FEIN# 46-3351818
DUNS# 079148120

Manager and Location Building
John P. Duvendeck - Lewis Cass Building, 320 S. Walnut
Contract Number # MA 180000000755

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, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs

Period of Agreement:
This contract shall commence on October 1, 2018 and continue through September 30, 2019. This agreement is in full force and effect for the period specified.

Program Budget and Agreement Amount:
Total funding available for specialty supports and services is identified in the annual Legislative Appropriation for community mental health services programs. Payment to the PIHP will be paid based on the funding amount specified in Part II (A), Section 8.0 of this contract. The estimated value of this contract is contingent upon and subject to enactment of legislative appropriations and availability of funds.

The terms and conditions of this contract are those included in: (a) Part I: General Provisions, (b) Part II (A): General Statement of Work, Part II (B) SUD Statement of Work and (c) Part III: MDHHS Responsibilities, (d) all Attachments as specified in Parts I, II (A), II (B), III of the contract.

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

Signature Section:

For the Michigan Department of Health and Human Services

Christine H. Sanches, Director
Bureau of Grants & Purchasing

8.22.18
Date

For the CONTRACTOR:

Willie E Brooks
Name (print)

Signature

CEO
Title (print)

6/21/2018
Date

FEIN# 46-3351818
DUNS# 079148120

Manager and Location Building
John P. Duvendeck - Lewis Cass Building, 320 S. Walnut
Contract Number # MA 180000000755

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, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs

Period of Agreement:
This contract shall commence on October 1, 2018 and continue through September 30, 2019. This agreement is in full force and effect for the period specified.

Program Budget and Agreement Amount:
Total funding available for specialty supports and services is identified in the annual Legislative Appropriation for community mental health services programs. Payment to the PIHP will be paid based on the funding amount specified in Part II (A), Section 8.0 of this contract. The estimated value of this contract is contingent upon and subject to enactment of legislative appropriations and availability of funds.

The terms and conditions of this contract are those included in: (a) Part I: General Provisions, (b) Part II (A): General Statement of Work, Part II (B) SUD Statement of Work and (c) Part III: MDHHS Responsibilities, (d) all Attachments as specified in Parts I, II (A), II (B), III of the contract.

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

Signature Section:

For the Michigan Department of Health and Human Services

Christine H. Sanches, Director
Bureau of Grants & Purchasing

8.22.18
Date

For the CONTRACTOR:

Willie E Brooks
Name (print)

Signature

CEO
Title (print)

6/21/2018
Date

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

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, the Flint 1115 Waiver and Substance Use Disorder Community Grant Programs

Period of Agreement:
This contract shall commence on October 1, 2018 and continue through September 30, 2019. This agreement is in full force and effect for the period specified.

Program Budget and Agreement Amount:
Total funding available for specialty supports and services is identified in the annual Legislative Appropriation for community mental health services programs. Payment to the PIHP will be paid based on the funding amount specified in Part II (A), Section 8.0 of this contract. The estimated value of this contract is contingent upon and subject to enactment of legislative appropriations and availability of funds.

The terms and conditions of this contract are those included in: (a) Part I: General Provisions, (b) Part II (A): General Statement of Work, Part II (B) SUD Statement of Work and (c) Part III: MDHHS Responsibilities, (d) all Attachments as specified in Parts I, II (A), II (B), III of the contract.

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

Signature Section:

For the Michigan Department of Health and Human Services

_____ _____
Christine H. Sanches, Director Date
Bureau of Grants & Purchasing

For the CONTRACTOR:

_____ _____
Name (print) Title (print)

_____ _____
Signature Date

CONTRACT ATTACHMENTS

P.1.4.1 Technical Requirement for Behavior Treatment Plans
P.4.1.1 Access Standards
P.4.4.1.1 Person-Centered Planning Practice Guideline
P.4.7.1 Self Determination Practice & Fiscal Intermediary Guideline
P.4.7.4 Technical Requirement for SED Children
P.4.13.1 Recovery Policy & Practice Advisory
P.6.3.1. Customer Services Standards
P.6.3.1.1 Appeal and Grievance Resolution Processes Technical Requirement
P.6.3.2.1.B.i Technical Advisory for Estimated Cost of Services
P.6.3.2.1.B.ii Technical Requirement for Explanation of Benefits
P.6.4.1 Medicaid Verification Process
P.7.1.1 Credentialing and Re-Credentialing Processes
P.7.3.1 PIHP-MHP Model Agreement
P.7.3.1.1 Reciprocity Standards
P.7.7.1.1 PIHP Reporting Requirements for Medicaid Specialty Supports and Services Beneficiaries
P.7.9.1 Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans
P.7.10.2.1 Inclusion Practice Guideline
P.7.10.2.2 Housing Practice Guideline
P.7.10.2.3 Consumerism Practice Guideline
P.7.10.2.4 Personal Care in Non-Specialized
P.7.10.2.5 Family-Driven and Youth-Guided Policy & Practice Guideline
P.7.10.2.6 Employment Works! Policy
P.7.10.3.1 Jail Diversion Practice Guidelines
P.7.10.4.1 School to Community Transition Planning
P.8.0.1 Contract Financing
P.8.6.4.1 Internal Service Fund Technical Requirement
P.8.9.1 PIHP Performance Objectives
P.13.0.B Application for Participation
P.37.0.1 Procurement Technical Requirement
P.39.0.1 Compliance Examination Guidelines
P.39.0.1.1 Appeal Process for Compliance Examination Decisions
P.39.3.1. MDHHS Audit Report and Appeal Process
P.II.B.A. Substance Use Disorder Policy Manual

DEFINITIONS/EXPLANATION OF TERMS

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

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

Capitated Payments: Monthly payments based on the Capitation Rate that are payable to the PIHP by the MDHHS for the provision of Medicaid services and supports pursuant to Part II (A) Section 8.0 of this contract.

Capitation Rate: The fixed per person monthly rate payable to the PIHP by the MDHHS for each Medicaid eligible person covered by the Concurrent 1915(b)/1915(c) Waiver Program, regardless of whether or not the individual who is eligible for Medicaid receives covered specialty services and supports during the month. There is a separate, fixed per person monthly rate payable for each eligible person covered by the Healthy Michigan Program. The capitated rate does not include funding for beneficiaries enrolled in the Medicaid 1915(c) Children's Waiver, children enrolled in Michigan's separate health insurance program (MiChild) under Title XXI of the Social Security Act.

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

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

Contractor: See PIHP.

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

Customer: In this contract, customer includes all Medicaid eligible individuals located in the defined service area who are receiving or may potentially receive covered services and supports. The following terms may be used within this definition: clients, recipients, enrollees, beneficiaries, consumers, individuals, persons served, Medicaid Eligible.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): EPSDT is Medicaid's comprehensive and preventive child health program for beneficiaries under age 21.

Health Care Professional: A physician or any of the following: podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), registered/certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

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

The Act provides for improved portability of health benefits and enables better defense against abuse and fraud, reduces administrative costs by standardizing format of specific healthcare information to facilitate electronic claims, directly addresses confidentiality and security of patient information - electronic and paper. HIPAA was amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), as set forth in Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009. The United States Department of Health and Human Services (DHHS) promulgated administrative rules to implement HIPAA and HITECH, which are found at 45 C.F.R. Part 160 and Subpart E of Part 164 (the "Privacy Rule"), 45 C.F.R. Part 162 (the "Transaction Rule"), 45 C.F.R. Part 160 and Subpart C of Part 164 (the "Security Rule"), 45 C.F.R. Part 160 and Subpart D of Part 164 (the "Breach Notification Rule") and 45 C.F.R. Part 160, subpart C (the "enforcement Rule"). DHHS also issued guidance pursuant to HITECH and intends to issue additional guidance on various aspects of HIPAA and HITECH compliance. Throughout this contract, the term "HIPAA" includes HITECH and all DHHS implementing regulations and guidance.

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

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

Intellectual/Developmental Disability: As described in Section 330.1100a of the Michigan Mental Health Code.

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

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

Michigan Medicaid Provider Manual-Mental Health/Substance Abuse Chapter: The Michigan Department of Health and Human Services periodically issues notices of proposed policy for the Medicaid program. Once a policy is final, MDHHS issues policy bulletins that explain the new policy and give its effective date. These documents represent official Medicaid policy and are included in the Michigan Medicaid Provider Manual: Mental Health Substance Abuse section.

Per Eligible Per Month (PEPM): A fixed monthly rate per Medicaid eligible person payable to the PIHP by the MDHHS for provision of Medicaid services defined within this contract.

Persons with Limited English Proficiency (LEP): Individuals who cannot speak, write, read or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies.

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

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

Prepaid Inpatient Health Plan (PIHP): In Michigan and for the purposes of this contract, a PIHP is defined as 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. (In Medicaid regulations Part 438., Prepaid Health Plans (PHPs) that are responsible for inpatient services as part of a benefit package are now referred to as "PIHP" 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. "

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 MHDDS 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.

Regional Entity: An entity established by a combination of community mental health services programs under section 204b of the Michigan Mental Health Code- Act 258 of 1974 as amended.

Sentinel Events: Is an "unexpected occurrence" involving death (not due to the natural course of a health condition) or serious physical or psychological injury or risk thereof. Serious injury specifically includes permanent loss of limb or function. The phrase "or risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome. (JCAHO, 1998) Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

Serious Emotional Disturbance: As described in Section 330.1100c of the Michigan Mental Health Code, a serious emotional disturbance is a diagnosable mental, behavioral, or emotional

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

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

Serious Mental Illness: As described in Section 330.1100c of the Michigan Mental Health Code, a serious mental illness is 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 published by the American Psychiatric Association and approved by the MDHHS and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illness includes dementia with delusions, dementia with depressed mood, and dementia with behavioral disturbances, but does not include any other dementia unless the dementia occurs in conjunction with another diagnosable serious mental illness.

Sub-Contractor: A person, business or organization which has a contract with the PIHP to provide some portion of the work or services which the PIHP has agreed to perform within this contract.

Substance Use Disorder (SUD): The taking of alcohol or other drugs as 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.

SUD Community Grant: A combination of the federal grant received by the State from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the general fund dollars appropriated by the legislature for the prevention and treatment of SUD.

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

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

PART I: CONTRACTUAL SERVICES TERMS AND CONDITIONS
GENERAL PROVISIONS

1.0 PURPOSE

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

Under approval granted by the Centers for Medicare and Medicaid Services (CMS), MDHHS operates a Section 1915(b) Medicaid Managed Specialty Services and Support Program Waiver. Under this waiver, selected Medicaid state plan specialty services related to mental health and developmental disability services, as well as certain covered substance abuse services, have been "carved out" (removed) from Medicaid primary physical health care plans and arrangements. The 1915(b) Specialty Services Waiver Program operates in conjunction with Michigan's existing 1915(c) Habilitation Supports Waiver for persons with developmental disabilities. From the Healthy Michigan Amendment: In addition, CMS has approved an 1115 Demonstration project titled the Healthy Michigan Plan which provides health care coverage for adults who become eligible for Medicaid under section 1902(2) (10)(A)(i)(VIII) of the Social Security Act. Such arrangements have been designated as "Concurrent 1915(b)/(c)" Programs by CMS. In Michigan, the Concurrent 1915(b)/(c) Programs and the Healthy Michigan Plan are managed on a shared risk basis by specialty Prepaid Inpatient Health Plans (PIHPs), selected through the Application for Participation (AFP) process. Further, under the approval of SAMHSA, MDHHS operates a SUD prevention and treatment program under the SUD Community Grant.

The purpose of this contract is to obtain the services of the selected PIHP to manage the Concurrent 1915(b)/(c) Programs, the Healthy Michigan Plan and SUD Community Grant Programs, and relevant I Waivers in a designated services area and to provide a comprehensive array of specialty mental health and substance abuse services and supports as indicated in this contract. The PIHP shall manage its responsibilities in a manner that promotes maximum value, efficiency and effectiveness consistent with state and federal statute and applicable waiver standards. These values include limiting managed care administrative duplication thereby reducing avoidable costs while maximizing the medical loss ratio. The PIHP shall actively manage behavioral health services throughout its service area using standardized methods and measures for determination of need and appropriate delivery of service. The PIHP shall ensure that cost variances in services are supported by quantifiable measures of need to ensure accountability, value and efficiency. The PIHP shall minimize duplication of contracts and reviews for providers contracting with multiple CMHSPs in a region.

This contract is a cost reimbursement contract under OMB Circular A-2 CFR 200 Subpart E Cost Principles. It is therefore subject to compliance with the principles and standards of OMB Circular 2 CFR 200 Subpart E for determining costs for Federal awards carried out through cost reimbursement contracts, and other agreements with State and local governments and federally recognized Indian tribal governments (governmental units).

2.0 ISSUING OFFICE

This contract is issued by the Michigan Department of Health and Human Services (MDHHS). The MDHHS is the sole point of contact regarding all procurement and contractual matters relating to the services described herein. MDHHS is the only entity authorized to change,

modify, amend, clarify, or otherwise alter the specifications, terms, and conditions of this contract. Inquiries and requests concerning the terms and conditions of this contract, including requests for amendment, shall be directed by the PIHP to the attention of the Director of MDHHS's Bureau of State Hospitals and Behavioral Health Administrative Operations Mental Health and Substance Abuse Services and by the MDHHS to the contracting organization's Executive Director.

3.0 CONTRACT ADMINISTRATOR

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

Thomas R. Renwick, Director
Bureau of Community Based Services
Department of Health and Human Services
5th Floor – Lewis Cass Building
320 South Walnut Street
Lansing, Michigan 48913

4.0 TERM OF CONTRACT

The term of this contract shall be from October 1, 2018 through September 30, 2019. The contract may be extended in increments no longer than 12 months, contingent upon mutual agreement to an amendment to the financial obligations reflected in Attachment P 8.4.1, and other changes required by the department. No more than three (3) one-year extensions after September 30, 2019 shall occur. Fiscal year payments are contingent upon and subject to enactment of legislative appropriations.

5.0 PAYMENT METHODOLOGY

The financing specifications are provided in Part II, Section 8.0 "Contract Financing" and estimated payments are described in Attachment P 8.4.1 to this contract. The Contractor is required by PA 533 of 2004 to receive payments by electronic funds transfer. The payment methodology for SUD Community Grant services is addressed in Part II (B), SUD Services.

6.0 LIABILITY

6.1 Liability: Cost

The MDHHS assumes no responsibility or liability for costs under this contract incurred by the PIHP prior to October 1, 2018. Total liability of the MDHHS is limited to the terms and conditions of this contract.

6.2 Liability: Contract

A. All liability, loss, or damage as a result of claims, demands, costs, or judgments arising out of activities to be carried out pursuant to the obligation of the PIHP under this contract shall be the responsibility of the PIHP, and not the responsibility of the MDHHS, if the liability, loss, or damage is caused by, or arises out of, the actions or failure to act on the part of the PIHP, its employees, officers or agent. Nothing herein shall be

construed as a waiver of any governmental immunity for the county(ies), the PIHP, its agencies or employees as provided by statute or modified by court decisions.

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

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

7.0 PIHP RESPONSIBILITIES

The PIHP shall be responsible for the operation of the Concurrent 1915(b)/(c), SUD Community Grant, the Healthy Michigan Plan, the Autism Program, and other public funding within its designated service area. Operation of the Concurrent 1915(b)/(c) Program must conform to regulations applicable to the concurrent program and to each (i.e., 1915(b) and 1915 (c) and 1115) Waiver. The PIHP shall also be responsible for development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract. If the PIHP elects to subcontract, the PIHP shall comply with applicable provisions of federal procurement requirements, as specified in Attachment P 37.0.1, except as waived for CMHSPs in the 1915(b) Waiver. The PIHP is responsible for complying with all reporting requirements as specified in Part II, Section 7.7.1 of the contract and the finance reporting requirements specified in Part II, Section 8.7. Additional requirements are identified in Attachment P 8.9.1 (Performance Objectives).

7.1 PIHP Governance and Board Requirements

For the purposes of this contract, the designation as a PIHP applies to single county Community Mental Health Service Programs or regional entities (organized under Section 1204b of the Mental Health Code or Urban Cooperation Act) serving the PIHP regions as defined by MDHHS. The PIHP must either be a single county CMHSP, or a regional entity jointly and representatively governed by all CMHSPs in the region pursuant to Section 204 or 205 of Act 258 of the Public Acts of 1974, as amended in the Mental Health Code.

7.2 PIHP Substance Use Disorder Oversight Policy Board

The PIHP shall establish a SUD Oversight Policy Board by October 1, 2014, through a contractual arrangement with the PIHP and each of the counties served under appropriate state law. The SUD Oversight Policy Boards shall include the members called for in the establishing agreement, but shall have at least one board member appointed by the County Board of Commissioners for each county served by the PIHP.

7.3 PIHP Reciprocity Standards

The PIHP shall be responsible for the Reciprocity Standards policy. See attachment P7.3.1.1.

8.0 PUBLICATION RIGHTS

When applicable, all of the following standards apply regarding the Publication Rights of MDHHS and the PIHP;

1. Where the Contractor exclusively develops books, films, or other such copyrightable materials through activities supported by this agreement, the Contractor may copyright those materials. The materials that the Contractor copyrights cannot include service recipient information or personal identification data. Contractor grants the Department a royalty-free, non-exclusive and irrevocable license to reproduce, publish and use such materials and authorizes others to reproduce and use such materials.
2. Any materials copyrighted by the Contractor or modifications bearing acknowledgment of the Department's name must be approved by the Department before reproduction and use of such materials. The State of Michigan may modify the material copyrighted by the Contractor and may combine it with other copyrightable intellectual property to form a derivative work. The State of Michigan will own and hold all copyright and other intellectual property rights in any such derivative work, excluding any rights or interest granted in this agreement to the Contractor. If the Contractor ceases to conduct business for any reason, or ceases to support the copyrightable materials developed under this agreement, the State of Michigan has the right to convert its licenses into transferable licenses to the extent consistent with any applicable obligations the Contractor has to the federal government.
3. The Contractor shall give recognition to the Department in any and all publications papers and presentations arising from the program and service contract herein: the Department will do likewise.
4. The Contractor must notify the Department's Grants and Purchasing Division 30 days before applying to register a copyright with the U.S. Copyright Office. The Contractor must submit an annual report for all copyrighted materials developed by the Contractor through activities supported by this agreement and must submit a final invention statement and certification within 90 days of the end of the agreement period.

9.0 DISCLOSURE

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

10.0 CONTRACT INVOICING AND PAYMENT

MDHHS funding obligated through this contract is Medicaid capitation payments. Detail regarding the MDHHS financing obligation is specified in Part II, Section 8.0 of this contract and in Attachment P 8.0.1 to this contract.

11.0 MODIFICATIONS, CONSENTS AND APPROVALS

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

12.0 SUCCESSOR

Any successor to the PIHP must be prior approved by the MDHHS. Such approval or disapproval shall be the sole discretion of the MDHHS.

13.0 ENTIRE AGREEMENT

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

A. This contract including attachments and appendices
B. The standards as contained in the 2013 Application for Participation as they pertain to the provision of specialty services to Medicaid beneficiaries and the implementation plans submitted and approved by MDHHS and any stated conditions, as reflected in the MDHHS approval of the application unless prohibited by federal or state law
C. SUD Administrative Rules:
    a. Program Match Requirements, R 325.4151 - 325.4156
    b. Substance Use Disorders Service Program, R 325.14101 - 325.14125
    c. Licensing of Substance Use Disorder Programs, R 325.14201 - 325.14214
    d. Recipient Rights, R 325.14301 - 325.14306
    e. Methadone Treatment and Other Chemotherapy, R 325.14401 - 325.14423
    f. Prevention, R 325.14501 - 325.14530
    g. Case-finding, R 325.14601 - 325.14623
    h. Outpatient Programs, R 325.14701 - 325.14712
    i. Inpatient Programs, R 325.14801 - 325.14807
    j. Residential Program, R 325.14901 - 325.14928
D. Michigan Mental Health Code and Administrative Rules
E. Michigan Public Health Code and Administrative Rules
F. Approved Medicaid Waivers and corresponding CMS conditions, including 1915(b), (c) and 1115 Demonstration Waivers
G. MDHHS Appropriations Acts in effect during the contract period
H. Balanced Budget Act of 1997 (BBA) final rule effective 42 CFR Part 438 effective June 14, 2002All other applicable pertinent Federal, State and local Statutes, Rules and Regulations
I. All final MDHHS guidelines, and final technical requirements, as referenced in the contract. Additional guidelines and technical requirements must be added as provided for in Part 1, Section 11.0 of this contract
J. Michigan Medicaid Provider Manual
K. MSA Policy Bulletin Number: MSA 13-09

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

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

14.0 LITIGATION

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

agree to make all reasonable efforts to cooperate with each other in the defense of any litigation brought by any person or people not a party to the contract.

The PIHP shall submit annual litigation reports providing the following detail for all civil litigation, relevant to this contract that the PIHP is party to. Reports must include the following details:

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

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

15.0 CANCELLATION

The MDHHS may cancel this contract for material default of the PIHP. Material default is defined as the substantial failure of the PIHP to fulfill the obligations of this contract, or the standards promulgated by the department pursuant to P.A. 597 of the Public Acts of 2002 (MCL 330.1232b). In case of material default by the PIHP, the MDHHS may cancel this contract without further liability to the State, its departments, agencies, and employees, and procure services from other PIHPs.

In canceling this contract for material default, the MDHHS shall provide written notification at least thirty (30) days prior to the cancellation date of the MDHHS intent to cancel this contract to the PIHP and the relevant Governing Board. The PIHP may correct the problem during the thirty (30) day interval, in which case cancellation shall not occur. In the event that this contract is canceled, the PIHP shall cooperate with the MDHHS to implement a transition plan for recipients. The MDHHS shall have the sole authority for approving the adequacy of the transition plan, including providing for the financing of said plan, with the PIHP responsible for providing the required local match funding. The transition plan shall set forth the process and time frame for the transition. The PIHP will assure continuity of care for all people being served under this contract until all service recipients are being served under the jurisdiction of another contractor selected by MDHHS. The PIHP will cooperate with MDHHS in developing a transition plan for the provision of services during the transition period following the end of this contract, including the systematic transfer of each recipient and clinical records from the PIHP's responsibility to the new contractor.

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

16.0 CLOSEOUT

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

1. Within 45 days (interim), and 90 days (final), following the end date imposed under Section 12.0, the PIHP shall provide to MDHHS, all financial, performance, and other reports required by this contract.
2. Payment for any and all valid claims for services rendered to covered recipients prior to the effective end date shall be the PIHP's responsibility, and not the responsibility of the MDHHS.

3. The portion of all reserve accounts accumulated by the PIHP that were funded with MDHHS funds and related interest are owed to MDHHS within 90 days, less amounts needed to cover outstanding claims or liabilities, unless otherwise directed in writing by MDHHS.
4. Reconciliation of equipment with a value exceeding $5,000, purchased by the PIHP or its provider network with funds provided under this contract, since January 1, 2015 will occur as part of settlement of this contract. The PIHP will submit to the MDHHS an inventory of equipment meeting the above specifications within 45 days of the end date. The inventory listing must identify the current value and proportion of Medicaid funds used to purchase each item, and also whether or not the equipment is required by the PIHP as part of continued service provision to the continuing service population. MDHHS will provide written notice within 90 days or less of any needed settlements concerning the portion of funds ending. If the PIHP disposes of the equipment, the appropriate portion of the value must be returned to MDHHS (or used to offset costs in the final financial report). See Attachment P7.7.1.1 PIHP Reporting.
5. All earned carry-forward funds and savings from prior fiscal years that remain unspent as of the end date, must be returned to MDHHS within 90 days. No carry-forward funds or savings as provided in section 8.6.2, can be earned during the year this contract ends, unless specifically authorized in writing by the MDHHS.
6. All financial, administrative, and clinical records under the PIHP's responsibility must be retained according to the retention schedules in place by the Department of Management and Budget's (DTMB) General Schedule #20 at: http://michigan.gov/dmb/0,4568,7-150-9141_21738_31548-56101--,00.html unless these records are transferred to a successor organization or the PIHP is directed otherwise in writing by MDHHS.

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

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

17.0 CONFIDENTIALITY

MDHHS and the PIHP shall maintain the confidentiality, security and integrity of beneficiary information that is used in connection with the performance of this contract to the extent and under the conditions specified in HIPAA, the Michigan Mental Health Code (PA 258 of 1974, as amended), the Michigan Public Health Code (PA 368 of 1978 as amended), and 42 C.F.R. Part 2.

18.0 ASSURANCES

The following assurances are hereby given to the MDHHS:

18.1 Compliance with Applicable Laws

The PIHP shall comply with all federal, state and local laws, and require that all PIHPs 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. Statutory and regulatory provisions related to Title XXI (The Children's Health Insurance Program) are applicable to

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.

In addition, the PIHP's Substance Use Disorder service delivery system shall comply with:

1. The Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse;
2. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616) as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism;
3. §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee 3), as amended, relating to confidentiality of alcohol and drug abuse patient records
4. Any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and,
5. The requirements of any other nondiscrimination statute(s) which may apply to the application.

18.1.1 Anti-Lobbying Act

The PIHP will comply with the Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq, and Section 503 of the Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act (Public Law 104-209). Further, the PIHP shall require that the language of this assurance be included in the award documents of all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

18.1.2 Non-Discrimination

In the performance of any contract or purchase order resulting here from, the PIHP agrees not to discriminate against any employee or applicant for employment or service delivery and access, with respect to their hire, tenure, terms, conditions or privileges of employment, programs and services provided or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. The PIHP further agrees that every subcontract entered into for the performance of any contract or purchase order resulting here from will contain a provision requiring non-discrimination in employment, service delivery and access, as herein specified binding upon each subcontractor. This covenant is required pursuant to the Elliot Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.2201 et seq. and the Persons with Disabilities Civil Rights Act, 1976 PA 220, as amended, MCL 37.1101 et seq. and Section 504 of the Federal Rehabilitation Act 1973, PL 93-112, 87 Stat. 394, and any breach thereof may be regarded as a material breach of the contract or purchase order.

Additionally, assurance is given to the MDHHS that pro-active efforts will be made to identify and encourage the participation of minority-owned, women-owned, and handicapper-owned businesses in contract solicitations. The PIHP shall incorporate language in all contracts

awarded: (1) prohibiting discrimination against minority-owned, women-owned, and handicapper-owned businesses in subcontracting; and (2) making discrimination a material breach of contract.

18.1.3 Debarment and Suspension

Assurance is hereby given to the MDHHS that the PIHP will comply with Federal Regulation 45 CFR Part 76 and certifies to the best of its knowledge and belief that it, including its employees and subcontractors:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or PIHP;
2. Have not within a three-year period preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
3. Are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state or local) with commission of any of the offenses enumerated in section 2, and;
4. Have not within a three-year period preceding this agreement had one or more public transactions (federal, state or local) terminated for cause or default.

18.1.4 Pro-Children Act

Assurance is hereby given to the MDHHS that the PIHP will comply with Public Law 103-227, also known as the Pro-Children Act of 1994, 20 USC 6081 et seq, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The PIHP also assures that this language will be included in any sub-awards that contain provisions for children's services.

The PIHP also assures, in addition to compliance with Public Law 103-227, any service or activity funded in whole or in part through this agreement will be delivered in a smoke-free facility or environment. Smoking shall not permitted anywhere in the facility, or those parts of the facility under the control of the PIHP. If activities or services are delivered in residential facilities or in facilities or areas that are not under the control of the PIHP (e.g., a mall, residential facilities or private residence, restaurant or private work site), the activities or services shall be smoke free.

18.1.5 Hatch Political Activity Act and Intergovernmental Personnel Act

The PIHP will comply with the Hatch Political Activity Act, 5 USC 1501-1509, and 7324-7328, and the Intergovernmental Personnel Act of 1970, as amended by Title VI of the Civil Service Reform Act, Public Law 95-454, 42 USC 4728 - 4763. Federal funds cannot be used for partisan political purposes of any kind by any person or organization involved in the administration of federally assisted programs.

18.1.6 Limited English Proficiency

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

18.1.7 Health Insurance Portability and Accountability Act and 42 CFR PART 2

To the extent that MDHHS and PIHP are HIPAA Covered Entities and/or Programs under 42 CFR Part 2, each agrees that it will comply with HIPAA's Privacy Rule, Security Rule, Transaction and Code Set Rule and Breach Notification Rule and 42 CFR Part 2 (as now existing and as may be later amended) with respect to all Protected Health Information and substance use disorder treatment information that it generates, receives, maintains, uses, discloses or transmits in the performance of its functions pursuant to this Agreement. To the extent that PIHP determines that it is a HIPAA Business Associate of MDHHS and/or a Qualified Service Organization of MDHHS, then MDHHS and PIHP shall enter into a HIPAA Business Associate Agreement and a Qualified Service Organization Agreement that complies with applicable laws and is in a form acceptable to both MDHHS and PIHP.

1. The PIHP must not share any protected health data and information provided by the Department that falls within HIPAA requirements except as permitted or required by applicable law; or to a subcontractor as appropriate under this agreement.

2. The PIHP will ensure that any subcontractor will have the same obligations as the Contractor not to share any protected health data and information from the Department that falls under HIPAA requirements in the terms and conditions of the subcontract.

3. The PIHP must only use the protected health data and information for the purposes of this agreement.

4. The PIHP must have written policies and procedures addressing the use of protected health data and information that falls under the HIPAA requirements. The policies and procedures must meet all applicable federal and state requirements including the HIPAA regulations. These policies and procedures must include restricting access to the protected health data and information by the Contractor's employees.

5. The PIHP must have a policy and procedure to immediately report to the Department any suspected or confirmed unauthorized use or disclosure of protected health data and information that falls under the HIPAA requirements of which the Contractor becomes aware. The Contractor will work with the Department to mitigate the breach, and will provide assurances to the Department of corrective actions to prevent further unauthorized uses or disclosures.

6. Failure to comply with any of these contractual requirements may result in the termination of this agreement in accordance with Part I, Section 15.0 Cancellation. In accordance with HIPAA

requirements, the Contractor is liable for any claim, loss or damage relating to unauthorized use or disclosure of protected health data and information by the Contractor received from the Department or any other source.

7. The PIHP will enter into a business associate agreement should the Department determine such an agreement is required under HIPAA.

8. All recipient information, medical records, data and data elements collected, maintained, or used in the administration of this contract shall be protected by the PIHP from unauthorized disclosure as required by state and federal regulations. The PIHP must provide safeguards that restrict the use or disclosure of information concerning recipients to purposes directly connected with its administration of the contract.

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

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

18.1.8 Byrd Anti-Lobbying Amendment

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

18.1.9 Davis-Bacon Act

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

18.1.10 Contract Work Hours and Safety Standards

(All contracts in excess of $2,000 for construction and $2,500 employing mechanics or laborers). (40 U.S.C. 327 - 333) -- Where applicable, all contracts awarded by recipients in excess of $2,000 for construction contracts and in excess of $2,500 for other contracts that involve the employment of mechanics or laborers shall include a provision for compliance with Section 102 and 107 of the Contract Work Hours and Safety Standards Act (40 U.S.C. 327 - 333), as

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

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

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

18.1.13 HCBS Transition Implementation
The PIHPs and their provider network will work with MDHHS to assure full compliance with the Home and Community Based Setting requirements for CMS approved Medicaid Authorities and the state's approved transition plan no later than March 2019 as required by the rule. Activities to include but not limited to, complete survey process, review data collected from survey, notify providers of corrective action, collect corrective action, approve corrective action and resurvey to assure both initial and ongoing compliance.

Effective October 1, 2018, the PIHP will not enter into new contracts with new providers of services covered by the Federal HCBS Rule (42 CFR Parts 430,431, 435, 436, 440, 441 and 447) unless the provider has obtained provisional approval status through completion of the HCBS New Provider Survey, demonstrating that the provider does not require heightened scrutiny. Provisional approval allows a new provider or an existing provider with a new setting or service to provide services to HCBS participants for 90 days. Providers and participants will receive the comprehensive HCBS survey within 90 days of the individuals IPOS. Providers will complete the HCBS survey and cooperate with the PIHP to demonstrate 100% compliance with the Federal HCBS rule and State requirements as promulgated by the Michigan Department of Health and Human Services and documented in the Michigan Statewide Transition Plan. Failure to complete the provisional approval process and the ongoing approval process will result in the exclusion from participating in Medicaid or Healthy Michigan Plan funded HCBS services.

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.

19.0 DISPUTE RESOLUTION

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

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

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

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

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

20.0 NO WAIVER OF DEFAULT

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

21.0 SEVERABILITY

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

22.0 DISCLAIMER

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

23.0 RELATIONSHIP OF THE PARTIES (INDEPENDENT CONTRACTOR)

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

24.0 NOTICES

Any notice given to a party under this contract must be written and shall be deemed effective, if addressed to such party at the address indicated on the signature page and Section 3.0 of this contract upon (a) delivery, if hand delivered; (b) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (c) the third (3rd) business day after being sent by U.S. mail, postage prepaid, return receipt requested; or (d) the next business day after being sent by a nationally recognized overnight express courier with a reliable tracking system. Either party may change its address where notices are to be sent by giving written notice in accordance with this section.

25.0 UNFAIR LABOR PRACTICES

Pursuant to 1980 PA 278, as amended, MCL 423.321 et seq., the State shall not award a contract or subcontract to an employer or any subcontractor, manufacturer or supplier of the employer, whose name appears in the current register compiled by the Michigan Department of Licensing and Regulatory Affairs. The State may void any contract if, subsequent to award of the contract, the name of the PIHP as an employer, or the name of the subcontractor, manufacturer or supplier of the PIHP appears in the register.

26.0 SURVIVOR

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

27.0 GOVERNING LAW

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

28.0 MEDIA CAMPAIGNS

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media. Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. Any media campaigns funded through Substance Use Disorder Community Grant funds must be compatible with MDHHS values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. The PIHP shall not finance any media campaign using Department-administered funding without prior written approval by the Department.

29.0 ETHICAL CONDUCT

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

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

30.0 CONFLICT OF INTEREST

The PIHP and MDHHS are subject to the federal and state conflict of interest statutes and regulations that apply to the PIHP under this contract, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. §423): 18 U.S.C. §207)): 18 U.S.C. §208: 42 CFR §438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222.

31.0 HUMAN SUBJECT RESEARCH

The PIHP will comply with Protection of Human Subjects Act, 45 CFR, Part 46, subpart A, sections 46.101-124 and HIPAA. The PIHP agrees that prior to the initiation of the research, the PIHP will submit institutional Review Board (IRB) application material for all research involving human subjects, which is conducted in programs sponsored by the Department or in programs which receive funding from or through the State of Michigan, to the Department's IRB for review and approval, or the IRB application and approval materials for acceptance of the review of another IRB. All such research must be approved by a federally assured IRB, but the Department's IRB can only accept the review and approval of another institution's IRB under a formally-approved interdepartmental agreement. The manner of the review will be agreed upon between the Department's IRB Chairperson and the Contractor's IRB Chairperson or Executive Officer(s).

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.

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).

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

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

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

a. Excluded individuals cannot be a director, officer, or partner of the PIHP:
b. Excluded individuals cannot have a beneficial ownership of five percent or more of the PIHP's equity: and
c. 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.

34.1 PIHP Responsibilities for Monitoring Ownership and Control Interests Within Their Provider Networks

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

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

34.2 PIHP Responsibility for Disclosing Criminal Convictions

PIHPs are required to promptly notify the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS if:

- **a.** Any disclosures are made by providers with regard to the ownership or control by a person that has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. (See42 CFR 1001.1001(a)(1): or
- **b.** Any staff member, director, or manager of the PIHP, individual with beneficial ownership of five percent or more, or an individual with an employment, consulting, or other arrangement with the PIHP has been convicted of a criminal offense described under sections 1128(a) and 1128(b)(1), (2), or (3) of the Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. (See 42 CFR 1001.1001(a)(1))

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

34.3 PIHP Responsibility for Notifying MDHHS of Administrative Actions That Could Lead to Formal Exclusion

The PIHP must promptly notify the Division of Program Development, Consultation and Contracts, Behavioral Health and Developmental Disabilities Administration in MDHHS if it has taken any administrative action that limits a provider's participation in the Medicaid program, including any provider entity conduct that results in suspension or termination from the PIHP's provider network.

The United States General Services Administration (GSA) maintains a list of parties excluded from federal programs. The "excluded parties lists" (EPLS) and any rules and/or restrictions pertaining to the use of EPLS data can be found on GSA's web page at the following internet address: http://exclusions.oig.hhs.gov. The state sanctioned list is at: www.michigan.gov/medicaidproviders click on Billing and Reimbursement, click on List of Sanctioned Providers. Both lists must be regularly checked.

35.0 PUBLIC HEALTH REPORTING

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

36.0 MEDICAID POLICY

PIHPs shall comply with provisions of Medicaid policy developed under the formal policy consultation process, as established by the Medical Assistance Program.

37.0 PROVIDER PROCUREMENT

The PIHP is responsible for the development of the service delivery system and the establishment of sufficient administrative capabilities to carry out the requirements and obligations of this contract. Where the PIHP and its provider network fulfill these responsibilities through subcontracts, they shall adhere to applicable provisions of federal procurement requirements as specified in Attachment P.37.0.1.

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

1. May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification;
2. Must give those providers not selected for inclusion in the network written notice of the reason for its decision;
3. Is not required to contract with providers beyond the number necessary to meet the needs of its beneficiaries, and is not precluded from using different practitioners in the same specialty. Nor is the PIHP prohibited from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to its beneficiaries. In addition, the PIHP's selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatments. Also, the PIHP must ensure that it does not

employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

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.

39.0 FISCAL AUDITS AND COMPLIANCE EXAMINATIONS

Required Audit and Compliance Examination

The PIHP shall submit to MDHHS a Single Audit or Financial Statement Audit depending on the level of Federal awards expended, and a Compliance Examination as described below. The PIHP must also submit a Corrective Action Plan for any audit or examination findings that impact MDHHS-funded programs, and the management letter (if issued) with a response.

Single Audit

PIHPs that expend $750,000 or more in Federal awards, during the PIHP's fiscal year shall submit a Single Audit to MDHHS. The Single Audit must comply with the requirements of the Single Audit Act Amendments of 1996, and 2 CFR 200, Subpart F. Also, the PIHP must comply with all requirements contained in the MDHHS Substance Abuse Prevention and Treatment Audit Guidelines, current edition, as issued by the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance.

Financial Statement Audit

PIHPs exempt from the Single Audit requirement shall submit to MDHHS a Financial Statement Audit prepared in accordance with generally accepted auditing standards (GAAS).

Compliance Examination

PIHPs shall submit a contract end date (September 30th) Compliance Examination conducted in accordance with the American Institute of CPA's (AICPA's) Statements on Standards for Attestation Engagements (SSAE) 10 - Compliance Attestation (as amended by SSAE 11, 12, and 14), and the Compliance Examination Guidelines contained in Attachment P.39.0.1.

Due Date and Where to Send

The required Single Audit or Financial Statement Audit, Compliance Examination, and any other required submissions (i.e. Corrective Action Plan and management letter with a response) must be submitted to MDHHS within 30 days after receipt of the practitioner's reports, but no later than June 30th following the contract year end by e-mail to MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in a PDF file compatible with Adobe Acrobat (read only). The subject line must state the PIHP name and fiscal year end. MDHHS reserves the right to request a hard copy of the materials if for any reason the electronic submission process is not successful.

Penalty

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

Management Decisions

MDHHS shall issue a management decision on findings, comments, and questioned costs contained in the PIHP Single Audit, Financial Statement Audit, and Compliance Examination Report. The management decision relating to the Single Audit or Financial Statement Audit will be issued within six months after the receipt of a complete and final reporting package. The management decision relating to the Compliance Examination will be issued within eight months after the receipt of a complete and final reporting package. The management decision will include whether or not the finding or comment is sustained; the reasons for the decision, and the expected PIHP 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, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the PIHP relating to MDHHS management decisions on Compliance Examination findings, comments, and disallowed costs is included in Attachment P.39.0.1.1.

Other Audits

MDHHS or federal agencies may also conduct or arrange for additional audits to meet their needs.

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.

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.

39.3 MDHHS Audits

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

PIHP's and its contract service providers' financial records, policies, contracts, and financial management practices, conducted by the MDHHS Bureau of Audit, Reimbursement, and Quality Assurance, or its agent, or by a federal agency or its agent, to verify the PIHP's compliance with legal and contractual requirements.

2. The MDHHS will schedule MDHHS audits at mutually acceptable start dates to the extent possible. The MDHHS will provide the PIHP with a list of documents to be audited at least 30 days prior to the date of the audit. An entrance meeting will be conducted with the PIHP to review the nature and scope of the audit.
3. MDHHS audits of PIHPs will generally supplement the independent auditor's Compliance Examination and may include one or more of the following objectives (The MDHHS may, however, modify its audit objectives as deemed necessary):
    a. to assess the PIHP's effectiveness and efficiency in complying with the contract and establishing and implementing specific policies and procedures as required by the contract and;
    b. to assess the PIHP's effectiveness and efficiency in reporting their financial activity to the MDHHS in accordance with contractual requirements: applicable federal, state, and local statutory requirements; Medicaid regulations; and applicable accounting standards; and
    c. to determine the MDHHS's share of costs in accordance with applicable MDHHS requirements and agreements, and any balance due to/from the PIHP.

To accomplish the above listed audit objectives, MDHHS auditors will review PIHP documentation, interview PIHP staff members, and perform other audit procedures as deemed necessary. The audit report and appeal process is identified in Attachment 39.3.1 and is a part of this contract.

PART II (A)
GENERAL STATEMENT OF WORK

1.0 SPECIFICATIONS

The following sections provide an explanation of the specifications and expectations that the PIHP must meet and the services that must be provided under the contract. The PIHP and its provider network are not, however, constrained from supplementing this with additional services or elements deemed necessary to fulfill the intent of the Managed Specialty Services and Supports Program, the Flint 1115 Waiver and SUD Community Grant.

1.1 Targeted Geographical Area for Implementation

The PIHP shall manage the Concurrent 1915(b)/(c) Program, SUD Community Grant, and the Healthy Michigan Plan under the terms of this agreement in the county(ies) of your geographic service area. These county(ies) are identified in Attachment P.8.9.1 and hereafter referred to as "service area" or exclusively as "Medicaid specialty service area."

1.2 Target Population

The PIHP shall serve Medicaid beneficiaries in the service area described in 1.1 above who require the Medicaid services included under: the 1915(b) Specialty Services Waiver; who are eligible for the Healthy Michigan Plan, the Flint 1115 Waiver or Community Block Grant, who

are enrolled in the 1915(c) Habilitation Supports Waiver; who are enrolled in the MIChild program; or for whom the PIHP has assumed or been assigned County of Financial Responsibility (COFR) status under Chapter 3 of the Mental Health Code. The PIHP shall serve individuals covered under the SUD Community Grant.

1.3 Responsibility for Payment of Authorized Services

The PIHP shall be responsible for payment for services that the PIHP authorizes, including Medicaid substance use disorder and SUD Community Grant services. This provision presumes the PIHP and its agents are fulfilling their responsibility to individuals according to terms specified in the contract.

Services shall not be delayed or denied as a result of a dispute of payment responsibility between two or more PIHPs. In the event there is an unresolved dispute between PIHPs, either one may request MDHHS involvement to resolve the dispute, and make a determination. Likewise, services shall not be delayed or denied as a result of a dispute of payment responsibility between the PIHP and another agency.

The PIHP/PIHP Designee must be contacted for authorization for post-stabilization specialty care. The PIHP is financially responsible for post-stabilization specialty care services obtained within or outside the PIHP that are pre-approved by the PIHP or the plan provider if authorization is delegated to it by the PIHP.

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

- The PIHP does not respond to a request for pre-approval within 1 hour;
- The PIHP cannot be contacted; or
- The PIHP representative and the treating physician cannot reach an agreement concerning the beneficiary's care and a PIHP physician is not available for consultation. In this situation, the PIHP must give the treating physician the opportunity to consult with a PIHP physician and the treating physician may continue with care of the patient until a PIHP physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

When the MDHHS office in the PIHP's service area places a child outside of the service area on a non-permanent basis and the child needs specialty supports and services, the PIHP retains responsibility for services unless the family relocates to another service area, in which case responsibility transfers to the PIHP where the family has relocated.

1.4 Behavior Treatment Plan Review Committee

The PIHP shall ensure that its provider network uses a specially-constituted committee, such as a behavior treatment plan review committee, to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. The Committee shall substantially incorporate the standards in Attachment P 1.4.1 Technical Requirement for Behavior Treatment Plans.

2.0 1915(b)/(c) AND HEALTHY MICHIGAN PROGRAMS

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in the Michigan Medicaid Provider Manual:-Mental Health-Substance Abuse section, mental health and intellectual/developmental disabilities services may also be

provided in other locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness.

2.1 1915(b) Services
State Plan Services: Under the 1915(b) Waiver component of the 1915(b)/(c) program, the PIHP is responsible for providing the covered services as described in the Michigan Medicaid Provider Manual: Mental Health – Substance Abuse section.

2.2 1915(b)(3) Services
As specified in the most current CMS waiver approval, the services aimed at providing a wider, more flexible, and mutually negotiated set of supports and services; that will enable individuals to exercise and experience greater choice and control will be offered under Michigan's approved 1915(b) Waiver Renewal, using the authority of Section 1915(b)(3) of Title XIX of the Social Security Act. The PIHP shall use Medicaid capitation payments to offer and provide more individualized, cost-effective supports and services, according to the beneficiary's needs and requests, in addition to provision of the state plan coverage(s) for which the beneficiary qualifies. The listing of these services, their definitions, medical necessity criteria, and amount scope and duration requirements for the 1915(b)(3) services is included in the Michigan Medicaid Provider Manual.

2.3 1915(c) Services
The PIHP is responsible for provision of certain enhanced community support services for those beneficiaries in the service areas who are enrolled in Michigan's 1915(c) Home and Community Based Services Waiver for persons with developmental disabilities. Covered services are described in the Mental Health/Substance Abuse Chapter of the Michigan Medicaid Provider Manual.

2.4 Autism Services
State Plan Services: The 1915(b) Waiver component of the 1915(b)/(c) program, the PIHP is responsible for providing the covered Autism services as described in the Michigan Medicaid Provider Manual.

2.5 Healthy Michigan Plan
The PIHP is responsible for providing the covered services described in the Mental Health/Substance Abuse Chapter of the Michigan Medicaid Provider Manual as well as the additional Substance Use Disorder services and supports described in the Medicaid Provider Manual for individuals who are eligible for the Healthy Michigan Plan.

2.6 SUD Community Grant Services
Under the State's SUD Community Grant Agreement between MDHHS and the PIHP, the PIHP is responsible for providing or arranging for the provision of SUD prevention and treatment services to eligible individuals.

2.7 MIChild
The PIHP shall also provide medically necessary defined mental health benefits to children enrolled in the MIChild program.

2.8 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 MHDDS 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.

2.9 IMD Services

The PIHP is responsible for providing the covered services in an IMD up to 15 days per month per individual.

3.0 SERVICE REQUIREMENTS

The PIHP must limit Medicaid, SUD Community Grant and MIChild services to those that are medically necessary and appropriate, and that conform to accepted standards of care. PIHPs must operate the provision of their Medicaid services consistent with the applicable sections of the Social Security Act, the Code of Federal Regulations (CFR), the CMS/HCFA State Medicaid & State Operations Manuals, Michigan's Medicaid State Plan, and the Michigan Medicaid Provider Manual: Mental Health -Substance Abuse section.

The PIHP shall provide covered state plan or 1915(c) services (for beneficiaries enrolled in the 1915(c) Habilitation Supports Waiver) in sufficient amount, duration and scope to reasonably achieve the purpose of the service. Consistent with 42 CFR 440.210 and 42 CFR 440.220, services to recipients shall not be reduced arbitrarily. Criteria for medical necessity and utilization control procedures that are consistent with the medical necessity criteria/service selection guidelines specified by MDHHS and based on practice standards may be used to place appropriate limits on a service (CFR 42 sec.440.230).

3.1 Program Operation

The PIHP shall provide the necessary administrative, professional, and technical staff for operation of the program.

3.2 Notification of Modifications

Provide timely notification to the Department, in writing, of any action by its governing board or any other funding source that would require or result in significant modification in the provision of services, funding or compliance with operational procedures.

3.3 Software Compliance

The Contractor must ensure software compliance and compatibility with the Department's data systems for services provided under this agreement including, but not limited to: stored data, databases, and interfaces for the production of work products and reports. All required data under this agreement shall be provided in an accurate and timely manner without interruption. failure or errors due to the inaccuracy of the Contractor's business operations for processing date/time data.

4.0 ACCESS ASSURANCE

4.1 Access Standards

The PIHP shall ensure timely access to supports and services in accordance with the Access Standards in Attachment P 4.1.1 and the following timeliness standards, and report its performance on the standards in accordance with Attachment P 7.7.1.1 of this contract.

4.2 Medical Necessity

The definition of medical necessity for Medicaid services is included in the Michigan Medicaid Provider Manual: Mental Health –Substance Abuse section.

4.3 Service Selection Guidelines

The criteria for service selection are included in the in the Michigan Medicaid Provider Manual: Mental Health -Substance Abuse section.

4.4 Person Centered Planning

The Michigan Mental Health Code establishes the right for all individuals to have an Individual Plan of Service (IPS) developed through a person-centered planning process (Section 712, added 1996). The PIHP shall implement person-centered planning in accordance with the MDHHS Person-Centered Planning Practice Guideline (Attachment P 4.4.1.1). This provision is not a requirement of Substance Abuse Services.

4.5 Cultural Competence

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

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

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

4.6 Early Periodic Screening, Diagnosis and Treatment (EPSDT)

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.

4.7. Self-Determination
It is the expectation that PIHPs will assure compliance among their network of service providers with the elements of the Self-Determination Policy and Practice Guideline dated 10/1/12 contract attachment 4.7.1. This provision is not a requirement of Substance Abuse Services.

4.8 Choice
In accordance with 42 CFR 438.6(m), the PIHP must assure that the beneficiary is allowed to choose his or her health care professional, i.e., physician, therapist, etc. to the extent possible and appropriate. This standard does not apply to SUD Community Grant services.

4.9 Second Opinion
If the beneficiary requests, the PIHP must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the beneficiary to obtain one outside the network, at no cost to the beneficiary. This standard does not apply to SUD Community Grant services.

4.10 Out of Network Responsibility
If the PIHP is unable to provide necessary medical services covered under the contract to a particular beneficiary the PIHP must adequately and timely cover these services out of network for the beneficiary, for as long as the entity is unable to provide them within the network. Since there is no cost to the beneficiary for the PIHP's in-network services, there may be no cost to beneficiary for medically-necessary specialty services provided out-of-network.

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

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

4.13 Recovery Policy
All Supports and Services provided to individuals with mental illness, including those with co-occurring conditions, shall be based in the principles and practices of recovery outlined in the Michigan Recovery Council document "Recovery Policy and Practice Advisory" included as Attachment P4.13.1 to this contract.

5.0 SPECIAL COVERAGE PROVISIONS

The following sub-sections describe special considerations, services, and/or funding arrangements that may be required by this contract.

5.1 Nursing Home Placements
The PIHP agrees to provide medically necessary Medicaid specialty services to facilitate placement from or to divert admissions to a nursing home, for eligible beneficiaries determined by the OBRA screening assessment to have a mental illness and/or developmental disability and in need of placement and/or services. Funding allocated for OBRA placement and for treatment services shall continue to be directed to this population.

5.2 Nursing Home Mental Health Services

Residents of nursing homes with mental health needs shall be given the same opportunity for access to PIHP services as other individuals covered by this contract.

5.3 Capitated Payments and Other Pooled Funding Arrangements

Medicaid capitation funds paid to the PIHP under the 1915(b) component of the Concurrent 1915(b)/(c) Waiver Program may be utilized for the implementation of or continuing participation in locally established multi-agency pooled funding arrangements developed to address the needs of beneficiaries served through multiple public systems. Medicaid funds supplied or expensed to such pooled funding arrangements must reflect the expected cost of covered Medicaid services for Medicaid beneficiaries participating in or referred to the multi-agency arrangement or project. Medicaid funds cannot be used to supplant or replace the service or funding obligation of other public programs.

5.4 Payments to FQHCs and RHCs

When the PIHP pays Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for specialty services included in the specialty services waivers the PIHP shall ensure that payments are no less than amounts paid to non-FQHC and RHCs for similar services. This standard does not apply to SUD Community Grant services.

5.5 Special Health Care Needs

Beneficiaries with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR 438.208(c)(4). This standard does not apply to SUD Community Grant services.

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.

6.0 PIHP ORGANIZATIONAL STRUCTURE

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

6.1 Critical Incidents

The PIHP must require all of its residential treatment providers to prepare and file critical incident reports that include the following components:

1. Provider determination whether critical incidents are sentinel events.

2. Following identification as a sentinel event, the provider must ensure that a root cause analysis or investigation takes place.
3. Based on the outcome of the analysis or investigation, the provider must ensure that a plan of action is developed and implemented to prevent further occurrence of the sentinel event. The plan must identify who is responsible for implementing the plan, and how implementation will be monitored. Alternatively, the provider may prepare a rationale for not pursuing a preventive plan.

The PIHP is responsible for oversight of the above processes.

Requirements for reporting data on Sentinel Events are contained in attachment P7.7.1.1 PIHP Reporting Requirements, via these reporting requirements are narrower in scope than the responsibility to identify and follow up on critical incidents and sentinel events.

6.2 Administrative Personnel

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

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

Administrator (Chief Executive Officer)
Medical Director

6.3 Customer Services: General

Customer Services is an identifiable function that operates to enhance the relationship between the individual and the PIHP. This includes orienting new individuals to the services and benefits available including how to access them, helping individuals with all problems and questions regarding benefits, handling individual complaints and grievances in an effective and efficient manner, and tracking and reporting patterns of problem areas for the organization. This requires a system that will be available to assist at the time the individual has a need for help, and being able to help on the first contact in most situations. Standards for customer services are in Attachment P.6.3.1.

The Customer Services Attachment to the PIHP contract requires the PIHP to provide individuals with the information outlined in 42 CFR 438.10(f)(4), which references information identified in 42 CFR 438.10 (f)(6). The information is currently required to be given out annually or sooner if substantial changes have been made. CMS has instructed the Department that 42 CFR 438.10(f)(4) requires that, if the state delegates this function, the PIHP must give each enrollee written notice of any significant change in the information specified in 438.10(f)(6) at least 30 days before the intended effective date of the change. Language regarding the 30-day timeframe will need to be added to the contract.

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

6.3.1 Recipient Rights/Grievance and Appeals

The PIHP shall adhere to the requirements stated in the MDHHS Grievance and Appeal Technical Requirement, which is an attachment to this contract (Attachment P 6.3.1.1) in addition to provisions specified in 42 CFR 438.100.

Individuals enrolled in Medicaid, Healthy Michigan and the Flint 1115 Waiver must be informed of their right to if dissatisfaction is expressed at any point during the rendering of state plan services. PIHPs must offer a local appeal process to resolve the dispute. The local process must be completed or deemed exhausted due to notice or timing requirements not being met before the MDHHS administrative hearing process is requested. The PIHP shall follow fair hearing guidelines and protocols issued by the MDHHS.

The PIHP has no responsibility to conduct oversight activity with regards to the Office of Recipient Rights (ORR) operated by CMHSPs in the PIHP's provider network. Recipient rights requirements for SUD services are specified in 2(d).

The PIHP must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

The PIHP must maintain records of grievances and appeals.

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. 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 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 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.

B. Additional Information Requirements

1. The PIHP shall ensure that beneficiaries are notified that oral interpretation is available for any language, written information is available in prevalent languages, and auxiliary aids and services are available upon request at no cost, and how to access those services. The PIHP shall also ensure that beneficiaries are notified how to access alternative formats.
2. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the PIHP region, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by § 438.71(a). Large print means printed in a font size no smaller than 18 point.

    a. The PIHP must provide the following information to all beneficiaries who receive specialty supports and services:
        i. A listing of contracted providers that identifies provider name as well as any group affiliation, locations, telephone numbers, web site URL (as appropriate), specialty (as appropriate), the provider's cultural capability, any non-English languages spoken, if the provider's office /facility has accommodations for people with physical disabilities, and whether they are accepting new beneficiaries. This includes any restrictions on the beneficiary's freedom of choice among network providers. The listing would be available in the format that is preferable to the beneficiary: written paper copy or on-line. The listing must be kept current and offered to each beneficiary annually.
        ii. Their rights and protections, as specified in "Grievance and Appeal Technical Requirement PIHP Grievance and Appeal System for Medicaid Beneficiaries."
        iii. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.
        iv. Procedures for obtaining benefits, including authorization requirements.
        v. The extent to which, and how, beneficiaries may obtain benefits and the extent to which, and how, after-hours crisis services are provided.

vi. Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost to the PIHP of each covered support and service he/she is receiving. Technical Advisory P 6.3.2.1.B.i provides principles and guidance for transmission of this information.

vii. The Contractor is required to provide Explanation of Benefits (EOBs) to 5% of the consumers receiving services. The EOB distribution must comply with all State and Federal regulations regarding release of information as directed by MDHHS. MDHHS will monitor EOB distribution annually. A model Explanation of Benefits consistent with Technical Requirement P 6.3.2.1.B.ii is attached to this contract. A PIHP may, but is not required to utilize the model template.

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

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

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

i. Information on the structure and operation of the MCO or PIHP;

ii. Upon request physician incentive plans in use by the PIHP or network providers as set forth in 42 CFR 438.6(h).

iii. The PIHP must provide information on how to contact their designated person or entity for coordination of services.

6.4 Medicaid Services Verification

PIHPs shall perform Verification of Medicaid claims in accordance with operational developments by MDHHS in collaboration with PIHPs and shall be finalized no later than September 30, 2019.

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.

7.1 Provider Credentialing

The PIHP shall have written credentialing policies and procedures for ensuring that all providers rendering services to individuals are appropriately credentialed within the state and are qualified to perform their services. Credentialing shall take place every two years. The PIHP must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state. The PIHP also must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the PIHP's standards. Reference Attachment P 7.1.1.

7.2 Collaboration with Community Agencies

PIHPs and their provider network must work closely with local public and private community-based organizations and providers to address prevalent human conditions and issues that relate to a shared customer base to provide a more holistic health care experience for the consumer. Such agencies and organizations may include local health departments, local MDHHS human service offices, Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), community and migrant health centers, nursing homes, Area Agency and Commissions on Aging, Medicaid Waiver agents for the Home Community Based Waiver (HCBW) program, school systems, and Michigan Rehabilitation Services. Local coordination and collaboration with these entities will make a wider range of essential supports and services available to the PIHP individuals. PIHPs will coordinate with these entities through participation in multi-purpose human services collaborative bodies, and other similar community groups.

The PIHP shall have a written coordination agreement with each of the pertinent agencies noted above describing the coordination arrangements agreed to and how disputes between the agencies will be resolved. To ensure that the services provided by these agencies are available to all PIHPs, an individual contractor shall not require an exclusive contract as a condition of participation with the PIHP.

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

7.3 Medicaid Health Plan (MHP) Agreements

Many Medicaid beneficiaries receiving services from the PIHP will be enrolled in a MHP for their health care services. The MHP is responsible for non-specialty level mental health services. It is therefore essential that the PIHP have a written, functioning coordination agreement with each MHP serving any part of the PIHP's service area. The written coordination agreement shall describe the coordination arrangements, inclusive of but not limited to, the exchange of information, referral procedures, care coordination and dispute resolution. At a minimum these arrangements must address the integration of physical and mental health services provided by the MHP and PIHP for the shared consumer base plans. A model coordination agreement is herein included as Attachment P 7.3.1.

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.

7.5 Health Care Practitioner Discretions

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

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

7.6 Home and Community Character

The PIHP must assure that the residential (adult foster care, specialized residential, provider owned/controlled) and non-residential services (skill building, supported employment, community living supports, prevocational, out of home non-vocational) where individuals are supported by funds from the Medicaid 1915(c) waiver programs (Habilitation Supports Waiver, Children's Waiver, and Children's SED Waiver, B Waiver) each maintains a "home and community character" as required by federal regulation and the resultant, Michigan-specific, CMS approved plan.

7.7 Management Information Systems

The PIHP shall ensure that Management Information Systems and practices have the capacity that the obligations of this contract are fulfilled by the entity and/or its subcontractors. Management information systems capabilities are necessary for at least the following areas:

1. Monthly downloads of Medicaid eligible information
2. Individual registration and demographic information
3. Provider enrollment
4. Third party liability activity
5. Claims payment system and tracking
6. Grievance and complaint tracking
7. Tracking and analyzing services and costs by population group, and special needs categories as specified by MDHHS
8. Encounter and demographic data reporting
9. Quality indicator reporting
10. HIPAA compliance
11. UBP compliance
12. Individual access and satisfaction

In addition, the PIHP shall meet the following requirements:

1. The PIHP shall utilize Benefit Enrollment and Maintenance (834) and Payment Order Remittance Advice (820) reconciliation files as the primary source for eligibility determination for PIHP functions. Eligibility Inquiry and Response (270/271) is intended as the primary tool for the CMHSP and provider system to determine eligibility, and should rarely be utilized by the PIHP.
2. A PIHP organized as a regional entity shall ensure that health plan information technology functions are clearly defined and separately contracted from any other function provided by a CMHSP. A PIHP organized as a regional entity may have a single CMHSP perform PIHP health plan information technology functions on behalf of the regional entity if each of the following requirements are met:
    a. The contract between the PIHP and the CMHSP clearly describes the CMHSP's contractual responsibility to the PIHP for the health plan information technology related functions.
    b. The contract between the PIHP and the CMHSP for PIHP health plan information technology functions shall be separate from other EHR functions performed as a CMHSP.

3. The PIHP shall analyze claims and encounter data to create information about region wide and CMHSP specific service utilization. The PIHP shall provide regular reports to each CMHSP as to how the CMHSP's individual utilization compares to the PIHP's region as a whole. The PIHP shall utilize this information to inform risk management strategies and other health plan functions.
4. The PIHP shall actively participate with the Department to develop metrics the Department will use to provide useful reports to the PIHPs, i.e., benchmarking individual PIHP's data against statewide data.
5. The PIHP shall participate with the Department and CMHSPs in activities to standardize and consistently implement encounter submissions involving County of Financial Responsibility (COFR) issues, when the CMHSP identified as the COFR is not part of the PIHP's geographic region.

7.7.1 Uniform Data and Information

To measure the PIHP's accomplishments in the areas of access to care, utilization, service outcomes, recipient satisfaction, and to provide sufficient information to track expenditures and calculate future capitation rates, the PIHP must provide the MDHHS with uniform data and information as specified by MDHHS as previously agreed, and such additional or different reporting requirements (with the exemption of those changes required by federal or state law and/or regulations) as the parties may agree upon from time to time. Any changes in the reporting requirements, required by state and federal law, will be communicated to the PIHP at least 90 days before they are effective unless state or federal law requires otherwise. Both parties must agree to other changes, beyond routine modifications, to the data reporting requirements.
The PIHP's timeliness in submitting required reports and their accuracy will be monitored by MDHHS and will be considered by MDHHS in measuring the performance of the PIHP. Regulations promulgated pursuant to the Balance Budget Act of 1997 (BBA) require that the CEO or designee certify the accuracy of the data.

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

MDHHS and the PIHPs agree to use the Encounter Data Integrity Group (EDIT) for the development of instructions with costing related to procedure codes, and the assignment of Medicaid and non-Medicaid costs. The recommendations from the EDIT group have been incorporated into the Attachment P 7.7.1.1.

7.7.2 Encounter Data Reporting

In order to assess quality of care, determine utilization patterns and access to care for various health care services, affirm capitation rate calculations and estimates, the PIHP shall submit encounter data containing detail for each recipient encounter reflecting all services provided by the PIHP. Encounter records shall be submitted monthly via electronic media in the HIPAA-compliant format specified by MDHHS. Encounter level records must have a common identifier that will allow linkage between MDHHS's and the PIHP's management information systems.

Encounter data requirements are detailed in the PIHP Reporting Requirements Attachment P.7.7.1.1 to this contract.

The following ASC X12N 837 Coordination of Benefits loops and segments are required by MDHHS for reporting services provided by and/or paid for by the PIHP and/or CMHSP.
Loop 2320 – Other Subscriber Information
SBR – Other Subscriber Information
DMG – Subscriber Demographic Information
OI – Other Insurance Coverage Information
Loop 2330A – Other Subscriber Name
NM1 – Other Subscriber Name
Loop 2330B – Other Payer Name
NM1 – Other Payer Name
REF – Other Payer Secondary Identifier
Submission of data for any other payer other than the PIHP and/or CMHSP is optional.
Reporting monetary amounts in the ASC X12N 837 version 4010 is optional.

7.7.3 Supports Intensity Scale
The PIHP will:

1. Ensure that each individual Michigan Medicaid-eligible, age 18 and older with an Intellectual/Developmental Disability, who are currently receiving case management or supports coordination or respite only services is assessed using the Supports Intensity Scale (SIS) at minimum of once every 3 years (or more or if the person experiences significant changes in their support needs). The PIHP will need to assure that a proportioned number of assessments are completed each year to assure that all are done in the 3 year cycle, which began on June 30, 2014 and the cycle concludes on September 30, 2019.
2. Ensure an adequate cadre of qualified SIS assessors across its region to ensure that all individuals are assessed in the required timeframe.
3. Be responsible to ensure an adequate cadre of recognized SIS Assessors to complete the SIS assessment for all Medicaid eligible adults with IDD within a 3 year period. Provide for an adequate number of qualified and Quality Leads to assure that all assessors continue assessments within the three year time frame. Overall, approximately 10 Quality Leads will be cultivated, one per PIHP for the 10 PIHPs. The State will provide for an initial process to offer training for one QL in each region for one year through September 30. 2016. In addition an opportunity for QL Training for new QLs will be provided and sponsored by MDHHS 2 times a year in FY2016-17.
4. Participate in the SIS Steering Committee. Each PIHP will have an identified "lead" person serve on the committee to assure two way communication between the PIHP and its designees and MDHHS.
5. Assure SIS is administered by an independent assessor free of conflict of interest.
6. Collaborate with BHDDA to plan for and participate in stakeholder SIS related informational forums
7. Collaborate with BHDDA in planning and provision of training to Supports Coordination/Care Management staff

8. SIS assessors must meet state specified required criteria including the following minimum criteria:
    a. Bachelor's Degree in human services or four years of equivalent work experience in a related field
    b. At least one year experience with individuals that have a developmental or intellectual disability
    c. Participation in a minimum of one Periodic Drift Review and one IRQR per year conducted by an AAIDD recognized SIS® Quality Lead
    d. Maintain annual Interviewer Reliability Qualification Review (IRQR) status at "Qualified" status as determined by an AAIDD recognized Quality Lead
    e. Assessors skills will be evaluated as part of quality framework that includes AAIDD/MORC-SNAC/Online reports
    f. Participate in Michigan SIS® Assessor conference calls
    g. Attend annual Michigan SIS® Assessor Continuing Education. In addition PIHPs shall provide opportunities for all SIS assessors to participate in regional support, communication, mentorship, and educational opportunities to enhance their skill.
    h. SIS Assessors must be independent from the current supports and services staff and may not report to the same department within the organization where the individual is being served. In addition, SIS Assessors will remain conflict free as evidenced by annual review and annual signing of the SIS Assessor Conflict Free Agreement.
    i. Assessors should not facilitate a SIS® interview for an individual for whom they are providing another ongoing clinical service.
    j. It is acceptable for Interviewers to contract with or be employed by a PIHP, CMHSP, or other provider agency as deemed appropriate by the PIHP and consistent with avoidance of conflict of interest.
9. Requirements for SIS Quality Leads

    SIS Quality Leads will be developed to ensure that all assessors continue to meet the AAIDD quality and reliability standards and allow the completion of assessments within the three year time frame.

    - Passed (at the Qualified; Excellent for higher level) an IRQR conducted by an AAIDD recognized trainer
    - Have experience conducting assessments for a range of individuals with varying needs and circumstances
    - Participated in regular Quality Assurance and Drift Reviews to develop their skills

10. Ensure that SIS data is entered into or collected using SISOnline, the AAIDD web-based platform designed to support administering, scoring, and retrieving data and generating reports (http://aaidd.org/sis/sisonline) within state specified time frames.
11. Provide for necessary DUA's and related tasks required for use of SIS online.
12. MDHHS will cover annual licensing fees, reports, and SISOnline maintenance. The PIHPs are responsible for SIS-A integration into their EMR.
13. Co-own SIS data with MDHHS

14. Have complete access to all SIS data entered on behalf of the PIHP, including both detail and summary level data.

Level of Care Utilization System (LOCUS)
The PIHP will:

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

7.7.4. National Core Indicators

The PIHP will provide mailing addresses and pre-survey and background information (information/demographics needed to schedule and conduct the face to face surveys for the identified participants in their geographic region who have been selected by MDHHS for NCI surveys). The PIHP shall also obtain consents, if required, coordinate appointments, and provide required background information on selected participants as necessary for the Department's identified contractor to complete face to face interviews with identified participants in the PIHP's geographic region (a total of at least 500 interviews will be completed for the entire State of Michigan). The PIHP shall help with dissemination and use of the NCI data in the PIHP's quality improvement activities.

7.7.5 Michigan Fidelity Assistance Support Team (MiFAST)

A Michigan Fidelity Assessment Support Team (MiFAST) review is required prior to implementation or use of specific Medicaid codes or modifiers. The specific Medicaid codes or modifiers are at the following link:

http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765-463726--,00.html

PIHPs are responsible for requesting/applying for a MiFAST review prior to the use or implementation of services to be reported under the previously listed codes. MDHHS recognizes that MiFAST reviews can take some period of time to schedule and complete, and recognizes that any findings require a reasonable period of correction. Therefore, MDHHS will provide provisional approval to the PIHP for the use of the specified codes and/or modifiers provided that an application by the PIHP has been properly made. This provisional approval shall continue until the MiFAST review process has completed. The outcome of the MiFAST review process, once completed, shall terminate the MDHHS provisional approval granted in this section. Once approved through the MiFAST process, continuing use of codes and/or modifiers is subject to MiFAST re-reviews that are conducted every two-to-three years and are required for continued use. There shall be no provisional approval for use of codes and/or modifiers listed in this section once an initial MiFAST approval is provided. Should the MiFAST review result in a denial, the PIHP shall discontinue use of the codes and/or modifiers listed in this section. The denial shall not be applied retroactively, and shall not affect the validity of services reported under the codes and/or modifiers listed in this section, that were rendered during the period of provisional approval.

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

- It is the expectation that the PIHP provider network will engage in the GAIN-I Core 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 for any trainings they 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.
- 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 adjust the original assessment to reflect those changes, and indicate as updated in the notes. 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 Care for FY2019. 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 10/1/2018. The PIHP may begin this transition to the GAIN-I Core on 10/1/2018 as long as it is fully implemented by March 30, 2019. By September 30, 2019 all other forms of biopsychosocial assessments are to be eliminated.

7.8 Financial Management System: General

The PIHP shall maintain all pertinent financial and accounting records and evidence pertaining to this contract based on financial and statistical records that can be verified by qualified auditors. The PIHP will comply with generally accepted accounting principles (GAAP) for government units when preparing financial statements. The PIHP will use the principles and standards of OMB Circular 2 CFR 200 Subpart E for determining all costs related to the management and provision of Medicaid covered specialty services under the Concurrent

1915(b)/(c) Waiver, SUD Community Grant, Healthy Michigan, the Flint 1115 Waiver and MIChild Programs reported on the financial status report. The accounting and financial systems established by the PIHP shall be a double entry system having the capability to identify application of funds to specific funding streams participating in service costs for individuals. The accounting system must be capable of reporting the use of these specific fund sources by major population groups (MIA, MIC, DD and SA). In addition, cost accounting methodology used by the PIHP must ensure consistent treatment of costs across different funding sources and assure proper allocation to costs to the appropriate source.

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

7.8.1 Rental Costs

The following limitations regarding rental costs1 shall apply to all PIHPs. All rental costs that exceed the limits in this section are not allowable and shall not be charged as a cost to Medicaid.

13. Subject to the limitations in subsection b and c of this section, rental costs are allowable to the extent that the rates are reasonable in light of such factors as: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased. Rental arrangements should be reviewed periodically to determine if circumstances have changed and other options are available.
14. All rental costs are subject to OMB Circular 2 CFR 200 Subpart E.
15. Rental costs under leases which are required to be treated as capital leases under GAAP are allowable only up to the amount (depreciation or use allowance, maintenance, interest, taxes and insurance) that would be allowed had the PIHP purchased the property on the date the lease was executed. Financial Accounting Standards Board Statement 13, Accounting for Leases, shall be used to determine whether a lease is a capital lease. Interest expenses related to the capital leases are allowable to the extent that they meet the criteria in OMB Circular 2 CFR 200 Subpart E. Unallowable costs include amounts paid for profit, management fees, and taxes that would not have been incurred had the PIHP purchased the facility.

7.8.2 Claims Management System

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

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

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

7.8.2.1 Post-Payment Review

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

7.8.2.2 Total Payment

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

7.8.2.3 Electronic Billing Capacity

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

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.

7.8.2.5 Vouchers

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

rendered. Those accepting vouchers may not require any additional payment from the individual.

Voucher arrangements for purchase of individual-directed supports delivered by non-professional practitioners may be through a fee-for-service arrangement. The use of vouchers is not subject to the provisions of Section 37.0 (Provider Contracts and Procurement) and Section 38.0 (Subcontracting) of this contract.

7.8.2.6. Programs with Community Inpatient Hospitals
Upon request from MDHHS, the PIHP must develop programs for improving access, quality, and performance with providers. Such programs must include MDHHS in the design methodology, data collection, and evaluation.

MDHHS and the PIHP will develop revised methods for the programs with community inpatient hospitals to ensure they comply with 42 CFR 438.6(d).

7.9 Quality Assessment/Performance Improvement Program and Standards
The PIHP shall have a fully operational Quality Assessment and Performance Improvement Program in place that meets the conditions specified in the Quality Assessment and Performance Improvement Program Technical Requirement," Attachment P 7.9.1.

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.

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

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

There are remaining issues to be addressed before the standard consent form can be used to support electronic Health Information Exchange. However, for all non-electronic Health

Information Exchange environments, the PIHP shall implement a written policy that requires the PIHP and its provider network to use, accept, and honor the standard release form that was created by MDHHS under Public Act 129 of 2014.

7.10 Service and Utilization Management

The PIHP shall perform utilization management functions sufficient to control costs and minimize risk while assuring quality care. Additional requirements are described in the following subsections.

7.10.1 Beneficiary Service Records

The PIHP shall ensure that providers establish and maintain a comprehensive individual service record system consistent with the provisions of MSA Policy Bulletins, and appropriate state and federal statutes. The PIHP shall ensure that providers maintain in a legible manner, via hard copy or electronic storage/imaging, recipient service records necessary to fully disclose and document the quantity, quality, appropriateness, and timeliness of services provided. The records shall be retained according to the retention schedules in place by the Department of Management and Budget (DTMB) General Schedule #20 at: http://www.michigan.gov/dtmb/0,5552,7-150-9141_21738_31548-56101--,00.html This requirement must be extended to all of the PIHP's provider agencies.

7.10.2 Other Service Requirements

The PIHP shall assure that in addition to those provisions specified in Section 4.0 "Access Assurance," services are planned and delivered in a manner that reflects the values and expectations contained in the following guidelines:

- Inclusion Practice Guideline (Attachment P 7.10.2.1)
- Housing Practice Guideline (Attachment P 7.10.2.2)
- Consumerism Practice Guideline (Attachment P.7.10.2.3)
- Personal Care in Non-Specialized Home Guideline (Attachment P 7.10.2.4)
- Family-Driven and Youth-Guided Policy & Practice Guideline (Attachment P 7.10.2.5)
- Employment Works! Policy (Attachment P 7.10.2.6)

In addition, the PIHP must disseminate all practice guidelines it uses to all affected providers and upon request to beneficiaries. The PIHP must ensure that decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

7.10.3 Jail Diversion

The PIHP shall coordinate with the appropriate entities, services designed to divert beneficiaries that qualify for MH/DD specialty services from a possible jail incarceration, when appropriate. Such services should be consistent with the Jail Diversion Practice Guidelines. The PIHP will collect data reflective of jail diversion activities and outcomes as indicated in the Practice Guideline (Attachment P 7.10.3.1).

7.10.4 School-to Community Transition

The PIHP shall ensure the CMHSPs participate in the development of school-to-community transition services for individuals with serious mental illness, serious emotional disturbance, or developmental disability. Participation shall be consistent with the MDHHS School-to-Community Transition Guideline (Attachment P 7.10.4.1).

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.

7.11 Regulatory Management

The PIHP shall have an established process for carrying out corporate compliance activities across its service area. The process includes promulgation of policy that specifies procedures and standards of conduct that articulate the PIHP's commitment to comply with all applicable Federal and State standards. The PIHP must designate an individual to be a compliance officer, and establish a committee that will coordinate analytic resources devoted to regulatory identification, comprehension, interpretation, and dissemination. The compliance officer, committee members, and PIHP employees shall be trained about the compliance policy and procedures. The PIHP shall establish ongoing internal monitoring and auditing to assure that the standards are enforced, to identify other high-risk compliance areas, and to identify where improvements must be made. There are procedures for prompt response to identified problems and development of corrective actions.

7.12 P.A. 500 and 2013 Application for Participation Requirements

7.12.1 PIHP Boards

The membership of PIHP Boards shall include a representative from substance use disorder services (SUDs).

7.12.2 PIHP Substance Use Disorder Oversight Policy Boards

The PIHP shall establish a SUD Oversight Policy Board by October 1, 2014, through a contractual arrangement with the PIHP and each of the counties served under appropriate state law. The SUD Oversight Policy Boards shall include the members called for in the establishing agreement, but shall have at least one board member appointed by the County Board of Commissioners for each county served by the PIHP. The SUD Oversight Policy Board shall perform the functions and responsibilities assigned to it through the establishing agreement, which shall include at least the following responsibilities:

1. Approval of PIHP budget containing local funds for treatment, prevention, recovery or SUD.
2. Advice and recommendations regarding PIHP budgets for SUD prevention, treatment and recovery using other non-local funding sources.
3. Advice on recommendations regarding contracts with SUD treatment, recovery or prevention providers.
4. Any other terms as agreed to by the participating parties consistent with authorizing legislation.

The PIHP shall provide a list of members and criteria used to make selection of members.

7.12.3 Procedures for Approving Budgets and Contracts

The PIHP must approve budgets and contracts for SUD prevention, treatment and recovery services in accordance with established procedures.

7.12.4 Maintaining Provider Base

The PIHP must maintain the provider base for prevention, treatment, and recovery services under contract as of December 2018 until December 28, 2020.

7.12.5 Reports and Annual Budget Boilerplate Requirements

The PIHP must submit timely reports on annual budget boilerplate requirements including:

1. Legislative Reports (Section 908), FY2019 due by February 28, 2020.
2. Mental Health and Substance Use Disorder Services Integration Status Reports

8.0 CONTRACT FINANCING

The provisions provided in the following subsections describe the financing arrangements in support of this contract.

A PIHP shall accept transfers of all reserve accounts and related liabilities accumulated by PIHPs that formerly operated within the current PIHP's geographic region. A PIHP shall accept transfer of all liabilities accumulated by the PIHPs that formerly operated within the PIHP's geographic region that were incurred and paid on behalf of the new PIHP as pre-award costs.

Substance Abuse Prevention and Treatment Block Grant authorizations, Partnership for Success (2015-2020), State Disability Assistance and other funding authorizations associated with grants, awards and projects outside the scope of this contract may be initiated or revised without formal amendment of the contract and are incorporated by reference in this contract when specifically cited and transmitted in writing to the PIHP. This does not apply to the Medicaid, Autism or Healthy Michigan rates, or any other actuarially sound rates described in this agreement.

The PIHP agrees to provide to the MDHHS, for deposit into a separate contingency account, local funds as authorized in the State Appropriations Act. These funds shall not include either state funds received by a CMHSP for services provided to non-Medicaid recipients or the state matching portion of the Medicaid capitation payments made to a CMHSP or an affiliation of CMHSPs. The amount of such funds and payment schedule is included in Attachment P 8.0.1.

The rates included in attachment P 8.0.1 are in effect with the initial contract.
The Department of Health and Human Services (HHS), United States Comptroller General or their representatives must have access to the financial and administrative records of the PIHP related to the activities and timeframes of this contract.

8.1 Local Obligation

The PIHP shall provide the local financial obligation for those Medicaid funds determined to require local match. In the event a PIHP is unable to provide the required local obligation, the PIHP shall notify the MDHHS contract representative immediately.

8.1.1 If a state appropriations Act permits the contribution from internal resources, local funds to be used as a bona fide part of the state match required under the Medicaid program in order to increase capitation payments, the PIHP shall provide on a quarterly basis the PIHP obligation for local funds as a bona fide source of match for Medicaid. The payment dates and amounts are shown in a schedule in Attachment P 8.0.1.

8.1.2 MDHHS has determined that the method of payment used for these services provided the 1915(b) waiver and 1915(c) Habilitation Supports Waiver do not require the 10% local obligation.

8.2 Revenue Sources for Local Obligation

The following are potential revenue sources for the PIHP's obligation to provide local funds to match Federal Medicaid.

- **County Appropriations**
  Appropriations of general county funds to the PIHP by the County Board of Commissioners.
- **Other Appropriations and Service Revenues**
  Appropriations of funds to the PIHP or its contract agencies by cities or townships; funds raised by fee-for-service contract agencies and/or network providers as part of the agencies' contractual obligation, the intent of which is to satisfy and meet the local match obligation of the PIHP, as reflected in this contract.
- **Gifts and Contributions**
  Grants, bequests, donations, gifts from local non-governmental sources, charitable institutions or individuals; gifts that specify the use of the funds for any particular individual identified by name or relationship may not be used as local match funds.
- **Special Fund Account**
  Funds of participating CMHSPs from the Community Mental Health Special Fund Account, consistent with Section 226a of the Michigan Mental Health Code. The Supplemental Security Income (SSI) benefit received by some residents in adult foster care homes is a Federal income supplement program designed to help aged, blind, and disabled people, who have little or no income. It provides cash to meet basic needs for food, clothing, and shelter. SSI income shall not be collected or recorded as a recipient fee or third-party reimbursement for purposes of Section 226a of the Mental Health Code. This includes the state supplement to SSI.
- **Investment Interest**
  Interest earned on funds deposited or invested by or on behalf of the PIHP, except as otherwise restricted by GAAP or OMB circular 2 CFR 200 Subpart E. Also, interest earned on MDHHS funds by contract agencies and/or network providers as specified in its contracts with the PIHP.
- **Other Revenues for Mental Health Services**
  As long as the source of revenue is not federal or state funds, revenues from other county departments/funds (such as child care funds) or revenues from public or private school districts for PIHP mental health services.
- **Grants or Gifts Exclusions**
  Local funds exclude grants or gifts received by the county, the PIHP, or agencies contracting with the PIHP, from an individual or agency contracting to provide services to the PIHP. An exception may be made, where the PIHP can demonstrate that such funds constitute a transfer of grants or gifts made for the purposes of financing mental

health services, and are not made possible by PIHP payments to the contract agency that are claimed as matchable expenses for the purpose of state financing.

8.3 Local Obligations - Requirement Exceptions

The following Medicaid covered services shall not require the PIHP to provide a local obligation:

- Programs for which responsibility is transferred to the PIHP and the state is responsible for 100% of the cost of the program, consistent with the Michigan Mental Health Code, for example 307 transfers and Medicaid hospital-based services
- Other Medicaid covered specialty services, provided under the Concurrent 1915(b)/(c) Program, as determined by MDHHS
- Services provided to an individual under criminal sentence to a state prison

8.4 MDHHS Funding

MDHHS funding includes both Medicaid funds related to the 1915(b) Waiver the 1915(c) Habilitation Supports Waiver, the MIChild program, the 1115 Healthy Michigan Plan and the Flint 1115 Waiver. The financing in this contract is always contingent on the annual Appropriation Act. CMHSPs within a PIHP may, but are not required to, use GF formula funds to provide services not covered under the 1915(b) and 1915(c) Medicaid Habilitation Supports waivers for Medicaid beneficiaries who are individuals with serious mental illness, serious emotional disturbances or developmental disabilities, or underwrite a portion of the cost of covered services to these beneficiaries. MDHHS reserves the right to disallow such use of General Funds if it believes that the CMHSP was not appropriately assigning costs to Medicaid and to General Funds in order to maximize the savings allowed within the risk corridors.

Specific financial detail regarding the MDHHS funding is provided as Attachment P 8.0.1.

8.4.1. Medicaid

The MDHHS shall provide to the PIHP both the state and federal share of Medicaid funds as a capitated payment based upon a per eligible per month (PEPM) methodology. The MDHHS will provide access to an electronic copy of the names of the Medicaid eligible people for whom a capitation payment is made. A PEPM is determined for each of the populations covered by this contract, which includes services for people with a developmental disability, a mental illness or emotional disturbance, and people with a substance use disorder as reflected in this contract. PEPM is made to PIHP for all eligibles in its region, not just those with the above-named diagnoses.

The Medicaid PEPM rates and the annual estimate of current year payments are attached to this contract. The actual number of Medicaid eligibles shall be determined monthly and the PIHP shall be notified of the eligibles in their service area via the pre-payment process.

Beginning with the first month of this contract, the PIHP shall receive a pre-payment equal to one month. The MDHHS shall not reduce the PEPM to the PIHP to offset a statewide increase in the number of beneficiaries. All PEPM rates must be certified as falling within the actuarially sound rate range.

The Medicaid PEPM rates effective October 1, 2016 will be supplied as part of Attachment P 8.0.1. The actual number of Medicaid eligibles shall be determined monthly and the PIHP shall be notified of the eligibles in their service area via the pre-payment process.

The MDHHS shall provide to the PIHP both the state and federal share of Medicaid funds as a capitated payment based upon a per 1915 (c) Habilitation Supports Waiver enrollee per month methodology. The MDHHS will provide access to an electronic copy of the names of the Medicaid eligible and Habilitation Supports waiver enrolled people for whom a 1915 (c) waiver interim payment is made.

8.4.1.1 Medicaid Rate Calculation

The Medicaid financing strategy used by the MDHHS, and stated in the 1915(b) Waiver, is to contain the growth of Medicaid expenditures, not to create savings.

The Medicaid Rate Calculation is based on the actuarial documentation letter from Milliman USA. Three sets of rate calculations are required: 1) one set of factors for the 1915(b) state plan and 1915(b)(3) services; 2) one set of factors for 1915 (c) Habilitation Supports Waiver services; and 3) one set of factors for the 1115 Healthy Michigan Plan 4) one set of factors for the Flint 1115 Waiver. The Milliman USA letter documents the calculation rate methodology and provides the required certification regarding actuarial soundness as required by the Balanced Budget Act Rules effective August 13, 2002. The chart of rates and factors contained in the actuarial documentation is included in Attachment P.8.0.1.

Several groups of Medicaid eligibles are excluded from the capitation methodology/payments. The groups are identified in sections 8.4.1.3 and 8.4.1.4. In addition, the rate calculations and payments excluded eligibility months associated with periods of retro-eligibility. The PIHP is responsible for service to these individuals and may use their Medicaid funding for such services, except for that period of time each month prior to when the individual is spent-down and thus not Medicaid-eligible.

The MDHHS shall not reduce the 1915(b), 1915(b)(3) PEPM, 1115 Health Michigan Plan PEPM or the C-waiver rates to the PIHP to offset a statewide increase in the number of Medicaid eligibles. All PEPM rates must be certified as falling within the actuarially sound rate range.

8.4.1.2 Medicaid Payments

MDHHS will provide the PIHP two managed care payments each month for the Medicaid covered specialty services.

8.4.1.3 Medicaid State Plan and (b)(3) Payments

The capitation payment for the state plan and (b)(3) Mental Health, Developmental Disability and Substance Abuse services is based on all Medicaid eligibles within the PIHP region, excluding Children's Waiver enrollees, and persons residing in a ICF/IID or individuals enrolled in a Program for All Inclusive Care (PACE) organization, SED waiver enrollees, individuals incarcerated, and individuals with a Medicaid deductible. The capitation payment will be adjusted for recovery of payments for Medicaid eligibles for whom MDHHS has subsequently been notified of their date of death. When applicable, additional payments may be scheduled (i.e. retro-rate implementation). HIPAA compliant 834 and 820 transactions will provide eligibility and remittance information.

8.4.1.4 1915(c) Habilitation Supports Waiver Payments

The 1915(c) Habilitation Supports Waiver (HSW) interim payment will be made to the PIHPs based on HSW beneficiaries who have enrolled through the MDHHS enrollment process and have met the following requirements:

- Has a developmental disability (as defined by Michigan law)
- Is Medicaid-eligible (as defined in the CMS approved waiver)
- Is residing in a community setting
- If not for HSW services would require ICF/IID level of care services
- Chooses to participate in the HSW in lieu of ICF/IID services
- Receives at least one HSW approved service to each month enrolled

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other 1915(c) waiver, such as the Children's Waiver Program (CWP) and Children with Serious Emotional Disturbance Waiver (SEDW). The PIHP will not receive payments for HSW enrolled beneficiaries who reside in an ICF/IID, Nursing Home, CCI, or are incarcerated for an entire month. The PIHP will not receive payments for HSW enrolled beneficiaries enrolled with a Program All Inclusive Care (PACE) organization.

Enrollment Management: The 1915(c) HSW uses an "attrition management" model that allows PIHPs to "fill in behind" attrition with new beneficiaries up to the limits established in the CMS-approved waiver. MDHHS has allocated certificates to each of the PIHPs. The process for filling a certificate involves the following steps: 1) the PIHPs submit applications for Medicaid beneficiaries for enrollment based on vacant certificates within the PIHP and includes required documentation that supports the eligibility for HSW; 2) MDHHS personnel reviews the PIHP enrollment applications; and 3) MDHHS personnel approves (within the constraint of the total yearly number of available waiver certificates and priority populations described in the CMS-approved waiver) those beneficiaries who meet the requirements described above.

The MDHHS may reallocate an existing HSW certificate from one PIHP to another if:

- the PIHP has presented no suitable candidate for enrollment in the HSW within 60 days of the certificate being vacated; and
- there is a high priority candidate (person exiting the ICF/ IID or at highest risk of needing ICF/ IID placement, or young adult aging off CWP) in another PIHP where no certificate is available. MDHHS personnel review all disenrollments from the HSW prior to the effective date of the action by the PIHP excluding deaths and out-of-state moves which are reviewed after the effective date.

HSW Interim Payments: Per attachment P.8.0.1, the HSW interim payment will be based upon:

- Base Rates for HSW
- Residential Living Arrangement factor
- Placement from ICF/ IID – Mt. Pleasant factor
- Multiplicative Factor for geographic region
- For HSW enrollees of a PIHP that includes the county of financial responsibility (COFR), referred to as the "responsible PIHP", but whose county of residence is in another PIHP, referred to as the "residential PIHP", the HSW interim payment will be paid to the COFR within the "responsible PIHP" based on the multiplicative factor for the "residential PIHP".

The HSW interim payment will be scheduled to occur monthly. Adjustments to the payment schedule may occur to accommodate processing around State Holidays. Additional payments may be scheduled as required.

The monthly HSW interim payment will include payment for HSW enrolled beneficiaries who have met eligibility requirements for the current month, as well as retro-payments for HSW enrolled beneficiaries who met eligibility requirements for prior months, e.g., Medicaid deductible and/or retro-Medicaid eligibility. In addition, the HSW payment may be adjusted for:

- Recovery of payments previously made to beneficiaries prior to MDHHS notification of death
- Recovery of payments previously made to beneficiaries, who upon retrospective review, did not meet all HSW enrollment requirements
- Modifications to any of the HSW rate development factors

The PIHP must be able to receive and transmit HIPAA compliant files, such as:

- 834 – Enrollment/Eligibility
- 820 – Payment / Remittance Advice
- 837 – Encounter

Encounters for provision of services authorized in the CMS approved waiver must contain HK modifier to be recognized as valid HSW encounters. Valid HSW encounters must be submitted within 90 days of provision of the service regardless of claim adjudication status in order to assure timely HSW service verification.

The HSW interim payment for a service month will be recouped if there is no HSW-specific service encounter(s) accepted into the warehouse with a date of service for that month since this means that the service provision requirement has not been met. Once the recoupment has taken place, the PIHP should submit any corrected and valid HSW encounters; however, the recouped payment for that service month will not be repaid (e.g., no more final 'sweeps' or subsequent retro payments). It is intended that recoupments will take place in the fourth month following the service month. For example, October payments would be recouped in February.

8.4.1.5 Expenditures for Medicaid 1915 State Plan, 1915(b)(3), 1915(c), MIChild, Healthy Michigan Services and the Flint 1115 Waiver

On an ongoing basis, the PIHP can flexibly and interchangeably expend capitation payments received through the five sources or "buckets." Once capitation payments are received, the PIHP may spend any funds received on 1915(b) state plan, (b)(3), 1115 Healthy Michigan Plan, MIChild or 1915(c) waiver services. All funds must be spent on Medicaid beneficiaries for Medicaid services. Surplus funding generated in either Medicaid or Healthy Michigan may be utilized to cover a funding deficit in the other fund only after that fund sources risk reserve has been fully utilized.

While there is flexibility in month-to-month expenditures and service utilization related to the five "buckets," the PIHP must submit encounter data on service utilization - with transaction code modifiers that identify the service as 1915(b) state plan, (b)(3) services, or 1915(c) services – and this encounter data (including cost information) will serve as the basis for future 1915(b) state plan, (b)(3) services, and 1915(c) waiver interim payment rate development.

The PIHP has certain coverage obligations to MIChild enrollees and to Medicaid beneficiaries under the 1915(b) waiver (both state plan and (b)(3) services), and to enrollees under the 1915(c) waiver. It must use capitation payments to address these obligations.

The PIHP must monitor and track revenues and expenditures on 1915(b) state plan services, (b)(3) services, and 1915(c) services and assure that aggregate expenditures for (b)(3) services do not grow or rise faster than the respective aggregate expenditures for 1915(b) state plan and 1915(c) services.

Expenditures for Healthy Michigan Services must be covered by Healthy Michigan Plan capitation payment only.

8.4.1.6 MDHHS Incentive – Monetary Payments

The MDHHS Incentive payment will be made to the PIHPs based on children identified on the Quality Improvement File for whom the PIHP submitted an encounter. For the PIHPs to be eligible for an incentive payment the child must meet the following requirements:

- Have a Serious Emotional Disturbance (as defined by Michigan law)
- Eligible for Medicaid
- Be between the ages of 0 to 18
- Served in the MDHHS Foster Care System or Child Protective Services (Risk Categories I & II)
- Meets one of the following service criteria:
    - Service Criteria 1: At least one of the following services was provided in the eligible month:
        - H2021 – Wraparound Services
        - H0036 – Home Based Services
    - Service Criteria 2: Two or more state plan and/or 1915(b)(3) mental health services covered under the 1915(b) Specialty Supports and Services Waiver, excluding one-time assessments, were provided in the eligible month.

Incentive Payments: The incentive payment will occur quarterly. Each incentive payment will be determined by comparing the PIHP's identified eligible children with the encounter data submitted. Valid encounters must be submitted within 90 days of the provision of the service regardless of the claim adjudication status in order to assure timely incentive payment verification. Once the incentive payment has taken place there will not be any opportunities for submission of eligible children for a quarterly payment already completed.

Quarterly incentive payments will occur as follows:

1. April 2019: Based on eligible children and the supporting encounter data submitted for October 1, 2018 – December 31, 2019.
2. July 2019: Based on eligible children and the supporting encounter data submitted for January 1, 2019 – March 31, 2019.
3. October 2019: Based on eligible children and the supporting encounter data submitted for April 1, 2019 – June 30, 2019.
4. January 2020: Based on eligible children and the supporting encounter data submitted for July 1, 2019 – September 30, 2019.

The MDHHS will provide access to an electronic copy of the names of those individuals eligible for incentive payments, which incentive payment amount they are to receive, and the COFR.

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.

$$\frac{\text{Incurred Claims +/- ISF created/used– HRA – Taxes + Healthcare Quality Improvement + Fraud Reduction}}{\text{Current Year Premium Revenue +/- Savings used/created – HRA expense – Tax expense (HICA/Use)}}$$

Calculation Components

Incurred Claims. Include 1) direct claims paid to providers including all costs of CMHSP capitated contracts, 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.

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.

8.4.1.8 MIChild

The MDHHS shall provide to the PIHP the Federal and matching share of MIChild funds as a capitated payment based upon actuarially sound Per Enrolled Child Per Month (PECPM) methodology for MIChild-covered mental health services. The primary MIChild payment will be paid monthly. When applicable, additional payments may be scheduled (i.e., retro-rate implementation or adjustments to ensure actuarial soundness resulting from changes in treatment access or scope, duration or intensity of services necessary to meet medical necessity). HIPPA compliant 834 and 820 transactions will provide eligibility and remittance information. See attached P.8.0.1 for the PECPM rates.

8.4.2 Contract Withholds

The Department shall withhold .2% of the approved capitation payment to each PIHP. The withheld funds shall be issued by the Department to the PIHP in the following amounts within 60 days of when the required report is received by the Department:

1. .04% for timely submission of the Projection Financial Status Report – Medicaid
2. .04% for timely submission of the Interim Financial Status Report – Medicaid
3. .04% for timely submission of the Final Medicaid Contract Reconciliation and Cash Settlement
4. .04% for timely submission of the Medicaid Utilization and Cost Report
5. .04% for timely submission of encounters (defined in Attachment P 7.7.1.1.)

PA 107 of 2013 Sec. 105d (18)

(18) By October 1, 2015, the department of community health shall implement a retroactive withhold, at a minimum, 0.75% of payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool. Retention of funds from the performance bonus incentive pool is contingent on the specialty prepaid health plan's completion of the required performance of compliance metrics, which shall include, at a minimum, partnering with other contracted health plans to reduce non-emergent emergency department utilization, increased participation in patient-centered medical homes, increased use of electronic health records and data sharing with other providers, and identification of enrollees who may be eligible for services through the veterans administration. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

Distribution of funds from the performance bonus incentive pool will be contingent on the PIHP's completion of the required performance of compliance metrics related to:

a. partnering with other health plans to reduce non-emergent emergency department use and increase data sharing,
b. increased participation in patient-centered medical homes, and
c. identification of individuals who may be eligible for services from the Veterans Administration.

Performance bonus incentive calculation of a. above will be based on section 8.4.2.1 below. The regular reporting process for a. above (Joint Plan Care Teams and IP Psych 30 day FUH) shall suffice; redundant reporting is not required.

PIHPs will submit a narrative summary to MDHHS per the Master Reporting Calendar by November 15, 2019 summarizing improvements in b and c listed above. The narrative is expected to address:

a. use of electronic sources such as CC360 to monitor populations and coordinate care, and
b. progress made in support of the BHDDA Veteran and Military members Strategic Plan
    a. Outreach efforts and activities with Veterans and Veterans Advocate Groups and Veterans Providers of any type
    b. Level of CMH and other PIHP Provider involvement on TriCare Panel
    c. Population Health and Integrated Care efforts with local VA Medical Centers and Clinics

The Narrative is anticipated to be largely qualitative in nature and shall contain a summary of efforts, activities and achievements of PIHPs (and component CMHS if applicable) throughout FY 2019 related to the areas listed above.
Additional areas that may be addressed, but are not mandatory include:

a. CMH involvement on TriCare provider panels,
b. Veterans Community Action Team attendance,
c. integrated care efforts with local VA Medical Centers,
d. co-location of CMH staff in primary care settings, and vice versa
e. involvement with FQHCs, SIM, MIHealthLink, and
f. efforts to identify and consumers without primary care physician to facilitate establishing that relationship.

To the extent possible, measurement of performance in future years will be based on nationally recognized quality measures, for example access to preventive/ambulatory health services and ambulatory care sensitive condition, ER and inpatient medical-surgical hospital utilization rates.

8.4.2.1. 2019 Performance Bonus Integration of Behavioral Health and Physical Health Services

In an effort to ensure collaboration and integration between Medicaid Health Plans (MHPs) and Pre-paid Inpatient Health Plans (PIHPs), the Department of Health and Human Services has developed the following joint expectations for both entities. This excludes beneficiaries seeking SUD services unless appropriate consent is obtained. Each plan (both PIHP and MHP) will submit a response for each criterion. There are 100 points possible for this initiative in FY2019.

Category	Description	Criteria/Deliverables
1. **Implementation of Joint Care Management Processes** (50 points)	Collaboration between entities for the ongoing coordination and integration of services	1. Quarterly, each MHP and PIHP will demonstrate that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities. MDHHS will select beneficiaries randomly and review their care plans within CC360. 2. Quarterly, each MHP and PIHP will participate, via the MHP-PIHP Workgroup, in reviewing and validating MDHHS reports that would include but not be limited to the number of care coordination plans, the reasons for closing care coordination plans, and the average length of time for active care coordination plans. 3. The MHPs and PIHPs will work jointly to develop at least two standard of care protocols for care coordination as identified collaboratively with MDHHS.
2. Follow-up After Hospitalization for Mental Illness within 30 days (FUH) (50 points)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 days.	1. Plans will meet set standards for follow-up within 30 days for each rate (ages 6-20 and ages 21 and older). Plans will be measured against an adult minimum standard of N% and a child minimum standard of N%. See MDHHS measure specification for query, eligible population and additional details. Measurement period will be July 1, 2018-June 30, 2019. The 50 points will be awarded based on MHP/PIHP combination performance measure rates. The total points will be the same regardless of the number of MHP/PIHP combinations for a given entity. For example, a PIHP working with five MHPs will be awarded up to 10 points for each PIHP/MHP combination rate.

Assessment and PBIP Dispersal

Each PIHP shall submit a qualitative narrative for FY 2019 (October 1, 2018 – September 30, 2019) no later than 11/15/19. The Report shall encompass three (3) areas:

A. Achievement of required performance elements, Partnering with Health Plans (50% Joint Care Management and 50% Follow Up after inpatient psychiatric hospitalization) (20%)

B. Completion of narrative, (From AHRQ) Patient Centered Medical Home Participation (40%)
    a. Comprehensive Care
    b. Patient-Centered
    c. Coordinated Care
    d. Accessible Services
    e. Quality & Safety
C. Completion of narrative, Veterans' Needs and Services (40%)

Reports of efforts, activity, contacts, outreach, inter-agency collaborations and the like will suffice. Where available, PIHPs shall include quantitative data for the time period under review. The PIHPs shall prepare a Report Format for review by MDHHS by 07/01/2019 and approval by MDHHS by 08/01/2019. DHHS acknowledges that the MDHHS Veterans' Strategic Plan has been rolled in Phases by Region/PIHP.

MDHHS shall provide consultation draft review response to PIHPs by 1/10/2019. PIHPs shall have until 1/25/2019 to reply with information. The review and reconciliation process shall be completed with PIHPs notified by 2/28/19, with funds released in the April 2019 payment cycle.

PBIP funding awarded to the PIHPs shall be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

8.5 Operating Practices

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

- Generally Accepted Accounting Principles for Governmental Units.
- Audits of State and Local Governmental Units, issued by the American Institute of Certified Public Accountants (current edition).
- OMB Circular 2 CFR 200 Subpart E

8.6 Financial Planning

In developing an overall financial plan, the PIHP shall consider the parameters of the MDHHS/PIHP shared-risk corridor, the reinvestment of savings, and the strategic approach in the management of risk, as described in the following sub-sections.

8.6.1 Risk Corridor

The shared risk arrangements shall cover all Medicaid 1915, 1915(b)(3), 1115 Healthy Michigan Plan capitation and 1915(c) Habilitation Supports Waiver payments. The risk corridor is administered across all services, with no separation for mental health and substance abuse funding.

A. The PIHP shall retain unexpended risk-corridor-related funds between 95% and 100% of said funds. The PIHP shall retain 50% of unexpended risk-corridor related funds between 90% and 95% of said funds. The PIHP shall return unexpended risk-corridor-related funds to the MDHHS between 0% and 90% of said funds and 50% of the amount between 90% and 95%.
B. The PIHP may retain funds noted in 8.6.1.A, except as specified in Part 1, section 16.0 "Closeout".

C. The PIHP shall be financially responsible for liabilities incurred above the risk corridor-related operating budget between 100% and 105% of said funds contracted.
D. The PIHP shall be responsible for 50% of the financial liabilities above the risk corridor-related operating budget between 105% and 110% of said funds contracted.
E. The PIHP shall not be financially responsible for liabilities incurred above the risk corridor-related operating budget over 110% of said funds contracted.

The assumption of a shared-risk arrangement between the PIHP and the MDHHS shall not permit the PIHP to overspend its total operating budget for any fiscal year.

The PIHP shall not pass on, charge, or in any manner shift financial liabilities to Medicaid beneficiaries resulting from PIHP financial debt, loss and/or insolvency.

The PIHP financial responsibility for liabilities for costs between 100% and 110% must first be paid from the PIHP's ISF for risk funding or insurance for cost over-runs. The ISF balance shall be tracked by Medicaid and Healthy Michigan funds contributed. Each portion of the ISF shall retain its character as Medicaid and Healthy Michigan Funds but may be used for risk financing across the Medicaid and Healthy Michigan programs. Medicaid ISF amounts may be used for Medicaid or Healthy Michigan cost over runs into the risk corridor and Healthy Michigan ISF amounts may be used for Medicaid or Healthy Michigan cost over runs into the risk corridor.

If the PIHP's liability exceeds the amount available from ISF and insurance, other funding available to the PIHP may be utilized in accordance with the terms of the PIHP's Risk Management Strategy.

8.6.2 Savings and Reinvestment

Provisions regarding the Medicaid, Healthy Michigan Plan, the Flint 1115 Waiver savings and the PIHP reinvestment strategy are included in the following subsections. It should be noted that only a PIHP may earn and retain Medicaid/Healthy Michigan Plan savings. CMHSPs may not earn or retain Medicaid/Healthy Michigan Plan savings. Note that these provisions may be limited or canceled by the closeout provision in Part I, Section 16.0 Closeout, and may be modified by actions stemming from Part II A, Section 9.0 Contract Remedies and Sanctions.

8.6.2.1 Medicaid Savings

The PIHP may retain unexpended Medicaid Capitation funds up to 7.5% of the Medicaid/Healthy Michigan Plan pre-payment authorization. These funds shall be included in the PIHP reinvestment strategy as described below. All Medicaid savings funds reported at fiscal year-end must be expended within one fiscal year following the fiscal year earned for Medicaid or Healthy Michigan Program services to Medicaid or Healthy Michigan Plan covered consumers. All Healthy Michigan Plan savings funds reported at fiscal year-end must be expended within one fiscal year following the fiscal year earned for Medicaid or Healthy Michigan Plan services to Medicaid or Healthy Michigan Plan covered consumers. If MDHHS and CMS approval is required of the reinvestment plan the savings must be expended by the end of the fiscal year following the year the plan is approved. In the event that a final MDHHS audit report creates new Medicaid/Healthy Michigan Plan savings, the PIHP will have one year following the date of the final audit report to expend those funds according to Section 8.6.2.2. Unexpended Medicaid/Healthy Michigan Plan savings shall be returned to the MDHHS as part of the year-end settlement process. MDHHS will return the federal share of the unexpended savings to CMS.

8.6.2.2 Reinvestment Strategy - Medicaid Savings

The PIHP shall develop and implement a reinvestment strategy for all Medicaid savings realized. The PIHP reinvestment strategy shall be directed to the Medicaid population.

All Medicaid savings must be invested according to the criteria below. Any of these funds that remain unexpended at the end of the fiscal year must be returned to the MDHHS as part of the year-end settlement process.

8.6.2.3 Community Reinvestment Strategy

Services and supports must be directed to the Medicaid population. Community reinvestment plans to provide services contained in the State Medicaid Manual do not require prior approval by CMS and MDHHS. They must be expended in the fiscal year following the year they are earned. Prior approval by MDHHS and CMS is required for plans that include other expenditures in the community reinvestment plan. These must be expended within the fiscal year after the year of the CMS and MDHHS approval. Community reinvestment funds are to be invested in accordance with the following criteria:

Development of new treatment, support and/or service models; these shall be additional 1915(b)(3) services to Medicaid beneficiaries as allowed under the cost savings aspect of the waiver:

- Expansion or continuation of existing state plan or 1915(b)(3) approved treatment, support and/or service models to address projected demand increases.
- Community education, prevention and/or early intervention initiatives.
- Treatment, support and/or service model research and evaluation.
- The PIHP may use up to 15% of Medicaid savings for administrative capacity and infrastructure extensions, augmentations, conversions, and/or developments to: (a) assist the PIHP (as a PIHP) to meet new federal and/or state requirements related to Medicaid or Medicaid-related managed care activities and responsibilities; (b) implement consolidation or reorganization of specific administrative functions related to the Application for Participation and pursuant to a merger or legally constituted affiliation; or (c) initiate or enhance recipient involvement, participation, and/or oversight of service delivery activities, quality monitoring programs, or customer service functions.
- Identified benefit stabilization purposes. Benefit stabilization is designed to enable maintenance of contracted benefits under conditions of changing economic conditions and payment modifications. This enables the PIHP to utilize savings to assure the availability of benefits in the following year.

The reinvestment strategy becomes a contractual performance objective. All Medicaid savings funds must be expended within one fiscal year following CMS approval of the reinvestment plan. The PIHP shall document for audit purposes the expenditures that implement the reinvestment plan. Unexpended Medicaid savings shall be returned to the MDHHS as part of the year-end settlement process.

8.6.3 Risk Management Strategy

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

8.6.4 PIHP Assurance of Financial Risk Protection

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

The PIHP may use one or a combination of measures to assure financial risk protection, including pledged assets, reinsurance, and creation of an ISF. The use of an ISF in this regard must be consistent with the requirements of OMB Circular 2 CFR 200 Subpart E. Please see attachment P.8.6.4.1 Internal Service Fund Technical Requirement.

The PIHP will submit a specific written Risk Management Strategy to the Department no later than December 3, 2018. The Risk Management strategy will identify the amount of reserves, insurance and other revenues to be used by the PIHP to assure that its risk commitment is met. Whenever General Funds are included as one of the listed revenue sources, MDHHS may disapprove the list of revenue sources, in whole or in part, after review of the information provided and a meeting with the PIHP. Such a meeting will be convened within 45 days after submission of the risk management strategy. If disapproval is not provided within 60 days following this meeting, the use of general funds will be considered to be allowed. Such disapproval will be provided in writing to the PIHP within 60 days of the first meeting between MDHHS and the PIHP. Should circumstances change, the PIHP may submit a revision to its Risk Management Strategy at any time. MDHHS will provide a response to this revision, when it changes the PIHPs intent to utilize General Funds to meet its risk commitment, within 30 days of submission.

8.7 Finance Planning, Reporting and Settlement

The PIHP shall provide financial 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)

8.8 Legal Expenses

The following legal expenses are ALLOWABLE:

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

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

The following legal expenses are UNALLOWABLE:

- Where the Michigan Department of Health and Human Services (MDHHS) or the Centers for Medicare & Medicaid Services (CMS) takes action against the provider by initiating an enforcement action or issuing an audit finding, then the legal costs of responding to the action are allowable in these circumstances.

- The PIHP prevails and the action is reversed. Example: The audit finding is not upheld and the audit adjustment is reversed.
- The PIHP prevails as defined by reduction of the contested audit finding(s) by 50 percent or more. Example: An audit finding for an adjustment of $50,000 is reduced to $25,000. Or, in the case of several audit findings, a total adjustment of $100,000 is reduced to $50,000.
- The PIHP enters into a settlement agreement with MDHHS or CMS prior to any Hearing.
- Legal expenses for the prosecution of claims against the State of Michigan or the Federal Government.
- Legal expenses contingent upon recovery of costs from the State of Michigan or the Federal Government.

8.9 Performance Objectives
PIHP performance objectives are included in Attachment P 8.9.1.

9.0 CONTRACT REMEDIES AND SANCTIONS

The state will utilize a variety of means to assure compliance with contract requirements and with the provisions of Section 330.1232b of Michigan's Mental Health Code, regarding Specialty Prepaid Inpatient Health Plans. The state will pursue remedial actions and possibly sanctions as needed to resolve outstanding contract violations and performance concerns. The application of remedies and sanctions shall be a matter of public record. If action is taken under the provisions of Section 330.1232b of the Mental Health Code, an opportunity for a hearing will be afforded the PIHP, consistent with the provisions of Section 330.1232b.(6).

The MDHHS will utilize actions in the following order:

A. Notice of the contract violation and conditions will be issued to the PIHP with copies to the Board.
B. Require a plan of correction and specified status reports that becomes a contract performance objective.
C. If previous items above have not worked, impose a direct dollar penalty and make it a non-matchable PIHP administrative expense and reduce earned savings from that fiscal year by the same dollar amount.
D. For sanctions related to reporting compliance issues, MDHHS may delay up to 25% of scheduled payment amount to the PIHP until after compliance is achieved. MDHHS may add time to the delay on subsequent uses of this provision. (Note: MDHHS may apply this sanction in a subsequent payment cycle and will give prior written notice to the PIHP)
E. Initiate contract termination.

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

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

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

Sanctions Non-monetary: PIHPs are required to submit a plan of correction that addressed each review dimension for which there was a finding of partial or non-compliance. If a PIHP receives a repeat citation on a site review dimension, the MDHHS site review team may increase the size of the clinical record review sample for that dimension for the next site review.

Before imposing a sanction on a PIHP, the department shall provide that specialty prepaid inpatient health plan with timely written notice that explains both of the following:

a. The basis and nature of the sanction along with its statutory/regulatory/contractual basis and the objective evidence upon which the finding of fault is based.
b. The opportunity for a hearing to contest or dispute the department's findings and intended sanction, prior to the imposition of the sanction. A hearing under this section is subject to the provisions governing a contested case under the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.201 to 24.328, unless otherwise agreed to in the specialty prepaid health plan contract.

PART II (B)
SUBSTANCE USE DISORDER (SUD) SERVICES

1.0 STATEMENT OF WORK

The following section provides the budget, an explanation of the specifications and expectations that the Prepaid Inpatient Health Plan (PIHP) must meet and the substance use disorder services that must be provided under the contract. The Contractor agrees to undertake, perform and complete the services described in Attachment A, which is part of this agreement through reference.

The general SUD responsibilities of the PIHP under this Agreement, based on P.A. 500 of 2012, as amended, are to:

1. Develop comprehensive plans for substance use disorder treatment and rehabilitation services and substance use disorder prevention services consistent with guidelines established by the Department.
2. Review and comment to the Department of Licensing and Regulatory Affairs on applications for licenses submitted by local treatment, rehabilitation, and prevention organizations.

3. Provide technical assistance for local substance use disorder service programs.
4. Collect and transfer data and financial information from local programs to the Department of Licensing and Regulatory Affairs.
5. Submit an annual budget request to the Department for use of state administered funds for its substance use disorder treatment and rehabilitation services and substance use disorder prevention services in accordance with guidelines established by the Department.
6. Make contracts necessary and incidental to the performance of the department-designated community mental health entity's and community mental-health services program's functions. The contracts may be made with public or private agencies, organizations, associations, and individuals to provide for substance use disorder treatment and rehabilitation services and substance use disorder prevention services.
7. Annually evaluate and assess substance use disorder services in the department-designated community mental health entity in accordance with guidelines established by the Department.

1.1 Agreement Amount
The estimate of the funding to be provided by the MDHHS to the PIHP for SUD Community Grant activities is included as part of Attachment P 8.0.1 to this contract.

1.2 Purpose
The focus of the program is to provide for the administration and coordination of substance use disorder (SUD) services within the designated PIHP region.

1.3 Financial Requirements
The financial requirements shall be followed as described in Part II of this agreement and Attachment P.7.7.1.1 which is part of this agreement through reference.

1.4 Performance/Progress Report Requirements
The progress reporting methods, as applicable, shall be followed as described in Attachment P.7.7.1.1, which is part of this agreement through reference.

1.5 General Provisions
The Contractor agrees to comply with the General Provisions outlined in this agreement. The Contractor also agrees to comply with the reporting requirements found in Attachment P.7.7.1.1.and the requirements described in the SUD Services Policy Manual, which is part of this agreement through reference.

1.6 Action Plan
The PIHP will carry out its responsibilities under this Agreement consistent with the PIHP's most recent Action Plan as approved by the Department. The Annual Action Plan Guidelines are available on the MDHHS website at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html

2.0 SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT REQUIREMENTS AND APPLICABILITY TO STATE FUNDS

Federal requirements deriving from Public Law 102-321, as amended by Public Law 106-310, and federal regulations in 45 CFR Part 96 are pass-through requirements. Federal Substance

Abuse Prevention and Treatment (SAPT) Block Grant requirements that are applicable to states are passed on to PIHPs unless otherwise specified.

42 CFR Parts 54 and 54a, and 45 CFR Parts 96, 260, and 1050, pertaining to the final rules for the Charitable Choice Provisions and Regulations, are applicable to PIHPs as stated elsewhere in this Agreement.

Sections from PL 102-321, as amended, that apply to PIHPs and contractors include but are not limited to:

- 1921(b)
- 1922 (a)(1)(2)
- 1922(b)(1)(2)
- 1923
- 1923(a)(1) and (2), and 1923(b
- 1924(a)(1)(A) and (B
- 1924(c)(2)(A) and (B)
- 1927(a)(1) and (2), and 1927(b)(1)
- 1927(b)(2): 1928(b) and (c)
- 1929
- 1931(a)(1)(A), (B), (C), (D), (E) and (F)
- 1932(b)(1)
- 1941
- 1942(a)
- 1943(b)
- 1947(a)(1) and (2)

2.1 Selected Specific Requirements Applicable to PIHPs

1. Block Grant funds shall not be used to pay for inpatient hospital services except under conditions specified in federal law.
2. Funds shall not be used to make cash payments to intended recipients of services.
3. Funds shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility, or purchase major medical equipment.
4. Funds shall not be used to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding.
5. Funds shall not be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.
6. Funds shall not be used to enforce state laws regarding the sale of tobacco products to individuals under the age of 18.
7. Funds shall not be used to pay the salary of an individual at a rate in excess of Level I of the Federal Executive Schedule, or approximately $199,700.

SAPT Block Grant requirements also apply to the Michigan Department of Health and Human Services (MDHHS) administered state funds, unless a written exception is obtained from MDHHS.

2.2 Program Operation
The PIHP shall provide the necessary administrative, professional, and technical staff for operation of the program.

2.3 Notification of Modifications
The PIHP shall provide timely notification to the Department, in writing, of any action by its governing board or any other funding source that would require or result in significant modification in the provision of services, funding or compliance with operational procedures.

2.4 Software Compliance
The PIHP must ensure software compliance and compatibility with the Department's data systems for services provided under this agreement including, but not limited to: stored data, databases, and interfaces for the production of work products and reports. All required data under this agreement shall be provided in an accurate and timely manner without interruption, failure or errors due to the inaccuracy of the Contractor's business operations for processing date/time data.

2.5 Licensure of Subcontractors
The PIHP shall enter into agreements for substance use disorder prevention, treatment, and recovery services only with providers appropriately licensed for the service provided as required by Section 6234 of P.A. 501 of 2012, as amended.
The PIHP must ensure that network providers residing and providing services in bordering states meet all applicable licensing and certification requirements within their state that such providers are accredited per the requirements of this Agreement, and that provider staff are credentialed per the requirements of this Agreement.

2.6 Accreditation of Subcontractors
The PIHP shall enter into agreements for treatment services provided through outpatient, Methadone, sub-acute detoxification and residential providers only with providers accredited by one of the following accrediting bodies: The Joint Commission (TJC formerly JCAHO); Commission on Accreditation of Rehabilitation Facilities (CARF); the American Osteopathic Association (AOA); Council on Accreditation of Services for Families and Children (COA); National Committee on Quality Assurance (NCQA), or Accreditation Association for Ambulatory Health Care (AAAHC). The PIHP must determine compliance through review of original correspondence from accreditation bodies to providers.

Accreditation is not needed in order to provide access management system (AMS) services, whether these services are operated by a PIHP or through an agreement with a PIHP or for the provision of broker/generalist case management services. Accreditation is required for AMS providers that also provide treatment services and for case management providers that either also provide treatment services or provide therapeutic case management. Accreditation is not required for peer recovery and recovery support services when these are provided through a prevention license.

2.7 ASAM LOC Requirements for Subcontractors
The PIHP shall enter into agreements for SUD treatment with organizations that provide services based on the American Society of Addiction Medicine (ASAM) Level of Care (LOC) only. This requirement is for community grant and all Medicaid/Healthy Michigan Plan funded services.

The PIHP must ensure that to the extent licensing allows all of the following LOCs are available for adult and adolescent populations:

Level of Care	ASAM Title
0.5	Early Intervention
1	Outpatient Services
2.1	Intensive Outpatient Services
2.5	Partial Hospitalization Services
3.1	Clinically Managed Low Intensity Residential Services
3.3*	Clinically Managed Population Specific High Intensity Residential Services
3.5	Clinically Managed High Intensity Residential Services
3.7	Medically Monitored Intensive Inpatient Services
OTP Level 1**	Opioid Treatment Program
1-WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring
2-WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring
3.2-WM	Clinically Managed Residential Withdrawal Management
3.7-WM	Medically Monitored Inpatient Withdrawal Management

* Not designated for adolescent populations **Adolescent treatment per federal guidelines

It is further required that all SUD treatment providers complete the MDHHS Level of Care Designation Questionnaire and receive a formal designation for the LOC that is being offered. The PIHP shall enter into a contract for these two services only after the provider has received a state designation. The LOC designation must be renewed, every two years.

2.8 Provider Network Oversight Management

The provision of SUD treatment services must be based on the ASAM LOC criteria. To ensure compliance with and fidelity to ASAM the PIHP shall ensure that policies and practices of annually reviewing their provider network include the following:

- On-site review of the program, policies, practices and clinical records.
- A reporting process back to MDHHS on the compliance with the purported LOC for each provider, including any corrective action that may have been taken and documentation that indicates all LOCs are available in the region.
- Ensuring review documentation is available for MDHHS during biannual PIHP site visits for comparison with MDHHS provider reviews.

If the PIHP plans to purchase case management services or peer recovery and recovery support services, and only these services, from an agency that is not accredited per this agreement, the PIHP may request a waiver of the accreditation requirement.

3.0 SAMHSA/DHHS LICENSE

The federal awarding agency, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services (SAMHSA/DHHS), reserves a royalty-free, nonexclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for federal government purposes: (a) The copyright in any work developed under a grant, sub-grant, or contract under a grant or sub-grant; and (b) Any rights of copyright to which a grantee, sub-grantee or a contractor purchases ownership with grant support.

4.0 MONITORING OF DESIGNATED WOMEN'S SUBCONTRACTORS

In addition to the requirements referenced in number eight above, the PIHP is also required to monitor all Designated Women's Programs (DWP) for the following:

1. Outreach activities to promote and advertise women's programming and priority population status.
2. Gender-Responsive policy for treating the population.
3. Education/Training of staff identified as women's specialty clinicians and supervisors. Required 12 semester hours equivalent to 64 workshop type training hours.

5.0 ADMINISTRATIVE AND FINANCIAL MATCH RULES

Pursuant to Section 6213 of Public Act No. 368 of 1978, as amended, Michigan has promulgated match requirement rules. Rules 325.4151 through 325.4153 appear in the 1981 Annual Administrative Code Supplement. In brief, the rule defines allowable matching fund sources and states that the allowable match must equal at least ten percent of each comprehensive PIHP budget (see Attachment P II B to the Agreement) - less direct federal and other state funds. Per PA 368, Administrative Rules, and contract, direct state/federal funds are funds that come to the PIHP directly from a federal agency or another state source. Funds that flow to the PIHP from the Department are not in this category, such as, SDA, and, therefore, are subject to the local match requirement.

Match requirements apply both to budgeted funds during the agreement period and to actual expenditures at year-end.

"Fees and collections" as defined in the Rule include only those fees and collections that are associated with services paid for by the PIHP.

If the PIHP is found not to be in compliance with Match requirements, or cannot provide reasonable evidence of compliance, the Department may withhold payment or recover payment in an amount equal to the amount of the Match shortfall.

5.1 Unobligated Funds

Any unobligated balance of funds held by the Contractor at the end of the agreement period will be returned to the Department or treated in accordance with instructions provided by the Department.

5.2 Fees

The PIHP shall make reasonable efforts to collect 1st and 3rd party fees, where applicable, and report these as outlined by the Department's fiscal procedures. Any under recoveries of otherwise available fees resulting from failure to bill for eligible services will be excluded from reimbursable expenditures.

5.3 Reporting Fees and Collections Revenues

On the initial SUD Budget Report, the PIHP is required to report all estimated fees and collections revenue to be received by the PIHP and all estimated fees and collections revenue to be received and reported by its contracted services providers (see Attachment P II B to this Agreement). On the final SUD Budget Report, the PIHP is required to report all actual fees and collections revenue received by the PIHP and all actual fees and collections revenue received and reported by its contracted services providers (see Attachment P.7.7.1.1 to this Agreement). "Fees

and collections" are as defined in the Annual Administrative Code Supplement, Rule 325.4151 and in the Match Rule section of this Attachment.

5.4 Management of Department-Administered Funds
The PIHP shall manage all Department-administered funds under its control in such a way as to assure reasonable balance among the separate requirements for each funds source.

5.5 Sliding Fee Scale
The PIHP shall implement a sliding fee scale and attach a copy to the initial application every fiscal year, for Department approval. All treatment and prevention providers shall utilize the PIHP sliding fee scale. The sliding fee scale must be established according to the most recent year's Federal Poverty Guidelines. It must consist of a minimum of two distinctive fees based upon the income and family size of the individual seeking substance use disorders services.

The PIHP must assure that all available sources of payments are identified and applied prior to the use of Department-administered funds. The PIHP must have written policies and implement procedures to be used by network providers in determining an individual's ability or inability to pay, when payment liability is to be waived, and in identifying all other liable third parties. The PIHP must also have policies and procedures for monitoring providers and for sanctioning noncompliance.

Financial information needed to determine ability to pay (financial responsibility) must be reviewed annually or at a change in an individual's financial status, whichever occurs sooner. The scale must be applied to all persons (except Medicaid, and MIChild, recipients) seeking substance use disorders services funded in whole or in part by the PIHP. The PIHP has the option to charge fees for AMS services, or not to charge. If the PIHP charges for AMS services, the same sliding fee scale as applied to treatment services must be used.

5.6 Inability to Pay
Services may not be denied because of inability to pay. If a person's income falls within the PIHP's regional sliding fee scale, clinical need must be determined through the standard assessment and patient placement process. If a financially and clinically eligible person has third party insurance, that insurance must be utilized to its full extent. Then, if benefits are exhausted, or if the person needs a service not fully covered by that third party insurance, or if the co-pay or deductible amount is greater than the person's ability to pay, Community Grant funds may be applied. Community Grant funds may not be denied solely on the basis of a person having third party insurance.

5.7 Subcontracts with Hospitals
Funds made available through the Department shall not be made available to public or private hospitals which refuse, solely on the basis of an individual's substance use disorder, admission or treatment for emergency medical conditions.

6.0 RESIDENCY IN PIHP REGION

The PIHP may not limit access to the programs and services funded by this portion of the Agreement only to the residents of the PIHP's region, because the funds provided by the Department under this Agreement come from federal and statewide resources. Members of federal and state-identified priority populations must be given access to screening and to assessment and treatment services, consistent with the requirements of this portion of the Agreement, regardless of their residency. However, for non-priority populations, the PIHP may

give its residents priority in obtaining services funded under this portion of the Agreement when the actual demand for services by residents eligible for services under this portion of the Agreement exceeds the capacity of the agencies funded under this portion of the Agreement.

7.0 REIMBURSEMENT RATES FOR COMMUNITY GRANT, MEDICAID AND OTHER SERVICES

The PIHP must pay the same rate when purchasing the same service from the same provider, regardless of whether the services are paid for by Community Grant funds, Medicaid funds, or other Department administered funds, including MIChild funds.

8.0 MINIMUM CRITERIA FOR REIMBURSING FOR SERVICES TO PERSONS WITH CO-OCCURRING DISORDERS

Department funds made available to the PIHP through this Agreement, and which are allowable for treatment services, may be used to reimburse providers for integrated mental health and substance use disorder treatment services to persons with co-occurring substance use and mental health disorders. The PIHP may reimburse a Community Mental Health Services Program (CMHSP) or Pre-paid Inpatient Health Plan (PIHP) for substance use disorders treatment services for such persons who are receiving mental health treatment services through the CMHSP or PIHP. The PIHP may also reimburse a provider, other than a CMHSP or PIHP, for substance use disorders treatment provided to persons with co-occurring substance use and mental health disorders. As always, when reimbursing for substance use disorders treatment, the PIHP must have an agreement with the CMHSP (or other provider); and the CMHSP (or other provider) must meet all minimum qualifications, including licensure, accreditation and data reporting.

9.0 MEDIA CAMPAIGNS

A media campaign, very broadly, is a message or series of messages conveyed through mass media channels including print, broadcast, and electronic media. Messages regarding the availability of services in the PIHP region are not considered to be media campaigns. Media campaigns must be compatible with MDHHS values, be coordinated with MDHHS campaigns whenever feasible and costs must be proportionate to likely outcomes. The PIHP shall not finance any media campaign using Department-administered funding without prior written approval by the Department.

10.0 NOTICE OF EXCESS OR INSUFFICIENT FUNDS (NEIF)

PIHP's must notify the Department in writing if the amount of State Agreement funding may not be used in its entirety or appears to be insufficient. The notice must be submitted electronically by June 1 to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov

The contract requires that the PIHP expend all allocated funds per the requirements of the SUD contract within the contract year OR notify the Department via the NEIF that spending by year-end will be less than the amount(s) allocated. This requirement applies to individual allocations, earmarks and to the total PIHP allocation. Of particular importance are allocations for Prevention services and Women's Specialty Services (WSS), including the earmarked allocations for the Odyssey programs. The State must closely monitor these expenditures to ensure compliance with the Maintenance of Effort requirement in the federal SAPT Block Grant.

When it has been determined that a PIHP will not expend all of its allocated, WSS State Agreement funds (including the earmarked allocations for the Odyssey programs), these unspent funds must be returned to the Department for reallocation to other PIHPs who can appropriately

use these funds for WSS programs within their PIHP regions within the current fiscal year. A PIHP's failure to expend these funds for the purposes for which they are allocated and/or its failure to notify the Department of projected expenditures at levels less than allocated may result in reduced allocations to the PIHP in the subsequent contract year.

11.0 SUBCONTRACTOR INFORMATION TO BE RETAINED AT THE PIHP

1. Budgeting Information for Each Service.
2. Documentation of How Fixed Unit Rates Were Established: The PIHP shall maintain documentation regarding how each of the unit rates used in its agreements was established. The process of establishing and adopting rates must be consistent with criteria in OMB Circular 2 CFR 200 Subpart E, and with the requirements of individual fund sources.
3. Indirect Cost Documentation: The PIHP shall review subcontractor indirect cost documentation in accordance with OMB Circular 2 CFR 200 Subpart E, as applicable.
4. Equipment Inventories: The PIHP must apply the following to all subcontractors that have budgeted equipment purchases in their contracts with the PIHP:
    a. Any contractor equipment purchases supported in whole or in part through this agreement must be listed in the supporting Equipment Inventory Schedule. Equipment means tangible, non-expendable, personal property having useful life of more than one (1) year and an acquisition cost of $5,000 or more per unit. Title to items having a unit acquisition cost of less than $5,000 shall vest with the Contractor upon acquisition. The Department reserves the right to retain or transfer the title to all items of equipment having a unit acquisition cost of $5,000 or more, to the extent that the Department's proportionate interest in such equipment supports such retention or transfer of title.

12.0 LEGISLATIVE REPORTS (LRS) AND FINANCIAL REPORTS

If the PIHP does not submit the LR or the final RER (which includes MIChild Year-end Balance Worksheets and Administration / Service Coordination Report) within fifteen (15) calendar days of the due date, the Department may withhold from the current year funding an amount equal to five (5) percent of that funding (not to exceed $100,000) until the Department receives the required report. The Department may retain the amount withheld if the contractor is more than forty-five (45) calendar days delinquent in meeting the filing requirements.

The PIHP must assure that the financial data in these reports are consistent and reconcile between the reports; otherwise, the reports will be considered as not submitted and will be subject to financial penalty, as previously mentioned. Additional financial penalties are applicable to the Notice of Excess and Insufficient Funds.

The Department may choose to withhold payment when any financial report is delinquent by thirty (30) calendar days or more and may retain the amount withheld if the report is sixty (60) or more calendar days delinquent. This does not apply to the LR and final RER, as previously stated.

Financial reports are:

1. Revenues and Expenditures Report—INITIAL and FINAL;

2. Financial Status Report—1st thru 3rd quarter;
3. Financial Status Report—4th quarter;
4. Notice of Excess or Insufficient Funds; and
5. Primary Prevention Expenditures by Strategy Report.

13.0 NATIONAL OUTCOME MEASURES (NOMS)

Complete, accurate, and timely reporting of treatment and prevention data is necessary for the Department to meet its federal reporting requirements. For the SUD Treatment NOMS, it is the PIHP's responsibility to ensure that the client information reported on these records accurately describes each client's status at admission first date of service (admission) and on the last day of service (discharge).

14.0 MICHIGAN PREVENTION DATA SYSTEM (MPDS)

PIHPs are required to collect and report the state-required prevention data elements throughout the prevention provider network either through participation in the MPDS or through an upload of the state-required prevention data records to MPDS on a monthly basis.

PIHPs must assure that all records submitted to the state system are consistent with the MPDS Reference Manual. (See SUD Services Policy Manual.)

It is the responsibility of the PIHPs to ensure that the services reported to the system accurately reflects staff service provision and participant information for all PIHP-administered fund sources. It is the responsibility of the PIHPs to monitor provider completeness, timeliness and accuracy of provider data maintained in the system in a manner which will ensure a minimum of 90 percent accuracy.

15.0 CLAIMS MANAGEMENT SYSTEM

The PIHP shall make timely payments to all providers for clean claims. This includes payment at 90% or higher of clean claims from network providers within 60 days of receipt, and 99% or higher of all clean claims within 90 days of receipt.

A clean claim is a valid claim completed in the format and time frames specified by the PIHP and that can be processed without obtaining additional information from the provider. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A valid claim is a claim for services that the PIHP is responsible for under this Agreement. It includes services authorized by the PIHP.

The PIHP must have a provider appeal process to promptly and fairly resolve provider-billing disputes.

16.0 CARE MANAGEMENT

The PIHP may pay for care management as a service designed to support PIHP resource allocation as well as service utilization. Care management is in recognition that some clients represent such service or financial risk that closer monitoring of individual cases is warranted. Care management must be purchased and reported consistent with the instructions for the Administrative Expenditures Report in Attachment P.7.7.1.1 to this agreement.

17.0 PURCHASING DRUG SCREENS

This item does not apply to medication-assisted services.

Department-administered treatment funds can be used to pay for drug screens, if all of the following criteria are met:

1. No other responsible payment source will pay for the screens. This includes self-pay, Medicaid, and private insurance. Documentation must be placed in the client file;
2. The screens are justified by specific medical necessity criteria as having clinical or therapeutic benefit; and
3. Screens performed by professional laboratories can be paid for one time per admission to residential or detoxification services, if specifically justified. Other than these one-time purchases, Department funds may only be used for in house "dip stick" screens.

18.0 PURCHASING HIV EARLY INTERVENTION SERVICES

Department-administered Community Grant funds (blended SAPT Block Grant and General Fund) cannot be used to pay for HIV Early Intervention Services because Michigan is not a Designated State for HIV.

Per 45 CFR, Part 96, Substance Abuse Prevention and Treatment Block Grant, the definition of Early Intervention Services relating to HIV means:

1. appropriate pretest counseling for HIV and AIDS;
2. testing individuals with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease; appropriate post-test counseling; and
3. providing the therapeutic measures described in Paragraph (b) of this definition.

To review the full document, go to: http://law.justia.com/us/cfr/title45/45-1.0.1.1.53.12.html

19.0 SERVICES

19.1 12-Month Availability of Services

The PIHP shall assure that, for any subcontracted treatment or prevention service, each subcontractor maintains service availability throughout the fiscal year for persons who do not have the ability to pay.

The PIHP is required to manage its authorizations for services and its expenditures in light of known available resources in such a manner as to avoid the need for imposing arbitrary caps on authorizations or spending. "Arbitrary caps" are those that are not adjusted according to individualized determinations of the needs of clients. This requirement is consistent with Medical Necessity Criterion 1.4.3, under Treatment Services.

19.2 Persons Associated with the Corrections System

When the PIHP or its AMS services receives referrals from the Michigan Department of Corrections (MDOC), the PIHP shall handle such referrals as per all applicable requirements in this agreement. This would include determining financial and clinical eligibility, authorizing care as appropriate, applying admissions preferences, and other steps. MDOC referrals may come from probation or parole agents, or from MDOC Central Office staff. In situations where

persons have been referred from MDOC and are under their supervision, state-administered funds should be used as the payment of last resort.

When persons who are on parole or probation seek treatment on a voluntary basis from the PIHP's AMS services or from a panel provider, these self-referrals must be handled like any other self-referral to the MDHHS-funded network. AMS or provider staff may seek to obtain releases to communicate with a person's probation or parole agent but in no instance may this be demanded as a condition for admission or continued stay.

The PIHP may collaborate with MDOC, and with the Office of Community Alternatives (OCA) within MDOC, on the purchase of substance use disorders services and supports. This may include collaborative purchasing from the same providers, and for the same clients. In such situations, the PIHP must assure that:

a. All collaborative purchasing is supported by written agreements among the participants.
b. Rates paid to providers, whether by a single purchaser or two or more purchasers, do not exceed provider costs.
c. Rates paid to providers are documented and are developed consistent with applicable OMB Circular(s).
d. No duplication of payment occurs.

19.3 State Disability Assistance (SDA) *(Applies Only to Agencies Who Have Allocations for this Program)*

MDHHS continues to allocate SDA funding and to delegate management of this funding to the PIHP. The PIHP is responsible for allocating these funds to qualified providers. Minimum provider qualifications are MDHHS licensure as a residential treatment provider and accreditation by one of the approved accreditation bodies (identified elsewhere in this Agreement). A provider may be located within the PIHP's region or outside of the region. SDA funds shall not be used to pay for room and board in conjunction with sub-acute detoxification services.

When a client is determined to be eligible for SDA funding, the PIHP must arrange for assessment and authorization for SDA room and board funding and must reimburse for SDA expenditures based on billings from providers, consistent with PIHP/provider agreements. In addition, the PIHP may authorize such services for its own residents at providers within or outside its region.

The PIHP shall not refuse to authorize SDA funds for support of an individual's treatment solely on the basis of the individual's current or past involvement with the criminal justice system. For those individuals currently involved with MDOC and receiving services as part of MDOC programming, SDA funds shall only be used as the payment of last resort.

Qualified providers may be reimbursed up to twenty-seven ($27) per day for room and board costs for SDA-eligible persons during their stays in Residential treatment.

To be eligible for MDHHS-administered SDA funding for room and board services in a substance use disorder treatment program, a person must be determined to meet Michigan Department of Health and Human Services' (MDHHS) eligibility criteria; determined by the PIHP or its designee to be in need of residential treatment services; authorized by the PIHP for residential treatment when the PIHP expects to reimburse the provider for the treatment; at least

18 years of age or an emancipated minor, and in residence in a residential treatment program each day that SDA payments are made.

The PIHP may employ either of two methods for determining whether an individual meets MDHHS eligibility criteria:

The PIHP may refer the individual to the local MDHHS human services office. This method must be employed when there is a desire to qualify the individual for an incidental allowance under the SDA program. Or,

The PIHP may make its own determination of eligibility by applying the essential MDHHS eligibility criteria. See this MDHHS link for details: http://www.michigan.gov/mdhhs/0,1607,7-124-5453_5526---,00.html

For present purposes only, these criteria are:

1. Residency in substance use disorders residential treatment.
2. Michigan residency and not receiving cash assistance from another state.
3. U.S. citizenship or have an acceptable alien status.
4. Asset limit of $3,000 (cash assets only are counted).

Regardless of the method used, the PIHP must retain documentation sufficient to justify determinations of eligibility.

The PIHP must have a written agreement with a provider in order to provide SDA funds.

19.4 Persons Involved with the Michigan Department of Health and Human Services (MDHHS)

The PIHP must work with the MDHHS office(s) in its region to facilitate access to prevention, assessment and treatment services for persons involved with MDHHS, including families in the child welfare system and public assistance recipients. The PIHP must develop written agreements with MDHHS offices that specify payment and eligibility for services, access-to-services priority, information sharing (including confidentiality considerations), and other factors as may be of local importance.

19.5 Primary Care Coordination

The PIHP must take all appropriate steps to assure that substance use disorder treatment services are coordinated with primary health care. In the case PIHPs that PIHPs contract for the Medicaid substance abuse program, PIHPs are reminded that coordination efforts must be consistent with these contracts.

Treatment case files must include, at minimum, the primary care physician's name and address, a signed release of information for purposes of coordination, or a statement that the client has refused to sign a release.

Care coordination agreements or joint referral agreements, by themselves, are not sufficient to show that the PIHP has taken all appropriate steps related to coordination of care. Client case file documentation is also necessary.

19.6 Charitable Choice

The September 30, 2003 Federal Register (45 CFR part 96) contains federal Charitable Choice SAPT block grant regulations, which apply to both prevention and treatment providers/programs. In summary, the regulations require: 1) that the designation of religious (or faith-based) organizations as such be based on the organization's self-identification as religious (or faith based), 2) that these organizations are eligible to participate as providers—e.g. a "level playing field" with regard to participating in the PIHP provider panel, 3) that a program beneficiary receiving services from such an organization who objects to the religious character of a program has a right to notice, referral, and alternative services which meet standards of timeliness, capacity, accessibility and equivalency—and ensuring contact to this alternative provider, and 4) other requirements, including-exclusion of inherently religious activities and non-discrimination.

The PIHP is required to comply with all applicable requirements of the Charitable Choice regulations. The PIHP must ensure that treatment clients and prevention service recipients are notified of their right to request alternative services. Notice may be provided by the AMS or by providers that are faith-based. The PIHP must assign responsibility for providing the notice to the AMS, to providers, or both. Notification must be in the form of the model notice contained in the final regulations, or the PIHP may request written approval from MDHHS of an equivalent notice.

The PIHP must also ensure that its AMS administer the processing of requests for alternative services. This is applicable to all face-to-face services funded in whole or part by SAPT Block Grant funds, including prevention and treatment services. The PIHP must submit an annual report on the number of such requests for alternative services made by the agency during the fiscal year, per AttachmentP7.7.1.1 PIHP Reporting Requirements.

The model notice contained in the federal regulations is:

No provider of substance abuse services receiving Federal funds from the U.S. Substance Abuse and Mental Health Services Administration, including this organization, may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice. If you object to the religious character of this organization, Federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from this organization.

19.7 Treatment

Refer to Medicaid Manual Using criteria for medical necessity, a PIHP may:

1. Deny services a) that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care: b) that are experimental or investigational in nature: or c) for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support, that otherwise satisfies the standards for medically-necessary services: and/or
2. Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

3. Not deny SUD services solely based on PRESET limits of the cost, amount, scope, and duration of services: but instead determination of the need for services shall be conducted on an individualized basis. This does not preclude the establishment of quantitative benefit limits that are based on industry standards and consistent with this contract, and that are provisional and subject to modification based on individual clinical needs and clinical progress.

20.0 CLINICAL ELIGIBILITY: DSM - -DIAGNOSIS

In order to be eligible for treatment services purchased in whole or part by state-administered funds under the agreement, an individual must be found to meet the criteria for one or more selected substance use disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM). These disorders are listed below. This requirement is not intended to prohibit use of these funds for family therapy. It is recognized that persons receiving family therapy do not necessarily have substance use disorders.

Cannabis Related Disorders:

305.20	Cannabis Use Disorder – Mild
304.30	Cannabis Use Disorder – Moderate/Severe
292.89	Cannabis Intoxication
292.0	Cannabis Withdrawal
292.9	Unspecified Cannabis-Related Disorder

Hallucinogen Related Disorders:

305.90	Phencyclidine Use Disorder – Mild
304.60	Phencyclidine Use Disorder – Moderate/Severe
305.30	Other Hallucinogen Use Disorder – Mild
304.50	Other Hallucinogen Use Disorder – Moderate/Severe
292.89	Phencyclidine Intoxication
292.89	Other Hallucinogen Intoxication
292.89	Hallucinogen Persisting Perception Disorder
292.9	Unspecified Phencyclidine Related Disorder
292.9	Unspecified Hallucinogen Related Disorder

Inhalant Related Disorders:

305.90	Inhalant Use Disorder – Mild
304.60	Inhalant Use Disorder – Moderate/Severe
292.89	Inhalant Intoxication
292.9	Unspecified Inhalant Related Disorder

Opioid Related Disorder:

305.50	Opioid Use Disorder – Mild
304.00	Opioid Use Disorder – Moderate/Severe
292.89	Opioid Intoxication
292.0	Opioid Withdrawal
292.9	Unspecified Opioid Related Disorder

Sedative, Hypnotic, or Anxiolytic (SHA) Related Disorders

305.40	SHA – Mild

304.10	SHA – Moderate/Severe
292.89	SHA Intoxication
292.0	SHA Withdrawal
292.9	Unspecified SHA Related Disorder

Stimulant Related Disorders:

Stimulant Use Disorder –

305.70	Amphetamine Type – Mild
305.60	Cocaine – Mild
305.70	Other or Unspecified Stimulant – Mild
304.40	Amphetamine Type – Moderate/Severe
304.20	Cocaine – Moderate/Severe

Stimulant Intoxication

292.89	Amphetamine or other stimulant, without perceptual disturbances
292.89	Cocaine, without perceptual disturbances
292.89	Amphetamine or other stimulant, with perceptual disturbances
292.89	Cocaine, with perceptual disturbances
292.0	Stimulant Withdrawal
292.9	Unspecified Stimulant Related Disorder

Alcohol Use Disorders

305.00	Alcohol Use Disorder – Mild
303.90	Alcohol Use Disorder – Moderate/Severe
303.00	Alcohol Intoxication
291.80	Alcohol Withdrawal
291.9	Unspecified Alcohol-Related Disorder

Other (unknown) Substance Related Disorders:

305.90	Other (unknown) Substance Use Disorder – Mild
304.90	Other (unknown) Substance Use Disorder – Moderate/Severe
292.89	Other (unknown) Substance Intoxication
292.0	Other (unknown) Substance Withdrawal
292.9	Unspecified Other (unknown) Substance Related Disorder

21.0 SATISFACTION SURVEYS

The PIHP shall assure that all network subcontractors providing treatment conduct satisfaction surveys of persons receiving treatment at least once a year. Surveys may be conducted by individual providers or may be conducted centrally by the PIHP. Clients may be active clients or clients discharged up to 12 months prior to their participation in the survey. Surveys may be conducted by mail, telephone, or face-to-face. The PIHP must compile findings and results of client satisfaction surveys for all providers, and must make findings and results, by provider, available to the public.

22.0 MI CHILD

The PIHP must assure use of a standardized assessment process, including the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, to determine clinical eligibility for services based on medical necessity.

Substance use disorder services are covered when medically necessary as determined by the PIHP. This benefit should be construed the same as are medical benefits in a managed care program. Inpatient (hospital-based) services are covered, but the PIHP is permitted to substitute less costly services outside the hospital if they meet the medical needs of the patient. In the same way, the PIHP may substitute services for inpatient or residential services if they meet the child's needs and they are more cost effective. Covered services are as follows:

1. Outpatient Treatment
2. Residential Treatment
3. Inpatient Treatment
4. Laboratory and Pharmacy

These benefits apply only when a PIHP's employed or contracted physician writes a prescription for pharmacy items or lab.

22.1 Eligibility

Eligible persons are persons of age 18 or less who are determined eligible for the MIChild program by the MDHHS and enrolled by the Department's administrative vendor and live in the region covered by the PIHP. The PIHP is responsible for determining eligibility and for charging all authorized and allowable services to the MIChild program up to the PIHP's annual MIChild revenues.

22.2 Per Enrolled Child Per Month

Enrollees who receive substance use disorder services must be entered into the Substance Use Disorder Statewide Client Data System following the instructions in the data reporting specifications.

For the required reporting of encounters for MIChild eligible clients, the PIHP e encounters via the 837 as follows:
2000B Subscriber Hierarchical Level
SBR Subscriber Information
SBR04 Insured Group Name: Use "MIChild" for the group name.
MIChild reporting requirement are found in Attachment B, Reporting Requirements, page 14, section A.

23.0 ACCESS TIMELINESS STANDARDS

Access timeliness requirements are the same as those applicable to Medicaid substance use disorders services, as specified in the agreement between MDHHS and the PIHPs. Access must be expedited when appropriate based on the presenting characteristics of individuals.

24.0 INTENSIVE OUTPATIENT TREATMENT – WEEKLY FORMAT

The PIHP may purchase Intensive outpatient treatment (IOP) only if the treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, for at least three days and at least nine hours per week.

25.0 SERVICES FOR PREGNANT WOMEN, PRIMARY CAREGIVER WITH DEPENDENT CHILDREN, CAREGIVER ATTEMPTING TO REGAIN CUSTODY OF

THEIR CHILDREN

The PIHP must assure that providers screen and/or assess pregnant women, primary caregivers with dependent children, and primary Caregivers attempting to regain custody of their children to determine whether these individuals need and request the defined federal services that are listed below. All federally mandated services must be made available.

25.1 Federal Requirements

Federal requirements are contained in 45 CFR (Part 96) section 96.124, and may be summarized as:

Providers receiving funding from the state-administered funds set aside for pregnant women and women with dependent children must provide or arrange for the 5 types of services, as listed below. Use of state administered funds to purchase primary medical care and primary pediatric care must be approved, in writing, in advance, by the Department contract manager.

1. Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such treatment, child care;
2. Primary pediatric care for their children, including immunizations;
3. Gender specific substance use disorders treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting, and childcare while the women are receiving these services;
4. Therapeutic interventions for children in custody of women in treatment, which may, among other things, address their developmental needs, issues of sexual and physical abuse, and neglect; and
5. Sufficient case management and transportation to ensure that women and their dependent children have access to the above mentioned services.

The above five types of services may be provided through the MDHHS/PIHP agreement only when no other source of support is available and when no other source is financially responsible. MDHHS extends the federal requirements above to primary caregivers attempting to regain custody of their children or at risk of losing custody of their children due to a substance use disorder. These individuals are a priority service population in Michigan and; therefore, the five federal requirements listed above shall be made available to them.

25.2 Requirements Regarding Providers

Women's Specialty Services may only be provided by providers that are designated as gender-responsive by the Department or as gender-competent by the PIHP and that meet standard panel eligibility requirements. The provider may be designated by the Department as Women's Specialty providers, but such designation is not required. The PIHP must continue to provide choice from a list of providers who offer gender-competent treatment and identify providers that provide the additional services specified in the federal requirements.

25.3 Financial Requirements on Quarterly FSRs

On each quarterly FSR, the PIHP must report all allowable Women's Specialty Services expenditures that utilize State Agreement funds. Those funds are Community Grant and/or State Disability Assistance.

25.4 Treatment Episode Data Set SUD (TEDS) and Encounter Reporting Requirements

For SUD TEDS reporting purposes, the Agency must code 'yes' for all women eligible for and receiving qualified women's specialty services. At admission, this can be coded based on eligibility. To qualify, the women must be either pregnant, have custody of a minor child, or be

seeking to regain custody of a minor child. At minimum, the provider must be certified by the agency as gender competent. For all services that qualify based on qualifying characteristics both of the women and of the provider, the HD modifier must be used (See SUD Services Policy Manual/Section I Data Requirements: Substance Abuse Encounter Reporting HCPCS and Revenue Codes Chart).

26.0 ADMISSION PREFERENCE AND INTERIM SERVICES

The Code of Federal Regulations and the Michigan Public Health Code define priority population clients. The priority populations are identified as follows and in the order of importance:

1. Pregnant injecting drug user.
2. Pregnant.
3. Injecting drug user.
4. Parent at risk of losing their child(ren) due to substance use.
5. All others.

Access timeliness standards and interim services requirements for these populations are provided in the next section.

27.0 ACCESS TIMELINESS STANDARDS

The following chart indicates the current admission priority standards for each population along with the current interim service requirements. Suggested additional interim services are in italics: Admission Priority Requirements

Population	Admission Requirement	Interim Service Requirement	Authority
Pregnant Injecting Drug User	1) Screened & referred w/in 24 hrs. 2) Detox, Meth. or Residential – Offer Admission w/in 24 business hrs Other Levels of Care – Offer Admission w/in 48 Business hrs	**Begin w/in 48 hrs:** Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants Effects of alcohol & drug use on the fetus Referral for pre-natal care *Early Intervention Clinical Svc*	CFR 96.121; CFR 96.131; Tx Policy #04 Recommended
Pregnant Substance User	1) Screened & referred w/in 24 hrs 2) Detox, Meth or Residential Offer admission w/in 24 business hrs Other Levels of Care – Offer Admission w/in 48 Business hrs	**Begin w/in 48 hrs** 1. Counseling & education on: A. HIV & TB B. Risks of transmission to sexual partners & infants C. Effects of alcohol & drug use on the fetus 2. Referral for pre-natal care 3. *Early Intervention Clinical Svc*	CFR 96.121; CFR 96.131; Recommended
Injecting Drug User	Screened & Referred w/in 24 hrs; Offer Admission w/in 14 days	**Begin w/in 48 hrs – maximum waiting time 120 days** 1. Counseling & education on: A. HIV & TB B. Risks of needle sharing C. Risks of transmission to sexual partners & infants 2. *Early Intervention Clinical Svc*	CFR 96.121; CFR 96.126 Recommended
Parent at Risk of Losing Children	Screened & referred w/in 24 hrs. Offer Admission w/in 14 days	**Begin w/in 48 business hrs** *Early Intervention Clinical Services*	Michigan Public Health Code Section 6232 **Recommended**
All Others	Screened & referred w/in seven calendar days. Capacity to offer Admission w/in 14 days	**Not Required**	CFR 96.131(a) – sets the order of priority; MDHHS & PIHP contract

28.0 EARMARK-FUNDED SPECIAL PROJECTS: REPORTING REQUIREMENTS

The report must contain the following information:

1. The name of the PIHP whose residents were served through the earmarked funds during the year;
2. The number of persons served by that PIHP, through those funds; and
3. The total amount of earmarked funds paid to the provider for those services.

Annual report form and instructions are available on the MDHHS website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html

29.0 PARTNERSHIP FOR SUCCESS II (PFS II)

(Applies Only to Agencies Who Have Allocations for this Program)
The purpose of this grant is to strengthen and expand the PFSfive-step, data-driven process in designated counties through enhancement of community-level infrastructure. This enhanced infrastructure will address underage drinking among persons age 12-20 and prescription drug misuse and abuse among persons age 12-25. The project is expected to:

1. Build emotional health, prevent or delay the onset of, and mitigate symptoms and complications from substance abuse related to underage drinking among youth age 12-20; and
2. Build emotional healthy, prevent or delay the onset of, and mitigate symptoms and complications from substance abuse related to reducing prescription drug misuse and abuse among youth and young adults age 12-25.

All participating PIHPs received a Request for Information (RFI) document outlining the process for assessing community needs. Information from the RFI will be used by to develop and complete the Strategic Prevention Framework required. Report forms and instructions are available on the MDHHS website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html.

29.1 Required Annual Deliverables:

Request for Training and Technical Assistance Strategic Plan, Cost Detail Schedule, and Program Budget Summary and Justification (must be submitted together).

29.2 Project Requirements

PIHPs will contract with coalitions in the high-need counties to build and enhance the current substance abuse prevention infrastructure to meet the goals of the project. This will be achieved through the strengthening of partnerships with federally qualified health centers (FQHCs), local public health departments (LPHDs), Indian Health Services (IHS) and community college and university health and/or counseling centers (CC&UH/CC). Based on the determined needs in the community, coalitions in each county or jurisdiction will select one of two approved evidence-based programs, Communities that Care or Community Trials, to strengthen these collaborative partnerships. As part of building this capacity, the expectation is that the coalition or a prevention provider will develop mechanisms to implement screening, brief intervention, and problem identification and referral at a primary health clinic. The FQHC, LPHD, IHS, or CC&UH/CC will then assist coalitions in identifying and referring appropriate individuals and families to participate in one of two evidence-based programs: Strengthening Families or Active Parenting for Teens: Families in Action.

PIHPs will work with coalitions in the target counties/jurisdictions to assess data and capacity needs in order to implement the PFS II and achieve the goals of the project, including the need for training and technical assistance. One of the first steps in this process is to distribute a Request for Information (RFI). The RFI will be used for the PIHPs to identify, vet, and select a coalition with the capacity to most effectively achieve the goals outlined in the PFS II grant.

29.3 Role of the PIHP

The PIHPs will be responsible for:

1. Organizing and convening the Community Epidemiology Workgroup (CEW) and Community Strategic Prevention Planning Collaborative (CSPPC) partners and stakeholders for the purpose of implementing the PFS II project in the target county/jurisdiction.
2. Fostering community-wide and community-based collaborative among stakeholders and partners committed to addressing the priority problems.
3. Administrative activities and project management of PFS II funds including:
    a. Contracting and funding local training and technical assistance recommended by the CEWs and CSPPCs.
    b. Selecting and contracting with coalition/provider to implement the project in the target county/jurisdiction.
    c. Monitoring CEW, CSPPC, and provider progress.
    d. Preparing and submitting required financial and programmatic reports on PFS II program activity per contract requirements.
4. PIHPs will be required to convene a CEW that will conduct a county-level needs assessment utilizing local data derived from the SEOW.
5. Assisting the PFS II Evaluator in providing data services and technical assistance to programs reporting capacity, process, and outcome data.
6. PIHPs will work in collaboration with CSPPCs to develop a community-level and culturally competent Strategic Plan to implement the PFS II project.
7. PIHPs must submit a Request for Training and Technical Assistance form to BHDDA, with documented input of the CSPPC, CEW, and other stakeholders as appropriate.
8. PIHPs must submit a PFS II Strategic Plan to BHDDA with documents input of the CSPPC.

30.0 PREVENTION SERVICES

Prevention funds may be used for needs assessment and related activities. All prevention services must be based on a formal local needs assessment.

The Department's intent is to move toward a community-based, consequence-driven model of prevention. In the meantime, based on needs assessment, prevention activities must be targeted to high-risk groups and must be directed to those at greatest risk of substance use disorders and/or most in need of services within these high-risk groups. PIHPs are not required to implement prevention programming for all high-risk groups. The PIHP may also provide targeted prevention services to the general population.

The high risk subgroups include but are not limited to: children of substance abusers; pregnant women/teens; drop-outs; violent and delinquent youth; persons with mental health problems; economically disadvantaged citizens; persons who are disabled; victims of abuse; persons already using substances; and homeless and/or runaway youth Additionally, children exposed prenatally to ATOD are identified as a high-risk subgroup.

Prevention services must be provided through strategies identified by CSAP. These strategies are: information dissemination; education; alternatives; problem identification and referral; community based processes; and environmental change.

Prevention-related funding limitations the PIHP must adhere to are:

1. PIHP expenditure requirements for prevention, including Synar, as stipulated in the PIHP's allocation letter;
2. 90% of prevention expenditures are expected to be directed to programs which are implemented as a result of an evidence-based decision making process:
3. Alternative strategy activities, if provided must reflect evidence-based approaches and best practices such as multi-generational and adult to youth mentoring:
4. State-administered funds used for information dissemination must be part of a multi-faceted regional prevention strategy, rather than independent, stand-alone activity.

The PIHP must monitor and evaluate prevention programs at least annually to determine if the program outcomes, milestones and other indicators are achieved, as well as compliance with state and federal requirements. Indicators may include integrity to prevention best practice models including those related to planning prevention interventions such as risk/protective factor assessment, community assets/resource assessment, levels of community support, evaluation, etc. A written monitoring procedure, which includes requirements for corrective action plans to address issues of concern with a provider, is required.

31.0 SYNAR COVERAGE STUDY: PROTOCOL

Under the Substance Abuse Prevention and Treatment Block Grant requirement, states must conduct annual, unannounced, random inspections of tobacco retailers to determine the compliance rate with laws prohibiting the sale of tobacco products to persons under the age of 18. These Synar surveys involve choosing a random sample of tobacco retail outlets from a well-maintained master tobacco retailer list. Every three years, each state is also required to check the coverage and accuracy of that master list by conducting a coverage study as close as possible to the time of the Synar survey.

"Coverage" indicates how completely the list contains all of the eligible outlets in the state for the Synar survey. The coverage rate is the percentage of all eligible outlets in the state that actually appear on the master list (list frame). The Substance Abuse and Mental Health Services Administration (SAMHSA) recommendation is for a ninety (90) percent coverage rate; however, the actual mandate is for eighty (80) percent coverage. The study will also provide an additional means of checking address accuracy and outlet eligibility, beyond the various methods used to clean the list regularly. This document provides the requirements for the methods and procedures for conducting the Michigan Tobacco Retailer Coverage Study Activity. The Michigan Department of Health and Human Services (MDHHS), Office of Recovery Oriented Systems of Care (OROSC), formerly MDHHS/BSAAS, coverage study design required approval from the Center for Substance Abuse Prevention (CSAP). Therefore, **variance from these procedures is not allowable.**

MDHHS/OROSC will:

1. Select geographic areas to be sampled.

2. Coordinate the participation of the involved coordinating agencies.
3. Provide protocol and necessary training/technical assistance to selected coordinating agencies.
4. Provide specific starting points and boundaries, with mapped routes, guidance, and designated number of tobacco retailers. OROSC will also provide backup protocol in case the internet maps prove to be in error. (**Note:** Predetermined routes will be used to provide consistency.)
5. Allocate a stipend, contingent upon availability of funds, for each located tobacco retailer, up to the designated number in a contract amendment.
6. Distribute and collect necessary canvassing forms.
7. Determine coverage rate.
8. Update master tobacco retailer list (list frame).
9. Report the results to SAMHSA by December 18th every three years (next coverage study will be in FY 2019).

Coverage indicates how completely the master retail list contains (*covers*) all of the eligible outlets in the State for the Synar survey. An eligible outlet is a retailer that sells tobacco and is accessible to minors. The coverage rate is the percentage of all eligible outlets in the State that actually appear on the list frame. The coverage rate can be estimated through a coverage study, which is a special type of survey conducted to measure the coverage or incompleteness of the list. Coverage studies (CS) are conducted every three years as required and prescribed by CSAP. The selection of regional participants is usually based on the PIHPs with the lowest retailer violation rate (RVR) with consideration given to statewide geographic diversity. The goal is to provide the federal government a representative sample of our Master Retail List and verify that the method of updating guarantees that Michigan's list is at least 80% accurate. The last CS was conducted during October 2013. The 2019 CS will occur between August 20 through September 10th, and the reports will be due on September 30, 2019. Only PIHPs that are **selected** are required to canvas their region and report. If not selected, no reporting requirements have to be fulfilled.

PIHPs will:

1. Be responsible for the completion of the coverage study activities within their regions.
2. Provide two-person "field worker" teams (two adults over age 21).
3. Michigan Protocol for Tobacco Retailer Coverage Study Page 2
4. Train, schedule, and supervise the teams in purpose, protocol, routes, and use of canvassing forms.
5. Collect canvassing forms: review for completeness, legibility, and necessary signatures. Submit canvassing forms and contact information of canvassing team membership every three years (next coverage study will be in FY 2019), by due date specified to:

   By Email (preferred): Alicia Nordmann at NordmannA1@michigan.gov
   By Mail (signed forms): Alicia Nordmann, MDHHS/OROSC, 320 S. Walnut, Lewis Cass Bldg. Fifth Floor, Lansing, MI 48913

By Phone: Alicia Nordmann at 517-335-0176.

PIHPs will work with their Designated Youth Tobacco Use Representatives (DYTURs) to establish and identify canvassing teams.

CANVASSING TEAMS will understand that:

1. The purpose of the coverage study is to determine the quality of the master Michigan Tobacco Retailer List (TRL).
2. In no way is the existing TRL or retailers' history to be utilized or considered.
3. These teams will physically canvass all retailers until they have found and recorded **exactly the designated number** of those selling tobacco products, regardless of the number of unvisited retailers and tobacco retailers remaining within the community. Stop when quota is reached.
    a. In some cases, additional communities are listed besides the original selection. This is done to provide an additional location to canvass in case the first selection does not hold enough tobacco retailers to net the desired canvassing total within that county.

CANVASSING TEAMS will:

1. Review protocol; ensure understanding of task and responsibilities.
2. Acquire maps, routes, and canvassing forms from the PIHP.
3. Demonstrate professional etiquette. Understandably, it is expected that canvassers will conduct themselves professionally in a way that reflects well on the PIHP and OROSC. Provide an explanation of the study's purpose utilizing the language in the first paragraph of this document. Thank merchants for their cooperation.
4. Go to the designated starting point in the assigned city/township/village and conduct the coverage study.
5. Utilize the provided map and route to locate all retail businesses and physically enter in the order that they are encountered. CSAP recommends canvassing the entire selected area. Teams may stop when they have reached the quota; however, it is recommended that the Designated Youth Tobacco Use Representatives canvass the entire selected area and submit a complete list. If this cannot be done, please provide an explanation with the report for OROSC records.
6. Make no assumption regarding whether a particular business or a type of business does or does not sell tobacco products – all businesses must be entered and assessed for tobacco sales.
7. Make exceptions to physical entry/visitation only if: 1) exterior signage clearly prohibits entry to the establishment by persons under 18 years of age, or 2) the location is determined to be dangerous to the canvassers' safety. Do not canvass beyond boundaries given. At no time, canvass beyond the county limits.

8. Notify the PIHP Prevention Coordinator **if** the mapped route is in obvious error upon arrival at the starting point. If the team is in a commercial area, secure permission to use the following backup protocol:
    a. At the primary intersection, start in any single direction on one side of the street. Continue on that side for five (5) blocks until all retail establishments have been visited within that area.
    b. Cross the street and work the way back on the opposite side to the primary intersection starting point.

If additional tobacco retailer recordings are needed, this protocol is to be used **ONLY** if the provided primary mapping proves inadequate and **ONLY** after being granted permission from the PIHP. Stay within the boundaries indicated on the provided map, and check establishments while proceeding either:

1. Five (5) blocks forward on the same street.
2. Turn one block to the right or left, and then continue parallel to the first checked street and repeat the process above.
3. Complete the provided form.
4. Legibly record only tobacco retailers that are accessible to persons under 18 years of age. Do not record visited sites that do not sell tobacco products or are not accessible by youth.
5. Include complete data for the contact information: name of store, street number, street name, city, zip code, area code, and phone number. If owner information is available, please add that to back of the form along with the name of store listed on the front. Include their email information if available.
6. Complete the rest of form as directed by column headings.
7. Both canvassers must sign and date each page of the form.
8. Check the form for completeness legibility and signatures.
9. Return the form to the PIHP by the due date requested.

32.0 OPIOID TREATMENT SERVICES

The *Medication Assisted Treatment Guidelines for Opioid Use Disorders* shall be used to facilitate Prepaid Inpatient Health Plan (PIHP) compliance with the treatment of opioid use disorders in all publically funded opioid treatment programs. In reference to this document the term 'Guideline' shall be utilized in the medical sense, as research and application of technology/protocols and treatment pathways provided as a 'guidance' to physicians. PIHPs will work with the Department to establish and implement a timeline and bench marks toward full implementation of the Guidelines.

33.0 FETAL ALCOHOL SPECTRUM DISORDERS

Substance abuse treatment programs are in a unique position to have an impact on the fetal alcohol spectrum disorder (FASD) problem in two ways. First, it is required that these programs include FASD prevention within their treatment regimen for those women that are included in the selective or indicated group based on Institute of Medicine (IOM) prevention categories. Second, for those treatment programs that have contact with the children born to women who have used alcohol it is required that the program screen these children for FASD and, if appropriate, refer for further diagnostics services.

33.1 FASD Prevention Activities

FASD prevention should be a part of all substance abuse treatment programs that serve women. Providing education on the risks of drinking during pregnancy and FASD detection and services are easily incorporated into the treatment regimes.

The IOM Committee to Study Fetal Alcohol Syndrome has recommended three prevention approaches. The universal approach involves educating the public and influencing public policies. The selective approach is targeting interventions to groups that have increased risk for FASD problems such as women of childbearing age that drink. The indicated approach looks at groups who have already exhibited risk behaviors, such as, pregnant women who are drinking or who gave birth to a child who has been diagnosed with FASD. This policy recommends using one of the FASD prevention curriculums for women in the selected or indicated group

33.2 FASD Screening

For any treatment program that serves women, it is required that the program complete the FASD prescreen for children that they interact with during their mother's treatment episode. Substance abuse clinicians do not need to be able to diagnose a child with any disorder in the spectrum of FASD, but do need to be able to screen for the conditions of FASD and make the proper referrals for diagnosis and treatment. The decision to make a referral can be difficult. When dealing with the biological family, issues of social stigma, denial, guilt and shame may surface. For adoptive families, knowledge of alcohol use during pregnancy maybe limited. The following guidelines were developed to assist clinicians in making the decision as to whether a referral is needed. Each case should be evaluated individually. However, if there is any doubt, a referral to a FAS diagnostic clinic should be made.

The following circumstances should prompt a clinician to complete a screen to determine if there is a need for a diagnostic referral:

1. When prenatal alcohol exposure is known and other FAS characteristics are present, a child should be referred for a full FASD evaluation when substantial prenatal alcohol use by the mother (i.e., seven or more drinks per week, three or more drinks on multiple occasions, or both) has been confirmed.
2. When substantial prenatal alcohol exposure is known, in the absence of any other positive criteria (i.e., small size, facial abnormalities, or central nervous system problems), the primary care physician should document exposure and monitor the child for developmental problems.

3. When information regarding prenatal exposure is unknown, a child should be referred for a full FASD evaluation for any one of the following:
    a. Any report of concern by a parent or caregiver that a child has or might have FASD
    b. Presence of all three facial features
    c. Presence of one or more facial features with growth deficits in weight, height or both
    d. Presence of one or more facial features with one or more central nervous system problems
    e. Presence of one or more facial features with growth deficits and one or more central nervous system problems
4. There are family situations or histories that also may indicate the need for a referral for a diagnostic evaluation. The possibility of prenatal exposure should be considered for children in families who have experienced one or more of the following:
    a. Premature maternal death related to alcohol use (either disease or trauma)
    b. Living with an alcoholic parent
    c. Current or history of abuse or neglect
    d. Current or history of involvement with Child's Protective Services
    e. A history of transient care giving institutions
    f. Foster or adoptive placements (including kinship care)

The Fetal Alcohol Syndrome (FAS) Pre-Screen Form can be used to complete the screening process. It also lists the fetal alcohol diagnostic clinics located in Michigan with telephone numbers for easy referral. These clinics complete FASD evaluations and diagnostic services. The clinics also identify and facilitate appropriate health care, education and community services needed by persons diagnosed with FAS.

34.0 SUB-ACUTE DETOXIFICATION

Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required. Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate.

Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM PPC 2-R and individualized determination of client need. The following combinations of sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM PPC 2-R.

Outpatient Setting

- Ambulatory Detoxification without extended on-site monitoring corresponding to ASAM Level I-D, or ambulatory detoxification with extended on-site monitoring (ASAM Level II-D).
- Outpatient setting sub-acute detoxification must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed. ASAM Level II-D ambulatory detoxification services must be monitored by appropriately certified and licensed nurses.

Residential Setting

- Clinically Managed Residential Detoxification - Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level III.2-D). These services must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed.
- Medically Managed Residential Detoxification - Freestanding Detoxification Center: These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician (ASAM LevelIII.7-D).

This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.

35.0 RESIDENTIAL TREATMENT

Residential treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate certified professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day. The clinical program must be provided under the supervision of a Substance Abuse Treatment Specialist with either full licensure or limited licensure as a psychologist, master's social worker, professional counselor, marriage and family therapist or physician. Services may be provided by a substance abuse treatment specialist or a non-degreed staff.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

36.0 DISCRETIONARY AND CATEGORICAL GRANTS FROM OROSC

For all current discretionary and categorical grants, e.g., Partnerships for Success II Grant, distributed through OROSC to sub-recipient PIHPs for counties identified for impact, the PIHPs shall continue to commit to the identified communities for a seamless and efficient process during

the planning, transition and implementation periods. Substance use and mental health disorder Issues identified by the target communities (counties) must be maintained.

36.1 Addressing a Strategic Prevention Planning Framework

All prevention program planning, including mental health promotion must be conducted utilizing the SAMHSA Strategic Planning Framework (SPF) which features a data guided approach to developing strategic plans for SUD prevention and mental health promotion. PIHPs must, at a minimum, address the prevention strategic priority areas listed in the OROSC Strategic Plan - underage drinking, prescription drug abuse and youth access to tobacco - in their strategic plans utilizing the SPF process in a culturally competent manner. The PIHPs must also plan, implement and synchronize their prevention plans with interventions proven to be effective in reducing infant mortality and obesity.

For a complete description of the SPF and the OROSC publications: *Transforming Cultural and Linguistic Theory into Action; A Toolkit for Communities* and *Guidance Document; Selecting, Planning and Implementing Evidence-based Interventions for the Prevention of SUDs*, see the OROSC Prevention Website.

The development and implementation of prevention prepared communities (PPCs) will be the primary mechanism used to meet prevention goals associated with the OROSC Strategic Plan Priority Focus Areas. A PPC is a community equipped to use a comprehensive mix of data-driven prevention strategies, interventions, and programs across multiple sectors to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco), and suicide among youth, tribal communities, and military families.

36.2 Addressing Prevention and Mental Health Promotion Programming

Prevention programming is intended to reduce the consequences of SUDs in communities by preventing or delaying the onset of use, and reducing the progression of SUDs in individuals. Prevention is an ordered set of steps along a continuum that promotes individual, family and community health; prevents mental and behavioral disorders; supports resilience and recovery; and reinforces treatment principles to prevent relapse.

This multi-component and strategic approach should cover all age groups including support for children, senior citizens, all socio-economic classes, diverse cultures, minority and under-served populations, service men and women, gender-specific and targeted high-risk groups.

A minimum of 90 percent of the prevention services funded by the PIHPs must be evidence-based. For reference, see evidence-based guidance document.

Prevention service providers receiving community grant and other federal funding via PIHPs must evaluate prevention services implemented in the PIHP catchment areas as specified by contract and/or grant reporting requirements.

PART III
RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

1.0 RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

1.1 General Provisions

1. Notify the PIHP of the name, address, and telephone number, if available, of all Medicaid, MI Child and Healthy Michigan eligibles in the service area. The PIHP will be notified of changes, as they are known to the MDHHS.
2. Provide the PIHP with information related to known third-party resources and any subsequent changes as the department becomes aware of said information. Notify the PIHP of changes in covered services or conditions of providing covered services.
3. Protect against fraud and abuse involving MDHHS funds and recipients in cooperation with appropriate state and federal authorities.
4. Administer a Medicaid fair hearing process consistent with federal requirements.
5. Collaborate with the PIHP on quality improvement activities, fraud and abuse issues, and other activities that impact on the services provided to individuals.
6. Review PIHP Customer Services Manuals.
7. Apply contract remedies necessary to assure compliance with contract requirements.
8. Monitor the operation of the PIHP to ensure access to quality care for all individuals in need of and qualifying for services.
9. Monitor quality of care provided to individuals who receive PIHP services and supports.
10. Refer local issues back to the PIHP.
11. Monitor, in aggregate, the availability and use of alternative services.
12. Coordinate efforts with other state departments involved in services to the population.
13. When repeated health and welfare issues/emergencies are raised or concerns regarding timely implementation of medically necessary services the MDHHS authority to take action is acknowledged by the PIHP.

1.2 Contract Financing

MDHHS shall pay, to the PIHP, Medicaid funds as agreed to in the contract.

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

1. Action by the Michigan State Legislature or by the Center for Medicare and Medicaid Services that removes any MDHHS funding for, or authority to provide for, specified services.

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

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

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)
BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION
Standards for Behavior Treatment Plan Review Committees
Revision FY17

Application:

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

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

Preamble:

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

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

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

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

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

I. POLICY

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

II. COMMITTEE STANDARDS

A. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. A psychiatric hospital, psychiatric unit or psychiatric partial hospitalization program licensed under 1974 PA 258, MCL 330.1137, that receives public funds under contract with the CMHSP and does not have its own Committee must also have access to and use of the services of the CMHSP Committee regarding a behavior treatment plan for an individual receiving services from that CMHSP. If the CMHSP delegates the functions of the Committee to a contracted mental health service provider, the CMHSP must monitor that Committee to assure compliance with these standards.

B. The Committee shall be comprised of at least three individuals, one of whom shall be a board certified behavior analyst or licensed behavior analyst, and/or licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disabilities Chapter, with the specified training; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the

consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

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

D. The Committee shall meet as often as needed.

E. Expedited Review of Proposed Behavior Treatment Plans:

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

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

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

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

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

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

H. The functions of the Committee shall be to:

1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques [see definitions].
3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.
5. Assure that inquiry has been made about any known medical, psychological or other factors that the individual has, which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
6. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the individuals served.

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

I. On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
   1. Dates and numbers of interventions used.
   2. The settings (e.g., individual's home or work) where behaviors and interventions occurred

3. Observations about any events, settings, or factors that may have triggered the behavior.
4. Behaviors that initiated the techniques.
5. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
6. Description of positive behavioral supports used.
7. Behaviors that resulted in termination of the interventions.
8. Length of time of each intervention.
9. Staff development and training and supervisory guidance to reduce the use of these interventions.
10. Review and modification or development, if needed, of the individual's behavior plan.

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

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

III. BEHAVIOR TREATMENT PLAN STANDARDS

A. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan

needs to be developed and where there is documentation that functional behavioral assessments have been conducted to rule out physical, medical or environmental causes of the target behavior; and that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the target behavior.

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

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

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

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

E. Plans that are forwarded to the Committee for review shall be accompanied by:
   1. Results of assessments performed to rule out relevant physical, medical and environmental causes of the challenging behavior.
   2. A functional behavioral assessment.
   3. Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.
   4. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been used to ameliorate the behavior and have proved to be unsuccessful.
   5. Evidence of continued efforts to find other options.
   6. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
   7. References to the literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the plan

is the best option available. Citing of common procedures that are well researched and utilized within most behavior treatment plans is not required.

8. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

IV. DEFINITIONS

Term	Definition
Anatomical support	Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient's physical functioning.
Aversive techniques	Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management, control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to cons equate target behavior or to accomplish a negative association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purposed of this technical requirement.
Bodily function	The usual action of any region or organ of the body.
Emotional harm	Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.
Consent	A written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.
Functional Behavioral Assessment (FBA)	An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a particular behavior and guide the development of an effective and efficient behavior treatment plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a target behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the target behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the target behavior itself so that a new behavior or skill will be developed to provide the same function or meet the identified need of the recipient. Functional assessments should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.
Emergency Interventions	There are only two emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law

	enforcement intervention. Each agency shall have protocols specifying what physical management techniques are approved for use.
Imminent Risk	An event/action that is about to occur that will likely result in the serious physical harm of one's self or others.
Intrusive Techniques	Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.
Medical and dental procedures restraints	The use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.
Physical management	A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations.
Practice or Treatment Guidelines	Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.
Prone immobilization	Extended physical restraint of an individual in a face down (prone) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position for the purpose of control. Note: **PRONE IMMOBILIZATION IS PROHIBITED UNDER ANY CIRCUMSTANCES**
Positive Behavior Support (PBS)	A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.
Protective device	A device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective devices as defined in this subdivision and incorporated in written individual plan of service shall not be considered a restraint as defined in below.
Provider	The department, each community mental health service program, each licensed hospital, each psychiatric unit, and each psychiatric partial hospitalization program licensed under section 137 of the act, their employees, volunteers, and contractual agents.

Psychotropic drug	Any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior.
Request for Law Enforcement Intervention	Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance **only when**: caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others
Restraint	The use of physical devise to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support
Restrictive Techniques	Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.
Serious physical harm	Physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
Special Consent	Obtaining the written consent of the individual, the legal guardian, the parent with legal custody of a minor child, or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the individual, guardian or parent of a minor may only occur when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.
Therapeutic de-escalation	An intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the re3cipient is placed in an area or room, accompanied by staff who shall therapeutically engage the recipient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.
Time out	A voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.
Unreasonable force	Physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances: 1. There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others. 2. The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.

	3. The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service. The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.
Person-centered planning	A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.
Seclusion	The temporary placement of a recipient in a room, alone, where egress is prevented by any means. Note: Seclusion is prohibited except in a hospital or unit operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.
Support Plan	A written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.
Treatment Plan	A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, which are to be developed with and provided for a recipient.

V. LEGAL REFERENCES

1973 PA 116, MCL 722.111 to 722.128.
1997 federal Balanced Budget Act at 42 CFR 438.100
MCL 330.1700, Michigan Mental Health Code
MCL 330.1704, Michigan Mental Health Code
MCL 330.1712, Michigan Mental Health Code
MCL 330.1740, Michigan Mental Health Code
MCL 330.1742, Michigan Mental Health Code
MCL 330.1744, Michigan Mental Health Code
MDHHS Administrative Rule 7001(l)
MDHHS Administrative Rule 7001(r)
Department of Health and Human Services Administrative Rule 330.7199(2)(g)

PREPAID INPATIENT HEALTH PLANS AND COMMUNITY MENTAL HEALTH SERVICES PROGRAMS

ACCESS SYSTEM STANDARDS

Revised: September, 2015

Preamble

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

Functions

The key functions of an access system are to:

1. **Welcome** all individuals by demonstrating empathy and providing opportunity for the person presenting to describe situation, problems and functioning difficulties, exhibiting excellent customer service skills, and working with them in a non-judgmental way.
2. **Screen** individuals who approach the access system to determine whether they are in crisis and, if so, assure that they receive timely, appropriate attention.
3. **Determine** individuals' eligibility for Medicaid specialty services and supports, MIChild, Healthy Michigan Plan, Substance Abuse Block Grant (SABG) or,

for those who do not have any of these benefits as a person who is presenting needs for behavioral health services make them a priority to be served.

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

STANDARDS

These standards apply to all PIHPs and CMHSPs, whether the access system functions are directly provided by the PIHP or CMHSP, or are 'delegated' in whole or in part to a subcontract provider(s). Hereinafter, the above entities are referred to as "the organization." These standards provide the framework to address all populations that may seek out or request services of a PIHP or CMHSP including adults and children with developmental disabilities, mental illness, and co-occurring mental illness and substance use disorder.

I. WELCOMING

a. The organization's access system services shall be available to all residents of the State of Michigan, regardless of where the person lives, or where he/she contacts the system. Staff shall be welcoming, accepting and helping with all applicants for service[1].
b. The access system shall operate or arrange for an access line that is available 24 hours per day, seven days per week; including in-person and by-telephone access for hearing impaired individuals. Telephone lines are toll-free; accommodate Limited English Proficiency (LEP); are accessible for individuals with hearing impairments; and have electronic caller identification, if locally available[2].
    i. Callers encounter no telephone "trees," and are not put on hold or sent to voicemail until they have spoken with a live representative from the access system and it is determined, following an empathetic opportunity for the caller to express their situation and circumstances, that their situation is not urgent or emergent.
    ii. All crisis/emergent calls are immediately transferred to a qualified practitioner without requiring an individual to call back.

---

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

iii. For non-emergent calls, a person's time on-hold awaiting a screening must not exceed **three minutes** without being offered an option for callback or talking with a non-professional in the interim.
iv. All non-emergent callbacks must occur within **one business day** of initial contact.
v. For organizations with decentralized access systems, there must be a mechanism in place to forward the call to the appropriate access portal without the individual having to re-dial.

c. The access system shall provide a timely, effective response to all individuals who walk in.
   i. For individuals who walk in with urgent or emergent needs[3], an intervention shall be immediately initiated.
   ii. Those individuals with routine needs must be screened or other arrangements made within **thirty minutes.**
   iii. **It is expected that the Access Center/unit or function will operate minimally eight hours daily, Monday through Friday, except for holidays.**
d. The access system shall maintain the capacity to immediately accommodate individuals who present with:
   i. LEP and other linguistic needs
   ii. Diverse cultural and demographic backgrounds
   iii. Visual impairments
   iv. Alternative needs for communication
   v. Mobility challenges[4]
e. The access system shall address financial considerations, including county of financial responsibility as a secondary administrative concern, only after any urgent or emergent needs of the person are addressed. Access system screening and crisis intervention shall never require prior authorization; nor shall access system screening and referral ever require any financial contribution from the person being served[5].
f. The access system shall provide applicants with a summary of their rights guaranteed by the Michigan Mental Health Code, including information about their rights to the person-centered planning process and assure that they have access to the pre-planning process as soon as the screening and coverage determination processes have been completed[6].
g. The access system shall provide information regarding confidentiality (42 CFR) and recipient rights of substance use disorder clients to all individuals requesting services.

---

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

II. SCREENING FOR CRISES

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

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

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

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

III. PRIORITY POPULATION MANAGEMENT

a. The Substance Abuse Block Grant (SABG) requirements indicate that clients who are pregnant or injecting drug users have admission preference over any other client accessing the system and are identified as a priority population. Priority population clients must be admitted to services as follows: [11]

[7] MDHHS Administrative Rule 330.2006
[8] MHC § 330.1206 and 1409
[9] 42 CFR §438.6; MCL 700.5501 et seq
[10] 42 CFR §438.114. MDHHS/PIHP Contract, Part I, Section 1
[11] 45 CFR §96.131, MHC §333.6232

Population	Admission Requirement	Interim Service Requirement
Pregnant Injecting Drug User	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. d) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Pregnant Substance Use Disorders	1) Screened and referred within 24 hours. 2) Detoxification, Methadone, or Residential – Offer admission within 24 business hours. Other Levels or Care – Offer admission within 48 business hours.	*Begin within 48 hours:* 1. Counseling and education on: a) HIV and TB. b) Risks of transmission to sexual partners and infants. c) Effects of alcohol and drug use on the fetus. 2. Referral for pre-natal care. 3. Early intervention clinical services.
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 hours – maximum waiting time 120 days:* 1. Counseling and education on: a) HIV and TB. b) Risks of needle sharing. c) Risks of transmission to sexual partners and infants. 2. Early intervention clinical services.
Parent At-Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	*Begin within 48 business hours:* Early intervention clinical services.
All Others	Screened and referred within seven calendar days. Capacity to offer admission within 14 days.	Not required.

b. It is the expectation that the PIHP provide substance use disorder services to priority population clients before any other non-priority client is admitted for any other treatment services. Exceptions can be made when it is the client's choice to wait for a program that is at capacity.

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

a. The organization shall ensure access to public mental health services in accordance with the MDHHS/PIHP and MDHHS/CMHSP contracts[12] and:
   i. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the individual is a Medicaid beneficiary.
   ii. The MIChild Provider Manual if the individual is a MIChild beneficiary.
   iii. The Michigan Mental Health Code and the MDHHS Administrative Rules, if the individual is not eligible for Medicaid or MIChild[13]. For mental health services, CMHSPs shall serve individuals with serious mental illness, serious emotional disturbance and developmental disabilities, giving priority to those with the most serious forms of illness and those in urgent and emergent situations. Once the needs of these individuals have been addressed, MDHHS expects that individuals with other diagnoses of mental disorders with a diagnosis found in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM)[14], will be served based upon agency priorities and within the funding available.

b. The responsible organization shall ensure access to public substance abuse treatment services in accordance with the MDHHS/PIHP contract[15] and:
   i. The Mental Health and Substance Abuse Chapter of the Medicaid Provider Manual, if the individual is a Medicaid beneficiary.
   ii. The MIChild Provider Manual if the individual is a MIChild beneficiary.
   iii. The priorities established in the Michigan Public Health Code, if the individual is not eligible for Medicaid or MIChild[16].
   iv. Provisional diagnostic impression using all five axes of the current version of the DSM of Mental Disorders.
   v. Medical necessity and level of care determination criteria utilizing the American Society of Addiction Medicine (ASAM) Criteria.
      1. Dimension 1 – Alcohol Intoxication and/or Withdrawal Potential.
      2. Dimension 2 – Biomedical Conditions and Complications.
      3. Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications.
      4. Dimension 4 – Readiness to Change.

---

[12] MDHHS/PIHP & CMHSP Contracts, Part II, Section 3
[13] MHC §330.1208
[14] The **Diagnostic and Statistical Manual of Mental Disorders (DSM)** is an American handbook for mental health professionals that lists different categories of mental disorders and the criteria for diagnosing them, according to the publishing organization the American Psychiatric Association
[15] MDHHS/CA contract, Attachment A, Statement of Work, and Attachment E, Methadone Enrollment Criteria and Access Management Policy
[16] Public Health Code P.A. 368 of 1978 §333.6100 and 6200 and MDHHS Administrative Rule 325.14101

5. Dimension 5 – Relapse, Continued Use or Continued Problem Potential.
6. Dimension 6 – Recovery Environment.

c. The organization shall ensure that screening tools and admission criteria are based on eligibility criteria in parts III.a. and III.b. above, and are valid, reliable, and uniformly administered[17].
d. The organization shall be capable of providing the Early Periodic Screening, Diagnostic and Treatment (EPSDT) corrective or ameliorative services that are required by the MDHHS/PIHP specialty services and supports contract[18].
e. When clinical screening is conducted, the access system shall provide a written (hard copy or electronic) screening decision of the person's eligibility for admission based upon established admission criteria. The written decision shall include:
    i. Identification of presenting problem(s) and need for services and supports.
    ii. Initial identification of population group (DD, MI, SED, or SUD) that qualifies the person for public mental health and substance use disorder services and supports.
    iii. ASAM Criteria
    iv. Legal eligibility and priority criteria (where applicable).
    v. Documentation of any emergent or urgent needs and how they were immediately linked for crisis service.
    vi. Identification of screening disposition.
    vii. Rationale for system admission or denial.
f. The access system shall identify and document any third-party payer source(s) for linkage to an appropriate referral source, either in network, or out-of-network.
g. The organization shall not deny an eligible individual a service because of individual/family income or third-party payer source[19].
h. The access system shall document the referral outcome and source, either in-network or out-of-network.
i. The access system shall document when a person with mental health needs, but who is not eligible for Medicaid or MIChild, is placed on a 'waiting list' and why[20].
j. The organization shall assure that an individual who has been discharged back into the community from outpatient services, and is requesting entrance back into the PIHP/CMHSP or provider, within one year, will not have to go through the duplicative screening process. They shall be triaged for presenting mental health needs per urgent, emergent or routine.

---

[17] MDHHS AFP, Section 3.1.5
[18] MDHHS/PIHP Contract, Part II, Section 3.4.3. Michigan Medicaid Provider Manual, Practitioner Chapter
[19] MHC §330.1208
[20] MHC §330.1226

IV. COLLECTING INFORMATION

a. The access system shall avoid duplication of screening and assessments by using assessments already performed or by forwarding information gathered during the screening process to the provider receiving the referral, in accordance with applicable federal/state confidentiality guidelines (e.g. 42 CFR Part 2 for substance use disorders).
b. The access system shall have procedures for coordinating information between internal and external providers, including Medicaid Health Plans and primary care physicians[21].
c. Coordination of Care with the Court System[22]
    i. The access system must be able to utilize the substance use disorder screening information and treatment needs provided by district court probation officer assessments when the probation officer has the appropriate credentialing through the Michigan Certification Board for Addiction Professionals (MCBAP). A release of information form must accompany the district court probation officer referral. The information provided by the probation officer should supply enough information to the access system to apply ASAM Criteria to determine LOC and referral for placement. In situations where information is not adequate, the release of information will allow the access system to contact the district court probation officer to obtain other needed information. The access system must be able to authorize these services based on medical necessity, so PIHP funds can be used to pay for treatment.

V. REFERRAL TO PIHP or CMHSP PRACTITIONERS

a. The access system shall assure that applicants are offered appointments for assessments with mental health professionals of their choice within the MDHHS/PIHP and CMHSP contract-required standard timeframes[23]. Staff follows up to ensure the appointment occurred.
b. The access system shall ensure that, at the completion of the screening and coverage determination process, individuals who are accepted for services have access to the person-centered planning process[24].
c. The access system shall ensure that the referral of individuals with co-occurring mental illness and substance use disorders to PIHP or CMHSP or other practitioners must be in compliance with confidentiality requirements of 42 CFR.

---

[21] 42 CFR §438.208
[22] 45 CFR §96.132
[23] Choice of providers: 42 CFR §438.52. MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.4. Timeframes for access: Section 3.1
[24] MDHHS AFP, Section 3.2. MDHHS/PIHP & CMHSP Contracts, Part II, Section 3.4.1 and Attachment 3.4.1.1

VI. REFERRAL TO COMMUNITY RESOURCES

a. The access system shall refer Medicaid beneficiaries who request mental health services, but do not meet eligibility for specialty supports and services, to their Medicaid Health Plans[25] or Medicaid fee-for-service providers.
b. The access system shall refer individuals who request mental health or substance abuse services but who are neither eligible for Medicaid, Healthy Michigan Plan, or MIChild mental health and substance abuse services, nor who meet the priority population to be served criteria in the Michigan Mental Health Code or the Michigan Public Health Code for substance abuse services, to alternative mental health or substance abuse treatment services available in the community.
c. The access system shall provide information about other non-mental health community resources or services that are not the responsibility of the public mental health system to individuals who request it[26].

VII. INFORMING INDIVIDUALS

a. **General**
    i. The access system shall provide information about, and help people connect as needed with, the organization's Customer Services Unit, peer supports specialists and family advocates; and local community resources, such as: transportation services, prevention programs, local community advocacy groups, self-help groups, service recipient groups, and other avenues of support, as appropriate[27].
b. **Rights**
    i. The access system shall provide Medicaid, Healthy Michigan Plan and MIChild beneficiaries information about the local dispute resolution process and the state Medicaid Fair Hearing process[28]. When an individual is determined ineligible for Medicaid specialty service and supports, Healthy Michigan Plan or MIChild mental health services, he/she is notified both verbally and in-writing of the right to request a second opinion; and/or file an appeal through the local dispute resolution process; and/or request a state Fair Hearing.
    ii. The access system shall provide individuals with mental health needs or persons with co-occurring substance use/mental illness with information regarding the local community mental health Office of Recipient Rights (ORR)[29]. The access system shall provide individuals with substance use disorders, or persons with co-occurring substance use/mental illness with information

[25] 42 CFR §438.10
[26] MDHHS AFP, Section 2.9
[27] MDHHS AFP, Section 2.9
[28] 42 CFR § 438.10. MDHHS/PIHP Contract, Part II, Section 6.3.2 and Attachment 6.3.2.1
[29] MHC §330.1706

regarding the local substance abuse coordinating Office of Recipient Rights[30].

iii. When an individual with mental health needs who is not a Medicaid beneficiary is denied community mental health services, for whatever reason, he/she is notified of the right under the Mental Health Code to request a second opinion and the local dispute resolution process[31].

iv. The access system shall schedule and provide for a timely second opinion, when requested, from a qualified health care professional within the network, or arrange for the person to obtain one outside the network at no cost. The person has the right to a face-to-face determination, if requested[32].

v. The access system shall ensure the person and any referral source (with the person's consent) are informed of the reasons for denial, and shall recommend alternative services and supports or disposition[33].

c. **Services and Providers Available**

i. The access system shall assure that applicants are provided comprehensive and up-to-date information about the mental health and substance abuse services that are available and the providers who deliver them[34].

ii. The access system shall assure that there are available alternative methods for providing the information to individuals who are unable to read or understand written material, or who have LEP[35].

VIII. ADMINISTRATIVE FUNCTIONS

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

b. Community Outreach and Resources

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

ii. The organization shall have a regular and consistent outreach effort to commonly un-served or underserved populations who include children and families, older adults, homeless persons, members of ethnic, racial, linguistic and culturally-diverse groups, persons with dementia, and pregnant women.[36]

---

[30] MDHHS Administrative Rule 325.14302
[31] MHC §330.1706, MDHHS/CMHSP Contract, Part II, Attachment 6.3.2.1
[32] MDHHS/PIHP & CMHSP Contract, Part II, Section 3.4.5
[33] 42 CFR § 438.10
[34] 42 CFR § 438.10, MDHHS/PIHP Contract, Part II, Section 6.3.3. MDHHS AFP, Section 3.1.1
[35] 42 CFR § 438.10, MDHHS/PIHP Contract, Part II, Section 6.3.3
[36] MDHHS AFP, Section 3.1.2

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

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

c. Oversight and Monitoring

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

ii. The organization shall assure that the access system staff are qualified, credentialed and trained consistent with the Medicaid Provider Manual, MIChild Provider Manual, the Michigan Mental Health Code, the Michigan Public Health Code, and this contract[37].

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

iv. The organization shall monitor provider capacity to accept new individuals, and be aware of any provider organizations not accepting referrals at any point in time[38].

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

vi. The organization shall assure that the access system maintains medical records in compliance with state and federal standards[39].

vii. The organization staff shall work with individuals, families, local communities, and others to address barriers to using the access system, including those caused by lack of transportation[40].

d. Waiting Lists

i. The organization shall have policies and procedures for maintaining a waiting list for individuals not eligible for Medicaid or MIChild, and who request community mental health services but cannot be immediately served[41]. The policies and procedures shall minimally assure:

---

[37] 42 CFR §438.214. MDHHS/PIHP Contract. Part II. Attachment 6.7.1.1
[38] 42 CFR §438.10
[39] Michigan Medicaid Provider Manual, General Information Chapter, Section 13.1
[40] MDHHS AFP, Section 3.1.10
[41] MHC §330.1124

1. No Medicaid or MIChild beneficiaries are placed on waiting lists for any medically necessary Medicaid or MIChild service.
2. A local waiting list shall be established and maintained when the CMHSP is unable to financially meet requests for public mental health services received from those who are not eligible for Medicaid, , or MIChild[42]. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
3. Persons who are not eligible for Medicaid, or MIChild, who receive services on an interim basis that are other than those requested shall be retained on the waiting list for the specific requested program services. Standard criteria will be developed for who must be placed on the list, how long they must be retained on the list, and the order in which they are served.
4. Use of a defined process, consistent with the Mental Health Code, to prioritize any service applicants and recipients on its waiting list.
5. Use of a defined process to contact and follow-up with any individual on a waiting list who is awaiting a mental health service.
6. Reporting, as applicable, of waiting list data to MDHHS as part of its annual program plan submission report in accordance with the requirements of the Mental Health Code.
7. The PIHP is responsible for maintaining a SABG waiting list by contacting clients who are placed on it every 30 days to check their status/well-being and continued interest in services until they are linked with the appropriate level of care. Attempts and contacts shall be documented to ensure that the list is properly maintained. Those clients who are not able to be contacted, or who do not respond after 90 days, may be removed.
8. Priority population clients placed on a waiting list are required to be offered interim services[43]. Interim services must minimally include:
    a. Counseling and education about the human immunodeficiency virus (HIV) and tuberculosis (TB).
    b. The risks of needle sharing.

[42] MHC §330.1208
[43] section 96.121 of the Substance Abuse Block Grant

c. The risks of transmission to sexual partners, infants, and steps that can be taken to ensure that HIV and TB transmission does not occur.
d. HIV or TB treatment service referrals.
e. Counseling on the effects of alcohol and drug use on a fetus and referral for prenatal care are required for pregnant women.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
PERSON CENTERED PLANNING POLICY

June 5, 2017

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

I. WHAT IS THE PURPOSE OF THE MICHIGAN MENTAL HEALTH SYSTEM?

The purpose of the community mental health system is to support adults and children with intellectual and developmental disabilities, adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance to live successfully in their communities—achieving community inclusion and participation, independence, and productivity.
Person-Centered Planning (PCP) enables individuals to identify and achieve their personal goals. As described below, PCP for minors (family-driven and youth-guided practice) involves the whole family.

PCP is a way for people to plan their lives in their communities, set the goals that they want to achieve, and develop a plan for how to accomplish them. PCP is required by state law[the Michigan Mental Health Code (the Code)] and federal law [the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules] as the way that people receiving services and supports from the community mental health system plan how those supports are going to enable them to achieve their life goals. The process is used to plan the life that the person aspires to have, considering various options—taking the individual's goals, hopes, strengths, and preferences and weaving them into plans for the future. Through PCP, a person is engaged in decision making, problem solving, monitoring progress, and making needed adjustments to goals and supports and services provided in a timely manner. PCP is a process that involves support and input from those people who care about the person doing the planning. The PCP process is used any time an individual's goals, desires, circumstances, choices, or needs change. While PCP is the required planning approach for mental health and I/DD services provided by the CMHSP system, PCP can include planning for other public supports and privately-funded services chosen by the person.

The HCBS Final Rule requires that Medicaid-funded services and supports be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree

of access as individuals not receiving such services and supports. 42 CFR 441.700 et. seq. The HCBS Final Rule also requires that PCP be used to identify and reflect choice of services and supports funded by the mental health system.

Through the PCP process, a person and those he or she has selected to support him or her:

a. Focus on the person's life goals, interests, desires, choices, strengths and abilities as the foundation for the PCP process.

b. Identify outcomes based on the person's life goals, interests, strengths, abilities, desires and choices.

c. Make plans for the person to achieve identified outcomes.

d. Determine the services and supports the person needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.

e. After the PCP process, develop an Individual Plan of Services (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

PCP focuses on the person's goals, while still meeting the person's basic needs [the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code]. As appropriate for the person, the PCP process may address Recovery, Self-Determination, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning as described in the relevant MDHHS policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the person to work toward and achieve their personal goals.

For minor children, the concept of PCP is incorporated into a family-driven, youth-guided approach (see the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline). The needs of the child are interwoven with the needs of the family, and therefore supports and services impact the entire family. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the person reaches adulthood, his or her needs and goals become primary.

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

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

b. The minor is emancipated.

c. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the minor or substantial disruption of the planning process. Justification of the exclusion of parents shall be documented in the clinical record.

II. HOW IS PCP DEFINED IN LAW?

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

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

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

The HCBS Final Rule does not define PCP, but does require that the process be used to plan for Medicaid-funded services and supports. 42 CFR 441.725. The HCBS Final Rule also sets forth the requirements for using the process. These requirements are included in the PCP Values and Principles and Essential Elements below.

III. WHAT ARE THE VALUES AND PRINCIPLES THAT GUIDE THE PCP PROCESS?

PCP is an individualized process designed to respond to the unique needs and desires of each person. The following values and principles guide the PCP process whenever it is used.

a. Every person is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the person's ability to make choices.

b. Every person has strengths, can express preferences, and can make choices. The PCP approach identifies the person's strengths, goals, choices, medical and support needs and desired outcomes. In order to be strength-based, the positive attributes of the person are documented and used as the foundation for building the person's goals and plans for community life as well as strategies or interventions used to support the person's success.

c. The person's choices and preferences are honored. Choices may include: the family and friends involved in his or her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships and friendships, and transportation. Individual choice must be used to develop goals and to meet the person's needs and preferences for supports and services and how they are provided.

d. The person's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the person to implement their choices or preferences over time.

e. Every person contributes to his or her community, and has the right to choose how supports and services enable him or her to meaningfully participate and contribute to his or her community.

f. Through the PCP process, a person maximizes independence, creates connections and works towards achieving his or her chosen outcomes.

g. A person's cultural background is recognized and valued in the PCP process. Cultural background may include language, religion, values, beliefs, customs, dietary choices and other things chosen by the person. Linguistic needs, including ASL interpretation, are also recognized, valued and accommodated.

IV. WHAT ARE THE ESSENTIAL ELEMENTS OF THE PERSON-CENTERED PLANNING PROCESS?

The following elements are essential to the successful use of the PCP process with a person and the people invited by the person to participate.

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

b. **Person-Centered.** The planning process focuses on the person, not the system or the person's family, guardian, or friends. The person's goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the person's needs or choices, rather than viewed as an annual event.

c. **Outcome-Based.** The person identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.

d. **Information, Support and Accommodations.** As needed, the person receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the IPOS. Support and accommodations to assist the person to participate in the process are provided. The person is offered information on the full range of services available in an easy-to-understand format.

e. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process.

f. **Pre-Planning.** The purpose of pre-planning is for the person to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Each person must use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

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

1. When and where the meeting will be held.

2. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).

3. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them. (What will be discussed and not discussed.

4. The specific PCP format or tool chosen by the person to be used for PCP.

5. What accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).

6. Who will facilitate the meeting.

7. Who will take notes about what is discussed at the meeting.

g. **Wellness and Well-Being**. Issues of wellness, well-being, health and primary care coordination support needed for the person to live the way he or she want to live are discussed and plans to address them are developed. People are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, eating candy or other sweets). If the person chooses, issues of wellness and well-being can be addressed outside of the PCP meeting.

PCP highlights personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the person's right to assume some degree of personal risk. The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).

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

V. WHAT IS INDEPENDENT FACILITATION?

An Independent Facilitator is a person who facilitates the person-centered planning process in collaboration with the person. In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their person-centered planning process. The terms independent and external mean that the facilitator is independent of or external to the community mental health system. It means that the person has no financial interest in the outcome of the

supports and services outlined in the person-centered plan. Using an independent facilitator is valuable in many different circumstances, not just situations involving disagreement or conflict.

The PIHP/CMHSP must contract with a sufficient number of independent facilitators to ensure availability and choice of independent facilitators to meet their needs. The independent facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, assisting and representing their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The independent facilitator must not have any other role within the PIHP/CMHSP. The role of the independent facilitator is to:

a. Personally know or get to know the individual who is the focus of the planning, including what he or she likes and dislikes, personal preferences, goals, methods of communication, and who supports and/or is important to the person.

b. Help the person with all pre-planning activities and assist in inviting participants chosen by the person to the meeting(s).

c. Assist the person to choose planning tool(s) to use in the PCP process.

d. Facilitate the PCP meeting(s) or support the individual to facilitate his or her own PCP meeting(s).

e. Provide needed information and support to ensure that the person directs the process.

f. Make sure the person is heard and understood.

g. Keep the focus on the person.

h. Keep all planning participants on track.

i. Develop an individual plan of service in partnership with the person that expresses the person's goals, is written in plain language understandable by the person, and provides for services and supports to help the person achieve their goals.

The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called "Treatment Planning" (MPM MH&SAA Chapter, Section 3.25.) If the independent facilitator is paid for the provision of these activities, the PIHP/CMHSP may report the service under the code H0032.

An individual may use anyone he or she chooses to help or assist in the person-centered planning process, including facilitation of the meeting. If the person does not meet

the requirements of an Independent Facilitator, he or she cannot be paid, and responsibility for the Independent Facilitator duties described above falls to the Supports Coordinator/Case Manager. A person may choose to facilitate his or her planning process with the assistance of an Independent Facilitator.

VI. HOW IS PERSON CENTERED PLANNING USED TO WRITE AND CHANGE THE INDIVIDUAL PLAN OF SERVICE?

The Code establishes the right for all people to develop Individual Plans of Services (IPOS) through the PCP process. The PCP process must be used at any time the person wants or needs to use the process, but must be used at least annually to review the IPOS. The agenda for each PCP meeting should be set by the person through the pre- planning process, not by agency or by the fields or categories in a form or an electronic medical record

Assessments may be used to inform the PCP process, but is not a substitute for the process. Functional assessments must be undertaken using a person-centered approach. The functional assessment and the PCP process together should be used as a basis for identifying goals, risks, and needs; authorizing services, utilization management and review. No assessment scale or tool should be utilized to set a dollar figure or budget that limits the person-centered planning process.

While the Code requires that PCP be used to develop an Individual Plan of Services (IPOS) for approved community mental health services and supports, the purpose of the PCP process is for the person to identify life goals and decide what medically necessary services and supports need to be in place for the person to have, work toward or achieve those life goals. The person or representative chooses what services and supports are needed. Depending on the person, community mental health services and supports may play a small or large role in supporting him or her in having the life he or she wants. When a person is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life that he or she desires to have.

People are often at different points in the process of achieving their life goals. The PCP process should be individualized to meet each person's needs of the person for whom planning is done, i.e. meeting a person where he or she is. Some people may be just beginning to define the life they want and initially the PCP process may be lengthy as the person's goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once an IPOS is developed, subsequent use of the PCP process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent to which an IPOS is updated will be determined by the needs and desires of the person. If and when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs of the person as they arise.

An IPOS must be prepared in person-first singular language and be understandable by the person with a minimum of clinical jargon or language. The person must agree to the IPOS in writing. The IPOS must include all of the components described below:

a. A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.

b. The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.

c. The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports.

d. The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services and sup- ports from the mental health system. The PIHP/CMHSP is responsible for ensuring it meets these requirements of the HCBS Final Rule.

e. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

f. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.

g. Documentation of any restriction or modification of additional conditions must meet the standards.

h. The services which the person chooses to obtain through arrangements that support self-determination.

i. The estimated/prospective cost of services and supports authorized by the community mental health system pursuant to Contract Attachment P.6.3.2.1B.ii.

j. The roles and responsibilities of the person, the supports coordinator or case manager, the allies, and providers in implementing the IPOS.

k. The person or entity responsible for monitoring the plan.

l. The signatures of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).

m. The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.

n. A timeline for review.

o. Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

Once a person has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the person's needs, changes in the person's condition as determined through the PCP process or changes in the personal preferences for support).

The person and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. A person or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the person and his/her guardian or authorized representative, if any, shall occur not less than annually. Reviews will work from the existing IPOS to review progress on goals, assess personal satisfaction and to amend or update the IPOS as circumstances, needs, preferences or goals change or to develop a completely new plan, if the person desires to do so. The review of the IPOS at least annually is done through the PCP process.

The PCP process often results in personal goals that aren't necessarily supported by the CMHSP services and supports. Therefore, the PCP process must not be limited by program specific functional assessments. The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the PCP. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented. Non-paid supports, chosen by the person and agreed to by the unpaid provider, needed to achieve the goals must be documented. With the permission of the person, the IPOS should be discussed with family/friends/caregivers chosen by the person so that they fully understand it and their role(s).

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

VII. HOW MUST RESTRICTIONS ON A PERSON'S RIGHTS AND FREEDOMS BE DOCUMENTED IN THE IPOS?

Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS.

The rights and freedoms listed in the HCBS Final Rule are:

a. A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.

b. Sleeping or living units lockable by the individual with only appropriate staff having keys.

c. Individuals sharing units have a choice of roommate in that setting.

d. Individuals have the freedom to furnish and decorate their sleeping or living unites within the lease or other agreement.

e. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

f. Individuals are able to have visitors of their choosing at any time.

The following requirements must be documented in the IPOS when a specific health or safety need warrants such a restriction:

1. The specific and individualized assessed health or safety need.

2. The positive interventions and supports used prior to any modifications or additions to the IPOS regarding health or safety needs.

3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.

4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.

5. A regular collection and review of data to measure the ongoing effectiveness of the modification.

6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7. Informed consent of the person to the proposed modification.

8. An assurance that the modification itself will not cause harm to the person.

VIII. WHAT DO PIHPS, CMHSPS AND OTHER ORGANIZATIONS NEED TO DO TO ENSURE SUCCESSFUL USE OF THE PERSON-CENTERED PLANNING PROCESS?

Successful implementation of the PCP Process requires that agency policy, mission/ vision statements, and procedures incorporate PCP standards. A process for monitoring PCP should be implemented by both the PIHPs and CMHSP, along with the monitoring process through the MDHHS site review.

The following elements are essential for organizations responsible implementing the PCP process:

a. **Person-Centered Culture**. The organization provides leadership, policy direction, and activities for implementing PCP at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.

b. **Individual Awareness and Knowledge.** The organization provides easily understood information, support and when necessary, training, to people using services and supports, and those who assist them, so that they understand their right to and the benefits of PCP, know the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).

c. **Conflict of Interest.** The organization ensures that the conflict of interest requirements of the HCBS Final Rule are met and that the person responsible for the PCP process is separate from the eligibility determination, assessment, and service provision responsibilities.

d. **Training.** All Staff receive competency-based training in PCP so that they have consistent understanding of the process. Staff who are directly involved in IPOS services or supports implementation are provided with specific training.

e. **Roles and Responsibilities.** As an individualized process, PCP allows each person to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.

f. **System wide Monitoring.** The Quality Assurance/Quality Management (QA/QM) System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful use of the PCP process. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and

standards are in place to assure that the person directs the PCP process and ensures that PCP is consistently followed.

IX. WHAT DISPUTE RESOLUTION OPTIONS ARE AVAILABLE?

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). When a person is receiving services and no agreement on IPOS can be made through the person-centered planning process during the annual review, services shall continue until a notice of a denial, reduction, suspension, or termination is given in which case the rights and procedures for grievance and appeals take over. Other options are available to all recipients of Michigan mental health services and supports. Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate the dispute resolution processes.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration
SELF-DETERMINATION POLICY & PRACTICE GUIDELINE[i]

INTRODUCTION

Self-determination is the value that people served by the public mental health system must be supported to have a meaningful life in the community. The components of a meaningful life include: work or volunteer activities that are chosen by and meaningful to person, reciprocal relationships with other people in the community, and daily activities that are chosen by the individual and support the individual to connect with others and contribute to his or her community. With arrangements that support self-determination, individuals have control over an individual budget for their mental health services and supports to live the lives they want in the community. The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.

Person-centered planning (PCP) is a central element of self-determination. PCP is the crucial medium for expressing and transmitting personal needs, wishes, goals and aspirations. As the PCP process unfolds, the appropriate mix of paid/non-paid services and supports to assist the individual in realizing/achieving these personally defined goals and aspirations are identified.

The principles of self-determination recognize the rights of people supported by the mental health system to have a life with freedom, and to access and direct needed supports that assist in the pursuit of their life, with responsible citizenship. These supports function best when they build upon natural community experiences and opportunities. The person determines and manages needed supports in close association with chosen friends, family, neighbors, and co-workers as a part of an ordinary community life.

Person-centered planning and self-determination underscore a commitment in Michigan to move away from traditional service approaches for people receiving services from the public mental health system. In Michigan, the flexibility provided through the Medicaid 1915(b) Managed Specialty Supports and Services Plan (MSSSP), together with the Mental Health Code requirements of PCP, have reoriented organizations to respond in new and more meaningful ways. Recognition has increased among providers and professionals that many individuals may not need, want, or benefit from a clinical regimen, especially when imposed without clear choice. Many provider agencies are learning ways to better support the individual to choose, participate in, and accomplish a life with personal meaning. This has meant, for example, reconstitution of segregated programs into non-segregated options that connect better with community life.

Self-determination builds upon the choice already available within the public mental health system. In Michigan, all Medicaid beneficiaries who services through the public mental health system have a right under the Balanced Budget Act (BBA) to choose the

providers of the services and supports that are identified in their individual plan of service "to the extent possible and appropriate." Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel. Within the PIHP, choice of providers must be maintained at the provider level. The individual must be able to choose from at least two providers of each covered support and service and must be able to choose an out-of-network provider under certain circumstances. Provider choice, while critically important, must be distinguished from arrangements that support self- determination. The latter arrangements extend individual choice to his/her control and management over providers (i.e., directly employs or contracts with providers), service delivery, and budget development and implementation.

In addition to choice of provider, individuals using mental health services and supports have access to a full-range of approaches for receiving those services and supports. Agencies and providers have obligations and underlying values that affirm the principles of choice and control. Yet, they also have long-standing investments in existing programs and services, including their investments in capital and personnel resources. Some program approaches are not amenable to the use of arrangements that support self-determination because the funding and hiring of staff are controlled by the provider (for example, day programs and group homes) and thus, preclude individual employer or budget authority.

It is not anticipated that every person will choose arrangements that support self-determination. Traditional approaches are offered by the system and used very successfully by many people. An arrangement that supports self-determination is one method for moving away from predefined programmatic approaches and professionally managed models. The goals of arrangements that support self-determination, on an individual basis, are to dissolve the isolation of people with disabilities, reduce segregation, promote participation in community life and realize full citizenship rights.

The Department of Health and Human Services supports the desire of people to control and direct their specialty mental health services and supports to have a full and meaningful life. At the same time, the Department knows that the system change requirements, as outlined in this policy and practice guideline, are not simple in their application. The Department is committed to continuing dialogue with stakeholders; to the provision of support, direction and technical assistance so the system may make successful progress to resolve technical difficulties and apparent barriers; and to achieve real, measurable progress in the implementation of this policy. This policy is intended to clarify the essential aspects of arrangements that promote opportunity for self-determination and define required elements of these arrangements.

PURPOSE

I. To provide policy direction that defines and guides the practice of self-determination within the public mental health system (as implemented by Prepaid Inpatient Health Plans/Community Mental Health Services Programs

(PIHP/CMHSPs)[1] in order to assure that arrangements that support self-determination are made available as a means for achieving personally-designed plans of specialty mental health services and supports.

CORE ELEMENTS

I. People are provided with information about the principles of self-determination and the possibilities, models and arrangements involved. People have access to the tools and mechanisms supportive of self-determination, upon request. Self-determination arrangements commence when the PIHP/CMHSP and the individual reach an agreement on an individual plan of services (IPOS), the amount of mental health and other public resources to be authorized to accomplish the IPOS, and the arrangements through which authorized public mental health resources will be controlled, managed, and accounted for.

II. Within the obligations that accompany the use of funds provided to them, PIHP/CMHSPs shall ensure that their services planning and delivery processes are designed to encourage and support individuals to decide and control their own lives. The PIHP/CMHSP shall offer and support easily-accessed methods for people to control and direct an individual budget. This includes providing them with methods to authorize and direct the delivery of specialty mental health services and supports from qualified providers selected by the individual.

III. People receiving services and supports through the public mental health system shall direct the use of resources in order to choose meaningful specialty mental health services and supports in accordance with their IPOS as developed through the person-centered planning process.

IV. Fiscal responsibility and the wise use of public funds shall guide the individual and the PIHP/CMHSP in reaching an agreement on the allocation and use of funds comprising an individual budget. Accountability for the use of public funds must be a shared responsibility of the PIHP/CMHSP and the person, consistent with the fiduciary obligations of the PIHP/CMHSP.

V. Realization of the principles of self-determination requires arrangements that are partnerships between the PIHP/CMHSP and the individual. They require the active commitment of the PIHP/CMHSP to provide a range of options for

CORE ELEMENTS, continued

individual choice and control of personalized provider relationships within an overall environment of person-centered supports.

VI. In the context of this partnership, PIHP/CMHSPs must actively assist people with

[1] Both PIHPs and CMHSPs are referenced throughout the document because the both have contractual obligations to offer and support implementation of arrangements that support self-determination. However, it is understood that, on an individual basis, self-determination agreements are executed at the CMHSP level.

prudently selecting qualified providers and otherwise support them with successfully using resources allocated in an individual budget.

VII. Issues of wellness and well-being are central to assuring successful accomplishment of a person's IPOS. These issues must be addressed and resolved using the person-centered planning process, balancing individual preferences and opportunities for self-determination with PIHP/CMHSP obligations under federal and state law and applicable Medicaid Waiver regulations. Resolutions should be guided by the individual's preferences and needs, and implemented in ways that maintain the greatest opportunity for personal control and direction.

VIII. Self-determination requires recognition that there may be strong inherent conflicts of interest between a person's choices and current methods of planning, managing and delivering specialty mental health services and supports. The PIHP/CMHSP must watch for and seek to minimize or eliminate either potential or actual conflicts of interest between itself and its provider systems, and the processes and outcomes sought by the person.

IX. Arrangements that support self-determination are administrative mechanisms, allowing a person to choose, control and direct providers of specialty mental health services and supports. With the exception of fiscal intermediary services, these mechanisms are not themselves covered services within the array of state plan and mental health specialty services and supports. Self-determination arrangements must be developed and operated within the requirements of the respective contracts between the PIHPs and CMHSPs and the Michigan Department of Health and Human Services and in accordance with federal and state law. Using arrangements that support self-determination does not change an individual's eligibility for particular specialty mental health services and supports.

X. All of the requirements for documentation of Medicaid-funded supports and services, financial accountability for Medicaid funds, and PIHP/CMHSP monitoring requirements apply to services and supports acquired using arrangements that support self-determination.

XI. Arrangements that support self-determination involve mental health specialty services and supports, and therefore, the investigative authority of the Recipient Rights office applies.

POLICY

I. Opportunity to pursue and obtain an IPOS incorporating arrangements that support self-determination shall be established in each PIHP/CMHSP, for adults with developmental disabilities and adults with mental illness. Each PIHP/CMHSP shall develop and make available a set of methods that provide opportunities for the person to control and direct their specialty mental health services and supports arrangements.

A. Participation in self-determination shall be a voluntary option on the part of each person.

B. People involved in self-determination shall have the authority to select, control and direct their own specialty mental health services and supports arrangements by responsibly controlling the resources allotted in an individual budget, towards accomplishing the goals and objectives in their IPOS.

C. A PIHP/CMHSP shall assure that full and complete information about self-determination and the manner in which it may be accessed and applied is provided to everyone receiving mental health services from its agency. This shall include specific examples of alternative ways that a person may use to control and direct an individual budget, and the obligations associated with doing this properly and successfully.

D. Self-determination shall not serve as a method for a PIHP/CMHSP to reduce its obligations to a person or avoid the provision of needed specialty mental health services and supports.

E. Each PIHP/CMHSP shall actively support and facilitate a person's application of the principles of self-determination in the accomplishment of his/her IPOS.

II. Arrangements that support self-determination shall be made available to each person for whom an agreement on an IPOS along with an acceptable individual budget has been reached. A person initiates this process by requesting the opportunity to participate in self-determination. For the purposes of self-determination, reaching agreement on the IPOS must include delineation of the arrangements that will, or may, be applied by the person to select, control and direct the provision of those services and supports.

A. Development of an individual budget shall be done in conjunction with development of an IPOS using a person-centered planning process.

B. As part of the planning process leading to an agreement about self-

POLICY Section II. continued

determination, the arrangements that will, or may, be applied by the person to pursue self-determination shall be delineated and agreed to by the person and the PIHP/CMHSP.

C. The individual budget represents the expected or estimated costs of a concrete approach to accomplishing the person's IPOS.

D. The amount of the individual budget shall be formally agreed to by both the person and the PIHP/CMHSP before it may be authorized for use by the person. A copy of the individual budget must be provided to the person prior to the onset of a self-determination arrangement.

E. Proper use of an individual budget is of mutual concern to the PIHP/CMHSP and the person.

1. Mental Health funds included in an individual budget are the assets and responsibility of the PIHP/CMHSP, and must be used consistent with statutory and regulatory requirements. Authority over their direction is delegated to the individual, for the purpose of achieving the goals and outcomes contained in the individual's IPOS. The limitations associated with this delegation shall be delineated to the individual as part of the process of developing the IPOS and authorizing the individual budget.

2. An agreement shall be made in writing between the PIHP/CMHSP and the individual delineating the responsibility and the authority of both parties in the application of the individual budget, including how communication will occur about its use. The agreement shall reference the IPOS and individual budget, which shall all be provided to the person. The directions and assistance necessary for the individual to properly apply the individual budget shall be provided to the individual in writing when the agreement is finalized.

3. An individual budget, once authorized, shall be provided to the individual. An individual budget shall be in effect for a specified period of time. Since the budget is based upon the individual's IPOS, when the IPOS needs to change, the budget may need to be reconsidered as well. In accordance with the Person-Centered Planning Policy and Practice Guideline, the IPOS may be reopened and reconsidered whenever the individual, or the PIHP/CMHSP, feels it needs to be reconsidered.

4. The individual budget is authorized by the PIHP/CMHSP for the purpose of providing a defined amount of resources that may be

POLICY Section II.E.4 continued

directed by a person to pursue accomplishing his/her IPOS. An individual budget shall be flexible in its use.

a. When a person makes adjustments in the application of funds in an individual budget, these shall occur within a framework that has been agreed to by the person and the PIHP/CMHSP, and described in an attachment to the person's self-determination agreement.

b. A person's IPOS may set forth the flexibility that an individual can exercise to accomplish his or her goals and objectives. When a possible use of services and supports is identified in the IPOS, the person does not need to seek prior approval to use the services in this manner.

c. If a person desires to exercise flexibility in a manner that is not identified in the IPOS, then the IPOS must be modified before the adjustment may be made. The PIHP/CMHSP shall attempt to address each situation in an expedient manner appropriate for the complexity and scope of the change.

d. Funds allotted for specialty mental health services may not be used to purchase services that are not specialty mental health services. Contracts with providers of specialty mental health services should be fiscally prudent.

5. Either party—the PIHP/CMHSP or the person—may terminate a self-determination agreement, and therefore, the self-determination arrangement. Common reasons that a PIHP/CMHSP may terminate an agreement after providing support and other interventions described in this guideline, include, but are not limited to: failure to comply with Medicaid documentation requirements; failure to stay within the authorized funding in the individual budget; inability to hire and retain qualified providers; and conflict between the individual and providers that results in an inability to implement IPOS. Prior to the PIHP/CMHSP terminating an agreement, and unless it is not feasible, the PIHP/CMHSP shall inform the individual of the issues that have led to consideration of a discontinuation or alteration decision, in writing, and provide an opportunity for problem resolution. Typically resolution will be conducted using the person-centered planning process, with termination being the option of choice if other mutually-agreeable solutions cannot be found. In any instance of PIHP/CMHSP discontinuation or alteration of a self-determination arrangement, the

POLICY Section II.E.5 continued

local processes for dispute resolution may be used to address and resolve the issues.

6. Termination of a Self-Determination Agreement by a PIHP/CMHSP is not a Medicaid Fair Hearings Issue. Only a change, reduction, or termination of Medicaid services can be appealed through the Medicaid Fair Hearings Process, not the use of arrangements that support self-determination to obtain those services.

7. Discontinuation of a self-determination agreement, by itself, shall neither change the individual's IPOS, nor eliminate the obligation of the PIHP/CMHSP to assure specialty mental health services and supports required in the IPOS are provided.

8. In any instance of PIHP/CMHSP discontinuation or alteration, the person must be provided an explanation of applicable appeal, grievance and dispute resolution processes and (when required) appropriate notice.

III. Assuring authority over an individual budget is a core element of self-determination. This means that the individual may use, responsibly, an individual budget as the means to authorize and direct their providers of services and supports. A PIHP/CMHSP shall design and implement alternative approaches that people electing to use an individual budget may use to obtain individual-selected and -directed provider arrangements.

A. Within prudent purchaser constraints, a person shall be able to access any willing and qualified provider entity that is available to provide needed specialty mental health services and supports.

B. Approaches shall provide for a range of control options up to and including the direct retention of individual-preferred providers through purchase of services agreements between the person and the provider. Options shall include, upon the individual's request and in line with their preferences:

1. Services/supports to be provided by an entity or individual currently operated by or under contract with the PIHP/CMHSP.

2. Services/supports to be provided by a qualified provider chosen by the individual, with the PIHP/CMHSP agreeing to enter into a contract with that provider.

3. Services/supports to be provided by an individual-selected provider with whom the individual executes a direct purchase-of-services

POLICY Section III.B.3 continued

agreement. The PIHP/CMHSP shall provide guidance and assistance to assure that agreements to be executed with individual-selected providers are consistent with applicable federal regulations governing provider contracting and payment arrangements.

a. Individuals shall be responsible for assuring those individuals and entities selected and retained meet applicable provider qualifications. Methods that lead to consistency and success must be developed and supported by the PIHP/CMHSP.

b. Individuals shall assure that written agreements are developed with each provider entity or individual that specify the type of service or support, the rate to be paid, and the requirements incumbent upon the provider.

c. Copies of all agreements shall be kept current, and shall be made available by the individual, for review by authorized representatives of the PIHP/CMHSP.

d. Individuals shall act as careful purchasers of specialty mental health services and supports necessary to accomplish their IPOS. Arrangements for services shall not be excessive in cost. Individuals should aim for securing a better value in terms of outcomes for the costs involved. Existing personal and community resources shall be pursued and used before public mental health system resources.

e. Fees and rates paid to providers with a direct purchase-of-services agreement with the individual shall be negotiated by the individual, within the boundaries of the authorized individual budget. The PIHP/CMHSP shall provide guidance as to the range of applicable rates, and may set maximum amounts that a person may spend to pay providers of specific services and supports.

f. Conflicts of interest that providers may have must be considered. For example, a potential provider may have a competing financial interest such as serving as the individual's landlord. If a provider with a conflict of interest is used, the conflict must be addressed in the relevant agreements. The Medicaid Provider Manual has directly

POLICY Section III.B.3 continued

addressed one conflict stating that, individuals cannot hire or contract with legally responsible relatives (for an adult, the individual's spouse) or with his or legal guardian.

4. A person shall be able to access one or more alternative methods to choose, control and direct personnel necessary to provide direct support, including:

   a. Acting as the employer of record of personnel.

   b. Access to a provider entity that can serve as employer of record for personnel selected by the individual (Agency with Choice).

   c. PIHP/CMHSP contractual language with provider entities that assures individual selection of personnel, and removal of personnel who fail to meet individual preferences.

   d. Use of PIHP/CMHSP-employed direct support personnel, as selected and retained by the individual.

5. A person using self-determination shall not be obligated to utilize PIHP/CMHSP-employed direct support personnel or a PIHP/CMHSP-operated or -contracted program/service.

6. All direct support personnel selected by the person, whether she or he is acting as employer of record or not, shall meet applicable provider requirements for direct support personnel, or the requirements pertinent to the particular professional services offered by the provider.

7. A person shall not be required to select and direct needed provider entities or his/her direct support personnel if she or he does not desire to do so.

IV. A PIHP/CMHSP shall assist a person using arrangements that support self-determination to select, employ, and direct his/her support personnel, to select and retain chosen qualified provider entities, and shall make reasonably available, consistent with MDHHS Technical Advisory instructions, their access to alternative methods for directing and managing support personnel.

   A. A PIHP/CMHSP shall select and make available qualified third-party entities that may function as fiscal intermediaries to perform employer

POLICY Section IV.A continued

agent functions and/or provide other support management functions as described in the Fiscal Intermediary Technical Requirement (Contract Attachment P3.4.4), in order to assist the person in selecting, directing and controlling providers of specialty services and supports.

B. Fiscal intermediaries shall be under contract to the PIHP/CMHSP or a designated sub-contracting entity. Contracted functions may include:

1. Payroll agent for direct support personnel employed by the individual (or chosen representative), including acting as an employer agent for IRS and other public authorities requiring payroll withholding and employee insurances payments.

2. Payment agent for individual-held purchase-of-services and consultant agreements with providers of services and supports.

3. Provision of periodic (not less than monthly) financial status reports concerning the individual budget, to both the PIHP/CMHSP and the individual. Reports made to the individual shall be in a format that is useful to the individual in tracking and managing the funds making up the individual budget.

4. Provision of an accounting to the PIHP/CMHSP for the funds transferred to it and used to finance the costs of authorized individual budgets under its management.

5. Assuring timely invoicing, service activity and cost reporting to the PIHP/CMHSP for specialty mental health services and supports provided by individuals and entities that have a direct agreement with the individual.

6. Other supportive services, as denoted in the contract with the PIHP/CMHSP that strengthen the role of the individual as an employer, or assist with the use of other agreements directly involving the individual in the process of securing needed services.

For a complete list of functions, refer to the Fiscal Intermediary Technical Requirement (Contract Attachment P3.4.4),

C. A PIHP/CMHSP shall assure that fiscal intermediary entities are oriented to and supportive of the principles of self-determination, and able to work with a range of personal styles and characteristics. The PIHP/CMHSP shall exercise due diligence in establishing the qualifications,

POLICY Section IIV.C continued

characteristics and capabilities of the entity to be selected as a fiscal intermediary, and shall manage the use of fiscal intermediaries consistent with the Fiscal Intermediary Technical Requirement and MDHHS Technical Assistance Advisories addressing fiscal intermediary arrangements.

D. An entity acting as a fiscal intermediary shall be free from other relationships involving the PIHP/CMHSP or the individual that would have the effect of creating a conflict of interest for the fiscal intermediary in relationship to its role of supporting individual-determined services/supports transactions. These other relationships typically would include the provision of direct services to the individual. The PIHP/CMHSP shall identify and require remedy to any conflicts of interest of the entity that, in the judgment of the PIHP/CMHSP, interfere with the performance of a fiscal intermediary.

E. A PIHP/CMHSP shall collaborate with and guide the fiscal intermediary and each individual involved in self-determination to assure compliance with various state and federal requirements and to assist the individual in meeting his/her obligations to follow applicable requirements. It is the obligation of the PIHP/CMHSP to assure that fiscal intermediaries are capable of meeting and maintaining compliance with the requirements associated with their stated functions, including those contained in the Fiscal Intermediary Technical Requirement.

F. Typically, funds comprising an individual budget would be lodged with the fiscal intermediary, pending appropriate direction by the individual to pay individual-selected and contracted providers. Where a person selected and directed provider of services has a direct contract with the PIHP/CMHSP, the provider may be paid by the PIHP/CMHSP, not the fiscal intermediary. In that case, the portion of funds in the individual budget would not be lodged with the fiscal intermediary, but instead would remain with the PIHP/CMHSP, as a matter of fiscal efficiency.

DEFINITIONS

Agency with Choice

A provider agency that serves as employer of record for direct support personnel, yet enables the person using the supports to hire, manage and terminate workers.

CMHSP

For the purposes of this policy, a Community Mental Health Services Program is an entity operated under Chapter Two of the Michigan Mental Health Code, or an entity under contract with the CMHSP and authorized to act on its behalf in providing access to, planning for, and authorization of specialty mental health services and supports for people eligible for mental health services.

Fiscal Intermediary
A fiscal Intermediary is an independent legal entity (organization or individual) that acts as a fiscal agent of the PIHP/CMHSP for the purpose of assuring fiduciary accountability for the funds comprising an individual budget. A fiscal intermediary shall perform its duties as specified in a contract with a PIHP/CMHSP or its designated sub-contractor. The purpose of the fiscal intermediary is to receive funds making up an individual budget, and make payments as authorized by the individual to providers and other parties to whom an individual using the individual budget may be obligated. . A fiscal intermediary may also provide a variety of supportive services that assist the individual in selecting, employing and directing individual and agency providers. Examples of entities that might serve in the role of a fiscal intermediary include: bookkeeping or accounting firms and local Arc or other advocacy organizations.

Individual/Person
For the purposes of this policy, "Individual" or "person" means a person receiving direct specialty mental health services and supports. The person may select a representative to enter into the self-determination agreement and for other agreements that may be necessary for the person to participate in arrangements that support-self-determination. The person may have a legal guardian. The role of the guardian in self-determination shall be consistent with the guardianship arrangement established by the court. Where a person has been deemed to require a legal guardian, there is an extra obligation on the part of the CMHSP and those close to the person to assure that the person's preferences and dreams drive the use of self-determination arrangements, and that the best interests of the person are primary.

Individual Budget
An individual budget is a fixed allocation of public mental health resources denoted in dollar terms. These resources are agreed upon as the necessary cost of specialty mental health services and supports needed to accomplish a person's IPOS. The individual served uses the funding authorized to acquire, purchase, and pay for specialty mental health services and supports in his or her IPOS.

IPOS
An IPOS means the individual's individual plan of services and/or supports, as developed using a person-centered planning process.

PIHP
For the purposes of this policy, a Prepaid Inpatient Health Plan (PIHP) is a managed care entity that provides Medicaid-funded mental health specialty services and supports in an area of the state.

Qualified Provider
A qualified provider is an individual worker, a specialty practitioner, professional, agency or vendor that is a provider of specialty mental health services or supports that can

demonstrate compliance with the requirements contained in the contract between the Department of Health and Human Services and the PIHP/CMHSP, including applicable requirements that accompany specific funding sources, such as Medicaid. Where additional requirements are to apply, they should be derived directly from the person-centered planning process, and should be specified in the IPOS, or result from a process developed locally to assure the health and well-being of individuals, conducted with the full input and involvement of local individuals and advocates.

Self-Determination

Self-determination incorporates a set of concepts and values that underscore a core belief that people who require support from the public mental health system as a result of a disability should be able to define what they need in terms of the life they seek, have access to meaningful choices, and have control over their lives in order to build lives in their community (meaningful activities, relationships and employment). Within Michigan's public mental health system, self-determination involves accomplishing system change to assure that services and supports for people are not only person-centered, but person-defined and person-controlled. Self-determination is based on four principles. These principles are:

FREEDOM: The ability for individuals, with assistance from significant others (e.g., chosen family and/or friends), to plan a life based on acquiring necessary supports in desirable ways, rather than purchasing a program. This includes the **freedom** to choose where and with whom one lives, who and how to connect to in one's community, the opportunity to contribute in one's own ways, and the development of a personal lifestyle.

AUTHORITY: The assurance for a person with a disability to control a certain sum of dollars in order to purchase these supports, with the backing of their significant others, as needed. It is the **authority** to control resources.

SUPPORT: The arranging of resources and personnel, both formal and informal, to assist the person in living his/her desired life in the community, rich in community associations and contributions. It is the **support** to develop a life dream and reach toward that dream.

RESPONSIBILITY: The acceptance of a valued role by the person in the community through employment, affiliations, spiritual development, and caring for others, as well as accountability for spending public dollars in ways that are life-enhancing. This includes the **responsibility** to use public funds efficiently and to contribute to the community through the expression of responsible citizenship.

A hallmark of self-determination is assuring a person the opportunity to direct a fixed amount of resources, which is derived from the person-centered planning process and called an individual budget. The person controls the use of the resources in his/her individual budget, determining, with the assistance of chosen allies, which services and supports he or she will purchase, from whom, and under what circumstances. Through

this process, people possess power to make meaningful choices in how they live their life.

Specialty Mental Health Services
This term includes any service/support that can legitimately be provided using funds authorized by the PIHP/CMHSP in the individual budget. It includes alternative services and supports as well as Medicaid-covered services and supports.

FISCAL INTERMEDIARY TECHNICAL REQUIREMENT

I. Background

Fiscal Intermediary (FI) services are an essential component of providing financial accountability and Medicaid integrity for the individual budgets authorized for individuals using arrangements that support self-determination. Prepaid Inpatient Health Plans/Community Mental Health Service Programs (PIHP/CMHSPs) have been contractually required to offer arrangements that support self-determination to adults who use mental health services and supports since January 1, 2009 (90 days after the publication of the Choice Voucher System Technical Advisory version 2.0) (dated September 30, 2008) (CVS TA)[i]. PIHP/CMHSPs are also required to offer choice voucher arrangements to families of minor children on the Children's Waiver Program (CWP) and the Habilitation Supports Waiver (HSW) and may elect to provide choice voucher arrangements to other families of minor children. Entities that provide FI services also provide critical support to individuals who use arrangements that support self-determination that allow them to control and manage their arrangements effectively.

The primary role of the FI is to provide fiscal accountability for the funds in the individual budget. "The individual budget represents the expected or estimated costs of a concrete approach to accomplishing the person's IPOS." Self-Determination Policy and Practice Guideline (October 1, 2012) (SD Policy), Section II.C. "Development of an individual budget shall be done in conjunction with development of an IPOS using a person-centered planning process. As part of the planning process leading to an agreement about self-determination, the arrangements that will, or may, be applied by the person to pursue self-determination shall be delineated and agreed to by the person and the PIHP/CMHSP." SD Policy II.A &B.[i] The role of the FI is not to develop the individual budget or direct how services and supports are used, but to ensure that the payments it makes are correspond with the IPOS and the individual budget.

FI services were first identified in the SD Policy. "A fiscal Intermediary is an independent legal entity (organization or individual) that acts as a fiscal agent of the PIHP/CMHSP for the purpose of assuring fiduciary accountability for the funds comprising an individual budget SD Guideline Glossary. A PIHP/CMHSP shall select and make available qualified third-party entities that may function as fiscal intermediaries to perform employer agent functions and/or provide other support management functions." SD Policy IV.A Fiscal Intermediary Services was later made a 1915(b) waiver service (Medicaid Provider

Manual, Mental Health/Substance Abuse §17.3.0) and can be billed as an administrative activity for families using choice voucher arrangements under the Children's Waiver Program.

The purpose of this Technical Requirement is to clarify the qualifications, role and functions of entities that provide FI services as well as the requirements that PIHP/CMHSPs have in procuring and contracting with entities to provide FI services.

II. PIHP/CMHSP Requirements

Each PIHP/CMHSP is required to contract with at least one entity to provide FI services. In procuring and contracting with entities to provide FI services, the PIHP/CMHSP must ensure that the entities meet all of qualifications set forth in this technical requirement. The PIHP/CMHSP also must assure that fiscal intermediaries are oriented to and supportive of the principles of self-determination and able to work with a range of consumer styles and characteristics. PIHP/CMHSPs have an obligation to Identify and require remedy to any conflicts of interest that, in the judgment of the PIHP/CMHSP, interfere with the performance of the role of the entity providing FI services (see Section III Qualification for FI Entities below).

Contracts with entities providing FI services must identify the functions and scope of FI services, set forth accounting methods and methods for assuring timely invoicing, service activity and cost reporting to the PIHP/CMHSP for specialty mental health services, require indemnification and professional liability insurance for non-performance or negligent performance of FI duties (general business or liability insurance is insufficient), and identify a contact person or persons at the PIHP/CMHSP and at the FI entity for troubleshooting problems and resolving disputes. The PIHP/CMHSP should provide individuals using FI services and their allies with the opportunity to provide input into the development the scope of the FI services and the implementation of those services. In addition to the required functions identified in Section IV below, PIHP/CMHSPs may choose to contract with the entities to provide other supportive functions (such as verification of employee qualifications (background checks, provider qualification checks, etc.)) that are identified in the Self-Determination Implementation Technical Advisory (SDI TA), Appendix C, List of Fiscal Intermediary Functions, Section II Employment Support Functions. PIHP/CMHSPs may only pay entities that provide FI services on a flat rate basis or another basis that does not base compensation on a percentage of individual budgets.

In addition to contracting and procurement, each PIHP/CMHSP must monitor the performance of entities that provide FI services on an annual basis just as it monitors the performance of all other service providers. Minimally, this annual performance monitoring must include:

- Verification that the FI is fulfilling contractual requirements;
- Verification of demonstrated competency in safeguarding, managing and disbursing Medicaid and other public funds;

- Verification that indemnification and required insurance provisions are in place and updated as necessary;
- Evaluation of feedback (experience and satisfaction) from individuals using FI services and other FI performance data with alternate methods for collections data from individuals using services (more than mailed surveys); and
- An audit of a sample of individual budgets to compare authorizations versus expenditures.

III. Required Qualifications for FI Entities

Entities that provide FI services must have a positive track record of managing and accounting for funds. These entities must be independent and free from conflicts of interest. In other words, they cannot be a provider of any other mental health services and supports or any other publicly funded services (such as, but not limited to Home Help services available through the Department of Human Services (DHS)). In addition, FI entities cannot be a guardian, conservator, or trust holder or have any other compensated fiduciary relationship with any individual receiving mental health services and supports except for representative payee[i].

IV. Required Fiscal Intermediary Functions

Required FI functions include Financial Accountability functions and Employer Agent functions. Other possible functions are identified within the Administrative Functions and Employment Support Functions in the List of Fiscal Intermediary Functions (SDI TA, Appendix C).

A. Financial Accountability Functions

For all individuals using arrangements that support self-determination and families of minor children using choice voucher arrangements, entities providing FI services must:

- Have a mechanism to crosscheck invoices with authorized services and supports in each individual plan of service (IPOS) and individual budget and a procedure for handling invoices for unauthorized services and supports.
- Pay only invoices approved by the individual (or family of a minor child) for services and supports explicitly authorized in the IPOS and individual budget.
- Have a system in place for tracking and monitoring individual budget expenditures and identifying potential over- and under-expenditures that minimally includes the following:
    - Provide monthly financial status reports to the supports coordinator (and anyone else at the PIHP/CMHSP identified in the contract to receive monthly budget reports) and the individual (or the family of a minor child) by no later than 15 days after the end of month.
    - Contact the supports coordinator by phone or e-mail in the case of an over expenditure of 10 percent in one month prior to making payment for that expenditure.

- Contact the supports coordinator by phone or e-mail in the case of under expenditure of the pro rata share of the individual budget for the month that indicates that the individual is not receiving the services and supported in the IPOS.

- Have policies and procedures in place to assure adherence to federal and state laws and regulations (especially requirements related to Medicaid integrity) and ensure compliance with documentation requirements related to management of public funds.
- Have policies and procedures in place to assure financial accountability for the funds comprising the individual budgets, indemnify the PIHP/CMHSP for any amounts paid in excess of the individual budget and maintain required insurance for nonperformance or negligent performance of FI functions
- Assure timely invoicing, service activity and cost reporting to the PIHP/CMHSP for specialty mental health services as required by the contract between the PIHP/CMHSP and the entity providing FI services.

B. Employer Agent Functions

For all individuals using arrangements that support self-determination and families of minor children using choice voucher arrangements who are directly employing workers, entities providing FI services must facilitate the employment of service workers by the individual or family of a minor child, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting. These Employer Agent functions include:

- Obtain documentation from the participants and file it with the IRS so that the FI can serve as Employer Agent for individuals directly employing workers, and meet the requirements of state and local income tax authorities and unemployment insurance authorities.
- Have a mechanism in place to crosscheck timesheets for directly employed workers with authorized services and supports in the IPOS and individual budget and a mechanism to handle over-expenditures that exceed 10 percent of the individual budget prior to making payroll payments (such contacting the PIHP/CMHSP to determine if an additional authorization is necessary and/or notifying the employer that he or she is responsible for the costs related to approved timesheets in excess of the authorizations in the IPOS and individual budget).
- Issue payroll payments to directly employed workers for authorized services and supports that comport with the individual budget or have approval from the PIHP/CMHSP for payment.
- Withhold income, Social Security, and Medicare taxes from payroll payments and make payments to the appropriate authorities for taxes withheld.
- Make payments for unemployment taxes and worker's compensation insurance to the appropriate authorities, when necessary.
- Issue W-2 forms and tax statements.
- Assist the individual directly employing workers with purchasing worker's compensation insurance as required.

V. References

Michigan Self-Determination Policy and Practice Guideline, July 18, 2003
http://www.michigan.gov/documents/SelfDeterminationPolicy_70262_7.pdf

Michigan Medicaid Provider Manual
http://www.michigan.gov/MDHHS/0,1607,7-132--87572--,00.html

Choice Voucher System Technical Advisory, Version 2.0, September 30, 2008
http://www.michigan.gov/documents/MDHHS/Choice_Voucher_System_Transmittal_9_30_08_251403_7.pdf

Self-Determination Implementation Technical Advisory, January 1, 2013

TECHNICAL REQUIREMENT FOR SED CHILDREN
FINAL REVISED April 10, 2012
(10/2/15) revised 11/5/15

REGARDING: 1) MEDICAID ELIGIBILITY CRITERIA FOR CHILDREN WITH SERIOUS EMOTIONAL I 2) ESTABLISING GENERAL FUND PRIORITY FOR MENTAL HEALTH SERVICES FOR CHILDF EMOTIONAL DISTURBANCE

General Considerations:

This requirement provides a framework to be used by Prepaid Inpatient Health Plans (PIHPs) for de Medicaid specialty mental health services for children with serious emotional disturbance (SED). Th eligibility for specialty mental health services for children is based on the definition of serious emotional in the Mental Health Code (Section 330.1100d) which includes the three dimensions of diagnosis, func duration.

A key feature of the Medicaid eligibility criteria in the Technical Requirement is that diagnosis alone is not eligibility for Medicaid specialty mental health services. This means that the practice of using a defined or li to determine Medicaid eligibility, for services should cease. As stated in the Mental Health Code, any dia be used (with the exception of developmental disorder, substance abuse disorder or "V" codes unless th conjunction with another diagnosable serious emotional disorder), and should be coupled with functional in criteria for determination of serious emotional disturbance in a child.

The Medicaid eligibility criteria delineated in this document is intended to: (1) assist Prepaid Inpatient H determining severity, complexity and duration that would indicate a need for specialty mental health ser Medicaid children, and (2) bring more uniformity to these decisions for children across the system. Childr delineated in this document are considered to have a serious emotional disturbance, as defined in the (Please note that the criteria contained in this document presently do not apply to MIChild beneficiaries b sole provider of the mental health benefit for MIChild beneficiaries who are to be provided medically ne services by PIHPs regardless of functional impairment, however at January 1, 2016, MIChild beneficiaries recipients and eligibility for services by PIHP will be determined as a child with serious emotional disturba

Selection of Services

For Medicaid children, once an eligibility determination has been made based on the criteria delineated in th of services is determined based on person-centered planning and family-centered practice. Selection of s made based on medical necessity criteria, and, where applicable, the service-specific criteria, coverag parameters contained in the most recent version of the Medical Services Administration's Medicaid Poli decisions regarding access/eligibility should not be based on medical necessity criteria or service-speci decisions are a separate and subsequent process to eligibility determinations.

Special Note: For Direct Prevention Services Models (CCEP, School Success Program, Infant Mental Hea with a family or child care provider regarding an individual child, the service should be noted in the chil "medically necessary" and should be reported using the child's beneficiary identification number. "unspecified" diagnosis codes found in the ICD-9 for infants, young children and individuals who r intervention.

Definition of Child with Serious Emotional Disturbance 7 through 17 Years

The definition of SED for children 7 through 17 years delineated below is based on the Mental Health Coc In addition, extensive reviews and examinations of Child and Adolescent Functional Assessment Scale (C by CMHSPs for the children currently served were undertaken to establish functioning criteria consistent wi Health Code definition of serious emotional disturbance.[1] The parameters delineated below do not precluc the provision of services to an adult beneficiary who is a parent and who has diagnosis within the current ve and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that r environment that places the child at-risk for serious emotional disturbance.

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

Diagnosis

[1] The recommendations for the CAFAS scores as detailed under the functioning dimension described in this document would c children currently being served by CMHSPs.

Serious emotional disturbance means a diagnosable mental, behavioral, or emotional disorder affec or has existed during the past year for a period of time sufficient to meet diagnostic criteria speci diagnostic and statistical manual of mental disorders published by the American Psychiatric Associ the department and that has resulted in functional impairment as indicated below. The following only if they occur in conjunction with another diagnosable serious emotional disturbance: (a) a sub (b) a developmental disorder, or (c) "V" codes in the diagnostic and statistical manual of mental dis

Degree of Disability/Functional Impairment

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

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

Duration/History

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

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

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

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

However, as with infants and toddlers (birth through age three years), assessment must be sensitive to t development and functional impairment for the age group. Impairments in functioning are revealed acr

young child's regulation of emotion and behavior, social development (generalization of relationships be for peer relationships and play, etc.), physical and cognitive development, and the emergence of a se dimensions must be considered when determining whether a young child is eligible for mental health serv child with serious emotional disturbance.

The parameters delineated below do not preclude the provision of services to an adult beneficiary of a your and who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Ment International Classification of Diseases (ICD) that results in a care-giving environment that places the c emotional disturbance.

The following is the criteria for determining when a young child beneficiary is considered to have a serious All of the dimensions must be considered when determining whether a young child is eligible for ment supports.

The child shall meet each of the following:

Diagnosis

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

Degree of Disability/Functional Impairment

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

Area I:

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

Internalized Behaviors:

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

Externalized Behaviors:

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

Area II:

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

- bed wetting

- sleep disorders
- eating disorders
- encopresis
- somatic complaints

Area III:

Disturbances of thought, as indicated by the following behaviors:

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

Area IV:

Difficulty with social relationships as indicated by:

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

Area V:

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

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

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

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

Duration/History

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

However, indicators that a disorder is not transitory and will endure without intervention includ following:

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

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

Unique criteria must be applied to define serious emotional disturbance for the birth through age three po

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

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

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

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

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

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

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

The child shall meet each of the following:

Diagnosis

An infant or toddler has a mental, behavioral, or emotional disturbance sufficient to meet the diag in the most recent diagnostic and statistical manual of mental disorders published by the American P consistent with the *Diagnostic Classification of Mental Health and Developmental Disorders Childhood: Revised Edition* (see attached crosswalk) that has resulted in functional impairment a following disorders are included only if they occur in conjunction with another diagnosable serious (a) a substance abuse disorder, (b) a developmental disorder, or (c) "V" codes in the diagnostic ar mental disorders.

Degree of Disability/Functional Impairment

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

Area I:

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

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

Area II:

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

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

Area III:

Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as d assessment of infant/toddler, parent/caregiver and environmental characteristics. Indicators in the

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

The standardized assessment tool specifically targeting social-emotional functioning for infants a Early Childhood Assessment (Infant, Toddler or Clinical Version). Duration/History

The very young age and rapid transition of infants and toddlers through developmental sta symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endu include one or more of the following:

(1) The infant or toddler's disorder(s) is affected by persistent multiple barriers to normal deve parenting or care-giving, chaotic environment, etc.); or
(2) The infant or toddler has been observed to exhibit the functional impairments for more days t of two weeks (see Areas I-III above); or
(3) An infant or toddler has experienced a traumatic event involving actual or threatened death or to the physical or psychological integrity of the child, parent or caregiver, such as abuse (physic medical trauma and/or domestic violence.

Diagnostic Thinking Process

Assessment Framework: All Axis Crosswalk between DC:0-3R and DSM-5

October, 2015

Introduction

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

This crosswalk invites the clinician to work through a comprehensive set of assessment questions to guide a two-step proces formulation of primary presenting problems, then b) crosswalk to DSM-5 billable diagnosis. Two caveats: **Do not start with** Choose the diagnosis/diagnoses that characterize the focus of treatment.

Overview of assessment framework:

Part 1: Are the presenting problems primarily or substantially reactions to severe stress or related to issues of coping with that are affecting the family, undermining the caregivers' capacities, and challenging the child's adaptive capacitie undermined the caregiver's capacity to be protective? The presenting problems may indicate stresses or cumulativ presentation of symptoms related to stress or risk a focus of treatment?

Part 2: What is the role of physical health (constitutional), medical diagnoses, health care needs, or developmental factor determining the child's difficulties (Axis III). Is the child struggling with daily tasks due to health or developmental developmental disorder diagnoses are included on DC: 0-3R Axis III - diagnoses used by developmental specialists (OT, PT, special education)

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

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

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

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

Part 1

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

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

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

Part 2

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

AXIS III Medical and Developmental Disorders and Conditions		
DC:0-3 R - Developmental, Health/Medical disorders are recorded on Axis III	**DSM-5 Code**	**DSM-5**
For a primary diagnosis, crosswalk to:	309.9	Adjustment Disorder, Unspecified
	315.9	Unspecified Neurodevelopmental Disorder
If needed for secondary diagnosis		Crosswalk to DSM-5 Axis I and record as Secondary 307.9 Unspecified Communication Disorder 315.39 Social (Pragmatic) Communication Diso 315.9 Unspecified Neurodevelopmental Disorc 315.4 Developmental Coordination Disorder 315.8 Global Developmental Delay (under age 319 Unspecified Intellectual Disability
Codes are not needed for health/medical conditions. Provide descriptive information about medical/ health issues. Disting and current issues.		

AXIS III Medical and Developmental Disorders and Conditions		
DC:0-3 R - Developmental, Health/Medical disorders are recorded on Axis III	**DSM-5 Code**	**DSM-5**
Identify names of specific current and chronic medical diagnoses, e.g. asthma; obesity; ear infections; prematurity; genetic Prader Willis; sleep apnea.		

Part 3

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

AXIS V – Functional Social-Emotional Capacities	Functional competency may differ significantly from standardized te competency may differ in unstructured contexts that allow child to b contexts in which child is expected to follow another's ideas or respo Challenges presented in a child's functional competencies may involv functional competencies are not at age level, then the child does not capacities for "problem-solving" responses to challenges of daily life will face ongoing challenges to adjustment	
DC: 0-3R	**DSM-5 Code**	**DSM-5**
IF not at age-level in any one or more of the capacities:	309.9	Adjustment Disorder, Unspecified (Unspecified Traur
	315.9	Unspecified Neurodevelopmental Disorder

Treatment planning requires assessment to identify contribution of the factors undermining child's functional competency may be context specific vulnerabilities, immaturity, selective deficit, and may reflect constitutional issues.

In addition, functional difficulties may, in turn, contribute to regulatory problems, anxieties, relationship problems.

For treatment planning, specify the developmental processes that are not at age level and identify factors that are involve competencies, e.g., specific developmental delays or disorders, relational dynamics, or health issues. See Axis IV, III above

Part 4

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

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

Part 5

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

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

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

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

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

Diagnostic Thinking Process

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

October, 2015

Introduction

This diagnostic thinking process includes a crosswalk that is intended to help overcome the limited applicability of classificati and ICD for assessment and diagnostic formulation with clients in the birth through 5 age range. The assessment framework promotes diagnostic thinking that identifies contributions of constitutional (physical health), medical/developmental, relatio functional social-emotional factors to clinical understanding of the child's presentation of challenges and competencies. Each of significant features of a young child's symptoms and history. For example, a child's difficulties may be diagnosed as issues processes, relationship challenges, and/or functional developmental challenges highlighting the importance of including func processes (Axis V) and relationship dynamics (Axis II). Use of all DC:0-3R axes promotes a thorough assessment process that i formulation of the factors that are contributing to overall child functioning and capacity to successfully cope with the challen Integration of the data represented by the axes helps to establish a strong connection between diagnostic formulation and t Furthermore, this assessment framework supports identification of risks/stresses that threaten to derail overall developmen progress or contribute to significant deterioration in areas of life functioning or adaptive capacity. This breadth of perspectiv DSM and ICD Axis I for diagnostic formulation in work with young children and their families.

This crosswalk invites the clinician to work through a comprehensive set of assessment questions to guide a two-step proces formulation of primary presenting problems, then b) crosswalk to ICD-10 billable diagnosis. Two caveats: **Do not start with** Choose the diagnosis/diagnoses that characterize the focus of treatment:

Overview of assessment framework:

Part 1: Are the presenting problems primarily or substantially reactions to severe stress or related to issues of coping wit that are affecting the family, undermining the caregivers' capacities, and challenging the child's adaptive capacitie weakened the caregiver's capacity to be protective? The presenting problems may indicate risk or cumulative stre presentation of risk a focus of treatment?

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

developmental disorder diagnoses are included on DV: 0-3R Axis III - diagnoses used by developmental specialists, OT, PT, special education)

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

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

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

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

Part 1

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

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

300 Adjustment Disorder	F43.20 F43.21 F43.22 F43.23	Adjustment disorder, unspecified with depressed mood with anxiety with mixed anxiety and depressed mood (F43.24 RESERVED-– this code is reserved Emotional Disturbance – Axis I) (F43.25 RESERVED- that code is reserved f Axis II Relationship Disorder)
If stress/risk events meet DC: 0-3R Axis I criteria, and child's symptom presentation is pervasive across situations and relationships, evaluate:		
100 Post Traumatic Stress Disorder	F43.10	Post traumatic stress disorder, unspecified F43.11 acute F43.12 chronic
150 Deprivation/Maltreatment Disorder	F94.1	Reactive attachment disorder of childhood (inhibi
	F94.2	Reactive attachment disorder of childhood (disinh
		NOTE: These two diagnoses (94.1 and 94.2) are mutua

Part 2

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

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

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

Part 3

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

AXIS V – Functional Social-Emotional Capacities	Functional competency may differ significantly from standardized te competency may differ in unstructured contexts that allow child to b contexts in which child is expected to follow another's ideas or respc Challenges presented in a child's functional competencies may involv functional competencies are not at age level, then the child does not capacities for "problem-solving" responses to challenges of daily life will face ongoing challenges to adjustment.	
DC: 0-3R	**ICD-10 Code**	**ICD-10**
If not at age-level in any one or more of the capacities:	F94.9	Childhood disorder of social functioning
	F99	Not otherwise specified

Treatment planning requires assessment to identify the contributing factors undermining a child's functional competency. S indicated. Child's functional challenges may be context specific vulnerabilities, immaturity, selective deficit, and may reflect issues.

In addition, functional difficulties may, in turn, contribute to regulatory problems, anxieties, relationship problems.

For treatment planning, specify the developmental processes that are not at age level and identify factors that are involved competencies, e.g., specific developmental delays or disorders, relational dynamics, or health issues. See Axis IV, III above a

Part 4

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

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

Part 5

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

DC: 0-3 R	ICD-10 Code	ICD-10
In addition to difficulties identified above, is there a DC: 0-3 R Axis I diagnosis		
DC:0-3 Clinical Disorders		
100 Post Traumatic Stress Disorder	F43.10	Post traumatic stress disorder, unspecified F43.11 acute F43.12 chronic
150 Deprivation/Maltreatment Disorder	F94.1	Reactive attachment disorder of childhood (inhibi
	F94.2	Reactive attachment disorder of childhood (disinh
		NOTE: These two diagnoses (94.1 and 94.2) are mutua
200 Disorders of Affect		
210 Prolonged Bereavement/Grief Reaction	F43.20	Adjustment disorder, unspecified
	F43.9	Reaction to severe stress, unspecified
220 Anxiety Disorders		
221 Separation Anxiety	F93.0	Separation anxiety disorder of childhood
222 Specific Phobia	F40.9	Phobic anxiety disorder, unspecified
223 Social Anxiety Disorder	F40.10	Social phobia, unspecified
224 Generalized Anxiety Disorder	F41.1	Generalized anxiety disorder
225 Anxiety Disorder NOS	F41.9	Anxiety disorder, unspecified
230 Depression of Infancy and Early Childhood		

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

DC: 0-3 R	ICD-10 Code	ICD-10
602 Feeding Disorder of Caregiver-Infant Reciprocity (this dx is specific to feeding interactions so is less pervasive than a relationship disorder)	F98.2	Other feeding disorders of infancy and early childl Note: *IF primary diagnosis, the feeding diffi to or secondary to other problems.*
603 Infantile Anorexia		
604 Sensory Food Aversions		
605 Feeding Disorder associated with concurrent medical conditions		
606 Feeding disorder associated with insults to gastrointestinal tract		
700 Disorders of Relating and Communicating (Referred to as PDD in the ICD-10 classification.)		NOTE: A mental health diagnosis for a child who a Relating and Communicating (PDD) may focus trea anxieties, interaction problems with family memb Autism (F84.0) may be a secondary diagnosis with
DC:0-3R guides clinicians to diagnose differently for children age 2 and over and those under age 2. 710 Multisystem Developmental Disorder is limited to under age 2.		DC: 0-3R age distinctions do not apply in crosswall
710 Multisystem Developmental Disorder (MSDD)	F84.9	Pervasive developmental disorder , unspecified Note: *can be primary diagnosis*
	F41.9	Anxiety disorder, unspecified
For Secondary Diagnosis if needed This may be important for advocacy work with other service providers, agencies.		F84.0 Autistic disorder Note: Can be Secondary Diagnosis, but not
800 Other Disorders	Not relevant to Medicaid billing crosswalk	This code would be used to include diagnostic cod classifications into a DC: 0-3R formulation; in that as the primary system for diagnostic classification needed.

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

Transformation Steering Committee, Recovery Oriented System of Care
Recovery Policy and Practice Advisory
Version: 10.15.15

Purpose and Application

It is the policy of Michigan Department of Health and Human Services (MDHHS) that services and supports pr with behavioral health disorders (the term 'behavioral health' equates to substance use and mental health d recovery and embedded within a recovery oriented system of care. This policy and practice guideline specifie the Pre-paid Inpatient Health Plans (PIHPs), Community Mental Health Service Programs (CMHSPs) and their the culmination of a series of intentional milestones that include: the creation and evolution of the Recovery Care (ROSC) Transformation Steering Committee (TSC); the intension inclusion of persons with lived experier the behavioral health system (to give voice); establishment of Michigan Recovery Voices (to share resources) of a peer workforce to provide services and supports (to enhance the recovery services system).

In order to move toward a recovery-based system of services, the beliefs and knowledge about recovery mus MDHHS has worked diligently over the past several years toward the goal of effective transformation of beha be recovery oriented and based in a recovery oriented system. To that end, MDHHS requested that the ROS has adopted the following recovery statement, guiding principles and expectations for systems change:

Recovery Statement

***[An individual's]* Recovery from Mental Disorders and/or Substance Use Disorders:** A process of change thr improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA 201

Recovery oriented *system* of care supports an individual's journey toward recovery and wellness by creating networks of formal and informal services and supports. The opportunities established through collaboration broad array of services promote life enhancing recovery and wellness for individuals, families and communiti

Guiding Principles of Recovery

The following principles outline essential features of recovery for the individual, as well for creating and enha health recovery oriented system of care in which to embed recovery services and supports:

Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that pe the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greate leading, controlling, and exercising choice over the services and supports that assist their recovery and re they are empowered and provided the resources to make informed decisions, initiate recovery, build on or regain control over their lives.

The system of care promotes person driven recovery will be individualized, person/family/community-ce stage-appropriate, and flexible. It will adapt to the needs of individuals and communities, rather than re it. Individuals receiving services will have access to a menu of stage-appropriate choices that fit their nee recovery process. The approach will change from an acute, episode-based model to one that helps peop disorder throughout their lives. Prevention services will be developmentally appropriate and engage the settings that have an impact on health and wellness. Prevention efforts will be individualized based on th resources, and concerns.

Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—inclu experience—that affect and determine their pathway(s) to recovery. Recovery is built on the multiple ca talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly p include professional clinical treatment; use of medications; support from families and in schools; faith-ba support; and other approaches. Recovery is nonlinear, characterized by continual growth and improved f involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescri goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. Ir

pathways can be enabled by creating a supportive environment. This is especially true for children, who r or developmental capacity to set their own course.

Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This incluc practices, family, housing, employment, transportation, education, clinical treatment for mental disorder disorders, services and supports, primary healthcare, dental care, complementary and alternative service creativity, social networks, and community participation. The array of services and supports available shc coordinated.

This system will offer a continuum of care that includes prevention, early intervention, treatment, contin throughout recovery. Individuals will have a full range of stage-appropriate services to choose from at ar process. Prevention services will involve the development of coordinated community systems that provi rather than isolated, episodic programs.

Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vi supportive relationships, valued roles, and community. Through helping others and giving back to the co one's self. Peer-operated supports and services provide important resources to assist people along their and wellness. Professionals can also play an important role in the recovery process by providing clinical t services that support individuals in their chosen recovery paths. While peers and allies play an important recovery, their role for children and youth may be slightly different. Peer supports for families are very in with behavioral health problems and can also play a supportive role for youth in recovery.

This system of care will promote ongoing involvement of peers, through peer support opportunities for y peer recovery support services for individuals with behavioral health disorders. Individuals with relevant assist in providing these valuable supports and services.

Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in th recover; who offer hope, support, and encouragement; and who also suggest strategies and resources fo members, peers, providers, faith groups, community members, and other allies form vital support netwo relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., p friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonc and community participation.

Recovery is culturally-based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and bel determining a person's journey and unique pathway to recovery. Services should be culturally grounded, congruent, and competent, as well as personalized to meet each individual's unique needs.

The system of care will be culturally sensitive, gender competent, and age appropriate. There will be rec customs are diverse and can impact the outcomes of prevention and treatment efforts.

Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) or associated with alcohol and drug use, mental health problems, and related issues. Services and suppo informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, a

Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recov individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals shc speaking for themselves. Families and significant others have responsibilities to support their loved ones, and youth in recovery. Communities have responsibilities to provide opportunities and resources to addr to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

The system of care that fosters this dynamic will acknowledge the important role that families, significant communities can play in promoting wellness for all and recovery for those with behavioral health disorde incorporated, whenever it is appropriate, into needs-assessment processes, community planning efforts,

all support processes. In addition, our system will provide prevention, treatment, and other support serv members and significant others of people with behavioral health disorders.

Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and problems—including protecting their rights and eliminating discrimination—are crucial in achieving recov acknowledge that taking steps towards recovery may require great
courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in particularly important.

Inclusion of the voices and experiences of recovering individuals, youth, family, and community memb

The voices and experiences of all community stakeholders will contribute to the design and implementat People in recovery, youth, and family members will be included among decision-makers and have oversig service provision. Recovering individuals, youth, family, and community members will be prominently an represented on advisory councils, boards, task forces, and committees at state and local levels.

Integrated strength-based services

The system will coordinate and/or integrate efforts across service systems, particularly with primary care integrated service delivery system that responds effectively to the individual's or the community's unique strengths, desires, and needs. An integral aspect of this system is the partnership/consultant model that collaboration and less on hierarchy. Systems will be designed so that individuals, families, and communit direct their own journeys of recovery and wellness.

Services that promote health and wellness will take place within the community

Our system of care will be centered within the community, to enhance its availability and support the cap intimate social networks, community-based institutions, and other people in recovery. By strengthening support networks and addressing environmental determinants to health in which individuals participate, chances for successful recovery and community wellness.

Outcomes-driven

Our system will be guided by recovery-based process and outcome measures. These measures will be de collaboration with individuals in recovery and with the community. Outcome measures will be diverse ar of community wellness as well as the long-term global effects of the recovery process on the individual, f not just the remission of behavioral and biomedical symptoms. Outcomes will focus on individual, family indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

System-wide education and training

Our behavioral health system will seek to ensure that concepts of prevention, recovery, and wellness are of curricula, certification, licensure, accreditation, and testing mechanisms. The workforce also requires every level, to reinforce the tenets of ROSC. Our education and training commitments are reinforced thr and the overall service culture.

Research-based

Our system will be data driven and informed by research. Additional research with individuals in recover the processes of recovery (including cultural and spiritual aspects) will be essential to these efforts. Rese Behavioral health disorders will be supplemented by the experiences of people in recovery.

Expectations for Implementation of Recovery Practices

Based on the above guiding principles, the ROSC/TSC established the following expectations to guide organiz creating an environment and system of behavioral health services and supports that foster recovery and crea system of care:

1. Promote changes in state law and policies at all levels to create a system with an expanded recovery s easily accessed via many pathways by individuals needing services and supports.

   Requirements:

- Provide ongoing education to stakeholders on recovery principles and practices in conjunction wi influencing recovery service and supports.

- Develop and maintain a plan to educate and increase communication within the broader commur leadership from local and regional service providers, community prevention advocates, and recov committees/councils.

- Provide knowledge and education in partnership with the ROSC/TSC to stakeholders on recovery practices.

2. Develop policies and procedures that ensure seamless and timely entry and re-entry into services anc

   Requirements:

   - Utilize data and electronic recordkeeping to facilitate confidential access to individual informatior that will expedite access to services and supports, and reduce excess and duplicative information redundant paperwork.

   - Assure pathways are in place for expedited reentry into services for individuals who have been av once again need services and supports from the public behavioral health system.

   - Provide guidance during ongoing recovery planning including verbal and written information on h health and other community based services.

3. Align policies, procedures and practices to; 1) foster and protect individual choice, control, and self-d the provision of services that are holistic, culturally based and influenced, strength- and research-bas informed, and 3) are inclusive of person-centered planning process, community based services and su collaborative partnerships.

   Requirements:

- Develop and enhance recovery planning processes using baseline data and ongoing regional recov improve and expand the behavioral health recovery services system of care, and to strengthen th recovery services and supports.

- Assess an estimate the impact on cost of services annually, when significant changes occur to the plan via person-centered selection of culturally influenced, research and strength based services v oriented environment.

- Provide training and mentoring opportunities to individuals receiving services/peers to become in of both person-centered planning and self-determination practices.

4. Encourage the availability of peer services and supports including the option of working with Certifiec Specialists (CPSS) and/or Recovery Coaches as a choice for individuals throughout the service array, a individualized planning process.

   Requirements:
   - Develop and implement an educational approach with written materials to provide information t services and supports.

   - Provide information on the choices and options of working with peers in a journey of recovery inc Coaches as part of the person-centered planning process.

   - Collect baseline data on the number of individuals who receive peer services and supports - includ increasing the number of individuals utilizing these serves.

5. Align services and supports to promote and ensure access to quality health care and the integration c physical health care. Specific services and concerns to address include: screening; increased risk asses education; primary prevention; smoking cessation and weight reduction.

   Requirements:

- Regularly offer and provide classes ideally promoted, led and encouraged by peers related to whole health Action Toward Health (PATH), Wellness Recovery Action Planning (WRAP), physical activity, smoking cessa management etc.

- Collect information on behavioral health morbidity, mortality and co-morbid conditions with a str to address and decrease risk factors associated with early death. Include information on identifie for healthcare services.

- Provide referrals and outreach to assist individuals with meeting their basic needs, including findi having enough income to address risk factors associated with poverty, employment and educatio

- Identify, develop and strengthen community partnerships to promote models and access for the i and behavioral health.

- Discuss and coordinate transportation for individuals to attend appointments, classes and health- discussed in the person-centered planning process.

6. Assess and continually improve recovery promotion, competencies, and the environment in organiza recovery services system of care.

   Requirements:

   - Complete a strategic planning process that builds on the actions of and information from the ROS from the recovery survey implementation and review identified as part of the statewide RFA proc

   - Provide ongoing education on recovery services, recovery oriented systems of care, and environm recovery with all staff (executive management, psychiatrists, physicians, case managers, clinicians staff), leadership, board members, recovery councils, community members, etc.

   - Include a list of recovery oriented competencies (protocols and practice) in employee job descript evaluations.

- Work in partnership with individuals receiving services, CPSS/Recovery Coaches, program staff (m supervisory/administrative, support), and community and family members in all aspects of the de of recovery-oriented services and supports, needed trainings and recovery oriented activities.

How Michigan's Efforts Align with Federal Policy

MDHHS recognizes that recovery is highly individualized and requires support form a recovery oriented syste process, vision, conceptual framework that should adhere to guiding principles, but most importantly it is rec through a series of initiatives, trainings, and educations resources as well as state and national policies. Reco individual circumstances and needs, the strong voice and advocacy of people with lived experience, a broad supports within a recovery oriented system of care, and the commitment of partners and key stakeholders. E combination of personal experiences, a knowledgeable services system that promotes and supports recovery committed to health and wellness, a driving force for recovery oriented systems transformation is created ar

In 2012, the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Ac published this definition of recovery from Mental Disorders and/or Substance Use Disorders: A process of ch individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. with Guiding Principles of Recovery, including those from SAMHSA are provided earlier in this Policy and Prac at the core of Michigan's behavioral health recovery system and infrastructure.

After the review of recovery and recovery oriented systems of care definitions and guiding principles, the RO the following Elements of ROSC/Recovery to be adhered to by those providing behavioral health services.

Elements of a ROSC/Recovery:

- Holistic and integrated services beyond symptom reduction
- Person-Driven
- Continuity of care - assertive outreach and engagement; and ongoing monitoring and support
- Culturally responsive services.
- Occurs via many pathways
- Peer supports and services
- Community health and wellness.
- Family and Significant Other Involvement

- Systems/services anchored in the community
- Evidence- and Strength- based practices
- Trauma informed
- Based in respect

True change will require a series of legislative actions, state and federal policies and Mental Health and Publi intentionally designed to promote the construct and elements of recovery supports and services. Few states, have developed a policy and practice guideline on recovery, thus, MDHHS relied on the work, ideas of the no Recovery Council and the ongoing work and initiatives of the ROSC/TSC to craft this document.

Successful implementation of these guiding principles and recommendations for systems change will deman from MDHHS, the Behavioral Health and Developmental Disabilities Administration, the Pre-paid Inpatient H CMHSPs, and the behavioral health provider system, with active support form persons with lived experience, and communities across the state. This policy and practice advisory must be treated like recovery itself, with dedication to support individual and system change that will support recovery as "ongoing personal and unic growth, resilience and wellness." Great effort will be required to ensure that this policy and practice advisory implemented. The ROSC/TSC and MDHHS look forward to assessing progress toward these principles every y

Behavioral Health

Individual Recovery and Recovery Oriented S

Care

Planning, Reporting, and Evaluating

This document contains:

Information, directions, and forms for continued Recovery/ROSC transformation plan
evaluating;

and

An attachment to be utilized for educational and informational purpo

Table of Contents

Proposed Contract Language

To assure inclusion and application of recovery principles: PIHPs are required to contin and enhancement of recovery services and systems development through the use of C and Contextual alignment.

See attached forms and instructions.

Utilizing the Alignment Framework:

A Tool for Planning, Implementation, Enhancement, Reporting and

Instructions

This framework to guide the recovery transformation Planning, Implementation, Enhancement, Reporting and Evaluating process is th developed by Achara-Abrahams, Evans, & King, 2001). It involves three primary strategies that must be implemented in a way that pr competent service delivery system.

Conceptual Alignment: This alignment targets the promotion of conceptual and philosophical clarity regarding the system's coll transformation. During this process, the core values, principles, and ideas upon which a recovery oriented system of care will be l inclusive process.

Practice Alignment: This focuses on changing stakeholder behaviors and processes across the system, so that they are consisten recovery and resilience. Change leaders are focused on developing mechanisms to translate the theoretical concepts of recovery practices at various levels and in diverse parts of the system.

Contextual Alignment: Activities are designed to sustain the transformation over time. While practice changes constitute a nec these changes cannot be implemented in a vacuum. To be sustained over time, they must be accompanied by contextual change long-term success. Many of these changes in context include policy, regulatory, and fiscal changes; increased political advocacy; community support for people in recovery; and efforts that address stigma and strengthen the health of the community for all pe

These strategies are not linear, and at each phase of the transformation process there will be a continued need to align thinking, pract environment with the vision for the system. During some phases, however, certain strategies play a more prominent role. For exampl transformation process, it is critical that sufficient time be invested in developing a shared vision for the system.

Moving forward to transform, enhance, and maintain recovery services and a system that embraces and supports recovery, it is impor efforts used to strengthen the services/system as we proceed. The need to successfully grow a recovery oriented system of care popu facilitate individual recovery is incumbent on all parts of the behavioral health system. To bring structure to this process and make ea actions in this regard, the Behavioral Health and Developmental Disabilities Administration (BHDDA) is providing a mechanism and pr (implementation, enhancement) reporting and evaluating the regions ROSC/Recovery initiative and general progress.

Utilizing the framework described above, and providing a matrix to be used for planning and reporting on ROSC/Recovery transforma BHDDA is implementing this process to create consistency in the manner in which the ten PIHP Regions address continuing transform

Table 1: provides structure and guidance on the planning and reporting of Recovery/ROSC transformation and growth by defining the (conceptual, practice, and contextual); and this Table delineates the kinds of initiatives that should be undertaken within the scope of intermediate, and advanced) to advance and enhance Recovery/ROSC.

Table 2 is the actual matrix on which you will record your planning efforts and report the results of these initiatives. Portions of Table elements of ROSC/Recovery as identified within the guidelines for the same. These include: holistic and integrated services beyond sy driven; continuity of care – assertive outreach and engagement, and ongoing monitoring and support; culturally responsive services; c peer supports and services; community health and wellness; family and significant other involvement; systems/services anchored in th strength-based services; trauma informed; and based in respect. These elements are provided down the vertical axis at the left of the access you will find the three alignment types: conceptual, practice, and contextual as well as the phases of early, intermediate and ad alignment activities.

While planning services related to the elements of ROSC/Recovery consideration must also be given to the priorities for the direction services, which are: behavioral health and primary healthcare integration; community health promotion; recovery support services that services that are environmental and population-based; and services and supports whose focus is expanded, including both the contin treatment services to post-treatment services and supports) and the content of care (beyond supporting abstinence) to promoting co people build meaningful lives in the community.

Also within the matrix you will find some pre-filled examples of how to complete an item within a cross-hatched box – a cross-hatche which a line originated from the vertical axis intersects with a column from the horizontal axis. To assist in identifying where these exa one located in the cross-hatch box of Community Health and Wellness x Conceptual Alignment – Advanced. A second and third can l Peer Supports and Services x Practice Alignment – Advanced, and Family and Significant Other Involvement x Practice Alignment - Ea cross-hatch boxes, for each planned/reported activity, there needs to be: 1) the appropriate general type of initiative (selected from ta at the early, intermediate or advanced stage of this process within the region; and 3) the activity/initiative itself. If there are multiple a within the same cross-hatch box please number them consecutively. Again, the examples will assist in clarifying how to complete the

It is the PIHP that will complete **the plan** and/or the report matrices in Table 2 for their region. The plan however, is intended to be d intentionally selected, well informed individuals within the region, representing: behavioral health, other agency/organizations, key sta members/leadership, and persons with lived experience. **The report** will require the gathering of related information for each of the of this information when reporting on each planned, numbered item in the populated cross-hatched boxes.

The BHDDA intentionally developed a system that would complement surveys selected by the regions to measure progress in ROSC/F selected by each region, and approved by BHDDA, include one or more of the following, which were identified during the RFA proces (RSA) – Person in recovery version; Recovery Self Assessment (RSA) –Family/significant other/advocate version; Recovery Self Assessm

Recovery Self Assessment (RSA) – CEO/Agency director version; and the REE-MI. To link the questions on the RSA and REE surveys, ea (by a team of individuals) to one of the three alignment types from planning/reporting Tables 1 and 2. Each survey questions respons scale for grading responses with the exception of the REE-MI. In the case of that survey a number scale was assigned for this purpose practice and contextual alignment type questions, add up the points for each question/alignment type, then divide by the total numb· alignment type to determine an average score for that alignment – EXAMPLE: to begin let's assume that the following represent the s alignment type questions: 3, 4, 3, 1, 3, 2, 3, and these number scores were taken from the seven practice alignment type questions ide surveys. Then add the score from these seven questions, which equals 19, and dividing 19 by seven (the number of practice alignmen the average score of 2.71 for practice alignment. Continue this process until scores have been determine for the three alignment type surveys that you utilize. While this correlation and scoring process may take some time up front, the information received will be of gr

The next step in this process is to enter these results into Table 3a for all RSA surveys and Table 3b for the REE-MI survey. The tables name of the survey, the type of alignment, and provides a place for previous survey scores, current survey scores, and the variance be This is the first year that you are being required to use this process and these forms. Therefore, you are only required to enter inform results. Having made that clarification, if you would like to enter results from a previous implementation of these surveys, that would information that may aid in planning for next fiscal year, but this is not required. In the future (beyond this year's survey results), you year (as the previous year) and the new current year information and provide the variance.

By engaging in this process each PIHP region will be able to assess progress/growth, stagnation or decline in each ROSC/Recovery ali information will be reported to BHDDA, it will be used for informational purposes only, and to identify what technical assistance and t ROSC/Recovery may be of use to the different PIHP regions.
Planning, Reporting and Evaluation Due Dates:
Table 2: Annual Planning matrices are due, December 31, 2018
Table 2: Annual Reporting matrices are due by February 28, 2019
Table 3a and 3b: Annual Survey Information forms are due October 31, 2018

Table 1: ROSC Framework for the Transformation Process

	Phase I Beginning	Phase II Intermediate	
Conceptual Alignment (Develop consensus; promote an in-depth understanding of a culturally competent ROSC)	Increase awareness of the need for the development of a ROSC in Michigan Develop a shared vision for change among all stakeholders	Increase awareness of the implications of a ROSC for other systems (e.g., criminal justice, child welfare) Increase stakeholder understanding of effective ways of implementing recovery-oriented services and supports	Increase and supp to better Realign t lessons l [through

	Develop ROSC definition and guiding principles that apply to treatment and prevention Increase [regional and Local] stakeholder understanding of the differences between a ROSC and a traditional system, including implications for treatment and prevention		
Practice Alignment (Align services and supports with a recovery, resilience and culturally competent orientation)	Identify initial recovery-oriented practices that will be prioritized in the transformation process Disseminate information about practices throughout the system [and regionally/locally] Conduct baseline assessments Identify/initiate potential pilots Mobilize the recovery community and other community stakeholders	Support the implementation of recovery-oriented practices through the development of technical advisories, training, technical assistance, relevant work groups, etc. Support the implementation of pilot projects Conduct rapid-cycle change projects Collaborate across systems to promote practice alignment	Conduct Dissemin Provide a assistanc Increase around t services Identify a that will
Contextual Alignment (Change policy, fiscal, regulatory and administrative infrastructure so that it supports the sustainability of Michigan's culturally competent ROSC)	Identify fiscal, policy and regulatory barriers to delivering services and supports that promote recovery and resilience Identify strategies for addressing barriers to implementation Develop strategies to engage the community to support ROSC	Align fiscal and policy infrastructure to support recovery-oriented services Identify and address contextual challenges that arise within the pilot projects	Conduct of the sy Identify c Increase recovery contract Actively a impleme

Table 2: Plan and Report on Action/Progress toward ROSC/Recovery Implen Enhancement Select the Appropriate Option: ____ Annual Plan or ____ Quarterly Reporting F			
Elements of ROSC/Recovery	**Conceptual Alignment** **Phase 1: Early** **Phase 2: Intermediate** **Phase 3: Advanced** *When reporting Indicate to which phase your activity/accomplishment is associated*	**Practice Alignment** **Phase 1: Early** **Phase 2: Intermediate** **Phase 3: Advanced** *When reporting Indicate to which phase your activity/accomplishment is associated*	**Con** **Pha** **Ph** *When r phase you*
	(Develop consensus; promote an in-depth understanding of a ROSC/Recovery)	(Align services and supports with a ROSC/Recovery and resilience orientation)	(Change p administra supports i ROSC/Rec
▪ Holistic and integrated services beyond symptom reduction			
▪ Person-Driven			
▪ Continuity of care - assertive outreach and engagement; and ongoing monitoring and support			
▪ Culturally responsive services.			
▪ Occurs via many pathways			
▪ Peer supports and services		**Example:** [Identify additional recovery oriented practices that will be prioritized] Advanced: Continue the availability of effective peer run organizations which provide varying levels of peer support services.	
▪ Community health and wellness	**Example:** [Increase awareness of the types of services and supports within Michigan that are leading to better outcomes] Advanced: Established an advisory Council inclusive of persons with lived experience, to make		

	recommendations on environmental prevention strategies to improve community wellness		
▪ Family and Significant Other Involvement		**Example:** [Conducting baseline assessments] Early: Implemented Region –wide the Recovery Self-Assessment (RSA) – Family, Significant Other, Advocate Version	
▪ Systems/services anchored in the community			
▪ Evidence- and Strength- based practices			
▪ Trauma informed			
▪ Based in respect			

Utilizing the Recovery Survey Tools

Process for the RSA Survey User(s):

Identify each question on the individual RSA surveys tool as being associated to Conceptual, Practice, or Contextual Alignment. For e the scores given to each of those questions, then divide that total number by the number of that alignments questions...EXAMPLE: le survey has five Practice Alignment questions and the survey responses to these five quests are – 3.0, 4.0, 1.0, 4.0, and 4.0. Adding the you get 16.0., then divide by 5 and the average score for Practice alignment is 3.2. For those who have done baseline or previous usa same scoring process for that survey.

Once you have totaled the information from the previous and current survey periods compare the two number totals, and identify th progressive or regressive outcomes for transformation efforts related to each alignment. Use this information to inform your future p areas of regression or little to no progression. It may take some time to calculate your base line and current survey numbers, howeve good information for planning and showing progress in your transformation efforts.

Identify each of the RSA survey forms being used in your region, please show the previous survey result numbers compared to the c and the progressive or regressive variance.

Table 3a: RSA Survey Forms Information

	Previous RSA Survey Alignment Scores Date of Survey: _____	Current RSA Survey Alignment Scores Date of Survey: _____	Varian Curr
RSA Survey – Individual Recovery			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			
RSA Survey - Program Provider			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			
RSA Survey – Management/Administration			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			

	RSA Survey – Family and Significant Others		
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			

	RSA Survey Forms Table - EXAMPLE		
	Previous RSA Survey Alignment Scores Date of Survey: _____	**Current RSA Survey Alignment Scores Date of Survey:** _____	**Varian Curr**
	RSA Survey – Family and Significant Others		
Type of Alignment			
Conceptual Alignment	28.0	35.0	
Practice Alignment	16.0	12.0	
Contextual Alignment	21.0	21.0	

Process for the REE Survey User(s):

Beginning with section three of the REE Survey and going through section five identify each question on the individual RSA surveys t Conceptual, Practice, or Contextual Alignment. Then using the following scoring key assign every numbered and lettered question tl the key, i.e., a "strongly agree" response would be assigned the number four.

Strongly Agree (SA)	= 4.0
Agree (A)	= 3.0
Disagree (D)	= 2.0
Strongly Disagree (SD)	= 1.0

Next, for each type of alignment add up the scores given to each of those questions, then divide that total number by the number of questions...EXAMPLE: let's say that the REE survey, section three has five Practice Alignment questions and the survey responses value 3.0, 4.0, 1.0, 4.0, and 4.0. Adding the response numbers together you get 16.0., then divide by 5 and the average score for Practice ali have done baseline or previous usage of this survey utilize the same scoring process for that survey so that you can do a comparative

Once you have totaled the information from the previous and current survey periods compare the two number totals, and identify t progressive or regressive outcomes for transformation efforts related to each alignment. Use this information to inform your future p areas of regression or little to no progression. It may take some time to calculate your base line and current survey numbers, however good information for planning and showing progress in your transformation efforts.

Table 3b: REE-MI Survey Form Information

	Previous REE Survey Alignment Scores Date of Survey: _____	Current REE Survey Alignment Scores Date of Survey: _____	Varian Curi
REE Survey – Section III			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			
REE Survey – Section IV			
Type of Alignment			
Conceptual Alignment			
Practice Alignment			
Contextual Alignment			
REE Survey – Section V			
Type of Alignment			
Conceptual Alignment			

Practice Alignment			
Contextual Alignment			
REE Survey Form Table - EXAMPLE			
	Previous REE Survey Alignment Scores Date of Survey: _____	**Current REE Survey Alignment Scores Date of Survey:** _____	**Varian Curr**
REE Survey – Section III			
Type of Alignment			
Conceptual Alignment	28.0	35.0	
Practice Alignment	16.0	12.0	
Contextual Alignment	21.0	21.0	

Attachment:
Framework and Infrastructure for
Recovery Oriented Systems of Care and Individual Recovery Initiat

Effective pursuit and support of recovery has a dual focus: 1) the development and maintenance of a recovery oriented services system ar 2) a process that is dedicated to supporting personal recovery through the provision of necessary and needed services and supports. One

An individ existence

A ROSC is not a program; it is a philosophical construct by which a behavioral health system (SUD and mental health) shapes its perspective on how they will address recovery from alcoholism, addiction and other disorders. A ROSC approach is the basis of the development of the behavioral health service system. Its philosophy completely encompasses all aspects of SUD and Mental Health prevention and treatment services, including program structure and content, agency staffing, collaborations, partnerships, policies, regulations, trainings and staff/peer/volunteer orientation.

Within a ROSC, SUD and mental health service entities, as well as their collaborators and partners, cooperatively provide a flexible and fluid array of services in which individuals can move. People should be able to move among and within the system's service opportunities, without encountering rigid boundaries or silo-embedded services, to obtain the assistance needed to pursue recovery, and approach and maintain wellness. In Michigan we believe that behavioral health recovery is possible and can be achieved by individuals, families and communities.

As PIHPs develop recovery plans for their region, it is this type of system of care and this type of service array that should be considered.

of care. Without a services system

'Recovery is a process not an event'

built on recovery practices, policies, and programs, providing the infrastructure to support an individual's recovery efforts there would be no foundation from which to work and flourish.

Recovery is possible when a multi-faceted infrastructure of services and supports exists to enable and enhance the recovery efforts and environments of individuals, families and communities.

Elements of a ROSC/Recovery:

- Holistic and integrated services beyond symptom reduction
- Person-Driven
- Continuity of care - assertive outreach and engagement; and ongoing monitoring and support
- Culturally responsive services.
- Occurs via many pathways
- Peer support and services
- Community health and wellness.
- Family and Significant Other Involvement
- Systems/services anchored in the community
- Evidence- and Strength- based practices
- Trauma informed
- Based in respect

Individual Recovery and Recovery Oriented *System* of Ca

Principles:

These Guiding Principles will be utilized by BHDDA and the TSC to support and guide the dev oriented behavioral health services system.

SAMHSA's Ten Guiding Principle of Recovery *[for individual recov*

Guiding Principles for Recovery Oriented Systems of Care:

The numbered Guiding Principles, items one through ten, are those identified by SAMHSA. In separate statements under one number the second statement is an enhancement to include a information to the guiding principle. Guiding principles eleven through sixteen are additional connection between an individual's personal recovery and the services systems that support their efforts.

1) Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that people and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Five RC

1. Beha integ
2. Com
3. Reco
4. Prev popu
5. Serv inclu treat and supp com mea

2) Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

The system of care promotes person driven recovery will be individualized, person/family/community-centered, comprehensive, stage-appropriate, and flexible. It will adapt to the needs of individuals and communities, rather than requiring them to adapt to it. Individuals receiving services will have access to a menu of stage-appropriate choices that fit their recovery process. The approach will change from an acute, episode-based model to one that helps people manage this chronic disor Prevention services will be developmentally appropriate and engage the multiple systems and settings that have an impact on health efforts will be individualized based on the community's needs, resources, and concerns.

3) Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experience—tha pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value o pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in s approaches; peer support; and other approaches. Recovery is nonlinear, characterized by continual growth and improved functioning Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescrib for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for childrer or developmental capacity to set their own course.

4) Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care prac employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, pri complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of service should be integrated and coordinated.

This system will offer a continuum of care that includes prevention, early intervention, treatment, continuing care, and support throug have a full range of stage-appropriate services to choose from at any point in the recovery process. Prevention services will involve th coordinated community systems that provide ongoing support, rather than isolated, episodic programs.

5) Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an in Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued role helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resou their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical trea support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for ch slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a suppo recovery.

This system of care will promote ongoing involvement of peers, through peer support opportunities for youth and families and peer r individuals with behavioral health disorders. Individuals with relevant lived experiences will assist in providing these valuable supports

6) Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, communi form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in n caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusio participation.

7) Recovery is culturally-based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as persona unique needs.

The system of care will be culturally sensitive, gender competent, and age appropriate. There will be recognition that beliefs and cust impact the outcomes of prevention and treatment efforts.

8) Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or ass use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emo promote choice, empowerment, and collaboration.

9) Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals ha for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant c support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities an discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the speak collectively about their strengths, needs, wants, desires, and aspirations.

The system of care that fosters this dynamic will acknowledge the important role that families, significant others and communities can for all and recovery for those with behavioral health disorder challenges. It will be incorporated, whenever it is appropriate, into need community planning efforts, recovery planning and all support processes. In addition, our system will provide prevention, treatment, the family members and significant others of people with behavioral health disorders.

10) Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—in and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery r courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly imp

11) **Inclusion of the voices and experiences of recovering individuals, youth, family, and community members**

The voices and experiences of all community stakeholders will contribute to the design and implementation of our system. People in members will be included among decision-makers and have oversight responsibilities for service provision. Recovering individuals, yc members will be prominently and authentically represented on advisory councils, boards, task forces, and committees at state and loc

12) Integrated strength-based services

The system will coordinate and/or integrate efforts across service systems, particularly with primary care services, to achieve an integr that responds effectively to the individual's or the community's unique constellation of strengths, desires, and needs. An integral aspe partnership/consultant model that focuses more on collaboration and less on hierarchy. Systems will be designed so that individuals, feel empowered to direct their own journeys of recovery and wellness.

13) Services that promote health and wellness will take place within the community

Our system of care will be centered within the community, to enhance its availability and support the capacities of families, intimate s based institutions, and other people in recovery. By strengthening the positive social support networks and addressing environmenta which individuals participate, we can increase the chances for successful recovery and community wellness.

14) Outcomes-driven

Our system will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration witl with the community. Outcome measures will be diverse and encompass measures of community wellness as well as the long-term gl process on the individual, family, and community – not just the remission of behavioral and biomedical symptoms. Outcomes will foc community indicators of health and wellness, including benchmarks of quality-of-life changes for people in recovery.

15) System-wide education and training

Our behavioral health system will seek to ensure that concepts of prevention, recovery, and wellness are foundational elements of cur accreditation, and testing mechanisms. The workforce also requires continuing education, at every level, to reinforce the tenets of RO training commitments are reinforced through policy, practice, and the overall service culture.

16) Research-based

Our system will be data driven and informed by research. Additional research with individuals in recovery, recovery venues, and the p (including cultural and spiritual aspects) will be essential to these efforts. Research related to Behavioral health disorders will be suppl of people in recovery.

Embracing the Reasoning and Philosophy Behind Recovery and Recovery Orie

Care:

Gaining Insight that will Motivate Change

Information to Support the Need for Behavioral Health Systems and Services Recovery Trar

What is known about Mental Health and Substance Use Disorders, and why the system needs change:

1. People typically enter treatment after ten years of active addiction. The longer people use, the more difficult it is for them to ente
2. The longer the use, due to Substance Use Disorders, the higher the negative impacts for families and communities.
3. 90 percent of persons with mental health or substance use disorders have experienced trauma. 100 percent of persons with co-o experienced trauma.
4. Genetic and Social predisposition increase risk behavior and risk of developing the disease of addiction. [Look for data for co-occ
5. Risk for suicide is higher among those with mental health, substance use, and co-occurring disorders.

Why we need change:

1. Fifty percent of clients entering treatment have already had at least one prior episode of care.
2. SUD is a chronic condition, but we currently have an acute care treatment model. This model does not sustain the support necess our resources are needed to change this.
3. Cycling in and out of a series of disconnected treatment episodes is a product of the challenges within the current system – an recovery.
4. Scope of the system of services needs to be broadened.
5. Coordination of prevention, follow up and continuing care lacks integration and needs enhancement.
6. Working together in partnership and collaboration is the only way to provide all services needed to achieve and sustain recovery.
7. Limited Attraction: Less than 10% of people who meet the DSM (current version) criteria for a SUD currently seek treatment.
8. Poor Engagement and Retention: Less than half of those in treatment complete their treatment program.
9. Lack of Continuing Care: Post-discharge continuing care can enhance recovery outcomes, but only one in five receives it.
10. High Rates of Relapse: The majority of people completing addiction treatment resume alcohol and other drug use within one following discharge.
11. Resource Expenditures: Most resources are expended on a small portion of the population requesting services.
12. Readiness for Change: Services are not aligned with the client's readiness for change.
13. Data is not utilized in a manner that enhances services and monetary support- we need to empower change and enforce account
14. Current system is fragmented and not cost effective. There is poor use of resources and lack of communication between systems – create challenges.
15. Society, legislators, law enforcement, and physicians have a negative perception of individuals with mental health and/or substa low expectation of change.
16. Significant stigma exists within the behavioral health and primary health care systems.
17. It takes four to five years for the risk of SUD relapse to drop below 15%.
18. Current services system focuses on acute treatment.

19. Admission and discharge protocols compromise fluidity of service provision.

What we know about services that support recovery and resilience.

Effective ROSC services focus on:

1. Greater emphasis on continuity of care: effective prevention, assertive outreach and engagement, treatment, and ongoing monitc
2. Continuum of care in which services are holistic and integrated, culturally responsive, and with systems that are anchored in the c
3. Expanded availability of non-clinical services such as: peer supports, prevention, faith-based initiatives, etc.
4. Resources to help prevent the onset of substance use disorders.
5. A public health approach being taken to help create healthy communities.
6. More assertive outreach to families and communities impacted by substance use disorders.
7. More assertive post-treatment monitoring and support is provided.
8. A partnership/consultation approach rather than an expert/patient model.
9. Valued lives and experiences of other people in recovery used to help others on their journey.
10. Person-centered self-directed approach to recovery,
11. Use of peer support services to sustain an individualized recovery effort.
12. Use of services that build on each individual's recovery capital.
13. Sustained relationships help to maintain engagement.
14. Ongoing recovery activities are critical for sustaining recovery efforts.
15. Expanded knowledge and increased education efforts regarding all populations served.

Examples of how a ROSC differs from traditional service systems:

1. Treatment goals extend beyond abstinence or symptom management to helping people achieve a full, meaningful life in the com
2. Prior treatment is not viewed as a predictor of poor treatment outcomes and is not used as grounds for denial of treatment.
3. People are not discharged from treatment for relapsing and confirming their original diagnosis of addiction, which is a chronic anc
4. Post-treatment continuing care services are an integrated part of the service continuum rather than an afterthought.
5. Focus is on all aspects of the individual and the environment, using a strength-based perspective and emphasizing assessment of
6. Service system includes not just behavioral health providers but collaborators, stakeholders, and community partners as well.
7. Expansion to include innovative services that are comprehensive, dynamic, and always evolving.
8. Utilization of multi-disciplinary teams personalized to the individual's needs and goals (strength-based).
9. Provider/client relationship is key and partner oriented – not hierarchal.
10. Streamlined documentation and consistent reimbursement.

What are some implications for recovery services and supports?

1. Greater emphasis on outreach, pre-treatment supports, and engagement.
2. More diverse menu of services and supports available for people to choose from based on their needs.
3. A more assertive effort by providers to connect individuals to families and natural supports.
4. Expanded availability of non-clinical/peer-based recovery supports.
5. Post-treatment recovery check-ups.
6. Service relationships shift from an expert/patient model to a partnership/consultation approach.

7. Understanding of the impact of trauma.
8. Reduction of recidivism.
9. Reduction of stigma.

Embracing the philosophy, perspective and practice of Recovery/ROSC by:

1. Establishing a proactive partnership with the individual, that is person-centered.
2. Establishing and maintaining a system of care that is recovery oriented and supports recovery services.
3. Establishing and nurturing relationships with other community support service providers.
4. Creating the expectation that full recovery is a life-long pursuit sustained through service intervention and community support.
5. Acknowledging that multiple episodes needing treatment do occur and are reasonable, considering the nature of behavioral heal
6. Respecting that recovery requires ongoing relationships rather than brief interventions.
7. Being open to new and innovative approaches.
8. Confronting stigma whenever encountered.

PIHP CUSTOMER SERVICES STANDARDS
Revised: October, 2017

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 (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. It must also be made available 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 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.

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