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

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

PIHP_____
For
The Medicaid Managed Specialty Supports and Services Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs

1. **Period of Agreement:**
   This agreement shall commence on October 1, 2019 and continue through September 30, 2020.

2. **Period of Amendment:**
   October 1, 2019 through September 30, 2020.

3. **Program Budget and Agreement Amount:**
   Payment to the PIHP will be based on the total funding available for specialty supports and services as identified in the annual Legislative Appropriation for community mental health services programs for the period of October 1, 2019 through September 30, 2020. The estimated value is contingent upon and subject to enactment of legislative appropriations and availability of funds.

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

5. **The Specific Changes are Identified Below:**
   1. Part I, Section 18. New section 18.1.15 Electronic Visit Verification (EVV)
   2. Part II.A, Section 7.7.3 Supports Intensity Scale language
   3. Part II.A, Sections 8.4 through 8.4.15 including HSW
   4. New Section for Part II.B PIHP-MDOC SUD Agreement
   5. Contract attachment P7.7.1.1 PIHP Reporting Requirements
   6. Contract attachment P39.0.1 PIHP Compliance Examination Guidelines

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

7. **Special Certification:**

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

Signature Section:

For the Michigan Department of Health and Human Services

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

For the CONTRACTOR:

Name (print)	Title (print)
Signature	Date

Added to Section 18. Assurances:

18.1.15 Electronic Visit Verification (EVV)

The PIHP will ensure that its contracts, or those of their CMHSP participants, for personal care services demonstrate compliance with federal requirements regarding the use of electronic visit verification (EVV) in tandem with the MDHHS implementation timeline. PIHPs and/or their CMHSP participants must require compliance in the form of either the existence of an EVV system that meets state requirements as confirmed by a PIHP on-site review or participation in the MDHHS-sponsored statewide EVV system. The PIHP will make evidence of compliance available to the State upon request. The PIHP and/or their CMHSP Participant contracts must stipulate that the EVV system support self-directed arrangements, and should be minimally burdensome or disruptive to care. See attachment 7.7.1.1 PIHP Reporting Requirements for additional details.

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 SIS assessment is voluntary however the PIHP must document if the SIS assessment is declined. For newly eligible individuals an assessment using the Supports Intensity Scale (SIS) will be completed within the first year of service.
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. Opportunity for QL Training for new QLs will be provided and sponsored by MDHHS 2 times a year in FY2020.
4. Participate in the SIS Steering Committee. Each PIHP will have an identified "lead" person to 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.
5. Collaborate with BHDDA to plan for and participate in stakeholder SIS related informational forums
6. Collaborate with BHDDA in planning and provision of training to Supports Coordination/Care Management staff.
7. 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. It is important to maintain the agreed

upon training schedule. PIHPs are expected to provide 10 business days notice of cancelations.

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.

8. 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

9. 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.
10. Provide for necessary DUA's and related tasks required for use of SISOnline.
11. MDHHS will cover annual licensing fees, reports, and SISOnline maintenance. The PIHPs are responsible for SIS-A integration into their EMR.
12. Co-own SIS data with MDHHS
13. Have complete access to all SIS data entered on behalf of the PIHP, including both detail and summary level data.

8.4 MDHHS Funding

MDHHS funding includes both Medicaid funds related to the 1115 Waiver, 1915(i) Waiver, the 1915(c) Children Waivers [i.e., HSW/CWP/SEDW] , and the 1115 Healthy Michigan Plan. 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 1115, 1915(i) and 1915(c) 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, annual estimates of eligible by PIHP and rate cells, 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, 2019 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) enrollee per month methodology. The MDHHS will provide access to an electronic copy of the names of the Medicaid eligible and the enrolled people for whom a 1915 (c) waiver capitation payment is made.

8.4.1.1 Medicaid Rate Calculation

The Medicaid financing strategy used by the MDHHS, as stated in the 1115 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. Five sets of rate calculations are required: 1) one set of factors for the 1115 state plan and 1915(i) [formerly (b)(3)] services; 2) one set of factors for 1915 (c) Habilitation Supports Waiver services; 3) one set of factors for 1915 (c) Children's Waiver Program services; 4) one set of factors for 1915 (c) Waiver for Children with Serious Emotional Disturbances; 5) one set of factors for the 1115 Healthy Michigan Plan. 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.

The MDHHS shall not reduce the 1115, 1915(i) 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 with required managed care payments each month for the Medicaid covered specialty services under the listed Benefit Plan (BP). When applicable, additional payments may be scheduled (e.g. retro-rate implementation and up to 6 months retro eligibility). HIPAA compliant 834 and 820 transactions will provide eligibility and remittance information.

- Base Rates for Benefit Plan (BHMA, BHMA-MHP, BHMA-HMP, BHMA-HMP-MHP, HSW-MC, SED-MC, CWP-MC)
- Recovery of payments previously made for beneficiaries prior to MDHHS notification of death
- Recovery of payments previously made for beneficiaries, who upon retrospective review, did not meet all the Benefit Plan enrollment requirements
- Modifications to any of the Benefit Plan's rate development factors
- 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 capitation payment will be paid to the COFR within the "responsible PIHP" based on the multiplicative factor for the "residential PIHP".

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

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

8.4.1.3 Medicaid State Plan and (i) Payments

The capitation payment for the state plan and (i) Mental Health, Developmental Disability and Substance Abuse services is based on all Medicaid eligibles within the PIHP region, ,persons residing in an ICF/IID or individuals enrolled in a Program for All Inclusive Care (PACE) organization, individuals incarcerated, and individuals with a Medicaid deductible.

8.4.1.4.a 1915(c) Habilitation Supports Waiver Payments

The 1915(c) Habilitation Supports Waiver (HSW) capitation 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

Beneficiaries enrolled in the HSW Benefit Plan may not be enrolled simultaneously in any other 1915(c) waivers, such as the Children's Waiver Program (CWP) and Waiver for Children with Serious Emotional Disturbances (SEDW). The PIHP will not receive payments for HSW beneficiaries enrolled who reside

in an ICF/IID, Nursing Home, CCI, or are incarcerated for an entire month. The PIHP will not receive payments for HSW beneficiaries enrolled with a Program All Inclusive Care (PACE) organization.

Enrollment Management: The 1915(c) HSW and 1915(i) 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 Capitation Payments: Per attachment P.8.0.1, the HSW capitation payment will be based upon:

The HSW capitation payment will be scheduled and/or adjusted to occur monthly in accordance to the requirement factors listed in 8.4.1.4a and the payment factors in 8.4.1.2. Additional payments may be scheduled as required

Encounters for provision of services authorized in the CMS approved waiver must contain HK modifier to be recognized as valid HSW encounters. Encounters must be processed and submitted on time, as defined in section 7.8.2 Claims Management System and the Reporting Requirements Attachment P7.7.1.1, in order to assure timely HSW service verification.

8.4.1.4.b 1915(c) Children's Waiver Program.

A. The PIHP shall identify children who meet the eligibility criteria for the Children's Waiver Program Benefit Plan and submit to MDHHS prescreens for those children.

B. The PIHP shall carry out administrative and operational functions delegated by MDHHS to the PIHPs as specified in the CMS approved (c) waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.

C. The PIHP shall determine the appropriate Category of Care/Intensity of Care and the amount of publicly funded hourly care for each Children's Waiver Program recipient per the Medicaid Provider Manual.

D. The PIHP shall assure that services are provided in amount, scope, and duration as specified in the approved plan.

E. The PIHP shall comply with policy covering credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by the PIHPs, as it pertains to the rendering of services within the Children's Waiver Program. PIHPs are responsible for ensuring that each provider, directly or contractually employed, credentialed or non-credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and requirements. Please reference the applicable licensing statutes and standards, as well as the Medicaid Provider manual should you have questions concerning scope of practice or whether Medicaid funds can be used to pay for a specific service. Through the Critical Incident Reporting System, the PIHP will report the following incidents for children on the CWP: Suicide; Non-suicide death; Arrest of Consumer; Emergency Medical Treatment due to injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions; Hospitalization due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions.

The Children's Waiver Program (CWP) capitation payment will be made to the PIHPs based on CWP 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 CWP services would require ICF/IID level of care services
- Chooses to participate in the CWP in lieu of ICF/IID services

Beneficiaries enrolled in the CWP may not be enrolled simultaneously in any other 1915(c) waivers. In addition, beneficiaries enrolled in the CWP may not be enrolled simultaneously in the Habilitation Supports Waiver (HSW), Waiver for Children with Serious Emotional Disturbances (SEDW). The beneficiaries enrolled in the CWP may not be enrolled simultaneously with a Program All Inclusive Care (PACE) organization. The PIHP needs to assure that CWP services will not be provided for CWP enrolled beneficiaries who reside in an ICF/IID, Nursing Home, CCI, or are incarcerated for an entire month.

CWP Capitation Payments:

The CWP capitation payment will be scheduled and/or adjusted to occur monthly in accordance to the requirement factors listed in 8.4.1.4b and the payment factors in 8.4.1.2. Additional payments may be scheduled as required.

8.4.1.4.c 1915(c) Waiver for Children with Serious Emotional Disturbances

The intent of this program is to provide Home and Community Based Waiver Services, as approved by Centers for Medicare and Medicaid Services (CMS) for children with Serious Emotional Disturbances Benefit Plan, along with state plan services in accordance with the Medicaid Provider Manual.

A. PIHP shall assess eligibility for the SEDW and submit applications to the MDHHS for those

children the PIHP determines are eligible. For children determined ineligible for the SEDW, the PIHP, on behalf of MDHHS, informs the family of its right to request a fair hearing by providing written adequate notice of denial of the SEDW to the family.

B. The PIHP shall carry out administrative and operational functions delegated by MDHHS to the PIHPs as specified in the CMS approved (c) waiver application. These delegated functions include: level of care determination; review of participant service plans; prior authorization of waiver services; utilization management; qualified provider enrollment; quality assurance and quality improvement activities.

C. The PIHP shall assure that services are provided in amount, scope and duration as specified in the approved plan of service. Wraparound is a required service for all participants in the SEDW and PIHPs must assure sufficient service capacity to meet the needs of SEDW recipients.

D. The PIHP shall comply with credentialing, temporary/provisional credentialing and re-credentialing processes for those individuals and organizational providers directly or contractually employed by the PIHPs, as it pertains to the rendering of services within the SEDW. PIHPs are responsible for ensuring that each provider, directly or contractually employed, credentialed or non-credentialed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual qualifications and requirements.

E. Through the Critical Incident Reporting System (CIRS), the PIHP will report the following incidents for children on the SEDW**:** Suicide; Non suicide Death; Arrest of Consumer; Emergency Medical Treatment Due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions; Hospitalization due to Injury or Medication Error: Type of injury will include a subcategory for reporting injuries that resulted from the use of restrictive interventions.

The Waiver for Children with Serious Emotional Disturbance (SEDW) capitation payment will be made to the PIHPs based on SEDW beneficiaries who have enrolled through the MDHHS enrollment process. Beneficiaries enrolled in the SEDW may not be enrolled simultaneously in any other 1915(c) waivers. In addition, beneficiaries enrolled in the SEDW may not be enrolled simultaneously in the Children's Waiver Program (CWP) and the Habilitation Supports Waiver (HSW) under the 1115 demonstration waiver. The beneficiaries enrolled in the SEDW may not be enrolled simultaneously with a Program All Inclusive Care (PACE) organization. The PIHP must assure that SEDW services will not be provided for SEDW enrolled beneficiaries who reside in an institutional setting, including a Psychiatric Hospital, CCI, or are incarcerated for an entire month.

SEDW Capitation Payments: The SEDW capitation payment will be scheduled and/or adjusted to occur monthly in accordance to the requirement factors listed in 8.4.1.2 and the payment factors in 8.4.1.4c Additional payments may be scheduled as required.

MDHHS SEDW Child Welfare Project Procedural Requirements

- Develop local agreements with County local MDHHS offices outlining roles and responsibilities regarding the MDHHS SEDW Child Welfare Project.
- Local MDHHS workers, PIHP SEDW Coordinator, CMHSP SEDW Leads and Wraparound Supervisors identify a specific referral process for children identified as potentially eligible for the SEDW.

- Participate in required SEDW Child Welfare Project State/Local technical assistance meetings and trainings.
- Collect and report to MDHHS all data as requested by MDHHS.

8.4.1.5 Expenditures for Medicaid 1115 State Plan, 1915(i), 1915(c), 1115 Healthy Michigan Services

On an ongoing basis, the PIHP can flexibly and interchangeably expend capitation payments received through all sources or "buckets." Once capitation payments are received, the PIHP may spend any funds received on 1115 state plan, 1915(i), 1115 Healthy Michigan Plan, 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 all "buckets," the PIHP must submit encounter data on service utilization - with transaction code modifiers that identify the service as 1115 state plan, (1915(i) services, or 1915(c) services – and this encounter data (including cost information) will serve as the basis for future 1115 state plan, (i) services, and 1915(c) waiver capitation payment rate development.

The PIHP has certain coverage obligations to and to Medicaid beneficiaries under the 1115 waiver (both state plan and (i) services), and to enrollees under the 1915(c) waiver. It must use capitation payments to address these obligations.

2.10.1 Under an arrangement between the Michigan Department of Corrections (MDOC) and the Michigan Department of Health and Human Services (MDHHS), the PIHP shall be responsible for medically necessary community-based substance use disorder treatment services for individuals under the supervision of the Michigan Department of Corrections once those individuals are no longer incarcerated. These individuals are typically under parole or probation orders and excludes individuals referred by court and services through local community corrections (PA 5ll) systems.

REFERRALS, SCREENING AND ASSESSMENT:

Individuals under MDOC supervision are considered a priority population for assessment and admission for substance use disorder treatment services due to the public safety needs related to their MDOC involvement. The PIHP shall ensure timely access to supports and services in accordance with Section 26 and the Access Standards in Attachment P 4.1.1 (III) of this contract.

PIHPs shall designate a point of contact within each PIHP catchment area for referral, screening and assessment problem identification and resolution. The position title and contact information will be provided to MDHHS, which will provide the information to the MDOC Central Office Personnel. PIHPs will provide this contact information to MDOC Supervising Agents in their regions.

The MDOC Supervising Agent will refer individuals in need of substance use disorder treatment through the established referral process at each PIHP. The Supervising Agent will make best efforts to obtain from the individual a signed Michigan Behavioral Health Standard Consent Form (MDHHS 5515) and provide it to the PIHP and/or designated access point along with any pertinent background information and the most recent MDOC Risk Assessment summary.

The Supervising Agent will assist the individual in calling the PIHP or designated access point for a substance abuse telephonic screening for services. Individuals that are subsequently referred for substance use disorder treatment as a result of a positive screening must receive an in-person assessment. If the individual referred is incarcerated, the Supervising Agent will make best efforts to facilitate service initiation and appropriate contact with the PIHP/Designated Access Point. Provided that it is possible to do so the PIHP shall make best efforts to ensure the individual receives a telephonic, video or in-person screening for services at the designated location as arranged by MDOC Supervising Agent. The PIHP/designated access point may not deny an individual an in-person assessment via phone screening.

Assessments must be conducted in accordance with MDHHS-approved assessment instruments (if any) and admissions decisions based on MDHHS-approved medical necessity criteria included in this contract. In the case of MDOC supervised individuals, these assessments should include consideration of the individual's presenting symptoms and substance use/abuse history prior to and during incarceration and consideration of their SUD treatment history while incarcerated. To the extent consistent with HIPAA, the Michigan Mental Health Code and 42 CFR Part 2, and with the written consent of the individual, the PIHP/designated provider will provide notice of an admission decision to the Supervising Agent within one business day, and if accepted, the name and contact information of the individual's treatment provider. If the individual is not referred for treatment services, the PIHP/designated access point will provide information regarding community resources such as AA/NA or other support groups to the individual.

PIHPs will not honor Supervising Agent requests or proscriptions for level or duration of care, services or supports and will base admission and treatment decisions only on medical necessity criteria and professional assessment factors.

PLAN OF SERVICE

The individual's individualized master treatment plan shall be developed in a manner consistent with the principles of person-centered planning as applicable to individuals receiving treatment for substance use disorders as defined in this contract and applicable portions of contract attachment P.4.4.1.1.

The PIHP/designated provider agrees to inform the Supervising Agent when Medication Assisted Treatment (MAT) is being used, including medication type. If the medication type changes, the PIHP/designated provider must inform the Supervising Agent.

RESIDENTIAL SERVICES:

If an individual referred for residential treatment does not appear for or is determined not to meet medical necessity criteria for that level of care, the Supervising Agent will be notified with one business day. If an individual is participating in residential treatment, the individual may not be given unsupervised day passes, furloughs, etc. without consultation with the Supervising Agent. Leaves for any non-emergent medical procedure should be reviewed/coordinated with the Supervising Agent. If an individual leaves an off-site supervised therapeutic activity without proper leave to do so, the PIHP/designated provider must notify the Supervising Agent by the end of the day on which the event occurred.

The PIHP/designated provider may require individuals participating in residential treatment to submit to drug testing when returning from off property activities and any other time there is a suspicion of use. Positive drug test results and drug test refusals must be reported to the Supervising Agent.

Additional reporting notifications for individuals receiving residential care include:

- Death of an individual under supervision.
- Relocation of an individual's placement for more than 24 hours.
- The PIHP/designated provider must immediately and no more than one hour from awareness of the occurrence, notify the MDOC Supervising Agent any serious sentinel event by or upon an individual under MDOC supervision while on the treatment premises or while on authorized leaves.
- The PIHP/designated provider must notify the MDOC Supervising Agent of any criminal activity involving an MDOC supervised individual within one hour of learning of the activity.

SERVICE PARTICIPATION:

The PIHP will ensure the designated provider completes a monthly progress report on each individual on a template supplied by the MDOC and will ensure it is sent via encrypted email to the Supervising Agent by the 5th day of the following month.

The PIHP/designated provider must not terminate any referred individual from treatment for violation of the program rules and regulations without prior notification to the individual's Supervising Agent, except in extreme circumstances. The PIHP/designated provider must collaborate with the MDOC for any non-

emergency removal of the referred individual and allow the MDOC time to develop a transportation plan and a supervision plan prior to removal.

PIHP will ensure a recovery plan is completed and sent to the Supervising Agent within five business days of discharge. Recovery planning must include an offender's acknowledgment of the plan and the Contractor's referral of the offender to the prescribed aftercare services.

TESTIMONY:

With a properly executed release inclusive of the court with jurisdiction, the PIHP and/or its designated provider, shall provide testimony to the extent consistent with applicable law, including HIPAA and 42 CFR Part 2."

TRAINING:

In support of the needs of programs providing services to individuals under MDOC supervision, the MDHHS will make available in-person training on criminogenic risk factors and special therapy concerns regarding the needs of this population.

The PIHP shall ensure its provider network delivers services to individuals served consistent with professional standards of practice, licensing standards, and professional ethics.

COMPLIANCE MONITORING:

PIHPs are not accountable to the MDOC under this contract. The PIHP agrees to permit the MDHHS, or its designee, to visit the PIHP to monitor PIHP provider network oversight activities for the individuals served under this section.

PROVIDER NETWORK OVERSIGHT:

The PIHP is solely responsible for the composition, compensation and performance of its contracted provider network. To the extent necessary, the PIHP will include performance requirements/standards based on existing regulatory or contractual requirements applicable to the MDOC-supervised population. Provider network oversight must be in compliance with applicable sections of this contract.

Part II.B of the PIHP contract boilerplate:

The Code of Federal Regulations and the Michigan Public Health Code define the first four priority population clients. The fifth population is established by MDHHS due to its high-risk nature. 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. Individual under supervision of MDOC AND referred by MDOC OR individual being released directly from a MDOC facility without supervision AND referred by MDOC. Excludes individuals referred by court and services through local community corrections (PA 511 funded) systems.
6. 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. In a situation where a referred MDOC individual meets the criteria for one on of the previous populations, the admission standards for that population must be followed. 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**

Individual Under Supervision of MDOC and Referred by MDOC or Individual Being Released Directly from an MDOC Without Supervision and Referred by MDOC	**Screened & referred w/in 24 hrs.** **Offer Admission w/in 14 days**	**Begin w/in 48 business hrs** ***Early Intervention Clinical Services*** ***Recovery Coach Services***	**MDHHS & PIHP contract** **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

PIHP REPORTING REQUIREMENTS
Effective 10-1-19
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PIHP REPORTING REQUIREMENTS

FY 2020 MDHHS/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT

REPORTING REQUIREMENTS

Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2020 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs or substance use disorder programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

- "Supplemental Instructions for Encounter Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes. Code list that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDHHS and EDIT have assigned to them The code list also includes instructions on use of modifiers; the acceptable activities that may be reflected in the cost of each procedure; and whether an activity needs to be face-to-face in order to count.
- "Establishing Managed Care Administrative Costs" that provides instructions on what managed care functions should be included in the allocation of expenditures to managed care administration.
- "Michigan's Mission-Based Performance Indicator System" is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators.
- SUD Guidelines and instructions as found in the Agreement

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

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

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

PIHP REPORTING REQUIREMENTS

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
- External Quality Review
- Actuarial activities

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

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

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

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

Due Date	**Report Title**	**Report Frequency**	**Report Period and Submittal Instructions**
10/1/2019	SUD Budget Report	Projection/Initial	October 1 to September 30
12/3/2019	Risk Management Strategy	Annually	To cover the current fiscal year
12/31/2019	Medicaid Services Verification Report	Annually	October 1 to September 30
1/31/2020	SUD – Expenditure Report	Quarterly	October 1 to December 31
4/16/2020	SUD – Women's Specialty Services (WSS) Mid-Year Expenditure Status Report	Mid-Year	October 1 to March 31
4/30/2020	SUD – Expenditure Report	Quarterly	January 1 to March 31
5/15/2020	Program Integrity Activities	Quarterly	January 1 to March 31 using OIG's case tracking system
5/31/2020	Mid-Year Status Report	Mid-Year	October 1 to March 31
5/31/2020	Medicaid Unit Net Cost Report (MUNC)	Four month report Oct to Jan	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
6/01/2020	SUD – Notice of Excess or Insufficient Funds	Projection	October 1 to September 30

PIHP REPORTING REQUIREMENTS

7/31/2020	SUD – Expenditure Report	Quarterly	April 1 to June 30
8/15/2020	Program Integrity Activities	Quarterly	April 1 to June 30 using OIG's case tracking system
8/15/2020	SUD – Charitable Choice Report	Annually	October 1 to September 30
8/15/2020	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Shared Risk Calculation & Risk Financing	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Projection (Use tab in FSR Bundle)	October 1 to September 30
9/30/2020	Medicaid Unit Net Cost Report (MUNC)	Eight Month October to May	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
10/1/2020	Medicaid YEC Accrual	Final	October 1 to September 30
10/1/2020	SUD YEC Accrual	Final	October 1 to September 30
10/1/2020	SUD Budget Report	Projection	October 1 to September 30
		~~Four month report June to Sept~~	
11/10/2020	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Shared Risk Calculation & Risk Financing	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Interim (Use tab in FSR Bundle)	October 1 to September 30
11/15/2020	Program Integrity Activities	Quarterly	July 1 to September 30 using OIG's case tracking system
11/30/2020	SUD – Expenditure Report	Quarterly/Final	July 1 to September 30
12/31/2020	Medicaid Services Verification Report	Annually	October 1 to September 30
2/15/2021	Program Integrity Activities	Quarterly	October 1 to December 31 using OIG's case tracking system
2/28/2021	SUD – Primary Prevention Expenditures by Strategy Report	Annually	October 1to September 30
2/28/2021	SUD Budget Report	Final	October 1 to September 30

PIHP REPORTING REQUIREMENTS

2/28/2021	SUD – Legislative Report/Section 408	Annually	October 1 to September 30
2/28/2021	SUD – Special Project Report: (Applies only to PIHP's with earmarked allocations for Flint Odyssey House Sacred Heart Rehab Center Saginaw Odyssey House)	Annually	October 1 to September 30
2/28/2021	PIHP Medicaid FSR Bundle – MA. HMP, Autism & SUD	Final (Use tab in FSR Bundle)	October 1 to September 30
	Shared Risk Calculation & Risk Financing	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid – Internal Service Fund	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Settlement Worksheet	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Medicaid Contract Reconciliation & Cash Settlement	Final (Use tab in FSR Bundle)	October 1 to September 30
2/28/2021	Medicaid Unit Net Cost Report (MUNC)	October to September	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
2/28/2021	PIHP Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30
2/28/2021	Medical Loss Ratio	Annually	October 1 to September 30
2/28/2021	Attestation to accuracy, completeness, and truthfulness of claims and payment data	Annually	For the fiscal year ending 9/30/2020 Submit report to: QMPMeasures@michigan.gov
3/31/2021	SUD - Maintenance of Effort (MOE) Report	Annually	October 1 to September 30
4/01/2021	Direct Care Wage Attestation Form	Annually	For fiscal year ending 9/30/2020
6/30/2021	SUD – Audit Report	Annually	October 1 to September 30 (Due 9 months after close of fiscal year)
30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov
30 Days after submission	Compliance exam and plan of correction	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS

The PIHP shall provide the following reports to MDHHS as listed below.

PIHP REPORTING REQUIREMENTS

Due Date	**Report Title**	**Report Period**
10/30/2019	Strategic Enhancement Report	October 1 to September 30
1/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 1Q Narrative Report*	October 1 to December 31. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
1/31/2020	Children Referral Report	October 1 to December 31
1/31/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 to December 31
1/31/2020	Veteran Services Navigator (VSN) Data Collection form	October 1 to December 31 Submit through: DCH-File Transfer
2/19/2020	SUD Master Retail List	October 1 to September 30
03/31/2020	Performance Indicators	October 1 to December 31, 2019 Submit to: QMPMeasures@michigan.gov
4/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 2Q Narrative Report*	January 1 to March 31 Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
4/30/2020	Children Referral Report	January 1 to March 31
4/30/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	January 1 to March 31
4/30/2020	Veteran Services Navigator (VSN) Data Collection form	January 1 to March 31 Submit through: DCH-File Transfer
4/30/2020	Sentinel Events Data Report	October 1 to March 31
06/1/2020	Narrative report on findings and any actions taken to improve data quality on BHTEDS military and veterans fields.	October 1 to March 31, 2020 Submit through: DCH-File Transfer
06/30/2020	Performance Indicators	January 1 to March 31, 2020 Submit to: QMPMeasures@michigan.gov
06/30/2020	SUD – Tobacco/ Formal Synar Inspection period	June 1-June 30 (To be reported in Youth Access to Tobacco Compliance Check Report)
7/15/2020	Compliance Check Report (CCR)	Submit to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov with cc to: ohs@michigan.gov and ColemanL7@michigan.gov
7/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 3Q Narrative Report*	April 1 to June 30. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.

PIHP REPORTING REQUIREMENTS

7/31/2020	Children Referral Report	April 1 to June 30
7/31/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	April 1 to June 30
7/31/2020	Veteran Services Navigator (VSN) Data Collection form	April 1 to June 30 Submit through: DCH-File Transfer
7/31/2020	Increased data sharing with other providers/ ADT Narrative	October 1 to June 30 Submit through: DCH-File Transfer
09/30/2020	Performance Indicators	April 1 to June 30, 2020 Submit to: QMPMeasures@michigan.gov
10/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 4Q Narrative Report*	July 1 to September 30. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
10/31/2020	Children Referral Report	July 1 to September 30
10/31/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	July 1 to September 30
10/31/2020	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30
10/31/2020	Veteran Services Navigator (VSN) Data Collection form	October 1 to September 30 Submit through: DCH-File Transfer
10/31/2020	Sentinel Events Data Report	April 1 to September 30
TBD	SUD – Synar Coverage Study Canvassing Forms	Regions participating and Study Period TBD (August 2020)
11/15/2020	Performance Bonus Incentive Narrative on "Increased participation in patient-centered medical homes characteristics".	October 1 to September 30
11/30/2020	SUD – Communicable Disease (CD) Provider Information Report (Must submit only if PIHP funds CD services)	October 1 to September 30
11/30/2020	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2020	Performance Indicators	July 1 to September 30, 2020 Submit to: QMPMeasures@michigan.gov
Quarterly	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 – September 30 Due last day of month, following the last month of the quarter.

PIHP REPORTING REQUIREMENTS

Quarterly	Children Referral Report	October 1 – September 30 Due last day of month, following the last month of the quarter.
Monthly	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30 Due last day of month following month in which exception occurred. Must submit even if no data to report
Monthly	SUD – Behavioral Health Treatment Episode Data Set (BH-TEDS)	October 1 to September 30 Due last day of each month. Submit via DEG at : https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	SUD - Michigan Prevention Data System (MPDS)	October 1 to September 30 Due last day of each month, following month in which data was uploaded. Submit to: https://mpds.sudpds.com
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 Submit via DEG at: https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly*	Consumer level* Quality Improvement Encounter	October 1 to September 30 See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	Critical Incidents	Submit to PIHP Incident Warehouse at: https://mipihpwarehouse.org/MVC/Documentation
Monthly*	Michigan Gambling Disorder Prevention Project (MGDPP) Monthly Training Schedule*	Due on the 15th of every month which includes Gambling Disorder (GD) training dates and activities. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
Annually	SUD - Communicable Disease (CD) Provider Information Plan (Must submit only if PIHP funds CD services)	October 1 to September 30 Same due date as Annual Plan.

*Reports required for those PIHPs participating in optional programs

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

NOTE: To submit via DEG to MDHHS/MIS Operations
Client Admission and Discharge client records must be sent electronically to:
Michigan Department of Health and Human Services
Michigan Department of Technology, Management & Budget

PIHP REPORTING REQUIREMENTS

Data Exchange Gateway (DEG)
For admissions: put c:/4823 4823@dchbull
For discharges: put c:/4824 4824@dchbull

1. Send data to MDHHS MIS via DEG (see above)
2. Send data to MDHHS, BHDDA, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDHHS web site at www.michigan.gov/mdhhs/bhdda and click on Reporting Requirements

BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS)

PIHP REPORTING REQUIREMENTS
COLLECTION/RECORDING AND REPORTING REQUIREMENTS

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

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

A. Basis of Data Reporting

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

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

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

3 Legislative boilerplate annual reporting and semi-annual updates

B. Policies and Requirements Regarding Data

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

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

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

PIHP REPORTING REQUIREMENTS

1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

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

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

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

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

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

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

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

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

specifications.

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.

PIHP REPORTING REQUIREMENTS

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

Purpose: In the past basic consumer information from the QI (MH) and TEDS (SUD) files were sent to CHAMPS to be used as a validation that the consumer being reported in the Encounters is a valid consumer for the reporting PIHP. With QI eventually being phased out during FY16 and TEDS ending on 9/30/2015, BHTEDS will be replacing them both beginning 10/1/2015. To use BHTEDS to create the CHAMPS validation file would be difficult as there would be three different types of records – mental health substance use disorder and co-occurring.

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

The file specifications and error logic for the Registry are (will be) available on the MDHHS web site at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

Submissions of the BH Registry file by CHAMPS will be ready by 10/1/2015.

Data Record

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

PIHP REPORTING REQUIREMENTS

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

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

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

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

A summary of the relevant requirements is:

- Encounter data (service use) is to be submitted electronically on a Health Care Claim 5010.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837 includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.

PIHP REPORTING REQUIREMENTS

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- Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

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

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

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

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

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

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

The MDHHS-assigned 7-digit payer identification number must be used to identify the

PIHP with all data transactions.

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

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

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

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

*****5.*** ***Diagnosis***
Enter the ICD-9 primary diagnosis of the consumer.

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

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

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

*****9.*** ***Procedure Code***
Enter procedure code from code list for service/support provided. The code list is located on the MDHHS web site. Do not use procedure codes that are not on the code list.

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

Costing per Code List.

11.** ***Monetary Amount (effective 1/1/13):
Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

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

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

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

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

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

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

18. **Facility Location of the Specialized Residential Facility**
In instances in which the specialized licensed residential facility is not the Billing

Provider, report the name, address, NPI (if applicable) and LARA license of the facility in the Facility Location (2310C loop). (See Instructions for Reporting Specialized Residential Facility Details at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

****19. Provider National Provider Identifier (NPI), Employer Identification Number (EIN) or Social Security Number (SSN)*** Enter the appropriate identification number for the Billing Provider, and as applicable, the Rendering Provider. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

ENCOUNTER TIMELINESS CALCULATION

Requirements

1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service.
2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below).

Logic

Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month.

The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission.

These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse.

Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve.

The Department plans on continuing these test analyses through November 2019. The first production analyses will be run in December 2019.

PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDHHS management of PIHP contracts and rate-setting by the actuary. In the case of a regional entity, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its CMHSP partners. This report includes Medicaid Substance Use Disorder services provided in the service area. The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries,. Refer to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual for the complete and specific requirements for coverage for the State Plan, Additional services provided under the authority of Section 1115, 1915(i) Waiver of the Social Security Act, and the Habilitation Supports Waiver. All of the aforementioned Medicaid services and supports provided in the PIHP service area must be reported on this utilization and cost report. Instructions and current templates for completing and submitting the MUNC report may be found on the MDHHS web site at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html. Click on Behavioral Health and Substance Abuse, then Reporting Requirements. This report is due twice a year. One for the first six months of the fiscal year which will be due August 31st of the fiscal year a full year report due on February 28th following the end of the fiscal year. Templates for these reports will be made available at least 60 days prior to the due date.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM VERSION 6.0 FOR PIHPS

The purposes of the Michigan Mission Based Performance Indicator System (version 1.0) are:

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

- To link with existing health care planning efforts and to establish a foundation for future quality improvement monitoring within a managed health care system for the consumers of public mental health services in the state of Michigan.

All of the indicators here are measures of PIHP performance. Therefore, performance indicators should be reported by the PIHP for all the Medicaid beneficiaries for whom it is responsible. Medicaid beneficiaries who are not receiving specialty services and supports (1915(i)(c) waivers) but are provided outpatient services through contracts with Medicaid Health Plans, or sub-contracts with entities that contract with Medicaid Health Plans are not covered by the performance indicator requirements.

Due dates for indicators vary and can be found on the table following the list of indicators. Instructions and reporting tables are located in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by MDHHS six weeks prior to the due date and also available on the MDHHS website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html .

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**

2. a. Effective on and after January 1, 2020, the percentage of new persons during the quarter receiving a completed biopsychosocical assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.

2 b. Effective on and after January 1, 2020, the percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.

3. Effective on and after January 1, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations**:** MI-adults, MI-children, IDD-adults, and IDD-children).

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults (MI, DD) and all Medicaid SUD (sub-

acute de-tox discharges) **Standard = 95% in seven days**

5. The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SUD)

ADEQUACY/APPROPRIATENESS

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

EFFICIENCY

7. The percent of total expenditures spent on managed care administrative functions for PIHPs.

OUTCOMES

8. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who are in competitive employment.

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who earn state minimum wage or more from employment activities (competitive, self-employment, or sheltered workshop).

10. The percent of children and adults with MI and DD readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.

12. The percent of adults with developmental disabilities served, who live in a private residence alone, or with spouse or non-relative.

13. The percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative.

14. The percent of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and respite.

Note: Indicators #2, 3, 4, and 5 include Medicaid beneficiaries who receive substance use disorder services managed by the PIHP.

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
5. Medicaid penetration*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
6. HSW services*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
7. Admin. Costs*	10/01 to 9/30	1/31							MDHHS
8. Competitive employment*	10/01 to 9/30								MDHHS
9. Minimum wage*	10/01 to 9/30								MDHHS
10. Readmissions	10/01 to 9/30	3/31	1/01 to 3/31	6/30	4-01 to 6-30	9/30	7/01 to 9/30	12/31	PIHPs
11. RR complaints	10/01 to 9/30	12/31							PIHPs
12. & 13. Living arrangements	10/1 to 9/30	N/A							MDHHS
14. Children with DD	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS

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

STATE LEVEL DATA COLLECTION

CRITICAL INCIDENT REPORTING

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

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

Methodology and instructions for reporting are posted on the MDHHS web site at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

EVENT NOTIFICATION

The PIHP shall immediately notify MDHHS of the following events:

1. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:
    a. Name of beneficiary
    b. Beneficiary ID number (Medicaid, MiChild)
    c. Consumer I (CONID) if there is no beneficiary ID number
    d. Date, time and place of death (if a licensed foster care facility, include the license #)
    e. Preliminary cause of death
    f. Contact person's name and E-mail address
2. Relocation of a consumer's placement due to licensing suspension or revocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

Except for deaths, notification of the remaining events shall be made within five (5) business days to contract management staff members in MDHHS's Behavioral Health and Developmental Disabilities Administration (email: MDHHS-BHDDA-Contracts-MGMT@michigan.gov; FAX: (517) 335-5376; or phone: (517) 241-2139)

NOTIFICATION OF PROVIDER NETWORK CHANGES

The PIHP shall notify MDHHS within seven (7) days of any changes to the composition of the provider network organizations that negatively affect access to care. PIHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDHHS determines to negatively affect recipient access to covered services may be grounds for sanctions.

Community Mental Health

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Health and Human Services

Fiscal Year End September 30, 2020

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INTRODUCTION

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

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

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

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2020 and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

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

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

RESPONSIBILITIES

MDHHS Responsibilities

MDHHS must:

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

PIHP Responsibilities

PIHPs must:

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

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

CMHSP Responsibilities

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

CMHSPs must:

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

EXAMINATION REQUIREMENTS

PIHPs under contract with MDHHS to manage the Medicaid Contract and CMHSPs under contract with MDHHS to manage the GF Contract are required to contract annually with a certified public accountant in the practice of public accounting (hereinafter referred to as a

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

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

Practitioner Selection

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

Examination Objective

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

Practitioner Requirements

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

Practitioner's Report

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

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

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

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

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

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

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

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

Examination Report Submission

The examination must be completed and the reporting package described below must be submitted to MDHHS within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The PIHP or CMHSP must submit the reporting package by e-mail to MDHHS at MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat (read only). The subject line must state the agency name and fiscal year end. MDHHS reserves the right to request a hard copy of the compliance examination report materials if for any reason the electronic submission process is not successful.

Examination Reporting Package

The reporting package includes the following:

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

Penalty

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

Incomplete or Inadequate Examinations

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

Management Decision

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

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

COMPLIANCE REQUIREMENTS

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

COMPLIANCE REQUIREMENTS A-F

(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Medical Loss Ratio (MLR) Report

The PIHP's most recently completed Medical Loss Ratio Report complied with 42 CFR § 438.8 and Medical Loss Ratio Reporting requirements contained in the PIHP contract 8.4.1.7.

C. Procurement

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

D. Internal Service Fund (ISF)

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

E. Medicaid Savings and General Fund Carryforward

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

General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

F. Match Requirement

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

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

COMPLIANCE REQUIREMENTS G-I

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

G. CMHS Block Grant - Activities Allowed or Unallowed

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

H. CMHS Block Grant - Cash Management

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

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

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

COMPLIANCE REQUIREMENTS J-K

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

J. SAPT Block Grant – Activities Allowed or Unallowed

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

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

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

RETENTION OF WORKING PAPERS AND RECORDS

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

EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2019/2020 examinations. Any questions relating to these guidelines should be directed to:

John Duvendeck, Division Director
Division of Program Development, Consultation & Contracts
Bureau of Community Based Services
Michigan Department of Health and Human Services
Lewis Cass Building
320 S. Walnut Street
Lansing, Michigan 48913

duvendeckj@michigan.gov
Phone: (517) 241-5218 Fax: (517) 335-5376

GLOSSARY OF ACRONYMS AND TERMS

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

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

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

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

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

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

and Genesee Health Systems (GHS). The fee for service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.

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

MDHHS .....Michigan Department of Health and Human Services

Medicaid Program.....The Concurrent 1915(b)/(c) Medicaid Program and Healthy Michigan Program managed by PIHPs under contract with MDHHS.

PIHP.....Prepaid Inpatient Health Plan. In Michigan a PIHP is an organization that manages Medicaid specialty services under the state's approved Concurrent 1915(b)/1915(c) Waiver Program, on a prepaid, shared-risk basis, consistent with the requirements of 42 CFR Part 438. The PIHP, also known as a Regional Entity under MHC 330.1204b or a Community Mental Health Services Program, also manages the Autism Program, Healthy Michigan, Substance Abuse Treatment and Prevention Community Grant and PA2 funds.

Practitioner.....A certified public accountant in the practice of public accounting under contract with the PIHP or CMHSP to perform an examination engagement.

Serious Emotional Disturbances Waiver.....The Waiver for Children with Serious Emotional Disturbances Program that provides services to children who would otherwise require hospitalization in the State psychiatric hospital to remain in their home and community. Payment from MDHHS is on a fee for service basis.

SSAE.....AICPA’s Statements on Standards for Attestation Engagements.

SAPT Block Grant Program ..The program managed by PIHPs under contract with MDHHS to provide Substance Use Services Block Grant program services under CFDA 93.959.

SUD Services.....Substance Use Disorder Services funded by Medicaid, Healthy Michigan, and the "Community Grant" which consists of Federal SAPT Block Grant funds and State funds.