PASRR AGREEMENT

I. PURPOSE

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

II. REQUIREMENTS

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

1. Medicaid Provider Manual, Nursing Facility Chapter, . https://www.michigan.gov/mdhhs/0,5885,7-339--87572--,00.html

2. Federal Register/Vol 57, No. 230/Monday, November 30, 1992/Rules and Regulations/Subpart C -- Pre-admission Screening and Annual Resident Review of Mentally Ill and Developmental Disabled Individuals. https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part483.pdf

3. The CMHSP must ensure that all new employees and contracted workers, who administer PASRR, are trained at least one time on the policies and procedures with respect to the OBRA/PASRR process through Improving MI Practices website at: www.improvingmipractices.org.

4.

5. The OBRA Operations Manual (8th Edition, 2017) is provided for reference in the OBRA Electronic Application.

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

PRE-ADMISSION SCREENING

B. The CMHSP will provide evaluations and assessments for all individuals located in the

CMHSP's service area who are presented for admission to a nursing facility regardless of the location of the admitting facility and for whom a Level I Pre-admission Screening procedure (DCH Form 3877) has identified the possible presence of a mental illness or a developmental disability. This evaluation and assessment will be completed, and an appropriate determination made prior to admission of the individual to a nursing facility. This evaluation and assessment will be completed utilizing criteria specified in Paragraph A. above by OBRA electronic application or paper system requirements.

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

RESIDENT REVIEW (Hospital Exempt Discharged, Change in Condition)

D. The CMHSP will complete Resident Reviews (Level II Evaluations) to all nursing facility residents who are located in the CMHSP's service area and who have been identified through the PASRR process as having either a mental illness or developmental disability or who have otherwise been identified to the CMHSP by submission of DCH Form 3877. This evaluation and assessment must be completed utilizing criteria specified in Paragraph A. above.

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

III. RECORDS, BILLINGS, AND REIMBURSEMENT

A. The CMHSP will maintain all documentation and records concerning services provided, client treatment recommendations and treatment plans, and verification of compliance with standards for subsequent audit, and actual cost documentation for a period of seven (7) years and assure that all such documentations will be accessible for audit by appropriate DEPARTMENT staff and other authorized agencies.

B. The CMHSP will submit OBRA PASRR Grant Application annually through the State of Michigan EGrAMS Application. This application will identify CMHSP’s estimated yearly cost, certification/contacts information, project synopsis and target

area, and work plan. The yearly cost will show all Direct Expenses, Other Expenses, and Indirect Expenses. Indirect Costs will need to be calculated on Attachment B.4 Form DeMinimis Rate Calculation. Contractual Cost over $25,000 per subcontract/subaward are disallowed to be calculated from the Indirect Cost. Additional Other Expenses are also not allowed to be calculated for the Indirect Cost. These costs include Tuition Remissions, Rental Costs, Scholarships/Fellowships, Participant Support Costs, and Patient Care. Any OBRA PASRR Grant Application Amendments will be required to follow the MI E-Grants Project Based Amendment Schedule.

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

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

D. Payments earned by the CMHSP for these services will be included as earned revenue from the DEPARTMENT on the revenue and expenditure reports required by this contract. PASRR expenditures will be specifically identified as part of the "Other Services" section of the final FSR. Separation by MI and DD is not required. All payments made under this Agreement are subject to the requirements under the Single Audit Act of 1984. The CFDA number for the federally funded portion of payments made to the CMHSP under this Agreement is 93.778. The funding source consists of 75% Federal funds, and 25% State match.

IV. DEPARTMENT RESPONSIBILITIES

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

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

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

V. TERMINATION

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

DETAILED OF SERVICES BILLED

NURSING FACILITY EVALUATIONS

CMH BOARD NAME:	MONTH/YEAR:

NAME OF RESIDENT	D.O.B.	*TYPE OF SCREEN	MI OR DD	DATE OF SERVICE
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

*INDICATE PAS/ARR/CIC/HED/REV

Completing Detailed Billing Summary Instructions

1. List each consumer who had a Completed Level II Evaluation submitted during the respective month.
    a. If consumer had two completed Level II Evaluations in one month, list twice.
2. Do Not include any consumer who only had a Partial Level II Completed on this form.
3. Do Not include hours, visits, or costs on this form.

SUMMARY BILLING FOR PRE-ADMISSION SCREENING and RESIDENT REVIEWS (PASRR)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

I. DIRECT COSTS TOTAL

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

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

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

D. Subtotal Direct Costs: $_____

II. INDIRECT COSTS

A. Please Check Appropriate Indirect Method: DeMinimis ☐ Cost Allocation Plan ☐ Federal Approval Rate ☐

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

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

IV. FEDERAL REIMBURSEMENT

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

CMHSP CERTIFICATION

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

_____ _____
COMMUNITY MENTAL HEALTH SERVICES PROGRAMS DIRECTOR **DATE**

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

_____ _____
MDHHS Authorized Staff **DATE**

ATTACHMENT B.4

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIRECT COST: 10% DE MINIMIS RATE CALCULATION
FISCAL YEAR 2020 Grant Agreements

Grantee Name:	
Grant Program Name:	
Grant Project (if applicable)	

				BUDGETED AMOUNT
A.	**TOTAL DIRECT EXPENDITURES** Enter the total direct expenditures from the EGrAMS budget line called Total Direct Expenditures.			$0
B.	**COSTS DISALLOWED FROM 10% DE MINIMIS RATE INDIRECT BASE EXPENDITURES** Enter all costs for each category from the EGrAMS budget listed below.			**DISALLOWED COSTS** (The worksheet will calculate this column).
C.	**Fringe Benefits:**			
	Tuition Remissions		$0	$0
D.	**Calculation of disallowed "Contractual" costs over $25,000 per subcontract/subaward.** Enter the total subcontract amount in column E for each subcontract/sub-award. The worksheet will calculate the disallowed costs in column F. **Contractual (List Subcontracts/Sub awards, Agency Name, and Amount):**			
		NAME	**TOTAL AMOUNT**	
	1)		$0	$0
	2)		$0	$0
	3)		$0	$0
	4)		$0	$0
	5)		$0	$0
E.	**Equipment:**		$0	$0
G.	**Other Expenses:** List total cost for the following sub-categories included in "Total Other Expenses" budget category:			
	Rental Costs		$0	$0
	Scholarships/Fellowships		$0	$0
	Participant Support Cost		$0	$0
	Patient Care		$0	$0
F.	**Specific Assistance to Individuals:**		$0	$0
H.	**TOTAL DISALLOWED EXPENDITURES:**			**$0**
I.	**BASE EXPENDITURES** (A-G) (Enter amount for indirect calculation on budget):			**$0**
J.	10% De Minimis Rate - up to 10%: (Enter amount for indirect calculation on budget):			10%
K.	**INDIRECT COST: (enter amount on budget)**			**$0**

Expenditures for Capital Outlay are not allowable for MDHHS Grants. If an exception is approved contact MDHHS Grants Section for further instructions.

CMHSP
Indirect Cost Calculations
FY_____

	Current Month Total Expenses	**Current Month Expenses Allowed for Indirect Cost**	**Total Year to Date Expenses**
Salary			
Fringe Benefits			
Travel			
Supplies & Materials			
Rent			
Contractual			
Equipment			
TOTAL EXPENSES			
Indirect Cost Rate		**%**	
Total Indirect Cost Billed			

CERTIFICATE OF INDIRECT COSTS

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

1. All costs included in this proposal, dated_____, to establish billing or final indirect costs rates for fiscal year_____, are allowable in accordance with the requirements of the Federal Award to which they apply and OMB 2 CFR Part 200, Subpart E – Cost Principles. Unallowable costs have been adjusted for in allocating costs as indicated in the cost allocation plan.

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

I declare that the foregoing is true and correct.

Community Mental Health Agency:

Name:_____

Signature:_____

Title:_____

Date:_____