FEIN# 46-3351818
DUNS# 079148120

Manager and Location Building:
John P. Duvendeck– Lewis Cass Building, 320 S. Walnut
Contract Number#MA180000000755

Amendment No. 2 to the Agreement Between
Michigan Department of Health and Human Services
And

PIHP Detroit Wayne Mental Health Authority
For
The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs

1. **Period of Agreement:**
   This agreement shall commence on October 1, 2018 and continue through September 30, 2019.

2. **Period of Amendment:**
   October 1, 2018 through September 30, 2019.

3. **Program Budget and Agreement Amount:**
   Payment to the PIHP will be based on the total funding available for specialty supports and services as identified in the annual Legislative Appropriation for community mental health services programs for the period of October 1, 2018 through September 30, 2019. The estimated value is contingent upon and subject to enactment of legislative appropriations and availability of funds.

4. **Amendment Purpose:**
   This amendment incorporates changes to boilerplate contract language and related contract attachments.

5. **The Specific Changes are Identified Below:**
   - CMS required changes to various sections of the contract:
     - 18.1 Compliance with Applicable Laws
     - 18.1.14 Compliance with 42 CFR 438 State Responsibilities
     - 18.2 Special Waiver Provisions for MSSSP
     - Section 1557 of PPACA
     - 32.0 FISCAL SOUNDNESS OF THE RISK-BASED PIHP
     - 33.0 PROGRAM INTEGRITY
     - 34.0 PIHP OWNERSHIP AND CONTROL INTERESTS
     - 38.0 SUBCONTRACTING
     - 39.1 Reviews and Audits
     - 39.2 MDHHS Reviews

- 5.6 Indian Health Service/Tribally-Operated Facility or program/Urban Indian Clinic (I/T/U)
- 6.3.2 Information Requirements
- 7.0 PROVIDER NETWORK SERVICES
- 7.4 Integrated Physical and Mental Health Care
- 7.8.2.4 Third Party Resource Requirements
- 7.9.1 External Quality Review
- 7.10.5 Advance Directives
- 8.4.1.7 Medical Loss Ratio Reporting Requirements with an amendment to the calculations component of the boilerplate

- Contract attachments P6.3.1 Customer Service Standards and P6.3.1.1 Grievance and Appeals Technical Requirement
- PII.B.A Withdrawal Management Policy #13
- Section 7.7.6 GAIN I-core (Global Appraisal of Individual Needs)
- Contract attachment P39.0.1 PIHP Compliance Examination Guidelines
- Contract attachment P7.7.1.1 PIHP Reporting Requirements

6. **Original Agreement Conditions**
   It is understood and agreed that all other conditions of the original agreement remain the same.

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

Signature Section:

For the Michigan Department of Health and Human Services

Christine H. Sanches, Director
Bureau of Grants & Purchasing

4.8.19
Date

For the CONTRACTOR:

Cheryl C. Mundas, DO
Name (print)

Board Chairperson
Title (print)

Cheryl C. Mundas, DO
Signature

3/28/19
Date

DETROIT WAYNE MENTAL HEALTH AUTHORITY
BOARD ACTION

Board Action Number: 19-01 ☒ Revised Requisition Number: _____

Presented to Full Board at its Meeting on: March 20, 2019

Name of Provider: Fiscal Year (FY) 2019 Contractual Agreement Between the Michigan Department of Health and Human Services and Prepaid Inpatient Health Plan (PIHP) – Detroit Wayne Mental Health Authority (DWMHA).

Address where services are provided: varies

Presented to ☒ Program Compliance Committee ☐ Finance Committee at its meeting on: March 13, 2019

Presented to SUD Oversight Policy Board on: NA (if applicable)

Proposed Contract Term: October 1, 2018 – September 30, 2019

Amount of Contract: $675,407,887.00

Previous Fiscal Year: $676,758,665.00

☐ New Program ☒ Continuation of Existing Program/Contract ☐ Modification of Existing Program

Projected Number Served: FY18/19 70,000 Persons Served (previous fiscal year): 70,000

Date Contract First Initiated: 10/1/2018

Provider Impaneled: Yes ☐ No ☐

Program Description Summary: Provide brief description of services provided and target population. If propose contract is a modification, state reason and impact of change (positive and/or negative).

DWMHA received amended language from the Michigan Department of Health and Human Services (MDHHS) to the current Prepaid Inpatient Health Plan (PIHP) contract for FY 2019. The amendment incorporates changes to boilerplate contract language and related contract attachments. The amount of the contract is ($675,407,887.00) and the proposed contract term and period of amendment of (October 1, 2018 – September 30, 2019) will remain the same. There were several specific changes that were identified by MDHHS per Amendment No. 2 and they are as follows: 18.1 Compliance with Applicable Laws, 18.1.14 Compliance with 42 CFR 438 State Responsibilities, 18.2 Special Waiver Provisions for MSSSP, Section 1557 of PPACA, 32.0 FISCAL SOUNDNESS OF THE RISK-BASED PIHP, 33.0 PROGRAM INTEGRITY, 34.0 PIHP OWNERSHIP AND CONTROL INTERESTS, 38.0 SUBCONTRACTING, 39.1 Reviews and Audits, 39.2 MDHHS Reviews, 5.6 Indian Health Service/Tribally – Operated Facility or program/Urban Indian Clinic (I/T/U), 6.3.2 Information Requirements, 7.0 PROVIDER NETWORK SERVICES, 7.4 Integrated Physical and Mental Health

Care, 7.8.2.4 Third Party Resource Requirements, 7.9.1 External Quality Review, 7.10.5 Advance Directives, 8.4.1.7 Medical Loss Ratio Reporting Requirements with an amendment to the calculations component of the boilerplate, Contract attachments P6.3.1 Customer Service Standards and P6.3.1.1 Grievance and Appeals Technical Requirement, PII.B.A. Withdrawal Management Policy #13, Section 7.7.6 GAIN I-core (Global Appraisal of Individual Needs), Contract attachment P39.0.1 PIHP Compliance Examination Guidelines, Contract attachment P7.7.1.1 PIHP Reporting Requirements.

Outstanding Quality Issues: Yes ☐ No ☒ if yes, please describe_____

_____

_____

_____

See Board Portal for additional information if checked ☐ *(staff to check all that apply)*

Scope of Service and/or Statement of Work ☐ Program Information ☐ Outcome Data/

Quality Concerns ☐ Procurement Information ☐
Source of Funds: Medicaid, Healthy Michigan Plan and SUD Block Grant
Please specify e.g. (Medicaid, General Fund, Block Grant)

Fee for Service Yes ☐ No ☐

Revenue	FY 18/19	Annualized
Medicaid (including HSW and DHS)	$523,191,266.00	$523,191,266.00
Healthy Michigan Plan	$85,569,758.00	$85,569,758.00
Autism Medicaid	$46,000,000.00	$46,000,000.00
SED Waiver - Medicaid	$550,000.00	$550,000.00
SUD Block Grant	$19,396,863.00	$19,396,863.00
Children's Waiver	$700,000.00	$700,000.00
Total Revenue	$675,407,887.00	$675,407,887.00

Recommendations for contract: ☒ Continue ☐ Modify ☐ Discontinue

Type of contract: ☒ Business ☐ Clinical

Approved for Submittal to Board

Willie E. Brooks, Jr.
President/CEO

Date 3/12/19

Stacie Durant
Chief Financial Officer

Date 3/13/19

ACCOUNT NUMBER: Various 03/03/2019

☑ Budget
☐ Not in Budget

BOARD ACTION TAKEN

The following Action was taken by the Full Board on the 20th day of March, 2019

☑ Approved
☐ Rejected
☐ Modified as follows: _____

☐ Executive Director - Initial here: ____

☐ Tabled as follows: _____

Signature Lillian M. Blackshire
Board Liaison

Date 3/20/2019

Board Action# 19-01

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

MEMORANDUM

DATE: March 6, 2019

TO: PIHP Executive Directors

FROM: John Duvendeck, Director
Program Development, Consultation, and Contracts Division

SUBJECT: Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program Contract for FY2019

Action Required before March 29, 2019

The attached documents pertain to your fiscal year (FY) 2019 contractual agreement between the Michigan Department of Health and Human Services and your Prepaid Inpatient Health Plan. There are **four** attachments: 1.) Memo; 2.) Clean Boilerplate Contract Amendment with Attachments, 3.) Edited Boilerplate Contract Amendment with Attachments, and 4.) A Signature Page.

After reviewing the materials, please print out **one copy of the Signature Page, sign and date signifying acceptance by your agency, and return one scanned copy to the attention of harrisonj10@michigan.gov on or before *March 29, 2019.*** Following the receipt of your submitted Signature Page, we will obtain the necessary State signatures and provide you with a completed scanned copy.

It is important that you and your board review these changes over the course of the next few weeks, and authorize you or your board chair to sign it. I am suggesting this approach as it will help avoid having to call a special last-minute board meeting just to meet the State's processing deadline.

If you have any questions regarding the Amendment, please call me at 517-241-5218.

Thank you in advance for your continuing support and assistance.

Attachments

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

Amendment No. 2 to the Agreement Between
Michigan Department of Health and Human Services
And

PIHP_____
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Signature Section:

For the Michigan Department of Health and Human Services

_____ _____

Christine H. Sanches, Director
Bureau of Grants & Purchasing

Date

For the CONTRACTOR:

_____ _____

Name (print)

Title (print)

_____ _____

Signature

Date

18.1 Compliance with Applicable Laws

The PIHP shall comply with all federal, state and local laws, and require that all network providers and other subcontractors comply with all applicable Federal and State laws and regulations including MCL 15.342 Public officer or employee; prohibited conduct, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1973, and the Rehabilitation Act of 1973, the Americans with Disabilities Act, and Section 1557 of the Patient Protection and Affordable Care Act (ACA). Statutory and regulatory provisions related to Title XXI (The Children's Health Insurance Program) are applicable to Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19 21 services rendered under the MIChild program. The PIHP will also comply with all applicable general administrative requirements such as OMB Circulars covering cost principles, grant/agreement principles, and audits in carrying out the terms of this agreement. For purposes of this Agreement, OMB Circular 2 CFR 200 Subpart E is applicable to PIHPs that are local government entities, and OMB Circular 2 CFR 200 Subpart E is applicable to PIHPs that are non-profit entities.

18.1.14 Compliance with 42 CFR 438 State Responsibilities

The PIHP must provide that its Medicaid enrollees are not held liable for Covered services provided to the enrollee, for which The State does not pay the PIHP or The State, or the PIHP does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

The PIHP will ensure that data received from providers is accurate and complete by, verifying the accuracy and timeliness of reported data, including data from network providers the PIHP is compensating on the basis of capitation payments and by screening the data for completeness, logic, and consistency. The PIHP will make all collected data available to the State and upon request to CMS.

The PIHP will submit enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs. The PIHP will Submit all enrollee encounter data that the State is required to report to CMS under § 438.818.

18.2 Special Waiver Provisions for MSSSP

Michigan's Specialty Services and Supports Waiver Program authorized under 1915(b)(1), (3) and (4) of the Social Security Act is currently approved until currently authorized under approved extension.

The 1915(b) Waiver is concurrent with a five-year 1915(c) waiver, referred to as the Home and Community-Based Habilitation Supports Waiver, serving people with a developmental disability, is currently approved until September 30, 2016. Under these waivers, beneficiaries are entitled to specified medically necessary specialty supports and services from the PIHP.

Section 1557 of PPACA

Patient Protection and Affordable Care Act. This includes section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of section 1903(r)(1)(F) of the Act.

32.0 FISCAL SOUNDNESS OF THE RISK-BASED PIHP

Federal regulations require that the risk-based PIHPs maintain a fiscally solvent operation and MDHHS has the right to evaluate the ability of the PIHP to bear the risk of potential financial losses, or to perform services based on determinations of payable amounts under the contract. MDHHS does not preclude the PIHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. MDHHS requires that the PIHP may only operate a physician incentive plan if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. This contract requires that if the PIHP puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the PIHP must ensure that the physician/physician group has adequate stop-loss protection.

If LTSS are provided under the contract between the MDHHS and the PIHP, the PIHP must establish and maintain a member advisory committee. The member advisory committee will include at least a reasonably representative sample of the LTSS populations, or other individuals representing those enrollees, covered under the contract with the PIHP. If the PIHP is required by MDHHS to provide LTSS in a community-based setting that could be authorized through a section 1915(c) waiver, a section 1915(i) SPA, or a section 1915(k) SPA, the contract specifies that the long term services and supports must be provided in a setting which complies with the 42 CFR 441.301(c)(4) requirements for home and community-based settings.

When the PIHP is providing LTSS, the comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including an assessment of care between care settings. When the PIHP is providing LTSS, the comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including a comparison of services and supports received with those set forth in the enrollee's treatment/service plan. The PIHP is required to implement mechanisms to comprehensively assess each Medicaid enrollee identified as needing LTSS to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the MDHHS or the PIHP as appropriate.

33.0 PROGRAM INTEGRITY

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

The PIHP will provide prompt notification to MDHHS BHDDA when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including, changes in the enrollee's residence and the death of an enrollee.

The PIHPs that make or receive annual payments under the contract of at least $5,000,000, will make provision for written policies for all employees of the entity, and of any contractor or agent of the entity, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

The PIHPs shall require all contracted providers that make or receive at least $5,000,000 in payments under this contract to comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

Reports to MDHHS BHDDA within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. Recoveries of overpayments due to fraud, waste, or abuse shall be reported by the PIHP to MDHHS OIG in accordance with subpart F below.

The PIHP requires and has a mechanism for a network provider to report to the PIHP when it has received an overpayment, to return the overpayment to the PIHP within 60 calendar days after the date on which the overpayment was identified, and to notify the PIHP in writing of the reason for the overpayment.

The MDHHS Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Prepaid Inpatient Health Plan (PIHP) and all entities subcontracted by the PIHP.

A. General

1. The PIHP must have program integrity administrative and management arrangements or procedures, including a mandatory compliance program.
2. The PIHP's compliance program must include the following, as defined in 42 CFR 438.608:
a. Written policies and procedures that describe how the PIHP will comply with federal and State fraud, waste and abuse standards, and well publicized disciplinary standards for failure to comply.
b. The designation of a compliance officer who reports directly to the Chief Executive Officer and the Board of Directors, and a compliance committee, accountable to the senior management or Board of Directors, with effective lines of communication to the PIHP's employees.
c. Effective training and education for the compliance officer, senior management, and the PIHP's employees regarding fraud, waste and abuse, and the federal and State standards and requirements under this contract. While the compliance officer may provide training to PIHP employees, "effective" training for the compliance officer means it cannot be conducted by the compliance officer himself/herself.
d. Provisions for internal monitoring and auditing. Audits must include post payment reviews of paid claims to verify that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.). Acceptable audit methodology examples include:

– Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers
– Beneficiary interviews to confirm services rendered
– Provider self-audit protocols
The frequency and quantity of audits performed should be dependent on the number of fraud, waste and abuse complaints received as well as high risk activities identified through data mining and analysis of paid claims.
e. Provisions for the PIHP's prompt response to detected offenses and for the development of corrective action plans. "Prompt response" is defined as action taken within 15 business days of receipt by the PIHP of the information regarding a potential compliance problem.
g. Dissemination of the contact information (addresses and toll-free telephone numbers) for reporting fraud, waste or abuse to both the PIHP and the MDHHS-OIG. Dissemination of this information shall be made to all PIHP subcontractors and members annually. The PIHP must indicate that reporting of fraud, waste or abuse may be made anonymously.
3. Triannual meetings will be held between MDHHS-OIG and all PIHP Compliance Officers to train and discuss fraud, waste and abuse.

B. Contracted Entities
1. The PIHP shall include program integrity provisions and guidelines in all contracts with subcontracted entities.
2. The PIHP shall provide guidance to the program integrity activities of all its subcontracted entities, to the extent that the subcontracted entity is delegated responsibility by the PIHP. The PIHP-subcontractor contract shall require at least the following of the subcontracted entity:
– designation of a compliance officer;
– submission to the PIHP of quarterly reports detailing program integrity activities;
– assistance and guidance by the PIHP with audits and investigations, upon request of the subcontracted entity;
– provisions for routine internal monitoring;
– proper prompt response to potential offenses and implementation of corrective action plans;
– appropriate and prompt reporting of fraud, waste and abuse to the PIHP;
– implementation of training procedures regarding fraud, waste and abuse for the subcontracted entities' employees at all levels.
3. The PIHP shall provide MDHHS-OIG with documentation to support that these program integrity activities were performed by its subcontractors in its quarterly submission to the MDHHS-OIG.
4. Effective beginning Fiscal Year '19, by November 15th the PIHP shall submit to MDHHS-OIG a list of all entities with whom it and its participant CMHSPs (if applicable) have contracted to perform services for Fiscal Year '19, under this contract. This list shall contain all facility locations where services are provided or business is conducted, all NPI numbers assigned to the entity and what services the entity is contracted to provide. The PIHP is responsible for updates to this information in its quarterly submission (See Section G).

The list of contracted entities noted above that the PIHP submits shall be documentation to the state to demonstrate that it offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area 1) at the time it enters into a contract with MDHHS, and 2) any time there is a significant change (as defined by

the MDHHS) in the PIHP's operations that impacts services. The list of contracted entities shall also be documentation to the MDHHS to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area 1) at the time it enters into a contract with MDHHS, and 2) any time there is a significant change (as defined by the MDHHS) in the PIHP's operations that impacts services.

C. Investigations

1. The PIHP will investigate program integrity complaints/issues until it has determined that a suspicion of fraud exists, at which point the PIHP shall contact MDHHS-OIG and pause any recoupment/recovery/administrative action regarding the issue.
2. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, the Health Insurance Portability and Accountability Act (hereafter "HIPAA"), and the Michigan Mental Health Code, the PIHP will cooperate fully in any investigation by MDHHS-OIG or the Department of Attorney General and any subsequent legal action that may result from such investigation.

D. Reporting Fraud, Waste or Abuse

1. Upon receipt of allegations involving fraud, waste, or abuse regardless of entity (i.e. PIHP, employee, contracted entity, provider, or member), the PIHP shall perform a preliminary investigation. Upon completion of the preliminary investigation, if the PIHP determines a suspicion of fraud exists, the PIHP must promptly refer the matter to MDHHS OIG. These referrals must be made using the PIHP fraud referral template and be shared with MDHHS OIG via secure File Transfer Process (sFTP) using the PIHP's applicable MDHHS OIG sFTP area.
2. The PIHP must report all suspicion of waste or abuse on the Quarterly Submission described in Section G.
3. Questions regarding whether suspicions should be classified as fraud, waste or abuse should be presented to MDHHS-OIG for clarification prior to making the referral.
4. Documents containing protected health information or protected personal information must be submitted in a manner that is compliant with applicable federal and State privacy rules and regulations, including but not limited to HIPAA
5. The MDHHS requires the PIHP or subcontractor, to the extent that the subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the contract between the state and the PIHP, to implement and maintain arrangements or procedures that include provision for the MCP's suspension of payments to a network provider for which the state determines there is a credible allegation of fraud.
6. The MDHHS requires the PIHP or subcontractor, to the extent that the subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the contract between the state and the PIHP, to implement and maintain arrangements or procedures for notification to the state when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the PIHP.

E. Disclosure of Information

1. To the extent consistent with applicable federal and State law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP shall disclose protected

health information to MDHHS-OIG or the Department of Attorney General upon their written request, without first obtaining authorization from the beneficiary to disclose such information.

F. Overpayments

1. If the PIHP identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, the PIHP shall obtain written consent from MDHHS-OIG prior to recovering the overpayment.
2. If the PIHP identifies an overpayment involving waste or abuse prior to identification by MDHHS-OIG, the PIHP shall recover the overpayment and report the overpayment on its quarterly program integrity submission.
3. If MDHHS-OIG identifies an overpayment to a provider prior to the PIHP identifying the overpayment, MDHHS OIG will explore options in collaboration with MDHHS BHDDA, up to and including recovering the overpayment from the PIHP.
4. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

G. Quarterly Submissions

Effective beginning Fiscal Year '19, the PIHP must either (1) utilize MDHHS OIG's case tracking system to log in and track program integrity activities performed, or (2) provide information on program integrity activities performed quarterly using the template provided by the MDHHS-OIG. Program integrity activities include but are not limited to:

– Tips/grievances received
– Data mining and analysis of paid claims, including audits performed based on the results
– Audits performed
– Overpayments collected
– Identification and investigation of fraud, waste and abuse (as these terms are defined in the "Definitions" section of this contract
– Corrective action plans implemented
– Provider dis-enrollments
– Contract terminations

All program integrity activities performed each quarter must be reported to OIG according to the following schedule:

Reporting Period	Due Date
January through March	May 15th
April through June	August 15th
July through September	November 15th
October through December	February 15th

H. MDHHS-OIG Sanctions

When MDHHS-OIG sanctions providers, including for a credible allegation of fraud under 42 CFR § 455.23, the PIHP must, at minimum, apply the same sanction upon receipt of written notification of the sanction from MDHHS OIG to the PIHP. The PIHP may pursue additional measures/remedies independent of the State.

I. MDHHS-OIG Onsite Reviews

1. MDHHS-OIG may conduct onsite reviews of PIHP and/or its contracted entities.
2. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP is required to comply with MDHHS-OIG's requests for documentation and information related to program integrity and compliance.

34.0 PIHP OWNERSHIP AND CONTROL INTERESTS

The PIHP may not be any of the following, all of which are all specifically excluded from this contract:

1. An entity that could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

2. An entity that has a "substantial contractual relationship" either directly or indirectly, with:
    a. An individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act;
    b. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
    c. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in the immediately preceding subsection, 2.b.;
    d. An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act; or
    e. Any individual or entity that would provide those services through an individual or entity described in any of the immediately preceding four subsections, 2.b., c., or d.

    A "substantial contractual relationship" is any contractual relationship that provides for one or more of the following services: (i) the administration, management, or provision of medical services; and/or (ii) the establishment of policies or the provision of operational support, for the administration, management or provision of medical services.

3. An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one any individual or entity that is (or is affiliated, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person or entity that is):

    a. Debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
    b. Excluded from participation in any Federal health care program under section 1128 or 1128A of the Act; or
    c. Any individual or entity that would provide those services through an individual or entity described in any of the immediately preceding two subsections, 3.a. or b.

Additionally, in order to comply with 42 CFR 438.610:

1. The PIHP may not knowingly have a "relationship" of the type described below with any of the following:
    a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549;
    b. An individual or entity who is an "affiliate", as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in the immediately preceding subsection 1.(a).

2. The PIHP will not have a "relationship" of the type described below (each a "prohibited relationship") with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

For purposes of this section, a "relationship" means someone who the PIHP interacts with in any of the following capacities:

1. A director, officer, or partner of the PIHP;
2. A subcontractor of the PIHP;
3. A person with beneficial ownership of five (5) percent or more of the PIHP's equity; or
4. A network provider or person with an employment, consulting or other arrangement for the provision of items and services which are significant and material to the Board's obligations under the PIHP Contract.

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

If the State finds that the PIHP has a "prohibited relationship", as defined above, the State:

1. May continue an existing agreement with the PIHP, unless the Secretary directs otherwise; and
2. May not renew or otherwise extend the duration of an existing agreement with the PIHP unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

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

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

The MDHHS requires the PIHP to provide written disclosure in the case that any of the following is or becomes affiliated with any individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549:

1. Any director, officer, or partner;
2. Any subcontractor;
3. Any person with ownership of 5% or more of the PIHPs equity;
4. A network provider; and/or
5. Any party to an employment, consulting, or other agreement with the PIHP for the provision of contract items or services

The MDHHS requires the PIHP and subcontractors to disclose information on individuals or corporations with an ownership or control interest in the PIHP to the state at the following times:

1. When the PIHP submits a proposal in accordance with the state's procurement process;

2. When the PIHP executes a contract with the state;
3. When the state renews or extends the PIHP contract; and
4. Within 35 days after any change in ownership of the PIHP.

38.0 SUBCONTRACTING

The PIHP may subcontract for the provision of any of the services specified in this contract including contracts for administrative and financial management, and data processing. The PIHP shall be held solely and fully responsible to execute all provisions of this contract, whether or not said provisions are directly pursued by the PIHP, or pursued by the PIHP through a subcontract vendor. The PIHP shall ensure that all subcontract arrangements clearly specify the type of services being purchased. Subcontracts shall ensure that the MDHHS is not a party to the contract and therefore not a party to any employer/employee relationship with the subcontractor of the PIHP. Subcontracts entered into by the PIHP shall address such provisions as the PIHP deems necessary for the development of the service delivery system, and shall include standard terms and conditions as MDHHS may develop.

Subcontracts entered into by the PIHP shall address the following:

1. Duty to treat and accept referrals
2. Prior authorization requirements
3. Access standards and treatment time lines
4. Relationship with other providers
5. Reporting requirements and time frames
6. QA/QI Systems
7. Payment arrangements (including coordination of benefits) and solvency requirements
8. Financing conditions consistent with this contract
9. Anti-delegation clause
10. Compliance with Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency"
11. EPSDT requirements
12. In all contracts with health care professionals, the PIHP must comply with the requirements specified in the "Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans", Attachment P 7.9.1. and require the provider to cooperate with the PIHP's quality improvement and utilization review activities
13. Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy
14. Not prohibit a provider from discussing treatment options with a recipient that may not reflect the PIHP's position or may not be covered by the PIHP
15. Not prohibit a provider from advocating on behalf of the recipient in any grievance or utilization review process, or individual authorization process to obtain necessary health care services

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

All subcontracts entered into by the PIHP must be in writing and, if involving Medicaid funds fulfill the requirements of 42 CFR 434.6 and 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract. All employment agreements, provider contracts, or other arrangements, by which the PIHP intends to deliver services required under this contract, shall be subject to review by the MDHHS at its discretion.

Subcontracts that contain provisions for a financial incentive, bonus, withhold, or sanctions, (including sub-capitations) must include provisions that protect individuals from practices that result in the withholding of services that would otherwise be provided according to medical necessity criteria and best practice standards, consistent with 42 CFR 422.208. The PIHP shall provide a copy of specific contract language used for incentive, bonus, withhold or sanction provisions (including sub-capitations) to MDHHS at least 30 days prior to when the contract is issued to the provider. MDHHS reserves the right to disallow or require amendment of such provisions if the provisions appear to jeopardize individuals' access to services. MDHHS shall provide notice of approval or disapproval of submitted contract language within 25 days of receipt or else the language shall be deemed approved by MDHHS. The PIHP must provide information on its Provider Incentive Plan (PIP) to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a PIP). The PIHP must provide information regarding any provider incentive plans to CMS and to any Medicaid beneficiary, as required by 42 CFR 422.210

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

Contracts between the PIHP and subcontractors must require the subcontractor to:

1. Comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions;
2. Make available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees;
3. Agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit that occurs during such 10 year period, whichever is later; and
4. Agree that if the state, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time

39.1 Reviews and Audits

The MDHHS and federal agencies may conduct reviews and audits of the PIHP regarding performance under this contract. The MDHHS shall make good faith efforts to coordinate reviews and audits to minimize duplication of effort by the PIHP and independent auditors conducting audits and compliance examinations.

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

The MDHHS requires that the state, CMS, the OIG, the Comptroller General, and their designees have the right to:

1. Inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time;
2. Audit records or documents of the PIHP for 10 years from the final date of the contract period or from the date of completion of any audit that occurs within such 10 year period, whichever is later;
3. Audit records or documents of the PIHP's subcontractors for 10 years from the final date of the contract period or from the date of completion of any audit that occurs within such 10 year period, whichever is later

The MDHHS requires that the Secretary, the Department of Health and Human Services (DHHS), and the state (or any person or organization designated by either) have the right to audit and inspect any books or records of the PIHP or its subcontractors pertaining to:

- The ability of the PIHP to bear the risk of financial losses.
- Services performed or payable amounts under the contract.

The MDHHS requires that the PIHP and the PIHP's subcontractors retain, as applicable, enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

Subject to exceptions above MDHHS 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.

39.2 MDHHS Reviews

1. 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.
2. The MDHHS will schedule onsite 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.

3. Except as precluded in 34.2 (2) above, the guideline, protocol and/or instrument to be used to review the PIHP, or a detailed agenda if no protocol exists, shall be provided to the PIHP at least 30 days prior to the review.
4. At the conclusion of the review, the MDHHS shall conduct an exit interview with the PIHP. The purpose of the exit interview is to allow the MDHHS to present the preliminary findings and recommendations.
5. Following the exit review, the MDHHS shall generate a report within 45 days identifying the findings and recommendations that require a response by the PIHP.
    a. The PIHP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The PIHP may also present new information to the MDHHS that demonstrates it was in compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the exit interview and the POC). When access or care to individuals is a serious issue, the PIHP may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified in (4) above. If, during an MDHHS on-site visit, the site review team member identified an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in seven calendar days.
    b. The MDHHS will review the POC, seek clarifying or additional information from the PIHP as needed, and issue an approval of the POC within 30 days of having required information from the PIHP. The MDHHS will take steps to monitor the PIHP's implementation of the POC as part of performance monitoring.
    c. 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.
6. MDHHS follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDHHS.

5.6 Indian Health Service/Tribally-Operated Facility or program/Urban Indian Clinic (I/T/U)

PIHPs are required to pay any Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic (I/T/U), or I/T/U contractor, whether participating in the PIHP provider network or not, for PIHP authorized medically necessary covered Medicaid managed care services provided to Medicaid beneficiary/Indian enrollees who are eligible to receive services from the I/T/U provider either (1) at a rate negotiated between the PIHP and the

I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

IHCPs which are enrolled in Medicaid as Federally Qualified Health Centers (FQHC) but are not participating providers of the PIHP must be paid an amount equal to the amount the PIHP would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the PIHP pays and what the IHCP FQHC would have received under FFS.

When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the PIHP, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.

The PIHP must permit an out-of-network IHCP to refer an Indian enrollee to a network provider.

When the amount the IHCP receives from an PIHP is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the state must make a supplemental payment to the IHCP to make up the difference between the amount the MCP pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

6.3.2 Information Requirements

A. Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services, including but not limited to provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, shall meet the following standards:

1. All such materials shall be written at the 4th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 4th grade level criteria).
2. The provider directory must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on the PIHP's website, in a machine readable file and format. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information.
3. All materials shall be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in the PIHPs Region as identified by the State . Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002 Federal Register Vol. 65, August 16, 2002). All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act

(ADA), at no cost to the beneficiary. Beneficiaries shall be informed of how to access the alternative formats.

4. If the PIHP provides any required information electronically:
    a. It must be in a form that is readily accessible;
    b. It must be on the PIHP's Web site in a location that is prominent and readily accessible;
    c. It must be in an electronic form which can be electronically retained and printed;
    d. The information must be consistent with the content and language requirements of this 42 CFR 438.10; and
    e. The PIHP must inform the customer that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

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

6. For consistency in the information provided to enrollees, the PIHP must use the State developed model enrollee handbooks and enrollee notices, and State developed definitions for managed care terminology, including appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, physician services, prescription drug coverage, prescription drugs, primary care provider, rehabilitation services and devices, skilled nursing care, specialist, co-payment excluded services, health insurance, medically necessary, network, non-participating, plan preauthorization, participating provider, premium, provider and urgent care, as defined in the PIHP contract and/or Medicaid provider manual.

7.0 PROVIDER NETWORK SERVICES

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

In this regard, the PIHP agrees to:

1. 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.
2. Have clearly written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.
3. Provide a copy of the PIHP's prior authorization policies to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to prior authorization policies as changes are made.

4. Provide a copy of the PIHP's grievance, appeal and fair hearing procedures and timeframes to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to those procedures or timeframes.
5. Provide to MDHHS in the format specified by MDHHS, provider agency information profiles that contain a complete listing and description of the provider network available to recipients in the service area.
6. Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility.
7. Assure that network providers do not segregate PIHP individuals in any way from other people receiving their services.

In addition the PIHP agrees upon request from MDHHS either through an RFP or other means to:

1 Provide documentation on which the state bases its certification that the MCP complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.
2 Submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the state or Secretary.

7.4 Integrated Physical and Mental Health Care

The PIHP will initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid beneficiaries. These efforts will focus on persons that have a chronic condition such as a serious and persistent mental health illness, co-occurring substance use disorder or a developmental disability and have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports.

- The PIHP will implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the consumer's MHP as defined in 7.3.
- As authorized by the consumer, the PIHP will include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.
- The PIHP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.

The PIHP will make it's best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees. The PIHP will make subsequent attempts to conduct an initial screening of each enrollee's needs if the initial attempt to contact the enrollee is unsuccessful. Since the PIHPs are not an enrollment model, screening once an individual presents for services would meet this agreement.

7.8.2.4 Third Party Resource Requirements

Medicaid is a payer of last resort. PIHPs and their providers/contractors are required to identify and seek recovery from all other liable third parties in order to make themselves whole. Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a recipient's covered benefit. The PIHP shall collect any payments available from other health insurers including Medicare and private health insurance for services provided to its individuals in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, and the Michigan Mental Health Code and Public Health Code as applicable. The PIHP 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 as applicable.

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

If the MDHHS enters into a Coordination of Benefits Agreement (CBA) with Medicare for FFS, and if the PIHP contract includes responsibility for coordination of benefits for individuals dually eligible for Medicaid and Medicare, the MDHHS requires the PIHP to enter into a CBA with Medicare and participate in the automated claims crossover process.

7.9.1 External Quality Review

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

If the PIHP has received accreditation by a private independent accrediting entity it must authorize the private independent accrediting entity to provide MDHHS a copy of its most recent accreditation review, including its accreditation status, survey type, and level (as applicable). When the PIHP has received accreditation by a private independent accrediting entity it must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, recommended actions or improvements, corrective action plans, and summaries of findings. If the PIHP has received accreditation by a private independent accrediting entity it must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, including the expiration date of the accreditation.

7.10.5 Advance Directives

In accordance with 42 CFR 422.128 and 42 CFR 438.6, the PIHP shall maintain written policies and procedures for advance directives. The PIHP shall provide adult beneficiaries with written information on advance directive policies and a description of applicable state law and their rights under applicable laws. This information must be continuously updated to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective. The PIHP must inform individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Customer Services. This must include prohibiting the PIHP from conditioning the provision of care based on whether or not the individual has executed an advance directive. The PIHP will educate staff concerning the PIHP policies and procedures on advance directives.

8.4.1.7 Medical Loss Ratio Reporting Requirements

The PIHP must submit a report to MDHHS that includes at least the following information for each MLR reporting year:

- Total incurred claims.
- Expenditures on quality improving activities.
- Expenditures related to activities compliant with §438.608(a)(1) through (5), (7), (8) and (b).
- Non-claims costs.
- Premium revenue.
- Taxes, licensing and regulatory fees.
- Methodology(ies) for allocation of expenditures.
- Any credibility adjustment applied.
- The calculated MLR.
- Any remittance owed to the State, if applicable.
- A comparison of the information reported in this paragraph with the audited financial report required under §438.3(m).
- A description of the aggregation method used under paragraph (i) of this section.
- The number of member months.

The formula for calculation of the MLR is defined below.

Incurred Claims +/- ISF created/used– HRA – Taxes + Healthcare Quality Improvement + Fraud Reduction

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Current Year Premium Revenue +/- Savings used/created – HRA expense – Tax expense (HICA/Use)

The MLR should be completed in accordance with 42 CFR § 438.8, the additional calculation components outlined below are intended to provide clarity regarding state specific items.

Calculation Components

Incurred Claims. Include 1) direct claims paid to providers including all costs of CMHSP capitated contracts (excluding PIHP delegated Managed care administrative costs), 2) Unpaid claims for dates of service falling within the reporting year (accounts payable), 3) Estimate of claims incurred but not reported based on past experience, 4) payments to the ISF, and 5) incentives/bonuses paid to providers. Reduce claims by 6) Overpayment recoveries from providers, 7) prescription drug rebates, 8) claims recovered through fraud reduction efforts up to the amount of fraud reduction expense included in the numerator, 9) Hospital Rate Adjuster payments and 10) contribution to ISF fund.

The following items must be excluded from incurred claims, consistent with the Medical loss ratio (MLR) standards outlined in 42 CFR § 438.8.

(A) Non-claims costs, as defined in paragraph (b) of this section, which include the following:

(1) Amounts paid to third party vendors for secondary network savings.

(2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

(3) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

(4) Fines and penalties assessed by regulatory authorities.

(B) Amounts paid to the State as remittance under paragraph (j) of this section.

(C) Amounts paid to network providers under to § 438.6(d).

Healthcare Quality Improvement. Include all Quality Improvement functions, plus include Information Services costs if specifically related to the ability to accept, track, report, and analyze Quality Improvement data. Time and effort for individuals participating in External Quality Reviews (not already captured as Quality Improvement expenses) may be included.

Fraud Reduction. Costs for activities designed to detect and/or prevent payment for fraudulent requests for reimbursement. (i.e. Medicaid Verification Process, Clinical Chart Reviews, etc.)

Premium Revenue. Includes all capitation payments received from MDHHS plus additional cost settlement revenue less any lapse.

Savings. The use of Savings should increase premium revenue while the creation of Savings should reduce premium revenue.

The MLR reporting replaces the PIHP obligation to complete an administrative cost report. The MLR report will provide sufficient administrative cost reporting to meet the actuarial needs. In addition to information required above this will include non-benefit costs in the following categories:

- Administrative costs.
- Taxes, licensing and regulatory fees, and other assessments and fees.
- Contribution to reserves, risk margin, and cost of capital.
- Other material non-benefit costs.

MLR must be equal to or higher than 85 percent and the MLR must be calculated and reported for each MLR reporting year by the PIHP. Each MCP expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be

pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities. The credibility adjustment is added to the reported MLR calculation before calculating any remittances. The PIHP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If PIHP experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. The PIHP will aggregate data for all Medicaid eligibility groups covered under the contract with the state unless the state requires separate reporting and a separate MLR calculation for specific populations. If required by the state, the PIHP must provide a remittance for a MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher. The PIHP must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the PIHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. In any instance where MDHHS makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the MDHHS, the PIHP must re-calculate the MLR for all MLR reporting years affected by the change. In any instance where a MDHHS makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the MDHHS, the PIHP must submit a new MLR report meeting the applicable requirements. The PIHP must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

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- The PIHP shall provide MLR reports to the MDHHS as specified in this contract, and on forms and formats specified by the MDHHS. Forms and instructions are posted to the MDHHS website at: http://www.michigan.gov./mdhhs/0,1607,7-132-2941 38765---,00.html (See Finance Planning, Reporting and Settlement section of Attachment P 7.7.1.1)
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PIHP CUSTOMER SERVICES STANDARDS
Revised: October, 2018

Preamble

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

Functions

a. Welcome and orient individuals to services and benefits available, and the provider network.
b. Provide information about how to access behavioral health, primary health, and other community services.
c. Provide information about how to access the various rights processes.
d. Help individuals with problems and inquiries regarding benefits.
e. Assist people with and oversee local complaint and grievance processes.
f. Track and report patterns of problem areas for the organization.

Standards

1. There shall be a designated unit called "Customer Services."

2. There shall be at the PIHP a minimum of one FTE (full time equivalent) performing the customer services functions whether within the customer service unit or elsewhere within the PIHP. If the function is delegated, affiliate CMHSPs, and network providers, as applicable, shall have additional FTEs (or fractions thereof) as appropriate to sufficiently meet the needs of the people in the service area.

3. There shall be a designated toll-free customer services telephone line with access to alternative telephonic communication methods (such as Relays, TTY, etc). The customer services numbers shall be displayed in agency brochures and public information material.

4. Telephone calls to the customer services unit shall be answered by a live voice during business hours. Telephone menus are not acceptable. A variety of alternatives may be employed to triage high volumes of calls as long as there is response to each call within one business day.

5. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized. **It is expected that the customer services/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.**

6. The customer handbook shall contain the state-required topics and the PIHP will use the state developed notice forms. (See P.6.3.1.1.A)

7. The Medicaid coverage name and the state's description of each service shall be printed in the customer handbook.

8. The customer handbook shall contain a date of publication and revision(s).

9. The PIHP or delegate entity must provide each customer a customer handbook within a reasonable time after receiving notice of the beneficiary's enrollment. This may be provided by:
   a. mailing a printed copy to the customer's mailing address,
   b. emailed after obtaining the customer's agreement to receive information by email,
   c. If the PIHP posts the information on the website and advises the customer in paper or electronic form that the information is available on the internet provided that persons with disabilities who cannot access the information online are provided auxiliary aids and services upon request at no cost, or
   d. the information is provided by any other method that can reasonably be expected to result in the customer receiving the information.

10. Information about how to contact the Medicaid Health Plans or Medicaid fee-for- service programs in the PIHP service area, including plan or program name, locations, and telephone numbers, shall be provided in the handbook.

11. The PIHP or delegate unit shall maintain a current listings of all providers, practitioners, organizations and any group affiliation with whom the PIHP has contracts, street address(es), telephone number(s), website URL (if appropriate), the services they provide, cultural and linguistic capabilities (if they have completed cultural competency training), any non-English languages they speak (including American Sign Language), any specialty for which they are known, whether the provider's office/facility has accommodations for people with physical disabilities, and whether they are accepting new patients. This list must include independent PCP facilitators. The PIHP must make this available in paper form upon request and electronic form such as the PIHP, CMHSP, or network provider's website as applicable. Beneficiaries shall be given this list annually unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer services line is acceptable.

12. The provider directory must be made available in paper form upon request and electronic form. The provider directory must also be made available in a prominent, readily accessible location on the PIHP's website in a machine readable file and format.

13. The paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information.

14. If the PIHP provides any required information electronically:

    a. It must be in a form that is readily accessible:

    b. It must be on the PIHP's Web site in a location that is prominent and readily accessible:

c. It must be in an electronic form which can be electronically retained and printed;

d. The PIHP must inform the customer that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

15. Customer services unit shall have access to information about the PIHP including each CMHSP affiliate annual report, current organizational chart, CMHSP board member list, meeting schedule and minutes. Customer services will provide this information in a timely manner to individuals upon their requests.

16. Upon request, the customer services unit shall assist beneficiaries with filing grievances and appeals, accessing local dispute resolution processes, and coordinate as appropriate with Fair Hearing Officers and the local Office of Recipient Rights.

17. Customer services staff shall be trained to welcome people to the public behavioral health system and to possess current working knowledge, or know where in the organization detailed information can be obtained in at least the following:

    a. *The populations served (serious mental illness, serious emotional disturbance, developmental disability and substance use disorder) and eligibility criteria for various benefits plans (e.g., Medicaid, Healthy Michigan Plan, MIChild)
    b. *Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services
    c. Person-centered planning
    d. Self-determination
    e. Recovery & Resiliency
    f. Peer Specialists
    g. *Grievance and appeals, Fair Hearings, local dispute resolution processes, and Recipient Rights
    h. Limited English Proficiency and cultural competency
    i. *Information and referral about Medicaid-covered services within the PIHP as well as outside to Medicaid Health Plans, Fee-for-Services practitioners, and Department of Human Services
    j. The organization of the Public Behavioral Health System
    k. Balanced Budget Act relative to the customer services functions and beneficiary rights and protections
    l. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies)
    m. Public Health Code (for substance abuse treatment recipients if not delegated to the PIHP)

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

PIHP CUSTOMER SERVICES HANDBOOK
REQUIRED STANDARD TOPICS

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

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

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

*Must use boilerplate language in templates (attached)

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

Other Required Topics (not necessarily in this order)
Access process
Access to out-of-network services

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

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

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

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

Contact the PHIP and MDHHS-OIG at (addresses and toll-free telephone numbers) for reporting fraud, waste or abuse to both the PIHP and the MDHHS-OIG. The reporting of fraud, waste or abuse may be made anonymously.

Template #1: Confidentiality and Family Access to Information

You have the right to have information about your behavioral health treatment kept private. You also have the right to look at your own clinical records or to request and receive a copy of your records. You have the right to ask us to amend or correct your clinical record if there is something with which you do not agree. Please remember, though, your clinical records can only changed as allowed by applicable law. Generally, information about you can only be given to others with your permission. However, there are times when your information is shared in order to coordinate your treatment or when it is required by law.

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

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

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

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

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

Template #2: Coordination of Care

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

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

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

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

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

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

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

Post-Stabilization Services

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

Template #4: Glossary or Definition of Terms

GLOSSARY

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

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

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

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

Appeal: A review of an adverse benefit determination.

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

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

CMHSP: An acronym for Community Mental Health Services Program. There are 46

CMHSPs in Michigan that provide services in their local areas to people with mental illness and developmental disabilities. May also be referred to as CMH.

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

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

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

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

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

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

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

an authorization decision.

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

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

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

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

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

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

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

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

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

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

Hospital Outpatient Care: Is any type of care performed at a hospital when it is

not expected there will be an overnight hospital stay.

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

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

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

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

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

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

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

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

Participating Provider: Is the general term used for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide health care services; medical equipment; mental health, substance use disorder, intellectual/developmental disability, and long term supports and services. They are licensed or certified to provide health care services. They agree to work with the health plan, accept payment and not charge enrollees an extra amount. Participating providers are also called network providers.

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

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

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

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

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

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

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

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

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

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

Rehabilitation Services and Devices: Health care services that help a person keep,

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

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

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

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

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

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

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

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

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

alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

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

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

Template #5: Grievance and Appeals Processes

Grievances

You have the right to say that you are unhappy with your services or supports or the staff who provide them, by filing a "grievance." You can file a grievance *any time* by calling, visiting, or writing to the [Customer Services Office.] Assistance is available in the filing process by contacting_____. In most cases, your grievance will be resolved within 90-calendar days from the date the PIHP receives your grievance. You will be given detailed information about grievance and appeal processes when you first start services and then again annually. You may ask for this information at any time by contacting the [Customer Services Office]. *

Appeals

You will be given notice when a decision is made that denies your request for services or reduces, suspends or terminates the services you already receive. This notice is called an "Adverse Benefit Determination". You have the right to file an "appeal" when you do not agree with such a decision. If you would like to ask for an appeal, you will have to do so within 60-calendar days from the date on the Adverse Benefit Determination.

You may ask for a "Local Appeal" by contacting_____at____.

You will have the chance to provide information in support of your appeal, and to have someone speak for you regarding the appeal if you would like.

In most cases, your appeal will be completed in 30 calendar days or less. If you request and meet the requirements for an "expedited appeal" (fast appeal), your appeal will be decided within 72-hours after we receive your request. In all cases, the PIHP may extend the time for resolving your appeal by 14 calendar days if you request an extension, or if the PIHP can show that additional information is needed and that the delay is in your best interest.

You may ask for assistance from [Customer Services] to file an appeal.

State Fair Hearing

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

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

Benefit continuation

If you are receiving a Michigan Medicaid service that is reduced, terminated or suspended before your current service authorization, and you file your appeal within 10 calendar days (as instructed on the Notice of Adverse Benefit Determination), you may continue to receive your same level of services while your internal appeal is pending. You will need to state in your appeal request that you are asking for your service(s) to continue.

If your benefits are continued and your appeal is denied, you will also have the right to ask for your benefits to continue while a State Fair Hearing is pending if you ask for one within 10 calendar days. You will need to state in your State Fair Hearing request that you are asking for your service(s) to continue.

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

NOTE: If your benefits are continued because you used this process, you may be required to repay the cost of any services that you received while your appeal was pending if the final resolution upholds the denial of your request for coverage or payment of a service. State policy will determine if you will be required to repay the cost of any continued benefits.

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

Template #6: Language Assistance and Accommodations Language Assistance

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

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

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

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

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

Accessibility and Accommodations

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

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

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

Template #7: Payment for Services

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

Some members will be responsible for "Cost sharing". This refers to money that a member has to pay when services or drugs are received. You might also hear terms like "deductible, spend-down, copayment, or coinsurance," which are all forms of "cost sharing". Your Medicaid benefit level will determine if you will have to pay any cost-sharing responsibilities. If you are a Medicaid beneficiary with a deductible ("spend-down"), as determined by the Michigan Department of Health and Human Services (MDHHS) you may be responsible for the cost of a portion of your services.

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

If Medicare is your primary payer, the PIHP will cover all Medicare cost-sharing consistent with coordination of benefit rules.

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

Template #8: Person-Centered Planning

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

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

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

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

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

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

Topics Covered during Person-Centered Planning

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

Psychiatric Advance Directive

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

want when you cannot speak for yourself.

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

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

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

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

Template #9: Recipient Rights

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

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

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

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

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

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

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

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

Template #10: Recovery & Resiliency

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

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

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

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

Template #11: Service Array

MEDICAID SPECIALTY SUPPORTS AND SERVICES DESCRIPTIONS

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

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

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

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

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

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

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

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

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

***Assistive Technology** includes adaptive devices and supplies that are not covered

under the Medicaid Health Plan or by other community resources. These devices help individuals to better take care of themselves, or to better interact in the places where they live, work, and play.

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

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

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

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

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

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

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

Early Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under the age of 21 years, as specified in Section 1905(a)(4)(B) of the Social Security Act (the Act) and defined in 42 U.S.C. § 1396d(r)(5) and 42 CFR 441.50 or its successive regulation.

The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

Health plans are required to comply with all EPSDT requirements for their Medicaid enrollees under the age of 21 years. EPSDT entitles Medicaid and Children's Health

Insurance Program (CHIP) enrollees under the age of 21 years, to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions.

This requirement results in a comprehensive health benefit for children under age 21 enrolled in Medicaid In addition to the covered services listed above, Medicaid must provide any other medical or remedial care, even if the agency does not otherwise provide for these services or provides for them in a lesser amount, duration, or scope (42 CFR 441.57).

While transportation to EPSDT corrective or ameliorative specialty services is not a covered service under this waiver, the PIHP must assist beneficiaries in obtaining necessary transportation either through the Michigan Department of Health and Human Services or through the beneficiary's Medicaid health plan.

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

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

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

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

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

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

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

Intensive Crisis Stabilization is another short-term alternative to inpatient hospitalization.

Intensive crisis stabilization services are structured treatment and support activities provided by a behavioral health crisis team in the person's home or in another community setting.

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

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

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

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

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

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

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

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

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

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

Prevention Service Models (such as Infant Mental Health, School Success, etc.) use

both individual and group interventions designed to reduce the likelihood that individuals will need treatment from the public behavioral health system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Services for Persons with Substance Use Disorders

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

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

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

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

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

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

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

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

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

[Name and phone number of the local MDHHS Human Services office]

Medicaid Health Plan Services

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

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

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

[List of health plans and contact numbers]

Template #12: Service Authorization

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

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

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

Template #13: Tag Lines

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Syriac: ܙܘܗܪܐ ܬܘܩܦܬܐ ܥܠ ܗܠܝܢ ܕܡܬܚܬܐ ܒܐܡܪܝܟܐ ܡܫܠܡܐ، ܐܢܝ ܠܫܢܐ ܡܠܝܢ، ܘܐܘܪܚܐ ܬܐܡܪ، ܐܘ ܒܛܘܪܐ ܐܪܟܐ ܒܟܠܗ ܡܬܝܬܝܢܐ ܐܘ ܒܠܥܒܝܢ ܒܠܒܕ ܠܡܫܟܢܐ ܢܛܪܐ. ܐܡܝܬ ܠܝ

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

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

Non-Discrimination and Accessibility

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

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

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

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

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

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

Template #14: FRAUD, WASTE AND ABUSE

Fraud, waste and abuse uses up valuable Michigan Medicaid funds needed to help children and adults access health care. Everyone can take responsibility by reporting fraud and abuse. Together we can make sure taxpayer money is used for people who really need help.

Examples of Medicaid Fraud

- Billing for medical services not actually performed
- Providing unnecessary services
- Billing for more expensive services
- Billing for services separately that should legitimately be one billing
- Billing more than once for the same medical service
- Dispensing generic drugs but billing for brand-name drugs
- Giving or accepting something of value (cash, gifts, services) in return for medical services, (i. e., kickbacks)
- Falsifying cost reports

Or When Someone:

- Lies about their eligibility
- Lies about their medical condition
- Forges prescriptions
- Sells their prescription drugs to others
- Loans their Medicaid card to others

Or When a Health Care Provider Falsely Charges For:

- Missed appointments
- Unnecessary medical tests
- Telephoned services

If you think someone is committing fraud, waste or abuse, you may report it to Corporate Compliance. You may email concerns to [EMAIL], or report them anonymously on the PIHP website – [INSTRUCTIONS FOR USING THE WEBSITE].

Your report will be confidential, and you may not be retaliated against.

You may also report concerns about fraud, waste and abuse directly to Michigan's Office of Inspector General (OIG):

Online: www.michigan.gov/fraud

Call: 855-MI-FRAUD (643-7283) (voicemail available for after hours)

Send a Letter: Office of Inspector General
PO Box 30062
Lansing, MI 48909

When you make a compliant, make sure to include as much information as you can, including details about what happened, who was involved (including their address and phone number), Medicaid identification number, date of birth (for beneficiaries), and any other identifying information you have.

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

OCT. 2017

TABLE OF CONTENTS

I. PURPOSE AND BACKGROUND

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

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

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

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

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

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

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

II. DEFINITIONS

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

Adverse Benefit Determination: A decision that adversely impacts a Medicaid

Enrollee's claim for services due to: *(42 CFR 438.400)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

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

The Grievance and Appeal System must provide Enrollees:

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

IV. NOTICE OF ADVERSE BENEFIT DETERMINATION

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

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

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "...manner and format that may be easily understood and

is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency);

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

3. Description of Adverse Benefit Determination;

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

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

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

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

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

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

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

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

1. Adequate Notice of Adverse Benefit Determination:

   a. For a denial of payment for services requested (not currently provided), notice must be provided to the Enrollee at the time of the

action affecting the claim. *42 CFR 438.404(c)(2).*

b. For a Service Authorization decision that denies or limits services notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision. *42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3)&(6).*

c. For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. *42 CFR 438.404(c)(5).*

- NOTE, however, that the PIHP may be able to extend the standard (14 calendar day) or expedited (72-hour) Service Authorization timeframes for up to an additional 14 calendar days if either the Enrollee requests the extension, or if the PIHP can show that there is a need for additional information and that the extension is in the Enrollee's best interest *(42 CFR 438.210(d)(1)(ii)).* If the PIHP extends the time not at the request of the Enrollee, the PIHP must: (i) make reasonable efforts to give the Enrollee prompt oral notice of the delay; (ii) within 2 calendar days, provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4).*

2. Advance Notice of Adverse Benefit Determination:

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

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

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

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

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

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

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

v. The PIHP establishes that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

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

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

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

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

C. Required Recipients of Notice of Adverse Benefit Determination:

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

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

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

constitutes an adverse benefit determination, and requires a written notice of action.

V. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

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

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

2. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination). *42 CFR 438.420(a)*; and

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

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

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

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

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

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

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

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

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

VI. PIHP APPEAL PROCESS

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

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

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

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

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

B. PIHP Responsibilities when Enrollee Requests an Appeal:

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

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

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

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

   a. Were not involved in any previous level of review or decision-

making, nor a subordinate of any such individual;

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

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

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

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

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

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

C. Appeal Resolution Timing and Notice Requirements:

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

2. Expedited Appeal Resolution (timing):

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Appeal Resolution Notice Format:

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

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

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

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

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

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

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

   b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:
      i. Right to request a state fair hearing, and how to do so;
      ii. Right to request to receive benefits while the state fair hearing is pending. and how to make the request: and

iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

VII. GRIEVANCE PROCESS

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

B. Generally:

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

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

3. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution within **90 calendar days** of the date of the request. This constitutes an "Adverse Benefit Determination", and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

C. PIHP Responsibility when Enrollee Files a Grievance:

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

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

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

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

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

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

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

the Enrollee's condition or disease.

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

D. Grievance Resolution Timing and Notice Requirements

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

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

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

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

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

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

3. Format and Content of Notice of Grievance Resolution:

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

b. The notice of Grievance resolution must include:
i. The results of the Grievance process;
ii. The date the Grievance process was concluded;
iii. Notice of the Enrollee's right to request a State Fair Hearing.

if the notice of resolution is more than **90-days** from the date of the Grievance; and

iv. Instructions on how to access the State Fair Hearing process, if applicable .

VIII. STATE FAIR HEARING APPEAL PROCESS

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

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

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

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

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

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

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

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

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

H. Expedited hearings are available.

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

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

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

IX. RECORDKEEPING REQUIREMENTS

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

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

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

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

X. RECIPIENT RIGHTS COMPLAINT PROCESS

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

Exhibit A

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

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

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

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

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

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

This action is based on the following:

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

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

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

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

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

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

There are 2 kinds of internal appeals:

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

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

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

Continuation of services during an Internal Appeal

If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination <insert 10 calendar day date>, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

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

If you want someone else to act for you

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

Access to Documents

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

What happens next?

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

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

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

Get help & more information

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

- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
- [*If applicable, insert other state or local aging/disability waiver resources contact information.*]

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

Exhibit B

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

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

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

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

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

☐ You Filed A Grievance

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

WHAT THIS MEANS

We will review your grievance by <date received plus 90 calendar days>. A letter will be mailed to you within two (2) calendar days after we complete our investigation telling you what we found and what (if any) action we will take, or have taken.

☐ You Filed An Internal Appeal

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

WHAT THIS MEANS

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

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

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

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

FOR BOTH GRIEVANCES AND APPEALS

If you want someone to represent you

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

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

Get help & more information

- {Health plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal

process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.

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

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

Exhibit C

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

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

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

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

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

Your appeal was approved

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

What this means:

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

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

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

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

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

Getting your case file

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

Get help & more information

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

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

Exhibit D

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

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

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

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

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

Your internal appeal was denied

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

Why did we deny your appeal?

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

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

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

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

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

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

How to ask for a State Fair Hearing with MAHS

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

What happens next?

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

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) State Fair Hearing. Your request must be

in writing and clearly state that you are asking for a fast State Fair Hearing. Your request can be mailed or faxed to MAHS (see the enclosed Request for Hearing form for the address and fax number). If you qualify for a fast State Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

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

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

How to ask for an External Review with DIFS

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

What happens next?

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

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

Continuation of Services

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

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

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

Access to Documents

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

Get help & more information

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

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

TREATMENT POLICY #13

SUBJECT: Withdrawal Management Continuum of Services

ISSUED: May 5, 2017

EFFECTIVE: July 1, 2017

PURPOSE:
The purpose of this policy is to establish requirements for withdrawal management services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to support individualized services that maintain cultural, age, and gender appropriateness.

SCOPE:
This policy impacts the Prepaid Inpatient Health Plans (PIHP) and the withdrawal management service provider network.

BACKGROUND:
Withdrawal management includes a wide variety of covered services with the provision of these services expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited and do not reflect advances in science and practice. These changes have essentially left the administrative rules obsolete in the area of recommended services. This policy seeks to establish criteria that will result in services that are provided in accordance with those outlined by the ASAM Criteria, and are more reflective of interventions that have been shown to be effective in providing care to individuals receiving withdrawal management services.

Withdrawal management, or detoxification, has historically been available within residential programs only. However, this policy expands the opportunities for individuals requiring withdrawal management by supporting services at additional levels of care. An individual who does not meet medical necessity criteria for residential based withdrawal management may receive their services through a licensed outpatient program. Outpatient programs offering withdrawal management will be required to have access to appropriately licensed laboratories for testing. Only programs that offer Levels 3.2 and 3.7 will be required to maintain a Residential Detoxification license.

Withdrawal management services also include physicians or physician's designated representatives, and staffing requirements, and these requirements must be met, as appropriate, for each level of care. For instance, it is not necessary to have staffing 24 hours per day, 7 days per week in an outpatient withdrawal management level of care.

To ensure that all clients are served at the level of care that best meet their needs, it is necessary to increase the opportunity for withdrawal management beyond the traditional residential setting. Many clients have the ability to manage their withdrawal from substances through outpatient

services, while maintaining their everyday responsibilities, and it is necessary that the publicly funded SUD system is able to support their needs.

DEFINITIONS:

Toxicology Screening - screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non-laboratory urinalysis).

Biopsychosocial Screening and Assessment- screening is used to determine if problem is there, assessment determines nature of problem and a diagnostic impression. This also determines the level of care the individual should receive, as well as determines individualized care plan and treatment priorities.

Counseling - an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Crisis Intervention - a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher LOC if intervention is not provided.

Daily assessment – a tool used to determine clients progress and successes throughout program, can also be used to determine any weaknesses client may have in order to focus on strengthening those or determine any treatment changes.

Discharge – withdrawal signs and symptoms are sufficiently resolved that client can be safely managed at less intensive level of care or be sent home.

Group Counseling - face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

Group Psychotherapy - face-to-face, insight-oriented interventions with three or more clients.

Health Education Services – multidisciplinary approach to help clients understand how social factors, financing systems, organizational and familial systems, health technologies and personal behavior impact their health.

Individual Counseling - face-to-face intervention for the purpose of goal setting and achievement, and skill building. This is distinct from treatment planning, as this may be goals and achievements identified in case management or through peer based services.

Individualized Treatment Planning - direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education - services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as a "didactic" education.

Interactive Education Groups - activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

Medical Necessity - treatment that is reasonable, necessary, and appropriate based on individualized treatment planning and evidence-based clinical standards.

Psychotherapy - an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (Michigan Administrative Code, Social Work General Rules).

Recovery - a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf)

Recovery Planning - purpose is to highlight and organize a person's goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

Recovery Support and Preparation - services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Referral/Linking/Coordination of Services - office-based service activity performed by a primary clinician, or other assigned staff, to address needs identified through the assessment, and/or to ensure follow through with access to outside services, and/or to establish the client with another substance use disorder service provider.

Substance Use Disorder - a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

Withdrawal Management - monitoring for the purpose of preventing/alleviating medical complications related to no longer using, or decreasing the use of, a substance.

REQUIREMENTS:

The withdrawal management level of care from ASAM is established based on the intensity of the needs of the client within the six dimensions. Withdrawal management, or detoxification, will be identified by level of care, with a continuum of services offered under withdrawal management and based on the needs of the individual. PIHPs will need to have the capacity to provide a withdrawal management continuum that will meet the needs of clients at ASAM levels 1-WM, 2-WM, 3.2-WM, and 3.7-WM. Level 4-WM, as a medically managed intensive inpatient withdrawal management service, is not offered within the PIHP system, and if indicated by the LOC determination must be accessed through the physical health system. The frequency and duration of services are expected to be guided by the ASAM levels of care, and are described as follows:

ASAM Level 1 – Ambulatory Withdrawal Management without Extended On-Site Monitoring

This is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility, or in an individual's home by trained clinicians who provide medically supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. These services should be provided through regularly scheduled sessions and should be delivered under a defined set of policies and procedures or medical protocols.

Support Systems

Support systems at this level should include the availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems as indicated. As well as the ability to obtain a comprehensive medical history and physical examination of the individual at admission. They should also have affiliation with other levels of care, including other levels of specialty addiction treatment, for additional problems identified through a comprehensive biopsychosocial assessment. The ability to conduct and/or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing, is necessary. Twenty-four-hour access to emergency medical consultation services should they be necessary, by phone or face to face as indicated. Lastly, the ability to provide or assist in accessing transportation services for individuals who lack safe transportation.

Staff Requirements

Level 1-withdrawal management services should be staffed by physicians and nurses, who are essential to this type of service, though they need not be present in the treatment setting at all times. It is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in a less supervised setting would be safe.

Physicians do not need to be certified as addiction specialists and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal states is necessary. Services provided by counselors, psychologists and social workers may be available through withdrawal management service, or these services can be assessed through an affiliate of this level of care.

All clinicians who assess and treat individuals should be able to obtain and interpret information regarding the needs of these persons, and are knowledgeable about the biopsychosocial dimensions of alcohol, tobacco and other substance use disorders. This knowledge should include the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of these conditions and how to facilitate ongoing care for this individual.

ASAM Level 2- Ambulatory Withdrawal Management with Extended On-Site Monitoring

This level is an organized service that can be delivered in an office setting, a general health care or mental health care facility by medical and nursing professionals that provide evaluation, withdrawal management and referral services. Services are provided in regularly scheduled sessions or under a defined set of physician approved policies or clinical protocols.

Support Systems

Level 2 support systems include the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems. Programs must either provide or have the ability to obtain a comprehensive medical history and physical examination of the individual at admission, and have access to psychological and psychiatric consultation. This level of support also includes affiliation with other levels of care, including other levels of specialty addiction treatment, as well as general and psychiatric services for additional problems identified through a comprehensive biopsychosocial assessment.

The ability to conduct or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing, and 24-hour access to emergency medical consultation services are a necessity at this level. Lastly, this level of care includes the ability to provide or assist in accessing transportation services for individuals who lack safe transportation.

Staff Requirements

This level of care should be staffed by physicians and nurses, although they need not be present at all times. Since this level of care is administered on an outpatient basis, it is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in a less supervised setting is safe. Physicians do not need to be certified as addiction specialists and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal states is necessary.

Counselors, psychologists and social workers may be available through the withdrawal management service or may be accessed through affiliation with organizations providing other Level 2 services. All clinicians that assess and treat individuals must have knowledge regarding the needs of their clients, and knowledge about the biopsychosocial dimensions of alcohol and other drug addiction. Such knowledge includes signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care.

ASAM Level 3.2 – Clinically Managed Residential Withdrawal Management
Referred to as "social setting detoxification" or "social detox," this is an organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal. This level is characterized by its emphasis on peer and social support rather than typical medical or nursing care services. This level of care provides services for clients with severe intoxication/withdrawal signs and symptoms that require 24-hour structure and support.

Some programs may be staffed to supervise self-administered medications for the management of withdrawal. All Level 3.2 programs must rely on established clinical protocols to identify individuals that are in need of medical services beyond the capacity of the facility and to transfer these individuals to appropriate levels of care.

Support Systems
Level 3.2 Withdrawal Management support systems include the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems. Since this level is managed by clinicians and not medical or nursing staff, protocols are in place in case an individual's condition deteriorates and appears to need medical or nursing interventions.
These protocols are used to determine the nature of the medical or nursing interventions that may be required. Protocols include under what conditions and when transfer to a medically monitored facility or an acute care hospital is necessary. These protocols are developed and supported by a physician knowledgeable in addiction medicine. These programs must also be affiliated with other levels of care with the ability to arrange for appropriate laboratory and toxicology tests.

Staff Requirements
Level 3.2 programs are staffed by appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for individual observation and supervision, determination of appropriate levels of care, and facilitation of the individual's transition to continuing care. Social withdrawal management is a clinically managed withdrawal management service explicitly designed to safely assist individuals through withdrawal without the need for ready on-site access to medical and nursing personnel. Medical evaluation and consultation is available 24-hours a day, in accordance with treatment/transfer practice protocols and guidelines. All clinicians who assess and treat

individuals are able to obtain and interpret information regarding the needs of these individuals. This knowledge includes the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care. Facilities that supervise self-administered medications have appropriately licensed or credentialed staff and policies and procedures in accordance with state and federal law. The staff at this level of care should ensure that individuals are taking medication according to prescription and legal requirements.

ASAM Level 3.7 – Medically Monitored Inpatient Withdrawal Management
This level of care is an organized service that is delivered by medical and nursing professionals that provide 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician approved policies and physician-monitored procedures or clinical protocols.
This level of care provides care to individuals with withdrawal signs and symptoms that are sufficiently severe to require 24-hour inpatient care. It sometimes is provided by overlapping with Level 4 withdrawal management services, with a specialty unit of an acute care general or psychiatric hospital. 24-hour observation, monitoring, and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Support Systems
Level 3.7 Withdrawal Management support systems feature the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems. They also feature the availability of medical nursing care and observation as warranted based on clinical judgment, along with direct affiliation with other levels of care. Programs must have the ability to conduct or arrange for appropriate laboratory and toxicology tests.

Staff Requirements
Level 3.7 programs should be staffed by physicians that are available 24-hours a day by telephone. A physician is available to assess the individual within 24-hours of admission, or earlier if medically necessary, and is available to provide on-site monitoring of care and further evaluation on a daily basis. A registered nurse or other licensed and credentialed nurse is available to conduct a nursing assessment on admission. A nurse will be responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis. There will need to be appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders. The level of nursing care needs to be appropriate to the severity of the individual's needs.

Licensed, certified, or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care, and treatment services for individuals and their families. An interdisciplinary team of appropriately trained clinicians (such as physicians, nurses, counselors, social workers, and psychologists) is available to assess and treat the

individual and to obtain and interpret information regarding the individual's needs. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.

ASAM Level 4 – Medically Managed Intensive Inpatient Withdrawal Management
This level of withdrawal management is an organized service delivered by medical and nursing professionals that provide 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. This information is being provided for reference and guidance purposes only, and it is not an expectation that PIHPs provide this level of care. Services are delivered under a defined set of physician-approved policies and physician managed procedures and protocols.

This level of care also provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. Twenty-four hour observation, monitoring, and treatment are available at this level, and is designed for acute medical withdrawal management. It is required that the individual be assessed and a care plan for any of their treatment priorities be developed.

Support Systems
Support systems at this level of care feature the availability of specialized medical consultation, full medical acute care services and intensive care as needed.

Staff requirements
This level of care requires programs are staffed by physicians that are available 24-hours a day as active members of an interdisciplinary team of appropriately trained professionals and those that can medically manage the individual's care. A registered nurse or other licensed and credentialed nurse is available for primary nursing care and observation 24-hours a day.

This level of care also requires facility-approved addiction counselors or licensed, certified, or registered addiction clinicians be available eight (8) - hours per day to administer planned interventions according to the assessed needs of the individual. An interdisciplinary team of appropriately trained clinicians is available to assess and treat the individual with a substance use disorder, or an addicted individual with a concomitant acute biomedical, emotional or behavioral disorder.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by the individual:

Dimensional Interactions	Severity Increase	Severity Decrease
Dimension 1	Acute intoxication and/or withdrawal potential	Acute intoxication and/or withdrawal potential

Dimensional Interactions	Severity Increase	Severity Decrease
Dimension 2	Impaired liver function, comorbid neurological conditions that could be exacerbated by autonomic nervous system hyperarousal, pregnancy	Absence of comorbid medical condition
Dimension 3	Use or misuse of psychiatric medications that are metabolized in the liver, psychiatric disorganization that may affect patient adherence to withdrawal management regimen.	Absence of comorbid psychiatric condition
Dimension 4	Lack of readiness to change affecting adherence to withdrawal management protocols or causing premature discharge from withdrawal management, lack of readiness to change affecting effectiveness of ambulatory withdrawal management	Readiness to change at a level that facilitates adherence to ambulatory withdrawal management services
Dimension 5	Continued use of alcohol, illicit drugs, or non-medical use of prescription drugs	No continued use of alcohol, illicit drugs, or non-medical use of prescription drugs
Dimension 6	Lack of supportive recovery environment or transportation for ambulatory withdrawal management	A supportive recovery environment and transportation to ambulatory withdrawal management

PROCEDURE:

Admission Criteria

Admission to withdrawal management is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider's assessment process.
- Individualized determination of need.
- ASAM Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the ASAM Criteria below:
  1) Withdrawal potential.
  2) Medical conditions and complications.
  3) Emotional, behavioral, or cognitive conditions and complications.
  4) Readiness to change – as determined by the Stages of Change Model.
  5) Relapse, continued use or continued problem potential.
  6) Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development. Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM Criteria. As a client's needs change, the frequency, and duration, of services may be increased or decreased as medically necessary. Participation of the individual receiving services in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

Covered Services
The following services must be available in a Withdrawal Management setting regardless of the LOC and based on individual need:

Type	Withdrawal Management Services Description
Basic Care	Room, board, supervision, monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery-oriented. Levels 3.2 and 3.7 only: room and board.
Treatment Basics **Core Service**	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services; preparation for 'next step'.
Therapeutic Interventions **Core Service**	Individual, group, and family psychotherapy services appropriate for the individual's needs, and crisis intervention. Services provided by an appropriately licensed, credentialed, and supervised professional working within their scope of practice.
Interactive Education /Counseling **Core Service**	Interaction and teaching with client(s) and staff to process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Examples: disease of addiction, mental health, and substance use disorder.
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; treatment coordination; support groups; drug/alcohol free campus.
Medical Services **Core Service**	Medication prescribing and management. Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available.

Treatment/Recovery Planning

Individuals entering any level of withdrawal management services will have recovery and functional needs that will continue to require intervention once withdrawal based services are no longer appropriate. Therefore, withdrawal management should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the individual. Withdrawal management should never be presented to individuals as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once withdrawal management services are no longer necessary.

To make the transition to the next LOC, the withdrawal management provider may assist the client in choosing an appropriate service based on needs and location, helping to schedule appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the withdrawal management provider arrange for any needed assistance to ensure a seamless transfer to the next LOC.

Continuing Stay Criteria
Re-authorization or continued treatment should be based on ASAM Continued Service Criteria, medical necessity, and a reasonable expectation of benefit from continued care.

REFERENCES:
Mee-Lee, D, Shulman, GD, Fishman, M, Gastfriend, DR, Miller, MM, Eds. The *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* 3rd ed. Carson City, NV: The Change Companies®; 2013.

Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care. Michigan's ROSC Glossary of Terms. Retrieved from http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf.

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Substance Use Disorder Service Programs. Promulgated pursuant to Michigan Public Act 368 of 1978, Section 6231(1), as amended. Retrieved from http://w3.lara.state.mi.us/orr/Files/AdminCode/389_10365_AdminCode.pdf .

Approved by: _____ ***Signed*** _____
Larry P. Scott, Acting Director
Office of Recovery Oriented Systems of Care

7.7.6 GAIN (Global Appraisal of Individual Needs) I Core Process

- The PIHP and its SUD provider network will engage in the GAIN-I CORE training process with Chestnut Health Systems. The PIHP may make their identified Local Trainer staff available to train other clinicians across the state. This training may be funded through the CMHAM training contract with MDHHS or the PIHP may elect to sponsor this training. The PIHP may establish their own rate(s) of compensation/support for any trainings they provide directly.
- PIHPs are expected to establish and maintain a Data Use Agreement with Chestnut Health Systems for use of the GAIN ABS. MDHHS will maintain these agreements through FY 2020, and longer as funding allows

Community Mental Health

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Health and Human Services

MDHHS
Michigan Department of Health & Human Services

Fiscal Year End September 30, 2019

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INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Health and Human Services (MDHHS) to assist independent audit personnel, Prepaid Inpatient Health Plan (PIHP) personnel, and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDHHS and PIHPs or CMHSPs, and to assure examinations are completed in a consistent and equitable manner.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDHHS to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, Flint 1115 and Substance Use Disorder Community Grant Programs (hereinafter referred to as "Medicaid Contract"); the contracts between CMHSPs and MDHHS to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208 (hereinafter referred to as "GF Contract"); and, in certain circumstances, contracts between CMHSPs or PIHPs and MDHHS to manage the Community Mental Health Services Block Grant Program (hereinafter referred to as "CMHS Block Grant Program"). These CMH Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a PIHP or CMHSP expends $750,000 or more in federal awards[1], the PIHP or CMHSP must obtain a Single Audit.

PIHPs are ultimately responsible for the Medicaid funds received from MDHHS, and are responsible for monitoring the activities of network provider CMHSPs as necessary to ensure expenditures of Medicaid Contract funds are for authorized purposes in compliance with laws, regulations, and the provisions of contracts. Therefore, PIHPs must either require their independent auditor to examine compliance issues related to the Medicaid funds awarded to the network provider CMHSPs, or require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 8, 9, & 10).

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2019 and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

Failure to meet the requirements contained in these CMH Compliance Examination Guidelines may result in the withholding of current funds or the denial of future awards.

[1] Medicaid payments to PIHPs and CMHSPs for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended for the purposes of determining Single Audit requirements.

RESPONSIBILITIES

MDHHS Responsibilities

MDHHS must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code, and federal and state audit requirements; and to ensure the **COMPLIANCE REQUIREMENTS** contained in the CMH Compliance Examination Guidelines are complete and accurately represent requirements of PIHPs and CMHSPs; and distribute revised CMH Compliance Examination Guidelines to PIHPs and CMHSPs.
2. Review the examination reporting packages submitted by PIHPs and CMHSPs to ensure completeness and adequacy within eight months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination reporting package within eight months after the receipt of a complete and final reporting package.
4. Monitor the activities of PIHPs and CMHSPs as necessary to ensure the Medicaid Contract, GF Contract, and CMHS Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Contract, and GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely on PIHP or CMHSP Single Audits or the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure CMHSP Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS may, however, determine it is necessary to also perform a limited scope compliance examination or review of selected areas. Any additional reviews or examinations shall be planned and performed in such a way as to build upon work performed by other auditors. The following are some examples of situations that may trigger an MDHHS examination or review:
    a. Significant changes from one year to the next in reported line items on the FSR.
    b. A PIHP entering the MDHHS risk corridor.
    c. A large addition to an ISF per the cost settlement schedules.
    d. A material non-compliance issue identified by the independent auditor.
    e. The CPA that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.
    f. The CPA issued an adverse opinion on compliance due to their inability to draw conclusions because of the condition of the agency's records.

PIHP Responsibilities

PIHPs must:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200 , the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines is properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the PIHP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The PIHP shall <u>not</u> file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS and the PIHP will be notified of any required action in the management decision.
8. Monitor the activities of network provider CMHSPs as necessary to ensure the Medicaid Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. PIHPs must either (a.) require the PIHP's independent auditor (as part of the PIHP's examination engagement) to examine the records of the network provider CMHSP for compliance with the Medicaid Contract provisions, or (b.) require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. If the latter is chosen, the PIHP must incorporate the examination requirement in the PIHP/CMHSP contract and develop Compliance Examination Guidelines specific to their PIHP/CMHSP contract. Additionally, if the latter is chosen, the CMHSP examination must be completed in sufficient time so that the PIHP auditor may rely on the CMHSP examination when completing their examination of the PIHP if they choose to.
9. If requiring an examination of the network provider CMHSP, review the examination reporting packages submitted by network provider CMHSPs to ensure completeness and adequacy.

10. If requiring an examination of the network provider CMHSP, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in network provider CMHSP's examination reporting packages.

CMHSP Responsibilities

(as a recipient of Medicaid Contract funds from PIHP and a recipient of GF funds from MDHHS and a recipient of CMHS Block Grant funds from MDHHS)

CMHSPs must:

1. Maintain internal control over the Medicaid Contract, GF Contract, and CMHS Block Grant Program that provides reasonable assurance that the CMHSP is managing the Medicaid Contract, GF Contract, and CMHS Block Grant Program in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid Contract, GF Contract, and CMHS Block Grant Program.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract, GF Contract, and CMHSP Block Grant Program. Examples of these would include, but not be limited to: the Medicaid Contract, the Managed Mental Health Supports and Services Contract (General Fund Contract), the CMHS Block Grant Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines, and any examination required by the PIHP from which the CMHSP receives Medicaid Program funds are properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The CMHSP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS, and the CMHSP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

PIHPs under contract with MDHHS to manage the Medicaid Contract and CMHSPs under contract with MDHHS to manage the GF Contract are required to contract annually with a

certified public accountant in the practice of public accounting (hereinafter referred to as a practitioner) to examine the PIHP's or CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 18–Attestation Standards – Clarification and Redcodification–.AT – C Section 205 The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Additionally, CMHSPs under contract with MDHHS to provide CMHS Block Grant Program services with a total contract amount of greater than $187,500 are required to ensure the above referenced examination engagement includes an examination of compliance with specified requirements related to the CMHS Block Grant Program **IF** the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program. The specified requirements and specified criteria related to the CMHS Block Grant Program are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Practitioner Selection

In procuring examination services, PIHPs and CMHSPs must engage an independent practitioner, and must follow the Procurement Standards contained in 2 CFR 200.318 through 200.320. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, the results of MDHHS reviews, and price. When possible, PIHPs and CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the PIHP's or CMHSP's compliance with specified requirements is to express an opinion on the PIHP's or CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that the PIHP or CMHSP complied, in all material respects, based on the specified criteria.

Practitioner Requirements

The practitioner should exercise due care in planning, performing, and evaluating the results of his or her examination procedures; and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected. The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements." In the examination of the PIHP's or CMHSP's compliance with specified requirements, the practitioner should follow the requirements of AT-C 105 and 205.

Practitioner's Report

The practitioner's examination report on compliance should include the information detailed in AT-C 205.63 through 205.86, which includes the practitioner's opinion on whether the entity complied, in all material respects, with specified requirements based on the specified criteria. When an examination of the PIHP's or CMHSP's compliance with specified requirements discloses noncompliance with the applicable requirements that the practitioner believes have a material effect on the entity's compliance, the practitioner should modify the report as detailed in AT-C 205.68 through AT-C 205.75.

In addition to the above examination report standards, the practitioner must prepare:

1. A Schedule of Findings that includes the following:
    a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.
    b. Material noncompliance with the provisions of laws, regulations, or contract provisions related to the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.
    c. Known fraud affecting the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.

    Finding detail must be presented in sufficient detail for the PIHP or CMHSP to prepare a corrective action plan and for MDHHS to arrive at a management decision. The following specific information must be included, as applicable, in findings:
    a. The criteria or specific requirement upon which the finding is based including statutory, regulatory, contractual, or other citation. **The Compliance Examination Guidelines should NOT be used as criterion.**
    b. The condition found, including facts that support the deficiency identified in the finding.
    c. Identification of applicable examination adjustments and how they were computed.
    d. Information to provide proper perspective regarding prevalence and consequences.
    e. The possible asserted effect.
    f. Recommendations to prevent future occurrences of the deficiency(ies) noted in the finding.
    g. Views of responsible officials of the PIHP/CMHSP.
    h. Planned corrective actions.
    i. Responsible party(ies) for the corrective action.
    j. Anticipated completion date.

2. A schedule showing final **reported** Financial Status Report (FSR) amounts, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below)], and examined FSR amounts. **All examination adjustments must be explained.** This schedule is called the "Examined FSR Schedule." Note that Medicaid FSRs

must be provided for PIHPs. All applicable FSRs must be included in the practitioner's report regardless of the lack of any examination adjustments.

3. A schedule showing a revised cost settlement for the PIHP or CMHSP based on the Examined FSR Schedule. This schedule is called the "Examined Cost Settlement Schedule." This must be included in the practitioner's report regardless of the lack of any examination adjustments.

4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant program only in the event the individual comment or recommendation is expected to have an impact greater than or equal to $10,000; and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency.

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDHHS within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The PIHP or CMHSP must submit the reporting package by e-mail to 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.

Examination Reporting Package

The reporting package includes the following:

1. Practitioner's report as described above;
2. Corrective action plan prepared by the PIHP or CMHSP.

Penalty

If the PIHP or CMHSP fails to submit the required examination reporting package by June 30th following the contract year end and an extension has not been granted by MDHHS, MDHHS may withhold from current funding five percent of the examination year's grant funding (not to exceed $200,000) until the required reporting package is received. MDHHS may retain the withheld amount if the reporting package is delinquent more than 120 days from the due date and MDHHS has not granted an extension.

Incomplete or Inadequate Examinations

If MDHHS determines the examination reporting package is incomplete or inadequate, the PIHP or CMHSP, and possibly its independent auditor will be informed of the reason of inadequacy and its impact in writing. The recommendations and expected time frame for resubmitting the corrected reporting package will be provided to the PIHP or CMHSP.

Management Decision

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

If there are no findings, comments, and/or questioned costs, MDHHS will notify the PIHP or CMHSP when the review of the examination reporting package is complete and the results of the review.

COMPLIANCE REQUIREMENTS

The practitioner must examine the PIHP's or CMHSP's compliance with the A-F specified requirements based on the specified criteria stated below related to the Medicaid Contract and GF Contract. If the PIHP or CMHSP does not have a Single Audit or the Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the G-I specified requirements based on the specified criteria stated below that specifically relate to the CMHS Block Grant, but only if the total contract amount for the CMHS Block Grant is greater than $187,500. If the PIHP does not have a Single Audit, or the Single Audit does not include the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959) as a major Federal program, the practitioner must also examine the PIHP's compliance with the J-K specified requirements based on the specified criteria stated below that specifically relate to the SAPT Block Grant.

COMPLIANCE REQUIREMENTS A-F

(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

The final FSRs (entire reporting package applicable to the entity) comply with contractual provisions as follows:

a. FSRs agree with agency financial records (general ledger) as required by the reporting instructions. (Reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).
b. FSRs include only allowed activities as specified in the contracts; allowable costs as specified in the Federal cost principles (located at 2 CFR 200, Subpart E)(GF Contract, Section 6.6.1; and Medicaid Contract, Section 7.8); and

allowed activities and allowable costs as specified in the Mental Health Code, Sections 240, 241, and 242.

c. FSRs include revenues and expenditures in proper categories and according to reporting instructions.

Differences between the general ledger and FSRs should be adequately explained and justified. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule." Any reported expenditures that do not comply with the Federal cost principles, the Code, or contract provisions must be shown as adjustments on the auditor's "Examined FSR Schedule."

The following items should be considered in determining allowable costs:
Federal cost principles (2 CFR 200.402) require that for costs to be allowable they must meet the following general criteria:

a. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under the principles.
b. Conform to any limitations or exclusions set forth in the principles or in the Federal award as to types or amount of cost items.
c. Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
d. Be accorded consistent treatment.
e. Be determined in accordance with generally accepted accounting principles.
f. Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period.
g. Be adequately documented.

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness criteria of 2 CFR Part 200, Subpart E – Cost Principles, 200.404 was met. If subcontractors are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). When the PIHP pays Federally Qualified Heath Centers (FQHC) and Rural Health Centers (RHC) for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported rental costs for **less-than-arms-length transactions** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (c)). For example, the agency may rent their office building from the agency's board member/members, but

rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in 2 CFR Part 200.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (b)).

Capital asset purchases that cost greater than $5,000 must be capitalized and depreciated over the useful life of the asset rather than expensing it in the year of purchase (2 CFR Part 200, Subpart E – Cost Principles, 200.436 and 200.439). All invoices for a remodeling or renovation project must be accumulated for a total project cost when determining capitalization requirements; individual invoices should not simply be expensed because they are less than $5,000.

Costs must be allocated to programs in accordance with relative benefits received. Accordingly, **Medicaid costs must be charged to the Medicaid Program and GF costs must be charged to the GF Program**. Additionally, **administrative/indirect costs** must be distributed to programs on bases that will produce an equitable result in consideration of relative benefits derived in accordance with 2 CFR Part 200, Appendix VII.
Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported in accordance with the standards listed in 2 CFR Part 200, Subpart E – Cost Principles, 200.430 (i).

B. Administration Cost Report

The most recently completed PIHP's or CMHSP's Administration Cost Report complies with the applicable CMHSP/PIHP Administration Cost Reporting Instructions and the applicable standards in ESTABLISHING ADMINISTRATIVE COSTS WITHIN AND ACROSS THE CMHSP SYSTEM and contract provisions (instructions located at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html and reference guidelines located at http://www.michigan.gov/documents/mdch/Establishing_Admin_costs_480633_7.pdf).

C. Procurement

The PIHP or CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326. The PIHP or CMHSP ensured that organizations or individuals selected and offered contracts have not been debarred or suspended or otherwise excluded from or ineligible for participation in Federal assistance programs as required by 45 CFR 92.35.

D. Internal Service Fund (ISF)

The PIHP's Internal Service Fund complies with the Internal Service Fund Technical Requirement contained in Contract Attachment P 8.6.4.1 with respect to funding and maintenance.

E. Medicaid Savings and General Fund Carryforward

The PIHP's Medicaid Savings was expended in accordance with the PIHP's reinvestment strategy as required by Sections 8.6.2.2 and 8.6.2.3 of the Contract. The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

F. Match Requirement

The PIHP or CMHSP met the local match requirement, and all items considered as local match actually qualify as local match according to Section 7.2 of the General Fund Contract and Section 8.2 of the Medicaid Contract. Some examples of funds that do NOT qualify as local match are: (a.) revenues (such as workers' compensation refunds) that should be offset against related expenditures, (b.) interest earned from ISF accounts, (c.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (d.) donations of funds from subcontractors of the PIHP or CMHSP, (e.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSP's actual costs, and (f) donations of items that would not be an item generally provided by the PIHP or CMHSP in providing plan services.

If the PIHP or CMHSP does not comply with the match requirement in the Mental Health Code, Section 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

COMPLIANCE REQUIREMENTS G-I

(APPLICABLE TO PIHPs/CMHSPs WITH A CMHS BLOCK GRANT OF GREATER THAN $187,500 THAT DID NOT HAVE A SINGLE AUDIT OR THE CMHS BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

G. CMHS Block Grant - Activities Allowed or Unallowed

The CMHSP expended CMHS Block Grant (CFDA 93.958) funds only on allowable activities in accordance with Federal Block Grant provisions and the Grant Agreement between MDHHS and the CMHSP.

H. CMHS Block Grant - Cash Management

The CMHSP complied with the applicable cash management compliance requirements contained in the Federal Block Grant Provisions. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by CMHSP funds before reimbursement is requested from MDHHS.

I. CMHS Block Grant – Sub-recipient Management and Monitoring

If the CMHSP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal CMHS Block Grant Program, the CMHSP

complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h)

COMPLIANCE REQUIREMENTS J-K

(APPLICABLE TO PIHPs WITH A SAPT BLOCK GRANT THAT DID NOT HAVE A SINGLE AUDIT OR THE SAPT BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

J. SAPT Block Grant – Activities Allowed or Unallowed

The PIHP or CMHSP expended SAPT Block Grant (CFDA 93.959) funds only on allowable activities in accordance with the Federal Block Grant Provisions and the Grant Agreement.

K. SAPT Block Grant – Sub-recipient Management and Monitoring

If the PIHP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal SAPT Block Grant Program, the PIHP or complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h).

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDHHS. Also, PIHPs are required to keep affiliate CMHSP's reports on file for three years from date of receipt. All examination working papers must be accessible and are subject to review by representatives of the Michigan Department of Health and Human Services, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and provider network CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2018/2019 examinations. Any questions relating to these guidelines should be directed to:

John Duvendeck, Director
Division of Program Development, Consultation & Contracts

Bureau of Hospitals and Behavioral Health Administration
Michigan Department of Health and Human Services
Lewis Cass Building
320 S. Walnut Street
Lansing, Michigan 48913
duvendeckj@michigan.gov
Phone: (517) 241-5218 Fax: (517) 335-5376

GLOSSARY OF ACRONYMS AND TERMS

AICPA.....American Institute of Certified Public Accountants.

Children's Waiver.....The Children's Waiver Program that provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the program who, if not for the availability and provisions of the Waiver, would otherwise require the level of care and services provided in an Intermediate Care Facility for the Mentally Retarded. Payment from MDHHS is on a fee for service basis.

CMHS Block Grant Program.The program managed by CMHSPs under contract with MDHHS to provide Community Mental Health Services Block Grant program services under CFDA 93.958.

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

Examination Engagement.....A PIHP or CMHSP's engagement with a practitioner to examine the entity's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) –Attestation Standards – Clarification and Recodification - AT-C 205 (Codified Section of AICPA Professional Standards).

Flint 1115 Waiver .....The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014 through a state-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act, and is effective as of March 3, 2016 the date of

the signed approval through February 28, 2021. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the state plan. All such persons will have access to Targeted Case Management services under a fee for service contract between MDHHS and Genesee Health Systems (GHS). The fee for service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.

GF Program.....The program managed by CMHSPs under contract with MDHHS to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.

MDHHS.....Michigan Department of Health and Human Services

Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by PIHPs under contract with MDHHS.

PIHP.....Prepaid Inpatient Health Plan. In Michigan a PIHP is an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. The PIHP, also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program, also manages the Autism Program, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.

Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.

Serious Emotional Disturbances Waiver.....The Waiver for Children with Serious Emotional Disturbances Program that provides services to children who would otherwise require hospitalization in the State psychiatric hospital to remain in their home and community. Payment from MDHHS is on a fee for service basis.

SSAE.....AICPA's Statements on Standards for Attestation Engagements.

SAPT Block Grant Program ..The program managed by PIHPs under contract with MDHHS to provide Substance Use Services Block Grant program services under CFDA 93.959.

SUD Services.....Substance Use Disorder Services funded by Medicaid, Healthy Michigan, and the "Community Grant" which consists of Federal SAPT Block Grant funds and State funds.

PIHP REPORTING REQUIREMENTS
Effective 10-1-18
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FY 2019 MDHHS/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT

REPORTING REQUIREMENTS

Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2019 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs or substance use disorder programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

- "Supplemental Instructions for Encounter Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes. Code list that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDHHS and EDIT have assigned to them The code list also includes instructions on use of modifiers; the acceptable activities that may be reflected in the cost of each procedure; and whether an activity needs to be face-to-face in order to count.
- "Establishing Managed Care Administrative Costs" that provides instructions on what managed care functions should be included in the allocation of expenditures to managed care administration.
- "Michigan's Mission-Based Performance Indicator System, is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators.
- SUD Guidelines and instructions as found in the Agreement

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

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

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

PIHP REPORTING REQUIREMENTS

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management
- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- External Quality Review
- Actuarial activities

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

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

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

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

Due Date	Report Title	Report Frequency	Report Period and Submittal Instructions
10/1/2018	SUD Budget Report	Projection/Initial	October 1 to September 30
12/3/2018	Risk Management Strategy	Annually	To cover the current fiscal year
12/31/2018	Medicaid Services Verification Report	Annually	October 1 to September 30
1/31/2019	SUD – Expenditure Report	Quarterly	October 1 to December 31
4/16/2019	SUD – Women's Specialty Services (WSS) Mid-Year Expenditure Status Report	Mid-Year	October 1 to March 31
4/30/2019	SUD – Expenditure Report	Quarterly	January 1 to March 31
5/15/2019	Program Integrity Activities	Quarterly	January 1 to March 31 using OIG's case tracking system
5/31/2019	Mid-Year Status Report	Mid-Year	October 1 to March 31
6/01/2019	SUD – Notice of Excess or Insufficient Funds	Projection	October 1 to September 30
7/31/2019	SUD – Expenditure Report	Quarterly	April 1 to June 30
8/15/2019	Program Integrity Activities	Quarterly	April 1 to June 30 using OIG's case tracking system
8/15/2019	SUD – Charitable Choice Report	Annually	October 1 to September 30

PIHP REPORTING REQUIREMENTS

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

PIHP REPORTING REQUIREMENTS

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

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS

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

Due Date	**Report Title**	**Report Period**
11/30/2018	Recovery Policy & Practice Annual Planning – Table 2	See attachment P4.13.1
1/31/2019	Children Referral Report	October 1 to December 31
1/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 to December 31
2/19/2019	SUD Master Retail List	October 1 to September 30
03/31/2019	Performance Indicators	October 1 to December 31. 2018 Submit to: QMPMeasures@michigan.gov

PIHP REPORTING REQUIREMENTS

4/30/2019	Children Referral Report	January 1 to March 31
4/30/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	January 1 to March 31
4/30/2018	Sentinel Events Data Report	October 1 to March 31
06/30/2019	Performance Indicators	January 1 to March 31, 2019 Submit to: QMPMeasures@michigan.gov
06/30/2019	SUD – Tobacco/ Formal Synar Inspection period	June 1-June 30 (To be reported in Youth Access to Tobacco Compliance Check Report)
7/15/2019	Compliance Check Report (CCR)	Submit to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov with cc to: ohs@michigan.gov and ColemanL7@michigan.gov
7/31/2019	Children Referral Report	April 1 to June 30
7/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	April 1 to June 30
09/30/2019	Performance Indicators	April 1 to June 30, 2019 Submit to: QMPMeasures@michigan.gov
10/31/2019	Children Referral Report	July 1 to September 30
10/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	July 1 to September 30
10/31/2019	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30
10/31/2019	Sentinel Events Data Report	April 1 to September 30
TBD	SUD – Synar Coverage Study Canvassing Forms	Regions participating and Study Period TBD (August 2019)
11/30/2019	SUD – Communicable Disease (CD) Provider Information Report (Must submit only if PIHP funds CD services)	October 1 to September 30
11/30/2019	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2019	Performance Indicators	July 1 to September 30, 2019 Submit to: QMPMeasures@michigan.gov
2/28/2020	Recovery Policy & Practice Annual Survey Information Forms – Tables 3a and 3b	See attachment P4.13.1
TBD (originally 2/28/2020)	Recovery Policy & Practice Annual Reporting Matrices – Table 2	See attachment P4.13.1

PIHP REPORTING REQUIREMENTS

Quarterly	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 – September 30 Due last day of month, following the last month of the quarter.
Quarterly	Children Referral Report	October 1 – September 30 Due last day of month, following the last month of the quarter.
Monthly	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30 Due last day of month following month in which exception occurred. Must submit even if no data to report
Monthly	SUD – Behavioral Health Treatment Episode Data Set (BH-TEDS)	October 1 to September 30 Due last day of each month. Submit via DEG at : https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	SUD - Michigan Prevention Data System (MPDS)	October 1 to September 30 Due last day of each month, following month in which data was uploaded. Submit to: https://mpds.sudpds.com
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 Submit via DEG at: https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly*	Consumer level* Quality Improvement Encounter	October 1 to September 30 See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	Critical Incidents	Submit to PIHP Incident Warehouse at: https://mipihpwarehouse.org/MVC/Documentation
Annually	SUD - Communicable Disease (CD) Provider Information Plan (Must submit only if PIHP funds CD services)	October 1 to September 30 Same due date as Annual Plan.

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

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

1. Send data to MDHHS MIS via DEG (see above)

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

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

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

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

A. Basis of Data Reporting

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

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

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

3 Legislative boilerplate annual reporting and semi-annual updates

PIHP REPORTING REQUIREMENTS

B. Policies and Requirements Regarding Data

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

Policy:

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

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

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

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

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

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

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

PIHP REPORTING REQUIREMENTS

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

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

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

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

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

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

PROXY MEASURES FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

For FY19, the PIHPs are required to report a limited set of data items in the Quality Improvement (QI) file for consumers with an intellectual or developmental disability. The required items and instructions are shown below. Detailed file specifications are (will be) available on the MDHHS web site at: xxxxxxx

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

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

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

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

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* ***Reporting Period*** **(REPORTPD)**
The last day of the month in which the consumer data is being updated. Report year, month, day: yyyymmdd.

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

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

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* ***Consumer Unique ID*** **(CONID)**

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

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

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

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

****Disability Designation***

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

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

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

Date of birth **(DOB)**

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

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

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

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

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

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

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

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

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

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

Blank= Missing

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

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

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

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

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

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

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

1= Extensive involvement, such as daily emotional support/companionship
2= Moderate involvement, such as several times a month up to several times a week
3= Limited involvement, such as intermittent or up to once a month

4= Involved in planning or decision-making, but does not provide emotional support/companionship
5= No involvement
Blank = Missing

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

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

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

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

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging behaviors" include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

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

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

Indicate the presence of a behavior plan during the past 12 months.

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

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

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

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

Blank = Missing

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

Blank = Missing

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

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

1= One or more MMI diagnosis present

2= No MMI diagnosis present

Blank = Missing

PIHP REPORTING REQUIREMENTS

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

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

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

The file specifications and error logic for the Registry are (will be) available on the MDHHS web site at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

Submissions of the BH Registry file by CHAMPS will be ready by 10/1/2015.

Data Record

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

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

DATA REPORT

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

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

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

A summary of the relevant requirements is:

- Encounter data (service use) is to be submitted electronically on a Health Care Claim 5010.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837 includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
-

PIHP REPORTING REQUIREMENTS

- Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

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

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

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

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

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

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

1.b. ***CMHSP Plan Identification Number*** **(CMHID)**

The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

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

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

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

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

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

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

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

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

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

*11. ***Monetary Amount (effective 1/1/13)***:

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

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

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

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

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

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

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

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

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

ENCOUNTER TIMELINESS CALCULATION

Requirements

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

Logic

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

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

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

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

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

PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDHHS management of PIHP contracts and rate-setting by the actuary. In the case of a regional entity, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its CMHSP partners. This report includes Medicaid Substance Use Disorder services provided in the service area. The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries, **except** Children's Waiver beneficiaries. Refer to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual for the complete and specific requirements for coverage for the State Plan, Additional services provided under the authority of Section 1915(b)(3) of the Social Security Act, and the Habilitation Supports Waiver. All of the aforementioned Medicaid services and supports provided in the PIHP service area must be reported on this utilization and cost report. Instructions and current templates for completing and submitting the MUNC report may be found on the MDHHS web site at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html[WL(1)]. Click on Behavioral Health and Substance Abuse, then Reporting Requirements. This report is due twice a year. One for the first six months of the fiscal year which will be due August 31st of the fiscal year a full year report due on February 28th following the end of the fiscal year. Templates for these reports will be made available at least 60 days prior to the due date.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0 FOR PIHPS

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

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

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

All of the indicators here are measures of PIHP performance. Therefore, performance indicators should be reported by the PIHP for all the Medicaid beneficiaries for whom it is responsible. Medicaid beneficiaries who are not receiving specialty services and supports (1915(b)(c) waivers) but are provided outpatient services through contracts with Medicaid Health Plans, or sub-contracts with entities that contract with Medicaid Health Plans are not covered by the performance indicator requirements.

Due dates for indicators vary and can be found on the table following the list of indicators. Instructions and reporting tables are located in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by MDHHS six weeks prior to the due date and also available on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html .

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**

2. The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SUD). **Standard = 95% in 14 days**.

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults, DD children, and Medicaid SUD) **Standard = 95% in 14 days**

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults (MI, DD) and all Medicaid SUD (sub-acute de-tox discharges) **Standard = 95% in seven days**

5. The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SUD)

ADEQUACY/APPROPRIATENESS

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that

is not supports coordination.

EFFICIENCY

7. The percent of total expenditures spent on managed care administrative functions for PIHPs.

OUTCOMES

8. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who are in competitive employment.

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who earn state minimum wage or more from employment activities (competitive, self-employment, or sheltered workshop).

10. The percent of children and adults with MI and DD readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.

12. The percent of adults with developmental disabilities served, who live in a private residence alone, or with spouse or non-relative.

13. The percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative.

14. The percent of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and respite.

Note: Indicators #2, 3, 4, and 5 include Medicaid beneficiaries who receive substance use disorder services managed by the PIHP.

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
5. Medicaid penetration*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
6. HSW services*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
7. Admin. Costs*	10/01 to 9/30	1/31							MDHHS
8. Competitive employment*	10/01 to 9/30								MDHHS
9. Minimum wage*	10/01 to 9/30								MDHHS
10. Readmissions	10/01 to 9/30	3/31	1/01 to 3/31	6/30	4-01 to 6-30	9/30	7/01 to 9/30	12/31	PIHPs
11. RR complaints	10/01 to 9/30	12/31							PIHPs
12. & 13. Living arrangements	10/1 to 9/30	N/A							MDHHS
14. Children with DD	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS

*Indicators with * mean MDHHS collects data from encounters, quality improvement or cost reports and calculates performance indicators

STATE LEVEL DATA COLLECTION

[WL(2]

CRITICAL INCIDENT REPORTING

PIHPs will report the following events, except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on consumer ID, event date, and event type:

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- **Non-suicide death** for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.
- **Emergency Medical treatment due to Injury or Medication Error** for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.
- **Hospitalization due to Injury or Medication Error** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- **Arrest of Consumer** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

Methodology and instructions for reporting are posted on the MDHHS web site at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

EVENT NOTIFICATION

The PIHP shall immediately notify MDHHS of the following events:

1. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:
    a. Name of beneficiary
    b. Beneficiary ID number (Medicaid, MiChild)
    c. Consumer I (CONID) if there is no beneficiary ID number
    d. Date, time and place of death (if a licensed foster care facility, include the license #)
    e. Preliminary cause of death
    f. Contact person's name and E-mail address
2. Relocation of a consumer's placement due to licensing suspension or revocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

Except for deaths, notification of the remaining events shall be made within five (5) business days to contract management staff members in MDHHS's Behavioral Health and Developmental Disabilities Administration (email: MDHHS-BHDDA-Contracts-MGMT@michigan.gov; FAX: (517) 335-5376; or phone: (517) 241-2139)

NOTIFICATION OF PROVIDER NETWORK CHANGES

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

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

Amendment No. 2 to the Agreement Between
Michigan Department of Health and Human Services
And

PIHP_____
For
The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs

1. **Period of Agreement:**
   This agreement shall commence on October 1, 2018 and continue through September 30, 2019.

2. **Period of Amendment:**
   October 1, 2018 through September 30, 2019.

3. **Program Budget and Agreement Amount:**
   Payment to the PIHP will be based on the total funding available for specialty supports and services as identified in the annual Legislative Appropriation for community mental health services programs for the period of October 1, 2018 through September 30, 2019. The estimated value is contingent upon and subject to enactment of legislative appropriations and availability of funds.

4. **Amendment Purpose:**
   This amendment incorporates changes to boilerplate contract language and related contract attachments.

5. **The Specific Changes are Identified Below:**
   - CMS required changes to various sections of the contract:
     - 18.1 Compliance with Applicable Laws
     - 18.1.14 Compliance with 42 CFR 438 State Responsibilities
     - 18.2 Special Waiver Provisions for MSSSP
     - Section 1557 of PPACA
     - 32.0 FISCAL SOUNDNESS OF THE RISK-BASED PIHP
     - 33.0 PROGRAM INTEGRITY
     - 34.0 PIHP OWNERSHIP AND CONTROL INTERESTS
     - 38.0 SUBCONTRACTING
     - 39.1 Reviews and Audits
     - 39.2 MDHHS Reviews

  - 5.6 Indian Health Service/Tribally-Operated Facility or program/Urban Indian Clinic (I/T/U)
  - 6.3.2 Information Requirements
  - 7.0 PROVIDER NETWORK SERVICES
  - 7.4 Integrated Physical and Mental Health Care
  - 7.8.2.4 Third Party Resource Requirements
  - 7.9.1 External Quality Review
  - 7.10.5 Advance Directives
  - 8.4.1.7 Medical Loss Ratio Reporting Requirements with an amendment to the calculations component of the boilerplate
- Contract attachments P6.3.1 Customer Service Standards and P6.3.1.1 Grievance and Appeals Technical Requirement
- PII.B.A Withdrawal Management Policy #13
- Section 7.7.6 GAIN I-core (Global Appraisal of Individual Needs)
- Contract attachment P39.0.1 PIHP Compliance Examination Guidelines
- Contract attachment P7.7.1.1 PIHP Reporting Requirements

6. **Original Agreement Conditions**
   It is understood and agreed that all other conditions of the original agreement remain the same.

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

Signature Section:

For the Michigan Department of Health and Human Services

Christine H. Sanches, Director Bureau of Grants & Purchasing	Date

For the CONTRACTOR:

Name (print)	Title (print)
Signature	Date

~~Manager and Location Building~~

18.1 Compliance with Applicable Laws[LW1]

The PIHP shall comply with all federal, state and local laws, and require that all ~~PIHPs~~ network providers and other subcontractors ~~will~~ comply with all applicable Federal and State laws and regulations including MCL 15.342 Public officer or employee; prohibited conduct, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1973, and the Rehabilitation Act of 1973, ~~and~~ the Americans with Disabilities Act, and Section 1557 of the Patient Protection and Affordable Care Act (ACA). Statutory and regulatory provisions related to Title XXI (The Children's Health Insurance Program) are applicable to ~~o~~ Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19 21 services rendered under the MIChild program. The PIHP will also comply with all applicable general administrative requirements such as OMB Circulars covering cost principles, grant/agreement principles, and audits in carrying out the terms of this agreement. For purposes of this Agreement, OMB Circular 2 CFR 200 Subpart E is applicable to PIHPs that are local government entities, and OMB Circular 2 CFR 200 Subpart E is applicable to PIHPs that are non-profit entities.

18.1.14 Compliance with 42 CFR 438 State Responsibilities

The PIHP must provide that its Medicaid enrollees are not held liable for Covered services provided to the enrollee, for which The State does not pay the PIHP or The State, or the PIHP does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

The PIHP will ensure that data received from providers is accurate and complete by, verifying the accuracy and timeliness of reported data, including data from network providers the PIHP is compensating on the basis of capitation payments and by screening the data for completeness, logic, and consistency. The PIHP will make all collected data available to the State and upon request to CMS.

The PIHP will submit enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs. The PIHP will Submit all enrollee encounter data that the State is required to report to CMS under § 438.818.

18.2 Special Waiver Provisions for MSSSP

Michigan's Specialty Services and Supports Waiver Program authorized under 1915(b)(1), (3) and (4) of the Social Security Act is currently approved until currently authorized under approved extension.

The 1915(b) Waiver is concurrent with a five-year 1915(c) waiver, referred to as the Home and Community-Based Habilitation Supports Waiver, serving people with a developmental disability, is currently approved until September 30, 2016. Under these waivers, beneficiaries are entitled to specified medically necessary specialty supports and services from the PIHP.

Section 1557 of PPACA
Patient Protection and Affordable Care Act. This includes section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of section 1903(r)(1)(F) of the Act.

32.0 FISCAL SOUNDNESS OF THE RISK-BASED PIHP

Federal regulations require that the risk-based PIHPs maintain a fiscally solvent operation and MDHHS has the right to evaluate the ability of the PIHP to bear the risk of potential financial losses, or to perform services based on determinations of payable amounts under the contract.
MDHHS does not preclude the PIHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. MDHHS requires that the PIHP may only operate a physician incentive plan if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. This contract requires that if the PIHP puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the PIHP must ensure that the physician/physician group has adequate stop-loss protection.

If LTSS are provided under the contract between the MDHHS and the PIHP, the PIHP must establish and maintain a member advisory committee. The member advisory committee will include at least a reasonably representative sample of the LTSS populations, or other individuals representing those enrollees, covered under the contract with the PIHP. If the PIHP is required by MDHHS to provide LTSS in a community-based setting that could be authorized through a section 1915(c) waiver, a section 1915(i) SPA, or a section 1915(k) SPA, the contract specifies that the long term services and supports must be provided in a setting which complies with the 42 CFR 441.301(c)(4) requirements for home and community-based settings.

When the PIHP is providing LTSS, the comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including an assessment of care between care settings. When the ~~PIHPIHP~~ is providing LTSS, the comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including a comparison of services and supports received with those set forth in the enrollee's treatment/service plan. The PIHP is required to implement mechanisms to comprehensively assess each Medicaid enrollee identified as needing LTSS to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the MDHHS or the PIHP as appropriate. [MT(2]

33.0 PROGRAM INTEGRITY

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

The PIHP will provide prompt notification to MDHHS BHDDA when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including, changes in the enrollee's residence and the death of an enrollee.

The PIHPs that make or receive annual payments under the contract of at least $5,000,000, will make provision for written policies for all employees of the entity, and of any contractor or agent of the entity, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

The PIHPs shall require all contracted providers that make or receive at least $5,000,000 in payments under this contract to comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

Reports to MDHHS BHDDA within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. Recoveries of overpayments due to fraud, waste, or abuse shall be reported by the PIHP to MDHHS OIG in accordance with subpart F below.

The PIHP requires and has a mechanism for a network provider to report to the PIHP when it has received an overpayment, to return the overpayment to the PIHP within 60 calendar days after the date on which the overpayment was identified, and to notify the PIHP in writing of the reason for the overpayment.

The MDHHS Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Prepaid Inpatient Health Plan (PIHP) and all entities subcontracted by the PIHP.

A. General

1. The PIHP must have program integrity administrative and management arrangements or procedures, including a mandatory compliance program.
2. The PIHP's compliance program must include the following, as defined in 42 CFR 438.608:
a. Written policies and procedures that describe how the PIHP will comply with federal and State fraud, waste and abuse standards, and well publicized disciplinary standards for failure to comply.
b. The designation of a compliance officer who reports directly to the Chief Executive Officer and the Board of Directors, and a compliance committee, accountable to the senior management or Board of Directors, with effective lines of communication to the PIHP's employees.
c. Effective training and education for the compliance officer, senior management, and the PIHP's employees regarding fraud, waste and abuse, and the federal and State standards and requirements under this contract. While the compliance officer may provide training to PIHP

employees, "effective" training for the compliance officer means it cannot be conducted by the compliance officer himself/herself.
d. Provisions for internal monitoring and auditing. Audits must include post payment reviews of paid claims to verify that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.). Acceptable audit methodology examples include:
– Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers
– Beneficiary interviews to confirm services rendered
– Provider self-audit protocols
The frequency and quantity of audits performed should be dependent on the number of fraud, waste and abuse complaints received as well as high risk activities identified through data mining and analysis of paid claims.
e. Provisions for the PIHP's prompt response to detected offenses and for the development of corrective action plans. "Prompt response" is defined as action taken within 15 business days of receipt by the PIHP of the information regarding a potential compliance problem.
g. Dissemination of the contact information (addresses and toll-free telephone numbers) for reporting fraud, waste or abuse to both the PIHP and the MDHHS-OIG. Dissemination of this information shall be made to all PIHP subcontractors and members annually. The PIHP must indicate that reporting of fraud, waste or abuse may be made anonymously.
3. Triannual meetings will be held between MDHHS-OIG and all PIHP Compliance Officers to train and discuss fraud, waste and abuse.

B. Contracted Entities
1. The PIHP shall include program integrity provisions and guidelines in all contracts with subcontracted entities.
2. The PIHP shall provide guidance to the program integrity activities of all its subcontracted entities, to the extent that the subcontracted entity is delegated responsibility by the PIHP. The PIHP-subcontractor contract shall require at least the following of the subcontracted entity:
– designation of a compliance officer;
– submission to the PIHP of quarterly reports detailing program integrity activities;
– assistance and guidance by the PIHP with audits and investigations, upon request of the subcontracted entity;
– provisions for routine internal monitoring;
– proper prompt response to potential offenses and implementation of corrective action plans;
– appropriate and prompt reporting of fraud, waste and abuse to the PIHP;
– implementation of training procedures regarding fraud, waste and abuse for the subcontracted entities' employees at all levels.
3. The PIHP shall provide MDHHS-OIG with documentation to support that these program integrity activities were performed by its subcontractors in its quarterly submission to the MDHHS-OIG.
4. Effective beginning Fiscal Year '19, by November 15th the PIHP shall submit to MDHHS-OIG a list of all entities with whom it and its participant CMHSPs (if applicable) have contracted to perform services for Fiscal Year '19, under this contract. This list shall contain all facility locations where services are provided or business is conducted, all NPI numbers assigned to the entity and what services the entity is contracted to provide. The PIHP is responsible for updates to this information in its quarterly submission (See Section G).

The list of contracted entities noted above that the PIHP submits shall be documentation to the state to demonstrate that it offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area 1) at the time it enters into a contract with MDHHS, and 2) any time there is a significant change (as defined by the MDHHS) in the PIHP's operations that impacts services. The list of contracted entities shall also be documentation to the MDHHS to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area 1) at the time it enters into a contract with MDHHS, and 2) any time there is a significant change (as defined by the MDHHS) in the PIHP's operations that impacts services.

C. Investigations

1. The PIHP will investigate program integrity complaints/issues until it has determined that a suspicion of fraud exists, at which point the PIHP shall contact MDHHS-OIG and pause any recoupment/recovery/administrative action regarding the issue.
2. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, the Health Insurance Portability and Accountability Act (hereafter "HIPAA"), and the Michigan Mental Health Code, the PIHP will cooperate fully in any investigation by MDHHS-OIG or the Department of Attorney General and any subsequent legal action that may result from such investigation.

D. Reporting Fraud, Waste or Abuse

1. Upon receipt of allegations involving fraud, waste, or abuse regardless of entity (i.e. PIHP, employee, contracted entity, provider, or member), the PIHP shall perform a preliminary investigation. Upon completion of the preliminary investigation, if the PIHP determines a suspicion of fraud exists, the PIHP must promptly refer the matter to MDHHS OIG. These referrals must be made using the PIHP fraud referral template and be shared with MDHHS OIG via secure File Transfer Process (sFTP) using the PIHP's applicable MDHHS OIG sFTP area.
2. The PIHP must report all suspicion of waste or abuse on the Quarterly Submission described in Section G.
3. Questions regarding whether suspicions should be classified as fraud, waste or abuse should be presented to MDHHS-OIG for clarification prior to making the referral.
4. Documents containing protected health information or protected personal information must be submitted in a manner that is compliant with applicable federal and State privacy rules and regulations, including but not limited to HIPAA
5. The MDHHS requires the PIHP or subcontractor, to the extent that the subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the contract between the state and the PIHP, to implement and maintain arrangements or procedures that include provision for the MCP's suspension of payments to a network provider for which the state determines there is a credible allegation of fraud.
6. The MDHHS requires the PIHP or subcontractor, to the extent that the subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the contract between the state and the PIHP, to implement and maintain arrangements or procedures for notification to the state when it receives information about a change in a network provider's

circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the PIHP.

E. Disclosure of Information

1. To the extent consistent with applicable federal and State law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP shall disclose protected health information to MDHHS-OIG or the Department of Attorney General upon their written request, without first obtaining authorization from the beneficiary to disclose such information.

F. Overpayments

1. If the PIHP identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, the PIHP shall obtain written consent from MDHHS-OIG prior to recovering the overpayment.
2. If the PIHP identifies an overpayment involving waste or abuse prior to identification by MDHHS-OIG, the PIHP shall recover the overpayment and report the overpayment on its quarterly program integrity submission.
3. If MDHHS-OIG identifies an overpayment to a provider prior to the PIHP identifying the overpayment, MDHHS OIG will explore options in collaboration with MDHHS BHDDA, up to and including recovering the overpayment from the PIHP.
4. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

G. Quarterly Submissions

Effective beginning Fiscal Year '19, the PIHP must either (1) utilize MDHHS OIG's case tracking system to log in and track program integrity activities performed, or (2) provide information on program integrity activities performed quarterly using the template provided by the MDHHS-OIG. Program integrity activities include but are not limited to:

– Tips/grievances received
– Data mining and analysis of paid claims, including audits performed based on the results
– Audits performed
– Overpayments collected
– Identification and investigation of fraud, waste and abuse (as these terms are defined in the "Definitions" section of this contract
– Corrective action plans implemented
– Provider dis-enrollments
– Contract terminations

All program integrity activities performed each quarter must be reported to OIG according to the following schedule:

Reporting Period/Due Date

January through March	May 15th
April through June	August 15th
July through September	November 15th
October through December	February 15th

H. MDHHS-OIG Sanctions
When MDHHS-OIG sanctions providers, including for a credible allegation of fraud under 42 CFR § 455.23, the PIHP must, at minimum, apply the same sanction upon receipt of written notification of the sanction from MDHHS OIG to the PIHP. The PIHP may pursue additional measures/remedies independent of the State.

I. MDHHS-OIG Onsite Reviews

1. MDHHS-OIG may conduct onsite reviews of PIHP and/or its contracted entities.
2. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP is required to comply with MDHHS-OIG's requests for documentation and information related to program integrity and compliance.

34.0 PIHP OWNERSHIP AND CONTROL INTERESTS

The PIHP may not be any of the following, all of which are all specifically excluded from this contract:

1. An entity that could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.
2. An entity that has a "substantial contractual relationship" either directly or indirectly, with:
   a. An individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act;
   b. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
   c. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in the immediately preceding subsections;
   d. An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act; or
   e. Any entity that would provide those services through an individual or entity described in any of the immediately preceding four subsections.

A "substantial contractual relationship" is any contractual relationship that provides for one or more of the following services: (i) the administration, management, or provision of medical services; and/or (ii) the establishment of policies or the provision of operational support, for the administration, management or provision of medical services.

3. An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one any individual or entity that is (or is affiliated, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person or entity that is):

   a. Debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
   b. Excluded from participation in any Federal health care program under section 1128 or 1128A of the Act; or
   c. Any individual or entity that would provide those services through an individual or entity described in any of the immediately preceding two subsections, 3.a. or b.

Additionally, In in order to comply with 42 CFR 438.610:

1. The PIHP may not knowingly have a "relationship" of the type described below with any of the following:
   a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549;
   b. An individual or entity who is an "affiliate", as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in the immediately preceding subsection 1.(a).

2. The PIHP will not have a "relationship" of the type described below (each a "prohibited relationship") with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

For purposes of this section, a "relationship" means [illegible] with in any of the following capacities:

   a. Director, officer, or partner of the PIHP;
   b. [illegible] of the PIHP;

3. A person with beneficial ownership of five (5) percent or more of the PIHP's equity; or
4. A network provider or person with an employment, consulting or other arrangement for the provision of items and services which are significant and material to the Board's obligations under the PIHP Contract.

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

If the State finds that the PIHP has a "prohibited relationship", as defined above, the State:

1. May continue an existing agreement with the PIHP, unless the Secretary directs otherwise; and
2. May not renew or otherwise extend the duration of an existing agreement with the PIHP unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

~~the PIHP may not have any of the following relationships with an individual who is excluded from participating in Federal health care programs, including sanctioned individuals under section 1128(b)(8) of the act. Including individuals convicted of crimes described in section 1128(b)(8)(B) of the Act. This includes FAR and Executive Order 12549. It also included individuals furnishing health care, utilization review, medical social work, or administrative services under section 1128;~~

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

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

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

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

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

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

The MDHHS requires the PIHP to provide written disclosure in the case that any of the following is or becomes affiliated with any individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549:

1. Any director, officer, or partner;
2. Any subcontractor;
3. Any person with ownership of 5% or more of the PIHPs equity;
4. A network provider; and/or
5. Any party to an employment, consulting, or other agreement with the PIHP for the provision of contract items or services

[LW3]~~The MDHHS requires the PIHP to provide written disclosure of any director, officer, or partner who is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any director, officer, or partner who is affiliated with a person entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or is participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any subcontractor of the MCP who is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any subcontractor of the PIHP who is affiliated with a person entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or is participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any person with ownership of 5% or more of the PIHP's equity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any network provider that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any party to an employment, consulting, or other agreement with the PIHP for the provision of contract items or services that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any network provider who is affiliated with a person entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any employment, consulting, or other agreement for the provision of PIHP contract items or services with a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any employment, consulting, or other agreement for the provision of PIHP contract items or services with a person who is affiliated with a person entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

The MDHHS requires the PIHP and subcontractors to disclose information on individuals or corporations with an ownership or control interest in the PIHP to the state at the following times:

1.
   - When the PIHP submits a proposal in accordance with the state's procurement process;
2.
   - When the PIHP executes a contract with the state;
3.
   - When the state renews or extends the PIHP contract; and
4.
   - Within 35 days after any change in ownership of the PIHP.

38.0 SUBCONTRACTING

The PIHP may subcontract for the provision of any of the services specified in this contract including contracts for administrative and financial management, and data processing. The PIHP shall be held solely and fully responsible to execute all provisions of this contract, whether or not said provisions are directly pursued by the PIHP, or pursued by the PIHP through a subcontract vendor. The PIHP shall ensure that all subcontract arrangements clearly specify the type of services being purchased. Subcontracts shall ensure that the MDHHS is not a party to the contract and therefore not a party to any employer/employee relationship with the subcontractor of the PIHP. Subcontracts entered into by the PIHP shall address such provisions as the PIHP deems necessary for the development of the service delivery system, and shall include standard terms and conditions as MDHHS may develop.

Subcontracts entered into by the PIHP shall address the following:

1. Duty to treat and accept referrals
2. Prior authorization requirements
3. Access standards and treatment time lines
4. Relationship with other providers
5. Reporting requirements and time frames
6. QA/QI Systems

7. Payment arrangements (including coordination of benefits) and solvency requirements
8. Financing conditions consistent with this contract
9. Anti-delegation clause
10. Compliance with Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency"
11. EPSDT requirements
12. In all contracts with health care professionals, the PIHP must comply with the requirements specified in the "Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans", Attachment P 7.9.1. and require the provider to cooperate with the PIHP's quality improvement and utilization review activities
13. Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy
14. Not prohibit a provider from discussing treatment options with a recipient that may not reflect the PIHP's position or may not be covered by the PIHP
15. Not prohibit a provider from advocating on behalf of the recipient in any grievance or utilization review process, or individual authorization process to obtain necessary health care services
16. Require providers to meet Medicaid accessibility standards as established in Medicaid policy and this contract

All subcontracts entered into by the PIHP must be in writing and, if involving Medicaid funds fulfill the requirements of 42 CFR 434.6 and 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract. All employment agreements, provider contracts, or other arrangements, by which the PIHP intends to deliver services required under this contract, shall be subject to review by the MDHHS at its discretion.

Subcontracts that contain provisions for a financial incentive, bonus, withhold, or sanctions, (including sub-capitations) must include provisions that protect individuals from practices that result in the withholding of services that would otherwise be provided according to medical necessity criteria and best practice standards, consistent with 42 CFR 422.208. The PIHP shall provide a copy of specific contract language used for incentive, bonus, withhold or sanction provisions (including sub-capitations) to MDHHS at least 30 days prior to when the contract is issued to the provider. MDHHS reserves the right to disallow or require amendment of such provisions if the provisions appear to jeopardize individuals' access to services. MDHHS shall provide notice of approval or disapproval of submitted contract language within 25 days of receipt or else the language shall be deemed approved by MDHHS. The PIHP must provide information on its Provider Incentive Plan (PIP) to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a PIP). The PIHP must provide information regarding any provider incentive plans to CMS and to any Medicaid beneficiary, as required by 42 CFR 422.210

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

Contracts between the PIHP and subcontractors must require the subcontractor to:

1. ~~C~~comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions;
2. ~~Subcontractors also require the subcontractor to~~ Mmake available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees;
3. Agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit that occurs during such 10 year period[LW4], whichever is later; and
4. Agree that if the state, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time

~~PIHP subcontractor require the subcontractor to agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.~~

~~Subcontractor contracts must require that if the state, CMS, or the DHHS Inspector General, determine that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.~~

39.1 Reviews and Audits

The MDHHS and federal agencies may conduct reviews and audits of the PIHP regarding performance under this contract. The MDHHS shall make good faith efforts to coordinate reviews and audits to minimize duplication of effort by the PIHP and independent auditors conducting audits and compliance examinations.

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

The MDHHS requires that the state, CMS, the OIG, the Comptroller General, and their designees have the right to:

1. ~~be allowed to inspect~~ Inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time;
2. Audit records or documents of the PIHP for 10 years from the final date of the contract period or from the date of completion of any audit that occurs within such 10 year period[LWS], whichever is later;
3. Audit records or documents of the PIHP's subcontractors for 10 years from the final date of the contract period or from the date of completion of any audit that occurs within such 10 year period[LWS], whichever is later

~~The MDHHS requires that the state, CMS, the OIG, the Comptroller General and their designees have the right to audit records or documents of the PIHP for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.~~
~~The MDHHS requires that the state, CMS, the OIG, the Comptroller General and their designees have the right to audit records or documents of the PIHP's subcontractors for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.~~
The MDHHS requires that the Secretary, the Department of Health and Human Services (DHHS), and the state (or any person or organization designated by either) have the right to audit and inspect any books or records of the PIHP or its subcontractors pertaining to:

- ~~The~~ The ability of the PIHP to bear the risk of financial losses.
- Services performed or payable amounts under the contract.

The MDHHS requires that the ~~PIHP~~PIHP and the PIHP's subcontractors retain, as applicable, enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

Subject to exceptions above MDHHS 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.

39.2 MDHHS Reviews

1. 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.
2. The MDHHS will schedule onsite 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.

3. Except as precluded in 34.2 (2) above, the guideline, protocol and/or instrument to be used to review the PIHP, or a detailed agenda if no protocol exists, shall be provided to the PIHP at least 30 days prior to the review.
4. At the conclusion of the review, the MDHHS shall conduct an exit interview with the PIHP. The purpose of the exit interview is to allow the MDHHS to present the preliminary findings and recommendations.
5. Following the exit review, the MDHHS shall generate a report within 45 days identifying the findings and recommendations that require a response by the PIHP.
    a. The PIHP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The PIHP may also present new information to the MDHHS that demonstrates it was in compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the exit interview and the POC). When access or care to individuals is a serious issue, the PIHP may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified in (4) above. If, during an MDHHS on-site visit, the site review team member identified an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in seven calendar days.
    b. The MDHHS will review the POC, seek clarifying or additional information from the PIHP as needed, and issue an approval of the POC within 30 days of having required information from the PIHP. The MDHHS will take steps to monitor the PIHP's implementation of the POC as part of performance monitoring.
    c. 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.
6. MDHHS follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDHHS.

5.6 Indian Health Service/Tribally-Operated Facility or program/Urban Indian Clinic (I/T/U)

PIHPs are required to pay any Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic (I/T/U), or I/T/U contractor, whether participating in the PIHP provider network or not, for PIHP authorized medically necessary covered Medicaid managed care services provided to Medicaid beneficiary/Indian enrollees who are eligible to receive services from the I/T/U provider either (1) at a rate negotiated between the PIHP and the

I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

IHCPs which are enrolled in Medicaid as Federally Qualified Health Centers (FQHC) but are not participating providers of the PIHP must be paid an amount equal to the amount the PIHP would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the ~~PIPHPIHP~~ pays and what the IHCP FQHC would have received under FFS.

When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the PIHP, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.

The PIHP must permit an out-of-network IHCP to refer an Indian enrollee to a network provider.

When the amount the IHCP receives from an PIHP is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the state must make a supplemental payment to the IHCP to make up the difference between the amount the MCP pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

6.3.2 Information Requirements

A. Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services, including but not limited to provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, shall meet the following standards:

1. All such materials shall be written at the 4th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 4th grade level criteria).
2. The provider directory must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on the PIHP's website, in a machine readable file and format. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information.
3. All materials shall be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in the PIHPs Region as identified by the State . Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August

11, 2002 Federal Register Vol. 65, August 16, 2002). All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA), at no cost to the beneficiary. Beneficiaries shall be informed of how to access the alternative formats.

4. If the PIHP provides any required information electronically:
   a. It must be in a form that is readily accessible;
   b. It must be on the PIHP's Web site in a location that is prominent and readily accessible;
   c. It must be in an electronic form which can be electronically retained and printed;
   d. The information must be consistent with the content and language requirements of this 42 CFR 438.10; and
   e. The PIHP must inform the customer that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

~~If the PIHP provides information electronically, it must inform the customer that the information is available in paper form without charge and upon request and provides it upon request within 5 business days.~~

5. Material shall not contain false, confusing, and/or misleading information.
6. For consistency in the information provided to enrollees, the PIHP must use the State developed model enrollee handbooks and enrollee notices[MT(7)] ~~Definitions~~, and State developed definitions for managed care terminology, including appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, physician services, prescription drug coverage, prescription drugs, primary care provider, rehabilitation services and devices, skilled nursing care, specialist, co-payment excluded services, health insurance, medically necessary, network, non-participating, plan preauthorization, participating provider, premium, provider and urgent care, as defined in the PIHP contract and/or Medicaid provider manual.

7.0 PROVIDER NETWORK SERVICES

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

In this regard, the PIHP agrees to:

1. 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.

2. Have clearly written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.
3. Provide a copy of the PIHP's prior authorization policies to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to prior authorization policies as changes are made.
4. Provide a copy of the PIHP's grievance, appeal and fair hearing procedures and timeframes to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to those procedures or timeframes.
5. Provide to MDHHS in the format specified by MDHHS, provider agency information profiles that contain a complete listing and description of the provider network available to recipients in the service area.
6. Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility.
7. Assure that network providers do not segregate PIHP individuals in any way from other people receiving their services.

In addition the PIHP agrees upon request from MDHHS either through an RFP or other means to:

1. Provide documentation on which the state bases its certification that the MCP complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.
   - ~~Submit the name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.~~
   - ~~Submit the date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the PIHP and its subcontractors.~~
   - ~~Submit other tax identification number of any corporation with an ownership or control interest in the PIHP and any subcontractor in which the PIHP has a 5 percent or more interest.~~
   - ~~Submit the name, address, date of birth, and SSN of any managing employee of the PIHP. [MI(s)]~~
2. Submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the state or Secretary.

7.4 Integrated Physical and Mental Health Care

The PIHP will initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid beneficiaries. These efforts will focus on persons that have a chronic condition such as a serious and persistent mental health illness, co-occurring substance use disorder or a developmental disability and have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports.

- The PIHP will implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the consumer's MHP as defined in 7.3.
- As authorized by the consumer, the PIHP will include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.
- The PIHP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.

The PIHP will make it's best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees. The PIHP will make subsequent attempts to conduct an initial screening of each enrollee's needs if the initial attempt to contact the enrollee is unsuccessful. Since the PIHPs are not an enrollment model, screening once an individual presents for services would meet this agreement.[MT[9]]

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7.8.2.4 Third Party Resource Requirements

Medicaid is a payer of last resort. PIHPs and their providers/contractors are required to identify and seek recovery from all other liable third parties in order to make themselves whole. Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a recipient's covered benefit. The PIHP shall collect any payments available from other health insurers including Medicare and private health insurance for services provided to its individuals in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, and the Michigan Mental Health Code and Public Health Code as applicable. The PIHP 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 as applicable.

The PIHP must report third-party collections as required by MDHHS. When a Medicaid beneficiary is also enrolled in Medicare, Medicare will be the primary payer ahead of any PIHP,

if the service provided is a covered benefit under Medicare. The PIHP must make the Medicaid beneficiary whole by paying or otherwise covering all Medicare cost-sharing amounts incurred by the Medicaid beneficiary such as coinsurance, co-pays, and deductibles in accordance with coordination of benefit rules. In relation to Medicare-covered services, this applies whether the PIHP authorized the service or not.
If the MDHHS enters into a Coordination of Benefits Agreement (CBA) with Medicare for FFS, and if the PIHP contract includes responsibility for coordination of benefits for individuals dually eligible for Medicaid and Medicare, the MDHHS requires the PIHP to enter into a CBA with Medicare and participate in the automated claims crossover process.

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

If the PIHP has received accreditation by a private independent accrediting entity it must authorize the private independent accrediting entity to provide MDHHSA a copy of its most recent accreditation review, including its accreditation status, survey type, and level (as applicable). When the PIHP has received accreditation by a private independent accrediting entity it must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, recommended actions or improvements, corrective action plans, and summaries of findings. If the PIHP has received accreditation by a private independent accrediting entity it must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, including the expiration date of the accreditation.

7.10.5 Advance Directives
In accordance with 42 CFR 422.128 and 42 CFR 438.6, the PIHP shall maintain written policies and procedures for advance directives. The PIHP shall provide adult beneficiaries with written information on advance directive policies and a description of applicable state law and their rights under applicable laws. This information must be continuously updated to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective. The PIHP must inform individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Customer Services. This must include prohibiting the PIHP from conditioning the provision of care based on whether or not the individual has executed an advance directive. The PIHP/PIHP will educate staff concerning the PIHP policies and procedures on advance directives.

8.4.1.7 Medical Loss Ratio Reporting Requirements

The PIHP must submit a report to MDHHS that includes at least the following information for each MLR reporting year:

- Total incurred claims.
- Expenditures on quality improving activities.
- Expenditures related to activities compliant with §438.608(a)(1) through (5), (7), (8) and (b).
- Non-claims costs.
- Premium revenue.
- Taxes, licensing and regulatory fees.
- Methodology(ies) for allocation of expenditures.
- Any credibility adjustment applied.
- The calculated MLR.
- Any remittance owed to the State, if applicable.
- A comparison of the information reported in this paragraph with the audited financial report required under §438.3(m).
- A description of the aggregation method used under paragraph (i) of this section.
- The number of member months.

The formula for calculation of the MLR is defined below.

Incurred Claims +/- ISF created/used– HRA – Taxes + Healthcare Quality Improvement + Fraud Reduction

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Current Year Premium Revenue +/- Savings used/created – HRA expense – Tax expense (HICA/Use)

The MLR should be completed in accordance with 42 CFR § 438.8, ~~and that~~ the additional calculation components outlined below are intended to provide clarity regarding state specific items.

Calculation Components

Incurred Claims. Include 1) direct claims paid to providers including all costs of CMHSP capitated contracts (excluding PIHP delegated Managed care administrative costs), 2) Unpaid claims for dates of service falling within the reporting year (accounts payable), 3) Estimate of claims incurred but not reported based on past experience, 4) payments to the ISF, and 5) incentives/bonuses paid to providers. Reduce claims by 6) Overpayment recoveries from providers, 7) prescription drug rebates, 8) claims recovered through fraud reduction efforts up to the amount of fraud reduction expense included in the numerator. 9) Hospital Rate Adjuster payments and 10) contribution to ISF fund.

The following items ~~should be~~must be excluded from incurred claims, consistent with the Medical loss ratio (MLR) standards outlined in 42 CFR § 438.8. ~~Specifically, the following must be excluded from incurred claims:~~

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(A) Non-claims costs, as defined in paragraph (b) of this section, which include the following:

(1) Amounts paid to third party vendors for secondary network savings.

(2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

(3) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

(4) Fines and penalties assessed by regulatory authorities.

(B) Amounts paid to the State as remittance under paragraph (j) of this section.

(C) Amounts paid to network providers under to § 438.6(d).

Healthcare Quality Improvement. Include all Quality Improvement functions, plus include Information Services costs if specifically related to the ability to accept, track, report, and analyze Quality Improvement data. Time and effort for individuals participating in External Quality Reviews (not already captured as Quality Improvement expenses) may be included.

Fraud Reduction. Costs for activities designed to detect and/or prevent payment for fraudulent requests for reimbursement. (i.e. Medicaid Verification Process, Clinical Chart Reviews, etc.)

Premium Revenue. Includes all capitation payments received from MDHHS plus additional cost settlement revenue less any lapse.

Savings. The use of Savings should increase premium revenue while the creation of Savings should reduce premium revenue.

The MLR reporting replaces the PIHP obligation to complete an administrative cost report. The MLR report will provide sufficient administrative cost reporting to meet the actuarial needs. In addition to information required above this will include non-benefit costs in the following categories:

- Administrative costs.
- Taxes, licensing and regulatory fees, and other assessments and fees.
- Contribution to reserves, risk margin, and cost of capital.
- Other material non-benefit costs.

~~MLR must be equal to or higher than 85 percent and the MLR must be calculated and reported for each MLR reporting year by the PIHP.~~

Each MCP expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities. The credibility adjustment is added to the reported MLR calculation before calculating any remittances. The PIHP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If PIHP experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. The PIHP will aggregate data for all Medicaid eligibility groups covered under the contract with the state unless the state requires separate reporting and a separate MLR calculation for specific populations. If required by the state, the PIHP must provide a remittance for a MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher. The PIHP must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the PIHP or MDHHS, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. In any instance where MDHHS makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the MDHHS, the PIHP must re-calculate the MLR for all MLR reporting years affected by the change. In any instance where a MDHHS makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the MDHHS, the PIHP must submit a new MLR report meeting the applicable requirements. The PIHP must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

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- The PIHP shall provide MLR reports to the MDHHS as specified in this contract, and on forms and formats specified by the MDHHS. Forms and instructions are posted to the MDHHS website at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html (See Finance Planning, Reporting and Settlement section of Attachment P 7.7.1.1)
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PIHP CUSTOMER SERVICES STANDARDS
Revised: October, 2018

Preamble

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

Functions

a. Welcome and orient individuals to services and benefits available, and the provider network.
b. Provide information about how to access behavioral health, primary health, and other community services.
c. Provide information about how to access the various rights processes.
d. Help individuals with problems and inquiries regarding benefits.
e. Assist people with and oversee local complaint and grievance processes.
f. Track and report patterns of problem areas for the organization.

Standards

1. There shall be a designated unit called "Customer Services."

2. There shall be at the PIHP a minimum of one FTE (full time equivalent) performing the customer services functions whether within the customer service unit or elsewhere within the PIHP. If the function is delegated, affiliate CMHSPs, and network providers, as applicable, shall have additional FTEs (or fractions thereof) as appropriate to sufficiently meet the needs of the people in the service area.

3. There shall be a designated toll-free customer services telephone line with access to alternative telephonic communication methods (such as Relays, TTY, etc). The customer services numbers shall be displayed in agency brochures and public information material.

4. Telephone calls to the customer services unit shall be answered by a live voice during business hours. Telephone menus are not acceptable. A variety of alternatives may be employed to triage high volumes of calls as long as there is response to each call within one business day.

5. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized. **It is expected that the customer services/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.**

6. The customer handbook shall contain the state-required topics and the PIHP will use the state developed notice forms. (See P.6.3.1.1.A)

7. The Medicaid coverage name and the state's description of each service shall be printed in the customer handbook.

8. The customer handbook shall contain a date of publication and revision(s).

9. The PIHP or delegate entity must provide each customer a customer handbook within a reasonable time after receiving notice of the beneficiary's enrollment. This may be provided by:
   a. mailing a printed copy to the customer's mailing address,
   b. emailed after obtaining the customer's agreement to receive information by email,
   c. If the PIHP posts the information on the website and advises the customer in paper or electronic form that the information is available on the internet provided that persons with disabilities who cannot access the information online are provided auxiliary aids and services upon request at no cost, or
   d. the information is provided by any other method that can reasonably be expected to result in the customer receiving the information.

10. Information about how to contact the Medicaid Health Plans or Medicaid fee-for- service programs in the PIHP service area, including plan or program name, locations, and telephone numbers, shall be provided in the handbook.

11. The PIHP or delegate unit shall maintain a current listings of all providers, practitioners, organizations and any group affiliation with whom the PIHP has contracts, street address(es), telephone number(s), website URL (if appropriate), the services they provide, cultural and linguistic capabilities (if they have completed cultural competency training), any non-English languages they speak (including American Sign Language), any specialty for which they are known, whether the provider's office/facility has accommodations for people with physical disabilities, and whether they are accepting new patients. This list must include independent PCP facilitators. The PIHP must make this available in paper form upon request and electronic form such as the PIHP, CMHSP, or network provider's website as applicable. Beneficiaries shall be given this list annually unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer services line is acceptable.

12. The provider directory must be made available in paper form upon request and electronic form. The provider directory and all required information must also be made available in a prominent, readily accessible location on the PIHP's website in a machine readable file and format.

13. The paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information.

14. If the PIHP provides any required information electronically,

    a. It must be in a form that [illegible]

    b. It must [illegible] the PIHP's Web [illegible]

c. It must be in an electronic form which can be electronically retained and printed;

d. The PIHP must inform the customer that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

~~14. it must inform the customer that the information is available in paper form without charge and upon request and provides it upon request within 5 business days.~~

15. Customer services unit shall have access to information about the PIHP including each CMHSP affiliate annual report, current organizational chart, CMHSP board member list, meeting schedule and minutes. Customer services will provide this information in a timely manner to individuals upon their requests.

16. Upon request, the customer services unit shall assist beneficiaries with filing grievances and appeals, accessing local dispute resolution processes, and coordinate as appropriate with Fair Hearing Officers and the local Office of Recipient Rights.

17. Customer services staff shall be trained to welcome people to the public behavioral health system and to possess current working knowledge, or know where in the organization detailed information can be obtained in at least the following:

    a. *The populations served (serious mental illness, serious emotional disturbance, developmental disability and substance use disorder) and eligibility criteria for various benefits plans (e.g., Medicaid, Healthy Michigan Plan, MIChild)
    b. *Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services
    c. Person-centered planning
    d. Self-determination
    e. Recovery & Resiliency
    f. Peer Specialists
    g. *Grievance and appeals, Fair Hearings, local dispute resolution processes, and Recipient Rights
    h. Limited English Proficiency and cultural competency
    i. *Information and referral about Medicaid-covered services within the PIHP as well as outside to Medicaid Health Plans, Fee-for-Services practitioners, and Department of Human Services
    j. The organization of the Public Behavioral Health System
    k. Balanced Budget Act relative to the customer services functions and beneficiary rights and protections
    l. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies)
    m. Public Health Code (for substance abuse treatment recipients if not delegated to the PIHP)

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

PIHP CUSTOMER SERVICES HANDBOOK
REQUIRED STANDARD TOPICS

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

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

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

*Must use boilerplate language in templates (attached)

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

Other Required Topics (not necessarily in this order)
Access process
Access to out-of-network services

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

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

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

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

Contact the PHIP and MDHHS-OIG [LW1]at (addresses and toll-free telephone numbers) for reporting fraud, waste or abuse to both the PIHP and the MDHHS-OIG. The reporting of fraud, waste or abuse may be made anonymously.

Template #1: Confidentiality and Family Access to Information

You have the right to have information about your behavioral health treatment kept private. You also have the right to look at your own clinical records or to request and receive a copy of your records. You have the right to ask us to amend or correct your clinical record ~~and add a formal statement about them~~ if there is something with which you do not agree. Please remember, though, your clinical records can only changed as allowed by applicable law. ~~You have the right to request and receive a copy of the records.~~ Generally, information about you can only be given to others with your permission. However, there are times when your information is shared in order to coordinate your treatment or when it is required by law.

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

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

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

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

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

Template #2: Coordination of Care

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

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

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

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

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

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

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

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

Template #4: Glossary or Definition of Terms

GLOSSARY

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

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

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

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

Appeal: A review of an adverse benefit determination.

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

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

CMHSP: An acronym for Community Mental Health Services Program. There are 46

CMHSPs in Michigan that provide services in their local areas to people with mental illness and developmental disabilities. May also be referred to as CMH.

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

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

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

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

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

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

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

an authorization decision.

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

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

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

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

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

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

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

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

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

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

Hospital Outpatient Care: Is any type of care performed at a hospital when it is

not expected there will be an overnight hospital stay.

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

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

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

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

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

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

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

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

Participating Provider: Is the general term used for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide health care services; medical equipment; mental health, substance use disorder, intellectual/developmental disability, and long term supports and services. They are licensed or certified to provide health care services. They agree to work with the health plan, accept payment and not charge enrollees an extra amount. Participating providers are also called network providers.

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

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

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

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

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

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

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

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

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

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

Rehabilitation Services and Devices: Health care services that help a person keep,

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

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

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

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

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

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

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

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

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

alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

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

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

Template #5: Grievance and Appeals Processes

Grievances

You have the right to say that you are unhappy with your services or supports or the staff who provide them, by filing a "grievance." You can file a grievance *any time* by calling, visiting, or writing to the [Customer Services Office.] Assistance is available in the filing process by contacting_____. In most cases, your grievance will be resolved within 90-calendar days from the date the PIHP receives your grievance. You will be given detailed information about grievance and appeal processes when you first start services and then again annually. You may ask for this information at any time by contacting the [Customer Services Office]. *

Appeals

You will be given notice when a decision is made that denies your request for services or reduces, suspends or terminates the services you already receive. This notice is called an "Adverse Benefit Determination". You have the right to file an "appeal" when you do not agree with such a decision. There are some limits on when you can file an appeal once you receive a decision about your services. If you would like to ask for an appeal, you will have to do so within 60-calendar days from the date on the Adverse Benefit Determination.

You may:

- aAsk for a "Local Appeal" by contacting at____.

You will have the chance to provide information in support of your appeal, and to have someone speak for you regarding the appeal if you would like.
You
In most cases, your appeal will be completed quicklyin 30 calendar days or less. If you request and meet the requirements for an "expedited appeal" (fast appeal), your appeal will be decided within 72-hours after we receive your request. In all cases, the PIHP may extend the time for resolving your appeal by 14 calendar days if you request an extension, or if the PIHP can show that additional information is needed and that the delay is in your best interest.

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

State Fair Hearing

You must complete a local appeal before you can file a state fair hearing. However, if the PIHP fails to adhere to the notice and timing requirements, you will be deemed to have

exhausted the local appeal process. You may request a State Fair Hearing at that time.

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

Benefit continuation

If you are [LW2]receiving a Michigan Medicaid service that is reduced, terminated or suspended before your current service authorization, and you file your appeal within 10 calendar days (as instructed on the Notice of Adverse Benefit Determination), you may continue to receive your same level of services while your internal appeal is pending. You will need to state in your appeal request that you are asking for your service(s) to continue.

If your benefits are continued and your appeal is denied, you will also have the right to ask for your benefits to continue while a State Fair Hearing is pending. You must ask for one within 10 calendar days. You will need to state in your State Fair Hearing request that you are asking for your service(s) to continue.

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

NOTE: If your benefits are continued because you used this process, you may be required to repay the cost of any services that you received while your appeal was pending if the final resolution upholds the denial of your request for coverage or payment of a service. State policy will determine if you will be required to repay the cost of any continued benefits.

When requested by the enrollee, benefits that the PIHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state fair hearing within the timeframe specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

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

Template #6: Language Assistance and Accommodations Language Assistance

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

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

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

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

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

Accessibility and Accommodations

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

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

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

Template #7: Payment for Services

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

Some members will be responsible for "Cost sharing". This refers to money that a member has to pay when services or drugs are received. You might also hear terms like "deductible, spend-down, copayment, or coinsurance," which are all forms of "cost sharing". Your Medicaid benefit level will determine if you will have to pay any cost-sharing responsibilities. If you are a Medicaid beneficiary with a deductible ("spend-down"), as determined by the Michigan Department of Health and Human Services (MDHHS) you may be responsible for the cost of a portion of your services.

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

If Medicare is your primary payer, the PIHP will cover all Medicare cost-sharing consistent with coordination of benefit rules. The PIHP will provide cost sharing on any benefits carved-out of the contract and provided by the State. As well as How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided.

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

Template #8: Person-Centered Planning

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

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

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

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

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

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

Topics Covered during Person-Centered Planning

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

Psychiatric Advance Directive

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

want when you cannot speak for yourself.

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

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

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

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

Template #9: Recipient Rights

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

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

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

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

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

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

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

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

Template #10: Recovery & Resiliency

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

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

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

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

Template #11: Service Array

MEDICAID SPECIALTY SUPPORTS AND SERVICES DESCRIPTIONS

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

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

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

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

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

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

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

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

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

***Assistive Technology** includes adaptive devices and supplies that are not covered

under the Medicaid Health Plan or by other community resources. These devices help individuals to better take care of themselves, or to better interact in the places where they live, work, and play.

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

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

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

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

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

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

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

Early Periodic Screening, Diagnosis and Treatment (EPSDT[LW3]**)** EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under the age of 21 years, as specified in Section 1905(a)(4)(B) of the Social Security Act (the Act) and defined in 42 U.S.C. s 1396d(r)(5) and 42 CFR 441.50 or its successive regulation.

The EPSDT benefit is more robust than the Medicaid benefit package and is designed to assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible.

[illegible] are required to comply with all EPSDT rules pertaining to Medicaid [illegible] years of age of 21 years. EPSDT is [illegible] Healthy

Insurance Program (CHIP) enrollees under the age of 21 years, to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions.

This requirement results in a comprehensive health benefit for children under age 21 enrolled in Medicaid In addition to the covered services listed above, Medicaid must provide any other medical or remedial care, even if the agency does not otherwise provide for these services or provides for them in a lesser amount, duration, or scope (42 CFR 441.57).

~~Under Michigan's 1915(b) specialty service waiver, the PIHP is responsible for the provision of specialty services Medicaid benefits, and must make these benefits available to beneficiaries referred by a primary EPSDT screener, to correct or ameliorate a qualifying condition discovered through the screening process.~~

While transportation to EPSDT corrective or ameliorative specialty services is not a covered service under this waiver, the PIHP must assist beneficiaries in obtaining necessary transportation either through the Michigan Department of Health and Human Services or through the beneficiary's Medicaid health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>Services for Only Habilitation Supports Waiver (HSW) and Children's Waiver Participants</u>

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

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

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

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

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

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

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

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

Services for Persons with Substance Use Disorders
The Substance Abuse treatment services listed below are covered by Medicaid. These services are available through the PIHP.

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

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

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

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

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

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

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

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

[Name and phone number of the local MDHHS Human Services office]

Medicaid Health Plan Services

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

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

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

[List of health plans and contact numbers]

Template #12: Service Authorization

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

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

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

Template #13: Tag Lines

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Syriac: ܙܘܗܪܐ ܬܐܡܘܢܐ ܥܠ ܗܠܝܢ ܡܬܟܬܒܢܐ ܒܐܫܬܡܫܬܐ ܡܫܠܡܢܘܬܐ ، ܐܝܟ ܠܦܩܐ ܩܠܝܬܐ ، ܘܐܘܪܚ ܬܪܓܡܐ ، ܐܘ ܟܬܒܐ ܪܒܐ ܒܟܠܗ ܡܬܩܢܝܬܐ ܐܘ ܒܠܫܢܐ ܕܝܠܟ ܕܠܐ ܕܡܝܐ. ܐܩܪܐ ܠܗ

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

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

Non-Discrimination and Accessibility

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

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

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

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

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

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

Template #14: FRAUD, WASTE AND ABUSE

Fraud, waste and abuse uses up valuable Michigan Medicaid funds needed to help children and adults access health care. Everyone can take responsibility by reporting fraud and abuse. Together we can make sure taxpayer money is used for people who really need help.

Examples of Medicaid Fraud

- Billing for medical services not actually performed
- Providing unnecessary services
- Billing for more expensive services
- Billing for services separately that should legitimately be one billing
- Billing more than once for the same medical service
- Dispensing generic drugs but billing for brand-name drugs
- Giving or accepting something of value (cash, gifts, services) in return for medical services, (i. e., kickbacks)
- Falsifying cost reports

Or When Someone:

- Lies about their eligibility
- Lies about their medical condition
- Forges prescriptions
- Sells their prescription drugs to others
- Loans their Medicaid card to others

Or When a Health Care Provider Falsely Charges For:

- Missed appointments
- Unnecessary medical tests
- Telephoned services

If you think someone is committing fraud, waste or abuse, you may report it to Corporate Compliance. You may email concerns to [EMAIL], or report them anonymously on the PIHP website – [INSTRUCTIONS FOR USING THE WEBSITE].

Your report will be confidential, and you may not be retaliated against.

You may also report concerns about fraud, waste and abuse directly to Michigan's Office of Inspector General (OIG):

Online: www.michigan.gov/fraud

Call: 855-MI-FRAUD (643-7283) (voicemail available for after hours)

Send a Letter: Office of Inspector General
PO Box 30062
Lansing, MI 48909

[illegible] make sure to include as much information as [illegible] details about [illegible] who was involved (including their ad[illegible] and [illegible] number, date of birth (for beneficiaries), and any other [illegible] you have.

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

OCT. 2017

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I. PURPOSE AND BACKGROUND

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

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

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

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

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

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

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

II. DEFINITIONS

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

Adverse Benefit Determination: A decision that adversely impacts a Medicaid

Enrollee's claim for services due to: *(42 CFR 438.400)*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

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

The Grievance and Appeal System must provide Enrollees:

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

IV. NOTICE OF ADVERSE BENEFIT DETERMINATION

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

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

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e.. "...manner and format that may be easily understood and

is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency);

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

3. Description of Adverse Benefit Determination;

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

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

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

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

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

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

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

~~10.~~

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

1. Adequate Notice of Adverse Benefit Determination:

a. For a denial of payment for services requested (not currently provided), notice must be provided to the Enrollee at the time of the

action affecting the claim. *42 CFR 438.404(c)(2).*

b. For a Service Authorization decision that denies or limits services notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision. *42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3)&(6).*

c. For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. *42 CFR 438.404(c)(5).*

~~c.~~

- NOTE, however, that the PIHP may be able to extend the standard (14 calendar day) or expedited (72-hour) Service Authorization timeframes for up to an additional 14 calendar days ~~in certain circumstances~~ if either the Enrollee requests the extension, or if the PIHP can show that there is a need for additional information and that the extension is in the Enrollee's best interest *(42 CFR 438.210(d)(1)(ii))*. If the PIHP extends the time not at the request of the Enrollee, the PIHP must: (i) make reasonable efforts to give the Enrollee prompt oral notice of the delay; (ii) within 2 calendar days, provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4)*~~If so, the PIHP must: (i) provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4).*~~

~~2. The PIHP may extend the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the enrollee or the provider requests extension.~~

~~3. The PIHP may extend the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the PIHP justifies a need (to the state agency upon request) for additional information and shows how the extension is in the enrollee's best interest.~~

~~4.~~ Advance Notice of Adverse Benefit Determination:

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

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

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

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

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

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

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

   v. The PIHP establishes that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

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

   vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;

   viii. The date of action will occur in less than 10 calendar days.

   ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the Enrollee (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

C. Required Recipients of Notice of Adverse Benefit Determination:

1. The Enrollee must be provided written notice. *42 CFR 438.404(a); 42 CFR 438.210(c).*

2. The requesting provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing. *42 CFR 438.210(c).*

3. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an adverse benefit determination, and requires a written notice of action.

V. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

A. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: *42 CFR 438.420*

1. The Enrollee files the request for Appeal timely (within 60 calendar days from the date on the Adverse Benefit Determination Notice); *42 CFR 438.402(c)(2)(ii);*

2. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination). *42 CFR 438.420(a)*; and

3. The period covered by the original authorization has not expired.

B. Duration of Continued or Reinstated Benefits *(42 CFR 438.420(c))*. If the PIHP continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:

1. The Enrollee withdraws the Appeal or request for State Fair Hearing;

2. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal;

3. A State Fair Hearing office issues a decision adverse to the Enrollee.

C. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. *42 CFR 438.420(d).*

D. If the Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.

E. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. *42 CFR 438.424(b)*

F. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a).*

VI. PIHP APPEAL PROCESS

A. Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:

1. The Enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal. *42 CFR 438.402(c)(2)(ii).*

2. The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. *42 CFR 438.402(c)(3)(ii).*

   NOTE: Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). *42 CFR 438.406(b)(3).*

3. In the circumstances described above under the Section entitled "Continuation of Benefits," the PIHP will be required to continue/reinstate Medicaid Services until one of the events described in that section occurs.

B. PIHP Responsibilities when Enrollee Requests an Appeal:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of each Appeal. *42 CFR 438.406(b)(1).*

3. Maintain a record of appeals for review by the State as part of its quality strategy. *42 CFR 438.416.*

4. Ensure that the individual(s) who make the decisions on Appeals: *42* CFR 438.406(b)(2).

    a. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;

    b. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

    c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

5. Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing, and inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals; *42 CFR 438.406(b)(4).*

6. Provide the Enrollee and his/her representative the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. *42 CFR 438.406(b)(5).*

7. Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate; *42 CFR 438.406(b)(6).*

8. Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

C. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed **30 calendar days** from the day the PIHP receives the Appeal.

2. Expedited Appeal Resolution (timing):

   a. Available where the PIHP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee's behalf or supporting the Enrollee's request) that the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. *42 CFR 438.410(a).*

   b. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an Enrollee's appeal. *42 CFR 438.410(b).*

   c. If a request for expedited resolution is denied, the PIHP must:

      i. Transfer the appeal to the timeframe for standard resolution. 42 CFR 438.410(c)(1).

      ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial. *42 CFR 438.408(c)(2), 438.410(c)(2).*

      iii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision. *42 CFR 438.408(c)(2), 438.410(c)(2).*

      iv. Resolve the Appeal as expeditiously as the Enrollee's health condition requires but not to exceed 30 calendar days.

   d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72-hours** after the PIHP receives the request for expedited resolution of the Appeal. *42 CFR 438.408.*

3. Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*

a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

ii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision.

~~iii.~~ Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.

~~The PIHP~~ [LW1] ~~may extend the timeframe for processing a grievance by up to 14 calendar days if the enrollee requests the extension. The PIHP may extend the timeframe for processing a grievance by up to 14 calendar days if the PIHP shows that there is need for additional information and that the delay is in the enrollee's interest (upon state request). When the PIPH extends the timeline for a grievance not at the request of the enrollee, it must make reasonable efforts to give the enrollee prompt oral notice of the delay. The PIHP extends the timeline for a grievance not at the request of the enrollee, it must give the enrollee written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.~~

iii.

4. Appeal Resolution Notice Format:

a. The PIHP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. *42 CFR 438.408(d)(2).*

b. Attached to this agreement are recommended notice templates for grievance and appeals. They are titled, Exhibit A "Notice of Adverse Benefit Determination", Exhibit B "Notice of Receipt of Appeal/Grievance", Exhibit C Notice of Appeal Approval", and Exhibit D "Notice of Appeal Denial". These templates incorporate the information needed to meet the requirement of grievance and appeal recordkeeping in 42 CFR 438.416. Specifically, 42 CFR 438.416 indicates the State must require the PIHP maintain records with (at minimum) the following information:

(1) A general description of the reason for the appeal or grievance.
(2) The date received.
(3) The date of each review or, if applicable, review meeting.
(4) Resolution at each level of the appeal or grievance if applicable.

(5) Date of resolution at each level, if applicable.
(6) Name of the covered person for whom the appeal or grievance was filed.

Further this recordkeeping must be "accurately maintained in a manner accessible to the state and available upon request to CMS."

~~IF the PIHP chooses not to use the recommended notice templates the alternatives used by the PIHP must include the required information under 42 CFR 438.416 as noted above.~~

c. Enrollee notice must meet the requirements of *42 CFR 438.10* (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

5. Appeal Resolution Notice Content: *42 CFR 438.408(e)*

a. The notice of resolution must include the results of the resolution and the date it was completed.

b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:
   i. Right to request a state fair hearing, and how to do so;
   ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
   iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

VII. GRIEVANCE PROCESS

A. Federal regulations provide Enrollees the right to a grievance process to seek resolution to issues that are not Adverse Benefit Determinations. *(42 CFR 438.228)*

B. Generally:

1. Enrollees must file Grievances with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

2. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative. *42 CFR 438.402(c)(2)(i).*

3. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution within **90 calendar days** of the date of the request. This constitutes an

"Adverse Benefit Determination", and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

C. PIHP Responsibility when Enrollee Files a Grievance:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of the Grievance. *42 CFR 438.406(b)(1).*

3. Maintain a record of grievances for review by the State as part of its quality strategy.

4. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination. *42 CFR 434.32*

5. Ensure that the individual(s) who make the decisions on the Grievance:

   a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual. *42 CFR 438.406(b)(2)(i).*

   b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

   c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP received the Grievance.

2. Extension of Timeframes(s): The PIHP may extend the grievance resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c)*

a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

ii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision; and

iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires

~~f.~~3. Format and Content of Notice of Grievance Resolution:

a. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

b. The notice of Grievance resolution must include:
   i. The results of the Grievance process;
   ii. The date the Grievance process was concluded;
   iii. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and
   iv. Instructions on how to access the State Fair Hearing process, if applicable .

VIII. STATE FAIR HEARING APPEAL PROCESS

A. Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:

1. After receiving notice that the PIHP is, after Appeal, upholding an Adverse Benefit Determination. *42 CFR 438.408(f)(1);*

2. When the PIHP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in *42 CFR 438.408. 42 CFR 438.408(f)(1)(i).*

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State and PIHP, and not extend any timeframes or disrupt continuation of benefits). *42 CFR 438.408(f)(1)(ii).*

C. The PIHP may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.

D. Enrollees are given **120 calendar days** from the date of the applicable notice of resolution to file a request for a State Fair Hearing. *42 CFR 438.408(f)(2).*

E. The PIHP is required to continue benefits, if the conditions described in Section V, MEDICAID SERVICES CONTINUATION OR REINSTATEMENT are satisfied, and for the durations described therein.

F. If the Enrollee's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the Adverse Benefit Determination.

G. The parties to the State Fair Hearing include the PIHP, the Enrollee and his or her representative, or the representative of a deceased Enrollee's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

H. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:

www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html

OR

Department of Licensing and Regulatory Affairs
Michigan Administrative Hearing System Fair Hearing
http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html

IX. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain records of Enrollee Appeals and Grievances, which will be reviewed by the PIHP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy.

A PIHP's record of each Grievance or Appeal must contain, at a minimum:

A. A general description of the reason for the Grievance or Appeal;
B. The date received;
C. The date of each review, or if applicable, the review meeting;
D. The resolution at each level of the Appeal or Grievance, if applicable;
E. The date of the resolution at each level, if applicable;
F. Name of the covered person for whom the Grievance or Appeal was filed.

PIHPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.

X. RECIPIENT RIGHTS COMPLAINT PROCESS

Enrollees, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.

Exhibit A

NOTICE OF ADVERSE BENEFIT DETERMINATION
<Health Plan/CMHSP-PIHP name/ MI Choice Waiver Agency name>

Important: This notice explains your internal appeal rights. Read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows: Member Beneficiary ID: <Member's Medicaid ID Number>.*]*

This is to tell you that the following action has been taken:

[Enter information regarding the adverse benefit determination taken to deny, reduce, suspend or terminate a covered benefit or payment with effective dates]

This action is based on the following:

[Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.]

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our action, you have the right to an Internal Appeal

You have to ask <Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name> for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your doctor {provider} can send in your request that must include:

- Your Name
- Address
- Member number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters or other information that explains why you need the item or service. If you are asking for a fast appeal you will need a doctor's supporting statement. Call your doctor if you need this information.

Please keep a copy of everything you send us for your records.

There are 2 kinds of internal appeals:

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**. If you want to ask for an internal appeal, you can either call or send in a written request to:

<Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name>
Address
Phone Number TTY Phone Number
Fax Number

Expedited or Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. **We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request.** If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 calendar days. To ask for a Fast Appeal, you must call: **{Phone Number} {TTY Phone #}**

Continuation of services during an Internal Appeal

If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination <insert 10 calendar day date>, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

> Your benefits for that service will continue if you request an internal appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: <number(s)> to learn how to name your representative. TTY users call <number>. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

What happens next?

- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing. [*Licensed health plans in Michigan must also insert*: You can also ask for an External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial Services (DIFS).]

- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] and how to file the request.

- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
- [*If applicable, insert other state or local aging/disability waiver resources contact information.*]

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.*]

Exhibit B

Notice of Receipt of Appeal/Grievance
<Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name>

Important: Read this notice carefully. If you need help, you can call one of the numbers listed on the next page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name> **Beneficiary ID:** <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to a request that we received on <date received>.

☐ You Filed A Grievance

We received your grievance on <date received> about <subject of grievance>. We take your concerns seriously. Thank you for taking the time to bring this to our attention.

WHAT THIS MEANS

We will review your grievance by <date received plus 390 calendar days>. A letter will be mailed to you within two (2) calendar days after we complete our investigation telling you what we found and what (if any) action we will take, or have taken.

☐ You Filed An Internal Appeal

We received your request for an internal appeal on <date received>. You are appealing our decision to <description of subject of appeal>.

WHAT THIS MEANS

A decision on this appeal will be made by <date received plus thirty (30) days>. A letter will be mailed to you telling you what our decision is and why we made that decision.

<The appeal was received within ten (10) calendar days of the decision that you are appealing. Therefore, the service(s) you have been receiving may continue while the appeal is being reviewed.> You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

We may contact you for more information or if we have more questions. If you have any questions or additional information to provide please call <list an appeals specific phone number/fax number>.

FOR BOTH GRIEVANCES AND APPEALS

If you want someone to represent you

At any time during the process you may have another person act for you or help you. This person will be your representative. If you want someone to act for you, you must tell us that in writing.

If you already have someone to represent you, or if you have a legal guardian, power of attorney, or someone authorized to make health care decisions on your behalf, you do not have to do anything else.

Get help & more information

- {Health plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557/.]

Exhibit C

Notice of Appeal Approval
<Health Plan/CMHSP-PIHP / MI Choice Waiver Agency name>

Important: This notice explains the results of your appeal. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to the internal appeal request that we received on <date appeal received>

Your appeal was approved

Your appeal was thoroughly considered. This is to inform you that we approved your appeal for the service/item listed below:

What this means:

Because your Level 1 Appeal decision was approved, you may receive the following services as of <date authorized>: [*List the services that were approved, including any applicable information about coverage amount, duration, etc. Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage Member Handbook provisions as well as Plan policies procedures or assessment tools used to support the decision.*]

If you do not receive the services, or if the services are wrongly stopped or reduced, tell us immediately using the contact information below:

<Health Plan / CMHSP-PIHP / MI Choice Wavier Agency name>

<Name of Appeals/Grievance Department>
<Mailing Address for Appeals/Grievance Department>

Phone: <phone number> TTY: <TTY number>
Fax: <fax number>

Getting your case file

You can ask to see the medical records and other documents we reviewed during your appeal. You can also ask for a copy of the guidelines we used to make our decision. You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]

Exhibit D

Notice of Appeal Denial
<Health Plan/ CMHSP-PIHP / MI Choice Waiver Agency name>

Important: This notice explains your additional appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to the internal appeal request that we received on <date appeal received>.

Your internal appeal was denied

Your appeal was thoroughly considered. This is to inform you that we [*denied* or *partially denied*] your internal appeal for the service/item listed below:

Why did we deny your appeal?

We [*denied* or *partially denied*] your internal appeal for the service/item listed above because:
[*Include citations with descriptions that are understandable to the member or applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage Member Handbook provisions as well as Plan policies procedures or assessment tools used to support the decision.*]

You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider requested coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our decision, you have the right to further appeal

You have the right to an External Appeal. The External Appeal is reviewed by an independent organization that is not connected to us. You can file an External Appeal yourself.

[*Health plans must insert:* There are two ways to make an External Appeal: 1) State Fair Hearing with the Michigan Administrative Hearing System (MAHS) and/or 2) External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial Services (DIFS).] [*PIHP and MI Choice Waiver Agency must insert:* You can do this by asking for a State Fair Hearing with the Michigan Administrative Hearing System (MAHS).]

Below is information on how to request a State Fair Hearing with MAHS [*Health Plans must insert:* and an External Review with DIFS].

How to ask for a State Fair Hearing with MAHS

To ask for a Medicaid State Fair Hearing you must follow the directions on the enclosed Request for State Fair Hearing form. You must ask for a State Fair Hearing within **120 calendar days** from the mailing date of this notice. If your request is not received at MAHS by <insert 120 calendar day date>, you will not be granted a hearing. If you need another copy of the form, you can ask for one by calling <Health Plan/ CMHSP-PIHP/ MI Choice Waiver Agency name> Member Services at <phone number> or the Michigan Department of Health and Human Services Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

What happens next?

MAHS will schedule a hearing. You will get a written "Notice of Hearing" telling you the date and time. Most hearings are held by telephone, but you can ask to have a hearing in person. During the hearing, you'll be asked to tell an Administrative Law Judge why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision within 90 calendar days from the date your Request for Hearing was received by MAHS. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) State Fair Hearing. Your request must be

in writing and clearly state that you are asking for a fast State Fair Hearing. Your request can be mailed or faxed to MAHS (see the enclosed Request for Hearing form for the address and fax number). If you qualify for a fast State Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions about the State Fair Hearings process, including the fast State Fair Hearing, you can call MAHS at 1-877-833-0870.

[PIHP and MI Choice are not subject to PRIRA and should therefore delete the following section on filing with DIFS.]

How to ask for an External Review with DIFS

To ask for an External Review under the Patient Right to Independent Review Act (PRIRA) from DIFS, you must complete the Health Care Request for External Review form. The form is included with this notice. You can also get a copy of the form by calling DIFS at 1-877-999-6442. Complete the form and send it with all supporting documentation to the address or fax number listed on the form. You must submit your request within **60 calendar days** of your receipt of this appeal decision notice. You have the right to request and receive benefits while the hearing is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

What happens next?

DIFS will review your request. If your case does not require medical record review, DIFS will issue a decision within 14 calendar days after your request is accepted. If your case involves issues of medical necessity or clinical review criteria, DIFS will issue a decision within 21 calendar days.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) External Review. To ask for a fast External Review, you can call DIFS at 1-877-999-6442. A fast External Review is completed within 72 hours after your request has been accepted.

Continuation of Services

If we previously approved coverage for a service but then decided to change or stop the service before the authorization ended, you can continue your benefits during External Appeals in some cases.

> Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

If your benefits are continued during your appeal, you can keep getting the service until one of the following happens: 1) you withdraw the External Appeal; or 2) all entities that got your appeal decide "no" to your request.

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.
- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
- *[If applicable, insert other state or local aging/disability resources contact information.]*

[Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]

TREATMENT POLICY #13

SUBJECT: Withdrawal Management Continuum of Services

ISSUED: May 5, 2017

EFFECTIVE: July 1, 2017

PURPOSE:
The purpose of this policy is to establish requirements for withdrawal management services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to support individualized services that maintain cultural, age, and gender appropriateness.

SCOPE:
This policy impacts the Prepaid Inpatient Health Plans (PIHP) and the withdrawal management service provider network.

BACKGROUND:
Withdrawal management includes a wide variety of covered services with the provision of these services expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited and do not reflect advances in science and practice. These changes have essentially left the administrative rules obsolete in the area of recommended services. This policy seeks to establish criteria that will result in services that are provided in accordance with those outlined by the ASAM Criteria, and are more reflective of interventions that have been shown to be effective in providing care to individuals receiving withdrawal management services.

Withdrawal management, or detoxification, has historically been available within residential programs only. However, this policy expands the opportunities for individuals requiring withdrawal management by supporting services at additional levels of care. An individual who does not meet medical necessity criteria for residential based withdrawal management may receive their services through a licensed outpatient program. Outpatient programs offering withdrawal management will be required to have access to appropriately licensed laboratories for testing. Only programs that offer Levels 3.2 and 3.7 will be required to maintain a Residential Detoxification license.

Withdrawal management services also include physicians or physician's designated representatives, and staffing requirements, and these requirements must be met, as appropriate, for each level of care. For instance, it is not necessary to have staffing 24 hours per day, 7 days per week in an outpatient withdrawal management level of care.

~~By limiting withdrawal management services to residential programs, we have created a system with the expectation that all clients will equally benefit from the services being offered and resulted in clients with varying needs being admitted into the same program. This makes it more difficult to assure and provide services that are focused on addressing the individual needs of each client.~~ [us1]To ensure that all clients are served at the level of care that best meet their needs. it is necessary to increase the opportunity for withdrawal management beyond the traditional

residential setting. Many clients have the ability to manage their withdrawal from substances through outpatient services, while maintaining their everyday responsibilities, and it is necessary that the publicly funded SUD system is able to support their needs.

DEFINITIONS:

Toxicology Screening - screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non-laboratory urinalysis).

Biopsychosocial Screening and Assessment- screening is used to determine if problem is there, assessment determines nature of problem and a diagnostic impression. This also determines the level of care the individual should receive, as well as determines individualized care plan and treatment priorities.

Counseling - an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Crisis Intervention - a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher LOC if intervention is not provided.

Daily assessment – a tool used to determine clients progress and successes throughout program, can also be used to determine any weaknesses client may have in order to focus on strengthening those or determine any treatment changes.

Discharge – withdrawal signs and symptoms are sufficiently resolved that client can be safely managed at less intensive level of care or be sent home.

Group Counseling - face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

Group Psychotherapy - face-to-face, insight-oriented interventions with three or more clients.

Health Education Services – multidisciplinary approach to help clients understand how social factors, financing systems, organizational and familial systems, health technologies and personal behavior impact their health.

Individual Counseling - face-to-face intervention for the purpose of goal setting and achievement, and skill building. This is distinct from treatment planning, as this may be goals and achievements identified in case management or through peer based services.

Individualized Treatment Planning - direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education - services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as a "didactic" education.

Interactive Education Groups - activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

Medical Necessity - treatment that is reasonable, necessary, and appropriate based on individualized treatment planning and evidence-based clinical standards.

Psychotherapy - an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (Michigan Administrative Code, Social Work General Rules).

Recovery - a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf)

Recovery Planning - purpose is to highlight and organize a person's goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

Recovery Support and Preparation - services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Referral/Linking/Coordination of Services - office-based service activity performed by a primary clinician, or other assigned staff, to address needs identified through the assessment, and/or to ensure follow through with access to outside services, and/or to establish the client with another substance use disorder service provider.

Substance Use Disorder - a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

Withdrawal Management - monitoring for the purpose of preventing/alleviating medical complications related to no longer using, or decreasing the use of, a substance.

REQUIREMENTS:

The withdrawal management level of care from ASAM is established based on the intensity of the needs of the client within the six dimensions. Withdrawal management, or detoxification, will be identified by level of care, with a continuum of services offered under withdrawal management and based on the needs of the individual. PIHPs will need to have the capacity to provide a withdrawal management continuum that will meet the needs of clients at ASAM levels 1-WM, 2-WM, 3.2-WM, and 3.7-WM. Level 4-WM, as a medically managed intensive inpatient withdrawal management service, is not offered within the PIHP system, and if indicated by the LOC determination must be accessed through the physical health system. The frequency and duration of services are expected to be guided by the ASAM levels of care, and are described as follows:

ASAM Level 1 – Ambulatory Withdrawal Management without Extended On-Site Monitoring

This is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility, or in an individual's home by trained clinicians who provide medically supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. These services should be provided through regularly scheduled sessions and should be delivered under a defined set of policies and procedures or medical protocols.

Support Systems

Support systems at this level should include the availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems as indicated. As well as the ability to obtain a comprehensive medical history and physical examination of the individual at admission. They should also have affiliation with other levels of care, including other levels of specialty addiction treatment, for additional problems identified through a comprehensive biopsychosocial assessment. The ability to conduct and/or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing, is necessary. Twenty-four-hour access to emergency medical consultation services should they be necessary, by phone or face to face as indicated. Lastly, the ability to provide or assist in accessing transportation services for individuals who lack safe transportation. [JS2]

Staff Requirements

Level 1-withdrawal management services should be staffed by physicians and nurses, who are essential to this type of service, though they need not be present in the treatment setting at all times. It is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in a less supervised setting would be safe.

Physicians do not need to be certified as addiction specialists and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal states is necessary. Services provided by counselors, psychologists and social workers may be available through withdrawal management service, or these services can be assessed through an affiliate of this level of care.

All clinicians who assess and treat individuals should be able to obtain and interpret information regarding the needs of these persons, and are knowledgeable about the biopsychosocial dimensions of alcohol, tobacco and other substance use disorders. This knowledge should include the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of these conditions and how to facilitate ongoing care for this individual.

ASAM Level 2- Ambulatory Withdrawal Management with Extended On-Site Monitoring

This level is an organized service that can be delivered in an office setting, a general health care or mental health care facility by medical and nursing professionals that provide evaluation, withdrawal management and referral services. Services are provided in regularly scheduled sessions or under a defined set of physician approved policies or clinical protocols.

Support Systems

Level 2 support systems include the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems. Programs must either provide or have the ability to obtain a comprehensive medical history and physical examination of the individual at admission, and have access to psychological and psychiatric consultation. This level of support also includes affiliation with other levels of care, including other levels of specialty addiction treatment, as well as general and psychiatric services for additional problems identified through a comprehensive biopsychosocial assessment.

The ability to conduct or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing, and 24-hour access to emergency medical consultation services are a necessity at this level. Lastly, this level of care includes the ability to provide or assist in accessing transportation services for individuals who lack safe transportation.

Staff Requirements

This level of care should be staffed by physicians and nurses, although they need not be present at all times. Since this level of care is administered on an outpatient basis, it is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in a less supervised setting is safe. Physicians do not need to be certified as addiction specialists and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal states is necessary.

Counselors, psychologists and social workers may be available through the withdrawal management service or may be accessed through affiliation with organizations providing other Level 2 services. All clinicians that assess and treat individuals must have knowledge regarding the needs of their clients, and knowledge about the biopsychosocial dimensions of alcohol and other drug addiction. Such knowledge includes signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care.

[JS3][SAJ(4]

ASAM Level 3.2 – Clinically Managed Residential Withdrawal Management

Referred to as "social setting detoxification" or "social detox," this is an organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal. This level is characterized by its emphasis on peer and social support rather than typical medical or nursing care services. This level of care provides services for clients with severe intoxication/withdrawal signs and symptoms that require 24-hour structure and support.

Some programs may be staffed to supervise self-administered medications for the management of withdrawal. All Level 3.2 programs must rely on established clinical protocols to identify individuals that are in need of medical services beyond the capacity of the facility and to transfer these individuals to appropriate levels of care.

Support Systems

Level 3.2 Withdrawal Management support systems include the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems. Since this level is managed by clinicians and not medical or nursing staff, protocols are in place in case an individual's condition deteriorates and appears to need medical or nursing interventions.

These protocols are used to determine the nature of the medical or nursing interventions that may be required. Protocols include under what conditions and when transfer to a medically monitored facility or an acute care hospital is necessary. These protocols are developed and supported by a physician knowledgeable in addiction medicine. These programs must also be affiliated with other levels of care with the ability to arrange for appropriate laboratory and toxicology tests.

Staff Requirements

Level 3.2 programs are staffed by appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for individual observation and supervision, determination of appropriate levels of care, and facilitation of the individual's transition to continuing care. Social withdrawal management is a clinically managed withdrawal management service explicitly designed to safely assist individuals through withdrawal without the need for ready on-site access to medical and nursing personnel. Medical evaluation and consultation is available 24-hours a day, in accordance with treatment/transfer practice protocols and guidelines. All clinicians who assess and treat individuals are able to obtain and interpret information regarding the needs of these

individuals. This knowledge includes the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care. Facilities that supervise self-administered medications have appropriately licensed or credentialed staff and policies and procedures in accordance with state and federal law. The staff at this level of care should ensure that individuals are taking medication according to prescription and legal requirements.

ASAM Level 3.7 – Medically Monitored Inpatient Withdrawal Management
This level of care is an organized service that is delivered by medical and nursing professionals that provide 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician approved policies and physician-monitored procedures or clinical protocols.
This level of care provides care to individuals with withdrawal signs and symptoms that are sufficiently severe to require 24-hour inpatient care. It sometimes is provided by overlapping with Level 4 withdrawal management services, with a specialty unit of an acute care general or psychiatric hospital. 24-hour observation, monitoring, and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Support Systems
Level 3.7 Withdrawal Management support systems feature the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems. They also feature the availability of medical nursing care and observation as warranted based on clinical judgment, along with direct affiliation with other levels of care. Programs must have the ability to conduct or arrange for appropriate laboratory and toxicology tests.

Staff Requirements
Level 3.7 programs should be staffed by physicians that are available 24-hours a day by telephone. A physician is available to assess the individual within 24-hours of admission, or earlier if medically necessary, and is available to provide on-site monitoring of care and further evaluation on a daily basis. A registered nurse or other licensed and credentialed nurse is available to conduct a nursing assessment on admission. A nurse will be responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis. There will need to be appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders. The level of nursing care needs to be appropriate to the severity of the individual's needs.

Licensed, certified, or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care, and treatment services for individuals and their families. An interdisciplinary team of appropriately trained clinicians (such as physicians, nurses, counselors, social workers, and psychologists) is available to assess and treat the individual and to obtain and interpret information regarding the individual's needs. The

number and disciplines of team members are appropriate to the range and severity of the individual's problems.

ASAM Level 4 – Medically Managed Intensive Inpatient Withdrawal Management
This level of withdrawal management is an organized service delivered by medical and nursing professionals that provide 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. This information is being provided for reference and guidance purposes only, and it is not an expectation that PIHPs provide this level of care. Services are delivered under a defined set of physician-approved policies and physician managed procedures and protocols.

This level of care also provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. Twenty-four hour observation, monitoring, and treatment are available at this level, and is designed for acute medical withdrawal management. It is required that the individual be assessed and a care plan for any of their treatment priorities be developed.

Support Systems
Support systems at this level of care feature the availability of specialized medical consultation, full medical acute care services and intensive care as needed.

Staff requirements
This level of care requires programs are staffed by physicians that are available 24-hours a day as active members of an interdisciplinary team of appropriately trained professionals and those that can medically manage the individual's care. A registered nurse or other licensed and credentialed nurse is available for primary nursing care and observation 24-hours a day.

This level of care also requires facility-approved addiction counselors or licensed, certified, or registered addiction clinicians be available eight (8) - hours per day to administer planned interventions according to the assessed needs of the individual. An interdisciplinary team of appropriately trained clinicians is available to assess and treat the individual with a substance use disorder, or an addicted individual with a concomitant acute biomedical, emotional or behavioral disorder.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by the individual:

Dimensional Interactions	Severity Increase	Severity Decrease
Dimension 1	Acute intoxication and/or withdrawal potential	Acute intoxication and/or withdrawal potential

Dimensional Interactions	Severity Increase	Severity Decrease
Dimension 2	Impaired liver function, comorbid neurological conditions that could be exacerbated by autonomic nervous system hyperarousal, pregnancy	Absence of comorbid medical condition
Dimension 3	Use or misuse of psychiatric medications that are metabolized in the liver, psychiatric disorganization that may affect patient adherence to withdrawal management regimen.	Absence of comorbid psychiatric condition
Dimension 4	Lack of readiness to change affecting adherence to withdrawal management protocols or causing premature discharge from withdrawal management, lack of readiness to change affecting effectiveness of ambulatory withdrawal management	Readiness to change at a level that facilitates adherence to ambulatory withdrawal management services
Dimension 5	Continued use of alcohol, illicit drugs, or non-medical use of prescription drugs	No continued use of alcohol, illicit drugs, or non-medical use of prescription drugs
Dimension 6	Lack of supportive recovery environment or transportation for ambulatory withdrawal management	A supportive recovery environment and transportation to ambulatory withdrawal management

PROCEDURE:

Admission Criteria

Admission to withdrawal management is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider's assessment process.
- Individualized determination of need.
- ASAM Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the ASAM Criteria below:
  1) Withdrawal potential.
  2) Medical conditions and complications.
  3) Emotional, behavioral, or cognitive conditions and complications.
  4) Readiness to change – as determined by the Stages of Change Model.
  5) Relapse, continued use or continued problem potential.
  6) Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development. Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM Criteria. As a client's needs change, the frequency, and duration, of services may be increased or decreased as medically necessary. Participation of the individual receiving services in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

Covered Services
The following services must be available in a Withdrawal Management setting regardless of the LOC and based on individual need:

Type	Withdrawal Management Services Description
Basic Care	Room, board, supervision, monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery-oriented. Levels 3.2 and 3.7 only: room and board.
Treatment Basics **Core Service**	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services; preparation for 'next step'.
Therapeutic Interventions **Core Service**	Individual, group, and family psychotherapy services appropriate for the individual's needs, and crisis intervention. Services provided by an appropriately licensed, credentialed, and supervised professional working within their scope of practice.
Interactive Education /Counseling **Core Service**	Interaction and teaching with client(s) and staff to process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Examples: disease of addiction, mental health, and substance use disorder.
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; treatment coordination; support groups; drug/alcohol free campus.
Medical Services **Core Service**	Medication prescribing and management. Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available.

Treatment/Recovery Planning

Individuals entering any level of withdrawal management services will have recovery and functional needs that will continue to require intervention once withdrawal based services are no longer appropriate. Therefore, withdrawal management should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the individual. Withdrawal management should never be presented to individuals as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once withdrawal management services are no longer necessary.

To make the transition to the next LOC, the withdrawal management provider may assist the client in choosing an appropriate service based on needs and location, helping to schedule appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the withdrawal management provider arrange for any needed assistance to ensure a seamless transfer to the next LOC.

Continuing Stay Criteria
Re-authorization or continued treatment should be based on ASAM Continued Service Criteria, medical necessity, and a reasonable expectation of benefit from continued care.

REFERENCES:
Mee-Lee, D, Shulman, GD, Fishman, M, Gastfriend, DR, Miller, MM, Eds. The *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* 3rd ed. Carson City, NV: The Change Companies®; 2013.

Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care. Michigan's ROSC Glossary of Terms. Retrieved from http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf.

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Substance Use Disorder Service Programs. Promulgated pursuant to Michigan Public Act 368 of 1978, Section 6231(1), as amended. Retrieved from http://w3.lara.state.mi.us/orr/Files/AdminCode/389_10365_AdminCode.pdf .

Approved by: _____

Larry P. Scott, Acting Director
Office of Recovery Oriented Systems of Care

PIHP-PROPOSED REVISIONS, FEBRUARY 1, 2019

PIHPs proposed the following edits to section 7.7.6 (GAIN). Our edits are intended to focus the language exclusively on FY 19.

PIHPs continue to request that this be on our contract negotiations agenda for future amendments/fiscal years.

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7.7.6 GAIN (Global Appraisal of Individual Needs) I Core Process

- ~~It is the expectation that the~~ The PIHP and its SUD provider network will engage in the GAIN-I CORE~~ore~~ training process with Chestnut Health Systems. The PIHP may ~~when applicable~~ make their identified Local Trainer staff available to train other clinicians across the state. This training may be funded through the CMHAM training contract with MDHHS or the PIHP may elect to sponsor this training. The PIHP may establish their own rate(s) of compensation/support for any trainings they provide directly ~~engage in~~.
- PIHPs are expected to establish and maintain a Data Use Agreement with Chestnut Health Systems for use of the GAIN ABS~~, and contracted providers must do the same~~. MDHHS will maintain these agreements through FY 2020, and longer as funding allows[BC1][DJ[2][MT[3]]
- ~~Due to the ability to transfer the GAIN-I Core among provider agencies, a GAIN-I Core is an allowable expense every 6 months. This is the maximum allowable reimbursement for this clinical function. At a minimum re-assessment should be completed annually. If an individual has a significant change prior to the 6-month marker, the clinician can use the M-90 tool to reflect those changes. This 6-month maximum allowable assessment is for the purpose of updating information and establishing the individual's current goals.~~
- ~~PIHPs should be planning for full implementation of the GAIN-I COREare for FY202019. This includes training provider clinicians and phasing out other versions of a biopsychosocial assessment. Specifically the PIH will begin to use the GAIN-I Core as the exclusive substance use Disorder assessment tool and format beginning on 10/1/2020. The PIHP may begin this transition to the GAIN-I COREore on 10/1/20198 as long as it is fully implemented by March 30October 1, 202019, or one year after federal approval of the 1115 Waiver, whichever is later. By September 30, 2019 all other forms of biopsychosocial assessments are to be eliminated.~~ [MT[4]]

Community Mental Health

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Health and Human Services

MDHHS
Michigan Department of Health & Human Services

Fiscal Year End September 30, 2019

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INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Health and Human Services (MDHHS) to assist independent audit personnel, Prepaid Inpatient Health Plan (PIHP) personnel, and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDHHS and PIHPs or CMHSPs, and to assure examinations are completed in a consistent and equitable manner.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDHHS to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, Flint 1115 and Substance Use Disorder Community Grant Programs (hereinafter referred to as "Medicaid Contract"); the contracts between CMHSPs and MDHHS to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208 (hereinafter referred to as "GF Contract"); and, in certain circumstances, contracts between CMHSPs or PIHPs and MDHHS to manage the Community Mental Health Services Block Grant Program (hereinafter referred to as "CMHS Block Grant Program"). These CMH Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a PIHP or CMHSP expends $750,000 or more in federal awards[1], the PIHP or CMHSP must obtain a Single Audit.

PIHPs are ultimately responsible for the Medicaid funds received from MDHHS, and are responsible for monitoring the activities of network provider CMHSPs as necessary to ensure expenditures of Medicaid Contract funds are for authorized purposes in compliance with laws, regulations, and the provisions of contracts. Therefore, PIHPs must either require their independent auditor to examine compliance issues related to the Medicaid funds awarded to the network provider CMHSPs, or require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 8, 9, & 10).

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2019 and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

Failure to meet the requirements contained in these CMH Compliance Examination Guidelines may result in the withholding of current funds or the denial of future awards.

[1] Medicaid payments to PIHPs and CMHSPs for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended for the purposes of determining Single Audit requirements.

RESPONSIBILITIES

MDHHS Responsibilities

MDHHS must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code, and federal and state audit requirements; and to ensure the **COMPLIANCE REQUIREMENTS** contained in the CMH Compliance Examination Guidelines are complete and accurately represent requirements of PIHPs and CMHSPs; and distribute revised CMH Compliance Examination Guidelines to PIHPs and CMHSPs.
2. Review the examination reporting packages submitted by PIHPs and CMHSPs to ensure completeness and adequacy within eight months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination reporting package within eight months after the receipt of a complete and final reporting package.
4. Monitor the activities of PIHPs and CMHSPs as necessary to ensure the Medicaid Contract, GF Contract, and CMHS Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Contract, and GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely on PIHP or CMHSP Single Audits or the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure CMHSP Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS may, however, determine it is necessary to also perform a limited scope compliance examination or review of selected areas. Any additional reviews or examinations shall be planned and performed in such a way as to build upon work performed by other auditors. The following are some examples of situations that may trigger an MDHHS examination or review:
    a. Significant changes from one year to the next in reported line items on the FSR.
    b. A PIHP entering the MDHHS risk corridor.
    c. A large addition to an ISF per the cost settlement schedules.
    d. A material non-compliance issue identified by the independent auditor.
    e. The CPA that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.
    f. The CPA issued an adverse opinion on compliance due to their inability to draw conclusions because of the condition of the agency's records.

PIHP Responsibilities

PIHPs must:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200 , the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines is properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the PIHP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The PIHP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS and the PIHP will be notified of any required action in the management decision.
8. Monitor the activities of network provider CMHSPs as necessary to ensure the Medicaid Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. PIHPs must either (a.) require the PIHP's independent auditor (as part of the PIHP's examination engagement) to examine the records of the network provider CMHSP for compliance with the Medicaid Contract provisions, or (b.) require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. If the latter is chosen, the PIHP must incorporate the examination requirement in the PIHP/CMHSP contract and develop Compliance Examination Guidelines specific to their PIHP/CMHSP contract. Additionally, if the latter is chosen, the CMHSP examination must be completed in sufficient time so that the PIHP auditor may rely on the CMHSP examination when completing their examination of the PIHP if they choose to.
9. If requiring an examination of the network provider CMHSP, review the examination reporting packages submitted by network provider CMHSPs to ensure completeness and adequacy.

10. If requiring an examination of the network provider CMHSP, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in network provider CMHSP's examination reporting packages.

CMHSP Responsibilities

(as a recipient of Medicaid Contract funds from PIHP and a recipient of GF funds from MDHHS and a recipient of CMHS Block Grant funds from MDHHS)

CMHSPs must:

1. Maintain internal control over the Medicaid Contract, GF Contract, and CMHS Block Grant Program that provides reasonable assurance that the CMHSP is managing the Medicaid Contract, GF Contract, and CMHS Block Grant Program in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid Contract, GF Contract, and CMHS Block Grant Program.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract, GF Contract, and CMHSP Block Grant Program. Examples of these would include, but not be limited to: the Medicaid Contract, the Managed Mental Health Supports and Services Contract (General Fund Contract), the CMHS Block Grant Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines, and any examination required by the PIHP from which the CMHSP receives Medicaid Program funds are properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The CMHSP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS, and the CMHSP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

PIHPs under contract with MDHHS to manage the Medicaid Contract and CMHSPs under contract with MDHHS to manage the GF Contract are required to contract annually with a

certified public accountant in the practice of public accounting (hereinafter referred to as a practitioner) to examine the PIHP's or CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 18–Attestation Standards – Clarification and Redcodification–.AT – C Section 205 The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Additionally, CMHSPs under contract with MDHHS to provide CMHS Block Grant Program services with a total contract amount of greater than $187,500 are required to ensure the above referenced examination engagement includes an examination of compliance with specified requirements related to the CMHS Block Grant Program **IF** the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program. The specified requirements and specified criteria related to the CMHS Block Grant Program are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Practitioner Selection

In procuring examination services, PIHPs and CMHSPs must engage an independent practitioner, and must follow the Procurement Standards contained in 2 CFR 200.318 through 200.320. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, the results of MDHHS reviews, and price. When possible, PIHPs and CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the PIHP's or CMHSP's compliance with specified requirements is to express an opinion on the PIHP's or CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that the PIHP or CMHSP complied, in all material respects, based on the specified criteria.

Practitioner Requirements

The practitioner should exercise due care in planning, performing, and evaluating the results of his or her examination procedures; and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected. The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements." In the examination of the PIHP's or CMHSP's compliance with specified requirements, the practitioner should follow the requirements of AT-C 105 and 205.

~~1. Obtain an understanding of the specified compliance requirements (See AT 601.40).~~
~~2. Plan the engagement (See AT 601.41 through 601.44).~~
~~3. Consider the relevant portions of the PIHP's or CMHSP's internal control over compliance (See AT 601.45 through 601.47).~~
~~4. Obtain sufficient evidence including testing compliance with specified requirements (See AT 601.48 through 601.49).~~
~~5. Consider subsequent events (See AT 601.50 through 601.52).~~
~~6. Form an opinion about whether the entity complied, in all material respects with specified requirements based on the specified criteria (See AT 601.53).~~

Practitioner's Report

The practitioner's examination report on compliance should include the information detailed in AT-C 205.63 through 205.86, which includes the practitioner's opinion on whether the entity complied, in all material respects, with specified requirements based on the specified criteria. When an examination of the PIHP's or CMHSP's compliance with specified requirements discloses noncompliance with the applicable requirements that the practitioner believes have a material effect on the entity's compliance, the practitioner should modify the report as detailed in AT-C 205.68 through AT-C 205.75.

In addition to the above examination report standards, the practitioner must prepare:

1. A Schedule of Findings that includes the following:
    a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.
    b. Material noncompliance with the provisions of laws, regulations, or contract provisions related to the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.
    c. Known fraud affecting the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.

    Finding detail must be presented in sufficient detail for the PIHP or CMHSP to prepare a corrective action plan and for MDHHS to arrive at a management decision. The following specific information must be included, as applicable, in findings:
    a. The criteria or specific requirement upon which the finding is based including statutory, regulatory, contractual, or other citation. **The Compliance Examination Guidelines should NOT be used as criterion.**
    b. The condition found, including facts that support the deficiency identified in the finding.
    c. Identification of applicable examination adjustments and how they were computed.
    d. Information to provide proper perspective regarding prevalence and consequences.
    e. The possible asserted effect.

f. Recommendations to prevent future occurrences of the deficiency(ies) noted in the finding.
g. Views of responsible officials of the PIHP/CMHSP.
h. Planned corrective actions.
i. Responsible party(ies) for the corrective action.
j. Anticipated completion date.

2. A schedule showing final **reported** Financial Status Report (FSR) amounts, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below)], and examined FSR amounts. **All examination adjustments must be explained.** This schedule is called the "Examined FSR Schedule." Note that Medicaid FSRs must be provided for PIHPs. All applicable FSRs must be included in the practitioner's report regardless of the lack of any examination adjustments.

3. A schedule showing a revised cost settlement for the PIHP or CMHSP based on the Examined FSR Schedule. This schedule is called the "Examined Cost Settlement Schedule." This must be included in the practitioner's report regardless of the lack of any examination adjustments.

4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant program only in the event the individual comment or recommendation is expected to have an impact greater than or equal to $10,000; and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency.

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDHHS within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The PIHP or CMHSP must submit the reporting package by e-mail to 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.

Examination Reporting Package

The reporting package includes the following:

1. Practitioner's report as described above;
2. Corrective action plan prepared by the PIHP or CMHSP.

Penalty

If the PIHP or CMHSP fails to submit the required examination reporting package by June 30th following the contract year end and an extension has not been granted by MDHHS, MDHHS may withhold from current funding five percent of the examination year's grant funding (not to exceed $200,000) until the required reporting package is received. MDHHS may retain the withheld amount if the reporting package is delinquent more than 120 days from the due date and MDHHS has not granted an extension.

Incomplete or Inadequate Examinations

If MDHHS determines the examination reporting package is incomplete or inadequate, the PIHP or CMHSP, and possibly its independent auditor will be informed of the reason of inadequacy and its impact in writing. The recommendations and expected time frame for resubmitting the corrected reporting package will be provided to the PIHP or CMHSP.

Management Decision

MDHHS will issue a management decision on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination report within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the examination finding and/or comment is sustained; the reasons for the decision and the expected PIHP or CMHSP action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, MDHHS may request additional information or documentation from the PIHP or CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the PIHP or CMHSP is included in the applicable contract.

If there are no findings, comments, and/or questioned costs, MDHHS will notify the PIHP or CMHSP when the review of the examination reporting package is complete and the results of the review.

COMPLIANCE REQUIREMENTS

The practitioner must examine the PIHP's or CMHSP's compliance with the A-~~J~~F specified requirements based on the specified criteria stated below related to the Medicaid Contract and GF Contract. If the PIHP or CMHSP does not have a Single Audit or the Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the ~~K-M~~G-I specified requirements based on the specified criteria stated below that specifically relate to the CMHS Block Grant, but only if the total contract amount for the CMHS Block Grant is greater than $187,500. If the PIHP does not have a Single Audit, or the Single Audit does not include the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959) as a major Federal program, the practitioner must also examine the PIHP's compliance with the ~~N-P~~J-K specified requirements based on the specified criteria stated below that specifically relate to the SAPT Block Grant.

COMPLIANCE REQUIREMENTS A-F
(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

The final FSRs (entire reporting package applicable to the entity) comply with contractual provisions as follows:

a. FSRs agree with agency financial records (general ledger) as required by the reporting instructions. (Reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).
b. FSRs include only allowed activities as specified in the contracts; allowable costs as specified in the Federal cost principles (located at 2 CFR 200, Subpart E)(GF Contract, Section 6.6.1; and Medicaid Contract, Section 7.8); and allowed activities and allowable costs as specified in the Mental Health Code, Sections 240, 241, and 242.
c. FSRs include revenues and expenditures in proper categories and according to reporting instructions.

Differences between the general ledger and FSRs should be adequately explained and justified. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule." Any reported expenditures that do not comply with the Federal cost principles, the Code, or contract provisions must be shown as adjustments on the auditor's "Examined FSR Schedule."

The following items should be considered in determining allowable costs:
Federal cost principles (2 CFR 200.402) require that for costs to be allowable they must meet the following general criteria:

a. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under the principles.
b. Conform to any limitations or exclusions set forth in the principles or in the Federal award as to types or amount of cost items.
c. Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
d. Be accorded consistent treatment.
e. Be determined in accordance with generally accepted accounting principles.
f. Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period.
g. Be adequately documented.

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness

criteria of 2 CFR Part 200, Subpart E – Cost Principles, 200.404 was met. If subcontractors are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). When the PIHP pays Federally Qualified Heath Centers (FQHC) and Rural Health Centers (RHC) for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported rental costs for **less-than-arms-length transactions** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (c)). For example, the agency may rent their office building from the agency's board member/members, but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in 2 CFR Part 200.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (b)).

Capital asset purchases that cost greater than $5,000 must be capitalized and depreciated over the useful life of the asset rather than expensing it in the year of purchase (2 CFR Part 200, Subpart E – Cost Principles, 200.436 and 200.439-). All invoices for a remodeling or renovation project must be accumulated for a total project cost when determining capitalization requirements; individual invoices should not simply be expensed because they are less than $5,000.

Costs must be allocated to programs in accordance with relative benefits received. Accordingly, **Medicaid costs must be charged to the Medicaid Program and GF costs must be charged to the GF Program**. Additionally, **administrative/indirect costs** must be distributed to programs on bases that will produce an equitable result in consideration of relative benefits derived in accordance with 2 CFR Part 200, Appendix VII.
Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported in accordance with the standards listed in 2 CFR Part 200, Subpart E – Cost Principles, 200.430 (i).

B. Administration Cost Report

The most recently completed PIHP's or CMHSP's Administration Cost Report complies with the applicable CMHSP/PIHP Administration Cost Reporting Instructions and the applicable standards in ESTABLISHING ADMINISTRATIVE COSTS WITHIN AND ACROSS THE CMHSP SYSTEM and contract provisions (instructions located at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html and reference guidelines located at http://www.michigan.gov/documents/mdch/Establishing_Admin_costs_480633_7.pdf).

C. Procurement

The PIHP or CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326. The PIHP or CMHSP ensured that organizations or individuals selected and offered contracts have not been debarred or suspended or otherwise excluded from or ineligible for participation in Federal assistance programs as required by 45 CFR 92.35.

D. Internal Service Fund (ISF)

The PIHP's Internal Service Fund complies with the Internal Service Fund Technical Requirement contained in Contract Attachment P 8.6.4.1 with respect to funding and maintenance.

E. Medicaid Savings and General Fund Carryforward

The PIHP's Medicaid Savings was expended in accordance with the PIHP's reinvestment strategy as required by Sections 8.6.2.2 and 8.6.2.3 of the Contract. The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

F. Match Requirement

The PIHP or CMHSP met the local match requirement, and all items considered as local match actually qualify as local match according to Section 7.2 of the General Fund Contract and Section 8.2 of the Medicaid Contract. Some examples of funds that do NOT qualify as local match are: (a.) revenues (such as workers' compensation refunds) that should be offset against related expenditures, (b.) interest earned from ISF accounts, (c.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (d.) donations of funds from subcontractors of the PIHP or CMHSP, (e.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSP's actual costs, and (f) donations of items that would not be an item generally provided by the PIHP or CMHSP in providing plan services.

If the PIHP or CMHSP does not comply with the match requirement in the Mental Health Code, Section 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

COMPLIANCE REQUIREMENTS G-I

(APPLICABLE TO PIHPs/CMHSPs WITH A CMHS BLOCK GRANT OF GREATER THAN $187,500 THAT DID NOT HAVE A SINGLE AUDIT OR THE CMHS BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

G. CMHS Block Grant - Activities Allowed or Unallowed

The CMHSP expended CMHS Block Grant (CFDA 93.958) funds only on allowable activities in accordance with Federal Block Grant provisions and the Grant Agreement between MDHHS and the CMHSP.

H. CMHS Block Grant - Cash Management

The CMHSP complied with the applicable cash management compliance requirements contained in the Federal Block Grant Provisions. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by CMHSP funds before reimbursement is requested from MDHHS.

I. CMHS Block Grant – Sub-recipient Management and Monitoring

If the CMHSP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal CMHS Block Grant Program, the CMHSP complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h)

COMPLIANCE REQUIREMENTS J-K

(APPLICABLE TO PIHPs WITH A SAPT BLOCK GRANT THAT DID NOT HAVE A SINGLE AUDIT OR THE SAPT BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

J. SAPT Block Grant – Activities Allowed or Unallowed

The PIHP or CMHSP expended SAPT Block Grant (CFDA 93.959) funds only on allowable activities in accordance with the Federal Block Grant Provisions and the Grant Agreement.

K. SAPT Block Grant – Sub-recipient Management and Monitoring

If the PIHP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal SAPT Block Grant Program, the PIHP or complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h).

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDHHS. Also, PIHPs are required to keep affiliate CMHSP's reports on file for three years from date of receipt. All examination

working papers must be accessible and are subject to review by representatives of the Michigan Department of Health and Human Services, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and provider network CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2018/2019 examinations. Any questions relating to these guidelines should be directed to:

John Duvendeck, Director
Division of Program Development, Consultation & Contracts
Bureau of Hospitals and Behavioral Health Administration
Michigan Department of Health and Human Services
Lewis Cass Building
320 S. Walnut Street
Lansing, Michigan 48913
duvendeckj@michigan.gov
Phone: (517) 241-5218 Fax: (517) 335-5376

GLOSSARY OF ACRONYMS AND TERMS

AICPA.....American Institute of Certified Public Accountants.

Children's Waiver.....The Children's Waiver Program that provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the program who, if not for the availability and provisions of the Waiver, would otherwise require the level of care and services provided in an Intermediate Care Facility for the Mentally Retarded. Payment from MDHHS is on a fee for service basis.

CMHS Block Grant Program.The program managed by CMHSPs under contract with MDHHS to provide Community Mental Health Services Block Grant program services under CFDA 93.958.

CMHSP.....Community Mental Health Services Program (CMHSP). A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended.

Examination Engagement.....A PIHP or CMHSP's engagement with a practitioner to examine the entity's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) –Attestation Standards – Clarification and Recodification - AT-C 205 (Codified Section of AICPA Professional Standards).

Flint 1115 Waiver .....The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014 through a state-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act, and is effective as of March 3, 2016 the date of the signed approval through February 28, 2021. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the state plan. All such persons will have access to Targeted Case Management services under a fee for service contract between MDHHS and Genesee Health Systems (GHS). The fee for service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.

GF Program.....The program managed by CMHSPs under contract with MDHHS to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.

MDHHS.....Michigan Department of Health and Human Services

Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by PIHPs under contract with MDHHS.

PIHP.....Prepaid Inpatient Health Plan. In Michigan a PIHP is an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver

Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. The PIHP, also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program, also manages the Autism Program, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.

Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.

Serious Emotional Disturbances Waiver.....The Waiver for Children with Serious Emotional Disturbances Program that provides services to children who would otherwise require hospitalization in the State psychiatric hospital to remain in their home and community. Payment from MDHHS is on a fee for service basis.

SSAE.....AICPA's Statements on Standards for Attestation Engagements.

SAPT Block Grant Program ..The program managed by PIHPs under contract with MDHHS to provide Substance Use Services Block Grant program services under CFDA 93.959.

SUD Services.....Substance Use Disorder Services funded by Medicaid, Healthy Michigan, and the "Community Grant" which consists of Federal SAPT Block Grant funds and State funds.

Manager and Location Building:
John P. Duvendeck– Lewis Cass Building, 320 S. Walnut
Contract Number#_____

Amendment No. 2 to the Agreement Between
Michigan Department of Health and Human Services
And

PIHP_____
For
The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs

1. **Period of Agreement:**
   This agreement shall commence on October 1, 2018 and continue through September 30, 2019.

2. **Period of Amendment:**
   October 1, 2018 through September 30, 2019.

3. **Program Budget and Agreement Amount:**
   Payment to the PIHP will be based on the total funding available for specialty supports and services as identified in the annual Legislative Appropriation for community mental health services programs for the period of October 1, 2018 through September 30, 2019. The estimated value is contingent upon and subject to enactment of legislative appropriations and availability of funds.

4. **Amendment Purpose:**
   This amendment incorporates changes to boilerplate contract language and related contract attachments.

5. **The Specific Changes are Identified Below:**
   - CMS required changes to various sections of the contract:
     - 18.1 Compliance with Applicable Laws
     - 18.1.14 Compliance with 42 CFR 438 State Responsibilities
     - 18.2 Special Waiver Provisions for MSSSP
     - Section 1557 of PPACA
     - 32.0 FISCAL SOUNDNESS OF THE RISK-BASED PIHP
     - 33.0 PROGRAM INTEGRITY
     - 34.0 PIHP OWNERSHIP AND CONTROL INTERESTS
     - 38.0 SUBCONTRACTING
     - 39.1 Reviews and Audits
     - 39.2 MDHHS Reviews

  - 5.6 Indian Health Service/Tribally-Operated Facility or program/Urban Indian Clinic (I/T/U)
  - 6.3.2 Information Requirements
  - 7.0 PROVIDER NETWORK SERVICES
  - 7.4 Integrated Physical and Mental Health Care
  - 7.8.2.4 Third Party Resource Requirements
  - 7.9.1 External Quality Review
  - 7.10.5 Advance Directives
  - 8.4.1.7 Medical Loss Ratio Reporting Requirements with an amendment to the calculations component of the boilerplate
- Contract attachments P6.3.1 Customer Service Standards and P6.3.1.1 Grievance and Appeals Technical Requirement
- PII.B.A Withdrawal Management Policy #13
- Section 7.7.6 GAIN I-core (Global Appraisal of Individual Needs)
- Contract attachment P39.0.1 PIHP Compliance Examination Guidelines
- Contract attachment P7.7.1.1 PIHP Reporting Requirements

6. **Original Agreement Conditions**
   It is understood and agreed that all other conditions of the original agreement remain the same.

7. **Special Certification:**
   The individuals signing this agreement certify by their signatures that they are authorized to sign this agreement on behalf of the organization specified.

Signature Section:

For the Michigan Department of Health and Human Services

_____	_____
Christine H. Sanches, Director Bureau of Grants & Purchasing	Date

For the CONTRACTOR:

_____	_____
Name (print)	Title (print)
_____	_____
Signature	Date

~~Manager and Location Building~~

18.1 Compliance with Applicable Laws[LW1]

The PIHP shall comply with all federal, state and local laws, and require that all ~~PIHPs~~ network providers and other subcontractors ~~will~~ comply with all applicable Federal and State laws and regulations including MCL 15.342 Public officer or employee; prohibited conduct, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1973, and the Rehabilitation Act of 1973, ~~and~~ the Americans with Disabilities Act, and Section 1557 of the Patient Protection and Affordable Care Act (ACA). Statutory and regulatory provisions related to Title XXI (The Children's Health Insurance Program) are applicable to ~~a~~ Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 19 21 services rendered under the MIChild program. The PIHP will also comply with all applicable general administrative requirements such as OMB Circulars covering cost principles, grant/agreement principles, and audits in carrying out the terms of this agreement. For purposes of this Agreement, OMB Circular 2 CFR 200 Subpart E is applicable to PIHPs that are local government entities, and OMB Circular 2 CFR 200 Subpart E is applicable to PIHPs that are non-profit entities.

18.1.14 Compliance with 42 CFR 438 State Responsibilities

The PIHP must provide that its Medicaid enrollees are not held liable for Covered services provided to the enrollee, for which The State does not pay the PIHP or The State, or the PIHP does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

The PIHP will ensure that data received from providers is accurate and complete by, verifying the accuracy and timeliness of reported data, including data from network providers the PIHP is compensating on the basis of capitation payments and by screening the data for completeness, logic, and consistency. The PIHP will make all collected data available to the State and upon request to CMS.

The PIHP will submit enrollee encounter data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs. The PIHP will Submit all enrollee encounter data that the State is required to report to CMS under § 438.818.

18.2 Special Waiver Provisions for MSSSP

Michigan's Specialty Services and Supports Waiver Program authorized under 1915(b)(1), (3) and (4) of the Social Security Act is currently approved until currently authorized under approved extension.

The 1915(b) Waiver is concurrent with a five-year 1915(c) waiver, referred to as the Home and Community-Based Habilitation Supports Waiver, serving people with a developmental disability, is currently approved until September 30, 2016. Under these waivers, beneficiaries are entitled to specified medically necessary specialty supports and services from the PIHP.

Section 1557 of PPACA
Patient Protection and Affordable Care Act. This includes section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of section 1903(r)(1)(F) of the Act.

32.0 FISCAL SOUNDNESS OF THE RISK-BASED PIHP

Federal regulations require that the risk-based PIHPs maintain a fiscally solvent operation and MDHHS has the right to evaluate the ability of the PIHP to bear the risk of potential financial losses, or to perform services based on determinations of payable amounts under the contract.
MDHHS does not preclude the PIHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. MDHHS requires that the PIHP may only operate a physician incentive plan if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit medically necessary services to an enrollee. This contract requires that if the PIHP puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, the PIHP must ensure that the physician/physician group has adequate stop-loss protection.

If LTSS are provided under the contract between the MDHHS and the PIHP, the PIHP must establish and maintain a member advisory committee. The member advisory committee will include at least a reasonably representative sample of the LTSS populations, or other individuals representing those enrollees, covered under the contract with the PIHP. If the PIHP is required by MDHHS to provide LTSS in a community-based setting that could be authorized through a section 1915(c) waiver, a section 1915(i) SPA, or a section 1915(k) SPA, the contract specifies that the long term services and supports must be provided in a setting which complies with the 42 CFR 441.301(c)(4) requirements for home and community-based settings.

When the PIHP is providing LTSS, the comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including an assessment of care between care settings. When the ~~PIPHP~~PIHP is providing LTSS, the comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including a comparison of services and supports received with those set forth in the enrollee's treatment/service plan. The PIHP is required to implement mechanisms to comprehensively assess each Medicaid enrollee identified as needing LTSS to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the MDHHS or the PIHP as appropriate. [MT(2)]

33.0 PROGRAM INTEGRITY

The PIHP must have administrative and management arrangements or procedures for compliance with 42 CFR 438.608. Such arrangements or procedures must identify any activities that will be delegated and how the PIHP will monitor those activities.

The PIHP will provide prompt notification to MDHHS BHDDA when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including, changes in the enrollee's residence and the death of an enrollee.

The PIHPs that make or receive annual payments under the contract of at least $5,000,000, will make provision for written policies for all employees of the entity, and of any contractor or agent of the entity, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

The PIHPs shall require all contracted providers that make or receive at least $5,000,000 in payments under this contract to comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

Reports to MDHHS BHDDA within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. Recoveries of overpayments due to fraud, waste, or abuse shall be reported by the PIHP to MDHHS OIG in accordance with subpart F below.

The PIHP requires and has a mechanism for a network provider to report to the PIHP when it has received an overpayment, to return the overpayment to the PIHP within 60 calendar days after the date on which the overpayment was identified, and to notify the PIHP in writing of the reason for the overpayment.

The MDHHS Office of Inspector General (OIG) is responsible for overseeing the program integrity activities of the Prepaid Inpatient Health Plan (PIHP) and all entities subcontracted by the PIHP.

A. General

1. The PIHP must have program integrity administrative and management arrangements or procedures, including a mandatory compliance program.
2. The PIHP's compliance program must include the following, as defined in 42 CFR 438.608:
a. Written policies and procedures that describe how the PIHP will comply with federal and State fraud, waste and abuse standards, and well publicized disciplinary standards for failure to comply.
b. The designation of a compliance officer who reports directly to the Chief Executive Officer and the Board of Directors, and a compliance committee, accountable to the senior management or Board of Directors, with effective lines of communication to the PIHP's employees.
c. Effective training and education for the compliance officer, senior management, and the PIHP's employees regarding fraud, waste and abuse, and the federal and State standards and requirements under this contract. While the compliance officer may provide training to PIHP

employees, "effective" training for the compliance officer means it cannot be conducted by the compliance officer himself/herself.
d. Provisions for internal monitoring and auditing. Audits must include post payment reviews of paid claims to verify that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.). Acceptable audit methodology examples include:
– Record review, including statistically valid random sampling and extrapolation to identify and recover overpayments made to providers
– Beneficiary interviews to confirm services rendered
– Provider self-audit protocols
The frequency and quantity of audits performed should be dependent on the number of fraud, waste and abuse complaints received as well as high risk activities identified through data mining and analysis of paid claims.
e. Provisions for the PIHP's prompt response to detected offenses and for the development of corrective action plans. "Prompt response" is defined as action taken within 15 business days of receipt by the PIHP of the information regarding a potential compliance problem.
g. Dissemination of the contact information (addresses and toll-free telephone numbers) for reporting fraud, waste or abuse to both the PIHP and the MDHHS-OIG. Dissemination of this information shall be made to all PIHP subcontractors and members annually. The PIHP must indicate that reporting of fraud, waste or abuse may be made anonymously.
3. Triannual meetings will be held between MDHHS-OIG and all PIHP Compliance Officers to train and discuss fraud, waste and abuse.

B. Contracted Entities
1. The PIHP shall include program integrity provisions and guidelines in all contracts with subcontracted entities.
2. The PIHP shall provide guidance to the program integrity activities of all its subcontracted entities, to the extent that the subcontracted entity is delegated responsibility by the PIHP. The PIHP-subcontractor contract shall require at least the following of the subcontracted entity:
– designation of a compliance officer;
– submission to the PIHP of quarterly reports detailing program integrity activities;
– assistance and guidance by the PIHP with audits and investigations, upon request of the subcontracted entity;
– provisions for routine internal monitoring;
– proper prompt response to potential offenses and implementation of corrective action plans;
– appropriate and prompt reporting of fraud, waste and abuse to the PIHP;
– implementation of training procedures regarding fraud, waste and abuse for the subcontracted entities' employees at all levels.
3. The PIHP shall provide MDHHS-OIG with documentation to support that these program integrity activities were performed by its subcontractors in its quarterly submission to the MDHHS-OIG.
4. Effective beginning Fiscal Year '19, by November 15th the PIHP shall submit to MDHHS-OIG a list of all entities with whom it and its participant CMHSPs (if applicable) have contracted to perform services for Fiscal Year '19, under this contract. This list shall contain all facility locations where services are provided or business is conducted, all NPI numbers assigned to the entity and what services the entity is contracted to provide. The PIHP is responsible for updates to this information in its quarterly submission (See Section G).

The list of contracted entities noted above that the PIHP submits shall be documentation to the state to demonstrate that it offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area 1) at the time it enters into a contract with MDHHS, and 2) any time there is a significant change (as defined by the MDHHS) in the PIHP's operations that impacts services. The list of contracted entities shall also be documentation to the MDHHS to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area 1) at the time it enters into a contract with MDHHS, and 2) any time there is a significant change (as defined by the MDHHS) in the PIHP's operations that impacts services.

C. Investigations

1. The PIHP will investigate program integrity complaints/issues until it has determined that a suspicion of fraud exists, at which point the PIHP shall contact MDHHS-OIG and pause any recoupment/recovery/administrative action regarding the issue.
2. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, the Health Insurance Portability and Accountability Act (hereafter "HIPAA"), and the Michigan Mental Health Code, the PIHP will cooperate fully in any investigation by MDHHS-OIG or the Department of Attorney General and any subsequent legal action that may result from such investigation.

D. Reporting Fraud, Waste or Abuse

1. Upon receipt of allegations involving fraud, waste, or abuse regardless of entity (i.e. PIHP, employee, contracted entity, provider, or member), the PIHP shall perform a preliminary investigation. Upon completion of the preliminary investigation, if the PIHP determines a suspicion of fraud exists, the PIHP must promptly refer the matter to MDHHS OIG. These referrals must be made using the PIHP fraud referral template and be shared with MDHHS OIG via secure File Transfer Process (sFTP) using the PIHP's applicable MDHHS OIG sFTP area.
2. The PIHP must report all suspicion of waste or abuse on the Quarterly Submission described in Section G.
3. Questions regarding whether suspicions should be classified as fraud, waste or abuse should be presented to MDHHS-OIG for clarification prior to making the referral.
4. Documents containing protected health information or protected personal information must be submitted in a manner that is compliant with applicable federal and State privacy rules and regulations, including but not limited to HIPAA
5. The MDHHS requires the PIHP or subcontractor, to the extent that the subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the contract between the state and the PIHP, to implement and maintain arrangements or procedures that include provision for the MCP's suspension of payments to a network provider for which the state determines there is a credible allegation of fraud.
6. The MDHHS requires the PIHP or subcontractor, to the extent that the subcontractor is delegated responsibility by the PIHP for coverage of services and payment of claims under the contract between the state and the PIHP, to implement and maintain arrangements or procedures for notification to the state when it receives information about a change in a network provider's

circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the PIHP.

E. Disclosure of Information

1. To the extent consistent with applicable federal and State law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP shall disclose protected health information to MDHHS-OIG or the Department of Attorney General upon their written request, without first obtaining authorization from the beneficiary to disclose such information.

F. Overpayments

1. If the PIHP identifies an overpayment involving potential fraud prior to identification by MDHHS-OIG, the PIHP shall obtain written consent from MDHHS-OIG prior to recovering the overpayment.
2. If the PIHP identifies an overpayment involving waste or abuse prior to identification by MDHHS-OIG, the PIHP shall recover the overpayment and report the overpayment on its quarterly program integrity submission.
3. If MDHHS-OIG identifies an overpayment to a provider prior to the PIHP identifying the overpayment, MDHHS OIG will explore options in collaboration with MDHHS BHDDA, up to and including recovering the overpayment from the PIHP.
4. These overpayment provisions do not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

G. Quarterly Submissions

Effective beginning Fiscal Year '19, the PIHP must either (1) utilize MDHHS OIG's case tracking system to log in and track program integrity activities performed, or (2) provide information on program integrity activities performed quarterly using the template provided by the MDHHS-OIG. Program integrity activities include but are not limited to:

– Tips/grievances received
– Data mining and analysis of paid claims, including audits performed based on the results
– Audits performed
– Overpayments collected
– Identification and investigation of fraud, waste and abuse (as these terms are defined in the "Definitions" section of this contract
– Corrective action plans implemented
– Provider dis-enrollments
– Contract terminations

All program integrity activities performed each quarter must be reported to OIG according to the following schedule:

Reporting Period/Due Date

January through March	May 15th
April through June	August 15th
July through September	November 15th
October through December	February 15th

H. MDHHS-OIG Sanctions

When MDHHS-OIG sanctions providers, including for a credible allegation of fraud under 42 CFR § 455.23, the PIHP must, at minimum, apply the same sanction upon receipt of written notification of the sanction from MDHHS OIG to the PIHP. The PIHP may pursue additional measures/remedies independent of the State.

I. MDHHS-OIG Onsite Reviews

1. MDHHS-OIG may conduct onsite reviews of PIHP and/or its contracted entities.
2. To the extent consistent with applicable law, including but not limited to 42 CFR Part 2, HIPAA, and the Michigan Mental Health Code, the PIHP is required to comply with MDHHS-OIG's requests for documentation and information related to program integrity and compliance.

34.0 PIHP OWNERSHIP AND CONTROL INTERESTS

The PIHP may not be any of the following, all of which are all specifically excluded from this contract:

1. An entity that could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

2. An entity that has a "substantial contractual relationship" either directly or indirectly, with:
   a. An individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act;
   b. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
   c. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. 2.101, of a person described in the immediately preceding subsection, 2.b.;
   d. An individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act; or
   e. Any individual or entity that would provide those services through an individual or entity described in any of the immediately preceding four subsections, 2.b., c., or d.

A "substantial contractual relationship" is any contractual relationship that provides for one or more of the following services: (i) the administration, management, or provision of medical services; and/or (ii) the establishment of policies or the provision of operational support, for the administration, management or provision of medical services.

3. An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one any individual or entity that is (or is affiliated, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person or entity that is):

   a. Debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
   b. Excluded from participation in any Federal health care program under section 1128 or 1128A of the Act; or
   c. Any individual or entity that would provide those services through an individual or entity described in any of the immediately preceding two subsections, 3.a. or b.

Additionally, ~~In~~ in order to comply with 42 CFR 438.610:~~.~~

1. ~~The~~ PIHP may not knowingly have a "relationship" of the type described below with any of the following:
   a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549;
   b. An individual or entity who is an "affiliate", as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in the immediately preceding subsection 1.(a).

2. The PIHP will not have a "relationship" of the type described below (each a "prohibited relationship") with any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

For purposes of this section, a "relationship" means someone who the PIHP interacts with in any of the following capacities:

1. A director, officer, or partner of the PIHP;
2. A subcontractor of the PIHP;

3. A person with beneficial ownership of five (5) percent or more of the PIHP's equity; or
4. A network provider or person with an employment, consulting or other arrangement for the provision of items and services which are significant and material to the Board's obligations under the PIHP Contract.

"Excluded" individuals or entities are individuals or entities that have been excluded from participating, but not reinstated, in the Medicare, Medicaid, or any other Federal health care programs. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance loans.

If the State finds that the PIHP has a "prohibited relationship", as defined above, the State:

1. May continue an existing agreement with the PIHP, unless the Secretary directs otherwise; and
2. May not renew or otherwise extend the duration of an existing agreement with the PIHP unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

~~the PIHP may not have any of the following relationships with an individual who is excluded from participating in Federal health care programs, including sanctioned individuals under section 1128(b)(8) of the act. Including individuals convicted of crimes described in section 1128(b)(8)(B) of the Act. This includes FAR and Executive Order 12549. It also included individuals furnishing health care, utilization review, medical social work, or administrative services under section 1128.:~~

~~Excluded individuals cannot be a director, officer, or partner of the PIHP;~~

~~Excluded individuals cannot have a beneficial ownership of five percent or more of the PIHP's equity; and~~

~~Excluded individuals cannot have an employment, consulting, or other arrangement with the PIHP for the provision of items or services that are significant and material to the PIHP's obligations under its contract with the State.~~

~~"Excluded" individuals or entities are individuals or entities that have been excluded from participating, but not reinstated, in the Medicare, Medicaid, or any other Federal health care programs. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance loans.~~

Federal regulations require PIHPs to disclose information about individuals with ownership or control interests in the PIHP. These regulations also require the PIHP to identify and report any additional ownership or control interests for those individuals in other entities, as well as identifying when any of the individuals with ownership or control interests have spousal, parent-child, or sibling relationships with each other.

The PIHP shall comply with the federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 C.F.R. §455.104-106. In addition, the PIHP shall ensure that any and all contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment or services provided under the Medicaid agreement require compliance with 42 C.F.R. §455.104-106.

The MDHHS requires the PIHP to provide written disclosure in the case that any of the following is or becomes affiliated with any individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549:

1. Any director, officer, or partner;
2. Any subcontractor;
3. Any person with ownership of 5% or more of the PIHP's equity;
4. A network provider; and/or
5. Any party to an employment, consulting, or other agreement with the PIHP for the provision of contract items or services

~~[LW3]The MDHHS requires the PIHP to provide written disclosure of any director, officer, or partner who is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~
~~The MDHHS requires the PIHP to provide written disclosure of any director, officer, or partner who is affiliated with a person/entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~
~~The MDHHS requires the PIHP to provide written disclosure of any subcontractor of the MCP who is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~
~~The MDHHS requires the PIHP to provide written disclosure of any subcontractor of the PIHP who is affiliated with a person entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~
~~The MDHHS requires the PIHP to provide written disclosure of any person with ownership of 5% or more of the PIHP's equity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~
~~The MDHHS requires the PIHP to provide written disclosure of any person with ownership of 5% or more of the PIHP's equity who is affiliated with a person entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~
~~The MDHHS requires the PIHP to provide written disclosure of any network provider who is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~

~~The MDHHS requires the PIHP to provide written disclosure of any network provider who is affiliated with a person entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~
~~The MDHHS requires the PIHP to provide written disclosure of any employment, consulting, or other agreement for the provision of PIHP contract items or services with a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~
~~The MDHHS requires the PIHP to provide written disclosure of any employment, consulting, or other agreement for the provision of PIHP contract items or services with a person who is affiliated with a person/entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.~~
The MDHHS requires the PIHP and subcontractors to disclose information on individuals or corporations with an ownership or control interest in the PIHP to the state at the following times:

1.
   - When the PIHP submits a proposal in accordance with the state's procurement process;
2.
   - When the PIHP executes a contract with the state;
3.
   - When the state renews or extends the PIHP contract; and
4.
   - Within 35 days after any change in ownership of the PIHP.

38.0 SUBCONTRACTING

The PIHP may subcontract for the provision of any of the services specified in this contract including contracts for administrative and financial management, and data processing. The PIHP shall be held solely and fully responsible to execute all provisions of this contract, whether or not said provisions are directly pursued by the PIHP, or pursued by the PIHP through a subcontract vendor. The PIHP shall ensure that all subcontract arrangements clearly specify the type of services being purchased. Subcontracts shall ensure that the MDHHS is not a party to the contract and therefore not a party to any employer/employee relationship with the subcontractor of the PIHP. Subcontracts entered into by the PIHP shall address such provisions as the PIHP deems necessary for the development of the service delivery system, and shall include standard terms and conditions as MDHHS may develop.

Subcontracts entered into by the PIHP shall address the following:

1. Duty to treat and accept referrals
2. Prior authorization requirements
3. Access standards and treatment time lines
4. Relationship with other providers
5. Reporting requirements and time frames
6. QA/QI Systems

7. Payment arrangements (including coordination of benefits) and solvency requirements
8. Financing conditions consistent with this contract
9. Anti-delegation clause
10. Compliance with Office of Civil Rights Policy Guidance on Title VI "Language Assistance to Persons with Limited English Proficiency"
11. EPSDT requirements
12. In all contracts with health care professionals, the PIHP must comply with the requirements specified in the "Quality Assessment and Performance Improvement Programs for Specialty Prepaid Health Plans", Attachment P 7.9.1. and require the provider to cooperate with the PIHP's quality improvement and utilization review activities
13. Include provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy
14. Not prohibit a provider from discussing treatment options with a recipient that may not reflect the PIHP's position or may not be covered by the PIHP
15. Not prohibit a provider from advocating on behalf of the recipient in any grievance or utilization review process, or individual authorization process to obtain necessary health care services
16. Require providers to meet Medicaid accessibility standards as established in Medicaid policy and this contract

All subcontracts entered into by the PIHP must be in writing and, if involving Medicaid funds fulfill the requirements of 42 CFR 434.6 and 42 CFR 438.6 that are appropriate to the service or activity delegated under the subcontract. All employment agreements, provider contracts, or other arrangements, by which the PIHP intends to deliver services required under this contract, shall be subject to review by the MDHHS at its discretion.

Subcontracts that contain provisions for a financial incentive, bonus, withhold, or sanctions, (including sub-capitations) must include provisions that protect individuals from practices that result in the withholding of services that would otherwise be provided according to medical necessity criteria and best practice standards, consistent with 42 CFR 422.208. The PIHP shall provide a copy of specific contract language used for incentive, bonus, withhold or sanction provisions (including sub-capitations) to MDHHS at least 30 days prior to when the contract is issued to the provider. MDHHS reserves the right to disallow or require amendment of such provisions if the provisions appear to jeopardize individuals' access to services. MDHHS shall provide notice of approval or disapproval of submitted contract language within 25 days of receipt or else the language shall be deemed approved by MDHHS. The PIHP must provide information on its Provider Incentive Plan (PIP) to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a PIP). The PIHP must provide information regarding any provider incentive plans to CMS and to any Medicaid beneficiary, as required by 42 CFR 422.210

The PIHP shall provide a listing of all subcontracts for administrative or financial management, or data processing services to the MDHHS within 60 days of signing this contract. The listing shall include the name of the subcontractor, purpose, and amount of contract.

Contracts between the PIHP and subcontractors must require the subcontractor to:

1. -Ceomply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions;
2. ~~. Subcontractors also require the subcontractor to~~ Mmake available, for the purposes of an audit, evaluation, or inspection by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees;
3. Agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit that occurs during such 10 year period[LW4], whichever is later; and
4. Agree that if the state, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time

~~PIHP subcontractor require the subcontractor to agree that the right to audit by the state, CMS, the DHHS Inspector General, the Comptroller General or their designees, will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.~~

~~Subcontractor contracts must require that if the state, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.~~

39.1 Reviews and Audits

The MDHHS and federal agencies may conduct reviews and audits of the PIHP regarding performance under this contract. The MDHHS shall make good faith efforts to coordinate reviews and audits to minimize duplication of effort by the PIHP and independent auditors conducting audits and compliance examinations.

These reviews and audits will focus on PIHP compliance with state and federal laws, rules, regulations, policies, and waiver provisions, in addition to contract provisions and PIHP policy and procedure.

The MDHHS requires that the state, CMS, the OIG, the Comptroller General, and their designees have the right to:

1. ~~be allowed to inspect~~ Inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time;~~.~~
2. Audit records or documents of the PIHP for 10 years from the final date of the contract period or from the date of completion of any audit that occurs within such 10 year period[LW5], whichever is later;
3. Audit records or documents of the PIHP's subcontractors for 10 years from the final date of the contract period or from the date of completion of any audit that occurs within such 10 year period[LW6], whichever is later

~~The MDHHS requires that the state, CMS, the OIG, the Comptroller General and their designees have the right to audit records or documents of the PIHP for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.~~
~~The MDHHS requires that the state, CMS, the OIG, the Comptroller General and their designees have the right to audit records or documents of the PIHP's subcontractors for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.~~
The MDHHS requires that the Secretary, the Department of Health and Human Services (DHHS), and the state (or any person or organization designated by either) have the right to audit and inspect any books or records of the PIHP or its subcontractors pertaining to:

- ~~—~~The ability of the PIHP to bear the risk of financial losses.
- Services performed or payable amounts under the contract.

The MDHHS requires that the ~~PIHP~~PIHP and the PIHP's subcontractors retain, as applicable, enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

Subject to exceptions above MDHHS 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.

39.2 MDHHS Reviews

1. 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.
2. The MDHHS will schedule onsite 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.

3. Except as precluded in 34.2 (2) above, the guideline, protocol and/or instrument to be used to review the PIHP, or a detailed agenda if no protocol exists, shall be provided to the PIHP at least 30 days prior to the review.
4. At the conclusion of the review, the MDHHS shall conduct an exit interview with the PIHP. The purpose of the exit interview is to allow the MDHHS to present the preliminary findings and recommendations.
5. Following the exit review, the MDHHS shall generate a report within 45 days identifying the findings and recommendations that require a response by the PIHP.
    a. The PIHP shall have 30 days to provide a Plan of Correction (POC) for achieving compliance. The PIHP may also present new information to the MDHHS that demonstrates it was in compliance with the questioned provisions at the time of the review. (New information can be provided anytime between the exit interview and the POC). When access or care to individuals is a serious issue, the PIHP may be given a much shorter period to initiate corrective actions, and this condition may be established, in writing, as part of the exit conference identified in (4) above. If, during an MDHHS on-site visit, the site review team member identified an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in seven calendar days.
    b. The MDHHS will review the POC, seek clarifying or additional information from the PIHP as needed, and issue an approval of the POC within 30 days of having required information from the PIHP. The MDHHS will take steps to monitor the PIHP's implementation of the POC as part of performance monitoring.
    c. 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.
6. MDHHS follow-up will be conducted to ensure that remediation of out-of-compliance issues occurs within 90 days after the plan of correction is approved by MDHHS.

5.6 Indian Health Service/Tribally-Operated Facility or program/Urban Indian Clinic (I/T/U)

PIHPs are required to pay any Indian Health Service, Tribal Operated Facility Organization/Program/Urban Indian Clinic (I/T/U), or I/T/U contractor, whether participating in the PIHP provider network or not, for PIHP authorized medically necessary covered Medicaid managed care services provided to Medicaid beneficiary/Indian enrollees who are eligible to receive services from the I/T/U provider either (1) at a rate negotiated between the PIHP and the

I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

IHCPs which are enrolled in Medicaid as Federally Qualified Health Centers (FQHC) but are not participating providers of the PIHP must be paid an amount equal to the amount the PIHP would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the ~~PIPH~~PIHP pays and what the IHCP FQHC would have received under FFS.

When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the PIHP, it has the right to receive its applicable encounter rate published annually in the Federal Register by the IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.

The PIHP must permit an out-of-network IHCP to refer an Indian enrollee to a network provider.

When the amount the IHCP receives from an PIHP is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, the state must make a supplemental payment to the IHCP to make up the difference between the amount the MCP pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

6.3.2 Information Requirements

A. Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services, including but not limited to provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, shall meet the following standards:

1. All such materials shall be written at the 4th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 4th grade level criteria).
2. The provider directory must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on the PIHP's website, in a machine readable file and format. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information.
3. All materials shall be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in the PIHPs Region as identified by the State . Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August

11, 2002 Federal Register Vol. 65, August 16, 2002). All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA), at no cost to the beneficiary. Beneficiaries shall be informed of how to access the alternative formats.

4. If the PIHP provides any required information electronically:
   a. It must be in a form that is readily accessible;
   b. It must be on the PIHP's Web site in a location that is prominent and readily accessible;
   c. It must be in an electronic form which can be electronically retained and printed;
   d. The information must be consistent with the content and language requirements of this 42 CFR 438.10; and
   e. The PIHP must inform the customer that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

~~If the PIHP provides information electronically, it must inform the customer that the information is available in paper form without charge and upon request and provides it upon request within 5 business days.~~

5. Material shall not contain false, confusing, and/or misleading information.

6. For consistency in the information provided to enrollees, the PIHP must use the State developed model enrollee handbooks and enrollee notices[MT(7)]~~Definitions~~, and State developed definitions for managed care terminology, including appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, physician services, prescription drug coverage, prescription drugs, primary care provider, rehabilitation services and devices, skilled nursing care, specialist, co-payment excluded services, health insurance, medically necessary, network, non-participating, plan preauthorization, participating provider, premium, provider and urgent care, as defined in the PIHP contract and/or Medicaid provider manual.

7.0 PROVIDER NETWORK SERVICES

The PIHP is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract. The PIHP remains the accountable party for the Medicaid beneficiaries in its service area, regardless of the functions it has delegated to its provider networks.

In this regard, the PIHP agrees to:

1. 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.

2. Have clearly written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.
3. Provide a copy of the PIHP's prior authorization policies to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to prior authorization policies as changes are made.
4. Provide a copy of the PIHP's grievance, appeal and fair hearing procedures and timeframes to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to those procedures or timeframes.
5. Provide to MDHHS in the format specified by MDHHS, provider agency information profiles that contain a complete listing and description of the provider network available to recipients in the service area.
6. Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility.
7. Assure that network providers do not segregate PIHP individuals in any way from other people receiving their services.

In addition the PIHP agrees upon request from MDHHS either through an RFP or other means to:

1. Provide documentation on which the state bases its certification that the MCP complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.
~~Submit the name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.~~
~~Submit the date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the PIHP and its subcontractors.~~
~~Submit other tax identification number of any corporation with an ownership or control interest in the PIHP and any subcontractor in which the PIHP has a 5 percent or more interest.~~
~~Submit the name, address, date of birth, and SSN of any managing employee of the PIHP.~~ ~~[MT(8)]~~
2. Submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the state or Secretary.

7.

7.4 Integrated Physical and Mental Health Care

The PIHP will initiate affirmative efforts to ensure the integration of primary and specialty behavioral health services for Medicaid beneficiaries. These efforts will focus on persons that have a chronic condition such as a serious and persistent mental health illness, co-occurring substance use disorder or a developmental disability and have been determined by the PIHP to be eligible for Medicaid Specialty Mental Health Services and Supports.

- The PIHP will implement practices to encourage all consumers eligible for specialty mental health services to receive a physical health assessment including identification of the primary health care home/provider, medication history, identification of current and past physical health care and referrals for appropriate services. The physical health assessment will be coordinated through the consumer's MHP as defined in 7.3.
- As authorized by the consumer, the PIHP will include the results of any physical health care findings that relate to the delivery of specialty mental health services and supports in the person-centered plan.
- The PIHP will ensure that a basic health care screening, including height, weight, blood pressure, and blood glucose levels is performed on individuals who have not visited a primary care physician, even after encouragement, for more than 12 months. Health conditions identified through screening should be brought to the attention of the individual along with information about the need for intervention and how to obtain it.

The PIHP will make it's best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees. The PIHP will make subsequent attempts to conduct an initial screening of each enrollee's needs if the initial attempt to contact the enrollee is unsuccessful. [MT(9)]

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7.8.2.4 Third Party Resource Requirements

Medicaid is a payer of last resort. PIHPs and their providers/contractors are required to identify and seek recovery from all other liable third parties in order to make themselves whole. Third party liability (TPL) refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (e.g., Medicare) that has liability for all or part of a recipient's covered benefit. The PIHP shall collect any payments available from other health insurers including Medicare and private health insurance for services provided to its individuals in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, and the Michigan Mental Health Code and Public Health Code as applicable. The PIHP 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 as applicable.

The PIHP must report third-party collections as required by MDHHS. When a Medicaid beneficiary is also enrolled in Medicare, Medicare will be the primary payer ahead of any PIHP, if the service provided is a covered benefit under Medicare. The PIHP must make the Medicaid

beneficiary whole by paying or otherwise covering all Medicare cost-sharing amounts incurred by the Medicaid beneficiary such as coinsurance, co-pays, and deductibles in accordance with coordination of benefit rules. In relation to Medicare-covered services, this applies whether the PIHP authorized the service or not.
If the MDHHS enters into a Coordination of Benefits Agreement (CBA) with Medicare for FFS, and if the PIHP contract includes responsibility for coordination of benefits for individuals dually eligible for Medicaid and Medicare, the MDHHS requires the PIHP to enter into a CBA with Medicare and participate in the automated claims crossover process.

7.9.1 External Quality Review
The state shall arrange for an annual, external independent review of the quality and outcomes, timeliness of, and access to covered services provided by the PIHP. The PIHP shall address the findings of the external review through its QAPIP. The PIHP must develop and implement performance improvement goals, objectives and activities in response to the external review findings as part of the PIHP's QAPIP. A description of the performance improvement goals, objectives and activities developed and implemented in response to the external review findings will be included in the PIHP's QAPIP and provided to the MDHHS upon request. The MDHHS may also require separate submission of an improvement plan specific to the findings of the external review.

If the PIHP has received accreditation by a private independent accrediting entity it must authorize the private independent accrediting entity to provide MDHHSA a copy of its most recent accreditation review, including its accreditation status, survey type, and level (as applicable). When the PIHP has received accreditation by a private independent accrediting entity it must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, recommended actions or improvements, corrective action plans, and summaries of findings. If the PIHP has received accreditation by a private independent accrediting entity it must authorize the private independent accrediting entity to provide the state a copy of its most recent accreditation review, including the expiration date of the accreditation.

7.10.5 Advance Directives
In accordance with 42 CFR 422.128 and 42 CFR 438.6, the PIHP shall maintain written policies and procedures for advance directives. The PIHP shall provide adult beneficiaries with written information on advance directive policies and a description of applicable state law and their rights under applicable laws. This information must be continuously updated to reflect any changes in state law as soon as possible but no later than 90 days after it becomes effective. The PIHP must inform individuals that grievances concerning noncompliance with the advance directive requirements may be filed with Customer Services. This must include prohibiting the PIHP from conditioning the provision of care based on whether or not the individual has executed an advance directive. The PIHP/PIHP will educate staff concerning the PIHP policies and procedures on advance directives.

8.4.1.7 Medical Loss Ratio Reporting Requirements

The PIHP must submit a report to MDHHS that includes at least the following information for each MLR reporting year:

- Total incurred claims.
- Expenditures on quality improving activities.
- Expenditures related to activities compliant with §438.608(a)(1) through (5), (7), (8) and (b).
- Non-claims costs.
- Premium revenue.
- Taxes, licensing and regulatory fees.
- Methodology(ies) for allocation of expenditures.
- Any credibility adjustment applied.
- The calculated MLR.
- Any remittance owed to the State, if applicable.
- A comparison of the information reported in this paragraph with the audited financial report required under §438.3(m).
- A description of the aggregation method used under paragraph (i) of this section.
- The number of member months.

The formula for calculation of the MLR is defined below.

Incurred Claims +/- ISF created/used– HRA – Taxes + Healthcare Quality Improvement + Fraud Reduction

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Current Year Premium Revenue +/- Savings used/created – HRA expense – Tax expense (HICA/Use)

The MLR should be completed in accordance with 42 CFR § 438.8, and that the additional calculation components outlined below are intended to provide clarity regarding state specific items.

Calculation Components

Incurred Claims. Include 1) direct claims paid to providers including all costs of CMHSP capitated contracts (excluding PIHP delegated Managed care administrative costs), 2) Unpaid claims for dates of service falling within the reporting year (accounts payable), 3) Estimate of claims incurred but not reported based on past experience, 4) payments to the ISF, and 5) incentives/bonuses paid to providers. Reduce claims by 6) Overpayment recoveries from providers, 7) prescription drug rebates, 8) claims recovered through fraud reduction efforts up to the amount of fraud reduction expense included in the numerator, 9) Hospital Rate Adjuster payments and 10) contribution to ISF fund.

The following items should be excluded from incurred claims, consistent with the Medical loss ratio (MLR) standards outlined in 42 CFR § 438.8. Specifically, the following must be excluded from incurred claims:

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(A) Non-claims costs, as defined in paragraph (b) of this section, which include the following:

(1) Amounts paid to third party vendors for secondary network savings.

(2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

(3) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

(4) Fines and penalties assessed by regulatory authorities.

(B) Amounts paid to the State as remittance under paragraph (j) of this section.

(C) Amounts paid to network providers under to § 438.6(d).

Healthcare Quality Improvement. Include all Quality Improvement functions, plus include Information Services costs if specifically related to the ability to accept, track, report, and analyze Quality Improvement data. Time and effort for individuals participating in External Quality Reviews (not already captured as Quality Improvement expenses) may be included.

Fraud Reduction. Costs for activities designed to detect and/or prevent payment for fraudulent requests for reimbursement. (i.e. Medicaid Verification Process, Clinical Chart Reviews, etc.)

Premium Revenue. Includes all capitation payments received from MDHHS plus additional cost settlement revenue less any lapse.

Savings. The use of Savings should increase premium revenue while the creation of Savings should reduce premium revenue.

The MLR reporting replaces the PIHP obligation to complete an administrative cost report. The MLR report will provide sufficient administrative cost reporting to meet the actuarial needs. In addition to information required above this will include non-benefit costs in the following categories:

- Administrative costs.
- Taxes, licensing and regulatory fees, and other assessments and fees.
- Contribution to reserves, risk margin, and cost of capital.
- Other material non-benefit costs.

——MLR must be equal to or higher than 85 percent and the MLR must be calculated and reported for each MLR reporting year by the PIHP.

Each MCP expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities. The credibility adjustment is added to the reported MLR calculation before calculating any remittances. The PIHP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If PIHP experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. The PIHP will aggregate data for all Medicaid eligibility groups covered under the contract with the state unless the state requires separate reporting and a separate MLR calculation for specific populations. If required by the state, the PIHP must provide a remittance for a MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher. The PIHP must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the PIHP/PIHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. In any instance where MDHHS makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the MDHHS, the PIHP must re-calculate the MLR for all MLR reporting years affected by the change. In any instance where a MDHHS makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the MDHHS, the PIHP must submit a new MLR report meeting the applicable requirements. The PIHP must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

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- The PIHP shall provide MLR reports to the MDHHS as specified in this contract, and on forms and formats specified by the MDHHS. Forms and instructions are posted to the MDHHS website at: http://www.michigan.gov./mdhhs/0,1607,7-132-2941_38765---,00.html (See Finance Planning, Reporting and Settlement section of Attachment P 7.7.1.1)
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PIHP CUSTOMER SERVICES STANDARDS
Revised: October, 2018

Preamble

It is the function of the customer services unit to be the front door of the pre-paid inpatient health plan (PIHP), and to convey an atmosphere that is welcoming, helpful and informative. These standards apply to the PIHP and to any entity to which the PIHP has delegated the customer services function, including affiliate CMHSP(s), or provider network.

Functions

a. Welcome and orient individuals to services and benefits available, and the provider network.
b. Provide information about how to access behavioral health, primary health, and other community services.
c. Provide information about how to access the various rights processes.
d. Help individuals with problems and inquiries regarding benefits.
e. Assist people with and oversee local complaint and grievance processes.
f. Track and report patterns of problem areas for the organization.

Standards

1. There shall be a designated unit called "Customer Services."

2. There shall be at the PIHP a minimum of one FTE (full time equivalent) performing the customer services functions whether within the customer service unit or elsewhere within the PIHP. If the function is delegated, affiliate CMHSPs, and network providers, as applicable, shall have additional FTEs (or fractions thereof) as appropriate to sufficiently meet the needs of the people in the service area.

3. There shall be a designated toll-free customer services telephone line with access to alternative telephonic communication methods (such as Relays, TTY, etc). The customer services numbers shall be displayed in agency brochures and public information material.

4. Telephone calls to the customer services unit shall be answered by a live voice during business hours. Telephone menus are not acceptable. A variety of alternatives may be employed to triage high volumes of calls as long as there is response to each call within one business day.

5. The hours of customer service unit operations and the process for accessing information from customer services outside those hours shall be publicized. **It is expected that the customer services/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.**

6. The customer handbook shall contain the state-required topics and the PIHP will use the state developed notice forms, or equivalent notice forms with at least the same information included as that in the state notice forms. (See P.6.3.1.1.A)

7. The Medicaid coverage name and the state's description of each service shall be printed in the customer handbook.

8. The customer handbook shall contain a date of publication and revision(s).

9. The PIHP or delegate entity must provide each customer a customer handbook within a reasonable time after receiving notice of the beneficiary's enrollment. This may be provided by:
   a. mailing a printed copy to the customer's mailing address,
   b. emailed after obtaining the customer's agreement to receive information by email,
   c. If the PIHP posts the information on the website and advises the customer in paper or electronic form that the information is available on the internet provided that persons with disabilities who cannot access the information online are provided auxiliary aids and services upon request at no cost, or
   d. the information is provided by any other method that can reasonably be expected to result in the customer receiving the information.

10. Information about how to contact the Medicaid Health Plans or Medicaid fee-for- service programs in the PIHP service area, including plan or program name, locations, and telephone numbers, shall be provided in the handbook.

11. The PIHP or delegate unit shall maintain a current listings of all providers, practitioners, organizations and any group affiliation with whom the PIHP has contracts, street address(es), telephone number(s), website URL (if appropriate), the services they provide, cultural and linguistic capabilities (if they have completed cultural competency training), any non-English languages they speak (including American Sign Language), any specialty for which they are known, whether the provider's office/facility has accommodations for people with physical disabilities, and whether they are accepting new patients. This list must include independent PCP facilitators. The PIHP must make this available in paper form upon request and electronic form such as the PIHP, CMHSP, or network provider's website as applicable. Beneficiaries shall be given this list annually unless the beneficiary has expressly informed the PIHP that accessing the listing through an available website or customer services line is acceptable.

12. The provider directory must be made available in paper form upon request and electronic form. The provider directory ~~and all required information~~ must also be made available in a prominent, readily accessible location on the PIHP's website in a machine readable file and format.

13. The paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information.

14. If the PIHP provides any required information electronically:

    a. It must be in a form that is readily accessible;

    b. It must be on the PIHP's Web site in a location that is prominent and readily accessible;

c. It must be in an electronic form which can be electronically retained and printed;

d. The PIHP must inform the customer that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

~~14. it must inform the customer that the information is available in paper form without charge and upon request and provides it upon request within 5 business days.~~

15. Customer services unit shall have access to information about the PIHP including each CMHSP affiliate annual report, current organizational chart, CMHSP board member list, meeting schedule and minutes. Customer services will provide this information in a timely manner to individuals upon their requests.

16. Upon request, the customer services unit shall assist beneficiaries with filing grievances and appeals, accessing local dispute resolution processes, and coordinate as appropriate with Fair Hearing Officers and the local Office of Recipient Rights.

17. Customer services staff shall be trained to welcome people to the public behavioral health system and to possess current working knowledge, or know where in the organization detailed information can be obtained in at least the following:

    a. *The populations served (serious mental illness, serious emotional disturbance, developmental disability and substance use disorder) and eligibility criteria for various benefits plans (e.g., Medicaid, Healthy Michigan Plan, MIChild)
    b. *Service array (including substance abuse treatment services), medical necessity requirements, and eligibility for and referral to specialty services
    c. Person-centered planning
    d. Self-determination
    e. Recovery & Resiliency
    f. Peer Specialists
    g. *Grievance and appeals, Fair Hearings, local dispute resolution processes, and Recipient Rights
    h. Limited English Proficiency and cultural competency
    i. *Information and referral about Medicaid-covered services within the PIHP as well as outside to Medicaid Health Plans, Fee-for-Services practitioners, and Department of Human Services
    j. The organization of the Public Behavioral Health System
    k. Balanced Budget Act relative to the customer services functions and beneficiary rights and protections
    l. Community resources (e.g., advocacy organizations, housing options, schools, public health agencies)
    m. Public Health Code (for substance abuse treatment recipients if not delegated to the PIHP)

*Must have a working knowledge of these areas, as required by the Balanced Budget Act

PIHP CUSTOMER SERVICES HANDBOOK
REQUIRED STANDARD TOPICS

Each pre-paid inpatient health plan (PIHP) must have a customer services handbook that is provided to Medicaid beneficiaries when they first come to service. Thereafter, PIHPs shall offer the most current version of the handbook annually at the time of person-centered planning, or sooner if substantial changes have been made to the handbook. The list below contains the topics that shall be in each PIHP's customer services handbook. The PIHP may determine the order of the topics as they appear in the handbook and may add more topics. In order that beneficiaries receive the same information no matter where they go in Michigan, the topics with asterisks (*) below must use the standard language templates contained in this requirement. PIHPs should tailor the contact information in the brackets to reflect their local operations and may add local or additional information to the templates. Information in the handbook should be easily understood, and accommodations available for helping beneficiaries understand the information. The information must be available in the prevalent non-English language(s) spoken in the PIHP's service area.

Per direction from the federal Centers for Medicare and Medicaid Services, MDHHS must approve all customer services handbooks to assure compliance with the Balanced Budget Act. After initial approval, it is necessary to seek MDHHS approval only when a PIHP makes significant changes (i.e., beyond new address or new providers) to the customer services handbook.

PIHP's are required to produce supplemental materials (inserts, stickers) to their handbooks if/when MDHHS contractual requirements are updated so that a previously approved handbook continues to meet requirements. Supplemental materials must be provided to individuals with their copy of the customer services handbook.

*Must use boilerplate language in templates (attached)

Topics Requiring Template Language (not necessarily in this order)
*Confidentiality and family access to information
*Coordination of care
*Emergency and after-hours access to services
*Glossary
*Grievance and appeal
*Language accessibility/accommodation
*Payment for services
*Person-centered planning
*Recipient rights
*Recovery
*Service array, eligibility, medical necessity, & choice of providers in network
*Service authorization
* Non-Discrimination Tag Lines

Other Required Topics (not necessarily in this order)
Access process
Access to out-of-network services

Affiliate [for Detroit-Wayne, the MCPNs] the names, addresses and phone numbers of the following personnel:

- Executive director
- Medical director
- Recipient rights officer
- Customer services
- Emergency

Community resource list (and advocacy organizations)
Index
Right to information about PIHP operations (e.g., organizational chart, annual report)
Services not covered under contract
Welcome to PIHP
What is customer services and what it can do for the individual; hours of operation and process for obtaining customer assistance after hours?

Other Suggested Topics
Customer services phone number in the footer of each page
Safety information
Web Address

Contact the PHIP and MDHHS-OIG [LW1]at (addresses and toll-free telephone numbers) for reporting fraud, waste or abuse to both the PIHP and the MDHHS-OIG. The reporting of fraud, waste or abuse may be made anonymously.

Template #1: Confidentiality and Family Access to Information

You have the right to have information about your behavioral health treatment kept private. You also have the right to look at your own clinical records or to request and receive a copy of your records. You have the right to ask us to amend or correct your clinical record ~~and add a formal statement about them~~ if there is something with which you do not agree. Please remember, though, your clinical records can only changed as allowed by applicable law. ~~You have the right to request and receive a copy of the records.~~ Generally, information about you can only be given to others with your permission. However, there are times when your information is shared in order to coordinate your treatment or when it is required by law.

Family members have the right to provide information to [PIHP] about you. However, without a Release of Information signed by you, the [PIHP] may not give information about you to a family member. For minor children under the age of 18 years, parents/guardians are provided information about their child and must sign a release of information before information can be shared with others.

If you receive substance abuse services, you have rights related to confidentiality specific to substance abuse services.

> Under HIPAA (Health Insurance Portability and Accountability Act), you will be provided with an official Notice of Privacy Practices from your community mental health services program. This notice will tell you all the ways that information about you can be used or disclosed. It will also include a listing of your rights provided under HIPAA and how you can file a complaint if you feel your right to privacy has been violated.

If you feel your confidentiality rights have been violated, you can call the Recipient Rights Office where you get services.

[Note to PIHP: you may add additional information to this template]

Template #2: Coordination of Care

To improve the quality of services, [PIHP name] wants to coordinate your care with the medical provider who cares for your physical health. If you are also receiving substance abuse services, your mental health care should be coordinated with those services. Being able to coordinate with all providers involved in treating you improves your chances for recovery, relief of symptoms and improved functioning. Therefore, you are encouraged to sign a "Release of Information" so that information can be shared. If you do not have a medical doctor and need one, contact the [Customer Services Unit] and the staff will assist you in getting a medical provider.

[Note to PIHP: you may add additional information to this template]

Template #3: Emergency and After-Hours Access to Services

A "behavioral health emergency" is when a person is experiencing symptoms and behaviors that can reasonably be expected in the near future to lead him/her to harm self or another; or because of his/her inability to meet his/her basic needs he/she is at risk of harm; or the person's judgment is so impaired that he or she is unable to understand the need for treatment and that their condition is expected to result in harm to him/herself or another individual in the near future. You have the right to receive emergency services at any time, 24-hours a day, seven days a week, without prior authorization for payment of care.

If you have a behavioral health emergency, you should seek help right away. At any time during the day or night call:

[PIHP insert local emergency telephone numbers and place(s) to go for help]

Please note: if you utilize a hospital emergency room, there may be health-care services provided to you as part of the hospital treatment that you receive for which you may receive a bill and may be responsible for depending on your insurance status. These services may not be part of the PIHP emergency services you receive. Customer Services can answer questions about such bills.

Post-Stabilization Services
After you receive emergency behavioral health care and your condition is under control, you may receive behavioral health services to make sure your condition continues to stabilize and improve. Examples of post-stabilization services are crisis residential, case management, outpatient therapy, and/or medication reviews. Prior to the end of your emergency-level care, your local CMH will help you to coordinate your post-stabilization services.

Template #4: Glossary or Definition of Terms

GLOSSARY

Access: The entry point to the Prepaid Inpatient Health Plan (PIHP), sometimes called an "access center," where Medicaid beneficiaries call or go to request behavioral health services.

Adverse Benefit Determination: A decision that adversely impacts a Medicaid beneficiary's claim for services due to:

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited authorization decision within **72 hours** from the date of receipt of a request for expedited service authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP.
- Failure of the PIHP to act within **30 calendar days** from the date of a request for a standard appeal.
- Failure of the PIHP to act within **72 hours** from the date of a request for an expedited appeal.
- Failure of the PIHP to provide disposition and notice of a local grievance/complaint within **90 calendar days** of the date of the request.

Amount, Duration, and Scope: Terms to describe how much, how long, and in what ways the Medicaid services that are listed in a person's individual plan of service will be provided.

Appeal: A review of an adverse benefit determination.

Behavioral Health- Includes not only ways of promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also has as an aim preventing or intervening in substance abuse or other addictions. For the purposes of this handbook, behavioral health will include intellectual/developmental disabilities, mental illness in both adults and children and substance use disorders.

Beneficiary: An individual who is eligible for and enrolled in the Medicaid program in Michigan.

CMHSP: An acronym for Community Mental Health Services Program. There are 46

CMHSPs in Michigan that provide services in their local areas to people with mental illness and developmental disabilities. May also be referred to as CMH.

Deductible (or Spend-Down): A term used when individuals qualify for Medicaid coverage even though their countable incomes are higher than the usual Medicaid income standard. Under this process, the medical expenses that an individual incurs during a month are subtracted from the individual's income during that month. Once the individual's income has been reduced to a state-specified level, the individual qualifies for Medicaid benefits for the remainder of the month. Medicaid applications and deductible determinations are managed by the Michigan Department of Health and Human Services – independent of the PIHP service system.

Durable Medical Equipment: Any equipment that provides therapeutic benefits to a person in need because of certain medical conditions and/or illnesses. Durable Medical Equipment (DME) consists of items which:

- are primarily and customarily used to serve a medical purpose;
- are not useful to a person in the absence of illness, disability, or injury;
- are ordered or prescribed by a physician;
- are reusable;
- can stand repeated use, and
- are appropriate for use in the home.

Emergency Services/Care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical/behavioral emergency.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Flint 1115 Demonstration Waiver The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014 through a state-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act, and is effective as of March 3, 2016 the date of the signed approval through February 28, 2021. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the state plan. All such persons will have access to Targeted Case Management services under a fee for service contract between MDHHS and Genesee Health Systems (GHS). The fee for service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.

Grievance: Expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness or a provider or employee, or failure to respect beneficiary's rights regardless of whether remedial action is requested. Grievance includes a beneficiary's right to dispute an extension of time proposed by the PIHP to make

an authorization decision.

Grievance and Appeal System: The processes the PIHP implements to handle the appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them

Habilitation Services and Devices: Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.

Health Insurance: Coverage that provides for the payments of benefits as a result of sickness or injury. It includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): This legislation is aimed, in part, at protecting the privacy and confidentially of patient information. "Patient" means any recipient of public or private health care, including behavioral health care, services.

Healthy Michigan Plan is an 1115 Demonstration project that provides health care benefits to individuals who are: aged 19-64 years; have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology; do not qualify or are not enrolled in Medicare or Medicaid; are not pregnant at the time of application; and are residents of the State of Michigan. Individuals meeting Health Michigan Plan eligibility requirements may also be eligible for behavioral health services. The Michigan Medicaid Provider Manual contains complete definitions of the available services as well as eligibility criteria and provider qualifications. The Manual may be accessed at:

http://www.michigan.gov/mdhhs/0,4612,7-132-2945_42542_42543_42546_42553-87572--,00.html

Customer Service staff can help you access the manual and/or information from it.

Home Health Care: Is supportive care provided in the home. Care may be provided by licensed healthcare professionals who provide medical treatment needs or by professional caregivers who provide daily assistance to ensure the activities of daily living (ADLs) are met.

Hospice Services: Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. The goal is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible.

Hospitalization: A term used when formally admitted to the hospital for skilled behavioral services. If not formally admitted, it might still be considered an outpatient instead of an inpatient even if an overnight stay is involved.

Hospital Outpatient Care: Is any type of care performed at a hospital when it is

not expected there will be an overnight hospital stay.

Intellectual/Developmental Disability: Is defined by the Michigan Mental Health code as either of the following: (a) If applied to a person older than five years, a severe chronic condition that is attributable to a mental or physical impairment or both, and is manifested before the age of 22 years; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of the following major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration; (b) If applied to a minor from birth to age five, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in a developmental disability.

Limited English proficient (LEP): Means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

MDHHS: An acronym for Michigan Department of Health and Human Services . This state department, located in Lansing, oversees public-funded services provided in local communities and state facilities to people with mental illness, developmental disabilities and substance use disorders.

Medically Necessary: A term used to describe one of the criteria that must be met in order for a beneficiary to receive Medicaid services. It means that the specific service is expected to help the beneficiary with his/her mental health, developmental disability or substance use (or any other medical) condition. Some services assess needs and some services help maintain or improve functioning. PIHP's are unable to authorize (pay for) or provide services that are not determined as medically necessary foryou.

Michigan Mental Health Code: The state law that governs public mental health services provided to adults and children with mental illness, serious emotional disturbance and developmental disabilities by local community mental health services programs and in state facilities.

MIChild: A Michigan health care program for low-income children who are not eligible for the Medicaid program. This is a limited benefit. Contact the [Customer Services Unit] for more information.

Network: Is a list of the doctors, other health care providers, and hospitals that a plan has contracted with to provide medical care/services to its members.

Non-Participating Provider: A provider or facility that is not employed, owned, or operated by the PHIP/CMHSP and is not under contract to provide covered services to members.

Participating Provider: Is the general term used for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide health care services; medical equipment; mental health, substance use disorder, intellectual/developmental disability, and long term supports and services. They are licensed or certified to provide health care services. They agree to work with the health plan, accept payment and not charge enrollees an extra amount. Participating providers are also called network providers.

Physician Services: Refers to the services provided by an individual licensed under state law to practice medicine or osteopathy.

PIHP: An acronym for Prepaid Inpatient Health Plan. A PIHP is an organization that manages the Medicaid mental health, developmental disabilities, and substance abuse services in their geographic area under contract with the State. There are 10 PIHPs in Michigan and each one is organized as a Regional Entity or a Community Mental Health Services Program according to the Mental Health Code.

Preauthorization: Approval needed before certain services or drugs can be provided. Some network medical services are covered only if the doctor or other network provider gets prior authorization. Also called Prior Authorization.

Premium: An amount to be paid for an insurance policy, a sum added to an ordinary price or charge.

Prescription Drugs: Is a pharmaceutical drug that legally requires a medical prescription to be dispensed. In contrast, over-the-counter drugs can be obtained without a prescription.

Prescription Drug Coverage: Is a stand-alone insurance plan, covering only prescription drugs.

Primary Care Physician: A doctor who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.

Primary Care Provider: A health care professional (usually a physician) who is responsible for monitoring an individual's overall health care needs.

Provider: Is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.

Recovery: A journey of healing and change allowing a person to live a meaningful life in a community of their choice, while working toward their full potential.

Rehabilitation Services and Devices: Health care services that help a person keep,

get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy and speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Resiliency: The ability to "bounce back." This is a characteristic important to nurture in children with serious emotional disturbance and their families. It refers to the individual's ability to become successful despite challenges they may face throughout their life.

Specialty Supports and Services: A term that means Medicaid-funded mental health, developmental disabilities and substance abuse supports and services that are managed by the Pre-Paid Inpatient Health Plans.

SED: An acronym for Serious Emotional Disturbance, and as defined by the Michigan Mental Health Code, means a diagnosable mental, behavioral or emotional disorder affecting a child that exists or has existed during the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders; and has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities.

Serious Mental Illness: Is defined by the Michigan Mental Health Code to mean a diagnosable mental, behavioral or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual of Mental Disorders; and that has resulted in function impairment that substantially interferes with or limits one or more major life activities.

Skilled Nursing Care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A health care professional whose practice is limited to a particular area, such as a branch of medicine, surgery, or nursing; especially, one who by virtue of advanced training is certified by a specialty board as being qualified to so limit his or her practice.

State Fair Hearing: A state level review of beneficiaries' disagreements with CMHSP, or PIHP denial, reduction, suspension or termination of Medicaid services. State administrative law judges who are independent of the Michigan Department of Health and Human Services perform the reviews.

Substance Use Disorder (or substance abuse): Is defined in the Michigan Public Health Code to mean the taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of

alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

Urgent Care: Care for a sudden illness, injury, or condition that is not an emergency but needs care right away. Urgently needed care can be obtained from out-of-network providers when network providers are unavailable.

[Note to PIHP: you may add additional information to this template]

Template #5: Grievance and Appeals Processes

Grievances

You have the right to say that you are unhappy with your services or supports or the staff who provide them, by filing a "grievance." You can file a grievance *any time* by calling, visiting, or writing to the [Customer Services Office.] Assistance is available in the filing process by contacting_____. In most cases, your grievance will be resolved within 90-calendar days from the date the PIHP receives your grievance. You will be given detailed information about grievance and appeal processes when you first start services and then again annually. You may ask for this information at any time by contacting the [Customer Services Office]. *

Appeals

You will be given notice when a decision is made that denies your request for services or reduces, suspends or terminates the services you already receive. This notice is called an "Adverse Benefit Determination". You have the right to file an "appeal" when you do not agree with such a decision. ~~There are time limits on when you can file an appeal once you receive a decision about your services~~If you would like to ask for an appeal, you will have to do so within 60-calendar days from the date on the Adverse Benefit Determination.

You may:

- a~~A~~sk for a "Local Appeal" by contacting_at____.

You will have the chance to provide information in support of your appeal, and to have someone speak for you regarding the appeal if you would like.
~~Your~~
In most cases, your appeal will be completed ~~quickly~~in 30 calendar days or less. If you request and meet the requirements for an "expedited appeal" (fast appeal), your appeal will be decided within 72-hours after we receive your request. In all cases, the PIHP may extend the time for resolving your appeal by 14 calendar days if you request an extension, or if the PIHP can show that additional information is needed and that the delay is in your best interest.

~~, and you will have the chance to provide information or have someone speak for you regarding the appeal.~~ You may ask for assistance from [Customer Services] to file an appeal.

State Fair Hearing

You must complete a local appeal before you can file a state fair hearing. However, if the PIHP fails to adhere to the notice and timing requirements, you will be deemed to have

exhausted the local appeal process. You may request a State Fair Hearing at that time.

You can ask for a state fair hearing only after receiving notice that the service decision you appealed has been upheld. You can also ask for a state fair hearing if you were not provided your notice and decision regarding your appeal in the timeframe required. There are time limits on when you can file an appeal once you receive a decision about your local appeal.

Benefit continuation

If you are [LW2]receiving a Michigan Medicaid service that is reduced, terminated or suspended before your current service authorization, and you file your appeal within 10 calendar days (as instructed on the Notice of Adverse Benefit Determination), you may continue to receive your same level of services while your internal appeal is pending. You will need to state in your appeal request that you are asking for your service(s) to continue.

If your benefits are continued and your appeal is denied, you will also have the right to ask for your benefits to continue while a State Fair Hearing is pending if you ask for one within 10 calendar days. You will need to state in your State Fair Hearing request that you are asking for your service(s) to continue.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal or State Fair Hearing request; or 2) all entities that got your appeal decide "no" to your request.

NOTE: If your benefits are continued because you used this process, you may be required to repay the cost of any services that you received while your appeal was pending if the final resolution upholds the denial of your request for coverage or payment of a service. State policy will determine if you will be required to repay the cost of any continued benefits.

~~When requested by the enrollee, benefits that the PIPH seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.~~

*[Note to PIHPs: you may add detailed information about grievance and appeals to this template.]

Template #6: Language Assistance and Accommodations Language Assistance

If you are a person who does not speak English as your primary language and/or who has a limited ability to read, speak or understand English, you may be eligible to receive language assistance.

If you are a person who is deaf or hard of hearing, , you can utilize the Michigan Relay Center (MRC) to reach your PIHP, CMHSP or service provider. Please call 7-1-1 and ask MRC to connect you to the number you are trying to reach. If you prefer to use a TTY, please contact [customer services] at the following TTY phone number: (number).

If you need a sign language interpreter, contact the [customer services office] at (number) as soon as possible so that one will be made available. Sign language interpreters are available at no cost to you.

If you do not speak English, contact the [customer services office] at (number) so that arrangements can be made for an interpreter for you. Language interpreters are available at no cost to you.

[Note to PIHP: you should add in the handbook any other language assistance they have available]

Accessibility and Accommodations

In accordance with federal and state laws, all buildings and programs of the (PIHP name) are required to be physically accessible to individuals with all qualifying disabilities. Any individual who receives emotional, visual or mobility support from a qualified/trained and identified service animal such as a dog will be given access, along with the service animal, to all buildings and programs of the (PIHP name). If you need more information or if you have questions about accessibility or service/support animals, contact [customer services] at (phone number).

If you need to request an accommodation on behalf of yourself or a family member or a friend, you can contact [customer services] at (phone). You will be told how to request an accommodation (this can be done over the phone, in person and/or in writing) and you will be told who at the agency is responsible for handling accommodation requests.

[Note to PIHP: you may add additional information to this template. To accommodate multiple affiliates or provider networks, it is acceptable to format names and numbers in the most logical way]

Template #7: Payment for Services

If you are enrolled in Medicaid and meet the criteria for the specialty behavioral health services the total cost of your authorized behavioral health treatment will be covered. No fees will be charged to you.

Some members will be responsible for "Cost sharing". This refers to money that a member has to pay when services or drugs are received. You might also hear terms like "deductible, spend-down, copayment, or coinsurance," which are all forms of "cost sharing". Your Medicaid benefit level will determine if you will have to pay any cost-sharing responsibilities. If you are a Medicaid beneficiary with a deductible ("spend-down"), as determined by the Michigan Department of Health and Human Services (MDHHS) you may be responsible for the cost of a portion of your services.

Should you lose your Medicaid coverage, your PIHP/provider may need to re-evaluate your eligibility for services. A different set of criteria may be applied to services that are covered by another funding source such as General Fund, Block Grant, or a third party payer.

If Medicare is your primary payer, the PIHP will cover all Medicare cost-sharing consistent with coordination of benefit rules. ~~The PIHP will provide cost-sharing on any benefits carved out of the contract and provided by the state. As well as~~ How ~~and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided.~~

[Note to PIHP: you may add additional information to this template]

Template #8: Person-Centered Planning

The process used to design your individual plan of behavioral health supports, service, or treatment is called "Person-centered Planning (PCP)." PCP is your right protected by the Michigan Mental Health Code.

The process begins when you determine whom, beside yourself, you would like at the person-centered planning meetings, such as family members or friends, and what staff from [name of PIHP] you would like to attend. You will also decide when and where the person-centered planning meetings will be held. Finally, you will decide what assistance you might need to help you participate in and understand the meetings.

During person-centered planning, you will be asked what are your hopes and dreams, and will be helped to develop goals or outcomes you want to achieve. The people attending this meeting will help you decide what supports, services or treatment you need, who you would like to provide this service, how often you need the service, and where it will be provided. You have the right, under federal and state laws, to a choice of providers.

After you begin receiving services, you will be asked from time to time how you feel about the supports, services or treatment you are receiving and whether changes need to be made. You have the right to ask at any time for a new person-centered planning meeting if you want to talk about changing your plan of service.

You have the right to "independent facilitation" of the person-centered planning process. This means that you may request that someone other than the [name of PIHP] staff conduct your planning meetings. You have the right to choose from available independent facilitators.

Children under the age of 18 with developmental disabilities or serious emotional disturbance also have the right to person-centered planning. However, person-centered planning must recognize the importance of the family and the fact that supports and services impact the entire family. The parent(s) or guardian(s) of the children will be involved in pre-planning and person-centered planning using "family-centered practice" in the delivery of supports, services and treatment to their children.

Topics Covered during Person-Centered Planning

During person-centered planning, you will be told about psychiatric advance directives, a crisis plan, and self-determination (see the descriptions below). You have the right to choose to develop any, all or none of these.

Psychiatric Advance Directive

Adults have the right, under Michigan law, to a **"psychiatric advance directive."** A psychiatric advance directive is a tool for making decisions before a crisis in which you may become unable to make a decision about the kind of treatment you want and the kind of treatment you do not want. This lets other people, including family, friends, and service providers, know what you

want when you cannot speak for yourself.

If you do not believe you have received appropriate information regarding Psychiatric Advance Directives from your PIHP, please contact the customer services office to file a grievance.

Crisis Plan
You also have the right to develop a **"crisis plan."** A crisis plan is intended to give direct care if you begin to have problems in managing your life or you become unable to make decisions and care for yourself. The crisis plan would give information and direction to others about what you would like done in the time of crisis. Examples are friends or relatives to be called, preferred medicines, or care of children, pets, or bills.

Self-determination
Self-determination is an option for payment of medically necessary services you might request if you are an adult beneficiary receiving behavioral health services in Michigan. It is a process that would help you to design and exercise control over your own life by directing a fixed amount of dollars that will be spent on your authorized supports and services, often referred to as an "individual budget." You would also be supported in your management of providers, if you choose such control.

[Note to PIHP: you may add additional information to this template]

Template #9: Recipient Rights

Every person who receives public behavioral health services has certain rights. The Michigan Mental Health Code protects some rights. Some of your rights include:

- The right to be free from abuse and neglect
- The right to confidentiality
- The right to be treated with dignity and respect
- The right to treatment suited to condition

More information about your many rights is contained in the booklet titled "Your Rights." You will be given this booklet and have your rights explained to you when you first start services, and then once again every year. You can also ask for this booklet at any time.

You may file a Recipient Rights complaint *any time* if you think staff violated your rights. You can make a rights complaint either orally or in writing.

If you receive substance abuse services, you have rights protected by the Public Health Code. These rights will also be explained to you when you start services and then once again every year. You can find more information about your rights while getting substance abuse services in the "Know Your Rights" pamphlet.

You may contact your local community behavioral health services program to talk with a Recipient Rights Officer with any questions you may have about your rights or to get help to make a complaint. Customer Services can also help you make a complaint. You can contact the Office or Recipient Rights at:_____ or Customer Services at: _____.

Freedom from Retaliation
If you use public behavioral health services, you are free to exercise your rights, and to use the rights protection system without fear of retaliation, harassment, or discrimination. In addition, under no circumstances will the public behavioral health system use seclusion or restraint as a means of coercion, discipline, convenience or retaliation.

[Note to PIHP: you may add additional information to this template]

Template #10: Recovery & Resiliency

Recovery is a journey of healing and transformation enabling a person with a mental health/substance abuse problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential.
Recovery is an individual journey that follows different paths and leads to different locations. Recovery is a process that we enter into and is a lifelong attitude. Recovery is unique to each individual and can truly only be defined by the individual themselves. What might be recovery for one person may be only part of the process for another. Recovery may also be defined as wellness. Behavioral health supports and services help people with a mental illness/substance use disorder in their recovery journeys. The person-centered planning process is used to identify the supports needed for individual recovery.

In recovery there may be relapses. A relapse is not a failure, rather a challenge. If a relapse is prepared for, and the tools and skills that have been learned throughout the recovery journey are used, a person can overcome and come out a stronger individual. It takes time, and that is why **Recovery** is a process that will lead to a future that holds days of pleasure and the energy to persevere through the trials of life.

Resiliency and development are the guiding principles for children with serious emotional disturbance. Resiliency is the ability to "bounce back" and is a characteristic important to nurture in children with serious emotional disturbance and their families. It refers to the individual's ability to become successful despite challenges they may face throughout their life.

[Note to PIHP: you may add additional information to this template]

Template #11: Service Array

MEDICAID SPECIALTY SUPPORTS AND SERVICES DESCRIPTIONS

Note: If you are a Medicaid beneficiary and have a serious mental illness, or serious emotional disturbance, or developmental disabilities, or substance use disorder, you may be eligible for some of the Medicaid Specialty Supports and Services listed below.

Before services can be started, you will take part in an assessment to find out if you are eligible for services. It will also identify the services that can best meet your needs. You need to know that not all people who come to us are eligible, and not all services are available to everyone we serve. If a service cannot help you, your Community Mental Health will not pay for it. Medicaid will not pay for services that are otherwise available to you from other resources in the community.

During the person-centered planning process, you will be helped to figure out the medically necessary services that you need and the sufficient amount, scope and duration required to achieve the purpose of those services. You will also be able to choose who provides your supports and services. You will receive an individual plan of service that provides all of this information.

In addition to meeting medically necessary criteria, services listed below marked with an asterisk (*) require a doctor's prescription.

Note: the Michigan Medicaid Provider Manual contains complete definitions of the following services as well as eligibility criteria and provider qualifications. The Manual may be accessed at:

http://www.michigan.gov/mdhhs/0,4612,7-132-2945_42542_42543_42546_42553-87572--,00.html

Customer Service staff can help you access the manual and/or information from it.

Assertive Community Treatment (ACT) provides basic services and supports essential for people with serious mental illness to maintain independence in the community. An ACT team will provide behavioral health therapy and help with medications. The team may also help access community resources and supports needed to maintain wellness and participate in social, educational and vocational activities. ACT may be provided daily for individuals who participate.

Assessment includes a comprehensive psychiatric evaluation, psychological testing, substance abuse screening, or other assessments conducted to determine a person's level of functioning and behavioral health treatment needs. Physical health assessments are not part of this PIHP service.

***Assistive Technology** includes adaptive devices and supplies that are not covered

under the Medicaid Health Plan or by other community resources. These devices help individuals to better take care of themselves, or to better interact in the places where they live, work, and play.

Behavior Treatment Review If a person's illness or disability involves behaviors that they or others who work with them want to change, their individual plan of services may include a plan that talks about the behavior. This plan is often called a "behavior treatment plan." The behavior management plan is developed during person-centered planning and then is approved and reviewed regularly by a team of specialists to make sure that it is effective and dignified, and continues to meet the person's needs.

Behavioral Treatment Services/Applied Behavior Analysis are services for children under 21 years of age with Autism Spectrum Disorders (ASD).

Clubhouse Programs are programs where members (consumers) and staff work side by side to operate the clubhouse and to encourage participation in the greater community. Clubhouse programs focus on fostering recovery, competency, and social supports, as well as vocational skills and opportunities.

Community Inpatient Services are hospital services used to stabilize a behavioral health condition in the event of a significant change in symptoms, or in a behavioral health emergency. Community hospital services are provided in licensed psychiatric hospitals and in licensed psychiatric units of general hospitals.

Community Living Supports (CLS) are activities provided by paid staff that help adults with either serious mental illness or developmental disabilities live independently and participate actively in the community. Community Living Supports may also help families who have children with special needs (such as developmental disabilities or serious emotional disturbance).

Crisis Interventions are unscheduled individual or group services aimed at reducing or eliminating the impact of unexpected events on behavioral health and well-being.

Crisis Residential Services are short-term alternatives to inpatient hospitalization provided in a licensed residential setting.

Early Periodic Screening, Diagnosis and Treatment (EPSDT[LW3]**).** EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under the age of 21 years, as specified in Section 1905(a)(4)(B) of the Social Security Act (the Act) and defined in 42 U.S.C. § 1396d(r)(5) and 42 CFR 441.50 or its successive regulation.

The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

Health plans are required to comply with all EPSDT requirements for their Medicaid enrollees under the age of 21 years. EPSDT entitles Medicaid and Children's Health

Insurance Program (CHIP) enrollees under the age of 21 years, to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions.

This requirement results in a comprehensive health benefit for children under age 21 enrolled in Medicaid In addition to the covered services listed above, Medicaid must provide any other medical or remedial care, even if the agency does not otherwise provide for these services or provides for them in a lesser amount, duration, or scope (42 CFR 441.57).

~~Under Michigan's 1915(b) specialty service waiver, the PIHP is responsible for the provision of specialty services Medicaid benefits, and must make these benefits available to beneficiaries referred by a primary EPSDT screener, to correct or ameliorate a qualifying condition discovered through the screening process.~~

While transportation to EPSDT corrective or ameliorative specialty services is not a covered service under this waiver, the PIHP must assist beneficiaries in obtaining necessary transportation either through the Michigan Department of Health and Human Services or through the beneficiary's Medicaid health plan.

***Enhanced Pharmacy** includes doctor-ordered nonprescription or over-the-counter items (such as vitamins or cough syrup) necessary to manage your health condition(s) when a person's Medicaid Health Plan does not cover these items.

***Environmental Modifications** are physical changes to a person's home, car, or work environment that are of direct medical or remedial benefit to the person. Modifications ensure access, protect health and safety, or enable greater independence for a person with physical disabilities. Note that all other sources of funding must be explored first, before using Medicaid funds for environmental modifications.

Family Support and Training provides family-focused assistance to family members relating to and caring for a relative with serious mental illness, serious emotional disturbance, or developmental disabilities. "Family Skills Training" is education and training for families who live with and or care for a family member who is eligible for the Children's Waiver Program.

Fiscal Intermediary Services help individuals manage their service and supports budget and pay providers if they are using a "self-determination" approach.

Health Services include assessment, treatment, and professional monitoring of health conditions that are related to or impacted by a person's behavioral health condition. A person's primary doctor will treat any other health conditions they may have.

Home-Based Services for Children and Families are provided in the family home or in another community setting. Services are designed individually for each family, and can include things like behavioral health therapy, crisis intervention, service coordination, or other supports to the family.

Housing Assistance is assistance with short-term, transitional, or one-time-only expenses in an individual's own home that his/her resources and other community resources could not cover.

Intensive Crisis Stabilization is another short-term alternative to inpatient hospitalization. Intensive crisis stabilization services are structured treatment and support activities provided by a behavioral health crisis team in the person's home or in another community setting.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) provide 24-hour intensive supervision, health and rehabilitative services and basic needs to persons with developmental disabilities.

Medication Administration is when a doctor, nurse, or other licensed medical provider gives an injection, or an oral medication or topical medication.

Medication Review is the evaluation and monitoring of medicines used to treat a person's behavioral health condition, their effects, and the need for continuing or changing their medicines.

Mental Health Therapy and Counseling for Adults, Children and Families includes therapy or counseling designed to help improve functioning and relationships with other people.

Nursing Home Mental Health Assessment and Monitoring includes a review of a nursing home resident's need for and response to behavioral health treatment, along with consultations with nursing home staff.

***Occupational Therapy** includes the evaluation by an occupational therapist of an individuals' ability to do things in order to take care of themselves every day, and treatments to help increase these abilities.

Partial Hospital Services include psychiatric, psychological, social, occupational, nursing, music therapy, and therapeutic recreational services in a hospital setting, under a doctor's supervision. Partial hospital services are provided during the day – participants go home at night.

Peer-delivered and Peer Specialist Services. Peer-delivered services such as drop-in centers are entirely run by consumers of behavioral health services. They offer help with food, clothing, socialization, housing, and support to begin or maintain behavioral health treatment. Peer Specialist services are activities designed to help persons with serious mental illness in their individual recovery journey and are provided by individuals who are in recovery from serious mental illness. Peer mentors help people with developmental disabilities.

Personal Care in Specialized Residential Settings assists an adult with mental illness or developmental disabilities with activities of daily living, self-care and basic needs, while they are living in a specialized residential setting in the community.

***Physical Therapy** includes the evaluation by a physical therapist of a person's physical abilities (such as the ways they move, use their arms or hands, or hold their body), and treatments to help improve their physical abilities.

Prevention Service Models (such as Infant Mental Health, School Success, etc.) use both individual and group interventions designed to reduce the likelihood that individuals will need treatment from the public behavioral health system.

Respite Care Services provide short-term relief to the unpaid primary caregivers of people eligible for specialty services. Respite provides temporary alternative care, either in the family home, or in another community setting chosen by the family.

Skill-Building Assistance includes supports, services and training to help a person participate actively at school, work, volunteer, or community settings, or to learn social skills they may need to support themselves or to get around in the community.

***Speech and Language Therapy** includes the evaluation by a speech therapist of a person's ability to use and understand language and communicate with others or to manage swallowing or related conditions, and treatments to help enhance speech, communication or swallowing.

Substance Abuse Treatment Services (descriptions follow the behavioral health services)

Supports Coordination or Targeted Case Management: A Supports Coordinator or Case Manager is a staff person who helps write an individual plan of service and makes sure the services are delivered. His or her role is to listen to a person's goals, and to help find the services and providers inside and outside the local community mental health services program that will help achieve the goals. A supports coordinator or case manager may also connect a person to resources in the community for employment, community living, education, public benefits, and recreational activities.

Supported/Integrated Employment Services provide initial and ongoing supports, services and training, usually provided at the job site, to help adults who are eligible for behavioral health services find and keep paid employment in the community.

Transportation may be provided to and from a person's home in order for them to take part in a non-medical Medicaid-covered service.

Treatment Planning assists the person and those of his/her choosing in the development and periodic review of the individual plan of services.

Wraparound Services for Children and Adolescents with serious emotional disturbance and their families that include treatment and supports necessary to maintain the child in the family home.

<u>Services for Only Habilitation Supports Waiver (HSW) and Children's Waiver Participants</u>

Some Medicaid beneficiaries are eligible for special services that help them avoid having to go to an institution for people with developmental disabilities or nursing home. These special services are called the Habilitation Supports Waiver and the Children's Waiver. In order to receive these services, people with developmental disabilities need to be enrolled in either of these "waivers." The availability of these waivers is very limited. People enrolled in the waivers have access to the services listed above as well as those listed here:

Goods and Services (for HSW enrollees) is a non-staff service that replaces the assistance that staff would be hired to provide. This service, used in conjunctions with a self-determination arrangement, provides assistance to increase independence, facilitate productivity, or promote community inclusion.

Non-Family Training (for Children's Waiver enrollees) is customized training for the paid in-home support staff who provide care for a child enrolled in the Waiver.

Out-of-home Non-Vocational Supports and Services (for HSW enrollees) is assistance to gain, retain or improve in self-help, socialization or adaptive skills.

Personal Emergency Response devices (for HSW enrollees) help a person maintain independence and safety, in their own home or in a community setting. These are devices that are used to call for help in an emergency.

Prevocational Services (for HSW enrollees) include supports, services and training to prepare a person for paid employment or community volunteer work.

Private Duty Nursing (for HSW enrollees) is individualized nursing service provided in the home, as necessary to meet specialized health needs.

Specialty Services (for Children's Waiver enrollees) are music, recreation, art, or massage therapies that may be provided to help reduce or manage the symptoms of a child's mental health condition or developmental disability. Specialty services might also include specialized child and family training, coaching, staff supervision, or monitoring of program goals.

Services for Persons with Substance Use Disorders
The Substance Abuse treatment services listed below are covered by Medicaid. These services are available through the PIHP.

Access, Assessment and Referral (AAR) determines the need for substance abuse services and will assist in getting to the right services and providers.

Outpatient Treatment includes therapy/counseling for the individual, and family and group therapy in an office setting.

Intensive/Enhanced Outpatient (IOP or EOP) is a service that provides more frequent and longer counseling sessions each week and may include day or evening programs.

Methadone and LAAM Treatment is provided to people who have heroin or other opiate dependence. The treatment consists of opiate substitution monitored by a doctor as well as nursing services and lab tests. This treatment is usually provided along with other substance abuse outpatient treatment.

Sub-Acute Detoxification is medical care in a residential setting for people who are withdrawing from alcohol or other drugs.

Residential Treatment is intensive therapeutic services which include overnight stays in a staffed licensed facility.

If you receive Medicaid, you may be entitled to other medical services not listed above. Services necessary to maintain your physical health are provided or ordered by your primary care doctor. If you receive Community Mental Health services, your local community mental health services program will work with your primary care doctor to coordinate your physical and behavioral health services. If you do not have a primary care doctor, your local community mental health services program will help you find one.

Note: **Home Help Program** is another service available to Medicaid beneficiaries who require in-home assistance with activities of daily living, and household chores. In order to learn more about this service, you may call the local Michigan Department of Human Services' number below or contact the [Customer Services Office] for assistance.

[Name and phone number of the local MDHHS Human Services office]

Medicaid Health Plan Services

If you are enrolled in a Medicaid Health Plan, the following kinds of health care services are available to you when your medical condition requires them.

- Ambulance
- Chiropractic
- Doctor visits
- Family planning
- Health check ups
- Hearing aids
- Hearing and speech therapy
- Home Health Care
- Immunizations (shots)
- Lab and X-ray
- Nursing Home Care
- Medical supplies
- Medicine
- Mental health (limit of 20 outpatient visits)
- Physical and Occupational therapy
- Prenatal care and delivery
- Surgery
- Transportation to medical appointments
- Vision

If you already are enrolled in one of the health plans [listed below] you can contact the health plan directly for more information about the services listed above. If you are not enrolled in a health plan or do not know the name of your health plan, you can contact the [Customer Services Office] for assistance.

[List of health plans and contact numbers]

Template #12: Service Authorization

Services you request must be authorized or approved by [the PIHP or its designee]. That agency may approve all, some or none of your requests. You will receive notice of a decision within 14 calendar days after you have requested the service during person-centered planning, or within 72 hours if the request requires a quick decision.

Any decision that denies a service you request or denies the amount, scope or duration of the service that you request will be made by a health care professional who has appropriate clinical expertise in treating your condition. Authorizations are made according to medical necessity. If you do not agree with a decision that denies, reduces, suspends or terminates a service, you may file an appeal.

[Note to PIHP: you may add additional information to this template]

Template #13: Tag Lines

In order to establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each PIHP entity service area the list below is provided. Each PIHP must provide tag lines in the prevalent non-English languages in its particular service area included in the list below.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call

Albanian: KUJDES: Në qoftë se ju flisni anglisht, shërbimet e ndihmës gjuhësore, pa pagesë, janë në dispozicion për ty. Telefononi

Arabic: تنبيه: إذا كنت تتحدث العربية فإن خدمة الترجمة متوفرة لك مجانا فقط إتصل على الرقم

Bengali: □ৃ Þ ĞŅ Þ ęĔ þðĬ'ĸ, ĹŏŃńŇźą ő=ńěǫ ĸğl'ĆőĞĎőěĿŢą ęőĬĘ Þ ęĘð' ČĘǪ×ęĿΦ ĞĿ

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

German: Achtung: Wenn Sie Englisch sprechen, sind Sprache Assistance-Leistungen, unentgeltlich zur Verfügung. Rufen Sie .

Italian: Attenzione: Se si parla inglese, servizi di assistenza di lingua, gratuitamente, sono a vostra disposizione. Chiamare

Japanese: 注意: 英語を話す言語アシスタンス サービス、無料で、あなたに利用できま 。を呼び出す)

Korean: 주의: 당신이 영어, 언어 지원 서비스를 무료로 사용할 수 있습니다 당신에 게. □ □ .

Polish: UWAGI: Jeśli mówisz po angielsku, język pomocy usług, za darmo, są dostępne dla Ciebie. Wywołanie

Russian: ВНИМАНИЕ: Если вы говорите по-английски, языковой помощи, бесплатно предоставляются услуги для вас. Звоните

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (TTY- Telefon za osobe sa oštećenim govorom ili sluhom:).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al

Syriac: ܐܘܕܥܐ ܬܘܟܠܢܐ ܟܠ ܗܠܝܢ ܕܡܬܒܥܐ ܒܐܣܝܪܝܐ ܣܘܪܝܝܐ ܡܫܠܡܐ ، ܐܝܟ ܠܦܘܩܐ ܡܠܬܐ ، ܘܐܘܪܚܐ ܕܐܝܬ ، ܐܘ ܟܬܒܢܐ ܐܢܐ ܒܟܠܗ ܡܬܩܒܠܬܐ ܐܘ ܟܠܥܢܝ ܟܠܒ ܠܡܠܐ ܬܠܬܐ. ܐܝܬ ܠܝ

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa

Vietnamese: Chú ý: Nếu bạn nói tiếng Anh, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi

Non-Discrimination and Accessibility

In providing behavioral healthcare services, **[PIHP Name Here]** complies with all applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. **[PIHP Name]** does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

[PIHP Name] provides free aids and services to people with disabilities to communicate effectively with us, such as:
Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, Braille)
[PIHP Name] provides free language services to people whose primary language is not English or have limited English skills, such as:
Qualified interpreters
Information written in other languages
If you need these services, contact **[Your Organization's Contact Person, Department, and Title,** at **Your Organization's Contact Number]**

If you believe that **[Your Organization]** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **[Your Organization's Contact Person** at **Your Organization's Address, Phone Number, Fax and Email.]**

If you are a person who is deaf or hard of hearing, you may contact **[Your Organization]** at **[Your Organization's TTY Number]** or MI Relay Service at 711 to request their assistance in connecting you to **[Your Organization]**. You can file a grievance in person or by mail, fax or email. If you need help in filing a grievance, **[Your Organization's Grievance Coordinator]** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You may also file a grievance electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Toll Free: 1-800-368-1019

Template #14: FRAUD, WASTE AND ABUSE

Fraud, waste and abuse uses up valuable Michigan Medicaid funds needed to help children and adults access health care. Everyone can take responsibility by reporting fraud and abuse. Together we can make sure taxpayer money is used for people who really need help.

Examples of Medicaid Fraud

- Billing for medical services not actually performed
- Providing unnecessary services
- Billing for more expensive services
- Billing for services separately that should legitimately be one billing
- Billing more than once for the same medical service
- Dispensing generic drugs but billing for brand-name drugs
- Giving or accepting something of value (cash, gifts, services) in return for medical services, (i. e., kickbacks)
- Falsifying cost reports

Or When Someone:

- Lies about their eligibility
- Lies about their medical condition
- Forges prescriptions
- Sells their prescription drugs to others
- Loans their Medicaid card to others

Or When a Health Care Provider Falsely Charges For:

- Missed appointments
- Unnecessary medical tests
- Telephoned services

If you think someone is committing fraud, waste or abuse, you may report it to Corporate Compliance. You may email concerns to [EMAIL], or report them anonymously on the PIHP website – [INSTRUCTIONS FOR USING THE WEBSITE].

Your report will be confidential, and you may not be retaliated against.

You may also report concerns about fraud, waste and abuse directly to Michigan's Office of Inspector General (OIG):

Online: www.michigan.gov/fraud

Call: 855-MI-FRAUD (643-7283) (voicemail available for after hours)

Send a Letter: Office of Inspector General
PO Box 30062
Lansing, MI 48909

When you make a compliant, make sure to include as much information as you can, including details about what happened, who was involved (including their address and phone number), Medicaid identification number, date of birth (for beneficiaries), and any other identifying information you have.

GRIEVANCE AND APPEAL TECHNICAL REQUIREMENT PIHP GRIEVANCE AND APPEAL SYSTEM FOR MEDICAID BENEFICIARIES

OCT. 2017

TABLE OF CONTENTS

I. PURPOSE AND BACKGROUND

This Technical Advisory is intended to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with the Medicaid Enrollee Grievance and Appeal System requirements contained in Part 11, 6.3.1 of the Medicaid Managed Specialty Supports and Services contract with the Michigan Department of Health and Human Services (MDHHS). These requirements are applicable to all PIHPs, Community Mental Health Services Programs (CMHSPs) and their provider networks.

Although this technical advisory specifically addresses the federal Grievance and Appeal System processes required for Medicaid Enrollees, other dispute resolution processes available to all Mental Health consumers are identified and referenced.

Under the Due Process Clause of the U.S. Constitution, Medicaid Enrollees are entitled to "due process" whenever their Medicaid benefits are denied, reduced or terminated. Due process requires that Enrollees receive: (1) prior written notice of the adverse action; (2) a fair hearing before an impartial decision maker; (3) continued benefits pending a final decision; and (4) a timely decision, measured from the date the complaint is first made. Nothing about managed care changes these due process requirements. The Medicaid Enrollee Grievance and Appeal System provides a process to help protect Medicaid Enrollee due process rights.

Consumers of mental health services who are Medicaid Enrollees eligible for Specialty Supports and Services have various avenues available to them to resolve disagreements or complaints. There are three processes under authority of the Social Security Act and its federal regulations that articulate federal requirements regarding grievance and appeals for Medicaid beneficiaries who participate in managed care:

- State fair hearings through authority of 42 CFR 431.200 et seq.
- PIHP appeals through authority of 42 CFR 438.400 et seq.
- Local grievances through authority of 42 CFR 438.400 et seq.

Medicaid Enrollees, as public mental health consumers, also have rights and dispute resolution protections under authority of the State of Michigan Mental Health Code, Chapters 7,7A, 4 and 4A, including:

- Recipient Rights complaints through authority of the Mental Health Code (MCL 330.1772 et seq.).
- Medical Second Opinion through authority of the Mental Health Code (MCL 330.1705).

II. DEFINITIONS

The following terms and definitions are utilized in this Technical Requirement.

Adverse Benefit Determination: A decision that adversely impacts a Medicaid

Enrollee's claim for services due to: *(42 CFR 438.400)*

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. *42 CFR 438.400 (b)(1).*
- Reduction, suspension, or termination of a previously authorized service. *42 CFR 438.400(b)(2).*
- Denial, in whole or in part, of payment for a service. *42 CFR 438.400(b)(3).*
- Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service. *42 CFR 438.210(d)(1).*
- Failure to make an expedited Service Authorization decision within **seventy-two (72) hours** after receipt of a request for expedited Service Authorization. *42 CFR 438.210(d)(2).*
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person centered planning and as authorized by the PIHP. *42 CFR 438.400(b)(4).*
- Failure of the PIHP to resolve standard appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(2).*
- Failure of the PIHP to resolve expedited appeals and provide notice within **72 hours** from the date of a request for an expedited appeal. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3).*
- Failure of the PIHP to resolve grievances and provide notice within **90 calendar days** of the date of the request. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*
- For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under *§ 438.52(b)(2)(ii)*, to obtain services outside the network. *42 CFR 438.400(b)(6).*
- Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial responsibility. *42 CFR 438.400(b)(7).*

Adequate Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid Enrollee on the same date the Adverse Benefit Determination takes effect. *42 CFR 438.404(c)(2).*

Advance Notice of Adverse Benefit Determination: Written statement advising the Enrollee of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid Enrollee at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect. *42 CFR 438.404(c)(1); 42 CFR 431.211.*

Appeal: A review at the local level by a PIHP of an Adverse Benefit Determination, as defined above. *42 CFR 438.400.*

Authorization of Services: The processing of requests for initial and continuing service delivery. *42 CFR 438.210(b).*

Consumer: Broad, inclusive reference to an individual requesting or receiving mental health services delivered and/or managed by the PIHP, including Medicaid beneficiaries, and all other recipients of PIHP/CMHSP services.

Enrollee: A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program. *42 CFR 438.2.*

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by an Enrollee or the Enrollee's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the Enrollee requests the expedited review, the PIHP determines if the request is warranted. If the Enrollee's provider makes the request, or supports the Enrollee's request, the PIHP must grant the request. *42 CFR 438.410(a).*

Grievance: Enrollee's expression of dissatisfaction about PIHP/CMHSP service issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the Enrollee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, or an Enrollee's dispute regarding an extension of time proposed by the PIHP to make a service authorized decision. *42 CFR 438.400.*

Grievance Process: Impartial local level review of an Enrollee's Grievance.

Grievance and Appeal System: The processes the PIHP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. *42 CFR 438.400.*

Medicaid Services: Services provided to an Enrollee under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Notice of Resolution: Written statement of the PIHP of the resolution of a Grievance or Appeal, which must be provided to the Enrollee as described in *42 CFR 438.408.*

Recipient Rights Complaint: Written or verbal statement by a Enrollee, or anyone acting on behalf of the Enrollee, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope less than requested, all as required under applicable law, including but not limited to *42 CFR 438.210.*

State Fair Hearing: Impartial state level review of a Medicaid Enrollee's appeal of an adverse benefit determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing". The State Fair Hearing Process is set forth in detail in Subpart E of 42 CFR Part 431.

III. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

Federal regulation *(42 CFR 438.228)* requires the State to ensure through its contracts with PIHPs, that each PIHP has a grievance and appeal system in place for Enrollee's that complies with Subpart F of Part 438.

The Grievance and Appeal System must provide Enrollees:

- An Appeal process (one level, only) which enables Enrollees to challenge Adverse Benefit Determinations made by the PIHP or its agents.
- A Grievance Process.
- The right to concurrently file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
- Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the PIHP level Appeal.
- Information that if the PIHP fails to adhere to notice and timing requirements as outlined in PHIP Appeal Process, the Enrollee is deemed to have exhausted the PIHP's appeals process. The Enrollee may initiate a State fair hearing.
- The right to request, and have, Medicaid covered benefits continued while a local PIHP Appeal and/or State Fair Hearing is pending.
- With the written consent from the Enrollee, the right to have a provider or other authorized representative, acting on the Enrollee's behalf, file an Appeal or Grievance to the PIHP, or request a State Fair Hearing. The provider may file a grievance or request a state fair hearing on behalf of the Enrollee since the State permits the provider to act as the Enrollee's authorized representative in doing so. Punitive action may not be taken by the PIHP against a provider who acts on the Enrollee's behalf with the Enrollee's written consent to do so.

IV. NOTICE OF ADVERSE BENEFIT DETERMINATION

A PIHP is required to provide timely and "adequate" notice of any Adverse Benefit Determination. *42 CFR 438.404(a).*

A. Content & Format: The notice of Adverse Benefit Determination must meet the following requirements: *(42 CFR 438.404(a)-(b))*

1. Enrollee notice must be in writing, and must meet the requirements of 42 CFR 438.10 (i.e., "...manner and format that may be easily understood and

is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency);

2. Notification that *42 CFR 440.230(d)* provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;

3. Description of Adverse Benefit Determination;

4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;

5. Notification of the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Enrollee's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);

6. Notification of the Enrollee's right to request an Appeal, including information on exhausting the PIHP's single local appeal process, and the right to request a State Fair Hearing thereafter;

7. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;

8. Notification of the Enrollee's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the Enrollee may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination";

9. Description of the procedures that the Enrollee is required to follow in order to exercise any of these rights; and

10. An explanation that the Enrollee may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

~~10.~~

B. Timing of Notice: *(42 CFR 438.404(c))*

1. Adequate Notice of Adverse Benefit Determination:

a. For a denial of payment for services requested (not currently provided). notice must be provided to the Enrollee at the time of the

action affecting the claim. *42 CFR 438.404(c)(2).*

b. For a Service Authorization decision that denies or limits services notice must be provided to the Enrollee within 14-days following receipt of the request for service for standard authorization decisions, or within 72-hours after receipt of a request for an expedited authorization decision. *42 CFR 438.210(d)(1)-(2); 42 CFR 438.404(c)(3)&(6).*

c. For Service Authorization decisions not reached within 14-days for standard request, or 72-hours for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire. *42 CFR 438.404(c)(5).*

~~c.~~

- ~~NOTE, however, that the PIHP may be able to extend the standard (14 calendar day) or expedited (72-hour) Service Authorization timeframes for up to an additional 14 calendar days in certain circumstances if either the Enrollee requests the extension, or if the PIHP can show that there is a need for additional information and that the extension is in the Enrollee's best interest *(42 CFR 438.210(d)(1)(ii))*. If the PIHP extends the time not at the request of the Enrollee, the PIHP must: (i) make reasonable efforts to give the Enrollee prompt oral notice of the delay; (ii) within 2 calendar days, provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4)* ~~If so, the PIHP must: (i) provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and (ii) issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. *42 CFR 438.404(c)(4)*.~~

~~2. The PIHP may extend the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the enrollee or the provider requests extension.~~

~~3. The PIHP may extend the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the PIHP justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest.~~

~~•~~

~~4.~~2 Advance Notice of Adverse Benefit Determination:

a. Required for reductions, suspensions or terminations of previously authorized/ currently provided Medicaid Services.

b. Must be provided to the Enrollee at least ten (10) calendar days prior to the proposed effective date. *42 CFR 438.404(c)(1); 42 CFR 431.211.*

c. Limited Exceptions: The PIHP may mail an adequate notice of action, not later than the date of action to terminate, suspend or reduce previously authorized services, IF *(42 CFR 431.213; 42 CFR 431.214)*

   i. The PIHP has factual information confirming the death of an Enrollee;

   ii. The PIHP receives a clear written statement signed by an Enrollee that he no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the Enrollee understands that this must be the result of supplying that information;

   iii. The Enrollee has been admitted to an institution where he is ineligible under the plan for further services;

   iv. The Enrollee's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address;

   v. The PIHP establishes that the Enrollee has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

   vi. A change in the level of medical care is prescribed by the Enrollee's physician;

   vii. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;

   viii. The date of action will occur in less than 10 calendar days.

   ix. The PIHP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the Enrollee (in this case, the PIHP may shorten the period of advance notice to 5 days before the date of action).

C. Required Recipients of Notice of Adverse Benefit Determination:

1. The Enrollee must be provided written notice. *42 CFR 438.404(a); 42 CFR 438.210(c).*

2. The requesting provider must be provided notice of any decision by the PIHP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing. *42 CFR 438.210(c).*

3. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person centered planning process still constitutes an adverse benefit determination, and requires a written notice of action.

V. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

A. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the PIHP MUST continue the Enrollee's benefits if all of the following occur: *42 CFR 438.420*

1. The Enrollee files the request for Appeal timely (within 60 calendar days from the date on the Adverse Benefit Determination Notice); *42 CFR 438.402(c)(2)(ii);*

2. The Enrollee files the request for continuation of benefits timely (on or before the latter of (i) 10 calendar days from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination). *42 CFR 438.420(a)*; and

3. The period covered by the original authorization has not expired.

B. Duration of Continued or Reinstated Benefits *(42 CFR 438.420(c))*. If the PIHP continues or reinstates the Enrollee's benefits, at the Enrollee's request, while the Appeal or State Fair Hearing is pending, the PIHP must continue the benefits until one of following occurs:

1. The Enrollee withdraws the Appeal or request for State Fair Hearing;

2. The Enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after PIHP sends the Enrollee notice of an adverse resolution to the Enrollee's Appeal;

3. A State Fair Hearing office issues a decision adverse to the Enrollee.

C. If the final resolution of the Appeal or State Fair Hearing upholds the PIHP's Adverse Benefit Determination, the PIHP may, consistent with the state's usual policy on recoveries and as specified in the PIHP's contract, recover the cost of services furnished to the Enrollee while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements. *42 CFR 438.420(d).*

D. If the Enrollee's services were reduced, terminated or suspended without an advance notice, the PIHP must reinstate services to the level before the action.

E. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the appeal was pending, the PIHP or the State must pay for those services in accordance with State policy and regulations. *42 CFR 438.424(b)*

F. If the PIHP, or the MDHHS fair hearing administrative law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a).*

VI. PIHP APPEAL PROCESS

A. Upon receipt of an adverse benefit determination notification, federal regulations 42 CFR 400 et seq., provide Enrollees the right to appeal the determination through an internal review by the PIHP. Each PIHP may only have one level of appeal. Enrollees may request an internal review by the PIHP, which is the first of two appeal levels, under the following conditions:

1. The Enrollee has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal. *42 CFR 438.402(c)(2)(ii).*

2. The Enrollee may request an Appeal either orally or in writing. Unless the Enrollee requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal. *42 CFR 438.402(c)(3)(ii).*

   NOTE: Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal). *42 CFR 438.406(b)(3).*

3. In the circumstances described above under the Section entitled "Continuation of Benefits," the PIHP will be required to continue/reinstate Medicaid Services until one of the events described in that section occurs.

B. PIHP Responsibilities when Enrollee Requests an Appeal:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of each Appeal. *42 CFR 438.406(b)(1).*

3. Maintain a record of appeals for review by the State as part of its quality strategy. *42 CFR 438.416.*

4. Ensure that the individual(s) who make the decisions on Appeals: *42* CFR 438.406(b)(2).

    a. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;

    b. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

    c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

5. Provide the Enrollee a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing, and inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals; *42 CFR 438.406(b)(4).*

6. Provide the Enrollee and his/her representative the Enrollee's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the PIHP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. *42 CFR 438.406(b)(5).*

7. Provide opportunity to include as parties to the appeal the Enrollee and his or her representative, or the legal representative of a deceased Enrollee's estate; *42 CFR 438.406(b)(6*).

8. Provide the Enrollee with information regarding the right to request a State Fair Hearing and the process to be used to request one.

C. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The PIHP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the Enrollee's health condition requires, but not to exceed **30 calendar days** from the day the PIHP receives the Appeal.

2. Expedited Appeal Resolution (timing):

   a. Available where the PIHP determines (for a request from the Enrollee) or the provider indicates (in making a request on the Enrollee's behalf or supporting the Enrollee's request) that the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. *42 CFR 438.410(a).*

   b. The PIHP may not take punitive action against a provider who requests an expedited resolution or supports an Enrollee's appeal. *42 CFR 438.410(b).*

   c. If a request for expedited resolution is denied, the PIHP must:

      i. Transfer the appeal to the timeframe for standard resolution. 42 CFR 438.410(c)(1).

      ii. Make reasonable efforts to give the Enrollee prompt oral notice of the denial. *42 CFR 438.408(c)(2), 438.410(c)(2).*

      iii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision. *42 CFR 438.408(c)(2), 438.410(c)(2).*

      iv. Resolve the Appeal as expeditiously as the Enrollee's health condition requires but not to exceed 30 calendar days.

   d. If a request for expedited resolution is granted, the PIHP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72-hours** after the PIHP receives the request for expedited resolution of the Appeal. *42 CFR 438.408.*

3. Extension of Timeframes: The PIHP may extend the resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*

a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

ii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision.

~~iii.~~ Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires.

~~The PIHP~~ [LW1]~~may extend the timeframe for processing a grievance by up to 14 calendar days if the enrollee requests the extension. The PIHP may extend the timeframe for processing a grievance by up to 14 calendar days if the PIHP shows that there is need for additional information and that the delay is in the enrollee's interest (upon state request). When the PIHH extends the timeline for a grievance not at the request of the enrollee, it must make reasonable efforts to give the enrollee prompt oral notice of the delay. The PIHP extends the timeline for a grievance not at the request of the enrollee, it must give the enrollee written notice, within 2 calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.~~

iii.

4. Appeal Resolution Notice Format:

a. The PIHP must provide Enrollees with written notice of the resolution of their Appeal, and must also make reasonable efforts to provide oral notice in the case of an expedited resolution. *42 CFR 438.408(d)(2).*

b. Attached to this agreement are recommended notice templates for grievance and appeals. They are titled, Exhibit A "Notice of Adverse Benefit Determination", Exhibit B "Notice of Receipt of Appeal/Grievance", Exhibit C Notice of Appeal Approval", and Exhibit D "Notice of Appeal Denial". These templates incorporate the information needed to meet the requirement of grievance and appeal recordkeeping in 42 CFR 438.416. Specifically, 42 CFR 438.416 indicates the State must require the PIHP maintain records with (at minimum) the following information:

(1) A general description of the reason for the appeal or grievance.
(2) The date received.
(3) The date of each review or, if applicable. review meeting.
(4) Resolution at each level of the appeal or grievance if applicable.

(5) Date of resolution at each level, if applicable.
(6) Name of the covered person for whom the appeal or grievance was filed.

Further this recordkeeping must be "accurately maintained in a manner accessible to the state and available upon request to CMS."

~~IF the PIHP chooses not to use the recommended notice templates the alternatives used by the PIHP must include the required information under 42 CFR 438.416 as noted above.~~

c. Enrollee notice must meet the requirements of *42 CFR 438.10* (i.e., "...in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

5. Appeal Resolution Notice Content: *42 CFR 438.408(e)*

a. The notice of resolution must include the results of the resolution and the date it was completed.

b. When the appeal is not resolved wholly in favor of the Enrollee, the notice of disposition must also include notice of the Enrollee's:
   i. Right to request a state fair hearing, and how to do so;
   ii. Right to request to receive benefits while the state fair hearing is pending, and how to make the request; and
   iii. Potential liability for the cost of those benefits if the hearing decision upholds the PIHP's Adverse Benefit Determination

VII. GRIEVANCE PROCESS

A. Federal regulations provide Enrollees the right to a grievance process to seek resolution to issues that are not Adverse Benefit Determinations. *(42 CFR 438.228)*

B. Generally:

1. Enrollees must file Grievances with the PIHP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

2. Grievances may be filed at any time by the Enrollee, guardian, or parent of a minor child or his/her legal representative. *42 CFR 438.402(c)(2)(i).*

3. Enrollee's access to the State Fair Hearing process respecting Grievances is only available when the PIHP fails to resolve the grievance and provide resolution within **90 calendar days** of the date of the request. This constitutes an

"Adverse Benefit Determination", and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process. *42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1).*

C. PIHP Responsibility when Enrollee Files a Grievance:

1. Provide Enrollees reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a).*

2. Acknowledge receipt of the Grievance. *42 CFR 438.406(b)(1).*

3. Maintain a record of grievances for review by the State as part of its quality strategy.

4. Submit the written grievance to appropriate staff including a PIHP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination. *42 CFR 434.32*

5. Ensure that the individual(s) who make the decisions on the Grievance:

   a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual. *42 CFR 438.406(b)(2)(i).*

   b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Enrollee's condition or disease.

   c. Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution: Provide the Enrollee a written notice of resolution not to exceed **90 calendar days** from the day the PIHP received the Grievance.

2. Extension of Timeframes: The PIHP may extend the grievance resolution and notice timeframe by up to **14 calendar days** if the Enrollee requests an extension, or if the PIHP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the Enrollee's interest. *42 CFR 438.408(c).*

a. If the PIHP extends resolution/notice timeframes, it must complete all of the following: *42 CFR 438.408(c)(2)*

i. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

ii. Within 2-calendar days, give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if they disagree with the decision; and

iii. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and not later than the date the extension expires

~~f.~~3. Format and Content of Notice of Grievance Resolution:

a. Enrollee notice of Grievance resolution must meet the requirements of 42 CFR 438.10 (i.e., "…in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees," meets the needs of those with limited English proficiency and or limited reading proficiency).

b. The notice of Grievance resolution must include:
   i. The results of the Grievance process;
   ii. The date the Grievance process was concluded;
   iii. Notice of the Enrollee's right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and
   iv. Instructions on how to access the State Fair Hearing process, if applicable .

VIII. STATE FAIR HEARING APPEAL PROCESS

A. Federal regulations provide an Enrollee the right to an impartial review by a state level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:

1. After receiving notice that the PIHP is, after Appeal, upholding an Adverse Benefit Determination. *42 CFR 438.408(f)(1);*

2. When the PIHP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals, as described in *42 CFR 438.408. 42 CFR 438.408(f)(1)(i).*

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the Enrollee, free to Enrollee, independent of State and PIHP, and not extend any timeframes or disrupt continuation of benefits). *42 CFR 438.408(f)(1)(ii).*

C. The PIHP may not limit or interfere with an Enrollee's freedom to make a request for a State Fair Hearing.

D. Enrollees are given **120 calendar days** from the date of the applicable notice of resolution to file a request for a State Fair Hearing. *42 CFR 438.408(f)(2).*

E. The PIHP is required to continue benefits, if the conditions described in Section V, MEDICAID SERVICES CONTINUATION OR REINSTATEMENT are satisfied, and for the durations described therein.

F. If the Enrollee's services were reduced, terminated or suspended without advance notice, the PIHP must reinstate services to the level before the Adverse Benefit Determination.

G. The parties to the State Fair Hearing include the PIHP, the Enrollee and his or her representative, or the representative of a deceased Enrollee's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

H. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:

www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid Fair Hearings http://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-16825--,00.html

OR

Department of Licensing and Regulatory Affairs
Michigan Administrative Hearing System Fair Hearing
http://www.michigan.gov/lara/0,4601,7-154-10576_61718_77732---,00.html

IX. RECORDKEEPING REQUIREMENTS

The PIHP is required to maintain records of Enrollee Appeals and Grievances, which will be reviewed by the PIHP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy.

A PIHP's record of each Grievance or Appeal must contain, at a minimum:

A. A general description of the reason for the Grievance or Appeal;
B. The date received;
C. The date of each review, or if applicable, the review meeting;
D. The resolution at each level of the Appeal or Grievance, if applicable;
E. The date of the resolution at each level, if applicable;
F. Name of the covered person for whom the Grievance or Appeal was filed.

PIHPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.

X. RECIPIENT RIGHTS COMPLAINT PROCESS

Enrollees, as recipients of Mental Health Services, have rights to file recipient rights complaints under the authority of the State Mental Health Code. Recipient Rights complaint requirements are articulated in CMHSP Managed Mental Health Supports and Services contract, Attachment C6.3.2.1 - CMHSP Local Dispute Resolution Process.

Exhibit A

NOTICE OF ADVERSE BENEFIT DETERMINATION
<Health Plan/CMHSP-PIHP name/ MI Choice Waiver Agency name>

Important: This notice explains your internal appeal rights. Read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows: Member Beneficiary ID: <Member's Medicaid ID Number>.*]*

This is to tell you that the following action has been taken:

[Enter information regarding the adverse benefit determination taken to deny, reduce, suspend or terminate a covered benefit or payment with effective dates]

This action is based on the following:

[Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.]

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our action, you have the right to an Internal Appeal

You have to ask <Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name> for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your doctor {provider} can send in your request that must include:

- Your Name
- Address
- Member number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors' letters or other information that explains why you need the item or service. If you are asking for a fast appeal you will need a doctor's supporting statement. Call your doctor if you need this information.

Please keep a copy of everything you send us for your records.

There are 2 kinds of internal appeals:

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**. If you want to ask for an internal appeal, you can either call or send in a written request to:

<Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name>
Address
Phone Number TTY Phone Number
Fax Number

Expedited or Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. **We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request.** If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 calendar days. To ask for a Fast Appeal, you must call: **{Phone Number} {TTY Phone #}**

Continuation of services during an Internal Appeal

If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination <insert 10 calendar day date>, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

> Your benefits for that service will continue if you request an internal appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: <number(s)> to learn how to name your representative. TTY users call <number>. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

What happens next?

- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing. [*Licensed health plans in Michigan must also insert*: You can also ask for an External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial Services (DIFS).]

- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] and how to file the request.

- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
- [*If applicable, insert other state or local aging/disability waiver resources contact information.*]

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557/.*]

Exhibit B

Notice of Receipt of Appeal/Grievance
<Health Plan/CMHSP-PIHP/MI Choice Waiver Agency name>

Important: Read this notice carefully. If you need help, you can call one of the numbers listed on the next page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name> **Beneficiary ID:** <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to a request that we received on <date received>.

☐ You Filed A Grievance

We received your grievance on <date received> about <subject of grievance>. We take your concerns seriously. Thank you for taking the time to bring this to our attention.

WHAT THIS MEANS

We will review your grievance by <date received plus 390 calendar days>. A letter will be mailed to you within two (2) calendar days after we complete our investigation telling you what we found and what (if any) action we will take, or have taken.

☐ You Filed An Internal Appeal

We received your request for an internal appeal on <date received>. You are appealing our decision to <description of subject of appeal>.

WHAT THIS MEANS

A decision on this appeal will be made by <date received plus thirty (30) days>. A letter will be mailed to you telling you what our decision is and why we made that decision.

<The appeal was received within ten (10) calendar days of the decision that you are appealing. Therefore, the service(s) you have been receiving may continue while the appeal is being reviewed.> You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

We may contact you for more information or if we have more questions. If you have any questions or additional information to provide please call <list an appeals specific phone number/fax number>.

FOR BOTH GRIEVANCES AND APPEALS

If you want someone to represent you

At any time during the process you may have another person act for you or help you. This person will be your representative. If you want someone to act for you, you must tell us that in writing.

If you already have someone to represent you, or if you have a legal guardian, power of attorney, or someone authorized to make health care decisions on your behalf, you do not have to do anything else.

Get help & more information

- {Health plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the internal appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557/]

Exhibit C

Notice of Appeal Approval
<Health Plan/CMHSP-PIHP / MI Choice Waiver Agency name>

Important: This notice explains the results of your appeal. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to the internal appeal request that we received on <date appeal received>

Your appeal was approved

Your appeal was thoroughly considered. This is to inform you that we approved your appeal for the service/item listed below:

What this means:

Because your Level 1 Appeal decision was approved, you may receive the following services as of <date authorized>: [*List the services that were approved, including any applicable information about coverage amount, duration, etc. Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage Member Handbook provisions as well as Plan policies, procedures or assessment tools used to support the decision.*]

If you do not receive the services, or if the services are wrongly stopped or reduced, tell us immediately using the contact information below:

<Health Plan / CMHSP-PIHP / MI Choice Wavier Agency name>

<Name of Appeals/Grievance Department>
<Mailing Address for Appeals/Grievance Department>

Phone: <phone number> TTY: <TTY number>
Fax: <fax number>

Getting your case file

You can ask to see the medical records and other documents we reviewed during your appeal. You can also ask for a copy of the guidelines we used to make our decision. You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}.
- Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

[Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]

Exhibit D

Notice of Appeal Denial
<Health Plan/ CMHSP-PIHP / MI Choice Waiver Agency name>

Important: This notice explains your additional appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <Member's Plan ID Number>

Name: <Member's Name>

Beneficiary ID: <Member's Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member's Medicaid ID Number>.]

This Notice is in response to the internal appeal request that we received on <date appeal received>.

Your internal appeal was denied

Your appeal was thoroughly considered. This is to inform you that we [*denied or partially denied*] your internal appeal for the service/item listed below:

Why did we deny your appeal?

We [*denied or partially denied*] your internal appeal for the service/item listed above because:
[*Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage, Member Handbook provisions as well as Plan policies, procedures or assessment tools used to support the decision.*]

You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider requested coverage on your behalf, we have sent a copy of this decision to your provider.

If you don't agree with our decision, you have the right to further appeal

You have the right to an External Appeal. The External Appeal is reviewed by an independent organization that is not connected to us. You can file an External Appeal yourself.

[*Health plans must insert:* There are two ways to make an External Appeal: 1) State Fair Hearing with the Michigan Administrative Hearing System (MAHS) and/or 2) External Review under the Patient Right to Independent Review Act (PRIRA) with the Department of Insurance and Financial Services (DIFS).] [*PIHP and MI Choice Waiver Agency must insert:* You can do this by asking for a State Fair Hearing with the Michigan Administrative Hearing System (MAHS).]

Below is information on how to request a State Fair Hearing with MAHS [*Health Plans must insert:* and an External Review with DIFS].

How to ask for a State Fair Hearing with MAHS

To ask for a Medicaid State Fair Hearing you must follow the directions on the enclosed Request for State Fair Hearing form. You must ask for a State Fair Hearing within **120 calendar days** from the mailing date of this notice. If your request is not received at MAHS by <insert 120 calendar day date>, you will not be granted a hearing. If you need another copy of the form, you can ask for one by calling <Health Plan/ CMHSP-PIHP/ MI Choice Waiver Agency name> Member Services at <phone number> or the Michigan Department of Health and Human Services Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

What happens next?

MAHS will schedule a hearing. You will get a written "Notice of Hearing" telling you the date and time. Most hearings are held by telephone, but you can ask to have a hearing in person. During the hearing, you'll be asked to tell an Administrative Law Judge why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision within 90 calendar days from the date your Request for Hearing was received by MAHS. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) State Fair Hearing. Your request must be

in writing and clearly state that you are asking for a fast State Fair Hearing. Your request can be mailed or faxed to MAHS (see the enclosed Request for Hearing form for the address and fax number). If you qualify for a fast State Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions about the State Fair Hearings process, including the fast State Fair Hearing, you can call MAHS at 1-877-833-0870.

[PIHP and MI Choice are not subject to PRIRA and should therefore delete the following section on filing with DIFS.]

How to ask for an External Review with DIFS

To ask for an External Review under the Patient Right to Independent Review Act (PRIRA) from DIFS, you must complete the Health Care Request for External Review form. The form is included with this notice. You can also get a copy of the form by calling DIFS at 1-877-999-6442. Complete the form and send it with all supporting documentation to the address or fax number listed on the form. You must submit your request within **60 calendar days** of your receipt of this appeal decision notice. You have the right to request and receive benefits while the hearing is pending, and should submit your request to the (Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name.)

What happens next?

DIFS will review your request. If your case does not require medical record review, DIFS will issue a decision within 14 calendar days after your request is accepted. If your case involves issues of medical necessity or clinical review criteria, DIFS will issue a decision within 21 calendar days.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for a fast (also known as an expedited) External Review. To ask for a fast External Review, you can call DIFS at 1-877-999-6442. A fast External Review is completed within 72 hours after your request has been accepted.

Continuation of Services

If we previously approved coverage for a service but then decided to change or stop the service before the authorization ended, you can continue your benefits during External Appeals in some cases.

> Your benefits for that service will continue if you qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MAHS within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MAHS must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

If your benefits are continued during your appeal, you can keep getting the service until one of the following happens: 1) you withdraw the External Appeal; or 2) all entities that got your appeal decide "no" to your request.

Access to Documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

Get help & more information

- {Health Plan / CMHSP-PIHP / MI Choice Waiver Agency name}: If you need help or additional information about our decision and the appeal process, call Member Services at: {phone number} (TTY: {TTY number}), {hours of operation}. You can also visit our website at {plan website}.
- MDHHS Beneficiary Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).
- *[If applicable, insert other state or local aging/disability resources contact information.]*

[Add language and disclaimer notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to https://www.hhs.gov/civil-rights/for-individuals/section-1557.]

TREATMENT POLICY #13

SUBJECT: Withdrawal Management Continuum of Services

ISSUED: May 5, 2017

EFFECTIVE: July 1, 2017

PURPOSE:
The purpose of this policy is to establish requirements for withdrawal management services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) criteria, and to support individualized services that maintain cultural, age, and gender appropriateness.

SCOPE:
This policy impacts the Prepaid Inpatient Health Plans (PIHP) and the withdrawal management service provider network.

BACKGROUND:
Withdrawal management includes a wide variety of covered services with the provision of these services expected to be individualized to the needs of the client. The Administrative Rules for Substance Abuse Services, established in 1981, are very limited and do not reflect advances in science and practice. These changes have essentially left the administrative rules obsolete in the area of recommended services. This policy seeks to establish criteria that will result in services that are provided in accordance with those outlined by the ASAM Criteria, and are more reflective of interventions that have been shown to be effective in providing care to individuals receiving withdrawal management services.

Withdrawal management, or detoxification, has historically been available within residential programs only. However, this policy expands the opportunities for individuals requiring withdrawal management by supporting services at additional levels of care. An individual who does not meet medical necessity criteria for residential based withdrawal management may receive their services through a licensed outpatient program. Outpatient programs offering withdrawal management will be required to have access to appropriately licensed laboratories for testing. Only programs that offer Levels 3.2 and 3.7 will be required to maintain a Residential Detoxification license.

Withdrawal management services also include physicians or physician's designated representatives, and staffing requirements, and these requirements must be met, as appropriate, for each level of care. For instance, it is not necessary to have staffing 24 hours per day, 7 days per week in an outpatient withdrawal management level of care.

~~By limiting withdrawal management services to residential programs, we have created a system with the expectation that all clients will equally benefit from the services being offered and resulted in clients with varying needs being admitted into the same program. This makes it more difficult to assure and provide services that are focused on addressing the individual needs of each client.~~ [JS1]To ensure that all clients are served at the level of care that best meet their needs, it is necessary to increase the opportunity for withdrawal management beyond the traditional

residential setting. Many clients have the ability to manage their withdrawal from substances through outpatient services, while maintaining their everyday responsibilities, and it is necessary that the publicly funded SUD system is able to support their needs.

DEFINITIONS:

Toxicology Screening - screening used for the purpose of tracking ongoing use of substances when this has been established as a part of the treatment plan or an identified part of the treatment program. (This may include onsite testing such as portable breathalyzers or non-laboratory urinalysis).

Biopsychosocial Screening and Assessment- screening is used to determine if problem is there, assessment determines nature of problem and a diagnostic impression. This also determines the level of care the individual should receive, as well as determines individualized care plan and treatment priorities.

Counseling - an interpersonal helping relationship that begins with the client exploring the way they think, how they feel and what they do, for the purpose of enhancing their life. The counselor helps the client to set the goals that pave the way for positive change to occur.

Crisis Intervention - a service for the purpose of addressing problems/issues that may arise during treatment and could result in the client requiring a higher LOC if intervention is not provided.

Daily assessment – a tool used to determine clients progress and successes throughout program, can also be used to determine any weaknesses client may have in order to focus on strengthening those or determine any treatment changes.

Discharge – withdrawal signs and symptoms are sufficiently resolved that client can be safely managed at less intensive level of care or be sent home.

Group Counseling - face-to-face intervention for the purpose of goal setting and achievement, as well as skill building.

Group Psychotherapy - face-to-face, insight-oriented interventions with three or more clients.

Health Education Services – multidisciplinary approach to help clients understand how social factors, financing systems, organizational and familial systems, health technologies and personal behavior impact their health.

Individual Counseling - face-to-face intervention for the purpose of goal setting and achievement, and skill building. This is distinct from treatment planning, as this may be goals and achievements identified in case management or through peer based services.

Individualized Treatment Planning - direct and active client involvement in establishing the goals and expectations for treatment to ensure the appropriateness of the current LOC, to ensure true and realistic needs are being addressed, and to increase the client's motivation to participate in treatment. Treatment planning requires an understanding that each client is unique and each treatment plan must be developed based on the individual needs, goals, desires, and strengths of each client and be specific to the diagnostic impression and assessment.

Interactive Education - services that are designed or intended to teach information about addiction and/or recovery skills, often referred to as a "didactic" education.

Interactive Education Groups - activities that center on teaching skills to clients necessary to support recovery, including "didactic" education.

Medical Necessity - treatment that is reasonable, necessary, and appropriate based on individualized treatment planning and evidence-based clinical standards.

Psychotherapy - an advanced clinical practice that includes the assessment, diagnosis, or treatment of mental, emotional, or behavioral disorders, conditions, addictions, or other bio-psychosocial problems and may include the involvement of the intrapsychic, intrapersonal, or psychosocial dynamics of individuals (Michigan Administrative Code, Social Work General Rules).

Recovery - a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life. The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf)

Recovery Planning - purpose is to highlight and organize a person's goals, strengths, and capacities and to determine what barriers need to be removed or problems resolved to help a person achieve their goals. This should include an asset and strength-based assessment of the client.

Recovery Support and Preparation - services designed to support and promote recovery through development of knowledge and skills necessary for an individual's recovery.

Referral/Linking/Coordination of Services - office-based service activity performed by a primary clinician, or other assigned staff, to address needs identified through the assessment, and/or to ensure follow through with access to outside services, and/or to establish the client with another substance use disorder service provider.

Substance Use Disorder - a term inclusive of substance abuse and dependence, which also encompasses problematic use of substances.

Withdrawal Management - monitoring for the purpose of preventing/alleviating medical complications related to no longer using, or decreasing the use of, a substance.

REQUIREMENTS:

The withdrawal management level of care from ASAM is established based on the intensity of the needs of the client within the six dimensions. Withdrawal management, or detoxification, will be identified by level of care, with a continuum of services offered under withdrawal management and based on the needs of the individual. PIHPs will need to have the capacity to provide a withdrawal management continuum that will meet the needs of clients at ASAM levels 1-WM, 2-WM, 3.2-WM, and 3.7-WM. Level 4-WM, as a medically managed intensive inpatient withdrawal management service, is not offered within the PIHP system, and if indicated by the LOC determination must be accessed through the physical health system. The frequency and duration of services are expected to be guided by the ASAM levels of care, and are described as follows:

ASAM Level 1 – Ambulatory Withdrawal Management without Extended On-Site Monitoring

This is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility, or in an individual's home by trained clinicians who provide medically supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. These services should be provided through regularly scheduled sessions and should be delivered under a defined set of policies and procedures or medical protocols.

Support Systems

Support systems at this level should include the availability of specialized psychological and psychiatric consultation and supervision for biomedical, emotional, behavioral, and cognitive problems as indicated. As well as the ability to obtain a comprehensive medical history and physical examination of the individual at admission. They should also have affiliation with other levels of care, including other levels of specialty addiction treatment, for additional problems identified through a comprehensive biopsychosocial assessment. The ability to conduct and/or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing, is necessary. Twenty-four-hour access to emergency medical consultation services should they be necessary, by phone or face to face as indicated. Lastly, the ability to provide or assist in accessing transportation services for individuals who lack safe transportation. [JS2]

Staff Requirements

Level 1-withdrawal management services should be staffed by physicians and nurses, who are essential to this type of service, though they need not be present in the treatment setting at all times. It is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in a less supervised setting would be safe.

Physicians do not need to be certified as addiction specialists and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal states is necessary. Services provided by counselors, psychologists and social workers may be available through withdrawal management service, or these services can be assessed through an affiliate of this level of care.

All clinicians who assess and treat individuals should be able to obtain and interpret information regarding the needs of these persons, and are knowledgeable about the biopsychosocial dimensions of alcohol, tobacco and other substance use disorders. This knowledge should include the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of these conditions and how to facilitate ongoing care for this individual.

ASAM Level 2- Ambulatory Withdrawal Management with Extended On-Site Monitoring

This level is an organized service that can be delivered in an office setting, a general health care or mental health care facility by medical and nursing professionals that provide evaluation, withdrawal management and referral services. Services are provided in regularly scheduled sessions or under a defined set of physician approved policies or clinical protocols.

Support Systems

Level 2 support systems include the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems. Programs must either provide or have the ability to obtain a comprehensive medical history and physical examination of the individual at admission, and have access to psychological and psychiatric consultation. This level of support also includes affiliation with other levels of care, including other levels of specialty addiction treatment, as well as general and psychiatric services for additional problems identified through a comprehensive biopsychosocial assessment.

The ability to conduct or arrange for appropriate laboratory and toxicology tests, which can be point-of-care testing, and 24-hour access to emergency medical consultation services are a necessity at this level. Lastly, this level of care includes the ability to provide or assist in accessing transportation services for individuals who lack safe transportation.

Staff Requirements

This level of care should be staffed by physicians and nurses, although they need not be present at all times. Since this level of care is administered on an outpatient basis, it is important for medical and nursing personnel to be readily available to evaluate and confirm that withdrawal management in a less supervised setting is safe. Physicians do not need to be certified as addiction specialists and nurses do not need to be certified as addiction nurses, but training and experience in assessing and managing intoxication and withdrawal states is necessary.

Counselors, psychologists and social workers may be available through the withdrawal management service or may be accessed through affiliation with organizations providing other Level 2 services. All clinicians that assess and treat individuals must have knowledge regarding the needs of their clients, and knowledge about the biopsychosocial dimensions of alcohol and other drug addiction. Such knowledge includes signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care.

[JS3][SAJ(4]

ASAM Level 3.2 – Clinically Managed Residential Withdrawal Management

Referred to as "social setting detoxification" or "social detox," this is an organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal. This level is characterized by its emphasis on peer and social support rather than typical medical or nursing care services. This level of care provides services for clients with severe intoxication/withdrawal signs and symptoms that require 24-hour structure and support.

Some programs may be staffed to supervise self-administered medications for the management of withdrawal. All Level 3.2 programs must rely on established clinical protocols to identify individuals that are in need of medical services beyond the capacity of the facility and to transfer these individuals to appropriate levels of care.

Support Systems

Level 3.2 Withdrawal Management support systems include the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems. Since this level is managed by clinicians and not medical or nursing staff, protocols are in place in case an individual's condition deteriorates and appears to need medical or nursing interventions.

These protocols are used to determine the nature of the medical or nursing interventions that may be required. Protocols include under what conditions and when transfer to a medically monitored facility or an acute care hospital is necessary. These protocols are developed and supported by a physician knowledgeable in addiction medicine. These programs must also be affiliated with other levels of care with the ability to arrange for appropriate laboratory and toxicology tests.

Staff Requirements

Level 3.2 programs are staffed by appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for individual observation and supervision, determination of appropriate levels of care, and facilitation of the individual's transition to continuing care. Social withdrawal management is a clinically managed withdrawal management service explicitly designed to safely assist individuals through withdrawal without the need for ready on-site access to medical and nursing personnel. Medical evaluation and consultation is available 24-hours a day, in accordance with treatment/transfer practice protocols and guidelines. All clinicians who assess and treat individuals are able to obtain and interpret information regarding the needs of these

individuals. This knowledge includes the signs and symptoms of alcohol and other drug intoxication and withdrawal, as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care. Facilities that supervise self-administered medications have appropriately licensed or credentialed staff and policies and procedures in accordance with state and federal law. The staff at this level of care should ensure that individuals are taking medication according to prescription and legal requirements.

ASAM Level 3.7 – Medically Monitored Inpatient Withdrawal Management
This level of care is an organized service that is delivered by medical and nursing professionals that provide 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician approved policies and physician-monitored procedures or clinical protocols.
This level of care provides care to individuals with withdrawal signs and symptoms that are sufficiently severe to require 24-hour inpatient care. It sometimes is provided by overlapping with Level 4 withdrawal management services, with a specialty unit of an acute care general or psychiatric hospital. 24-hour observation, monitoring, and treatment are available. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary.

Support Systems
Level 3.7 Withdrawal Management support systems feature the availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral and cognitive problems. They also feature the availability of medical nursing care and observation as warranted based on clinical judgment, along with direct affiliation with other levels of care. Programs must have the ability to conduct or arrange for appropriate laboratory and toxicology tests.

Staff Requirements
Level 3.7 programs should be staffed by physicians that are available 24-hours a day by telephone. A physician is available to assess the individual within 24-hours of admission, or earlier if medically necessary, and is available to provide on-site monitoring of care and further evaluation on a daily basis. A registered nurse or other licensed and credentialed nurse is available to conduct a nursing assessment on admission. A nurse will be responsible for overseeing the monitoring of the individual's progress and medication administration on an hourly basis. There will need to be appropriately licensed and credentialed staff is available to administer medications in accordance with physician orders. The level of nursing care needs to be appropriate to the severity of the individual's needs.

Licensed, certified, or registered clinicians provide a planned regimen of 24-hour, professionally directed evaluation, care, and treatment services for individuals and their families. An interdisciplinary team of appropriately trained clinicians (such as physicians, nurses, counselors, social workers, and psychologists) is available to assess and treat the individual and to obtain and interpret information regarding the individual's needs. The

number and disciplines of team members are appropriate to the range and severity of the individual's problems.

ASAM Level 4 – Medically Managed Intensive Inpatient Withdrawal Management
This level of withdrawal management is an organized service delivered by medical and nursing professionals that provide 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. This information is being provided for reference and guidance purposes only, and it is not an expectation that PIHPs provide this level of care. Services are delivered under a defined set of physician-approved policies and physician managed procedures and protocols.

This level of care also provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. Twenty-four hour observation, monitoring, and treatment are available at this level, and is designed for acute medical withdrawal management. It is required that the individual be assessed and a care plan for any of their treatment priorities be developed.

Support Systems
Support systems at this level of care feature the availability of specialized medical consultation, full medical acute care services and intensive care as needed.

Staff requirements
This level of care requires programs are staffed by physicians that are available 24-hours a day as active members of an interdisciplinary team of appropriately trained professionals and those that can medically manage the individual's care. A registered nurse or other licensed and credentialed nurse is available for primary nursing care and observation 24-hours a day.

This level of care also requires facility-approved addiction counselors or licensed, certified, or registered addiction clinicians be available eight (8) - hours per day to administer planned interventions according to the assessed needs of the individual. An interdisciplinary team of appropriately trained clinicians is available to assess and treat the individual with a substance use disorder, or an addicted individual with a concomitant acute biomedical, emotional or behavioral disorder.

The ASAM Assessment Dimensions must be used to assist in the determination of the LOC needed by the individual:

Dimensional Interactions	Severity Increase	Severity Decrease
Dimension 1	Acute intoxication and/or withdrawal potential	Acute intoxication and/or withdrawal potential

Dimensional Interactions	Severity Increase	Severity Decrease
Dimension 2	Impaired liver function, comorbid neurological conditions that could be exacerbated by autonomic nervous system hyperarousal, pregnancy	Absence of comorbid medical condition
Dimension 3	Use or misuse of psychiatric medications that are metabolized in the liver, psychiatric disorganization that may affect patient adherence to withdrawal management regimen.	Absence of comorbid psychiatric condition
Dimension 4	Lack of readiness to change affecting adherence to withdrawal management protocols or causing premature discharge from withdrawal management, lack of readiness to change affecting effectiveness of ambulatory withdrawal management	Readiness to change at a level that facilitates adherence to ambulatory withdrawal management services
Dimension 5	Continued use of alcohol, illicit drugs, or non-medical use of prescription drugs	No continued use of alcohol, illicit drugs, or non-medical use of prescription drugs
Dimension 6	Lack of supportive recovery environment or transportation for ambulatory withdrawal management	A supportive recovery environment and transportation to ambulatory withdrawal management

PROCEDURE:

Admission Criteria

Admission to withdrawal management is limited to the following criteria:

- Medical necessity.
- Diagnosis: The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression of a substance use disorder (also known as provisional diagnosis). The diagnosis will be confirmed by the provider's assessment process.
- Individualized determination of need.
- ASAM Criteria is used to determine substance use disorder treatment placement/admission and/or continued stay needs, and are based on a LOC determination using the six assessment dimensions of the ASAM Criteria below:
  1) Withdrawal potential.
  2) Medical conditions and complications.
  3) Emotional, behavioral, or cognitive conditions and complications.
  4) Readiness to change – as determined by the Stages of Change Model.
  5) Relapse, continued use or continued problem potential.
  6) Recovery/living environment.

Treatment must be individualized based on a biopsychosocial assessment, diagnosis, and client characteristics that include, but are not limited to, age, gender, culture, and development. Authorization decisions on length of stay (including continued stay), change in LOC, and discharge must be based on the ASAM Criteria. As a client's needs change, the frequency, and duration, of services may be increased or decreased as medically necessary. Participation of the individual receiving services in referral, continuing care, and recovery planning must occur prior to a move to another LOC for continued treatment.

Covered Services
The following services must be available in a Withdrawal Management setting regardless of the LOC and based on individual need:

Type	Withdrawal Management Services Description
Basic Care	Room, board, supervision, monitoring, toxicology screening, transportation facilitating to and from treatment; and treatment environment is structured, safe, and recovery-oriented. Levels 3.2 and 3.7 only: room and board.
Treatment Basics **Core Service**	Assessment; Episode of Care Plan (addressing treatment, recovery, discharge and transition across episode); coordination and referral; medical evaluation and attempt to link to services; connection to next provider and medical services; preparation for 'next step'.
Therapeutic Interventions **Core Service**	Individual, group, and family psychotherapy services appropriate for the individual's needs, and crisis intervention. Services provided by an appropriately licensed, credentialed, and supervised professional working within their scope of practice.
Interactive Education /Counseling **Core Service**	Interaction and teaching with client(s) and staff to process skills and information adapted to the individual client needs. This includes alternative therapies, individual, group and family counseling, anger management, coping skills, recovery skills, relapse triggers, and crisis intervention. Examples: disease of addiction, mental health, and substance use disorder.
Milieu/Environment (building recovery capital)	Peer support; recreation/exercise; leisure activities; treatment coordination; support groups; drug/alcohol free campus.
Medical Services **Core Service**	Medication prescribing and management. Physician monitoring, nursing care, and observation available. Medical specialty consultation, psychological, laboratory and toxicology services available. Psychiatric services available.

Treatment/Recovery Planning

Individuals entering any level of withdrawal management services will have recovery and functional needs that will continue to require intervention once withdrawal based services are no longer appropriate. Therefore, withdrawal management should be viewed as a part of an episode of care within a continuum of services that will contribute toward recovery for the individual. Withdrawal management should never be presented to individuals as being a complete episode of care. To facilitate the client moving along the treatment continuum, it is expected that the provider, as part of treatment planning, begins to prepare the client for the next stage of the recovery process as soon after admission as possible. This will help to facilitate a smooth transition to the next LOC, as appropriate, and make sure that the client is aware that services will continue once withdrawal management services are no longer necessary.

To make the transition to the next LOC, the withdrawal management provider may assist the client in choosing an appropriate service based on needs and location, helping to schedule appointments, arranging for a meeting with the new service provider, arranging transportation, and ensuring all required paperwork is completed and forwarded to the new service provider in a timely manner. These activities are provided, as examples of activities that could take place if it were determined there would be a benefit to the client. There could potentially be many other activities or arrangements that may be needed, or the client may require very little assistance. To the best of their ability, it is expected that the withdrawal management provider arrange for any needed assistance to ensure a seamless transfer to the next LOC.

Continuing Stay Criteria
Re-authorization or continued treatment should be based on ASAM Continued Service Criteria, medical necessity, and a reasonable expectation of benefit from continued care.

REFERENCES:
Mee-Lee, D, Shulman, GD, Fishman, M, Gastfriend, DR, Miller, MM, Eds. The *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* 3rd ed. Carson City, NV: The Change Companies®; 2013.

Michigan Department of Health and Human Services, Office of Recovery Oriented Systems of Care. Michigan's ROSC Glossary of Terms. Retrieved from http://www.michigan.gov/documents/mdch/ROSC_Glossary_of_Terms_350345_7.pdf.

Michigan Department of Licensing and Regulatory Affairs, Michigan Administrative Code. (n.d.). [Administrative Rules for] Substance Use Disorder Service Programs. Promulgated pursuant to Michigan Public Act 368 of 1978, Section 6231(1), as amended. Retrieved from http://w3.lara.state.mi.us/orr/Files/AdminCode/389_10365_AdminCode.pdf .

Approved by: _____
Larry P. Scott, Acting Director
Office of Recovery Oriented Systems of Care

PIHP-PROPOSED REVISIONS, FEBRUARY 1, 2019

PIHPs proposed the following edits to section 7.7.6 (GAIN). Our edits are intended to focus the language exclusively on FY 19.

PIHPs continue to request that this be on our contract negotiations agenda for future amendments/fiscal years.

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7.7.6 GAIN (Global Appraisal of Individual Needs) I Core Process

- ~~It is the expectation that the~~ The PIHP and its SUD provider network will engage in the GAIN-I CORE~~ore~~ training process with Chestnut Health Systems. The PIHP may ~~when applicable~~ make their identified Local Trainer staff available to train other clinicians across the state. This training may be funded through the CMHAM training contract with MDHHS or the PIHP may elect to sponsor this training. The PIHP may establish their own rate(s) of compensation/support for any trainings they provide directly~~engage in~~.
- PIHPs are expected to establish and maintain a Data Use Agreement with Chestnut Health Systems for use of the GAIN ABS~~, and contracted providers must do the same~~. MDHHS will maintain these agreements through FY 2020, and longer as funding allows[BC1][DJ[2][MT[3]
- ~~Due to the ability to transfer the GAIN-I Core among provider agencies, a GAIN-I Core is an allowable expense every 6 months. This is the maximum allowable reimbursement for this clinical function. At a minimum re-assessment should be completed annually. If an individual has a significant change prior to the 6 month marker, the clinician can use the M-90 tool to reflect those changes. This 6 month maximum allowable assessment is for the purpose of updating information and establishing the individual's current goals.~~
- ~~PIHPs should be planning for full implementation of the GAIN-I COREare for FY202019. This includes training provider clinicians and phasing out other versions of a biopsychosocial assessment. Specifically the PIH will begin to use the GAIN-I Core as the exclusive substance use Disorder assessment tool and format beginning on 10/1/2020. The PIHP may begin this transition to the GAIN-I CORE~~ore on 10/1/20198 as long as it is fully implemented by March 30October 1, 202019, or one year after federal approval of the 1115 Waiver, whichever is later. By September 30, 2019 all other forms of biopsychosocial assessments are to be eliminated. [MT[4]

Community Mental Health

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Health and Human Services

Fiscal Year End September 30, 2019

TABLE OF CONTENTS

INTRODUCTION

These Community Mental Health (CMH) Compliance Examination Guidelines are issued by the Michigan Department of Health and Human Services (MDHHS) to assist independent audit personnel, Prepaid Inpatient Health Plan (PIHP) personnel, and Community Mental Health Services Program (CMHSP) personnel in preparing and performing compliance examinations as required by contracts between MDHHS and PIHPs or CMHSPs, and to assure examinations are completed in a consistent and equitable manner.

These CMH Compliance Examination Guidelines require that an independent auditor examine compliance issues related to contracts between PIHPs and MDHHS to manage the Concurrent 1915(b)/(c) Medicaid, Healthy Michigan, Flint 1115 and Substance Use Disorder Community Grant Programs (hereinafter referred to as "Medicaid Contract"); the contracts between CMHSPs and MDHHS to manage and provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208 (hereinafter referred to as "GF Contract"); and, in certain circumstances, contracts between CMHSPs or PIHPs and MDHHS to manage the Community Mental Health Services Block Grant Program (hereinafter referred to as "CMHS Block Grant Program"). These CMH Compliance Examination Guidelines, however, DO NOT replace or remove any other audit requirements that may exist, such as a Financial Statement Audit and/or a Single Audit. An annual Financial Statement audit is required. Additionally, if a PIHP or CMHSP expends $750,000 or more in federal awards[1], the PIHP or CMHSP must obtain a Single Audit.

PIHPs are ultimately responsible for the Medicaid funds received from MDHHS, and are responsible for monitoring the activities of network provider CMHSPs as necessary to ensure expenditures of Medicaid Contract funds are for authorized purposes in compliance with laws, regulations, and the provisions of contracts. Therefore, PIHPs must either require their independent auditor to examine compliance issues related to the Medicaid funds awarded to the network provider CMHSPs, or require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. Further detail is provided in the Responsibilities – PIHP Responsibilities Section (Item #'s 8, 9, & 10).

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2019 and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

Failure to meet the requirements contained in these CMH Compliance Examination Guidelines may result in the withholding of current funds or the denial of future awards.

[1] Medicaid payments to PIHPs and CMHSPs for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended for the purposes of determining Single Audit requirements.

RESPONSIBILITIES

MDHHS Responsibilities

MDHHS must:

1. Periodically review and revise the CMH Compliance Examination Guidelines to ensure compliance with current Mental Health Code, and federal and state audit requirements; and to ensure the **COMPLIANCE REQUIREMENTS** contained in the CMH Compliance Examination Guidelines are complete and accurately represent requirements of PIHPs and CMHSPs; and distribute revised CMH Compliance Examination Guidelines to PIHPs and CMHSPs.
2. Review the examination reporting packages submitted by PIHPs and CMHSPs to ensure completeness and adequacy within eight months of receipt.
3. Issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination reporting package within eight months after the receipt of a complete and final reporting package.
4. Monitor the activities of PIHPs and CMHSPs as necessary to ensure the Medicaid Contract, GF Contract, and CMHS Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely primarily on the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure Medicaid Contract, and GF Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS will rely on PIHP or CMHSP Single Audits or the compliance examination engagements conducted on PIHPs and CMHSPs by independent auditors to ensure CMHSP Block Grant Program funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. MDHHS may, however, determine it is necessary to also perform a limited scope compliance examination or review of selected areas. Any additional reviews or examinations shall be planned and performed in such a way as to build upon work performed by other auditors. The following are some examples of situations that may trigger an MDHHS examination or review:
    a. Significant changes from one year to the next in reported line items on the FSR.
    b. A PIHP entering the MDHHS risk corridor.
    c. A large addition to an ISF per the cost settlement schedules.
    d. A material non-compliance issue identified by the independent auditor.
    e. The CPA that performed the compliance examination is unable to quantify the impact of a finding to determine the questioned cost amount.
    f. The CPA issued an adverse opinion on compliance due to their inability to draw conclusions because of the condition of the agency's records.

PIHP Responsibilities

PIHPs must:

1. Maintain internal control over the Medicaid Contract that provides reasonable assurance that the PIHP is managing the contract in compliance with laws, regulations, and the contract provisions that could have a material effect on the contract.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract. Examples of these would include, but not be limited to: the Medicaid Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200 , the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines is properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the PIHP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The PIHP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS and the PIHP will be notified of any required action in the management decision.
8. Monitor the activities of network provider CMHSPs as necessary to ensure the Medicaid Contract funds are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts. PIHPs must either (a.) require the PIHP's independent auditor (as part of the PIHP's examination engagement) to examine the records of the network provider CMHSP for compliance with the Medicaid Contract provisions, or (b.) require the network provider CMHSP to contract with an independent auditor to examine compliance issues related to contracts between PIHPs and CMHSPs to manage the Medicaid Contract. If the latter is chosen, the PIHP must incorporate the examination requirement in the PIHP/CMHSP contract and develop Compliance Examination Guidelines specific to their PIHP/CMHSP contract. Additionally, if the latter is chosen, the CMHSP examination must be completed in sufficient time so that the PIHP auditor may rely on the CMHSP examination when completing their examination of the PIHP if they choose to.
9. If requiring an examination of the network provider CMHSP, review the examination reporting packages submitted by network provider CMHSPs to ensure completeness and adequacy.

10. If requiring an examination of the network provider CMHSP, issue a management decision (as described in the Examination Requirements – Management Decision Section) on findings and questioned costs contained in network provider CMHSP's examination reporting packages.

CMHSP Responsibilities

(as a recipient of Medicaid Contract funds from PIHP and a recipient of GF funds from MDHHS and a recipient of CMHS Block Grant funds from MDHHS)

CMHSPs must:

1. Maintain internal control over the Medicaid Contract, GF Contract, and CMHS Block Grant Program that provides reasonable assurance that the CMHSP is managing the Medicaid Contract, GF Contract, and CMHS Block Grant Program in compliance with laws, regulations, and the provisions of contracts that could have a material effect on the Medicaid Contract, GF Contract, and CMHS Block Grant Program.
2. Comply with laws, regulations, and the contract provisions related to the Medicaid Contract, GF Contract, and CMHSP Block Grant Program. Examples of these would include, but not be limited to: the Medicaid Contract, the Managed Mental Health Supports and Services Contract (General Fund Contract), the CMHS Block Grant Contract, the Mental Health Code (Michigan Compiled Laws 330.1001 – 330.2106), applicable sections of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards located at 2 CFR 200, the Medicaid Provider Manual, and Generally Accepted Accounting Principles (GAAP).
3. Prepare appropriate financial statements.
4. Ensure that the examination required by these CMH Compliance Examination Guidelines, and any examination required by the PIHP from which the CMHSP receives Medicaid Program funds are properly performed and submitted when due.
5. Follow up and take corrective action on examination findings.
6. Prepare a corrective action plan to address each examination finding, and comment and recommendation included in the current year auditor's reports including the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If the CMHSP does not agree with an examination finding or comment, or believes corrective action is not required, then the corrective action plan shall include an explanation and specific reasons.
7. The CMHSP shall not file a revised FSR and Cost Settlement based on the CMH Compliance Examination. Rather, adjustments noted in the CMH Compliance Examination will be evaluated by MDHHS, and the CMHSP will be notified of any required action in the management decision.

EXAMINATION REQUIREMENTS

PIHPs under contract with MDHHS to manage the Medicaid Contract and CMHSPs under contract with MDHHS to manage the GF Contract are required to contract annually with a

certified public accountant in the practice of public accounting (hereinafter referred to as a practitioner) to examine the PIHP's or CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 18–Attestation Standards – Clarification and Redcodification–.AT – C Section 205 The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Additionally, CMHSPs under contract with MDHHS to provide CMHS Block Grant Program services with a total contract amount of greater than $187,500 are required to ensure the above referenced examination engagement includes an examination of compliance with specified requirements related to the CMHS Block Grant Program **IF** the CMHSP does not have a Single Audit or the CMHSP's Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program. The specified requirements and specified criteria related to the CMHS Block Grant Program are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Practitioner Selection

In procuring examination services, PIHPs and CMHSPs must engage an independent practitioner, and must follow the Procurement Standards contained in 2 CFR 200.318 through 200.320. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, the results of MDHHS reviews, and price. When possible, PIHPs and CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

The objective of the practitioner's examination procedures applied to the PIHP's or CMHSP's compliance with specified requirements is to express an opinion on the PIHP's or CMHSP's compliance based on the specified criteria. The practitioner seeks to obtain reasonable assurance that the PIHP or CMHSP complied, in all material respects, based on the specified criteria.

Practitioner Requirements

The practitioner should exercise due care in planning, performing, and evaluating the results of his or her examination procedures; and the proper degree of professional skepticism to achieve reasonable assurance that material noncompliance will be detected. The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements." In the examination of the PIHP's or CMHSP's compliance with specified requirements, the practitioner should follow the requirements of AT-C 105 and 205.

~~1. Obtain an understanding of the specified compliance requirements (See AT 601.40).~~
~~2. Plan the engagement (See AT 601.41 through 601.44).~~
~~3. Consider the relevant portions of the PIHP's or CMHSP's internal control over compliance (See AT 601.45 through 601.47).~~
~~4. Obtain sufficient evidence including testing compliance with specified requirements (See AT 601.48 through 601.49).~~
~~5. Consider subsequent events (See AT 601.50 through 601.52).~~
~~6. Form an opinion about whether the entity complied, in all material respects with specified requirements based on the specified criteria (See AT 601.53).~~

Practitioner's Report

The practitioner's examination report on compliance should include the information detailed in AT-C 205.63 through 205.86, which includes the practitioner's opinion on whether the entity complied, in all material respects, with specified requirements based on the specified criteria. When an examination of the PIHP's or CMHSP's compliance with specified requirements discloses noncompliance with the applicable requirements that the practitioner believes have a material effect on the entity's compliance, the practitioner should modify the report as detailed in AT-C 205.68 through AT-C 205.75.

In addition to the above examination report standards, the practitioner must prepare:

1. A Schedule of Findings that includes the following:
    a. Control deficiencies that are individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.
    b. Material noncompliance with the provisions of laws, regulations, or contract provisions related to the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.
    c. Known fraud affecting the Medicaid Contract, GF Contract, CMHS Block Grant Program, and/or SAPT Block Grant Program.

    Finding detail must be presented in sufficient detail for the PIHP or CMHSP to prepare a corrective action plan and for MDHHS to arrive at a management decision. The following specific information must be included, as applicable, in findings:
    a. The criteria or specific requirement upon which the finding is based including statutory, regulatory, contractual, or other citation. **The Compliance Examination Guidelines should NOT be used as criterion.**
    b. The condition found, including facts that support the deficiency identified in the finding.
    c. Identification of applicable examination adjustments and how they were computed.
    d. Information to provide proper perspective regarding prevalence and consequences.
    e. The possible asserted effect.

f. Recommendations to prevent future occurrences of the deficiency(ies) noted in the finding.
g. Views of responsible officials of the PIHP/CMHSP.
h. Planned corrective actions.
i. Responsible party(ies) for the corrective action.
j. Anticipated completion date.

2. A schedule showing final **reported** Financial Status Report (FSR) amounts, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below)], and examined FSR amounts. **All examination adjustments must be explained.** This schedule is called the "Examined FSR Schedule." Note that Medicaid FSRs must be provided for PIHPs. All applicable FSRs must be included in the practitioner's report regardless of the lack of any examination adjustments.

3. A schedule showing a revised cost settlement for the PIHP or CMHSP based on the Examined FSR Schedule. This schedule is called the "Examined Cost Settlement Schedule." This must be included in the practitioner's report regardless of the lack of any examination adjustments.

4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, GF Contract, and/or CMHS Block Grant program only in the event the individual comment or recommendation is expected to have an impact greater than or equal to $10,000; and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency.

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDHHS within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The PIHP or CMHSP must submit the reporting package by e-mail to 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.

Examination Reporting Package

The reporting package includes the following:

1. Practitioner's report as described above;
2. Corrective action plan prepared by the PIHP or CMHSP.

Penalty

If the PIHP or CMHSP fails to submit the required examination reporting package by June 30th following the contract year end and an extension has not been granted by MDHHS, MDHHS may withhold from current funding five percent of the examination year's grant funding (not to exceed $200,000) until the required reporting package is received. MDHHS may retain the withheld amount if the reporting package is delinquent more than 120 days from the due date and MDHHS has not granted an extension.

Incomplete or Inadequate Examinations

If MDHHS determines the examination reporting package is incomplete or inadequate, the PIHP or CMHSP, and possibly its independent auditor will be informed of the reason of inadequacy and its impact in writing. The recommendations and expected time frame for resubmitting the corrected reporting package will be provided to the PIHP or CMHSP.

Management Decision

MDHHS will issue a management decision on findings, comments, and examination adjustments contained in the PIHP or CMHSP examination report within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the examination finding and/or comment is sustained; the reasons for the decision and the expected PIHP or CMHSP action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, MDHHS may request additional information or documentation from the PIHP or CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the PIHP or CMHSP is included in the applicable contract.

If there are no findings, comments, and/or questioned costs, MDHHS will notify the PIHP or CMHSP when the review of the examination reporting package is complete and the results of the review.

COMPLIANCE REQUIREMENTS

The practitioner must examine the PIHP's or CMHSP's compliance with the A-~~J~~F specified requirements based on the specified criteria stated below related to the Medicaid Contract and GF Contract. If the PIHP or CMHSP does not have a Single Audit or the Single Audit does not include the CMHS Block Grant (CFDA 93.958) as a major Federal program, the practitioner must also examine the CMHSP's compliance with the ~~K-M~~G-I specified requirements based on the specified criteria stated below that specifically relate to the CMHS Block Grant, but only if the total contract amount for the CMHS Block Grant is greater than $187,500. If the PIHP does not have a Single Audit, or the Single Audit does not include the Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959) as a major Federal program, the practitioner must also examine the PIHP's compliance with the ~~N-P~~J-K specified requirements based on the specified criteria stated below that specifically relate to the SAPT Block Grant.

COMPLIANCE REQUIREMENTS A-F
(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

The final FSRs (entire reporting package applicable to the entity) comply with contractual provisions as follows:

a. FSRs agree with agency financial records (general ledger) as required by the reporting instructions. (Reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).
b. FSRs include only allowed activities as specified in the contracts; allowable costs as specified in the Federal cost principles (located at 2 CFR 200, Subpart E)(GF Contract, Section 6.6.1; and Medicaid Contract, Section 7.8); and allowed activities and allowable costs as specified in the Mental Health Code, Sections 240, 241, and 242.
c. FSRs include revenues and expenditures in proper categories and according to reporting instructions.

Differences between the general ledger and FSRs should be adequately explained and justified. Any differences not explained and justified must be shown as an adjustment on the practitioner's "Examined FSR Schedule." Any reported expenditures that do not comply with the Federal cost principles, the Code, or contract provisions must be shown as adjustments on the auditor's "Examined FSR Schedule."

The following items should be considered in determining allowable costs:
Federal cost principles (2 CFR 200.402) require that for costs to be allowable they must meet the following general criteria:

a. Be necessary and reasonable for the performance of the Federal award and be allocable thereto under the principles.
b. Conform to any limitations or exclusions set forth in the principles or in the Federal award as to types or amount of cost items.
c. Be consistent with policies and procedures that apply uniformly to both federally-financed and other activities of the non-Federal entity.
d. Be accorded consistent treatment.
e. Be determined in accordance with generally accepted accounting principles.
f. Not be included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period.
g. Be adequately documented.

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness

criteria of 2 CFR Part 200, Subpart E – Cost Principles, 200.404 was met. If subcontractors are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). When the PIHP pays Federally Qualified Heath Centers (FQHC) and Rural Health Centers (RHC) for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported rental costs for **less-than-arms-length transactions** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (c)). For example, the agency may rent their office building from the agency's board member/members, but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in 2 CFR Part 200.

Reported costs for **sale and leaseback arrangements** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (b)).

Capital asset purchases that cost greater than $5,000 must be capitalized and depreciated over the useful life of the asset rather than expensing it in the year of purchase (2 CFR Part 200, Subpart E – Cost Principles, 200.436 and 200.439-). All invoices for a remodeling or renovation project must be accumulated for a total project cost when determining capitalization requirements; individual invoices should not simply be expensed because they are less than $5,000.

Costs must be allocated to programs in accordance with relative benefits received. Accordingly, **Medicaid costs must be charged to the Medicaid Program and GF costs must be charged to the GF Program**. Additionally, **administrative/indirect costs** must be distributed to programs on bases that will produce an equitable result in consideration of relative benefits derived in accordance with 2 CFR Part 200, Appendix VII.
Distributions of salaries and wages for employees that work on multiple activities or cost objectives, must be supported in accordance with the standards listed in 2 CFR Part 200, Subpart E – Cost Principles, 200.430 (i).

B. Administration Cost Report

The most recently completed PIHP's or CMHSP's Administration Cost Report complies with the applicable CMHSP/PIHP Administration Cost Reporting Instructions and the applicable standards in ESTABLISHING ADMINISTRATIVE COSTS WITHIN AND ACROSS THE CMHSP SYSTEM and contract provisions (instructions located at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html and reference guidelines located at http://www.michigan.gov/documents/mdch/Establishing_Admin_costs_480633_7.pdf).

C. Procurement

The PIHP or CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326. The PIHP or CMHSP ensured that organizations or individuals selected and offered contracts have not been debarred or suspended or otherwise excluded from or ineligible for participation in Federal assistance programs as required by 45 CFR 92.35.

D. Internal Service Fund (ISF)

The PIHP's Internal Service Fund complies with the Internal Service Fund Technical Requirement contained in Contract Attachment P 8.6.4.1 with respect to funding and maintenance.

E. Medicaid Savings and General Fund Carryforward

The PIHP's Medicaid Savings was expended in accordance with the PIHP's reinvestment strategy as required by Sections 8.6.2.2 and 8.6.2.3 of the Contract. The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

F. Match Requirement

The PIHP or CMHSP met the local match requirement, and all items considered as local match actually qualify as local match according to Section 7.2 of the General Fund Contract and Section 8.2 of the Medicaid Contract. Some examples of funds that do NOT qualify as local match are: (a.) revenues (such as workers' compensation refunds) that should be offset against related expenditures, (b.) interest earned from ISF accounts, (c.) revenues derived from programs (such as the Clubhouse program) that are financially supported by Medicaid or GF, (d.) donations of funds from subcontractors of the PIHP or CMHSP, (e.) Medicaid Health Plan (MHP) reimbursements for MHP purchased services that have been paid at less than the CMHSP's actual costs, and (f) donations of items that would not be an item generally provided by the PIHP or CMHSP in providing plan services.

If the PIHP or CMHSP does not comply with the match requirement in the Mental Health Code, Section 302, or cannot provide reasonable evidence of compliance, the auditor shall determine and report the amount of the shortfall in local match requirement.

COMPLIANCE REQUIREMENTS G-I

(APPLICABLE TO PIHPs/CMHSPs WITH A CMHS BLOCK GRANT OF GREATER THAN $187,500 THAT DID NOT HAVE A SINGLE AUDIT OR THE CMHS BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

G. CMHS Block Grant - Activities Allowed or Unallowed

The CMHSP expended CMHS Block Grant (CFDA 93.958) funds only on allowable activities in accordance with Federal Block Grant provisions and the Grant Agreement between MDHHS and the CMHSP.

H. CMHS Block Grant - Cash Management

The CMHSP complied with the applicable cash management compliance requirements contained in the Federal Block Grant Provisions. This includes the requirement that when entities are funded on a reimbursement basis, program costs must be paid for by CMHSP funds before reimbursement is requested from MDHHS.

I. CMHS Block Grant – Sub-recipient Management and Monitoring

If the CMHSP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal CMHS Block Grant Program, the CMHSP complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h)

COMPLIANCE REQUIREMENTS J-K

(APPLICABLE TO PIHPs WITH A SAPT BLOCK GRANT THAT DID NOT HAVE A SINGLE AUDIT OR THE SAPT BLOCK GRANT WAS NOT A MAJOR FEDERAL PROGRAM IN THE SINGLE AUDIT)

J. SAPT Block Grant – Activities Allowed or Unallowed

The PIHP or CMHSP expended SAPT Block Grant (CFDA 93.959) funds only on allowable activities in accordance with the Federal Block Grant Provisions and the Grant Agreement.

K. SAPT Block Grant – Sub-recipient Management and Monitoring

If the PIHP contracts with other sub-recipients ("sub-recipient" per the 2 CFR Part 200.330 definition) to carry out the Federal SAPT Block Grant Program, the PIHP or complied with the Sub-recipient Monitoring and Management requirements at 2 CFR Part 200.331 (a) through (h).

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDHHS. Also, PIHPs are required to keep affiliate CMHSP's reports on file for three years from date of receipt. All examination

working papers must be accessible and are subject to review by representatives of the Michigan Department of Health and Human Services, the Federal Government and their representatives. There should be close coordination of examination work between the PIHP and provider network CMHSP auditors. To the extent possible, they should share examination information and materials in order to avoid redundancy.

EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2018/2019 examinations. Any questions relating to these guidelines should be directed to:

John Duvendeck, Director
Division of Program Development, Consultation & Contracts
Bureau of Hospitals and Behavioral Health Administration
Michigan Department of Health and Human Services
Lewis Cass Building
320 S. Walnut Street
Lansing, Michigan 48913
duvendeckj@michigan.gov
Phone: (517) 241-5218 Fax: (517) 335-5376

GLOSSARY OF ACRONYMS AND TERMS

AICPA.....American Institute of Certified Public Accountants.

Children's Waiver.....The Children's Waiver Program that provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the program who, if not for the availability and provisions of the Waiver, would otherwise require the level of care and services provided in an Intermediate Care Facility for the Mentally Retarded. Payment from MDHHS is on a fee for service basis.

CMHS Block Grant Program.The program managed by CMHSPs under contract with MDHHS to provide Community Mental Health Services Block Grant program services under CFDA 93.958.

CMHSP.....Community Mental Health Services Program (CMHSP). A program operated under Chapter 2 of the Michigan Mental Health Code – Act 258 of 1974 as amended.

Examination Engagement.....A PIHP or CMHSP's engagement with a practitioner to examine the entity's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) –Attestation Standards – Clarification and Recodification - AT-C 205 (Codified Section of AICPA Professional Standards).

Flint 1115 Waiver .....The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014 through a state-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act, and is effective as of March 3, 2016 the date of the signed approval through February 28, 2021. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the state plan. All such persons will have access to Targeted Case Management services under a fee for service contract between MDHHS and Genesee Health Systems (GHS). The fee for service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.

GF Program.....The program managed by CMHSPs under contract with MDHHS to provide mental health services and supports to individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.

MDHHS.....Michigan Department of Health and Human Services

Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by PIHPs under contract with MDHHS.

PIHP.....Prepaid Inpatient Health Plan. In Michigan a PIHP is an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver

Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. The PIHP, also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program, also manages the Autism Program, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.

Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.

Serious Emotional Disturbances Waiver.....The Waiver for Children with Serious Emotional Disturbances Program that provides services to children who would otherwise require hospitalization in the State psychiatric hospital to remain in their home and community. Payment from MDHHS is on a fee for service basis.

SSAE.....AICPA's Statements on Standards for Attestation Engagements.

SAPT Block Grant Program ..The program managed by PIHPs under contract with MDHHS to provide Substance Use Services Block Grant program services under CFDA 93.959.

SUD Services.....Substance Use Disorder Services funded by Medicaid, Healthy Michigan, and the "Community Grant" which consists of Federal SAPT Block Grant funds and State funds.

PIHP REPORTING REQUIREMENTS
Effective 10-1-18
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Amendment #2

PIHP REPORTING REQUIREMENTS

FY 2019 MDHHS/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT

REPORTING REQUIREMENTS

Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2019 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs or substance use disorder programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

- "Supplemental Instructions for Encounter Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes. Code list that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDHHS and EDIT have assigned to them The code list also includes instructions on use of modifiers; the acceptable activities that may be reflected in the cost of each procedure; and whether an activity needs to be face-to-face in order to count.
- "Establishing Managed Care Administrative Costs" that provides instructions on what managed care functions should be included in the allocation of expenditures to managed care administration.
- "Michigan's Mission-Based Performance Indicator System, is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators.
- SUD Guidelines and instructions as found in the Agreement

These documents are posted on the MDHHS web site and are periodically updated when federal or state requirements change, or when in consultation with representatives of the public mental health system it deemed necessary to make corrections or clarifications. Question and answer documents are also produced from time to time and posted on the web site.

Collection of each element contained in the master contract attachment is required. Data reporting must be received by 5 p.m. on the due dates (where applicable) in the acceptable format(s) and by the MDHHS staff identified in the instructions. Failure to meet this standard will result in contract action.

The reporting of the data by PIHPs described within these requirements meets several purposes at MDHHS including:

PIHP REPORTING REQUIREMENTS

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management
- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- External Quality Review
- Actuarial activities

Individual consumer level data received at MDHHS is kept confidential and published reports will display only aggregate data. Only a limited number of MDHHS staff have access to the database that contains social security numbers, income level, and diagnosis, for example. Individual level data will be provided back to the agency that submitted the data for encounter data validation and improvement. This sharing of individual level data is permitted under the HIPAA Privacy Rules, Health Care Operations.

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

The PIHP shall provide the financial reports to MDHHS as listed below. Forms, instructions and other reporting resources are posted to the MDHHS website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html

Submit completed reports electronically (Excel or Word) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov except for reports noted in table below.

Due Date	Report Title	Report Frequency	Report Period and Submittal Instructions
10/1/2018	SUD Budget Report	Projection/Initial	October 1 to September 30
12/3/2018	Risk Management Strategy	Annually	To cover the current fiscal year
12/31/2018	Medicaid Services Verification Report	Annually	October 1 to September 30
1/31/2019	SUD – Expenditure Report	Quarterly	October 1 to December 31
4/16/2019	SUD – Women's Specialty Services (WSS) Mid-Year Expenditure Status Report	Mid-Year	October 1 to March 31
4/30/2019	SUD – Expenditure Report	Quarterly	January 1 to March 31
5/15/2019	Program Integrity Activities	Quarterly	January 1 to March 31 using OIG's case tracking system
5/31/2019	Mid-Year Status Report	Mid-Year	October 1 to March 31
6/01/2019	SUD – Notice of Excess or Insufficient Funds	Projection	October 1 to September 30
7/31/2019	SUD – Expenditure Report	Quarterly	April 1 to June 30
8/15/2019	Program Integrity Activities	Quarterly	April 1 to June 30 using OIG's case tracking system
8/15/2019	SUD – Charitable Choice Report	Annually	October 1 to September 30

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PIHP REPORTING REQUIREMENTS

8/15/2019	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Shared Risk Calculation & Risk Financing	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Projection (Use tab in FSR Bundle)	October 1 to September 30
8/31/2019	Medicaid Unit Net Cost Report (MUNC)	Six month report	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
10/1/2019	Medicaid YEC Accrual	Final	October 1 to September 30
10/1/2019	SUD YEC Accrual	Final	October 1 to September 30
10/1/2019	SUD Budget Report	Projection	October 1 to September 30
11/10/2019	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Shared Risk Calculation & Risk Financing	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Interim (Use tab in FSR Bundle)	October 1 to September 30
11/15/2019	• Program Integrity Activities	Quarterly	July 1 to September 30 using OIG's case tracking system
11/30/2019	SUD – Expenditure Report	Quarterly/Final	July 1 to September 30
12/31/2019	Medicaid Services Verification Report	Annually	October 1 to September 30
2/15/20~~19~~20	Program Integrity Activities	Quarterly	October 1 to December 31 using OIG's case tracking system
2/28/20~~19~~20	SUD – Primary Prevention Expenditures by Strategy Report	Annually	October 1to September 30
2/28/20~~19~~20	SUD Budget Report	Final	October 1 to September 30
2/28/20~~19~~20	SUD – Legislative Report/Section 408	Annually	October 1 to September 30
2/28/20~~19~~20	SUD – Special Project Report: (Applies only to PIHP's with earmarked allocations for Flint Odyssey House Sacred Heart Rehab Center	Annually	October 1 to September 30

PIHP REPORTING REQUIREMENTS

	Saginaw Odyssey House)		
2/28/20~~19~~20	PIHP Medicaid FSR Bundle – MA. HMP, Autism & SUD	Final (Use tab in FSR Bundle)	October 1 to September 30
	Shared Risk Calculation & Risk Financing	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Final (Use tab in FSR Bundle)	October 1 to September 30
2/28/20~~19~~20	• Medicaid Utilization and Cost Report (MUNC)	Final	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
2/28/20~~19~~20	PIHP Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30
2/28/20~~19~~20	Medical Loss Ratio	Annually	October 1 to September 30
3/31/20~~19~~20	SUD - Maintenance of Effort (MOE) Report	Annually	October 1 to September 30
6/30/20~~19~~20	SUD – Audit Report	Annually	October 1 to September 30 (Due 9 months after close of fiscal year)
30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov
30 Days after submission	Compliance exam and plan of correction	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS

The PIHP shall provide the following reports to MDHHS as listed below.

Due Date	Report Title	Report Period
~~10/31~~11/30/2018	Recovery Policy & Practice Annual Planning – Table 2~~Annual Survey Information Forms – Tables 3a & 3b~~	~~TBD~~ See attachment P4.13.1
1/31/2019	Children Referral Report	October 1 to December 31

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PIHP REPORTING REQUIREMENTS

1/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 to December 31
2/19/2019	SUD Master Retail List	October 1 to September 30
03/31/2019	Performance Indicators	October 1 to December 31, 2018 Submit to: QMPMeasures@michigan.gov
4/30/2019	Children Referral Report	January 1 to March 31
4/30/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	January 1 to March 31
4/30/2018~~9~~	Sentinel Events Data Report	October 1 to March 31
06/30/2019	Performance Indicators	January 1 to March 31, 2019 Submit to: QMPMeasures@michigan.gov
~~7/11/2019~~	~~Compliance Check Report (CCR) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov~~	~~Email OROSC backup to: ohs@michigan.gov and cc NordmannA@michigan.gov.~~
~~07/11/2019~~06/30/2019	SUD – Tobacco/ Formal Synar Inspection period s— ~~To be reported in Youth Access to Tobacco (YAT) Compliance Checks Report~~	June 1-June 30 (To be reported in Youth Access to Tobacco Compliance Check Report)~~June 1 to 30 Coverage study activities should be conducted between Aug. 29 to Sept. 17, 2018~~
7/15/2019	Compliance Check Report (CCR)	Submit to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov with cc to: ohs@michigan.gov and ColemanL7@michigan.gov
7/31/2019	Children Referral Report	April 1 to June 30
7/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	April 1 to June 30
~~08/31/2019~~	~~Consumer Satisfaction Survey raw data~~	~~Survey conducted in May~~
09/30/2019	Performance Indicators	April 1 to June 30, 2019 Submit to: QMPMeasures@michigan.gov
10/31/2019	Children Referral Report	July 1 to September 30
10/31/2019	SUD – Injecting Drug Users 90% Capacity Treatment Report	July 1 to September 30
10/31/2019	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30
10/31/2019	Sentinel Events Data Report	April 1 to September 30

PIHP REPORTING REQUIREMENTS

~~Applicable in FY19~~TBD	SUD – Synar Coverage Study Canvassing Forms	Regions participating and Study Period TBD (August 2019)~~Next Synar Coverage Study occurs in 2019~~
11/30/2019	SUD – Communicable Disease (CD) Provider Information Report (Must ~~be submitted~~submit only if PIHP funds CD services)	October 1 to September 30 ~~(e-mail to mdhhs-BDDHA@michigan.gov)~~
11/30/2019	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2019	Performance Indicators	July 1 to September 30, 2019 Submit to: QMPMeasures@michigan.gov
2/28/2020~~19~~	Recovery Policy & Practice Annual ~~Reporting Matrice – Table 2~~Survey Information Forms – Tables 3a and 3b	See attachment P4.13.1
TBD (originally 2/28/2020)	Recovery Policy & Practice Annual Reporting Matrices – Table 2	See attachment P4.13.1
Quarterly	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 – September 30 – Due last day of month, following the last month of the quarter.
Quarterly	Children Referral Report	October 1 – September 30 – Due last day of month, following the last month of the quarter.
Monthly ~~(Last day of month following month in which exception occurred) Must submit even if no data to report~~	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30 Due last day of month following month in which exception occurred. Must submit even if no data to report
Monthly ~~(Last day each month)~~	SUD – Behavioral Health Treatment Episode Data Set (BH-TEDS)	October 1 to September 30 Due last day of each month. Submit via DEG at ~~, Login at~~: https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly ~~(Last day of month following the month in which the data was uploaded)~~	SUD - Michigan Prevention Data System (MPDS)	October 1 to September 30 Due last day of each month, following month in which data was uploaded. Submit to: https://~~mdhhs~~mpds.sudpds.com~~)~~
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 Submit via ~~Login~~ DEG at: https://milogintp.michigan.gov.

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PIHP REPORTING REQUIREMENTS

		See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly*	Consumer level* ~~a.~~Quality Improvement Encounter	October 1 to September 30 See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	Critical Incidents	Submit to PIHP Incident Warehouse at: https://mipihpwarehouse.org/MVC/Documentation
Annually ~~(Same due date as Annual Plan)~~	~~b.~~ SUD - Communicable Disease (CD) Provider Information Plan (Must ~~be submitted~~submit only if PIHP funds CD services)	October 1 to September 30 Same due date as Annual Plan.

*Consumer level data must be submitted-within 30 days following adjudication of claims for services provided, or in cases where claims are not part of the PIHP's business practices, within 30 days following the end of the month in which services were delivered.

NOTE: To submit via DEG to MDHHS/MIS Operations
Client Admission and Discharge client records must be sent electronically to:
Michigan Department of Health and Human Services
Michigan Department of Technology, Management & Budget
Data Exchange Gateway (DEG)
For admissions: put c:/4823 4823@dchbull
For discharges: put c:/4824 4824@dchbull

1. Send data to MDHHS MIS via DEG (see above)
2. Send data to MDHHS, BHDDA, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDHHS web site at www.michigan.gov/mdhhs/bhdda and click on Reporting Requirements

BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS)

PIHP REPORTING REQUIREMENTS

COLLECTION/RECORDING AND REPORTING REQUIREMENTS

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at:
https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
~~http://www.michigan.gov/mdhhs/0,4612,7-132-2941_38765---,00.html~~

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

-BH-TEDS Discharge/Update/End Records (due monthly)

A. Basis of Data Reporting

The basis for data reporting policies for Michigan behavioral health includes:

1. Federal funding awarded to Michigan through the Combined SABG/MHBG Behavioral Health federal block grant.

2. SAMHSA's Behavioral Health Services Information Systems (BHSIS) award agreement administered through Synectics Management, Inc that awards MDHHS a contracted amount of funding if the data meet minimum timeliness, completeness and accuracy standards

3 Legislative boilerplate annual reporting and semi-annual updates

B. Policies and Requirements Regarding Data

BH TEDS Data reporting will encompass Behavioral Health services provided to persons supported in whole or in part with MDHHS-administered funds.

Policy:
Reporting is required for all persons whose services are paid in whole or in part with state administered funds regardless of the type of co-pay or shared funding arrangement made for the services.

For purposes of MDHHS reporting, an admission, or start, is defined as the formal acceptance of a client into behavioral health services. An admission or start has occurred if and only if the person begins receiving behavioral health services.

PIHP REPORTING REQUIREMENTS

1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

2. All SUD data collected and recorded on BH-TEDS shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDHHS at the program level.

3. There must be a unique Person identifier assigned and reported. It must be 11 characters in length, and alphanumeric. This same number is to be used to report data for BH-TEDS and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.

4. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.

5. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDHHS.

6. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

7. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.

8. Statements of MDHHS policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

Method for submission: BH-TEDS data are to be submitted in a fixed length format, per the file specifications.

PIHP REPORTING REQUIREMENTS

Due dates: BH TEDS data are due monthly. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

Who to report: The PIHP must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and substance use disorders who receive services funded in whole or in part with MDHHS-administered funding. PIHPs participating in the Medicare/Medicaid integration project are not to report BH-TEDS records for beneficiaries for whom the PIHP's financial responsibility is to a non-contracted provider during the 180-day continuity of care.

PROXY MEASURES FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

For FY19, the PIHPs are required to report a limited set of data items in the Quality Improvement (QI) file for consumers with an intellectual or developmental disability. The required items and instructions are shown below. Detailed file specifications are (will be) available on the MDHHS web site at: xxxxxxx

***Instructions**: The following elements are proxy measures for people with developmental disabilities. The information is obtained from the individual's record and/or observation. Complete when an individual begins receiving public mental health services for the first time and update at least annually. Information can be gathered as part of the person-centered planning process.*

For purposes of these data elements, when the term "support" is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- *"Limited" means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.*
- *"Moderate" means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.*
- *"Extensive" means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.*
- *"Total" means the person is unable to complete the activity and the caregiver is providing 100% support.*

Fields marked with an asterisk * cannot be blank or the file will be rejected.

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* ***Reporting Period*** **(REPORTPD)**
The last day of the month in which the consumer data is being updated. Report year, month, day: yyyymmdd.

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* ***PIHP Payer Identification Number*** **(PIHPID)**
The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transmissions.

* ***CMHSP Payer Identification Number*** **(CMHID)**
The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all data transmissions.

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* ***Consumer Unique ID*** **(CONID)**

PIHP REPORTING REQUIREMENTS

A numeric or alphanumeric code, of 11 characters that enables the consumer and related services to be identified and data to be reliably associated with the consumer across all of the PIHP's services. The identifier should be established at the PIHP level so agency level or sub-program level services can be aggregated across all program services for the individual. The consumer's unique ID must not be changed once established since it is used to track individuals, and to link to their encounter data over time. **A single shared unique identifier must match the identifier used in 837 encounter for each consumer.**

Social Security Number **(SSNO)**
The nine-digit integer must be recorded, if available.
Blank = Unreported [Leave nine blanks]

Medicaid ID Number **(MCIDNO)**
Enter the ten-digit integer for consumers with a Medicaid number.
Blank = Unreported [Leave ten blanks]

MIChild Number (CIN)
Blank = Unreported [Leave ten blanks]

Disability Designation

***Developmental disability** (Individual meets the Mental Health Code Definition of Developmental Disability regardless of whether or not they receive services from the I/DD or MI services arrays) **(DD)**
1 = Yes
2 = No
3 = Not evaluated

***Mental Illness or Serious Emotional Disturbance** individual has been evaluated and/or individual has a DSM MI diagnosis, exclusive of intellectual disability, developmental disability, or substance abuse disorder OR the individual has a Serious Emotional Disturbance.
1 = Yes
2 = No
3 = Not evaluated

Gender (GENDER)
Identify consumer as male or female.
M = Male
F = Female

Date of birth **(DOB)**

PIHP REPORTING REQUIREMENTS

Date of Birth - Year, month, and day of birth must be recorded in that order. Report in a string of eight characters, no punctuation: YYYYMMDD using leading zeros for days and months when the number is less than 10. For example, January 1, 1945 would be reported as 19450101.

. *Predominant Communication Style (People with developmental disabilities only)* (COMTYPE) 95% completeness and accuracy required

Indicate from the list below how the individual communicates **most of the time**:

1= English language spoken by the individual
2= Assistive technology used (includes computer, other electronic devices) or symbols such as Bliss board, or other "low tech" communication devices.
3= Interpreter used - this includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.
4= Alternative language used - this includes a foreign language, or sign language without an interpreter.
5= Non-language forms of communication used – gestures, vocalizations or behavior.
6= No ability to communicate.
Blank= Missing

. *Ability to Make Self Understood (People with developmental disabilities only)* (EXPRESS) 95% completeness and accuracy required.

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff

1= Always Understood – Expresses self without difficulty
2= Usually Understood – Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
3= Often Understood – Difficulty communicating AND prompting usually required
4= Sometimes Understood - Ability is limited to making concrete requests or understood only by a very limited number of people
5= Rarely or Never Understood – Understanding is limited to interpretation of very person-specific sounds or body language
Blank= Missing

. *Support with Mobility (People with developmental disabilities only)* (MOBILITY) 95% completeness and accuracy required

1= Independent - Able to walk (with or without an assistive device) or propel wheelchair and move about
2= Guidance/Limited Support - Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support.
3= Moderate Support - May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed
4= Extensive Support - Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed
5= Total Support - Uses wheelchair with total support to transfer, move the

wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day

Blank= Missing

. ***Mode of Nutritional Intake (People with developmental disabilities only)*** **(INTAKE) 95% completeness and accuracy required**

1= Normal – Swallows all types of foods
2= Modified independent – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
3= Requires diet modification to swallow solid food – e.g., mechanical diet (e.g., purée, minced) or only able to ingest specific foods
4= Requires modification to swallow liquids – e.g., thickened liquids
5= Can swallow only puréed solids AND thickened liquids
6= Combined oral and parenteral or tube feeding
7= Enteral feeding into stomach – e.g., G-tube or PEG tube
8= Enteral feeding into jejunem – e.g., J–tube or PEG-J tube
9= Parenteral feeding only—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
Blank = Missing

Support with Personal Care (People with developmental disabilities only) **(PERSONAL) 95% completeness and accuracy required.**

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score a "2" to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

1= Independent - Able to complete all personal care tasks without physical support
2= Guidance/Limited Support - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity
3= Moderate Physical Support - Able to perform personal care tasks with moderate support of another person
4= Extensive Support - Able to perform personal care tasks with extensive support of another person
5= Total Support – Requires full support of another person to complete personal care tasks (unable to participate in tasks)
Blank = Missing

. ***Relationships (People with developmental disabilities only)*** **(RELATION) 95% completeness and accuracy required**

Indicate whether or not the individual has "natural supports" defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

1= Extensive involvement, such as daily emotional support/companionship
2= Moderate involvement, such as several times a month up to several times a week
3= Limited involvement, such as intermittent or up to once a month

4= Involved in planning or decision-making, but does not provide emotional support/companionship
5= No involvement
Blank = Missing

***Status of Family/Friend Support System (People with developmental disabilities only)* (SUPPSYS) 95% completeness and accuracy required**

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

1= Care giver status is not at risk
2= Care giver is likely to reduce current level of help provided
3= Care giver is likely to cease providing help altogether
4= Family/friends do not currently provide care
5= Information unavailable
Blank = Missing

. *Support for Accommodating Challenging Behaviors (People with developmental disabilities only)* (BEHAV) 95% completeness and accuracy required

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging behaviors" include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

1= No challenging behaviors, or no support needed
2= Limited Support, such as support up to once a month
3= Moderate Support, such as support once a week
4= Extensive Support, such as support several times a week
5= Total Support – Intermittent, such as support once or twice a day
6= Total Support – Continuous, such as full-time support
Blank = Missing

. *Presence of a Behavior Plan (People with developmental disabilities only)* (PLAN) 95% accuracy and completeness required

Indicate the presence of a behavior plan during the past 12 months.

1= No Behavior Plan
2= Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
3= Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
Blank = Missing

. *Use of Psychotropic Medications (People with developmental disabilities only)* 95% accuracy and completeness required

Fill in the number of anti-psychotic and other psychotrophic medications the individual is prescribed. See the codebook for further definition of "anti-psychotic" and "other psychotropic" and a list of the most common medications.

51.1: Number of Anti-Psychotic Medications **(AP)** ___

PIHP REPORTING REQUIREMENTS

Blank = Missing

51.2: Number of Other Psychotropic Medications **(OTHPSYCH)** ___

Blank = Missing

Major Mental Illness (MMI) Diagnosis (People with developmental disabilities only) **95% accuracy and completeness required**

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each "x" in the codes.

1= One or more MMI diagnosis present

2= No MMI diagnosis present

Blank = Missing

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PIHP REPORTING REQUIREMENTS

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

Purpose: In the past basic consumer information from the QI (MH) and TEDS (SUD) files were sent to CHAMPS to be used as a validation that the consumer being reported in the Encounters is a valid consumer for the reporting PIHP. With QI eventually being phased out during FY16 and TEDS ending on 9/30/2015, BHTEDS will be replacing them both beginning 10/1/2015. To use BHTEDS to create the CHAMPS validation file would be difficult as there would be three different types of records – mental health substance use disorder and co-occurring.

Requirement: To simplify the process of creating this validation file, BHDDA is introducing a new file called the Behavioral Health Registry file. For this file, PIHPs are required to report five fields of data with only three being required. The required fields are: PIHP Submitter ID, Consumer ID and Begin Date (date less than or equal to first Date of Service reported in Encounters.) The following two fields will only be reported if the consumer has either: Medicaid ID and MIChild ID.

The file specifications and error logic for the Registry are (will be) available on the MDHHS web site at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.~~xxxxxx~~

Submissions of the BH Registry file by CHAMPS will be ready by 10/1/2015.

Data Record

Record Format: rc1041.06									
Element #	**Data Element Name**	**Picture**	**Usage**	**Format**	**From**	**To**	**Validated**	**Required**	**Definition**
1	Submitter ID	Char(4)	4		1	4	Yes	Yes	Service Bureau ID (DEG Mailbox ID)
2	Consumer ID	Char(11)	11		5	15	No	Yes	Unique Consumer ID
3	Medicaid ID	Char(10)	10		16	25	Yes	Conditional	Must present on file if available.
4	MIChild ID	Char(10)	10		26	35	Yes	Conditional	MICHILD ID [CIN] Must present on file if available.
5	Begin Date	Date	8	YYYYMMDD	36	43	Yes	Yes	

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER BENEFICIARY

DATA REPORT

Due dates: **Encounter data are due within 30 days following adjudication of the claim for the service provided, or in the case of a PIHP whose business practices do not include claims payment, within 30 days following the end of the month in which services were delivered.** It is expected that encounter data reported will reflect services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the PIHP. Submit the encounter data for an individual on any claims adjudicated, regardless of whether there are still other claims outstanding for the individual for the month in which service was provided. In order that the department can use the encounter data for its federal and state reporting, it must have the count of units of service provided to each consumer during the fiscal year. Therefore, the encounter data for the fiscal year must be reconciled within 90 days of the end of the fiscal year. Claims for the fiscal year that are not yet adjudicated by the end of that period, should be reported as encounters with a monetary amount of "0." Once claims have been adjudicated, a replacement encounter must be submitted.

Who to Report: The PIHP must report the encounter data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area for all services provided under MDHHS benefit plans. The PIHP must report the encounter data for all substance use disorder Medicaid beneficiaries in its service area. Encounter data is collected and reported for every beneficiary for which a claim was adjudicated or service rendered during the month by the PIHP (directly or via contract) regardless of payment source or funding stream. PIHP's and CMHSPs that contract with another PIHP or CMHSP to provide mental health services should include that consumer in the encounter data set. . In those cases the PIHP or CMHSP that provides the service via a contract should not report the consumer in this data set. Likewise, PIHPs or CMHSPs that contract directly with a Medicaid Health Plan, or sub-contract via another entity that contracts with a Medicaid Health Plan to provide the Medicaid mental health outpatient benefit, should not report the consumer in this data set.

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all consumer level data reported after October 16, 2002 must be compliant with the transaction standards.

A summary of the relevant requirements is:

- Encounter data (service use) is to be submitted electronically on a Health Care Claim 5010.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837 includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
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PIHP REPORTING REQUIREMENTS

- Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

The information on HIPAA contained in this contract relates only to the data that MDHHS is requiring for its own monitoring and/or reporting purposes, and does not address all aspects of the HIPAA transaction standards with which PIHPs must comply for other business partners (e.g., providers submitting claims, or third party payers). Further information is available at www.michigan.gov/mdhhs.

Data that is uploaded to CHAMPS must follow the HIPAA-prescribed formats for encounter data. The 837/5010 includes header and trailer information that identifies the sender and receiver and the type of information being submitted. If data does not follow the formats, entire files could be rejected by the electronic system.

HIPAA also requires that procedure codes, revenue codes and modifiers approved by the CMS be used for reporting encounters. Those codes are found in the Current Procedural Terminology (CPT) Manual, Fifth Edition, published by the American Medical Associations, the Health Care Financing Administration Common Procedure Coding System (HCPCS), the National Drug Codes (NDC), the Code on Dental Procedures and Nomenclature (CDPN), the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), ICD-10 and the Michigan Uniform Billing Manual. The procedure codes in these coding systems require standard units that must be used in reporting on the 837/5010.

MDHHS has produced a code list of covered Medicaid specialty and Habilitation Supports waiver supports and services names (as found in the Medicaid Provider Manual) and the CPT or HCPCS codes/service definition/units as soon as the majority of mental health services have been assigned CPT or HCPCS codes. This code list is available on the MDHHS web site.

The following elements reported on the 837/5010 encounter format will be used by MDHHS Quality Management and Planning Division for its federal and state reporting, the Contracts Management Section and the state's actuary. The items with an ** are required by HIPAA, and when they are absent will result in rejection of a file. Items with an ** must have 100% of values recorded within the acceptable range of values. Failure to meet accuracy standards on these items will result in contract action.

Refer to HIPAA 837 transaction implementation guides for exact location of the elements. Please consult the HIPAA implementation guides, and clarification documents (on MDHHS's web site) for additional elements required of all 837/5010 encounter formats. The Supplemental Instructions contain field formats and specific instructions on how to submit encounter level data.

1.a. ***PIHP Plan Identification Number* **(PIHPID) or PIHP CA Function ID

The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transactions.

1.b. ***CMHSP Plan Identification Number*** **(CMHID)**

The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

2. ***Identification Code/Subscriber Primary Identifier (please see the details in the submitter's manual)*
Ten-digit Medicaid number must be entered for a **Medicaid or MIChild** beneficiary.
If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.
If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID.**

3. ***Identification Code/Other Subscriber Primary Identifier (please see the details in the submitter's manual)*
Enter the consumer's unique identification number (**CONID**) assigned by the CMHSP **regardless** of whether it has been used above.

4. ***Date of birth*
Enter the date of birth of the beneficiary/consumer.

5. ***Diagnosis*
Enter the ICD-9 primary diagnosis of the consumer.

6. ***EPSDT*
Enter the specified code indicating the child was referred for specialty services by the EPSDT screening.

7. ***Encounter Data Identifier*
Enter specified code indicating this file is an encounter file.

8. ***Line Counter Assigned Number*
A number that uniquely identifies each of up to 50 service lines per claim.

9. ***Procedure Code*
Enter procedure code from code list for service/support provided. The code list is located on the MDHHS web site. Do not use procedure codes that are not on the code list.

*10. ***Procedure Modifier Code***
Enter modifier as required for Habilitation Supports Waiver services provided to enrollees; for Autism Benefit services under 1915 iSPA; for Community Living Supports and Personal Care levels of need; for Nursing Home Monitoring; and for evidence-based practices. See Costing per Code List.

*11. ***Monetary Amount (effective 1/1/13)***:

Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

12. *Quantity of Service
Enter the number of units of service provided according to the unit code type. **Only whole numbers should be reported.**

*13. **Place of Service Code***
Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc. (See PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes Chart at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements, then the codes chart)

*14. **Diagnosis Code Pointer***
Points to the diagnosis code at the claim level that is relevant to the service.

15. **Date Time Period
Enter date of service provided (how this is reported depends on whether the Professional, or the Institutional format is used).

16. **Billing Provider Name
Enter the name of the Billing Provider for all encounters. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements). If the Billing Provider is a specialized licensed residential facility also report the LARA license facility number (See Instructions for Reporting Specialized Residential Facility Details at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements).

17. **Rendering Provider Name
Enter the name of the Rendering Provider when different from the Billing Provider (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

18. **Facility Location of the Specialized Residential Facility**
In instances in which the specialized licensed residential facility is not the Billing Provider, report the name, address, NPI (if applicable) and LARA license of the facility in the Facility Location (2310C loop). (See Instructions for Reporting Specialized Residential Facility Details at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

19. ***Provider National Provider Identifier (NPI), Employer Identification Number (EIN) or Social Security Number (SSN)* Enter the appropriate identification number for the Billing Provider, and as applicable, the Rendering Provider. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

ENCOUNTER TIMELINESS CALCULATION

Requirements

1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service.
2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below).

Logic

Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month.

The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission.

These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse.

Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve.

The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019.

PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDHHS management of PIHP contracts and rate-setting by the actuary. In the case of a regional entity, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its CMHSP partners. This report includes Medicaid Substance Use Disorder services provided in the service area. The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries, **except** Children's Waiver beneficiaries. Refer to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual for the complete and specific requirements for coverage for the State Plan, Additional services provided under the authority of Section 1915(b)(3) of the Social Security Act, and the Habilitation Supports Waiver. All of the aforementioned Medicaid services and supports provided in the PIHP service area must be reported on this utilization and cost report. Instructions and current templates for completing and submitting the MUNC report may be found on the MDHHS web site at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html[WL(1)]. Click on Behavioral Health and Substance Abuse, then Reporting Requirements. This report is due twice a year. One for the first six months of the fiscal year which will be due August 31st of the fiscal year a full year report due on February 28th following the end of the fiscal year. Templates for these reports will be made available at least 60 days prior to the due date.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0 FOR PIHPS

The purposes of the Michigan Mission Based Performance Indicator System (version 1.0) are:

- To clearly delineate the dimensions of quality that must be addressed by the Public Mental Health System as reflected in the Mission statements from Delivering the Promise and the needs and concerns expressed by consumers and the citizens of Michigan. Those domains are: ACCESS, EFFICIENCY, and OUTCOME.
- To develop a state-wide aggregate status report to address issues of public accountability for the public mental health system (including appropriation boilerplate requirements of the legislature, legal commitments under the Michigan Mental Health Code, etc.)
- To provide a data-based mechanism to assist MDHHS in the management of PIHP contracts that would impact the quality of the service delivery system statewide.
- To the extent possible, facilitate the development and implementation of local quality improvement systems; and

- To link with existing health care planning efforts and to establish a foundation for future quality improvement monitoring within a managed health care system for the consumers of public mental health services in the state of Michigan.

All of the indicators here are measures of PIHP performance. Therefore, performance indicators should be reported by the PIHP for all the Medicaid beneficiaries for whom it is responsible. Medicaid beneficiaries who are not receiving specialty services and supports (1915(b)(c) waivers) but are provided outpatient services through contracts with Medicaid Health Plans, or sub-contracts with entities that contract with Medicaid Health Plans are not covered by the performance indicator requirements.

Due dates for indicators vary and can be found on the table following the list of indicators. Instructions and reporting tables are located in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by MDHHS six weeks prior to the due date and also available on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html . ~~www.michigan.gov/mdhhs. Click on Mental Health and Substance Abuse, then Reporting Requirements.~~

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**

2. The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SUD). **Standard = 95% in 14 days.**

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults, DD children, and Medicaid SUD) **Standard = 95% in 14 days**

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults (MI, DD) and all Medicaid SUD (sub-acute de-tox discharges) **Standard = 95% in seven days**

5. The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SUD)

ADEQUACY/APPROPRIATENESS

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

EFFICIENCY

7. The percent of total expenditures spent on managed care administrative functions for PIHPs.

OUTCOMES

8. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who are in competitive employment.

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who earn state minimum wage or more from employment activities (competitive, self-employment, or sheltered workshop).

10. The percent of children and adults with MI and DD readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.

12. The percent of adults with developmental disabilities served, who live in a private residence alone, or with spouse or non-relative.

13. The percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative.

14. The percent of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and respite.

Note: Indicators #2, 3, 4, and 5 include Medicaid beneficiaries who receive substance use disorder services managed by the PIHP.

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
5. Medicaid penetration*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
6. HSW services*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
7. Admin. Costs*	10/01 to 9/30	1/31							MDHHS
8. Competitive employment*	10/01 to 9/30								MDHHS
9. Minimum wage*	10/01 to 9/30								MDHHS
10. Readmissions	10/01 to 9/30	3/31	1/01 to 3/31	6/30	4-01 to 6-30	9/30	7/01 to 9/30	12/31	PIHPs
11. RR complaints	10/01 to 9/30	12/31							PIHPs
12. & 13. Living arrangements	10/1 to 9/30	N/A							MDHHS
14. Children with DD	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS

*Indicators with * mean MDHHS collects data from encounters, quality improvement or cost reports and calculates performance indicators

STATE LEVEL DATA COLLECTION

~~CONSUMER SATISFACTION SURVEY~~

~~**Adults with Serious Mental Illness & Children with Serious Emotional Disturbance**~~
~~-An annual survey using MHSIP 44 items for adults with MI and SUD, and MHSIP Youth and Family survey for families of children with SED will be conducted. Surveys are available on the MHSIP web site and have been translated into several languages. See www.mhsip.org/surveylink.htm~~
~~-The PIHPs will conduct the survey in the month of May for all people (regardless of medical assistance eligibility) currently receiving services in specific programs.~~
~~-Programs to be selected annually by QIC based on volume of units, expenditures, complaints and site review information.~~
~~-The raw data is due August 31st to MDHHS each year on an Excel template to be provided by MDHHS~~[WL(2)].

CRITICAL INCIDENT REPORTING

PIHPs will report the following events, except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on consumer ID, event date, and event type:

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- **Non-suicide death** for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.
- **Emergency Medical treatment due to Injury or Medication Error** for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.

- **Hospitalization due to Injury or Medication Error** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- **Arrest of Consumer** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

Methodology and instructions for reporting are posted on the MDHHS web site at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html. ~~www.michigan.gov/mdhhs. Click on Mental Health and Substance Abuse, then "Reporting Requirements"~~

EVENT NOTIFICATION

The PIHP shall immediately notify MDHHS of the following events:

1. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:
    a. Name of beneficiary
    b. Beneficiary ID number (Medicaid, MiChild)
    c. Consumer I (CONID) if there is no beneficiary ID number
    d. Date, time and place of death (if a licensed foster care facility, include the license #)
    e. Preliminary cause of death
    f. Contact person's name and E-mail address
2. Relocation of a consumer's placement due to licensing suspension or revocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

Except for deaths, notification of the remaining events shall be made ~~telephonically or other forms of communication~~ within five (5) business days to contract management staff members in

MDHHS's Behavioral Health and Developmental Disabilities Administration (email: MDHHS-BHDDA-Contracts-MGMT@michigan.gov; FAX: (517) 335-5376; or phone: (517) 241-2139).

NOTIFICATION OF PROVIDER NETWORK CHANGES

The PIHP shall notify MDHHS within seven (7) days of any changes to the composition of the provider network organizations that negatively affect access to care. PIHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDHHS determines to negatively affect recipient access to covered services may be grounds for sanctions.