHHS in the MDHHS Community Transition Program (MCTP), SHA maintains responsibility for

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

6.9.2 Individual Service Records

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

6.9.3 Other Service Requirements

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

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

6.9.4 Coordination

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

6.9.5 Jail Diversion

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

6.9.6 Special Ed-to Community Transition

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

6.9.7 CMHSP Trauma Policy

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

accordance with attachment C6.9.7.1 Trauma Policy.

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

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

7.0 CONTRACT FINANCING

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

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

7.1 Local Obligation

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

7.2 Revenue Sources for Local Obligation

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

7.2.1 County Appropriations

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

7.2.2 Other Appropriations and Service Revenues

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

7.2.3 Gifts and Contributions

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

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

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

7.2.4 Special Fund Account

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

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

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

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

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

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

7.2.5 Investment Interest

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

7.2.6 Other Revenues for Mental Health Services

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

7.3 Local Obligations - Requirement Exceptions

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

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

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

B. Services provided to people whose residency is transferred according to the provisions in Section 307 of the Michigan Mental Health Code.

C. Programs for which responsibility is transferred to the CMHSP and the state is responsible for 100% of the cost of the program, consistent with the Michigan Constitution.

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

7.4 MDHHS Funding

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

7.4.1 State Mental Health General Fund Formula Funding

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

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

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

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

7.4.1.1 GF Formula Funds Calculation

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

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

7.4.2 Special and/or Designated Funds: Exclusions

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

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

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

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

7.4.3 Implementation of Current Year Appropriation Act

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

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

7.4.4 The General Fund Distribution Model

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

7.5 Operating Practices

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

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

7.6 Audits

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

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

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

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

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

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

7.7 Financial Planning

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

7.7.1 Savings Carry Forward

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

7.7.1.1 General Fund Carry Forward

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

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

7.7.2 Expenditures to Retire Unfunded Pension Liabilities

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

7.8 Finance Planning, Reporting and Settlement

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

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

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

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

7.9 Legal Expenses

The following legal expenses are ALLOWABLE:

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

8.0 CONTRACT REMEDIES AND SANCTIONS

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

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

E. Initiate contract termination.

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

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

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

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

9.0 RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES

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

9.1 General Provisions

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

9.2 Contract Financing

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

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

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

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

9.3 State Facilities

The MDHHS agrees:

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

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

D. To comply with the IST & NGRI Protocol C 6.9.1.1.

E. To comply with attachment C 6.9.1.2.

9.4 Reviews and Audits

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

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

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

9.4.1 MDHHS Reviews

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

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

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

C. Except as precluded in Section 9.4.1 (B) above, the guideline, protocol and/or instrument to be used to review the CMHSP, or a detailed agenda if no protocol exists, shall be provided to the CMHSP at least 30 days prior to the review.

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

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

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

2. The MDHHS will review the POC, seek clarifying or additional information from the CMHSP as needed, and issue an approval of the POC within 30 days of having required information from the CMHSP. The MDHHS will

take steps to monitor the CMHSPs implementation of the POC as part of performance monitoring.

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

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

9.4.2 MDHHS Audits

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

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

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

C. The MDHHS audits of CMHSPs will generally supplement the independent auditor's Compliance Examination and may include one or more of the following objectives:

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

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

D. The audit report and appeal process is identified in Attachment C 9.3.2.1 and is a part of this contract.

10.0 RESPONSIBILITIES OF THE DEPARTMENT OF ATTORNEY GENERAL

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

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

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

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

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

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

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

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