MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
FY22 REPORTING REQUIREMENTS
Effective 10/1/21
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MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
FY22 REPORTING REQUIREMENTS
Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2022 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

- "Supplemental Instructions for Encounter and Quality Improvement Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter and quality improvement (demographic) data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- Mental Health Code list that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDHHS and EDIT have assigned to them.
- Cost per code instructions that contain instructions on use of modifiers; the acceptable activities that may be reflected in the cost of each procedure; and whether an activity needs to be face-to-face in order to count.
- "Establishing Managed Care Administrative Costs" that provides instructions on what managed care functions should be included in the allocation of expenditures to managed care administration
- "Michigan's Mission-Based Performance Indicator System, Version 6.0" is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators

These documents are posted on the MDHHS web site and are periodically updated when federal or state requirements change, or when in consultation with representatives of the public mental health system it deemed necessary to make corrections or clarifications. Question and answer documents are also produced from time to time and posted on the web site.

Collection of each element contained in the master contract attachment is required. Data reporting must be received by 5 p.m. on the due dates (where applicable) in the acceptable format(s) and by the MDHHS staff identified in the instructions. Failure to meet this standard will result in contract action.

The reporting of the data by PIHPs described within these requirements meets several purposes at MDHHS including:

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management
- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- Actuarial activities

Individual consumer level data received at MDHHS is kept confidential and published reports will display only aggregate data. Only a limited number of MDHHS staff members have access to the database that contains social security numbers, income level, and diagnosis, for example. Individual level data will be provided back to the agency that submitted the data for encounter data validation and improvement. This sharing of individual level data is permitted under the HIPAA Privacy Rules, Health Care Operations.

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

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

Submit completed reports electronically (Excel or Word) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov except for reports noted in table below.

Due Date	Report Title	Report Frequency	Report Period
1/31/22	1Q Special Fund Account – Section 226a, PA of the MHC	Quarterly (Use standalone form)	October 1 to December 31
4/30/22	2Q Special Fund Account – Section 226a, PA of the MHC	Quarterly (Use standalone form)	October 1 to March 31
5/31/2022	Mid-Year Status Report	Mid-Year	October 1 to March 31
6/30/2022	Semi-annual Recipient Rights Data Report	Mid-Year	October 1 to March 31. Section I only. See section "Recipient Rights Data Report" for additional information in this attachment.
8/15/2022	3Q Special Fund Account – Section 226a, PA of the MHC	Quarterly (Use standalone form)	October 1 to June 30
8/15/2022	CMHSP FSR Bundle – All Non-Medicaid,	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• State Services Utilization, Reconciliation & Cash Analysis	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Contract Settlement Worksheet	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Reconciliation and Cash Settlement	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Projection (Use tab in FSR Bundle)	October 1 to September 30
10/1/2022	General Fund – Year End Accrual Schedule	Final	October 1 to September 30
FY22 Monthly	PASARR Agreement Monthly Billing	Monthly	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.
11/10/2022	CMHSP FSR Bundle – All Non-Medicaid,	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• State Services Utilization, Reconciliation & Cash Analysis	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Contract Settlement Worksheet	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Reconciliation and Cash Settlement	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Interim (Use tab in FSR Bundle)	October 1 to September 30
11/10/2022	Categorical Funding – Multi-cultural Annual Report	Annually	October 1 to September 30
12/01/2022	Special Education to Community Transition Data Tracking Report	Annually	October 1 to September 30
12/30/2022	Annual Recipient Rights Data Report	Annually	October 1 to September 30. Sections I, II, III & IV. See section "Recipient Rights Data Report" for additional information in this attachment.
1/31/2023	Annual Report on Fraud and Abuse Complaints	Annually	October 1 to September 30
2/28/2023	CMHSP FSR Bundle – All Non-Medicaid	Final (Use tab in FSR Bundle)	October 1 to September 30
	• State Services Utilization, Reconciliation & Cash Analysis	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Final (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Reconciliation and Cash Settlement	Final (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Contract Settlement Worksheet	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Final (Use tab in FSR Bundle)	October 1 to September 30
2/28/2023	Sub-Element Cost Report	Annually	See Attachment 6.5.1.1 Submit report to: QMPMeasures@michigan.gov
2/28/2023	Annual Submission Requirement Form – Estimated FTE Equivalents	Annually	For the fiscal year ending September 30, 2021
2/28/2023	Annual Submission Requirement Form – Requests for Services and Disposition of Requests	Annually	For the fiscal year ending September 30, 2021

2/28/2023	Annual Submission Requirement Form – Waiting List	Annually	For the fiscal year ending September 30, 2021
2/28/2023	Annual Submission Requirement Form – Community Needs Assessment	Annually	For the fiscal year ending September 30, 2021
2/28/2023	CMHSP Administrative Cost Report	Annually	For the fiscal year ending September 30, 2021
2/28/2023	Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30, 2021
30 days after receipt, but no later than June 30, 2022	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually	October 1 to September 30th Submit reports to: MDHHS-AuditReports@michigan.gov
30 days after receipt, but no later than June 30, 2022	Compliance exam and plan of correction	Annually	October 1 to September 30th Submit reports to: MDHHS-AuditReports@michigan.gov

FY 2021 DATA REPORT DUE DATES

	Nov 21	Dec	Jan 22	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec 22	Jan 23
1. Consumer level** Demographic BHTEDS (monthly)[1] b. Encounter (monthly)[1]	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2.PIHP level a. Medicaid Utilization and Net Cost Report: annually)[2]				√											
b. Performance indicators (quarterly)[2]					√			√			√			√	
c. Consumer Satisfaction (annually) [2]										√					
d. CAFAS and PECFAS [3]													√		
e. Critical incidents (monthly)[3]															

NOTES:

1. Send data to MDHHS MIS via DEG
2. Send data to MDHHS, Behavioral Health & Developmental Disabilities Administration, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDHHS web site at: www.michigan.gov/dhhs Click on "Reporting Requirements"

**Consumer level data must be submitted immediately within 30 days following adjudication of claims for services provided, or in cases where claims are not part of the PIHP's business practices within 30 days following the end of the month in which services were delivered.

PIHP level reports are due at 5 p.m. on the last day of the month checked

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

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at: http://www.michigan.gov/mdhhs/0,4612,7-132-2941_38765---,00.html

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

-BH-TEDS Discharge/Update/End Records (due monthly)

A. Basis of Data Reporting

The basis for data reporting policies for Michigan behavioral health includes:

1. Federal funding awarded to Michigan through the Combined SABG/MHBG Behavioral Health federal block grant.

2. SAMHSA's Behavioral Health Services Information Systems (BHSIS) award agreement administered through Synectics Management, Inc that awards MDHHS a contracted amount of funding if the data meet minimum timeliness, completeness and accuracy standards

3 Legislative boilerplate annual reporting and semi-annual updates

B. Policies and Requirements Regarding Data

BH-TEDS Data reporting will encompass Behavioral Health services provided to persons supported in whole or in part with MDHHS-administered funds.

Policy:

Reporting is required for all persons whose services are paid in whole or in part with state administered funds regardless of the type of co-pay or shared funding arrangement made for the services.

For purposes of MDHHS reporting, an admission, or start, is defined as the formal acceptance of a client into behavioral health services. An admission or start has occurred if and only if the person begins receiving behavioral health services.

1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information

developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

2. All SUD data collected and recorded on BH-TEDS shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDHHS at the program level.

3. There must be a unique Person identifier assigned and reported. It must be 11 characters in length, and alphanumeric. This same number is to be used to report data for BH-TEDS and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.

4. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.

5. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDHHS.

6. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

7. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.

8. Statements of MDHHS policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

Method for submission: BH-TEDS data are to be submitted in a fixed length format, per the file specifications.

Due dates: BH-TEDS data are due monthly. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly

data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

Who to report: The PIHP must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and substance use disorders who receive services funded in whole or in part with MDHHS-administered funding. PIHPs participating in the Medicare/Medicaid integration project are not to report BH-TEDS records for beneficiaries for whom the PIHP's financial responsibility is to a non-contracted provider during the 180-day continuity of care.

PROXY MEASURES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

For FY21, the CMHSPs are required to report a limited set of data items in the Quality Improvement (QI) file for consumers with an intellectual or developmental disability. The required items and instructions are shown below. Detailed file specifications are (will be) available on the MDHHS web site.

Instructions*: The following elements are proxy measures for people with developmental disabilities. The information is obtained from the individual's record and/or observation. Complete when an individual begins receiving public mental health services for the first time and update at least annually. Information can be gathered as part of the person-centered planning process.*

For purposes of these data elements, when the term "support" is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- *"Limited" means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.*
- *"Moderate" means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.*
- *"Extensive" means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.*
- *"Total" means the person is unable to complete the activity and the caregiver is providing 100% support.*

Fields marked with an asterisk * cannot be blank or the file will be rejected.

***** ***Reporting Period*** **(REPORTPD)**
The last day of the month in which the consumer data is being updated**.** Report year, month, day: yyyymmdd.

***** ***PIHP Payer Identification Number*** **(PIHPID)**

The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transmissions.

* ***CMHSP Payer Identification Number*** **(CMHID)**
The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all data transmissions.

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* ***Consumer Unique ID*** **(CONID)**
A numeric or alphanumeric code, of 11 characters that enables the consumer and related services to be identified and data to be reliably associated with the consumer across all of the PIHP's services. The identifier should be established at the PIHP level so agency level or sub-program level services can be aggregated across all program services for the individual. The consumer's unique ID must not be changed once established since it is used to track individuals, and to link to their encounter data over time. **A single shared unique identifier must match the identifier used in 837 encounter for each consumer.**

Social Security Number **(SSNO)**
The nine-digit integer must be recorded, if available.
Blank = Unreported [Leave nine blanks]

Medicaid ID Number **(MCIDNO)**
Enter the ten-digit integer for consumers with a Medicaid number.
Blank = Unreported [Leave ten blanks]

MIChild Number (CIN)
Blank = Unreported [Leave ten blanks]

****Disability Designation***

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

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

Gender (GENDER)

Identify consumer as male or female.

M = Male

F = Female

***Date of birth* (DOB)**

Date of Birth - Year, month, and day of birth must be recorded in that order. Report in a string of eight characters, no punctuation: YYYYMMDD using leading zeros for days and months when the number is less than 10. For example, January 1, 1945 would be reported as 19450101.

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

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

1 = English language spoken by the individual

2 = Assistive technology used (includes computer, other electronic devices) or symbols such as Bliss board, or other "low tech" communication devices.

3 = Interpreter used - this includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.

4 = Alternative language used - this includes a foreign language, or sign language without an interpreter.

5 = Non-language forms of communication used – gestures, vocalizations or behavior.

6 = No ability to communicate

Blank = Missing

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

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

1 = Always Understood – Expresses self without difficulty

2 = Usually Understood – Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required

3 = Often Understood – Difficulty communicating AND prompting usually required

4 = Sometimes Understood - Ability is limited to making concrete requests or understood only by a very limited number of people

5 = Rarely or Never Understood – Understanding is limited to interpretation of very person-specific sounds or body language

Blank = Missing

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

1 = Independent - Able to walk (with or without an assistive device) or propel wheelchair

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

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

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

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

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

1 = Independent - Able to complete all personal care tasks without physical support
2 = Guidance/Limited Support - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity
3 = Moderate Physical Support - Able to perform personal care tasks with moderate support of another person

4 = Extensive Support - Able to perform personal care tasks with extensive support of another person
5 = Total Support – Requires full support of another person to complete personal care tasks (unable to participate in tasks)
Blank = Missing

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

Indicate whether or not the individual has "natural supports" defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.
1 = Extensive involvement, such as daily emotional support/companionship
2 = Moderate involvement, such as several times a month up to several times a week
3 = Limited involvement, such as intermittent or up to once a month
4 = Involved in planning or decision-making, but does not provide emotional support/companionship
5 = No involvement
Blank = Missing

***Status of Family/Friend Support System (People with developmental disabilities only)* (SUPPSYS) 95% completeness and accuracy required**

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.
1 = Care giver status is not at risk
2 = Care giver is likely to reduce current level of help provided
3 = Care giver is likely to cease providing help altogether
4 = Family/friends do not currently provide care
5 = Information unavailable
Blank = Missing

***Support for Accommodating Challenging Behaviors (People with developmental disabilities only)* (BEHAV) 95% completeness and accuracy required**

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging behaviors" include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)
1 = No challenging behaviors, or no support needed
2 = Limited Support, such as support up to once a month
3 = Moderate Support, such as support once a week
4 = Extensive Support, such as support several times a week
5 = Total Support – Intermittent, such as support once or twice a day
6 = Total Support – Continuous, such as full-time support
Blank = Missing

***Presence of a Behavior Plan (People with developmental disabilities only)* (PLAN) 95% accuracy and completeness required**

Indicate the presence of a behavior plan during the past 12 months.
1 = No Behavior Plan
2 = Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
3 = Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
Blank = Missing

***Use of Psychotropic Medications (People with developmental disabilities only)* 95% accuracy and completeness required**

Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of "anti-psychotic" and "other psychotropic" and a list of the most common medications.

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

51.2: Number of Other Psychotropic Medications **(OTHPSYCH) ___**
Blank = Missing

***Major Mental Illness (MMI) Diagnosis (People with developmental disabilities only)* 95% accuracy and completeness required**

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each "x" in the codes.
1 = One or more MMI diagnosis present
2 = No MMI diagnosis present
Blank = Missing

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

Purpose: In the past basic consumer information from the QI (MH) and TEDS (SUD) files were sent to CHAMPS to be used as a validation that the consumer being reported in the Encounters is a valid consumer for the reporting PIHP. With QI eventually being phased out during FY16 and

TEDS ending on 9/30/2015, BHTEDS will be replacing them both beginning 10/1/2015. To use BHTEDS to create the CHAMPS validation file would be difficult as there would be three different types of records – mental health, substance use disorder and co-occurring.

Requirement: To simplify the process of creating this validation file, BHDDA is introducing a new file called the Behavioral Health Registry file. For this file, PIHPs are required to report five fields of data with only three being required. The required fields are: PIHP Submitter ID, Consumer ID and Begin Date (date less than or equal to first Date of Service reported in Encounters.) The following two fields will only be reported if the consumer has either: Medicaid ID and MIChild ID.

The file specifications and error logic for the Registry are (will be) available on the MDHHS web site at: http://www.michigan.gov/mdhhs/0,4612,7-132-2941_38765---,00.html Submissions of the BH Registry file by CHAMPS will be ready by 10/1/2015.

Data Record

Record Format: rc1041.06									
Element #	**Data Element Name**	**Picture**	**Usage**	**Format**	**From**	**To**	**Validated**	**Required**	**Definition**
1	Submitter ID	Char(4)	4		1	4	Yes	Yes	Service Bureau ID (DEG Mailbox ID)
2	Consumer ID	Char(11)	11		5	15	No	Yes	Unique Consumer ID
3	Medicaid ID	Char(10)	10		16	25	Yes	Conditional	Must present on file if available.
4	MIChild ID	Char(10)	10		26	35	Yes	Conditional	MICHILD ID [CIN] Must present on file if available.
5	Begin Date	Date	8	YYYYMMDD	36	43	Yes	Yes	

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE ABUSE BENEFICIARY
DATA REPORT

Due dates: Encounter data are due within 30 days following adjudication of the claim for the service provided, or in the case of a PIHP whose business practices do not include claims payment, within 30 days following the end of the month in which services were delivered. It is expected that encounter data reported will reflect services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the PIHP. Submit the encounter data for an individual on any claims adjudicated, regardless of whether there are still other claims outstanding for the individual for the month in which service was provided. In order that the department can use the encounter data for its federal and state reporting, it must have the count of units of service provided to each consumer during the fiscal year. Therefore, the encounter data for the fiscal year must be reconciled within 90 days of the end of the fiscal year. Claims for the fiscal year that are not yet adjudicated by the end of that period, should be reported as encounters with a monetary amount of "0." Once claims have been adjudicated, a replacement encounter must be submitted.

Who to Report: The CMHSP must report the encounter data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area for all services provided under MDHHS benefit plans. The PIHP must report the encounter data for all substance use disorder Medicaid beneficiaries in its service area. Encounter data is collected and reported for every beneficiary for which a claim was adjudicated or service rendered during the month by the PIHP (directly or via contract) regardless of payment source or funding stream. PIHP's and CMHSPs that contract with another PIHP or CMHSP to provide mental health services should include that consumer in the encounter data set. In those cases the PIHP or CMHSP that provides the service via a contract should not report the consumer in this data set. Likewise, PIHPs or CMHSPs that contract directly with a Medicaid Health Plan, or sub-contract via another entity that contracts with a Medicaid Health Plan to provide the Medicaid mental health outpatient benefit, should not report the consumer in this data set.

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all consumer level data reported after October 16, 2002 must be compliant with the transaction standards. A summary of the relevant requirements is:

- Encounter data (service use) is to be submitted electronically on a Health Care Claim 5010 as appropriate.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.

- The 837includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
- Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

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

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

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

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

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

****1.a. *PIHP Plan Identification Number* (PIHPID) or PIHP CA Function ID**

The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transactions.

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

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

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

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

*****5.*** ***Diagnosis***
Enter the ICD-10 primary diagnosis of the consumer.

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

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

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

*****9.*** ***Procedure Code***
Enter procedure code from code list for service/support provided. The code list is located on the MDHHS web site.

****10.*** ***Procedure Modifier Code***
Enter modifiers as required for Habilitation Supports Waiver services provided to enrollees; for Autism Benefit services; for Community Living Supports and Personal Care levels of need; for Nursing Home Monitoring; and for evidence-based practices. See Costing per Code List.

****11.*** ***Monetary Amount (effective 10/1/13)***:

Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

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

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

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

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

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

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

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

19. *Provider National Provider Identifier (NPI), Employer Identification Number (EIN) or Social Security Number (SSN)

Enter the appropriate identification number for the Billing Provider, and as applicable, the Rendering Provider. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

FY21 SUB-ELEMENT COST REPORT

This report provides the total service data necessary for MDHHS management of CMHSP contracts and reporting to the Legislature. The data set reflects and describes the support activity provided to or on behalf of all consumers receiving services from the CMHSP **regardless of funding stream** (Medicaid, general fund, grant funds, private pay, third party pay, autism, contracts). The format is presented by procedure code, beginning with facility services reported by revenue code. Most of the activity reported here will also have been reported in the encounter data system. Refer to the PIHP/CMHSP Encounter Reporting Costing per Code and Code Chart on the MDHHS web site for a crosswalk between services and the appropriate codes.

Instructions and reporting templates can be found at:

http://www.michigan.gov/MDHHS/0,4612,7-132-2941_38765---,00.html

FY21 CMHSP GENERAL FUND COST REPORT

This report provides the general fund cost and service data necessary for MDHHS management of CMHSP contracts. The data set of cases, units and costs reflects and describes the support activity provided to or on behalf of all uninsured and underinsured consumers receiving services from the CMHSP paid with general funds. This report also includes information on consumers who are enrolled in a benefit plan (-e.g., Medicaid, or Children's Waiver) but who are also receiving a general fund-covered service like family friend respite or state inpatient, or are on spend-down and receiving some of their services funded by general fund. The format is presented by procedure code, beginning with facility services reported by revenue code. Most of the activity reported here will also have been reported in the encounter data system. Refer to the PIHP/CMHSP Encounter Reporting Costing per Code and Code Chart on the MDHHS web site for a crosswalk between services and the appropriate codes.

Instructions and reporting templates can be found at:

http://www.michigan.gov/MDHHS/0,4612,7-132-2941_38765---,00.html

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM
VERSION 6.0
FOR CMHSPS

The Michigan Mission Based Performance Indicator System (version 1.0) was first implemented in FY'97. That original set of indicators reflected nine months of work by more than 90 consumers, advocates, CMHSP staff, MDHHS staff and others. The original purposes for the development of the system remain. Those purposes include:

- To clearly delineate the dimensions of quality that must be addressed by the Public Mental Health System as reflected in the Mission statements from Delivering the Promise and the needs and concerns expressed by consumers and the citizens of Michigan. Those domains are: ACCESS, EFFICIENCY, and OUTCOME.
- To develop a state-wide aggregate status report to address issues of public accountability for the public mental health system (including appropriation boilerplate requirements of the legislature, legal commitments under the Michigan Mental Health Code, etc.)
- To provide a data-based mechanism to assist MDHHS in the management of CMHSP contracts that would impact the quality of the service delivery system statewide.
- To the extent possible, facilitate the development and implementation of local quality improvement systems; and
- To link with existing health care planning efforts and to establish a foundation for future quality improvement monitoring within a managed health care system for the consumers of public mental health services in the state of Michigan.

All of the indicators here are measures of CMHSP performance. Therefore, performance indicators should be reported by the CMHSP for all the Medicaid beneficiaries for whom it is responsible. Medicaid beneficiaries who are not receiving specialty services and supports (1915(b)(c) waivers) but are provided outpatient services through contracts with Medicaid Health Plans, or sub-contracts with entities that contract with Medicaid Health Plans are not covered by the performance indicator requirements. Due dates for indicators vary and can be found on the table following the list of indicators. Instructions and reporting tables are located in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by MDHHS six weeks prior to the due date and also available on the MDHHS website: www.michigan.gov/MDHHS. Click on Mental Health and Substance Abuse, then Reporting Requirements.

CMHSP PERFORMANCE INDICATOR SYSTEM

NOTE: Consumers covered by the Medicaid autism benefits are to be excluded from the calculations.

ACCESS

1. The percent of all adults and children receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.
    a. Standard = 95% in three hours
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers

2. The percent of new persons receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, and DD children).
    a. Standard = 95% in 14 days
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, DD adults, DD children, and Medicaid SA

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults and DD children)
    a. Standard = 95% in 14 days
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    e. Scope: MI adults, MI children, DD adults, DD children, and Medicaid SA

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults -MI, DD).
    a. Standard = 95%
    b. Quarterly report
    c. PIHP for all Medicaid beneficiaries
    d. CMHSP for all consumers
    Scope: All children and all adults (MI, DD) - Do not include dual eligibles (Medicare/Medicaid) in these counts.

5. The percent of face-to-face assessments with professionals that result in decisions to deny CMHSP services. (MI and DD) (Old Indicator #6)
    a. Quarterly report
    b. CMHSP
    c. Scope: all MI/DD consumers

6. The percent of Section 705 second opinions that result in services. (MI and DD) (Old Indicator #7)

a. Quarterly report
b. CMHSP
c. Scope: all MI/DD consumers

EFFICIENCY

*7. The percent of total expenditures spent on administrative functions for CMHSPs. (Old Indicator #9)

a. Annual report (MDHHS calculates from cost reports)
b. PIHP for Medicaid administrative expenditures
c. CMHSP for all administrative expenditures

OUTCOMES

*8. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by CMHSP who are in competitive employment. (Old Indicator #10)

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

*9. The percent of adults with mental illness, the percent of adults with developmental disabilities, and the percent of dual MI/DD adults served by the CMHSP who earn minimum wage or more from employment activities (competitive, supported or self-employment, or sheltered workshop). (Old Indicator #11)

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid adult beneficiaries
c. CMHSP for all adults
d. Scope: MI only, DD only, dual MI/DD consumers

10. The percent of MI and DD children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge**.** (Old Indicator #12)

a. Standard = 15% or less within 30 days
b. Quarterly report
c. PIHP for all Medicaid beneficiaries
c. CMHSP
d. Scope: All MI and DD children and adults - Do not include dual eligibles (Medicare/Medicaid) in these counts.

11. The annual number of substantiated recipient rights complaints per thousand persons served with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II. (Old Indicator #13)

*13. The percent of adults with developmental disabilities served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from QI data)

b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

*14. The percent of adults with serious mental illness served, who live in a private residence alone, with spouse, or non-relative(s).

a. Annual report (MDHHS calculates from QI data)
b. PIHP for Medicaid beneficiaries
c. CMHSP for all adults
d. Scope: DD adults only

CMHSP PERFORMANCE INDICATOR REPORTING DUE DATES

FY 2022 Due Dates

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screening	10/01 to 12/31	3/31/22	1/01 to 3/31	6/30/22	4/01 to 6/30	9/30/22	7/01 to 9/30	12/31/22	CMHSPs
2. 1st request	10/01 to 12/31	3/31/22	1/01 to 3/31	6/30/22	4/01 to 6/30	9/30/22	7/01 to 9/30	12/31/22	CMHSPs
3. 1st service	10/01 to 12/31	3/31/22	1/01 to 3/31	6/30/22	4/01 to 6/30	9/30/22	7/01 to 9/30	12/31/22	CMHSPs
4. Follow-up	10/01 to 12/31	3/31/22	1/01 to 3/31	6/30/22	4/01 to 6/30	9/30/22	7/01 to 9/30	12/31/22	CMHSPs
5. Denials	10/01 to 12/31	3/31/22	1/01 to 3/31	6/30/22	4/01 to 6/30	9/30/22	7/01 to 9/30	12/31/22	CMHSPs
6. 2nd Opinions	10/01 to 12/31	3/31/22	1/01 to 3/31	6/30/22	4/01 to 6/30	9/30/22	7/01 to 9/30	12/31/22	CMHSPs
7. Admin Costs*	10/01 to 9/30	2/27/23							CMHSPs
8. Competitive employment*	10/01 to 9/30	N/A							MDHHS
9. Minimum wage*	10/01 to 9/30	N/A							MDHHS
10. Readmissions	10/01 to 12/31	3/31/22	1/01 to 3/31	6/30/22	4-01 to 6-30	9/30/22	7/01 to 9/30	12/31/22	CMHSPs
11. RR complaints	10/01 to 9/30	12/31/22							CMHSPs
13. Residence (DD)*	10/01 to 9/30	N/A							MDHHS
14. Residence (MI)*	10/01 to 9/30	N/A							MDHHS

*Indicators with *: MDHHS collects data from encounters, quality improvement or cost reports and calculates performance indicators

STATE LEVEL DATA COLLECTION

Please see the separate document for CAFAS/PECFAS reporting

Consumer Satisfaction Survey: Adults with Serious Mental Illness & Children with Serious Emotional Disturbance

-An annual survey using MHSIP 44 items for adults with MI and substance use disorder, and MHSIP Youth and Family survey for families of children with SED will be conducted. Surveys are available on the MHSIP web site and have been translated into several languages. See www.mhsip.org/surveylink.htm

-The PIHPs will conduct the survey in the month of May for all people (regardless of medical assistance eligibility) currently receiving services in specific programs.

-Programs to be selected annually by QIC based on volume of units, expenditures, complaints and site review information.

-The raw data is due August 31st to MDHHS each year on an Excel template to be provided by MDHHS.

CRITICAL INCIDENT REPORTING

PIHPs will report the following events, except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on consumer ID, event date, and event type:

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- **Non-suicide death** for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.
- **Emergency Medical treatment due to Injury or Medication Error** for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.
- **Hospitalization due to Injury or Medication Error** for individuals who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- **Arrest of Consumer** for individuals who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule

R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

Methodology and instructions for reporting are posted on the MDHHS web site at www.michigan.gov/MDHHS. Click on Mental Health and Substance Abuse, then "Reporting Requirements"

TECHNICAL REQUIREMENT FOR RECIPIENT RIGHTS DATA REORTING REQUIREMENTS

I. Background/Regulatory Overview

The purpose of this Technical Requirement is to establish processes for mandated data reporting requirements for Community Mental Health Services Programs (CMHSP) set forth in the following sections of the Michigan Mental Health Code:

330.1232 (a) (1) Subject to section 114a, the department shall promulgate rules to establish standards for certification and the certification review process for community mental health services programs. The standards shall include but not be limited to all of the following:(b) Promotion and protection of recipient rights.

330.1232 (a) (6) The department shall conduct an annual review of each community mental health services program's recipient rights system to ensure compliance with standards established under subsection (1)(b). An on-site review shall be conducted once every 3 years.

330.1755 (5) Each office of recipient rights established under this section shall do all of the following: (j)Semiannually provide summary complaint data consistent with the annual report required in subsection (6), together with a summary of remedial action taken on substantiated complaints by category, to the department and to the recipient rights advisory committee of the community mental health services program or licensed hospital.

330.1755 (6) The executive director or hospital director shall submit to the board of the community mental health services program or the governing board of the licensed hospital and the department an annual report prepared by the office of recipient rights on the current status of recipient rights in the community mental health services program system or licensed hospital system and a review of the operations of the office of recipient rights.

II. Reporting Requirements for CMHSP Triennial On-Site Assessments

A. Every January, MDHHS-ORR will provide notice to all CMHSPs of the reporting requirements and assessment dates for on-site assessments during that year.

B. CMHSP-ORRs will be required to provide requested data to MDHHS-ORR no later than 30 business days prior to the start date of the assessment. Data requested will address, at a minimum,

   i. Complete case log information (redacting the names of complainants and recipients) *;
   ii. Complete information (dates of visits, remedial action requested, and results of plans of correction) regarding all visits to service sites for the three-year period prior to the start date of the assessment*;
   iii. Dates of hire and dates of recipient rights training for all persons hired by the CMHSP and all of its contractual providers*;
   iv. One signed, current contract for each type of service provided:
      a) Residential providers (both in and out of service area)
      b) Other service providers
      c) Inpatient psychiatric units (both in and out of service area)
      d) Professional staff (psychiatrists, OTs, PTs, etc.)

v. The training checklist identifying where each item on the Required Training Standards (Attachment 5.3.2.3B) can be found within your training materials and all materials used in Recipient Rights training.
vi. The ORR Policy Review Standards document, identifying the name and number of the policy as well as the page numbers where policy elements can be found.
*Note: Information for items B i, ii, and iii must be provided utilizing the excel templates provided by MDHHS-ORR in the January distribution of assessment information,

C. At the time of the on-site visit the CMHSP will be required to provide the following items:
i. Agency organization chart.
ii. Job description for rights officer and rights advisors.
iii. A list of recipient rights advisory committee members.
iv. A list of categories represented on the committee.
v. Minutes of the RRAC committee for the assessment period.
vi. Informational packets/brochures given to the public or consumers. (Include any poster which identifies the Rights Officer/Advisors and the means of contacting them).
vii. Documentation from all site monitoring activities for the period covered in the excel spreadsheet.
viii. Access to policies/procedures of any service providers allowed by contract to develop their own policies.
ix. Records that document attendance at rights training for all agency staff and all contract employees.
x. Documents reflecting approved training received by all staff employed by the rights office since the last assessment.

III. Reporting Requirements for the Semi-Annual Data Report

A. The period covered for the semi-annual report will be from October 1 – March 31.
B. The report is due to MDHHS-ORR on June 30 of each year.
C. An Excel spreadsheet must be utilized to submit the required data and information. The Excel template will be provided to CMHSP rights offices by March 31st of each year.
D. Content will include statistical data on complaints received for the reporting period and a summary of remedial action taken on substantiated complaints by category.

IV. Reporting Requirements for the Annual Data Report

A. The period covered for the semi-annual report will be from October 1 – March 31.
B. The report is due to MDHHS-ORR on December 30 of each year.
C. An Excel spreadsheet must be utilized to submit the required data and information. The Excel template will be provided to CMHSP rights offices by September 30 of each year.
D. Content will include:
    i. Summary data by category regarding the rights of recipients receiving services from the community mental health services program or licensed hospital including complaints received, the number of reports filed, and the number of reports investigated by provider.
    ii. The number of substantiated rights violations by category and provider.
    iii. The remedial actions taken on substantiated rights violations by category and provider.
    iv. Training received by staff of the office of recipient rights.
    v. Training provided by the office of recipient rights to contract providers.

vi. Desired outcomes established for the office of recipient rights and progress toward these outcomes.
vii. Recommendations to the community mental health services program board.