Provider Network Council (PNC) Minutes
Community Mental Health of Ottawa County

Teams

Monday, March 15th, 2021 2pm-4pm

PNC Purpose Statement

This Council's purpose is to discuss and prioritize issues related to the CMHOC Provider Network. This type of forum will assure that there is a common and consistent message going out from CMHOC to the provider network.

1. **Welcome**

   Kelly Goetzinger, Program Coordinator, Contracts and Training
   kgoetzinger@miottawa.org

   Thank you for participating in our second Virtual Provider Network Council (PNC) meeting. We appreciate your patience with us during this pandemic.

2. **Training Requirements**

   Kelly Goetzinger, Program Coordinator, Contracts, & Training kgoetzinger@miottawa.org
   Matthew (Matt) Postma, Mental Health Trainer mpostma@miottawa.org
   Hybrid First Aid-CPR-AED and MANDT Training attached to the meeting minutes

   a. **Training Requirements**

   - Kelly brought our provider network through our Community Mental Health of Ottawa County home page to explain where they could find information on the training center. https://www.miottawa.org/Health/CMH/training.htm
     - Kelly outlined on the training center's home page, there is important notice about classroom training outlined in red. This should be something that all our providers pay attention to during COVID-19 for important training updates.
     - Lakeshore Learning Management System (LMS) is the region's platform for classroom and online courses. This learning platform is a self-registration system in which each student registers for both classroom and online courses they are required to complete. https://lakeshoretraining.org/ottawa/
     - Classroom Training Schedule – March 2021 and April 2021 are available, and May will be available soon. Please keep a look out for this to schedule your trainings.
   - **Attachment I**
     - This attachment is broken down by service type.
     - Whenever there is an "X" in your service type, that means it is a required course for your staff to be trained in per your contract.
     - To get more details about specific trainings, on page 3 on Attachment I, it gives a brief description of the training, the frequency in which this training should be completed, when it should be completed to make sure your staff are in compliance, and how to obtain the training.
       - Please make sure you are monitoring and tracking your staff's trainings to make sure they are always in compliance.

Next Meeting –Location and time TBA

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- **Hybrid First Aid-CPR-AED**
  - Starting in Mid-December, CMHOC decided to have 5-10 people in a classroom wasn't the best option and we switched it to having an online portion and a much smaller period that is face-to-face.
    - To register for the 1-hour skills portion on the Lakeshore LMS training website please note that the times are for 1 person only. Many times, during the day there are 6 different time slots.
    - Example: **"Ottawa-Hybrid First Aid/CPR/AED 01/04/21 - 09:00-10:00 (classroom) – TC"**
    - Once registered I will email them the information to the online training from another site (American Trauma Event Management-see below). There are multiple videos to watch and questions to answer.
      - This can take staff anywhere between 1.5-2 hours to complete.
      - Please note, this training isn't a training you can take partially and come back to later, it must be completed in one sitting.
    - Once staff complete the training, they need to email me a screen shot of their certificate of completion prior to attending their 1-hr skills session.
      - Please make sure you have completed the training prior to attending the hands-on session. There are times where it hasn't been completed and this takes away from a time slot for someone else to attend.
    - After completing the skills, they get their card and the training should be reflected on their Lakeshore training transcript.
    - For a list of **LARA approved CPR/FA/AED** providers please go to
      - https://www.michigan.gov/lara/0,4601,7-154-89334_63294_5529_49572_49583-82382--,00.html
      - **The requirement for LARA is that there is a hands-on component.**
- **MANDT Training**
  - Online training for MANDT CANNOT be registered via the Lakeshore training site. It is done through the MANDT site and Matt has to register the staff. All online training registration is conducted as followed:
    - Supervisor/Manager/Homeowner emails me with name of staff and which online training they would like them to take.
    - Matt requests a purchase of this training through our fiscal services.
    - Courses are purchased and fiscal services emails an invoice to agency.
    - Matt then can then assign the training to the specific staff immediately after fiscal services notify me the course was purchased.

Next Meeting –Location and time TBA

- They get an email with log-in information from MANDT (not Ottawa CMH).
  - If staff does not retrieve the information, they should notify Matt the same day. Matt can initiate a username and password reset.

- **Training Options**
  - New Hire staff options
    - Take Day 1,2,3 in-person (must be taken in sequence)
    - Do Day 1 & 2 online through the MANDT website ($33.99) and do Day 3 in person.
  - First year Recert options
    - Take MANDT Recert in-person
    - Take first 3 chapters online ($28.75) then come to a Day 3 in-person. This also works for people whose certification has expired.
  - Second year+ Recerts have two options
    - Take MANDT Recert in-person
    - Take all 6-chapter tests as an online test ($8.25) out then come to a half-day technical skills course. This is an electronic version that is a "test-out". Study guides are provided every year and are encouraged to review prior to taking the test. Tests can be taken anywhere.
    - If your certification is expired, then you have to cover the information on Day 1 and Day 3 (First year Recert option above).
    - Currently half-day courses are scheduled as needed. If there is a higher volume of staff who need to schedule the half-day courses, then Matt will put them on the calendar. As of right now they are only scheduled when needed.

3. **Fiscal Updates**

Courtney Fritzsche, Accountant II-Fiscal Services cfritzsche@miottawa.org
PowerPoint presentation attached in the meeting minutes

a. Contract Attachment B

- **Timeliness reminders:**
  - For claims which DO NOT require an EOB:
    - Claims submitted more than 60 days after the date of service will be denied.
    - Claims submitted more than 365 days after the date of service will be denied.
  - For claims which DO require an EOB:
    - If Coordination of Benefits is required for a claim, the Contractor shall submit the claim to CMH within 30 days of receipt of the EOB

from the third-party payor. The claim shall include the third-party EOB as evidence that the primary payor was billed. Claims submitted more than 365 days after the date of service will be denied.

- Previously denied claims should be corrected and re-billed to the CMH within 60 days from the date of the denial for re-processing and reimbursement. Re-billed claims submitted more than 60 days from the date of denial will be ineligible for payment.

- **Year End Reminder**
  - Claims/Invoices: All invoices for the fiscal year are due to CMHOC by **October 22, 2021**. Any disputed claims and/or invoices must be reported to CMHOCFINANCE@miottawa.org by **November 15, 2021**. Claims/invoices not submitted by these deadlines will be denied.
  - Disputed/Outstanding Claims: Any disputed claims, resubmissions, or claims awaiting Coordination of Benefits must be reported to **CMHOCFINANCE@miottawa.org by November 15, 2021**. Claims not submitted by these deadlines will be denied. Please submit a **single Excel file** of all agency outstanding/disputed claims, including any that you are working with other CMHOC staff to resolve. The file must include consumer number, date of service(s), code(s), unit(s), and estimated liability.

b. GIVA

- GIVA is the Fiscal Services helpdesk. https://cmhoc.giva.net/home.cfm
- Tickets are created two ways.
  - 1. By simply emailing cmhocfinance@miottawa.org
  - 2. By logging into the GIVA helpdesk and creating a ticket from the dashboard.
- GIVA allows pre-approved users the ability to create help-desk tickets for issues like missing an EOB, claims corrections, and general trouble with billing. GIVA is also where you notify Fiscal Services of issues that will negatively impact your ability to meet the 60-day billing requirement.
  - A few examples of such issues may be waiting on an authorization to be entered/updated, or a delay in rendering provider setup. When we're notified of issues which impact your ability to meet the timeliness requirement, we give you a ticket number to reference when you can bill. This ticket number is a flag to the claims processor to override the claim/claims that are automatically denied by the 60-day billing rule.
- When CMHOC sends you an attachment through GIVA, it does require you to login to the site. Attachments cannot be viewed through the email, so it's a good idea to familiarize yourself with the dashboard setup and login every few weeks to keep your dashboard profile active.
  - GIVA deactivates the dashboard for a user when it hasn't been used after 30/60 days.
- When using the dashboard, you can select what's called a Nature of Request, which helps give us an idea of what the ticket is about. If you're not sure

what Nature of Request your issue falls under, or if you don't see a Nature of Request that accurately describes your request, you can always default to "Other".

- GIVA is a secure site. Please do not send any encrypted emails to GIVA, we get an error notification, and a ticket is not created.

c. Provider Connect

- When you are **billing across authorizations**, remember to bill based on the authorization start and end dates.
  - Example: IPOS meeting was on the 15th and the new authorization starts then, you would bill all of the services the 1st of the month through the 14th and then bill the remainder of the services for the rest of the month through the second authorization (15th- 30th/31st).
  - If you bill for a date of service that fall in both authorizations, the system will not allow you to enter the code you are trying to bill.
    - You can verify the authorization in the Authorizations tab.
- **Multiple dates of service**
  - Remember to click on the "filter on Multi Dates" button to progress to the next step
  - Everything must be the same to use this feature

d. New Billing Requirements

- **Start/Stop time billing updates for ABA and CLS providers**
  - Effective 3/1/21 all ABA and CLS services require start and stop times.
  - ProviderConnect or 837 files are required to include start and stop times.
  - This change will not impact any previously billed services, or services submitted and processed prior to March 1st.
  - Start and stop times are required on all ABA and CLS services submitted and processed by CMHOC, thereafter, regardless of the date of service being processed.
- Group CLS
  - Effective 10/1/2020 all group CLS must be reported by group size and now must include start and stop times.

e. Potential Future Changes

- **97151**
  - Effective 1/1/2021 BHHDA revised its rules to allow providers to bill for indirect time
  - We are waiting on further direction from the state on how they would like this reported and will let you know once we find out more information.
  - Indirect time is referred to as documentation.
    - Please continue to bill as normal until we get more clarification. If we need to make corrections to account for the indirect time, then we can do that.
  - We are looking into the back billing for 97151 to January 1, 2021. We are not sure, but this is being discussed internally.

- **COVID – 19 Telemedicine Code Chart**
  - Once COVID-19 restrictions have been lifted you will no longer have to report "GT" modifier to denote telemedicine and will just be using the Place of Service. More to come on this.
  - During the pandemic, the GT modifier should continue to be used.
- **Group modifier "TT" will be ending 9/30/2021**
  - Effective 10/01/21 group services will be required to follow the same group size modifier reporting requirements as group CLS.
    - Skill Building
    - Respite
    - Supported Employment

f. **Overall Modifier Changes**

- **ASAM Modifiers**
  - Previously ASAM modifiers were assigned the following
    - 3.1 – No modifier
    - 3.3 – UB modifier
    - 3.5 – TF modifier
    - 3.7 – TG modifier
  - They will be changed to:
    - 3.1 – W1 modifier
    - 3.3 – W3 modifier
    - 3.5 – W5 modifier
    - 3.7 – W7 modifier
- **Treatment Plan Monitoring**
  - TS modifier is being eliminated
- **Provider Education Level-Specific Credentialing**
  - This is bigger than what has normally been in our ABA providers contracts. The state is wanting a modifier for each individual rendering provider.
  - Looking at how this effects our provider's. Right now, it doesn't make sense to put this in your contract, so CMHOC is looking at how we can push this into our encounters. More to come with this.

4. **Credentialing and OIG Updates**

Amber Vondra, Program Evaluator and Kristen Henninges, Compliance Manager
avondra@miottawa.org; khenninges@miottawa.org

PowerPoint presentation attached in the meeting minutes

a. Clinical Application

- When sending a new clinical application, please make sure proof of provider's highest education and licensure are attached.
  - Legible Transcripts or Diploma
  - Copy of actual license NOT LARA verification

- If the job position requires necessary trainings (such as RBT or Recovery Coach Training, CAADC, or DP-C) please make sure it is attached to the application.
  - Please include actual copies of these trainings, certifications, or plans
  - Please make sure clinical application are completed in their entirety when submitted.
  - Please indicate the degree for the employee.
- **"The Effective Date"**
  - The date the Program Evaluator (Amber Vondra) receives the completed clinical application with all appropriate supporting documentation is the date the staff will be set up for billing
- You will receive a confirmation email once the provider has been set up for billing in Ottawa County
  - Do not have your staff provide any services until this email is received
  - The credentialing process takes at minimum 1-week to set up a staff for billing. Amber stated that it is a 30-day max to get them set up.
- The date the Program Evaluator (Amber Vondra) is notified of updated licensure is the day the update is effective for billing
  - If staff bill for services provided with this updated licensure prior to letting the Program Evaluator know, it will cause billing issues
  - It is recommended that you fill out a new clinical application and provide Amber with the necessary proofs for the change.
- **Service Site Address:**
  - Please list all the service sites the staff will be providing services so Amber can credential the staff appropriately.
- **Agency/Supervision Signature**
  - Please make sure that the staff's supervisor or HR department is signing off on the clinical application. By signing the clinical application, they certify that the clinical application has been completed fully for the individual requiring credentialing by CMHOC.
  - Please DO NOT have the staff sign the clinical application

b. Criminal Background Checks

- Providers will require criminal background checks at a minimum of every two years for all persons (staff, management and non-management) providing services to or interacting with Individuals served by CMHSP or persons who have the authority to access or create CMHSP information.
- Please note that Criminal Background Checks cannot be documented via a excel spreadsheet. You must be able to show proof of date the check was performed.
- Please note, the LARA fingerprinting process provides background check, OIG, Michigan Sanctioned Providers, and SAM checks for employees. It's also what's referred to as "wrap back" so that as long as an employee is signed up through a provider, that provider will be notified if there are *ever* any findings.

- Regular fingerprinting outside of LARA does not provide a "wrap back".
- *Student Interns* – it is a best practice to have interns to have criminal background checks performed. Right now, it is not required, but is preferred.

c. OIG Checks

- Providers shall ensure an initial examination of Federal and State databases of excluded parties and litigation checks (OIG checks) are conducted.
  - The OIG Checks must take place at the time of hire and monthly thereafter
  - For all Provider employees and persons joining Provider Board of Directors
- Again, the LARA fingerprinting process provides background check, OIG, Michigan Sanctioned Providers, and SAM checks for employees. It's also what's referred to as "wrap back" so that as long as an employee is signed up through a provider, that provider will be notified if there are *ever* any findings.
- When filling out a clinical application, Amber is only looking for the date of when the criminal background check and OIG checks were performed. The only time CMHOC will request documentation is during an audit.
  - Please keep a **screenshot, or PDF, or hard copy** of the OIG check so we can verify the specific date the OIG check was performed. During audits, we will need to have proof of the specified date.
  - Please note that OIG checks cannot be documented via a excel spreadsheet. You must be able to show proof of date the check was performed.
- *Student Interns* – it is a best practice to have interns to have OIG checks performed. Right now, it is not required, but is preferred.

5. **Financial Requirements**

Keith Falkowski, Finance Manager
kfalkowski@miottawa.org

a. Audit/Reviews

- According to your contract, a provider must obtain an annual financial audit when the total fiscal year (10/01-9/30) revenue from all sources is $750,001 or more
  - The audit will cover Provider's fiscal year.
  - Audit must be performed by a Certified Public Accountant (CPA) to ensure the financial statements are presented in conformance with accounting principles generally accepted in the United States of America.
  - Management letter issued as a result of the review by the Certified Public Accountant must be submitted to CMHSP.
- According to your contract, a provider must obtain an annual financial review when total fiscal year (10/01-9/30) revenue is between $250,000 and $750,000, unless Provider is required to obtain an audit for some other reason.
  - In cases where Provider's total fiscal year revenue is less than $250,000, CMHSP may request a financial review.

  - The review will cover Provider's fiscal year.
  - The review must be performed by a CPA to provide limited assurance that there are not material modifications that should be made to the financial statements in order for them to be in conformance with accounting principles generally accepted in the United States of America.
  - Management letter issued as a result of the review by the Certified Public Accountant must be submitted to CMHSP.
- Provider's must submit the items above to CMHOC's Finance Manager and/or Contract Manager within one hundred and fifty (150) days following Provider's fiscal year end. Any deviation from this requirement must be requested in writing and in advance and must be approved by CMHOC.

b. COVID Temporary Direct Care Wage (DCW) Increase

- MDHHS has extended and increased the DCW as of 3/1/2021 for $2.52/hour and additional codes will be added.
  - New invoices will be sent out to providers to fill out.
  - Right now, DCW is only for individuals who care for consumers directly. Supervision is not included in this. More clarification on this will come once the new bulletin is sent out.
  - MDHHS is expanding the codes, but we have not seen what codes they are. We will send out a letter once it has been received.
- We have not received an official bulletin for this, which is why we have not made the changes in your contracts yet. Once we get clarification from the state, we will reissue invoices and update your contracts to reflect these changes.
- You will still fill out the invoices each month as of now. The governor has issued support in making the DCW permanent. If that is the case it will be incorporated within your contract rates.
  - CMHOC's plan is issue the payments through invoices over the next 3 months similar to what has been done over the past year, and June 1st, we will modify your rates in your contract.
  - This is not certain but is CMHOC's plan if it is made permanent once the bulletin has been released.

6. **Contract Updates**

Tori Clark, Contract Manger
tclark@miottawa.org; CMHContractServices@miottawa.org

Contract Application and Dispute Resolution PDFs are attached in the minutes

a. Contract Amendments

- As soon as we get a finalized bulletin for the DCW, CMHOC will be sending out revised amendments. Your current amendments have the $2/hour increase so this will have to be updated once the bulletin is finalized.

Next Meeting –Location and time TBA

- If MDHHS finalizes the DCW to be permanent, then we will be modifying your rates within your contract to include the DCW increase. At this point, you will have to sign off on another amendment.
    - We apologize that there are going to be multiple amendments but please be patient as there are many providers with CMHOC that receive the DCW. We will issue them as soon as we receive a finalized notice.
- There are many changes that are occurring 10/01/2021.
    - Once we have more concreate answers on these changes, we will be amending your contracts to reflect these changes. We are working diligently now to make sure you will have all the changes in your amendment before the end of the fiscal year.

b. Evergreen Contracts

- As you know, CMHOC's Standard Common Contract has become evergreen. This means that your contract will automatically renew every year for the next five (5) years. For many of you that means we will not renew your contract until 2024- 2025. However, the LRE/Beacon still require all providers to complete a contract application every year.
    - We prefer if you submit your contract application to CMHOC in alignment with your insurance expiration, so we have the most up to date information.
    - All the contract managers in the region have developed one contract application that will be standard across the board. This means we will no longer have a contract application specific to CMHOC. CMHOC's contract application will be integrated into the LRE/Beacon contract application, so providers only have one document to fill out for the region. The following CMHSPs are included in the region besides Ottawa:
        - Network 180
        - HealthWest
        - Allegan
        - West Michigan
    - Please note that we request documentation on your specific locations that pertain to CMHOC, but since you can use the same application for all the CMHSPs in the region, you can include all your locations within one application. Please just specify the CMHSP for each location.
    - This application will be a fillable form, so you do not have to print it off and fill it out. You can fill it out and sign the document right on the computer.
        - If you prefer to have a hard copy of the contract application, please notify CMHContractServices@miottawa.org.

c. Dispute Resolution Policy

- CMHOC has a new contracting email CMHContractServices@miottawa.org. This email will be used for all contract-based questions or concerns.

Next Meeting –Location and time TBA

- If you have a Dispute Resolution Request, please submit them to the new email so we can review and respond to your request within a timely manner.
- Attached to the minutes is CMHOC's dispute resolution policy and levels of appeals and the LRE's dispute resolution policy.

7. **Satisfaction Survey**
   Amber Vondra, Program Evaluator avondra@miottawa.org
   PowerPoint presentation attached in the meeting minutes

   a. The Standardized Lakeshore Regional Satisfaction Survey
   - Measures these 3 areas:
     - Access/Availability
     - Quality measures
     - Outcome measures
   - LRE put together a workgroup in 2020 to update this satisfaction survey
     - New survey will be used for 2021
     - Includes HSAG requirements
   - All data was collected during a random, 2-week period during the year
     - Paper versions of the satisfaction survey were mailed out with an enclosed return envelope
     - There was an online version of the satisfaction survey for SUD Providers using Qualtrics
     - SUD providers emailed the survey link to consumers they were seeing virtually.
       - Online survey was only active during the random, 2-week time-period, with a follow up email sent one week into survey

   b. Results:
   - MI = 128 (21%) based on total served
   - SUD = 100 (14%) based on total served
   - DD = 179 (35%) based on total served
   - FS = 47 (10%) based on total served
   - BTRC = 23 (56%) based on total served

8. **Performance Improvement (PI) Plan**
   Amber Vondra, Program Evaluator avondra@miottawa.org
   PowerPoint presentation attached in the meeting minutes

   a. Purpose
   - To solve performance issues and/or recognize opportunities for enhancement in performance at the organizational, system, process, and employee levels to achieve desired organizational results of high quality, sustainable behavioral health services that increase positive outcomes for consumers.

- The function of the Performance Improvement Plan is to perfect the quality of services provided and performance of the agency using performance and quality improvement.
- **ASPIRE** methodology and the cycle of continuous quality improvement (CQI). (As recommended by CARF)
    - **A**ssess the environment
    - **S**et strategy
    - **P**ersons served (provides input into design and delivery of quality services)
    - **I**mplement the plan
    - **R**eview Results
    - **E**ffect change

b. **QI Standing Committee and Organizational Goals**

- Committee Chairs provide the QI team with updates on committee goals. The committee chairs will also provide updates on these goals annually in December 2020/January 2021 for a status update.
    - *Per our last update meeting, 7 new goals were added for all committees*
- COVID-19 have impacted our typical service-delivery model and have driven many of this year's goals.
    - Switching to telehealth
    - Enhancing our safe work practices for clients and staff
    - Continuation of many PI goals from previous year
- Some of the goals for the coming year are also driven by our affiliation with the LRE and the changes in MDHHS and their contract requirements; some of which are on the horizon.
    - New Data Requirements
    - EVV
    - State Parity Projects
    - ANSA Standardization
    - PIP Projects
    - HSAG Audits
    - MCO Alignment

9. **LRE and Beacon Updates**
   Lynne Doyle, Executive Director
   a. There is a new CEO at the Lakeshore Regional Entity – Mary Marlatt-Dumas.
      - Greg Hoffman has retired and Bill Riley who functioned as the interim is still around for the transition.
      - There are big changes with our contract with Beacon Health Options
        - CMHOC will be taking back a lot of the utilization management functions and continued stay reviews (inpatient hospital stays). More information will be coming out about these changes as it is finalized.
        - Beacon Health Options will still be doing fair hearings and data analysis.
        - The LRE was placed on a month-to-month contract with the state, however there are negotiations that are in place that are very positive and we anticipate that it will be a year long contract soon similar to the other PIHPs within the state.

10. **COVID-19 Updates**
    a. COVID-19 Vaccination distribution
    - Working with the Ottawa County Department of Public Health and Holland hospital to host a vaccine clinical specifically for consumers who are Intellectual/Developmental Disability individuals will be eligible, their families, and caregivers only. They will be hosting a COVID-19 vaccine clinic this Friday, March 19th, 2021 from 9:00am-2:00pm at the GVSU Holland Campus at 515 S Waverly Road in Holland. This clinic is especially designated for Community Mental Health of Ottawa County I/DD consumers 18 years and older and is by appointment only.
      - There is very limited space for caregivers to receive the vaccine if they have not already done so.
      - **First-dose Appointment on Friday, March 19th:** https://ocdph.as.me/HHCMHClinicIDD1stDose?utm_medium=email&utm_source=govdelivery
        - If you need assistance scheduling an appointment, please call 616-396-5266.
        - After you've successfully scheduled your appointment, you will see a green check mark confirming your appointment. You will also receive an email confirmation. If you do not get an email confirmation within a few minutes, please try scheduling your appointment again.
      - **Second-dose Appointment of Friday, April 16th:** https://ocdph.as.me/HHCMHClinicIDD2ndDose?utm_medium=email&utm_source=govdelivery

- If you need assistance scheduling an appointment, please call 616-396-5266.
- After you've successfully scheduled your appointment, you will see a green check mark confirming your appointment. You will also receive an email confirmation. If you do not get an email confirmation within a few minutes, please try scheduling your appointment again.

- The goal is to get all our consumers vaccinated in the future. We will try to host/coordinate vaccinations in the future.

b. Personal Protective Equipment (PPE)

- We do have a shipment of cloth masks coming in soon. If you need PPE, please let us know. The best person to contact at Community Mental Health of Ottawa County if you need PPE is Kristen Henninges at khenninges@miottawa.org.

11. **Outpatient capacity (consistent concern)**

Ann Heerde, Family Services Program Supervisor
aheerde@miottawa.org

In the family services world (birth-21 years old), we are seeing a notable increase for request for services. As an overview:

- Last month (February) we had 30 new youth come in
- So far this month (March) there has been 14 new youth come in
- There are around 20 new youth about to come in

If you are a current outpatient provider with CMHOC and you want to hear more from Ann on how she anticipates this going or increasing the number of kiddos you currently see, please let us know.

12. **Questions/Feedback**

The next Provider Network Council meeting will be announced soon. Send any suggestions for agenda topics to CMHOC's Contract email at CMHContractServices@miottawa.org

TRAINING REQUIREMENTS BY SERVICE

	Applied Behavioral Analysis	ACT	Assessment	Behavior Treatment Review	Children's Waiver	Clinical Services –(OT/PT/SLP)	Clubhouse	CLS (Non-Specialized setting)	Crisis Intervention	Crisis Residential	Direct Prevention	Enhanced Pharmacy	Family Support and Training	Fiscal Intermediary	Health Services	Home Based	Housing Assistance	Intensive Crisis Stabilization	Ind. Adult/Family/Group Tx.	Nursing Facility MH Monitor.
1. Advance Directives		x							x	x										x
2a. Behavioral Treatment/Crisis Intervention(MANDT)-**Relational**		R					R		x	x±						R		x		
2b. Behavioral Treatment/Crisis Intervention(MANDT)-**Conceptual**		R					R			x±						R				
2c. Behavioral Treatment/Crisis Intervention(MANDT) -**Technical**										x*±										
3. Corporate Compliance	x	x	x	x	x	x	x	x**	x	x	x	x	x	x	x	x		x	x	x
4. Cultural Competence	x	x	x	x	x	x	x	x**	x	x	x	x	x		x	x		x	x	x
5. Emergency Preparedness										x										
6. Knowledge of First Aid					x			x												
7. First Aid Certification	x									x										
8. CPR Certification					x					x										
9. Grievance and Appeals	x	x	x	x	x	x	x	x	x	x			x		x	x		x	x	x
10. Health & Wellness										x										
11. HIPAA	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x
12. Introduction to Human Services										x										
13. Limited English Proficiency (LEP)	x	x	x	x	x	x	x	x**	x	x	x	x	x		x	x		x	x	x
14. Medication Series										x										
15. Nutrition & Food Safety										x										
16. Person-Centered Planning & Self-Determination	x	x	x	x	x	x	x	x	x	x						x		x	x	x
17. Recipient Rights	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
18. Standard Precautions	x	x	x		x	x	x	x**	x	x	x		x		x	x		x	x	x
19. Trauma Informed Care		x	x	x	x	x	x	x	x	x	x		x		x	x		x	x	x

R Recommended

** Waiver from participation in MANDT **Conceptual or Technical** session is available upon request and approval from the contracting CMHSP.*

*** For CLS services being provided in a non-licensed setting, the subject areas denoted with ** are covered in the **Community Living Supports** classroom course and do not need to be completed as separate online courses. The **Community Living Supports** classroom course is not on this grid but is required for all CLS services being provided in a non-licensed setting for consumers of Ottawa County CMH.*

± Waiver from participation in MANDT for Children's Specialized Residential Settings or residential settings where there are multiple payors is available upon request and approval from contracting CMHSP.

¥ Adult population only

TRAINING REQUIREMENTS BY SERVICE

	OBRA PAS/SAR	Peer Delivered Services	Personal Care/CLS in Specialized Res. Setting	Private Duty Nursing	Psychiatric Services	Respite	Skill Building	SUD Community Based Tx	SUD Medication Assisted Tx.	SUD Outpatient Tx.	SUD Residential Treatment	SUD Res. Withdrawal Mgmt.	Supported Employment	Supports Coordination	Targeted Case Management	Transportation	Treatment Planning	Wraparound
1. Advance Directives								x	x	x	x	x		x¥	x¥		x	
2a. Behavioral Treatment/Crisis Intervention (MANDT) - **Relational**			x±					R			R	R		R	R			
2b. Behavioral Treatment/Crisis Intervention (MANDT) - **Conceptual**			x±					R			R	R		R	R			
2c. Behavioral Treatment/Crisis Intervention (MANDT) - **Technical**			x±															
3. Corporate Compliance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
4. Cultural Competence	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
5. Emergency Preparedness			x															
6. Knowledge of First Aid						x	x											
7. First Aid Certification			x															
8. CPR Certification			x															
9. Grievance and Appeals	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
10. Health & Wellness			x															
11. HIPAA	x	x	x	x		x	x	x	x	x	x	x	x	x	x	x	x	x
12. Introduction to Human Services			x															
13. Limited English Proficiency (LEP)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
14. Medication Series			x															
15. Nutrition & Food Safety			x															
16. Person-Centered Planning & Self-Determination		x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x
17. Recipient Rights	X	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
18. Standard Precautions	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
19. Trauma Informed Care	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

LAKESHORE REGIONAL ENTITY

TRAINING REQUIREMENTS: FREQUENCY AND METHOD

TRAINING	DESCRIPTION	FREQUENCY	WHEN	HOW TO OBTAIN	REQUIREMENT
1. Advance Directives	This training will cover: • the types of Advance Directives (AD) • Why have an AD • Who may create an AD • The powers of a patient advocate • The role of the clinician in AD • Where to find additional information about AD	Initial & Every 2 years	Initial • ≤ 30 days of hire and prior to working independently with individuals served Ongoing • Every 2 years	Initial & Ongoing • CMH classroom training if available • Lakeshore LMS online course (being developed) • As otherwise approved by CMH	• MDHHS Contract section 6.8.6 on Advance Directives
2a. Behavioral Treatment / Crisis Intervention (MANDT) **RELATIONAL**	Mandt Relational stresses the importance of building positive, healthy relationships with everyone. Chapters include: • Healthy Relationships • Healthy Communication • Healthy Conflict Management	Initial & Annual	Initial • < 60 days of hire Ongoing • As per certification or otherwise required NOTE • MANDT must be taken sequentially and within a consecutive 2-month period.	Initial & Ongoing • classroom training by a certified Mandt trainer	• MDHHS Contract Technical Requirement for Behavior Treatment Plan Review Committee. • Administrative Rule 330.7001 (z) • OSHA Publication 3148-06 R (2016)
2b. Behavioral Treatment / Crisis Intervention (MANDT) **CONCEPTUAL**	Mandt Conceptual introduces additional information to help how we think about things, people, and situations. Chapters include: • Trauma Informed Cultures • Positive Behavior Interventions and Supports • Medical Risk Factors	Initial & Annual	Initial • < 60 days of hire Ongoing • As per certification or otherwise required NOTE • MANDT must be taken sequentially and within a consecutive 2-month period.	Initial & Ongoing • classroom training by a certified Mandt trainer	• MDHHS Contract Technical Requirement for Behavior Treatment Plan Review Committee. • Administrative Rule 330.7001 (z) • OSHA Publication 3148-01 R (2004)

TRAINING	DESCRIPTION	FREQUENCY	WHEN	HOW TO OBTAIN	REQUIREMENT
2c. Behavioral Treatment / Crisis Intervention (MANDT) **TECHNICAL**	Mandt Technical provides staff with technical physical skills to keep people safe while working with them. Chapters include: • Assisting • Separating • Physical Techniques	Initial & Annual	Initial • < 60 days of hire Ongoing • As per certification or otherwise required NOTE • MANDT must be taken sequentially and within a consecutive 2-month period.	Initial & Ongoing • classroom training by a certified Mandt trainer	• MDHHS Contract Technical Requirement for Behavior Treatment Plan Review Committee. • Administrative Rule 330.7001 (z) • OSHA Publication 3148-01 R (2004)
3. Corporate Compliance	This training will acquaint staff members with the general laws and regulations governing waste, fraud, and abuse, and other compliance issues in both the CMHSP and the provider organization.	Initial & Annual	Initial • <60 days of hire Ongoing • Annual update	Initial • CMH classroom training if available • Lakeshore LMS online course • As otherwise approved by CMH Ongoing • CMH classroom training if available • Lakeshore LMS online course • As otherwise approved by CMH	• Medicaid Integrity Program (MIP) Section 33 • Medicaid False Claims Act of 1977 • Michigan False Claims Act, Act 72 of 1977 • Deficit Reduction Act of 2005 • Affordable Care Act of 2010 • CARF 1. A. 7 if applicable • Code of Federal Regulations 42 CFR 438 608
4. Cultural Competence	This training will cover: effect of culture and how it affects our perception of life, various aspects of culture, understanding that every individual has the right to receive culturally proficient services, steps in providing culturally responsive services, and realizing that being culturally competent/proficient is a continual process.	Initial & Annual	Initial • ≤ 60 days of hire Ongoing • Annual update	Initial • CMH Classroom Training if available • Lakeshore LMS online course • As otherwise approved by CMH Ongoing • Lakeshore LMS online course • As otherwise approved by CMH	• Code of Federal Regulations 42 CFR 438.206(c)(2) Cultural Considerations • MDHHS Contract Part II 3.0, Access Assurance Section 3.4.2 on Cultural Competence • MDHHS Contract Part I, 15.7 (LEP) • CARF 1.I.5 if applicable • Medicaid Provider Manual 4.5

TRAINING	DESCRIPTION	FREQUENCY	WHEN	HOW TO OBTAIN	REQUIREMENT
5. Emergency Preparedness	The goal of this course is to provide information that helps increase employee awareness and knowledge of various emergency situations to promote effective response practices. At the completion of this program, participants should be able to: identify risk factors that lead to an emergency situation; implement proper safety and prevention practices; report emergencies promptly to proper authorities; respond to various emergency situations in an effective manner.	Initial	Initial • ≤ 60 days of hire • Staff working independently or as lead workers need to complete all training prior to any direct care assignment	Initial • CMH Classroom Training if available • Lakeshore LMS online course	• R330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings) • CARF 1.H.4 if applicable
6. Knowledge of First Aid	This training will provide staff with information about basic first aid action principles and situations requiring first aid.	Initial and 2-year Update	Initial • ≤ 60 days of hire and prior to working independently with individuals served Ongoing • Update every 2 years	Initial & Ongoing • Lakeshore LMS online course • Options as approved by CMH	• Medicaid Provider Manual 2.4, 14.5.A, and 15.2.C
7. First Aid Certification	This training will provide staff with certification in basic first aid action principles, situations requiring first aid, and basic first aid skills in areas including: • Medical Emergencies • Injury Emergencies • Environmental Emergencies	Initial and Ongoing	Initial • Current certification ≤ 60 days of hire and prior to working independently with individuals served Ongoing • As per certificate	Initial & Ongoing • CMH or Community Classroom Training which must include return demonstration • Through an American Red Cross, American Heart Association, OR National Safety Council certified trainer which must include return demonstration	• R330.1806 (Specialized Residential) • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings) • CARF 3.G.22; 2.F.3.d
8. CPR Certification	This class provides certification in the basics skills for cardio-pulmonary resuscitation for adults and children including checking a conscious or unconscious victim, conscious choking, CPR (30 – 2), unconscious airway obstruction, and automated external defibrillators (AED) as determined by certifying organizations (American Red Cross, American Heart Association, National Safety Council).	Initial and Ongoing	Initial • Current certification ≤ 60 days of hire and prior to working independently with individuals served Ongoing • As per certificate	Initial & Ongoing • CMH or Community Classroom Training which must include return demonstration • Through an American Red Cross, American Heart Association, OR National Safety Council certified trainer which must include return demonstration	• Medicaid Provider Manual 14.5.A • R330.1806 (Specialized Residential) • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • CARF 3.G.22; 2.F.3.d

TRAINING	DESCRIPTION	FREQUENCY	WHEN	HOW TO OBTAIN	REQUIREMENT
9. Grievance & Appeals	This class demonstrates that due process/grievance and appeals are the right of every person seeking or receiving mental health or developmental disability services from a Community Mental Health Service Program or its contracted agencies. All individuals have the right to a fair and efficient process for resolving complaints regarding their services and supports.	Initial and Annual	Initial • ≤ 30 days of hire and prior to working independently with individuals served Ongoing • Annual update	Initial & Ongoing • LRE classroom training if applicable • Options as approved by CMHSP	• MDHHS Contract Attachment 6.3.2.1 • Lakeshore Regional Entity Policy 6.2
10. Health & Wellness	This course provides staff with the information and skills to work as a health coach. Necessary skills include: promoting wellness, understanding the role of treatment options, monitoring a person's current health status, and responding to changes in healthcare needs.	Initial	Initial • ≤ 60 days of hire and prior to working independently with individuals served	Initial • CMH classroom training if available • Lakeshore LMS online hybrid course (both online AND classroom portions)	• MCL 330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings)
11. HIPAA	This training will provide staff with information about HIPAA privacy and HIPAA security, confidentiality and informed consent, applying it in appropriate contexts, how to release information legally, when information can be discussed and what information cannot be discussed, HIPAA requirements, and Michigan Mental Health Code requirements.	Initial and Annual	Initial • ≤ 60 days of hire Ongoing • Annual update	Initial & Ongoing • CMH Classroom Training if available • Lakeshore LMS online course • As otherwise approved by CMH	• Code of Federal Regulations – 45CFR 164.308(a)(5)(i) and 164.530 (b)(1) • CARF 1.I.5
12. Introduction to Human Services	This course provides an overview of Developmental Disabilities, Mental Illness, Substance Use Disorders, and provides information about documentation and the role of staff.	Initial	Initial • ≤ 30 days of hire and prior to working independently with individuals served	Initial • Lakeshore LMS online course • CMH Classroom Training if available	• MCL 330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Homes) • R400.2122 (Congregate Settings)
13. Limited English Proficiency (LEP)	This course will provide information on the language assistance entitlements available to individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.	Initial and Annual	Initial • ≤ 60 days of hire Ongoing • Annual update	Initial • CMH Classroom Training if available • Lakeshore LMS online course • As otherwise approved by CMH Ongoing • Lakeshore LMS online course • As otherwise approved by CMH	• Code of Federal Regulations 42 CFR 438.206(c)(2) Cultural Considerations • MDHHS Contract Part I, 15.7 (LEP) • Medicaid Provider Manual 18.1.6 & 6.3.2

TRAINING	DESCRIPTION	FREQUENCY	WHEN	HOW TO OBTAIN	REQUIREMENT
14. Medication Series **May include:** **Lakeshore course series that includes online and classroom demo portions (see How to Obtain column)** **OR** **Standalone CMH classroom training(s) if available**	This training series provides an overview of the rights of medication administration; legal, ethical, and liability considerations of medication administration; commonly prescribed medications for individuals receiving services; special considerations of administering psychotropic and other medications; correct drug routes, dosages; pharmacy labels and physician orders; drug information sheets; possible side effectives, possible adverse effects of, and contraindications; transcription of medication orders; medication storage; how to document medication refusal and inability to administer medications as scheduled; how to document medication errors; disposal of discontinued, expired and/or contaminated medications per agency policy and procedure and FDA guidelines. This series provides preliminary information about this topic. Providers will work with staff to build and develop competency.	Initial	Initial • ≤ 60 days of hire and prior to working independently with individuals served	Initial • Lakeshore LMS course series that includes these online AND classroom portions: 1. Medications: Types, Uses & Effects (online) 2. Medication Administration & Monitoring (online) 3. Medication & Health Skills Demonstration (classroom) Medication Administration & Monitoring online module MUST be completed BEFORE the classroom Skills Demo. • Standalone CMH classroom training(s) if available	• MCL 330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings)
15. Nutrition & Food Safety	This course provides staff information so they may: understand the effect of food intake on health and wellness; identify and help people understand healthy food options; recognize and implement menus which encourage healthy meals and snacks based on setting; be able to shop in accordance with dietary and budgetary considerations; describe the link between improper food handling, poor personal hygiene, and food-borne illness; list signs/symptoms of food-borne illness; list criteria for safe food handling, storing, and serving; and, Identify appropriate response to food recalls.	Initial	Initial • ≤ 60 days of hire and prior to working independently with individuals served	Initial • CMH classroom training if available • Lakeshore LMS online course	• MCL 330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings)

TRAINING	DESCRIPTION	FREQUENCY	WHEN	HOW TO OBTAIN	REQUIREMENT
16. Person-Centered Planning and Self-Determination	This training provides information on the core principles of person-centered planning (PCP), self-determination, and the Individual Plan of Service (IPOS). Emphasis is placed on discovering the preferences of the individuals being served and improving ability to implement the IPOS accordingly; understanding what the person wants to achieve with each goal and objective in his/her IPOS; and understanding that the IPOS is the prescription for the services that staff provide.	Initial & Annual	Initial • < 60 days of hire Ongoing • Annual update for all staff	Initial • CMH classroom training if available • Lakeshore LMS online course • As otherwise approved by CMH Ongoing • As otherwise approved by CMH • Lakeshore LMS online course	• MDHHS contract Part 3.4.1.1.IV.A.4 • Administrative Rule R 330.1700 (G)
17. Recipient Rights	This course will provide a basic understanding of recipient rights and reporting requirements. When a person receives behavioral health services, Michigan's Mental Health Code and other state and federal laws safeguard their rights. Staff are responsible to protect these rights.	Initial & Annual	Initial • ≤ 30 days of hire Ongoing • Annual update	Initial • CMH classroom training • Options as approved by CMH Office of RR Ongoing • CMH classroom training • Options as approved by CMH Office of RR	• MH Code: Sec 330.1755(5)(f)
18. Standard Precautions	This course provides information on: the epidemiology and symptoms of infectious diseases; how infectious diseases are transmitted; exposure control plans; recognizing what job activities may present a risk for potentially infectious situations; appropriate engineering controls, work practices, and personal protective equipment; an emergency involving blood or other potentially infectious material; appropriate response to an exposure incident including immediate care, documentation, and medical follow up; and, appropriate cleaning and disinfecting following a biohazard incident.	Initial & Annual	Initial • Prior to working with individuals served Ongoing • Annual update	Initial & Ongoing • CMH Classroom Training if available • Lakeshore LMS online course • OSHA approved Standard Precautions curriculum	• OSHA 1910.1030 • Administrative Rule R325.7000 • Administrative Rule R 325.70016 (7)(a) – specifies initial training and annual retraining • Administrative Rule R330.2807 (10) • CARF 1.H.11.b.

TRAINING	DESCRIPTION	FREQUENCY	WHEN	HOW TO OBTAIN	REQUIREMENT
19. Trauma Informed Care	This course addresses the nature of trauma and its effects on people. Being able to provide trauma informed services to individuals receiving services is a crucial skill set for staff. Recognizing that an alarming majority of people receiving services have had trauma in their lives, it is staff's responsibility to work with them in a manner which supports and does not worsen the impact of previous trauma.	Initial & Ongoing	Initial • < 6 months of hire Ongoing • As identified by MDHHS contract	Initial • CMH classroom training (Mandt Conceptual) • Other CMH classroom training if available • As otherwise approved by CMH Ongoing • CMH classroom training (Mandt Conceptual) • Other CMH classroom training if available • As otherwise approved by CMH	• MDHHS/CMHSP Contract Attachment C6.9.9.1

Additionally: If through the Quality Monitoring Review or MDHHS Site Review deficiencies are noted in this area, additional training may be required. •When applicable laws and/or regulations change CMHSP may require a training update

Specialized Res: Staff working independently or as lead workers need to complete all training prior to any direct care assignment.

For Self-Directed Arrangements, please see training requirements documented in the Self-Determination Agreement.

Hybrid First Aid-CPR-AED

1. Staff will need to register for the 1-hr skills portion on Lakeshore training website.
    a. Example: **"Ottawa-Hybrid First Aid/CPR/AED 01/04/21 - 09:00-10:00 (classroom) – TC"**

2. Once registered I will email them the information to the online training from another site (American Trauma Event Management-see below). There are multiple videos to watch and questions to answer.

3. Once staff complete the training, they need to email me a screen shot of their certificate of completion prior to attending their 1-hr skills session.

4. After completing the skills, they get their card and the training should be reflected on their Lakeshore training transcript.

For a list of LARA approved CPR/FA/AED providers please go to

https://www.michigan.gov/lara/0,4601,7-154-89334_63294_5529_49572_49583-82382--,00.html

Mandt training

Online training for Mandt CANNOT be registered via the Lakeshore training site. It is done through the Mandt site, but I'm required to register staff. All online training registration is conducted as followed…

1. Supervisor/Manager/Homeowner emails me with name of staff and which online training they would like them to take.

2. I request a purchase of this training through our fiscal services.

3. Courses are purchased and fiscal services emails an invoice to agency.

4. I can then assign the training to the specific staff immediately after fiscal services notify me the course was purchased.

5. They get an email with log-in information from Mandt (not Ottawa CMH).
    a. If staff does not retrieve the information, they should notify me the same day. I can initiate a username and password reset.

<u>Training Options</u>

- New Hire staff options
    - Take Day 1,2,3 in-person
    - Do Day 1 & 2 online through the Mandt website **($33.99)** and do Day 3 in person.
- First year Recert options
    - Take Mandt Recert in-person

    - Take first 3 chapters online **($28.75)** then come to a Day 3 in-person. This also works for people whose certification has expired.
- Second year+ Recerts have two options
    - Take Mandt Recert in-person
    - Take all 6-chapter tests as an online test **($8.25)** out then come to a half-day technical skills course.
    - Currently half-day courses are scheduled as needed.

Fiscal Updates

PRESENTED BY COURTNEY FRITZSCHE

OVERVIEW

ATTACHMENT B

GIVA

PROVIDERCONNECT

NEW BILLING REQUIREMENTS

POTENTIAL FUTURE CHANGES

ATTACHMENT B - TIMELINESS

3RD PARTY	NON-3RD PARTY	INVOICE
For claims which DO require an EOB:	For claims which DO NOT require an EOB:	
Agency will submit the claim(s) to CMHOC within 30 days of receipt of the EOB	Claims submitted more than 60 days after the date of service will be denied	
Claims submitted more than 365 days from the date of service will be denied		

ATTACHMENT B – YEAR END REMINDER

- Claims/Invoices: All invoices for the fiscal year are due to CMHOC by **October 22, 2021**. Any disputed claims and/or invoices must be reported to CMHOCFINANCE@miottawa.org by **November 15, 2021**. Claims/invoices not submitted by these deadlines will be denied.
- Disputed/Outstanding Claims: Any disputed claims, resubmissions, or claims awaiting Coordination of Benefits must be reported to **CMHOCFINANCE@miottawa.org by November 15, 2021**. Claims not submitted by these deadlines will be denied. Please submit a single Excel file of all agency outstanding/disputed claims, including any that you are working with other CMHOC staff to resolve. The file must include consumer number, date of service(s), code(s), unit(s), and estimated liability.

GIVA

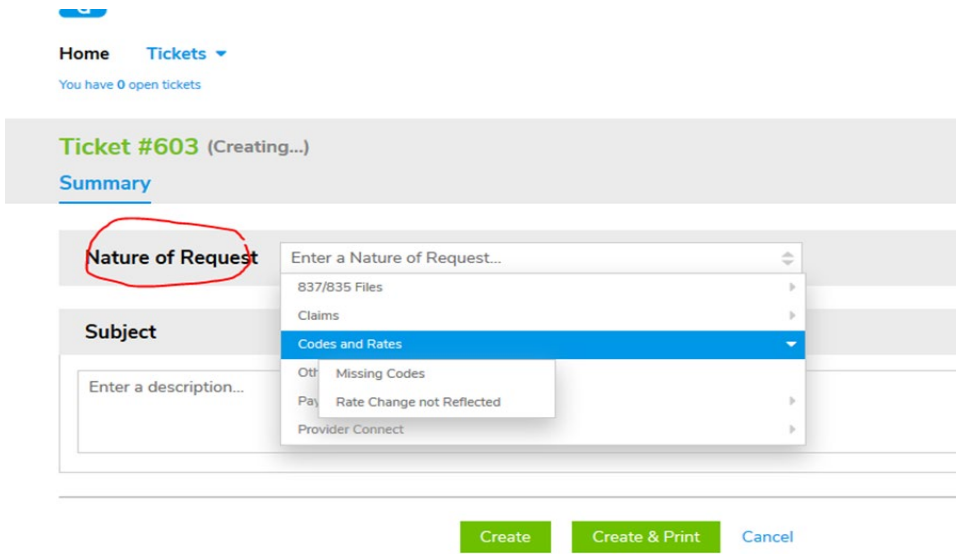
The Fiscal Services Helpdesk portal:
https://cmhoc.giva.net/home.cfm

Two ways to create a helpdesk ticket:

1. email cmhocfinance@miottawa.org
2. login to GIVA directly

GIVA

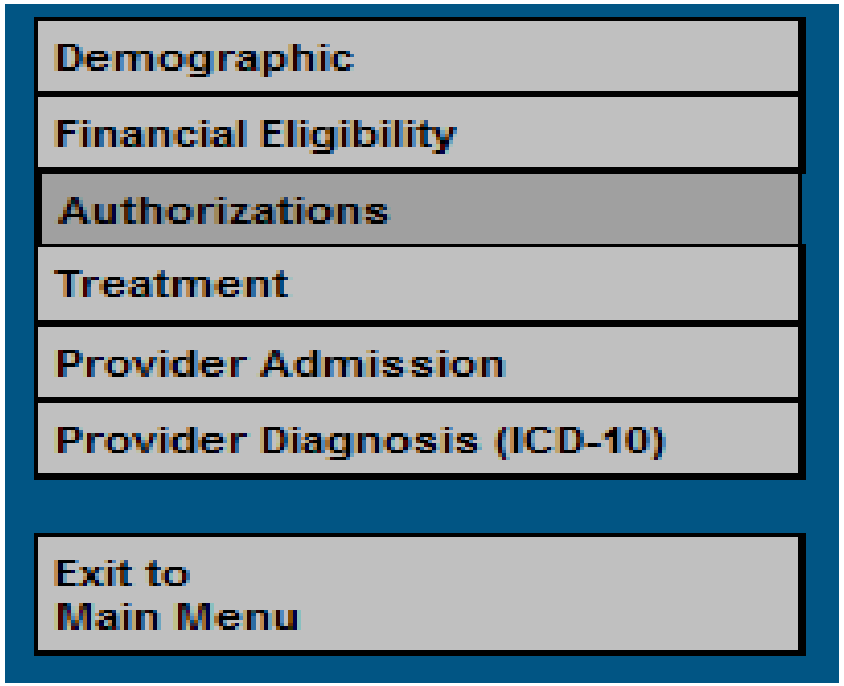

Testman Jones
CMHOC Billings & Claims Service Desk
Home Tickets
You have 0 open tickets
Search
+ Create New Ticket
Find Tickets
Enter either keyword(s) or ticket number to find tickets.
Find Tickets
Your Open Tickets


Home Tickets
You have 0 open tickets
Ticket #603 (Creating...)
Summary
Nature of Request
Enter a Nature of Request...
837/835 Files
Claims
Codes and Rates
Missing Codes
Rate Change not Reflected
Provider Connect
Subject
Enter a description...
Create
Create & Print
Cancel

PROVIDERCONNECT

BILLING ACROSS AUTHORIZATIONS

Remember to bill based on the authorization start and end dates

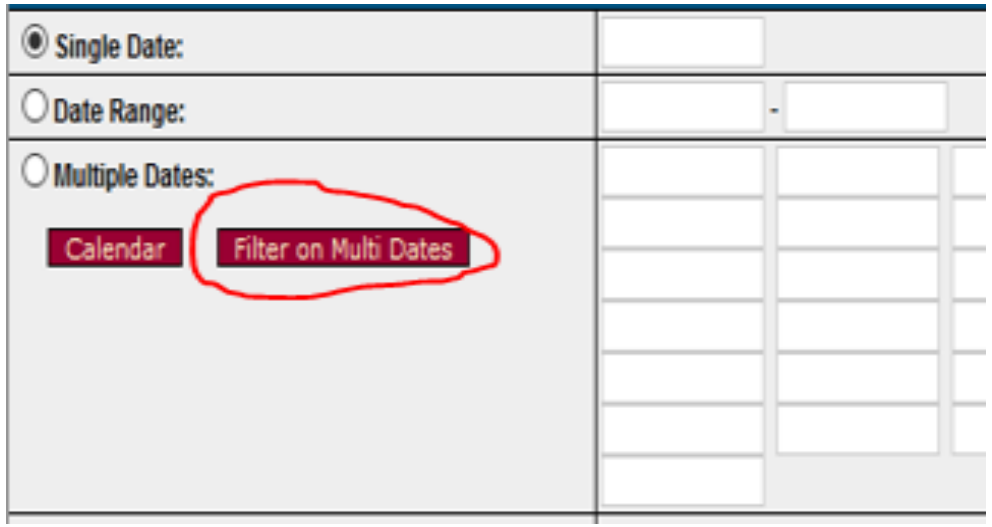


PROVIDERCONNECT

BILLING FOR MULTIPLE DOS

Remember to click on the “filter on Multi Dates” button to progress to the next step

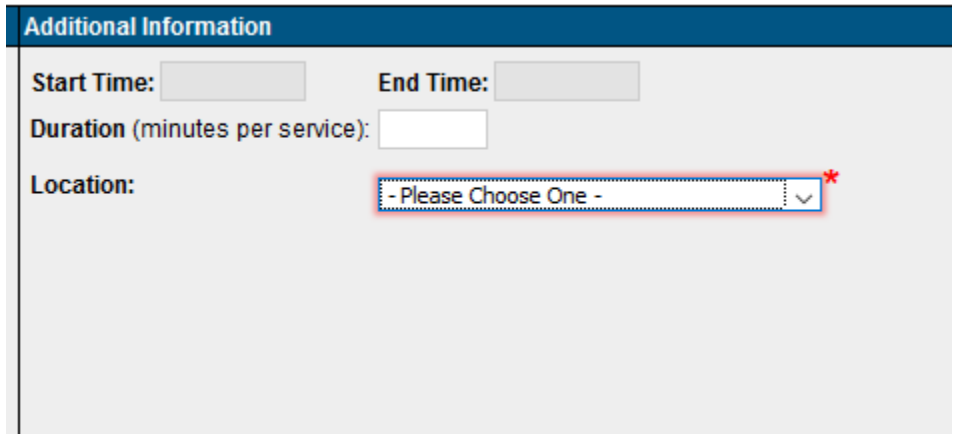
Everything must be the same to use this feature



PROVIDERCONNECT

START AND STOP TIMES

Effective 3/1/21 all ABA and CLS services require start and stop times.



NEW BILLING REQUIREMENT: START AND STOP TIMES

Effective March 1, 2021, all ABA and CLS claims submitted via ProviderConnect or 837 files are required to include start and stop times.

This change will not impact any previously billed services, or services submitted and processed prior to March 1st.

Start and stop times are required on all ABA and CLS services submitted and processed by CMHOC, thereafter, regardless of the date of service being processed.

START AND STOP TIMES

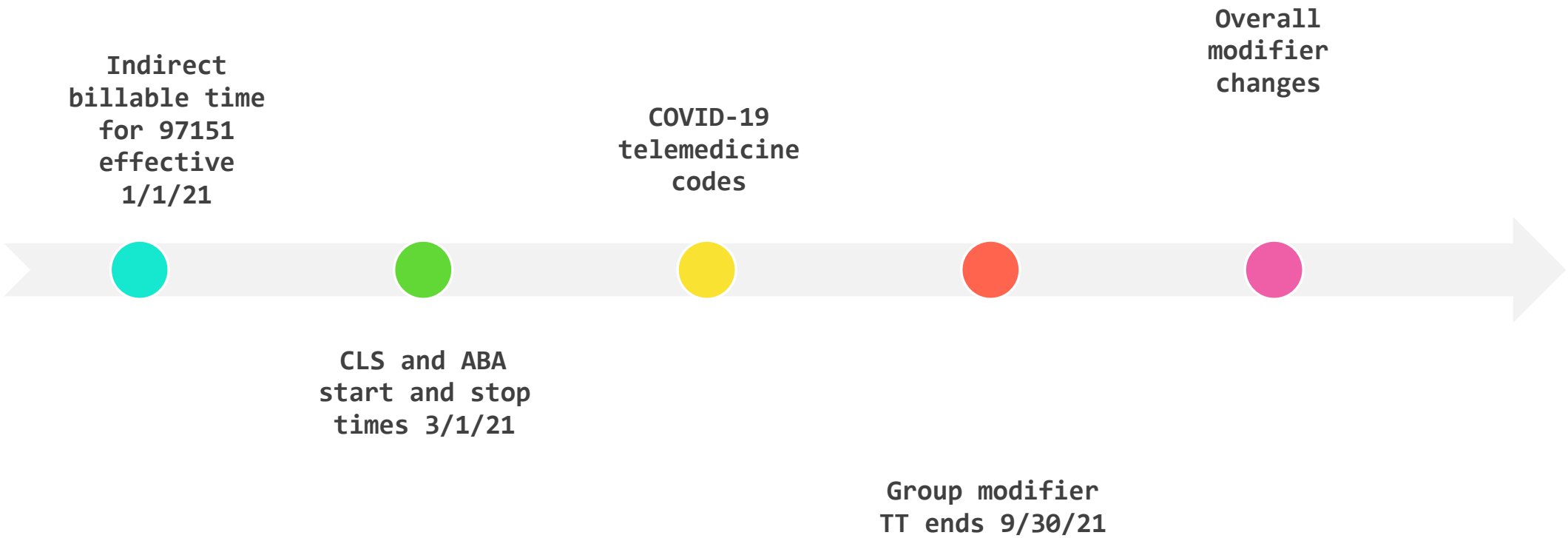
ABA Codes:	CLS Codes:
96130-33	H2015*
96136-39	H2015UN
97151	H2015UP
97153-58	H2015UQ
0359T	H2015UR
0362T	H2015US
0373T	*Please review your agency contract. This list is not inclusive of all the H2015 code and modifier options that now require start and stop times.

GROUP CLS

H2015UN	H2015UP	H2015UQ	H2015UR	H2015US
2 consumers served	3 consumers served	4 consumers served	5 consumers served	6+ consumers served

Reminder that group CLS needs to be reported by group size, and now must include start and stop times.

CHANGES TO KEEP AND EYE OUT FOR!



INDIRECT BILLABLE 97151 TIME

Effective 1/1/2021, BHHDA revised its rules to allow indirect time to be billable for 97151.

TELEMEDICINE

CURRENT ALLOWABLE TELEMEDICINE SERVICES

During the COVID-19 Emergency BHDDA put together a database of allowable telemedicine codes. This database can be found here: www.Michigan.gov/BHDDA / Reporting Requirements / COVID-19 Encounter Code Chart

Additionally, once the COVID-19 Emergency is over, BHDDA has developed a new database of allowable telemedicine services which will go into effect once the COVID-19 Encounter Chart is no longer in effect. This database can be found here: www.Michigan.gov/BHDDA / Reporting Requirements / BHDDA Telemedicine Database

Please note BHDDA is moving away from using the modifiers GT and 95 to denote telemedicine and will just be using the Place of Service of 02 once the COVID-19 Emergency is over. During the pandemic, the GT modifier and POS of 02 should continue to be used. Once the pandemic is over, we will require just the POS 02 be used on all allowable telemedicine services listed in the BHDDA Telemedicine Database.

All telemedicine services must include the Place of Service Code of 02. See database of allowable services for listing. These services shall occur through real-time interactions between beneficiaries and the designated staff person responsible for completing the service. MDHHS requires a secure, real time interactive video system at both the originating and distant site, allowing an instantaneous, synchronous interaction between the patient and health care professional via the telecommunication system. Please refer to the telemedicine section within the Medicaid Provider Manual and all applicable bulletins for additional requirements.

The Health Insurance Portability and Accountability Act (HIPAA) compliance requirements and other confidentiality requirements related to the provision of behavioral health services must be followed when engaged in telemedicine services. Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards.

GROUP MODIFIER TT

Effective 10/01/21 group services like skill building, SE, and respite will be required to follow the same group size modifier reporting requirements as group CLS.

H2015UN	H2015UP	H2015UQ	H2015UR	H2015US
2 consumers served	3 consumers served	4 consumers served	5 consumers served	6+ consumers served

OVERALL MODIFIER CHANGES

- ASAM modifiers:

3.1	3.3	3.5	3.7
No modifier, will be:	UB, will be:	TF, will be:	TG, will be:
W1	W3	W5	W7

- Treatment plan monitoring (TS) modifier elimination
  - Codes iH2000, H0032
- Provider education level-specific credentialing

QUESTIONS

COMMUNITY MENTAL HEALTH

OTTAWA COUNTY

CONTACT INFORMATION

cmhocfinance@miottawa.org

616-494-5560

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

Credentialing and OIG Checks

Clinical Applications

- What you need to know:
  - When sending a new clinical application, please make sure proof of provider's highest education and licensure are attached.
    - Legible Transcripts or Diploma
    - Copy of actual license **NOT LARA** verification
  - If the job position requires necessary trainings (such as RBT or Recovery Coach Training, CAADC, or DP-C) please make sure it is attached to the application.
    - Please include actual copies of these trainings, certifications, or plans
  - Please make sure clinical application are completed in their entirety when submitted.
  - "The Effective Date"
    - The date the Program Evaluator (Amber Vondra) receives the completed clinical application with all appropriate supporting documentation **is the date the staff will be set up for billing**

Clinical Applications

- What you need to know:
  - The Confirmation Email
    - You will receive a confirmation email once the provider has been set up for billing in Ottawa County
    - Do not have your staff provide any services until this email is received
  - Provider License Update
    - The date the Program Evaluator (Amber Vondra) is notified of updated licensure is the day the update is effective for billing
    - If staff bill for services provided with this updated licensure prior to letting the Program Evaluator know, it will cause billing issues
  - Credentialing Resources
    - If you have any further questions in regards to credentialing please refer you to your specific Attachment A located on our website

Clinical Applications

- Provider Expectations:
  - Maintain policies and procedures to ensure contracted physicians and other health care professionals (e.g., social workers, OT, PT, etc.) are licensed by the state of Michigan and are qualified to perform their services
  - Immediately notify the LRE and CMHSP if any license is terminated, revoked or suspended during the term of this agreement
  - Maintain policies and procedures to ensure licenses and certifications are current and valid

Clinical Applications

- Provider Expectations:
  - Maintain policies and procedures to ensure support care staff who are not required to be licensed are qualified to perform their jobs
  - Agree to immediately notify CMHSP of any state licensure or certification investigation
  - FOR SUD PROVIDERS: Organizations/programs must be licensed for SUD service provision

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CLINICAL APPLICATION

All sections must be completed in their entirety.

The date Community Mental Health of Ottawa County (CMHOC) receives the fully completed Clinical Application is the effective date of billing for CMHOC services.

An incomplete application may result in a delay of credentialing approval and effective date.

Once an individual is credentialed and approved to provide services the agency will receive a confirmation email from the CMHOC Program Evaluator.

AGENCY NAME: _____

Provide the following **service site information** for the individual listed:

Service Site Name: _____
Service Site Address: _____
Service Site Phone Number: _____

SECTION I: PERSONNEL INFORMATION

Services cannot be provided and billed until CMHOC has credentialed the individual listed.

First and Last Name: _____
Date of Birth: _____
Sex: ☐Male ☐Female ☐Unknown
Social Security Number: _____
Date of Hire: _____
Date of Criminal Background Check: _____
Date of Medicaid Sanction Check (Office of Inspector General - OIG): _____
National Provider Identifier (NPI): _____

SECTION II: TYPE OF STAFF

Check all that apply to the services provided by the individual listed in Section I.

☐ Autism (please specify) _____
☐ Case Management/Supports Coordination
☐ Psychology/Behavior Support
☐ Occupational Therapy
☐ Physical Therapy
☐ Speech/Language Pathology
☐ Nursing
☐ Other (please specify) _____

SECTION III: CREDENTIALS

Attach the following documents appropriate to the services provided by the individual listed in Section I.

- ☐ Professional License
- ☐ Professional Certificate
- ☐ Professional Registration
- ☐ Practitioner Specialty (*mark all that apply on page 2) _____
- ☐ Highest Educational Degree
- ☐ DEA (Medical Professional only)
- ☐ Malpractice Insurance (if required by contract)

SECTION IV: AGENCY/SUPERVISION SIGNATURE

By completing the information and signing below, the agency and supervisor listed certify that the Clinical Application has been completed fully for the individual requiring credentialing by CMHOC.

Signature: _____ Date: _____

Print Name: _____

Title: _____

Revised on 1/14/2019

SUBSTANCE USE DISORDER CLINICAL APPLICATION

All sections must be completed in their entirety.

The date Community Mental Health of Ottawa County (CMHOC) receives the fully completed Clinical Application is the effective date of billing for CMHOC services.

An incomplete application may result in a delay of credentialing approval and effective date.

Once an individual is credentialed and approved to provide services the agency will receive a confirmation email from the CMHOC Program Evaluator.

AGENCY NAME: _____

Provide the following **service site information** for the individual listed:

Service Site Name: _____
Service Site Address: _____
Service Site Phone Number: _____

SECTION I: PERSONNEL INFORMATION

Services cannot be provided and billed until CMHOC has credentialed the individual listed.

First and Last Name: _____
Position: _____
Date of Birth: _____
Sex: ☐Male ☐Female ☐Unknown
Social Security Number: _____
Date of Hire: _____
Date of Criminal Background Check: _____
Date of Medicaid Sanction Check (Office of Inspector General - OIG): _____
National Provider Identifier (NPI): _____

SECTION II: TYPE OF STAFF

Check all that applies to the services provided by the individual listed in Section I.

- ☐ Treatment Supervisor (circle): CCS-M, CCS-R, or DP-CCS
- ☐ Specifically Focused Staff (specify): _____
- ☐ Treatment Adjunct Staff (specify): _____
- ☐ Intern – Internship Completion Date: _____
- ☐ Substance Abuse Treatment Specialist (SATS), NPI# _____
- ☐ Substance Abuse Treatment Practitioner (SATP), NPI# _____
- ☐ Other (specify): _____

SECTION III: CREDENTIALS

Attach the following documents appropriate to the services provided by the individual listed in Section I.

Complete the sections below for all types of staff marked in Section II.

1. **Substance Abuse Treatment Specialist:** In order to qualify as a substance abuse treatment specialist an individual must meet the criteria detailed in **any one of** the following three categories **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

   Please select the appropriate category below and provide the information requested below the item:

☐	Possesses one of the following certifications from the Michigan Certification Board of Addiction Professionals **or** a Development Plan for achievement.	☐CADC ☐CCDP ☐CADC-M ☐CCDP-D ☐CAADC ☐Dev. Plan ☐CCJP-R	MCBAP Certification Expiration Date: _____
☐	Individual has a development plan with MCBAP **and** possesses one of the following licensures: MD/DO, PA, NP, RN, LPN, LP, LLP, TLLP, LPC, LLPC, LMFT, LLMFT, LMSW, LLMSW, LBSW, or LLBSW.	License #: _____	License Expiration Date: _____
☐	Individual possesses one of the following alternative certifications. Please identify which certification:	☐ ASAM ☐APA ☐UMICAD	Certification Expiration Date: _____

2. **Substance Abuse Treatment Practitioner:** In order to qualify as a substance abuse treatment practitioner an individual must have a MCBAP development Plan in place **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

   MCBAP Development Plan Expected Completion Date: _____

3.

Levels of Care to be provided:	Service Categories:
☐ Outpatient	☐ Assessment
☐ Intensive Outpatient Program (IOP)	☐ Individual
☐ Detox	☐ Group
☐ Residential	☐ Didactic
☐ Methadone	☐ Case Management *
	☐ Peer Recovery Support **

* This employee has additional education, training, or experience qualifications for performing the duties of this position. *Please describe below (or attach an additional sheet):*

** Peer Recovery Support. Please attach an additional sheet to include responses to ALL of the following:

- Three (3) references of support;
- Current support system for PRS staff;
- Program's selection criteria for hiring PRS staff;
- How his/her recovery was verified and how recovery will be monitored;
- Date of his/her last treatment (if applicable);
- Specify types of services to be provided by PRS Associate or PRS Coach;
- Documentation of training received.

4. This employee has a degree in one of the following:
   - ☐ Social Work (circle): Masters or Bachelor's
   - ☐ Guidance & Counseling (circle): Masters or Bachelor's
   - ☐ Clinical Psychology (circle): Masters or Bachelor's
   - ☐ Physician
   - ☐ Ph.D. Psychologist
   - ☐ Other counseling related field (specify): _____
   - ☐ Other (specify): _____

SECTION IV: AGENCY/SUPERVISION SIGNATURE

Supervision for SATS and SATP staff must be provided by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications

By completing the information and signing below, the agency and supervisor listed certify that the Clinical Application has been completed fully for the individual requiring credentialing by CMHOC.

Signature: _____ Date: _____
Print Name: _____
Title: _____

Criminal Background Checks

- Provider will require criminal background checks at a minimum of every two years for all persons (staff, management and non-management) providing services to or interacting with Individuals served by CMHSP or persons who have the authority to access or create CMHSP information.
  - Criminal background checks must be completed through:
    - State of Michigan Licensing and Regulatory Affairs (LARA) Workforce Background Check System
    - Internet Criminal History Access Tool (ICHAT)
    - OR other service as approved by the LRE prior to starting work with Individuals
  - Provider shall inform CMHSP if any board member has been convicted of a felony or misdemeanor related to:
    - Patient Abuse
    - Health care or any type of fraud
    - Controlled substance
    - OR obstruction of any investigation.

OIG Checks

- Providers shall ensure an initial examination of Federal and State databases of excluded parties and litigation checks (OIG checks) are conducted.
  - Such examinations must take place:
    - At time of hire and monthly thereafter
    - For all Provider employees and persons joining Provider Board of Directors
      - If there is litigation initiated against a provider, you must notify us immediately
  - Please refer to your contract 2.4 Provider Panel Eligibility Requirements, Subsection 2.4.1.5 for further information
- All agency providers must be compliant with trainings, criminal background checks, and OIG checks
  - Keep proof of these in your files
  - Evidence of staff training and compliance must be available for MDHHS, LRE, and/or CMHSP audits
- If you have questions about which trainings staff need in order to be compliant, please refer back to Attachment I on the CMH website.

2.4 Provider Panel Eligibility Requirements

2.4.1 Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs. To ensure compliance with the Social Security Act Sections 1128, 1128A, 1156, 42 CFR 438.6, 455.10 and 45 CFR Part 76, Provider must ensure the following:

2.4.1.1 Provider and its subcontractors, board members, and employees are not debarred, suspended, proposed for debarment, declared ineligible, or excluded from a federal or state health care program.

2.4.1.2 Provider and its subcontractors, board members, and employees have not been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal/State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.

2.4.1.3 Provider and its subcontractors, board members, and employees are not indicted or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated above (see subparagraph 2.4.1.2).

2.4.1.4 Provider and its subcontractors, board members, and employees have not within a three (3) year period preceding this Agreement had one or more public transactions (Federal, State or local) terminated for cause or default.

2.4.1.5 Provider shall ensure an initial examination of federal and state databases of excluded parties and litigation checks are conducted. Such examination must take place at the time of hire, and monthly thereafter, for all Provider employees and persons joining Provider Board of Directors.

2.4.1.6 Provider will notify CMHSP immediately when there is litigation initiated against Provider.

2.4.1.7 Provider shall immediately disclose to CMHSP any information regarding the ownership or control by a person convicted of a criminal offense described under Sections 1128(a)(b) and 1128(b)(1), (2), or (3) of the Social Security Act and if any staff member, member of the Board of Directors, manager, or person with an employment, consulting or other arrangement with Provider has been convicted of a criminal offense described under Section 1128A of the Social Security Act.

2.4.1.8 Provider agrees to immediately notify CMHSP of any threatened, proposed, or actual exclusion from any Federally-funded health care program of it or its staff.

Contact Information

If you have any comments, questions, or concerns about credentialing and compliance, please refer to your contract and/or feel free to reach out to us

My contact information is:

Amber Vondra
Phone Number: 616-393-5682
Email: avondra@miottawa.org

CHAPTER: **9**	SECTION: **19**	SUBJECT: **HUMAN RESOURCES – PROVIDER NETWORK**
TITLE: **PROVIDER DISPUTE RESOLUTION**		
EFFECTIVE DATE: **May 1, 2017**		REVISED DATE: **4/25/2018, 3/3/2020**
ISSUED AND APPROVED BY: LYNNE DOYLE, EXECUTIVE DIRECTOR		

I. PURPOSE:

To outline a process by which providers contracted with Community Mental Health of Ottawa County (CMHOC) can request dispute resolution for decisions of non-service related issues, including:

A. Denial or suspension of provider panel status with cause.
B. Request for Proposal (RFP) awards/denials.
C. Claims payments and authorizations.
D. Reduction, suspension or adjustments of payments to providers.
E. Results from provider monitoring activities and/or results reported on the Provider Summary Report.
F. A sanction or decision to place provider on provisional status.
G. Credentialing or re-credentialing decisions.
H. Other non-services issues.

In accordance with MCL 330.1784, this policy does not apply to recipient rights complaints.

II. APPLICATION:

All Community Mental Health of Ottawa County (CMHOC) providers and contract providers as specified by contract.

III. DEFINITIONS:

Dispute Resolution: The process for resolving differences between two or more parties or groups.

Grievance: An official statement of a complaint over something believed to be wrong or unfair.

Appeal: A formal process which is established so that providers may request reconsideration of an action or decision that has been made by CMHOC.

Adverse Notification: A notice, by any means, that documents a denial of authorization or claim; a reduction, suspension or adjustment to a claim; or the denial of participation as a panel provider.

IV. POLICY:

It is the policy of CMHOC to monitor contracted services to assure that a continuum of quality supports/services are provided by members of the Provider Network. When contract disputes occur between parties, this policy will allow for CMHOC and providers to collaboratively resolve disputes that may arise from the contractual relationship and cannot be resolved within the normal roles between the agency and CMHOC. Providers contracted with CMHOC can submit complaints and request reconsideration (appeal) of decisions rendered by CMHOC through the Provider Dispute Resolution Process.

V. PROCEDURE:

A. Providers shall be notified of their right to request dispute resolution via the RFP decision; sanction notice; notice of change to claims payment and authorizations; notice of reductions, suspension, or adjustments of payments; and in the contractual agreements with CMHOC.

B. Providers are encouraged to resolve problems and disagreements with the appropriate CMHOC staff person prior to making a formal request for dispute resolution.

C. When a dispute cannot be resolved informally, the provider has the option of filing a formal written request for dispute resolution. Written request for dispute resolution can be made to CMHOC Contract Manager and submitted to CMHContractServices@miottawa.org. CMHOC reserves the right to use on-site claims, utilization, provider monitoring reviews and interviews with involved parties to make decisions.

D. CMHOC Contact Manager, in conjunction with the Compliance Committee, shall notify the provider in writing of a decision regarding a grievance within 30 calendar days of receipt of the request and offer an option for appeal.

E. If the provider disagrees with the final CMHOC dispute resolution decision, they may initiate an appeal in writing within 30 calendar days after receiving adverse notification from CMHOC. Written request for an appeal can be made to CMHOC Compliance Office.

1. First Level Appeal
   The appeal is reviewed by the CMHOC department overseeing the area the appeal addresses. A written decision will be issued within 30 calendar days to the provider by the department making the decision.

2. Second Level Appeal
   If the provider is dissatisfied with the decision of the Level 1 Appeal, they may file in writing for a Level 2 Appeal within 20 calendar days to the Executive Director. A written decision will be issued by the Executive Director to the provider within 30 calendar days.

3. Third Level Appeal
   If the provider is dissatisfied with the decision of the Level 2 Appeal, they may file in writing for a Level 3 Appeal within 20 calendar days to the CMHOC governing board, whose decision will be considered final. A written decision will be issued by the governing board to the provider within 30 calendar days.

F. If the provider fails to submit a timely request for appeal of the dispute resolution decision, the provider will be deemed to have accepted CMHOC's determination and will have waived all further internal or external processes regarding the issues.

VI. ATTACHMENT:

A. Provider Dispute Resolution Operational Guideline
B. Contract Dispute Resolution Request Form
C. Contract Dispute Decision Form
D. Contract Dispute Appeal Forms
   a. 1st Level Appeal
   b. 2nd Level Appeal
   c. 3rd Level Appeal
E. Contract Dispute Appeal Decision Forms
   a. 1st Level Appeal Decision
   b. 2nd Level Appeal Decision
   c. 3rd Level Appeal Decision

VI. REFERENCE:

A. Lakeshore Regional Entity Network Provider Appeals and Grievances (Policy 4.7)
B. Mental Health Code (MCL 330.1784)
C. Dispute Resolution Contractual Language (3.9)

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CONTRACT DISPUTE RESOLUTION REQUEST FORM

To be completed by agency filing dispute resolution.

Date: _____

Agency: _____

Contract issue under disput is primarily (check which best apply):

☐ Claims/Reimbursement Dispute ☐ Rate Dispute

☐ Contract/Quality Dispute ☐ Other:

Describe issue under dispute (attach additional documents as needed):

☐ Supporting documentation attached

Describe actions taken so far to resolve dispute (attach additional documents as needed):

☐ Supporting documentation attached

Sign and submit to CMHOC Contract Manager:

Signature: _____

Print Name: _____

Print Title: _____

Phone/Email: _____

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CONTRACT DISPUTE APPEAL FORM
1st Level Appeal

To be completed by agency filing dispute resolution appeal.

Date: _____

Agency: _____

Attach copies of the following documents:

☐ Contract Dispute Resolution Request form

☐ Contract Dispute Decision form

Describe reason(s) why agency disagrees with CMHOC position:

☐ Supporting documentation attached

Sign and submit appeal to CMHOC Compliance Office:

Signature: _____

Print Name: _____

Print Title: _____

Phone/Email: _____

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CONTRACT DISPUTE APPEAL FORM
2nd Level Appeal

To be completed by agency filing dispute resolution appeal.

Date: _____

Agency: _____

Attach copies of the following documents:

☐ Contract Dispute Resolution Request form
☐ Contract Dispute Decision form
☐ Contract Dispute Appeal – 1st Level form
☐ Contract Dispute Appeal Decision – 1st Level form

Describe reason(s) why agency disagrees with CMHOC 1st Level Appeal:

☐ Supporting documentation attached

Sign and submit appeal to CMHOC Compliance Office:

Signature: _____

Print Name: _____

Print Title: _____

Phone/Email: _____

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

CONTRACT DISPUTE APPEAL FORM
3rd Level Appeal

To be completed by agency filing dispute resolution appeal.

Date: _____

Agency: _____

Attach copies of the following documents:

☐ Contract Dispute Resolution Request form
☐ Contract Dispute Decision form
☐ Contract Dispute Appeal – 1st Level form
☐ Contract Dispute Appeal Decision – 1st Level form
☐ Contract Dispute Appeal – 2nd Level form
☐ Contract Dispute Appeal Decision – 2nd Level form

Describe reason(s) why agency disagrees with CMHOC 2nd Level Appeal:

☐ Supporting documentation attached

Sign and submit appeal to CMHOC Compliance Office:

Signature: _____

Print Name: _____
Print Title: _____
Phone/Email: _____

Policy 4.7

POLICY TITLE:	NETWORK PROVIDER APPEALS AND GRIEVANCES	POLICY # 4.7	ADAPTED FROM	
Topic Area:	PROVIDER NETWORK MANAGEMENT	Page 1 of 4	REVIEW DATES	
Applies to:	LRE Staff and LRE Network Providers	ISSUED BY: Chief Executive Officer		
Developed and Maintained by:	LRE CEO	APPROVED BY: Board of Directors		
Supersedes:	N/A	Effective Date: 12/15/2016	Revised Date:	

I. POLICY

It is the policy of the Lakeshore Regional Entity (LRE) that Network Providers have the right to submit grievances as defined in this policy. Network Providers may appeal adverse actions taken by the LRE and/or member Community Mental Health Service Providers (CMHSPs) with regard to denials of payment of Medicaid claims and/or changes in provider status.

II. PURPOSE

To outline a process by which provider complaints (grievances) and requests for reconsideration of non-clinical decisions (appeals) are resolved.

A. Grievances may be filed by the Network Provider when it is perceived that the LRE or the CMHSP have not acted fairly in decisions related, but not limited to issues such as:

1. Results reported through provider monitoring reviews.
2. Compliance issues resulting in a sanction or decision to place the provider on a provisional status
3. Actions related to a change in provider status
4. Actions related to provider's non-compliance, professional competency, or conduct
5. Overall professional conduct related to contract management and oversight.

B. Appeals may be filed relate to non-clinical issues including, but not limited to:

1. Reduction, suspension or adjustments to provider payments for Medicaid covered services
2. Non-payment of Medicaid claims.
3. Instances where there is a breach of contract or where there is potential cause for termination of the contract due to discrimination, non-compliance with applicable laws, or non-compliance with consumer recipient rights and consumer grievance procedures.

4. Suspension or termination of a provider with cause (instances when a CMHSP has chosen to discontinue a provider's participation status within the network based on quality of care/service concerns)
5. Credentialing or re-credentialing decisions
6. Material breaches of contract
7. Alterations to the regional common contract boilerplate language.

C. This policy does NOT apply to the following:

1. Medicaid Fair Hearing Appeals or Grievances;
2. Medical necessity appeals;
3. Conditions that result in immediate termination (ie: loss of required certification/licensure; suspension by the State of Michigan from participating in the Michigan Medicaid and/or Medicare programs; the provider being listed in the State of Michigan registry for Unfair Labor Practices);
4. Contracts the LRE holds with member CMHSPs
5. Consumer rights regarding appeals and grievances

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to all LRE staff, CMHSP Member agencies, and contracted providers within the region.

IV. MONITORING AND REVIEW

This policy will be monitored by the LRE Chief Executive Officer or designee and reviewed annually.

V. DEFINITIONS

Adverse Notification: A notice, by any means, that documents a denial of authorization or claim; a reduction, suspension or adjustment to a claim; or the denial of participation as a panel provider.

Appeal: A formal process which is established so that providers may request reconsideration of an action or decision that has been made by the PIHP or contracting CMHSP.

Grievance: An expression of dissatisfaction by a provider regarding a perceived inequitable issue, aspects of interpersonal relation or other related issues.

VI. PROCEDURES

A. Role of the Participant CMHSP: As required in the PIHP/CMHSP Sub Contract, participating CMHSPs are required to have a local Provider grievance and appeal policy and procedure that comports with the Participant Sub-Contract and Medicaid regulations *(Article XIX, Section F: The Member agrees to adhere to the Payor's policies and procedures governing subcontracted provider grievances, disputes and appeals, including without limitation any grievance, dispute or appeal of changes in the*

subcontracted provider's status as a subcontracted provider in the Payor's subcontracted provider network.). The CMHSP will convey its procedure for provider appeals to each of its contracted providers. The procedure must include timeframes to appeal and at least two levels to submit appeals and identify the individuals/staff responsible to respond to appeals and the timeframes by which responses to appeal must be made.

1. Prior to initiating the grievance or appeal process with the LRE, the Provider must have accessed and completed the contracting CMHSP dispute resolution process
2. If after having completed the CMHSP dispute resolution process, a provider disagrees with the determination by the contracting CMHSP in the application process or during review of a provider's status and wishes to have the matter reviewed at a higher level, the provider may do so by submitting a written request to the LRE Chief Executive Officer or designee within thirty (30) calendar days of the disposition.
3. The request must be submitted on the LRE Grievance/Appeals Request form and include:
    a) *Reason for the dispute*
    b) *Documentation to support the grievance/appeal*
4. The Grievance/Appeals Request Form and supporting documentation should be sent to:

Lakeshore Regional Entity
Attn: Chief Executive Officer
5000 Hakes Drive, Suite 500
Norton Shores, MI 49441

or

Fax: (888) 409-9320

B. Grievances: Upon receipt of the completed Grievance/Appeals Request Form, the LRE CEO or designee will assist the parties in resolving the grievance issue. The decision of the LRE CEO and/or designee related to the grievance will be considered final and there will be no opportunity for reconsideration.

C. Appeals: An appeal of contract termination shall have no effect on the immediate termination of the contract and services under contract. The termination will remain in effect until the appeals process is completed, and will be rescinded only if the termination is not upheld on appeal, in effect until the appeal process is completed, and will be rescinded only if the termination is not upheld on appeal.

D. Role of the Lakeshore Region Entity:

1. First Level Review: A first level review will occur as follows:
   a) Within 20 calendar days of receipt of the request.
   b) Review will be completed by three qualified individuals and may be completed by qualified individuals in the areas of finance, compliance, utilization, quality, and provider network.
   c) Members of the LRE Quality Management team may be used for this level review.
   d) A written summary of the LRE's first level review of the complaint and outcome will be given to the provider with 14 calendar days of completion

2. Second-level review: Should the first level review prove to be unsatisfactory to the appealing provider, a second level review may occur as follows:
   a) Request for second-level review must be submitted in writing to the LRE CEO within 14 days of disposition from the first level appeal.
   b) The request will be reviewed within 14 calendar days of receipt by the LRE CEO. The LRE CEO will enlist assistance from LRE Executive and/or Management staff as needed.
   c) A written summary of the LRE's second level review of the complaint and outcome will be given to the provider and involved CMHSP within 14 calendar days of completion

E. Upon completion of the second level review, the decision of the LRE CEO regarding the dispute shall be considered final.

NOTE: If a provider has been issued a dismissal notice from the network by the contracting CMHSP, the provider is considered to be a participating provider through the last date of participation as indicated on the notice. If the notice is received on or after the last date of participation as indicated on the notice, the provider must be given reasonable time to initiate the dispute resolution process. Any corrective action plan issued by the contracting CMHSP to the network provider regarding action being disputed by the provider shall be on hold until such time as a final decision is made by the LRE.

VII. RELATED POLICIES AND PROCEDURES

None

VIII. REFERENCES/SUPPORTING DOCUMENTS

- MDHHS/PIHP Medicaid Managed Specialty Supports and Service Contract
- PIHP/CMHSP Sub Contract Agreement
- Member CMHSP Dispute Resolution Policy and Procedures
- LRE Network Provider Grievance and Appeal Form

PROVIDER GRIEVANCE AND APPEAL FORM

Prior to submitting this form to the Lakeshore Regional Entity, please review LRE Policy 4.7: Network Provider Appeals and Grievance

DATE:	
PROVIDER ORGANIZATION NAME:	**CMHSP:**
PROVIDER CONTACT INFORMATION: NAME: PHONE: EMAIL	
SUMMARY OF COMPLAINT (provide detailed information on issues that have not been resolved through the **CMHSP Provider Grievance and Appeal Process** - attach additional pages if needed):	
SUMMARY OF ACTIVITY WITH CMHSP (Provide detailed steps that have been taken to resolve this complaint with the contracting CMHSP – attach additional pages if needed):	
SUMMARY OF CMHSP RESPONSE (Attach all relevant documentation received from the CMHSP responding to this complaint):	

LRE USE ONLY:	***Date Received:***
LRE STAFF ASSIGNED:	

Note: Upon completion of this form please submit for processing to:

Lakeshore Regional entity
ATTN: Chief Executive Officer
5000 Hakes Drive, Suite 500
Norton Shore, MI 49441

Beacon Health Options, Inc. Facility/Organizational Provider Application

Beacon Health Options (Beacon) is the administrator for the Lakeshore Regional Entity for the below Community Mental Health Services Programs. The application and supporting documents are required to credential you as a Lakeshore Regional Entity provider according to the National Committee for Quality Assurance (NCQA) standards.

Community Mental Health Services Program Requesting Credentialing:

- ☐ Allegan County Community Health Services
- ☐ HealthWest
- ☐ Network180
- ☐ Ottawa County Community Mental Health Services
- ☐ West Michigan CMH System

To ensure timely processing of your application, please return the following:

- ☐ Completed Facility/Organizational Provider Application (Attached)
- ☐ Completed Service Location Addendum(s) – If you have multiple practice locations one form is needed for each (Attached)
- ☐ Copy of all applicable state licenses
- ☐ Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identifies the limits of liability of $1mil/$3mil and/or $100,000/$300,000 and the policy period (documents must show "Professional Liability")
- ☐ Copy of a completed W-9 form or IRS letter
- ☐ Copy of NPI Enumerator Documentation
- ☐ Copy of Staff Roster
- ☐ Accreditation Certificate(s)
  - ☐ JCAHO – Joint Commission on Accreditation of Healthcare Organizations]
  - ☐ HFAP – Healthcare Facilities Accreditation Program
  - ☐ CARF – Council on Accreditation of Rehabilitation Facilities
  - ☐ AOA – American Osteopathic Association
  - ☐ COA – Council on Accreditation
  - ☐ CHAP – Community Health Accreditation Program
  - ☐ AAAHC – Accreditation Association for Ambulatory Health Care
  - ☐ DNV – Det Norske Veritas
- ☐ Certification(s):
  - ☐ Other State licensure reports (i.e., Michigan Department of Health and Human Services) Medicaid
  - ☐ Medicare
- ☐ Copy of current Fidelity Bonding Certificate
- ☐ Copy of Disclosure of Ownership & Controlling Interest Statement

NON ACCREDITED ORGANIZATIONS:
If your organization is not accredited by JCAHO, CARF, COA, AOA, CHAP, AAAHC, DNV or HFAP, then a site review of your Facility/Program will need to be conducted based upon the need for providers in your area. A site survey preparation document will be sent to you in advance of the site survey which will be scheduled at a mutually agreed upon date. A copy of a CMS Certification letter or on site survey results performed by the State may be accepted in lieu of an on-site review by Beacon Health Options, Inc. Please provide this information with your application if applicable.

INDIVIDUAL TAX IDENTIFICATION NUMBERS AND NPI NUMBERS:
Beacon Health Options, Inc. Credentials and Contracts facilities based on single Tax Identification Numbers (TIN's/EIN's). If your organization bills under multiple Tax Identification Numbers, you will need to complete multiple application packets. However, if your organization has multiple NPI (National Provider Identification) numbers, please include that information in this application with an explanation to which programs and/or locations to which the multiple NPI numbers apply.

Beacon Health Options, Inc. Facility/Organizational Provider Application

I. GENERAL INFORMATION (Please print/type) **NPI #:** _____

A. TIN Owner Name/Legal Name: _____

DBA/Trade Name: _____

Primary Mailing Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone #: ( ) _____ TAX ID#: _____

B. Facility/Program points of contact

Chief Executive Officer: _____ Phone: _____

Managed Care Director: _____ Phone: _____

Person completing this application / Title: _____

Phone: _____ Fax: _____ Email: _____

Billing/Claims Contact Person: _____ Phone: _____

Contracting Contact Person / Title: _____

Phone: _____ Fax: _____ Email: _____

Website Address of Facility: www._____

C. Please complete if facility/program is part of a corporate health system:

Corporate Name: _____

Contact Name: _____ Title: _____

Primary Mailing Address: _____

City: _____ State: _____ Zip Code: _____-_____ County: _____

Phone #: _(____)_____ Fax #: (____)_____

Beacon Health Options, Inc. Facility/Organizational Provider Application

D. Select one description from the following list that best describes the facility:

- ☐ General Hospital
- ☐ Free standing Acute Psychiatric Facility
- ☐ Residential Treatment Center
- ☐ Community Mental Health Center
- ☐ Other: _____
- ☐ Free standing Partial/Day Treatment Facility
- ☐ Free standing Intensive Outpatient Program
- ☐ Home Health Agency
- ☐ Free standing Substance Abuse Rehabilitation Facility
- ☐ Adult Foster Care Home

E. Business Classification (Please Check only one box for Ownership and only one box for Status)

1. Ownership: ☐ Private ☐ Public ☐ Government Program
2. Status: ☐ For-Profit ☐ Not-for-Profit

F. This organization is accredited or certified by one or more of the following:

☐ JCAHO ☐ CARF ☐ AOA ☐ COA ☐ CHAP ☐ AAAHC ☐ DNV ☐ HFAP

☐ OTHER:_____ ☐ None

☐ MEDICARE #_____(Please provide supporting documentation)

☐ MEDICAID #_____(Please provide supporting documentation)

G. The following information is required for the Provider Directory:

1. Languages available: _____
2. Accepting new patients: ☐ YES ☐ NO
3. Cultural competency training completed: ☐ YES ☐ NO

II. PROVIDER PROFILE / MALPRACTICE CLAIM HISTORY

PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTIONS ABOVE (1-5) THAT WERE ANSWERED "YES"

A. Please answer the following questions regarding your organization's **behavioral health program(s):**

1. Has the facility/program had professional liability insurance refused, revoked, declined or accepted on special terms in the past five years? ☐ Yes ☐ No
2. Has any government agency suspended, revoked, or taken other action against the facility/ program's license to conduct business in the past five years? (To include Medicaid /Medicare) ☐ Yes ☐ No
3. Have any memberships in professional organizations and/or accreditations been revoked, reduced, denied, or suspended by others or voluntarily given up by the facility/program in the last five years, or are any actions now under way which may lead to such sanctions? ☐ Yes ☐ No
4. Have any owners, officers, or shareholders of the facility/program **ever** been convicted of a crime, excluding misdemeanors? ☐ Yes ☐ No

5. Has the facility/program **ever** been previously denied acceptance into the Beacon Health Options Network, disenrolled from the Beacon Health Options Network, or withdrawn from Beacon Health Options Network participation? ☐ Yes ☐ No

PLEASE COMPLETE THE MALPRACTICE CLAIM INFORMATION WORKSHEET ON THE FOLLOWING PAGE FOR ANY QUESTIONS ABOVE (6-7) THAT WERE ANSWERED "YES"

6. Has the facility/program had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If Yes, enter the total number:_____ ☐ Yes ☐ No

7. If the facility/program is **not** JCAHO, AOA, CARF, COA, CHAP or AAAHC accredited, please answer the following question: Has the facility/program been a defendant in five (5) or more lawsuits within the **past five (5) years** in regard to the practice of **behavioral health treatment** or any lawsuits in the **past five (5) years** where there has been awards or payments of $250,000.00 (two hundred and fifty thousand dollars) or more? If Yes, enter the total number:_____ ☐ Yes ☐ No ☐ N/A- Only if Accredited

PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTION 8 IF ANSWERED "NO"

8. Does the facility/program comply with §1128 of the Social Security Act by not hiring, continuing to employ, or contracting with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)? ☐ Yes ☐ No

MALPRACTICE CLAIM INFORMATION WORKSHEET

B. Please attach information on what the organization's response was to the allegations and what steps were taken to prevent any future incidents for each claim listed below. This page can be copied to accommodate additional claim information.

1. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_____

2. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_____

3. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_____

4. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_____

5. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_____

IV. PARTICIPATION STATEMENT

The Facility grants (i) Beacon and its credentialing verification organizations (CVO) (individually and collectively as "Beacon Entity") permission and consent to obtain and verify information contained in this application and, as part of this process, to consult with State licensing agencies, accreditation agencies, malpractice insurance carriers, and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain or verify information concerning the Facility's professional competence and qualifications.

The Facility also grant permission and consent for all persons, organizations, or other entity to release to Beacon Entity all information they have in their control that relates to the Facility's competence or ability to render clinical services in a professional, cost effective manner. The Facility releases Beacon Entity and each of their respective employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating the Facility's application.

The Facility further authorizes Beacon Entity (other than CVO) to release to any of their affiliates, any information that is included in this application or obtained during such investigation related to my application, but only to the extent permitted by law and only for the limited purposes of credentialing being undertaken by or on behalf of the receiving Beacon Entity in regard to the Facility's credentialing status before that Beacon Entity. As used herein, the term "Beacon" shall mean, individually and collective, as applicable, Beacon Health Strategies, Beacon Health Options, Inc., and each of their respective subsidiaries and affiliates.

The signatory of this application represents and warrants that it is authorize to bind the Facility to the terms of this application without the requirement of any further action being undertaken. The signatory certifies that the information in this application is true, correct and complete, and that s/he understands and agrees that any information entered in this application, which subsequently is found to be false, may result in the termination of the contract.

_____
Facility Name

_____ Dated (mm/dd/yy):_____/_____/_____
Authorized Signature

_____
Name (Please Print)

_____
Title

beacon health options

FACILITY LOCATIONS AND SERVICES FORM (LSF)

Complete one form per service location (copy as needed)

SERVICE LOCATION:

Site Name:_____

Address Line 1:_____

Address Line 2:_____

City, State, ZIP:_____

Phone Number:_____

Site Medicare Number:_____

Site Medicaid Number:_____

Site NPI Number:_____

BILLING ADDRESS: (Please confer with your Billing Dept.)

Tax ID Number: _____

Payable To: _____

Address Line 1: _____

Address Line 2: _____

City, State, ZIP: _____

This Location is:

Americans with Disabilities Act Compliant ☐ Yes ☐ No

Accessible by Public Transportation ☐ Yes ☐ No

PLEASE COMPLETE BELOW BASED ON THE BEHAVIORAL HEALTH SERVICES OFFERED AT THE SITE.

FACILITY SERVICES	TOTAL # BEDS	CHILD 0-12	ADOL 13-17	ADULT 18-64	GERI 65+	NOTES/ RESTRICTIONS
INPATIENT PSYCHIATRIC						
INPATIENT (ACUTE) DETOXIFICATION						
INPATIENT SUBSTANCE USE REHAB						
INPATIENT DUAL DIAGNOSIS						
INPATIENT EATING DISORDER						
RESIDENTIAL TREATMENT (MH)						
RESIDENTIAL TREATMENT (SUD)						
RESIDENTIAL TREATMENT (DUAL DIAGNOSIS)						
RESIDENTIAL TREATMENT EATING DISORDER						
PARTIAL HOSPITALIZATION (MH)						
PARTIAL HOSPITALIZATION (SUD)						
PARTIAL HOSPITAL (DUAL DIAGNOSIS)						
PARTIAL HOSPITAL EATING DISORDER						
DAY TREATMENT (MH)						
DAY TREATMENT (SUD)						
DAY TREATMENT (DUAL DIAGNOSIS)						
DAY TREATMENT EATING DISORDER						
INTENSIVE OUTPATIENT (MH)						
INTENSIVE OUTPATIENT (SUD)						
INTENSIVE OUTPATIENT (DUAL DIAGNOSIS)						
INTENSIVE OUTPATIENT EATING DISORDER						
AMBULATORY DETOX / OUTPATIENT—MEDICALLY SUPERVISED WITHDRAWAL						
COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM (CPEP)						

SUBSTANCE USE TREATMENT SERVICES	SERVICE: YES/NO	# DAYS PER WEEK	AGE RANGE	NOTES/ RESTRICTIONS
METHADONE MEDICATION AND DISPENSING			TO	
SUBOXONE MEDICATION AND DISPENSING			TO	
VIVITROL (INJECTABLE NALTREXONE)			TO	
PHYSICIAN VISIT IN AN SUD FACILITY			TO	
MEDICATION MONITORING—MAT IN AN SUD FACILITY			TO	
SUB ACUTE DETOX				

SPECIALTY SERVICES	AGE RANGE	NOTES/RESTRICTIONS
23-HOUR OBSERVATION BED	TO	
HALFWAY HOUSE	TO	
HOME HEALTH CARE—PSYCH RN	TO	
HOME HEALTH CARE—AIDE	TO	
CRISIS/EVALUATION IN ER	TO	
CRISIS STABILIZATION	TO	
CRISIS INTERVENTION	TO	
INPATIENT ECT	TO	
MOBILE CRISIS	TO	
TREATMENT GROUP HOME	TO	

OUTPATIENT SERVICES	AGE RANGE	NOTES/RESTRICTIONS
OUTPATIENT CLINIC (MH) (OUTPATIENT FEE SCHEDULE)	TO	
OUTPATIENT CLINIC (SUD)	TO	
OUTPATIENT CLINIC (DUAL DIAGNOSIS)	TO	
EAP—EMPLOYEE ASSISTANCE PROGRAM	TO	
ABA—APPLIED BEHAVIOR ANALYSIS	TO	
TELEHEALTH (MH)	TO	
TELEHEALTH (SUD)	TO	

MISCELLANEOUS SERVICES	AGE RANGE	NOTES/RESTRICTIONS
ASSERTIVE COMMUNITY TREATMENT (ACT)	TO	
CASE MANAGEMENT FOR SERIOUSLY & PERSISTENTLY MENTALLY ILL	TO	
COMMUNITY INTEGRATION COUNSELING	TO	
COMPREHENSIVE MEDICAID CASE MANAGEMENT	TO	
CONTINUING DAY TREATMENT	TO	
MOBILE MENTAL HEALTH CARE	TO	

PEER-DELIVERED SERVICES	TO	
COMMUNITY LIVING SUPPORTS/BASED LIVING SUPPORT	TO	
PDN HOME CARE	TO	
DD SPECIALIZED RESIDENTIAL	TO	
ADULT FOSTER CARE	TO	
NURSING SERVICES/MONITORING	TO	
CARE FOR DD/MI IN 24 HOUR SETTING	TO	
CARE FOR TBI / PHYSICALLY HANDICAPPED 24 HOUR SETTING	TO	
RESPITE, RESIDENTIAL & DAY CAMP	TO	
FISCAL INTERMEDIARY	TO	
HOME AND COMMUNITY BASED SERVICES –NON RESIDENTIAL	TO	
HOME AND COMMUNITY BASED SERVICES - RESIDENTIAL	TO	

MISCELLANEOUS SERVICES	AGE RANGE	NOTES/RESTRICTIONS
PEER MONITORING	TO	
POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS (PBIS)	TO	
STRUCTURED DAY PROGRAM	TO	

OTHER SERVICES	TOTAL # BEDS	CHILD 0-12	ADOL 13-17	ADULT 18-64	GERI 65+	NOTES/RESTRICTIONS

The listing of a service above does not guarantee that the service will be covered under every health plan. To be reimbursed, a service provided to a member must be a covered benefit under the member's health plan and the member must be eligible for coverage on the date of service.

Attestation Statement:
I hereby attest that the location listed above is licensed to render the services indicated herein. I also attest that the information provided in this document is true, accurate and complete to the best of my knowledge as of this date and I understand that falsification, omission, or concealment of material fact may subject me to rejection or termination as a network provider, in addition to any administrative, civil or criminal penalties provided by law. I further agree to inform promptly Beacon Health Options, Inc., Beacon Health Strategies LLC and/or its affiliate(s) of all material changes to the information I have provided.

Name:_____ Title: _____

Signature:_____ Date: _____

Directions:

In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100- 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program or any line of business that provides healthcare for federal employees. The Centers for Medicaid and Medicare Services (CMS) requires Beacon Health Options, Inc. to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal and state health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid.

Please complete the following 2 pages below and fax the completed forms to: **866-612-7795.** This form is required if you wish to participate or continue to participate in the plan. You are also reminded that any changes to this information in the future must be reported to Beacon Health Options, Inc. within 35 business days of the change and updated information will be requested upon recredentialing. Please provide information for Owners, persons with Control interests, Agents and Managing employees of the Provider Entity. Attach a separate sheet/report if needed.

Definitions:

Provider Entity: Any individual or entity engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in that State if such licensure or certification is required by State law or regulation.

Master List: The list of owners the provider will be disclosing on form.
- All owners on the master list, must include their Home Address, SSN, DOB, % of Ownership
- If any owners are a Non-Profit agency please indicate the following:
    - Name of Entity
    - Owner DOB & Owner SSN leave Blank.
    - N/A in the % of Ownership column,
    - Check YES in the Non-Profit column.
    - Business address of Entity

Owner: is a person or business entity which owns 5% or more of the assets, stock or profits of the Provider Entity.
- This 5% may be Direct ownership or Indirect ownership i.e., an individual might own 50% of a company that owns the actual Provider Entity meaning their indirect ownership is 50%.
- In addition to ownership of stock, (2) Owner is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the Provider Entity.

Control Interest is someone who directs the Provider Entity and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership.

Managing Employee is someone who makes the day to day decisions for the Provider Entity. These individuals include office or billing managers for smaller providers, and for larger Provider Entities the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

Debarred or Excluded means an individual or entity that is not allowed to do business with the Federal government, including healthcare programs receiving Federal funding or reimbursement.

Terminated means the Provider lost the right to bill a State's Medicaid or CHIP programs for a cause related to fraud or abuse.

Immediate Family is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. Member of Household is, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Agent is an individual who has the legal ability to bind the Provider Entity, i.e., the Provider Entity may use an Agent to obtain contracts for it.

Subcontractor is a person or company that this Provider Entity has contracted with to do some of the Provider Entities' management functions, i.e., billing agent, or provide medical services i.e. a medical lab.

Supplier means an individual, agency, or organization from which the Provider Entity purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy.)

I. Identifying Information

____
Name of Person Completing Form

____
Phone Number of Person Completing Form

____
Provider's Name

Provider Entity Information:

____
Name of Entity

____
Entity DBA (If Different from Entity Name)

____
Entity Tax ID

____
Entity NPI Number

____
Practice Address Line 1

____
Practice Address Line 2

____
City

____
State

______
ZIP

II. OWNER OR CONTROL INFORMATION *(If more than 4 owners, please submit make copies of this page)*

A. Master List:

Owners must have minimum of 5% ownership to be considered part of the Master List. Totals of Master list must equal 100%, unless the agency is Non-Profit.

OWNER NAME	OWNER DOB	OWNER SSN	% OF OWNERSHIP	Non-Profit
				Yes ☐ No ☐

OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP

OWNER NAME	OWNER DOB	OWNER SSN	% OF OWNERSHIP	Non-Profit
				Yes ☐ No ☐

OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP

OWNER NAME	OWNER DOB	OWNER SSN	% OF OWNERSHIP	Non-Profit
				Yes ☐ No ☐

OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP

OWNER NAME	OWNER DOB	OWNER SSN	% OF OWNERSHIP	Non-Profit
				Yes ☐ No ☐

OWNER'S ADDRESS LINE 1	OWNER'S ADDRESS LINE 2	CITY	STATE	ZIP

B. Specific Questions

1. Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling? If attaching a report, please indicate corresponding columns below.
   Yes ☐ No ☐

NAME OF FIRST RELATED PERSON	NAME OF SECOND RELATED PERSON	TYPE OF RELATIONSHIP

2. Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**? ? If attaching a report, please indicate corresponding columns below.
   Yes ☐ No ☐

NAME OF OTHER PROVIDER ENTITY	ADDRESS	CITY	STATE	ZIP	TAX ID

3. Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Tricare or the CHIP services program since the inception of those programs?
   Yes ☐ No ☐

NAME ON COURT RECORDS	SSN/TIN	MATTER OF OFFENSE	CONVICTION DATE	EXCLUSION PERIOD (IF APPLICABLE)

4. Have any of the individuals or entities on the **Master List** ever been **Debarred or Excluded** from participation in Federal Government contracts (Medicaid, Medicare, CHIP or Tricare)?
   Yes ☐ No ☐

WHEN WERE YOU DEBARRED	LENGTH OF DEBARMENT	REASON FOR DEBARMENT

5. Has any person or entity on the **Master List** ever been **Terminated or had Civil Monetary Penalties** from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)?
Yes ☐ No ☐

PRACTICING STATE WHEN TERMINATED	REASON FOR TERMINATION	DATE OF TERMINATION

6. Did anyone on the **Master List** obtain their **Direct or Indirect Ownership** interest 1) as a result of a transfer of Direct or Indirect ownership from someone who was about to be Excluded or Terminated from participation in a Federal healthcare program, or was in fact Excluded or terminated from participation in a federal healthcare program and 2) where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of** the current owner's household, at the time of the transfer of ownership? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐

NAME OF ORIGINAL OWNER	SSN OR TAX ID OF ORIGINAL OWNER	PLACE OF TRANSFER	DATE OF TRANSFER

7. Do you have any **Subcontractor** in which this **Provider Entity** has a Direct or Indirect **Ownership** interest of at least a 5%?
(A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** management functions, i.e., billing agent, or provide medical services i.e. a medical lab) If attaching a report, please indicate corresponding columns below
Yes ☐ No ☐

NAME OF SUBCONTRACTOR	ADDRESS	CITY	STATE	ZIP	TAX ID

8. For each **Subcontractor(s)** listed in question 7 above please provide the following information for the individuals with Direct or Indirect **Ownership** or **Control Interest** in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary. If attaching a report, please indicate corresponding columns below.

NAME	ADDRESS	CITY	STATE	ZIP	TAX ID	% OF OWNERSHIP	TITLE

9. Is any persons from question 7, in the list above related to any person in the **Master List**? If attaching a report, please indicate corresponding columns below.

NAME OF FIRST RELATED PERSON	NAME OF SECOND RELATED PERSON	TYPE OF RELATIONSHIP

III. BUSINESS TRANSACTIONS

1. Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Provider Entities'** total operating expenses *or* $25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.7a. in which you have an **Direct or Indirect Ownership interest**. If attaching a report, please indicate corresponding columns below.

NAME	ADDRESS	CITY	STATE	ZIP

2. Does the **Provider Entity** *wholly own* a **Supplier**? If attaching a report, please indicate corresponding columns below.
Yes ☐ No ☐ If yes, supply the following information about the **Supplier:**

NAME	ADDRESS	CITY	STATE	ZIP	NPI	TAX ID

Answer the following questions by checking '"Yes" or "No'. If any of the questions are answered "Yes," list names and addresses of individuals or corporations and/or provide date and an explanation on a separate sheet of paper:

1. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVRN providers only) Yes ☐ No ☐
2. Has there been a change in ownership or control within the last year? Yes ☐ No ☐
3. Do you anticipate any change of ownership or control within the year? Yes ☐ No ☐
4. Do you anticipate filing for bankruptcy within the year? Yes ☐ No ☐
5. Is this facility, agency, institution or organization operated by a management company, or leased in whole or part by another organization? Yes ☐ No ☐
6. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? Yes ☐ No ☐
7. Is this facility, agency, institution or organization chain affiliated? (If yes, list name, address of Corporation, and EIN) Yes ☐ No ☐
8. If the answer to Question 7 is No, was the facility, agency, institution or organization ever affiliated with a chain? Yes ☐ No ☐
9. (For Facilities Only) Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? Yes ☐ No ☐

IV. Signature

Beacon Health Options, Inc. may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below MUST be the written signature of an individual who can legally bind this Provider Entity;

_____ Name of Entity Owner

_____ Signature of Entity Owner

_____ Title

_____ Date

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

Satisfaction Survey Results FY20

MI, SUD, DD, FS, AND BTRC SERVICES

PRESENTED BY AMBER VONDRA

Survey Tool: LRE Standard 10 Question Survey

Standardized Lakeshore Regional Satisfaction Survey was used

Measures these 3 areas:

- Access/Availability
- Quality measures
- Outcome measures

LRE put together a workgroup in 2020 to update this satisfaction survey

- New survey will be used for 2021
- Includes HSAG requirements

COMMUNITY MENTAL HEALTH OTTAWA COUNTY

Survey Process

How was the data collected:

- All data was collected during a random, 2-week period during the year
- For MI, DD, BTRC, and Family Services:
  - Paper versions of the satisfaction survey were mailed out with an enclosed return envelope
- For SUD Services:
  - Program Evaluator created an online version of the satisfaction survey using Qualtrics.
  - BOTH online version and paper version were given to SUD providers
  - SUD Providers emailed the survey link to consumers being seen virtually
    - Online survey was only active during the random, 2-week time period, with a follow up email sent one week into survey
  - SUD Providers gave a copy of paper survey to consumers seen in person while they were in waiting room
  - Completed surveys collected day after the end of random, 2-week time period

COMMUNITY MENTAL HEALTH
OTTAWA COUNTY

Survey Response Totals

Results:

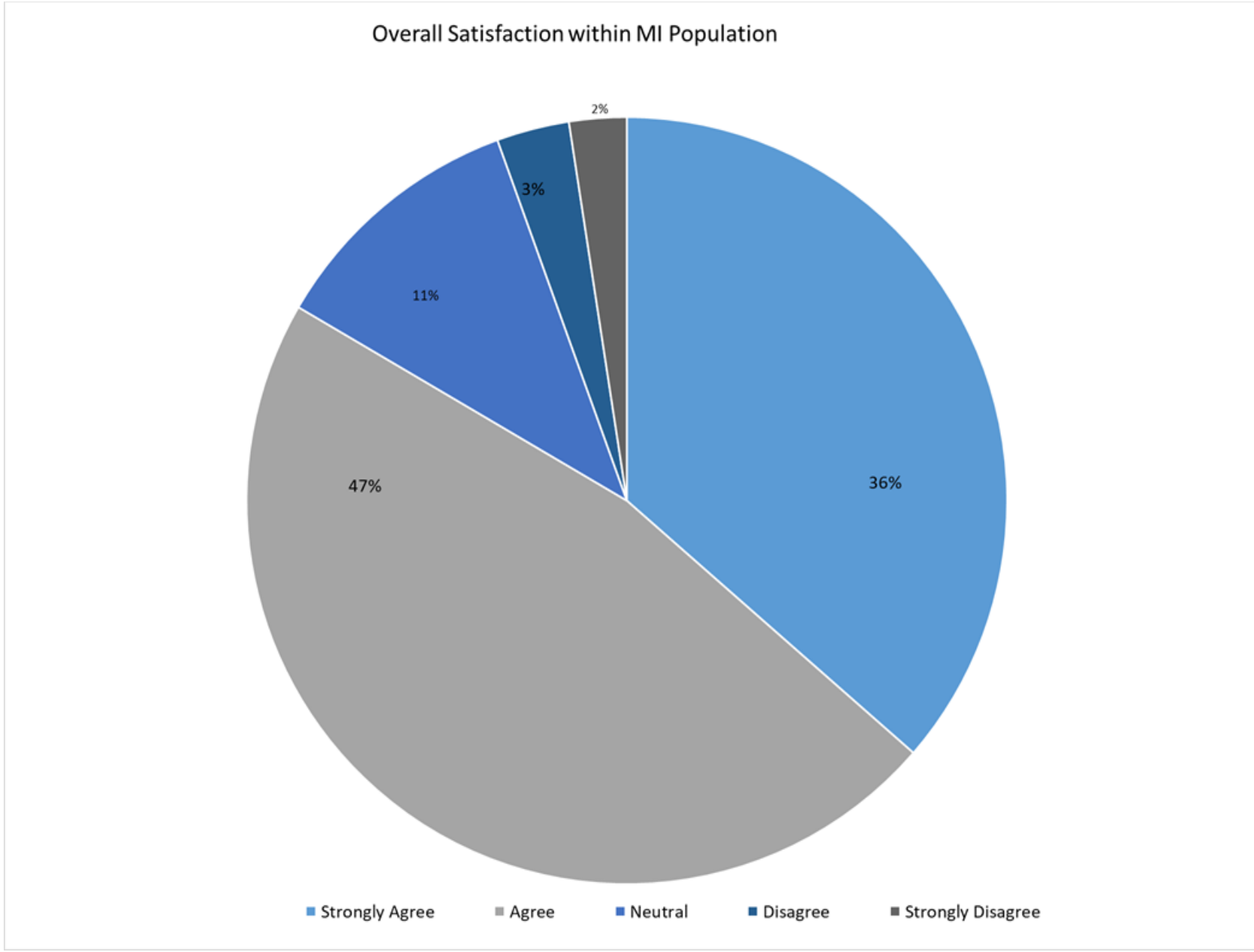
- MI = 128 (21%) based on total served
- SUD = 100 (14%) based on total served
- DD = 179 (35%) based on total served
- FS = 47 (10%) based on total served
- BTRC = 23 (56%) based on total served

COMMUNITY MENTAL HEALTH OTTAWA COUNTY

Data summary: MI Overall Satisfaction

MI – Adult Population

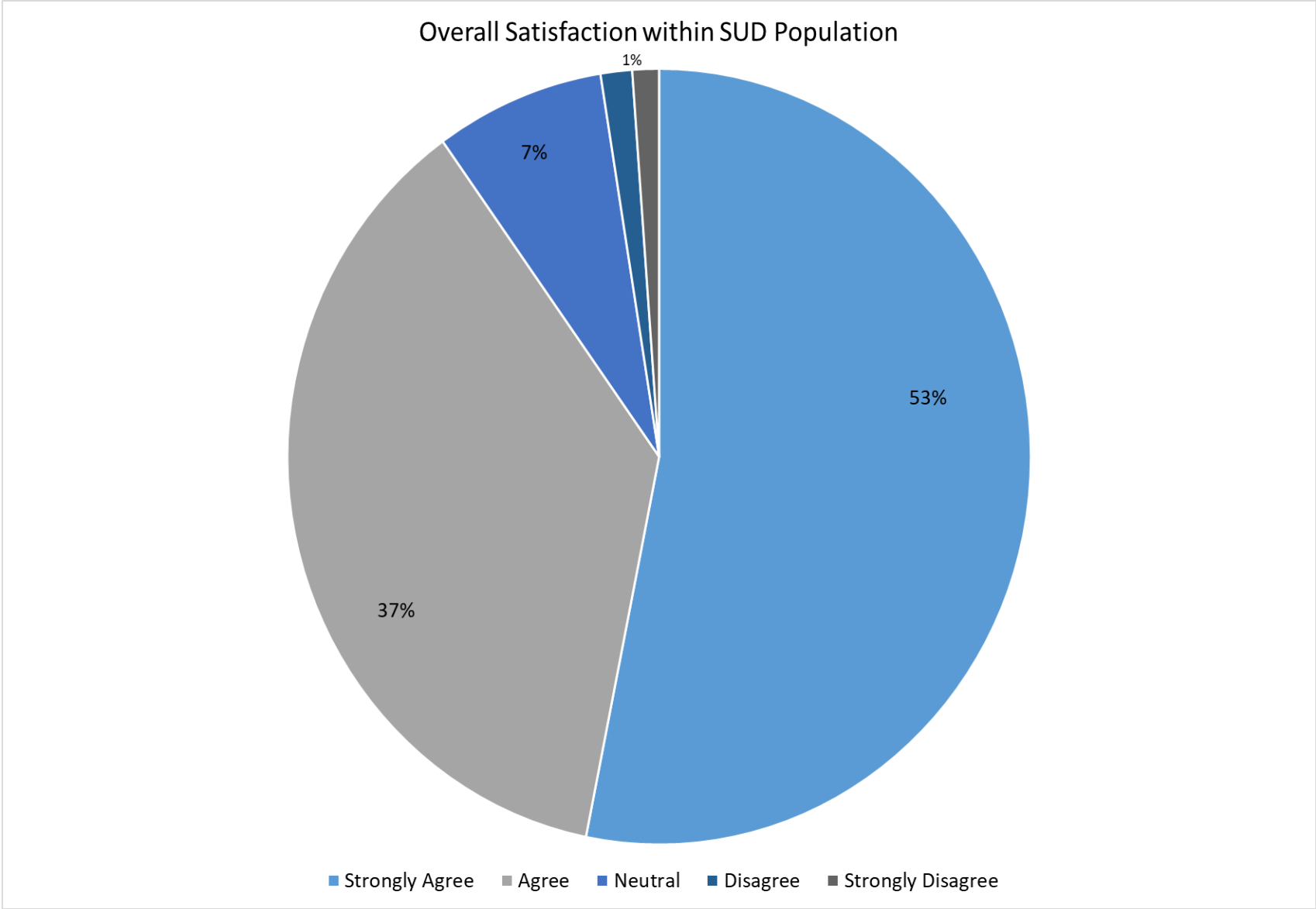
- Overall Satisfaction Score: 4.12/5
- 83% Strongly Agree/Agree
- 11 % Neutral
- 2% Strongly Disagree, 3% Disagree



Data summary: SUD Overall Satisfaction

SUD Population

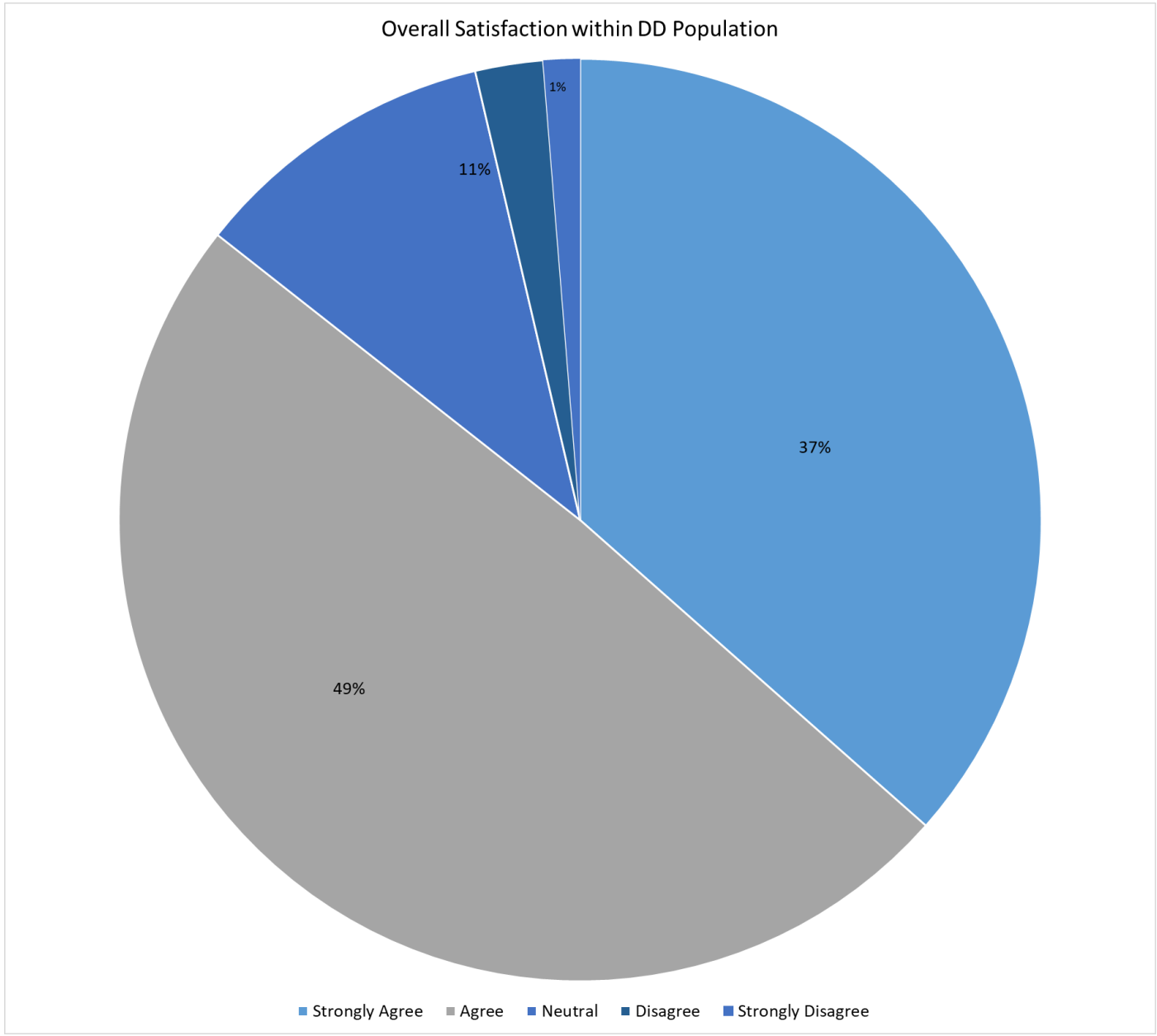
- Overall Satisfaction Score: 4.4/5
- 90% Strongly Agree/Agree
- 7% Neutral
- 2% Strongly Disagree/Disagree



Data summary: DD Overall Satisfaction

DD - Population

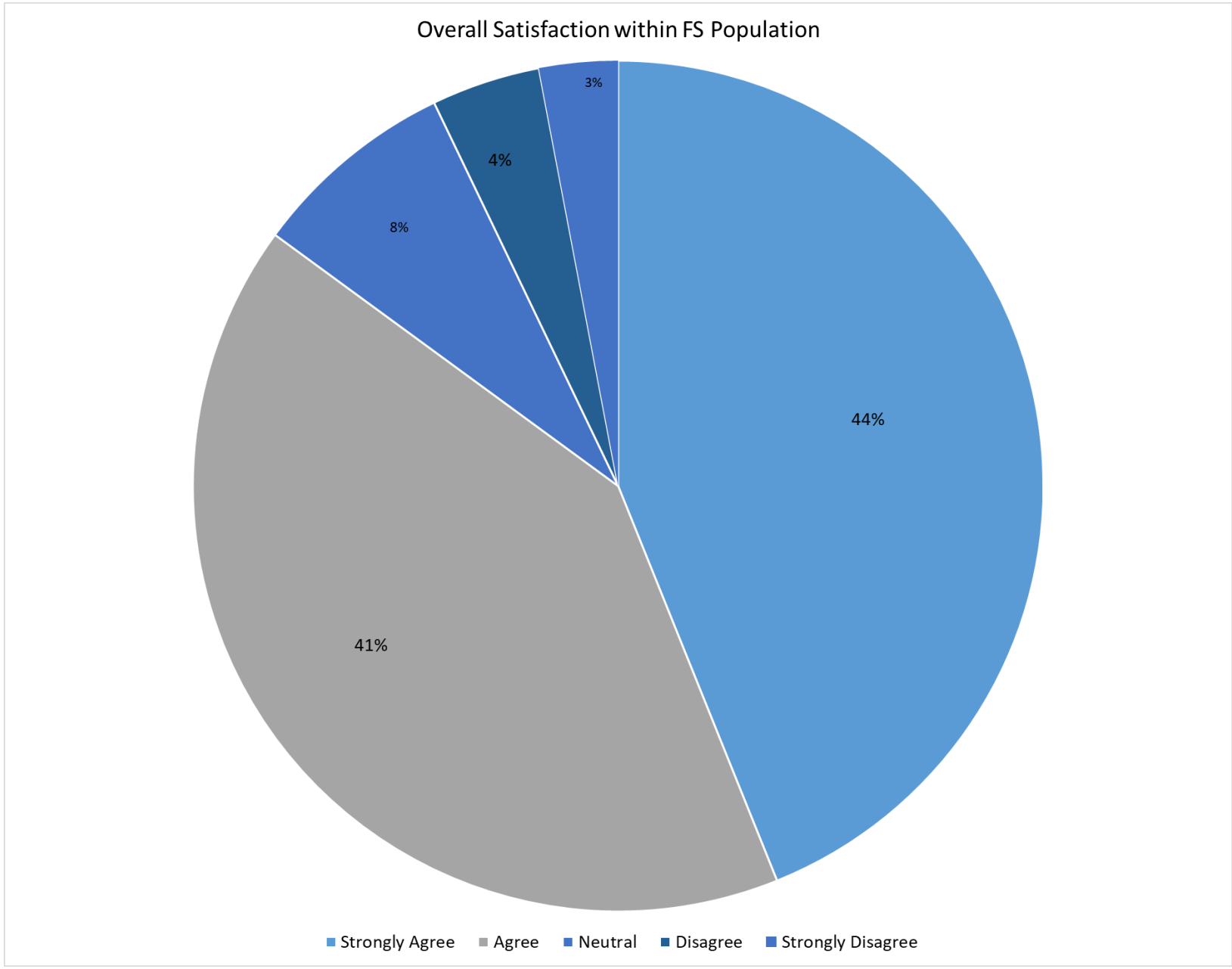
- Overall Satisfaction Score: 4.17/5
- 86 % Strongly Agree/Agree
- 11 % Neutral
- 1% Strongly Disagree, 2% Disagree



Data summary: FS Overall Satisfaction

Family Services Population

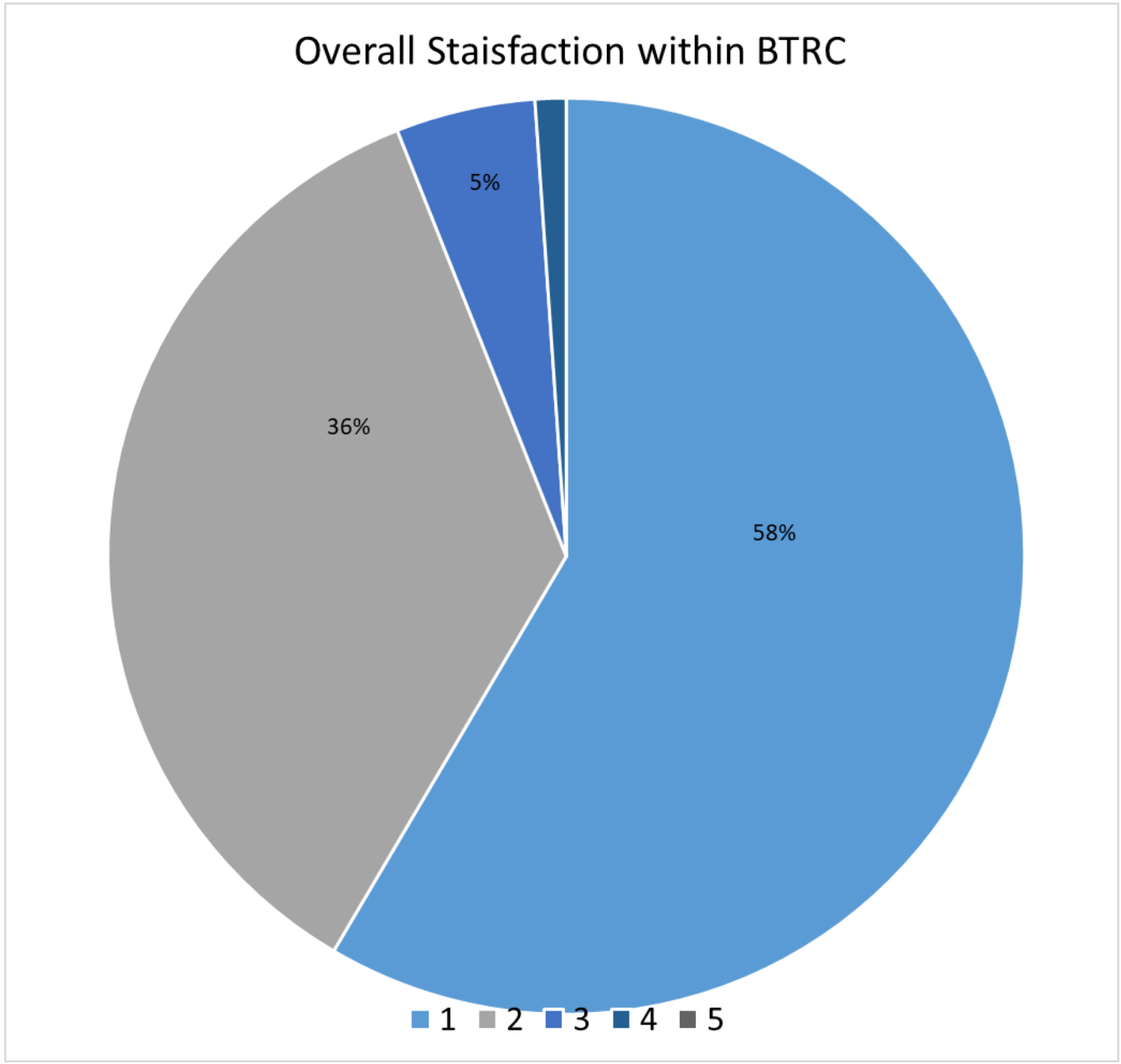
- Overall Satisfaction Score: 4.19/5
- 85% Strongly Agree/Agree
- 8% Neutral
- 4% Disagree, 3% Strongly Disagree



Data summary: BTRC Overall Satisfaction

BTRC Population

- Overall Satisfaction Score: 4.5/5
- 94 % Strongly Agree/Agree
- 5 % Neutral
- 0% Strongly Disagree, 1% Disagree



CHMOC Performance Improvement Plan (PI Plan/QAPIP 2020-2021)

By:

Rich Francisco & Amber Vondra

PI Plan Contents

Purpose

To solve performance issues and/or recognize opportunities for enhancement in performance at the organizational, system, process, and employee levels in order to achieve desired organizational results of high quality, sustainable behavioral health services that increase positive outcomes for consumers.

The function of the Performance Improvement Plan is to perfect the quality of services provided and performance of the agency using performance and quality improvement.

PI Plan Contents

Plan Requirements : (Some Examples)

MMBPIS : Meet the minimum performance standards as set by the Michigan Department of Health and Human Services (MDHHS). Failure to meet the standard for two consecutive quarters will result in an initiation of a performance improvement project.

Develop internal standards for performance when these standards are not set by MDHHS, CARF, the Lakeshore Regional Entity, and/or federal standards.

PI Plan Contents

ASPIRE methodology and the cycle of continuous quality improvement (CQI). (As recommended by CARF)

- **A**ssess the environment
- **S**et strategy
- **P**ersons served (provides input into design and delivery of quality services)
- **I**mplement the plan
- **R**eview Results
- **E**ffect change

NOTE: CMHOC is also working with Ottawa County to add more tools like LEAN to identify opportunities for Innovation.

PI Plan Contents

KATA Framework for Continuous Improvement

- KATA is a Japanese word that describes habit/form/routine. In the context of quality improvement, CMHOC practices the 4 steps of Improvement KATA to derive positive outcomes and achieve goals and desired benchmarks.
- Uses a scientific approach to quality improvement and continuous improvement (through experimentation and testing).
- KATA is a tool to implement LEAN principles: https://quality-one.com/lean/#What
- The KATA process does not jump to conclusions but allows for a process to discover solutions in the testing or experimentation (PDCA – Plan, Do, Check, Act) phase.

PI Plan Contents

Involvement of Persons Served:

CMHOC will assure that persons served will be offered input and involvement into the performance improvement via:

- Primary consumers of mental health services serve on the CMH Board.
- CMHOC consumers serve as full members on the Consumer Advisory Committee.
- Satisfaction Surveys : Various surveys are completed throughout the year for different populations we serve.

PI Plan Contents

QI Standing Committees

Utilization Management (UM)

Health Information Management (HIM)

Behavior Treatment Review Committee (BTRC)

Compliance

Health and Safety

Recipient Rights (RR)

Information Technology (IT)

Pharmacy and Therapeutics Medication (P/T Medication)

HR/Credentialing (Training)

Consumer Advisory Council (CAC)

Clinical Case Review – MI

IPLT- Family Services

IPLT – MI Adult Services

IPLT – DD Services

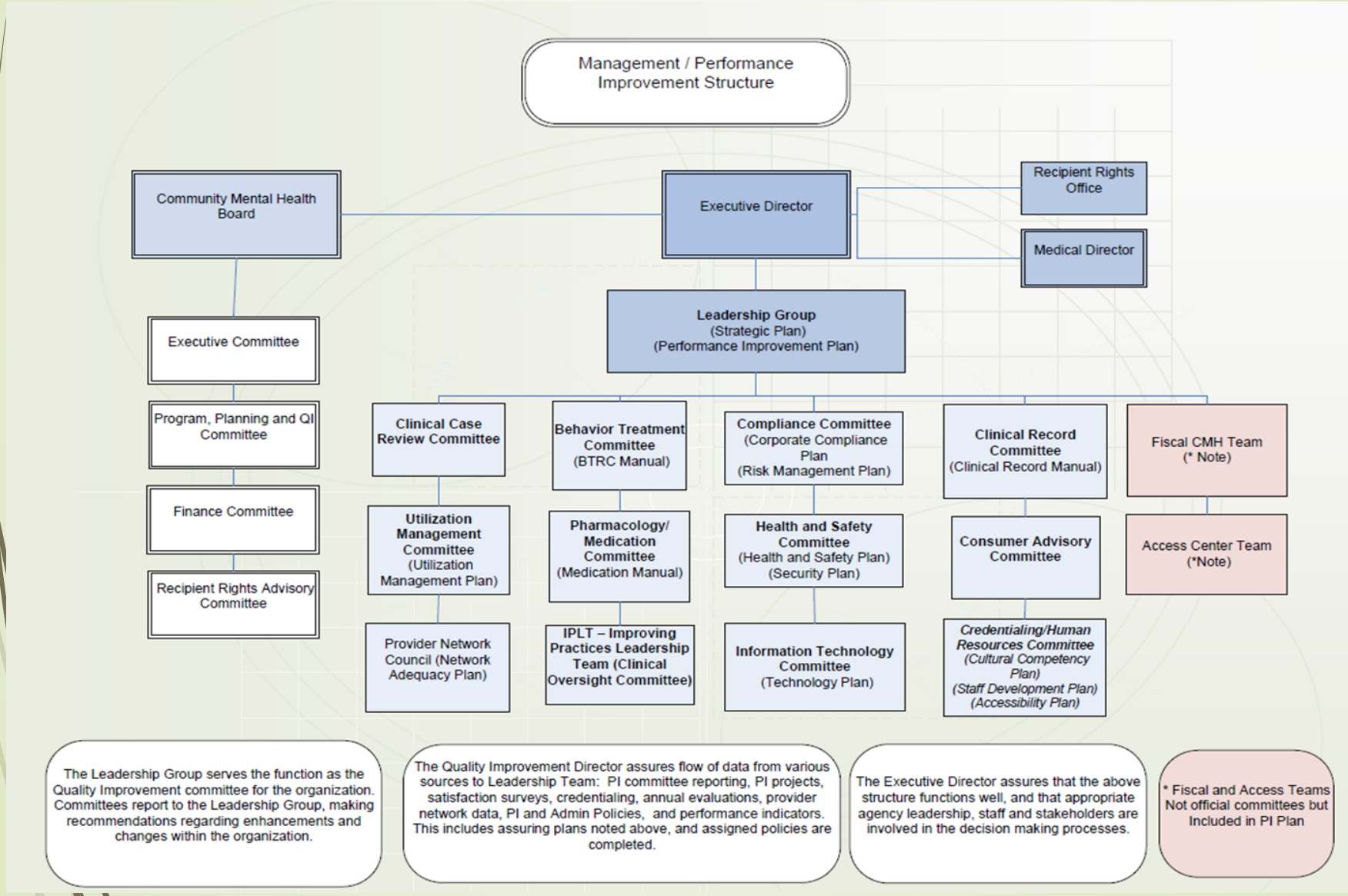
Agency

Provider Network Council (PNC)

Fiscal Services

Access

PI Plan Contents



PI Plan Contents

QI Standing Committee and Organizational Goals.

- Committee Chairs provide the QI team with updates on committee goals. The committee chairs will also provide updates on these goals annually in December 2020/January 2021 for a status update.
  - **Per our last update meeting, 7 new goals were added for all committees**
- COVID-19 have impacted our typical service-delivery model and have driven many of this year's goals.
  - Switching to telehealth
  - Enhancing our safe work practices for clients and staff
  - Continuation of many PI goals from previous year
- Some of the goals for the coming year are also driven by our affiliation with the LRE and the changes in MDHHS and their contract requirements; some of which are on the horizon.
  - New Data Requirements
  - EVV
  - State Parity Projects
  - ANSA Standardization
  - PIP Projects
  - HSAG Audits
  - MCO Alignment

Some Goals/Projects for 2020-2021

Some of the goals identified for this year-out of 35 news goals and projects identified by QI committees.

- **CRC(Clinical Records Committee)** – Goal to improve our quality records management standard through conducting a more thorough quality review process ensuring information collected is used to improve the quality of services through performance improvement activities.
- **Access Center** – Michigan No-Show Learning Collaborative to decrease no-show rates. This is done by using the scientific method to see if emailing appointment information impacts tele-health show rates.
- **Agency/CRC**—Work with Ottawa County to implement KATA and gain a new tool for continuous improvement. Trainings are ongoing, and KATA remains at CMHOC. Goal of acculturation rate to be 60% by December 31st, 2020. Currently at 57% acculturated.
- **Health and Safety** – Active Shooter Training was completed for all staff. Goal is to have a live drill.
- **BTRC**—Attend Regional BTRC Oversight meetings and help specify Health and Safety definitions; specifically physician prescribed medical devices that are not used for behavioral reasons.
- **HR/Credentialing Committee**—Completed New Employee Orientation; Working on customizing in-person trainings in MyLearningPointe to also be available online.
- **P/T Medication Committee**—Evaluate prescribing practice and consulted with CMHOC Medical director on Clozapine use. Develop guidelines.
- **Family Services**—Received SAMHSA & MDHHS Grants to improve Mobile Crisis Teams.
- **UM**—Continually working on adding efficiencies to existing reports as needed, and have added SUD report data to UM Committee review; Transitioning to Tableau to improve reporting; have added UM Data Technician to the team, are transitioning them to the UM Chair within the year.
- Ongoing KATA acculturation project and KATA as the primary tool for Continuous improvement.

Note: Not all of these goals are indicative of all the work that was done.