Meeting Agenda

CMHOC Board of Directors

Board Room – 12220 Fillmore Street, West Olive, MI

Friday, April 26, 2024 9:00 am

Join Zoom Meeting

Dial: 1 (646) 876-9923 Meeting ID: 876 9491 2747 Passcode: 007978

ANNUAL ORGANIZATIONAL MEETING

1. Call to Order – Donna Bunce, Nominating Committee Chair

2. Nomination and Election of Officers – Donna Bunce, Committee Chair
   Suggestion Motion: To elect the CMHOC Board Chair as recommended by the Nominating Committee

   Suggestion Motion: To elect the CMHOC Board Vice-Chair as recommended by the Nominating Committee

   Suggestion Motion: To elect the CMHOC Board Secretary as recommended by the Nominating Committee

3. Adjournment –Chair

REGULAR MONTHLY MEETING

1. Call to Order – Chair

2. Invocation

3. CMHOC Mission and Vision Statements
   Mission Statement: *Community Mental Health of Ottawa County partners with people with mental illness, intellectual/developmental disabilities and substance use disorders and the broader community to improve lives and be a premier mental health agency in Michigan.*

   Vision: *Community Mental Health of Ottawa County strives to enhance quality-of-life for all residents.*

4. Public Comment

5. Consent Items
   Suggested Motion: To approve by consent the following items:
   a. Agenda for the April 26, 2024, CMHOC Board of Directors Meeting
   b. Minutes for the March 22, 2024, CMHOC Board of Directors Meeting

6. Old Business

7. New Business
   April 2024 Service Contracts *(Attachment A)* – Bill Phelps
   Suggested Motion: To approve the April 2024 service contracts as presented.

   FY2024 March Financial Statement *(Attachment B)* – Amy Bodbyl-Mast
   Suggested Motion: To approve the FY2024 March Financial Statement as presented.

   Amendment #1 to the FY24 Grant Agreement Between Michigan Department of Health and Human Services (MDHHS) and Community Mental Health of Ottawa County *(Attachment C)*
   Suggested Motion: To authorize the Deputy Director to sign Amendment #1 to the FY24 Grant Agreement Between Michigan Department of Health and Human Services (MDHHS) and Community Mental Health of Ottawa County

   Discussion: Executive Director Recruitment and Human Resources – Gretchen Cosby

8. Executive (Deputy) Director's Report

9. General Information, Comments and Meetings Attended

10. Public Comment

11. Adjourn

Meeting Minutes

CMHOC Board of Directors

Board Room – 12220 Fillmore Street, West Olive, MI

Friday, March 22, 2024

Immediately following Recipient Rights Advisory Committee

In attendance: Donna Bunce, Gretchen Cosby (10:02 am), Christian Kleinjans, Lucy Ebel, David Parnin, Sylvia Rhodea, Stephen Rockman, Terry Goldberg, Vonnie VanderZwaag, Kendra Wenzel

Absent: Steven Savage

CALL TO ORDER

Vonnie VanderZwaag, CMHOC Board Vice-Chair, called the March 22, 2024, CMHOC Board meeting to order at 10:42 a.m.

INVOCATION

Ms. Cosby provided the invocation.

CMHOC MISSION AND VISION STATEMENTS

Ms. VanderZwaag noted the CMHOC Mission and Vision Statements

PUBLIC COMMENT

Rosalie Austin – Holland City

Denise Newhouse

Barbara Lee VanHorssen – Grand Haven City

CONSENT ITEMS

CMH 24-017 Motion: To approve by consent the following items:

a. Agenda for the March 22, 2024, CMHOC Board of Directors Meeting
b. Minutes for the February 23, 2024, CMHOC Board of Directors Meeting

Moved by: Cosby Support: Rhodea

MOTION CARRIED

PRESENTATION

Stakeholder Survey Results – Anna Bednarek

The survey, required by MDHHS every two years to assess mental health needs in the community, was completed in early February. MDHHS determines which stakeholders receive the survey. A total of 105 surveys were submitted, with 85 surveys being completed. Based on responses received, CMHOC is required to identify five priority areas. Access to Services was the highest priority gap identified in survey responses followed by housing, mental health, community resources, and staffing. A response will be submitted to the state identifying the top five priorities and planned actions to address these gaps.

OLD BUSINESS

No Old Business

NEW BUSINESS

March 2024 Service Contracts– Bill Phelps

Mr. Phelps reviewed details of the March contracts presented for Board approval.

CMH 24-018 Motion: To approve the March 2024 service contracts in groups, considering ABA contracts together, grant-funded contracts together, Flatrock Manor individually, and the remaining contracts together.
Moved by: Rhodea Support: Cosby
MOTION CARRIED

CMH 24-019 Motion: To approve the contracts with Arts in Motion, MOKA and Robynn Gobbel
Moved by: Rhodea Support: Cosby
MOTION CARRIED

CMH 24-020 Motion: To approve the amended contract with Flatrock manor adding the Flint Township South home for a 90-day probationary period.
Moved by: Rhodea Support: Goldberg
MOTION CARRIED

CMH 24-021 Motion: To approve the contracts with Professional Rehabilitation Services, Inc DBA Rebound Home and Community Therapy; Hope Discovery ABA Services, LLC; Therapy Research Autism Center (TRAC), Inc.; and Positive Behavior Supports Corporation
Moved by: Cosby Support: Goldberg
MOTION CARRIED

CMH 24-220 Motion: To approve the contracts with Gabriela Croese, Preferred Employment and Living Supports, Bethesda Farms, Home Safe Home, Protocall, and Streamline Verify
Moved by: Rhodea Support: Goldberg
MOTION CARRIED

FY2024 February Financial Statement – Amy Bodbyl-Mast

MH/SUD Fund continue to be in a healthy position. That state will adjust rates in April and the budget will be adjusted accordingly. No concerns with millage and grant funds were noted.

CMH 24-023 Motion: To approve the FY2024 February Financial Statement as presented.
Moved by: Rockman Support: Goldberg
MOTION CARRIED

FY2024 CMHOC Recipient Rights Operating Budget

CMH 24-024 Motion: To approve the FY24 CMHOC Recipient Rights budget as presented to assure sufficient funding, and to assure the Recipient Rights Office does not have pressures which could interfere with the impartial, even-handed, and thorough performance of its duties.
Moved by: Parnin Support: Goldberg
MOTION CARRIED

EXECUTIVE (DEPUTY) DIRECTOR'S REPORT

MDHHS - Electronic Visit Verification (EVV) implementation for mental health services goes live September 1. Information ensures consumers are receiving care as expected. Training will be provided.

Lakeshore Regional Entity – Current Medicaid rates are under review due to a higher-than-expected number of individuals being disenrolled as a result of the Public Health Emergency Unwind.

CMHOC

- Partners Advancing Self Determination Group presented at a recent conference in Baltimore. The presenters included 3 parents of adults with Intellectual/Developmental Disabilities who receive CMH services and the CMH Self-Determination, Respite Coordinator, the Arc and Developmental Disabilities Institute.
- Working with Human Resources to bring a CMH IT Business Analyst position to the Board of Commissioners for approval.
- The Millage Steering Committee continues to meet regularly. Current members of the Committee consist of CMH Staff, Board members, and community stakeholders.

GENERAL INFORMATION, COMMENTS AND MEETINGS ATTENDED

Appointment of Nominating Committee – Vonnie VanderZwaag

Ms. VanderZwaag appointed Donna Bunce and Chris Kleinjans to serve as the Nominating Committee, with Ms. Bunce serving as Chair of that Committee.

PUBLIC COMMENT

Rosalie Austin – City of Holland

ADJOURN

CMH 24-025 Motion: To adjourn the March 22, 2024, CMHOC Board of Directors meeting.
Moved by: Goldberg Support: Parnin
MOTION CARRIED

Ms. VanderZwaag adjourned the March 22, 2024, CMHOC Board of Directors meeting at 12:48 p.m.

Board Chair

Secretary

ATTACHMENT A

Community Mental Health of Ottawa County
Board Summary
April 26, 2024

Count	Contract Agency	Contract Type	Service	Purpose	Contract Period Start	Contract Period End	Financial Category	Primary Funding Source	Contract Amount Included in Budget
1	Grayson Enterprise, LLC	Amendment	Community Living Supports and Personal Care	Provision of an enhanced rate for one consumer placed in the home.	4/15/2024	9/30/2025	$50,001 - $250,000	LRE (Medicaid)	Yes
2	Georgetown Harmony Homes, Inc. DBA Harmony Communities	New	Health and Wellness Opportunities for I/DD adults	Increase health and wellness opportunities for adults with I/DD such as exercise classes at Holland Aquatic Center, Art Classes and Music Therapy	5/1/2024	9/30/2024	$3,200.00	Grant: Michigan Health Endowment Fund	Yes
3	Brightside Living	New	Community Living Supports and Personal Care	Personal Care/Community Living Supports (PC/CLS) licensed provider of 2 homes within Kent County. Provider serves adults with Intellectual/Developmental Disability and Mental Illness.	5/1/2024	9/30/2025	$50,000 - $250,000	LRE (Medicaid)	Yes
4	The Arc Muskegon	Renewal	Independent Facilitation	Contract renewal with ARC Muskegon to provide Independent Facilitation Services when requested	4/1/2024	12/31/2024	$0 - $50,000	LRE (Medicaid)	Yes
5	Big Heart 2 AFC	New	Community Living Supports and Personal Care	Personal Care/Community Living Supports (PC/CLS) licensed provider of a home within ingham County. Provider serves adults with Intellectual/Developmental Disability and Mental Illness.	4/22/2024	9/30/2025	$0 - 50,000	LRE (Medicaid)	Yes

SERVICE CONTRACTS FOR BOARD APPROVAL

Contractor Name:	Grayson Enterprise, LLC
Board Summary Reference Number:	1
Contract Type:	Amendment
Contract Dates:	4/15/2024 – 9/30/2025
Purpose of Contract:	To amend an existing contract with Grayson Enterprise, LLC to provide an enhanced rate for Community Living Supports and Personal Care services for consumers with intellectual/developmental disabilities (I/DD) and mental illness needs in a Specialized Residential Services setting at this Adult Foster Care home.
Agency Overview:	Grayson Enterprise, LLC is a contractual agency currently in good standing with CMHOC. Grayson Enterprise, LLC provides services to consumers with I/DD and mental health needs in a Specialized Residential setting at 1 licensed Adult Foster Care home.
LARA website link:	Statewide Search For Adult Foster Care / Homes for the Aged Facilities
Location of Home:	Zeeland, MI
Agency Website:	N/A
Program Description:	Specialized Residential placements are reimbursed through a combination of two Medicaid-billable services – Personal Care and Community Living Supports. Placement in specialized residential settings are based on the Person-Centered Planning process and the consumer's individual needs.
Reimbursement Process:	Specialized Residential placements are reimbursed at a per diem (daily) rate for Personal Care and Community Living Supports services.
Financial Category:	$50,001 - $250,000
Funding Source(s):	Lakeshore Regional Entity (Medicaid)
Contract Boilerplate:	Common Contract FY24

SERVICE CONTRACTS FOR BOARD APPROVAL

Contractor Name:	Georgetown Harmony Homes, Inc. DBA Harmony Communities
Board Summary Reference Number:	2
Contract Type:	New
Contract Dates:	5/1/2024 – 9/30/2024
Purpose of Contract:	Addition of a new program to Harmony Communities service array for programming to provide additional opportunities for health and wellness activities for consumers with Intellectual/Developmental Disabilities (I/DD).
Agency Overview:	Harmony Communities is a contractual agency currently in good standing with CMHOC. Harmony Communities provides housing opportunities for adults with special needs. The provider has 1 residential home located in Jenison, MI and 3 residential homes located in Hudsonville, MI.
Agency Website:	https://harmonycommunities.org
Program Description:	Through this contract, Harmony Communities will obtain memberships to the Visser Family YMCA located in Grandville, MI. Memberships and staff coordination will allow for participation in activities and classes offered at this YMCA location.
Reimbursement Process:	Lump sum payment with monthly reporting requirements for services provided.
Financial Category:	$0 - $50,000
Funding Source(s):	Michigan Health Endowment Fund Grant
Contract Boilerplate:	Service Agreement (non-Medicaid)

SERVICE CONTRACTS FOR BOARD APPROVAL

Contractor Name:	Brightside Living
Board Summary Reference Number:	3
Contract Type:	New
Contract Dates:	5/1/2024 – 9/30/2025
Purpose of Contract:	Enter contract with Brightside Living to have ability to utilize two homes within the organization.
Agency Overview:	Brightside Living is a former contract agency with CMHOC. Contract was ended in October 2023 due to no CMHOC consumers residing in the homes and no forecasted plans to utilize the homes. Brightside Living provides services to consumers with intellectual/developmental disabilities (I/DD) and mental health needs in a Specialized Residential Services setting at both of these Adult Foster Care homes.
LARA website link:	Cedar Springs Home: Statewide Search For Adult Foster Care / Homes for the Aged Facilities Whispering Oaks Home: Statewide Search For Adult Foster Care / Homes for the Aged Facilities
Location of Homes:	Cedar Springs Home: Cedar Springs, MI Whispering Oaks Home: Caledonia, MI
Agency Website:	https://brightside-living.com
Program Description:	Specialized Residential placements are reimbursed through a combination of two Medicaid-billable services – Personal Care and Community Living Supports. Placement in specialized residential settings are based on the Person-Centered Planning process and the consumer's individual needs.
Reimbursement Process:	Specialized Residential placements are reimbursed at a per diem (daily) rate for Personal Care and Community Living Supports services.
Financial Category:	$50,000.00 - $250,000.00
Funding Source(s):	Lakeshore Regional Entity (Medicaid)
Contract Boilerplate:	Common Contract FY24

SERVICE CONTRACTS FOR BOARD APPROVAL

Contractor Name:	The Arc Muskegon
Board Summary Reference Number:	4
Contract Type:	Renewal
Contract Dates:	4/1/2024 – 12/31/2024
Purpose of Contract:	Renewal Contract with ARC Muskegon to provide Independent Facilitation services to consumers and families when requested to assist with the Person-Centered Planning process.
Agency Overview:	The Arc Muskegon provides advocacy, education and support services to people with intellectual and developmental disabilities (I/DD).
Agency Website:	https://arcmuskegon.org
Program Description:	Independent Facilitation was added to the Mental Health Code in 1995 and established the rights for all individuals receiving services to have their Individual Plan of Service (IPOS) developed using the Person-Centered Planning (PCP) process, including the use of Independent Facilitators when requested. Independent Facilitators help individuals and families by providing assistance in coordinating pre-planning and PCP meetings, acting and a facilitator and advocate in PCP meetings and conducting post interviews with families to determine level of satisfaction and to see if additional supports are needed.
Reimbursement Process:	Independent Facilitation services are reimbursed by invoice submitted to CMHOC.
Financial Category:	$0.00 - $50,000.00
Funding Source(s):	Lakeshore Regional Entity (Medicaid)
Contract Boilerplate:	Service Agreement Contract

SERVICE CONTRACTS FOR BOARD APPROVAL

Contractor Name:	Big Heart 2
Board Summary Reference Number:	5
Contract Type:	New
Contract Dates:	4/22/2024 – 9/30/2025
Purpose of Contract:	Enter contract with Big Heart 2 AFC and place one consumer in this home.
Agency Overview:	Big Heart 2 AFC home is a newly licensed home located in East Lansing. Big Heart 2 provides services to consumers with intellectual/developmental disabilities (I/DD) and mental health needs in a Specialized Residential Services setting at this Adult Foster Care home.
LARA website link:	Statewide Search For Adult Foster Care / Homes for the Aged Facilities
Location of Homes:	East Lansing, MI
Agency Website:	none
Program Description:	Specialized Residential placements are reimbursed through a combination of two Medicaid-billable services – Personal Care and Community Living Supports. Placement in specialized residential settings are based on the Person-Centered Planning process and the consumer's individual needs.
Reimbursement Process:	Specialized Residential placements are reimbursed at a per diem (daily) rate for Personal Care and Community Living Supports services.
Financial Category:	$0.00 - $50,000.00
Funding Source(s):	Lakeshore Regional Entity (Medicaid)
Contract Boilerplate:	Common Contract FY24

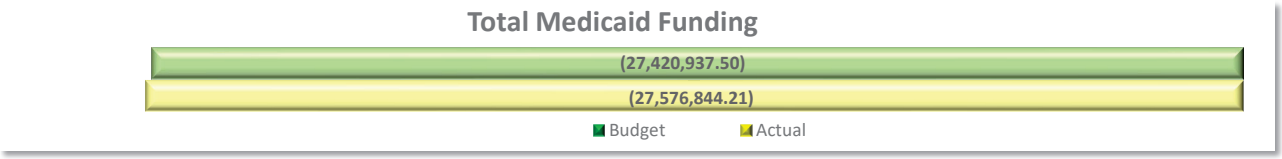
COMMUNITY MENTAL HEALTH OTTAWA COUNTY

Community Mental Health of Ottawa County
Fiscal Year 2024 Statement of Activities
For Period Ending March 31 2024

ATTACHMENT B

222 Mental Health and SUD Fund

		Annual Budget	YTD Budget	YTD Actual	Over/ (Under) Budget
Revenues					
Medicaid		41,031,649.00	20,515,824.50	20,970,879.88	455,055.38
Healthy Michigan		3,810,226.00	1,905,113.00	1,608,474.74	(296,638.26)
Autism		6,000,000.00	3,000,000.00	3,335,699.29	335,699.29
General Fund		3,874,164.00	1,937,082.00	2,160,158.00	223,076.00
COFR		317,300.00	158,650.00	51,745.11	(106,904.89)
Grants		174,337.00	87,168.50	58,439.07	(28,729.43)
Transfers		118,904.00	59,452.00	-	(59,452.00)
Local Funds		462,167.00	231,083.50	231,083.50	-
Other - Revenue		439,697.00	219,848.50	68,953.74	(150,894.76)
	Sub-Total	56,228,444.00	28,114,222.00	28,485,433.33	371,211.33
SUD Medicaid		1,000,000.00	500,000.00	576,967.28	76,967.28
SUD Healthy Michigan		3,000,000.00	1,500,000.00	1,084,823.02	(415,176.98)
SUD Grants		1,692,766.00	846,383.00	594,095.89	(252,287.11)
SUD Other - Revenue		293,378.00	146,689.00	104,208.67	(42,480.33)
	SUD Sub-Total	5,986,144.00	2,993,072.00	2,360,094.86	(632,977.14)
Total Revenue		**62,214,588.00**	**31,107,294.00**	**30,845,528.19**	**(261,765.81)**
Expenses					
Salaries & Benefits		15,896,688.00	7,948,344.00	6,802,757.89	(1,145,586.11)
	General Client Care	31,118,143.00	15,559,071.50	14,504,654.75	(1,054,416.75)
	Psychiatrist	641,507.00	320,753.50	435,443.56	114,690.06
	Respite	325,000.00	162,500.00	149,384.51	(13,115.49)
	Personal Care	4,896,650.00	2,448,325.00	2,793,921.24	345,596.24
	Transportation	12,900.00	6,450.00	5,106.60	(1,343.40)
	Contractual Services	255,703.00	127,851.50	95,088.91	(32,762.59)
Supplies		239,015.00	119,507.50	76,527.17	(42,980.33)
Other		1,432,320.00	716,160.00	609,307.08	(106,852.92)
Administration		1,282,460.00	641,230.00	641,229.12	(0.88)
	Sub-Total	56,100,386.00	28,050,193.00	26,113,420.83	(1,936,772.17)
SUD Salaries & Benefits		1,100,264.00	550,132.00	360,999.51	(189,132.49)
	General Client Care	4,446,933.00	2,223,466.50	2,010,927.88	(212,538.62)
	Room & Board	101,000.00	50,500.00	21,052.17	(29,447.83)
	Transportation	10,000.00	5,000.00	1,039.80	(3,960.20)
SUD Supplies		31,205.00	15,602.50	4,620.31	(10,982.19)
SUD Other		14,521.00	7,260.50	4,049.80	(3,210.70)
SUD Admin		178,524.00	89,262.00	89,261.88	(0.12)
	SUD Sub-Total	5,882,447.00	2,941,223.50	2,491,951.35	(449,272.15)
Total Expenses		**61,982,833.00**	**30,991,416.50**	**28,605,372.18**	**(2,386,044.32)**
Increase (decrease) in net position		**231,755.00**	**115,877.50**	**2,240,156.01**	**2,124,278.51**



Medicaid Revenues Budget to Actual **155,907**

Actual % **46%**
Target % 50%

Date Prepared: 4/18/2024

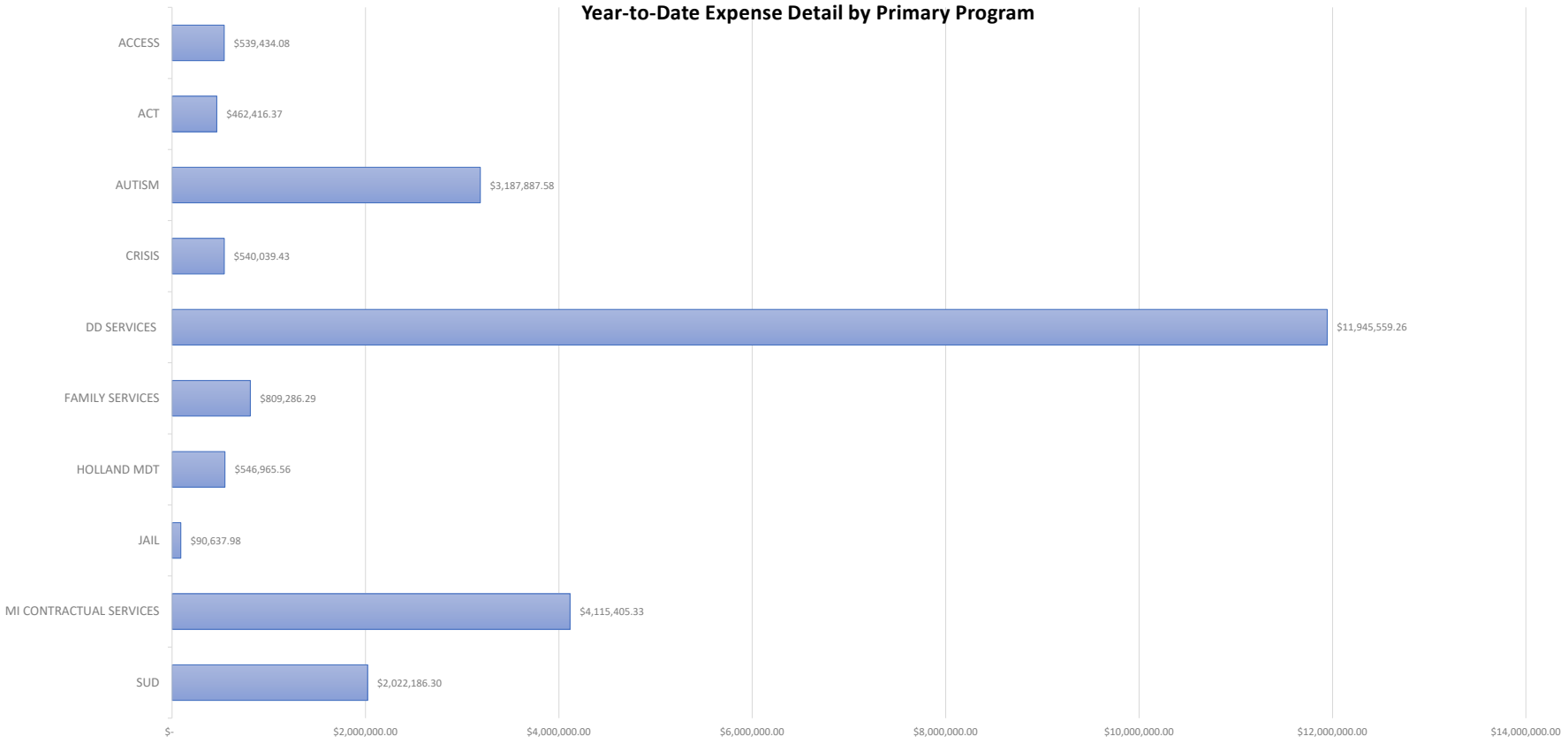
Community Mental Health of Ottawa County
Fiscal Year 2024 Statement of Activities
For Period Ending March 31 2024

223 Millage and Grants Fund

	Annual Budget	YTD Budget	YTD Actual	Over/ (Under)
Revenues				
Property Taxes	$ 4,416,017	$ 2,208,009	$ 4,091,571	$ 1,883,563
Grants	$ 3,392,038	$ 1,696,019	$ 949,268	(746,751)
Transfers	$ 368,904	$ 184,452	$ 250,000	65,548
Other - Revenue	$ 587,448	$ 293,724	$ 1,161	(292,563)
Total Revenue	**8,764,407**	**4,382,204**	**5,292,000**	**909,796**
Millage Expenses				
Autism Services	$ 98,133	$ 49,067	$ 46,323	(2,743)
MI Adult Treatment Services	$ 141,838	$ 70,919	$ 77,811	6,892
DD Treatment Services	$ 2,720,219	$ 1,360,110	$ 2,146,482	786,373
Family Services	$ 172,000	$ 86,000	$ 77,265	(8,735)
Community Services	$ 678,534	$ 339,267	$ 159,683	(179,584)
Sub-Total	3,810,724	1,905,362	2,507,565	602,203
Grant Expenses				
Salaries & Benefits	$ 1,958,499	$ 979,250	$ 893,678	(85,571)
Contractual Services	$ 1,972,603	$ 986,302	$ 568,167	(418,134)
Supplies	$ 127,273	$ 63,637	$ 18,818	(44,818)
Other	$ 259,931	$ 129,966	$ 36,753	(93,213)
Sub-Total	4,318,306	2,159,153	1,517,416	(641,737)
Total Expenses	**8,129,030**	**4,064,515**	**4,024,982**	**(39,533)**
Increase (decrease) in net position	**$ 635,377**	**$ 317,689**	**$ 1,267,018**	**$ 949,330**

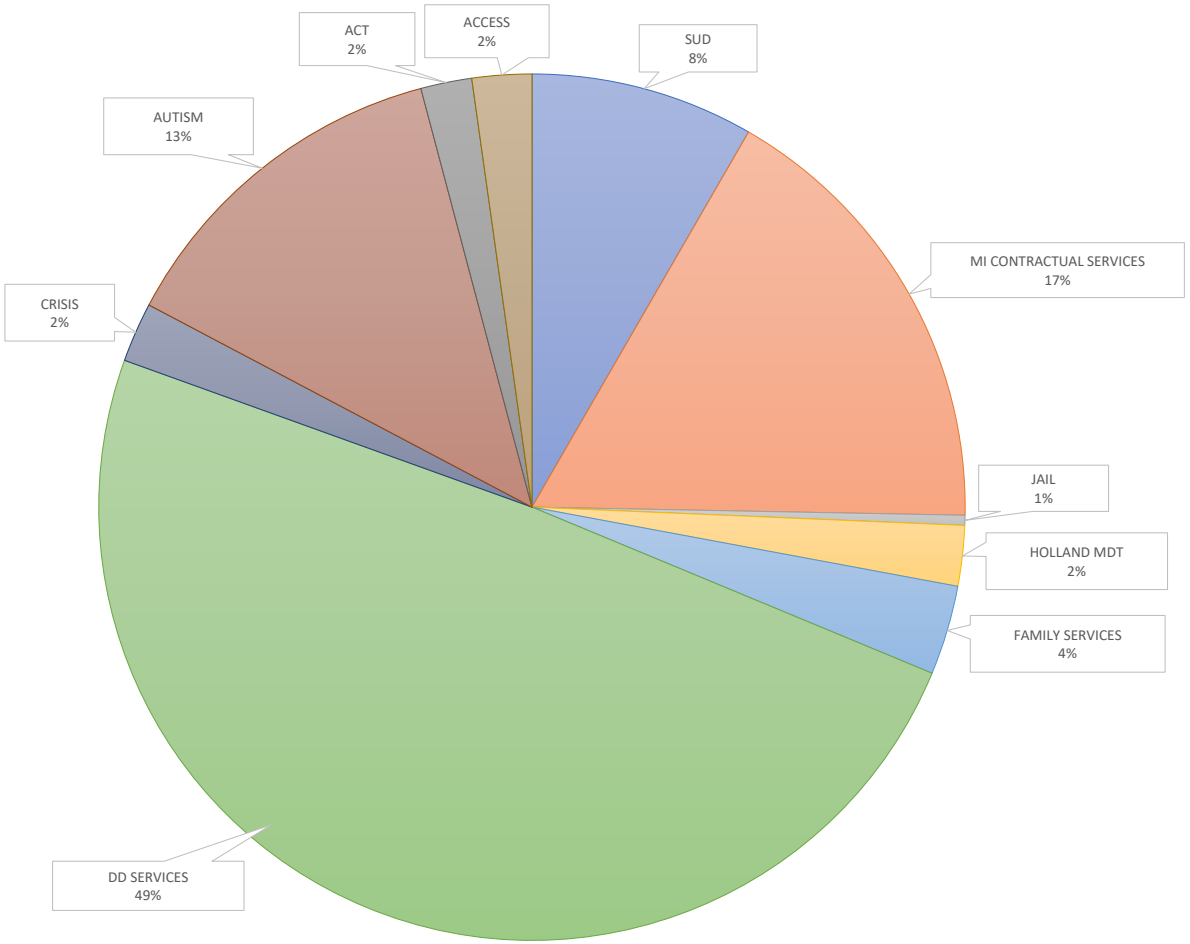
Actual %	**50%**
Target %	50%
Date Prepared:	4/18/2024

Community Mental Health of Ottawa County
Additional FY24 Budget Detail
Reporting October 1 2024 through March 31 2024

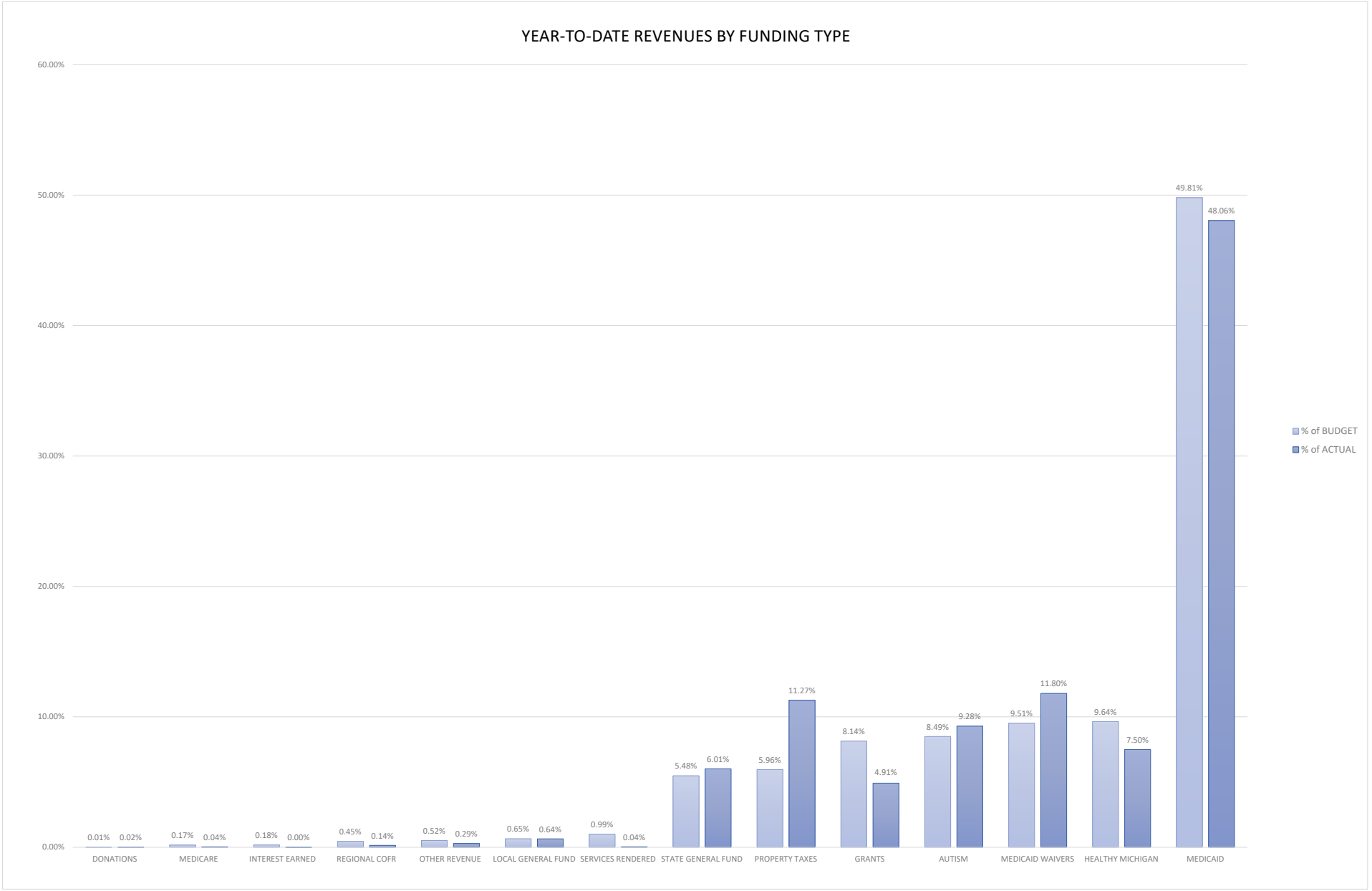


Community Mental Health of Ottawa County
Additional FY24 Budget Detail
Reporting October 1 2023 through March 31 2024

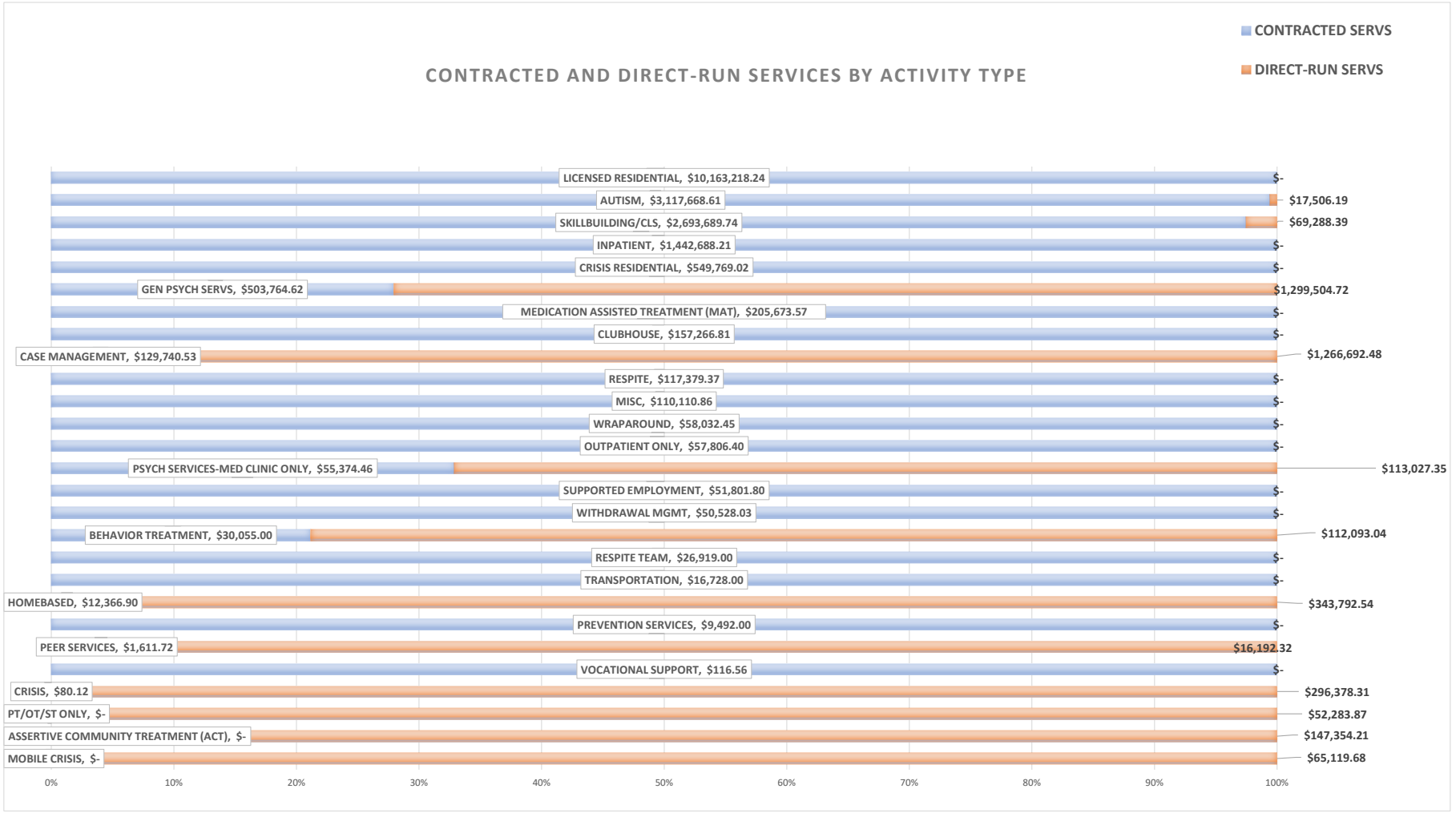
YEAR-TO-DATE EXPENSE SUMMARY BY PRIMARY PROGRAM TYPE



Community Mental Health of Ottawa County
Additional FY24 Budget Detail
Reporting October 1 2023 through March 31 2024



Community Mental Health of Ottawa County
Additional FY24 Budget Detail
Reporting October 1 2023 through March 31 2024



ATTACHMENT C

Contract #:

Amendment No. 1 to the
Agreement Between
the Michigan Department of Health and Human Services
and
CMH of Ottawa County
for
Community Mental Health Services Programs - 2024

1. Period of Agreement

This agreement shall commence on October 1, 2023 and continue through September 30, 2024. This agreement is in full force and effect for the period specified.

2. Program Budget and Agreement Amount

This amendment does not change the total or Department's agreement amount of the original agreement.

The source of funding provided by the Department and approved indirect rate shall be followed as described in Attachment 1, of this agreement, which is part of this agreement through reference.

3. Amendment Purpose

The purpose of the amendment is to modify Attachment C6.5.1.1 CMHSP Reporting Requirements, and Attachment C7.6.1 CMH Compliance Examination Guidelines.

4. Original Amendment Conditions

It is understood and agreed that all other conditions of the original agreement remain the same.

5. Special Certification

The individual or officer signing this amendment certifies by his or her signature that he or she is authorized to sign this amendment on behalf of the responsible governing board, official or contractor.

6. Signature Section

FOR the CMH of Ottawa County

_____

Name Title

FOR the Michigan Department of Health and Human Services

Christine H. Sanches 04/24/2024

_____

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

Modified Documents

CMHSP Reporting Requirements

CMH Compliance Examination Guidelines

MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
REPORTING REQUIREMENTS
Effective 10/1/23
TABLE OF CONTENTS

MDHHS/CMHSP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
REPORTING REQUIREMENTS
Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2024 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are

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

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

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

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

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

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

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

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

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

Due Date	Report Title	Report Frequency	Report Period
1/31/2024	1Q Special Fund Account – Section 226a, PA of the MHC	Quarterly (Use standalone form)	October 1 to December 31
4/01/2024	Special Education to Community Transition Data Tracking Report	Annually	October 1 to September 30 Submit reports to: MDHHS-CPI-Section@michigan.gov
4/30/2024	2Q Special Fund Account – Section 226a, PA of the MHC	Quarterly (Use standalone form)	October 1 to March 31
5/31/2024	Mid-Year Status Report	Mid-Year	October 1 to March 31
6/30/2024	Semi-annual Recipient Rights Data Report	Mid-Year	October 1 to March 31. Section I only. See section "Recipient Rights Data Report" for additional information in this attachment.
8/15/2024	CMHSP FSR Bundle – All Non-Medicaid,	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• State Services Utilization, Reconciliation & Cash Analysis	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Contract Settlement Worksheet	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Reconciliation and Cash Settlement	Projection (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Projection (Use tab in FSR Bundle)	October 1 to September 30
9/15/24	Guardian Reimbursement Distribution Report	Annually	June 30, 2023 to July 1, 2024
10/1/2024	General Fund – Year End Accrual Schedule	Final	October 1 to September 30
FY24 Monthly	PASARR Agreement Monthly Billing	Monthly	Only one (1) bill will be considered for payment per month, and should be submitted for payment to the

			DEPARTMENT within forty-five (45) days after the end of the month in which the service was provided, except for the September bill which shall be submitted within fifteen (15) days after the end of the month.

11/10/2024	CMHSP FSR Bundle – All Non-Medicaid,	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• State Services Utilization, Reconciliation & Cash Analysis	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Contract Settlement Worksheet	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Reconciliation and Cash Settlement	Interim (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Interim (Use tab in FSR Bundle)	October 1 to September 30
11/10/2024	Categorical Funding – Multi-cultural Annual Report	Annually	October 1 to September 30
12/30/2024	Annual Recipient Rights Data Report	Annually	October 1 to September 30. Sections I, II, III & IV. See section "Recipient Rights Data Report" for additional information in this attachment.
1/31/2025	Annual Report on Fraud and Abuse Complaints	Annually	October 1 to September 30
2/28/2025	CMHSP FSR Bundle – All Non-Medicaid	Final (Use tab in FSR Bundle)	October 1 to September 30
	• State Services Utilization, Reconciliation & Cash Analysis	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Final (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Reconciliation and Cash Settlement	Final (Use tab in FSR Bundle)	October 1 to September 30
	• General Fund Contract Settlement Worksheet	Final (Use tab in FSR Bundle)	October 1 to September 30
	• Special Fund Account – Section 226a, PA of the MHC	Final (Use tab in FSR Bundle)	October 1 to September 30
2/28/2025	Sub-Element Cost Report	Annually	See Attachment 6.5.1.1 Submit report to: QMPMeasures@michigan.gov
2/28/2025	Annual Submission Requirement Form – Estimated FTE Equivalents	Annually	For the fiscal year ending September 30, 2024

2/28/2025	Annual Submission Requirement Form – Requests for Services and Disposition of Requests	Annually	For the fiscal year ending September 30, 2024
2/28/2025	Annual Submission Requirement Form – Waiting List	Annually	For the fiscal year ending September 30, 2024
2/28/2025	Annual Submission Requirement Form – Community Needs Assessment	Annually	For the fiscal year ending September 30, 2024
2/28/2025	Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30, 2024
30 days after receipt, but no later than June 30, 2024	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually	October 1 to September 30th Submit reports to: MDHHS-AuditReports@michigan.gov
30 days after receipt, but no later than June 30, 2024	Compliance exam and plan of correction	Annually	October 1 to September 30th Submit reports to: MDHHS-AuditReports@michigan.gov

FY 2024 DATA REPORT DUE DATES

	Nov 23	Dec	Jan 24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec 24	Jan 25
1. Consumer level** Demographic BHTEDS (monthly)[1] b. Encounter (monthly)[1]	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
2.PIHP level a. Medicaid Utilization and Net Cost Report: annually)[2]				√											
b. Performance indicators (quarterly)[2]					√			√			√			√	
c. Consumer Satisfaction (annually) [2]										√					
d. CAFAS and PECFAS [3]													√		
e. Critical incidents (monthly)[3]															

NOTES:

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

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

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

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

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

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

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

A. Basis of Data Reporting

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

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

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

3. Legislative boilerplate annual reporting and semi-annual updates

B. Policies and Requirements Regarding Data

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

Policy:

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

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

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

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

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

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

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

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

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

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

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

Due dates: BH-TEDS data are due monthly. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

Who to report: The PIHP must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and substance use disorders who receive services funded in whole or in part with MDHHS-administered funding. PIHPs participating in the Medicare/Medicaid integration project are not to report BH-TEDS records for beneficiaries for

whom the PIHP's financial responsibility is to a non-contracted provider during the 180-day continuity of care.

PROXY MEASURES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

For FY23, the CMHSPs are required to report a limited set of data items in the Quality Improvement (QI) file for consumers with an intellectual or developmental disability. The required items and instructions are shown below. Detailed file specifications are (will be) available on the MDHHS web site.

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

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

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

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

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

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

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

***** ***Consumer Unique ID*** **(CONID)**
A numeric or alphanumeric code, of 11 characters that enables the consumer and related services to be identified and data to be reliably associated with the consumer across all of the PIHP's services. The identifier should be established at the PIHP level so agency level

or sub-program level services can be aggregated across all program services for the individual. The consumer's unique ID must not be changed once established since it is used to track individuals, and to link to their encounter data over time. **A single shared unique identifier must match the identifier used in 837 encounter for each consumer.**

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

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

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

****Disability Designation***

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

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

Gender (GENDER)
Identify consumer as male or female.
M = Male
F = Female

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

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

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

1 = English language spoken by the individual
2 = Assistive technology used (includes computer, other electronic devices) or symbols such as Bliss board, or other "low tech" communication devices.
3 = Interpreter used - this includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.
4 = Alternative language used - this includes a foreign language, or sign language without an interpreter.
5 = Non-language forms of communication used – gestures, vocalizations or behavior.
6 = No ability to communicate
Blank = Missing

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

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff
1 = Always Understood – Expresses self without difficulty
2 = Usually Understood – Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
3 = Often Understood – Difficulty communicating AND prompting usually required
4 = Sometimes Understood - Ability is limited to making concrete requests or understood only by a very limited number of people
5 = Rarely or Never Understood – Understanding is limited to interpretation of very person-specific sounds or body language
Blank = Missing

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

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

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

1 = Normal – Swallows all types of foods

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

Support with Personal Care (People with developmental disabilities only) **(PERSONAL) 95% completeness and accuracy required.**
Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score a "2" to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

1 = Independent - Able to complete all personal care tasks without physical support
2 = Guidance/Limited Support - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity
3 = Moderate Physical Support - Able to perform personal care tasks with moderate support of another person
4 = Extensive Support - Able to perform personal care tasks with extensive support of another person
5 = Total Support – Requires full support of another person to complete personal care tasks (unable to participate in tasks)
Blank = Missing

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

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

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

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

1 = Care giver status is not at risk
2 = Care giver is likely to reduce current level of help provided
3 = Care giver is likely to cease providing help altogether
4 = Family/friends do not currently provide care
5 = Information unavailable
Blank = Missing

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

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging behaviors" include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

1 = No challenging behaviors, or no support needed
2 = Limited Support, such as support up to once a month
3 = Moderate Support, such as support once a week
4 = Extensive Support, such as support several times a week
5 = Total Support – Intermittent, such as support once or twice a day
6 = Total Support – Continuous, such as full-time support
Blank = Missing

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

Indicate the presence of a behavior plan during the past 12 months.

1 = No Behavior Plan
2 = Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
3 = Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
Blank = Missing

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

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

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

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

This measure identifies major mental illnesses characterized by psychotic symptoms or

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

CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

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

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

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

Data Record

Record Format: rc1041.06									
Element #	**Data Element Name**	**Picture**	**Usage**	**Format**	**From**	**To**	**Validated**	**Required**	**Definition**
1	Submitter ID	Char(4)	4		1	4	Yes	Yes	Service Bureau ID (DEG Mailbox ID)
2	Consumer ID	Char(11)	11		5	15	No	Yes	Unique Consumer ID
3	Medicaid ID	Char(10)	10		16	25	Yes	Conditional	Must present on file if available.

Record Format: rc1041.06									
Element #	**Data Element Name**	**Picture**	**Usage**	**Format**	**From**	**To**	**Validated**	**Required**	**Definition**
4	MIChild ID	Char(10)	10		26	35	Yes	Conditional	MICHILD ID [CIN] Must present on file if available.
5	Begin Date	Date	8	YYYYMMDD	36	43	Yes	Yes	

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

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

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

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

- Encounter data (service use) is to be submitted electronically on a Health Care Claim 5010 as appropriate.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
- Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in

the encounter being rejected by the CHAMPS system.

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

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

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

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

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

****1.a.** ***PIHP Plan Identification Number*** **(PIHPID) or PIHP CA Function ID**
The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transactions.

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

****2**. ***Identification Code/Subscriber Primary Identifier (please see the details in the submitter's manual)***
Ten-digit Medicaid number must be entered for a **Medicaid, or MIChild** beneficiary.

If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.
If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID.**

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

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

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

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

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

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

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

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

****11.*** ***Monetary Amount (effective 10/1/13)***:
Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

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

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

Requirements, then the codes chart)

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

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

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

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

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

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

SUB-ELEMENT COST REPORT

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

Instructions and reporting templates can be found at:

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

CMHSP GENERAL FUND COST REPORT

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

Instructions and reporting templates can be found at:

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

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM
VERSION 6.0
FOR CMHSPS

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

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

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

CMHSP PERFORMANCE INDICATOR SYSTEM

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

ACCESS

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

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

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

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

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

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

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

EFFICIENCY

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

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

OUTCOMES

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

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

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

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

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

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

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

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

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

d. Scope: DD adults only

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

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

CMHSP PERFORMANCE INDICATOR REPORTING DUE DATES

FY 2024 Due Dates

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screening	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
2. 1st request	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
3. 1st service	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
4. Follow-up	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
5. Denials	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
6. 2nd Opinions	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4/01 to 6/30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
7. Admin Costs*	10/01 to 9/30	2/27/24							CMHSPs
8. Competitive employment*	10/01 to 9/30	N/A							MDHHS
9. Minimum wage*	10/01 to 9/30	N/A							MDHHS
10. Readmissions	10/01 to 12/31	3/31/24	1/01 to 3/31	6/30/24	4-01 to 6-30	9/30/24	7/01 to 9/30	12/31/24	CMHSPs
11. RR complaints	10/01 to 9/30	12/31/24							CMHSPs
13. Residence (DD)*	10/01 to 9/30	N/A							MDHHS
14. Residence (MI)*	10/01 to 9/30	N/A							MDHHS

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

STATE LEVEL DATA COLLECTION

Please see the separate document for CAFAS/PECFAS reporting

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

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

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

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

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

CRITICAL INCIDENT REPORTING

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

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

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

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

RECIPIENT RIGHTS DATA REORTING REQUIREMENTS

I. Background/Regulatory Overview

The Michigan Mental Health Code requires each CMHSP and licensed hospital to provide complaint data to MDHHS-ORR [MCL 330.1755(5)(i) and MCL 330.1755(6)]. MDHHS-ORR is required to review the submitted data [MCL 330.1754(6)(l)] and submit the data to the MDHHS Director and State Legislature [MCL330.1754(6)(o)]. This requirement establishes how complaint data are reported to MDHHS-ORR.

Additionally, MCL.330.1232a(6) requires MDHHS-ORR conduct an on-site review of each CMHSP's recipient rights system to ensure compliance with standards every three years. This requirement describes the process for providing necessary data and documentation to facilitate these reviews.

II. Recipient Rights Data Reports

A. The CMHSP will submit an aggregated data report on the current status of recipient rights in the CMHSP system and a review of the operations of the Office of Recipient Rights on a semi-annual basis.
B. MDHHS-ORR will provide a tool that must be utilized to report required data.
C. The report must be complete and provide an accurate aggregation of data collected at the CMHSP.
D. The Semi-Annual Report
    1. The Semi-Annual Report covers complaint data for the period of October 1 through March 31.
    2. The Semi-Annual Report is due to MDHHS-ORR by June 30.
E. The Annual Report
    1. The Annual Report is a comprehensive report on the status of rights protection at the agency for the period of October 1 through September 30.
    2. The Annual Report is due to MDHHS-ORR by December 30.

III. CMHSP Triennial On-Site Assessments

A. MDHHS-ORR will provide notice to all CMHSPs of the reporting requirements and assessment dates for on-site assessments to be conducted during the year by January 31.
B. The CMHSP-ORR to be assessed must provide requested data to MDHHS-ORR no later than 30 business days prior to the start date of the assessment. MDHHS-ORR will provide the tool that must be utilized to report required data. Data to be provided will include, at a minimum:
    1. The recipient rights complaint log for the three-year period prior to the start date of the assessment (redacting the names of complainants and recipients);
    2. Complete information (dates of visits, remedial action requested, and results of plans of correction) regarding all visits to service sites for the three-year period prior to the start date of the assessment;
    3. Dates of hire and dates of recipient rights new hire training for all CMHSP employees and employees of contracted providers hired during the three-year period prior to the start date of the assessment;
    4. One signed, current contract for each type of service provided:
        a. Residential providers
        b. Other service providers
        c. Inpatient psychiatric units (include an out of state contract if applicable)
        d. Professional staff (psychiatrists, OTs, PTs, etc.)

5. Training materials used in Recipient Rights training.
6. The completed ORR Policy Review Standards document, identifying the name and number of the policy as well as the page numbers where policy elements are located.

C. At the time of the on-site visit the CMHSP will provide the following information:
1. Agency organizational chart.
2. Job descriptions for staff of the ORR.
3. A list of Recipient Rights Advisory Committee (RRAC) members and a separate list of categories represented on the RRAC.
4. Minutes of the RRAC for the three-year period prior to the start date of the assessment.
5. Informational packets/brochures provided to the public, recipients, or family members. (Include any poster which identifies the Rights Officer/Advisors and the means of contacting them).
6. Documentation using the tool provided by MDHHS-ORR for all site monitoring activities for the period covered will be submitted in preparation for the on-site assessment.
7. Access to policies/procedures of any service providers allowed by contract to develop their own policies.
8. Access to all records documenting the completion of recipient rights training for CMHSP employees and employees of contracted providers hired during the three-year period prior to the start date of the assessment.
9. Access to all records documenting the completion of approved training received by Recipient Rights Office staff for the three-year period prior to the start date of the assessment.

D. Review of the recipient rights policies and rights system of each licensed hospital under contract with the community mental health services program to ensure that the rights protection system is in compliance with this act and is of a uniformly high standard pursuant to MCL 330.1755(1)(g) is the responsibility of the State Office of Recipient Rights.

Community Mental Health Service Programs

COMPLIANCE EXAMINATION GUIDELINES

Michigan Department of Health and Human Services

Fiscal Year End September 30, 2024

TABLE OF CONTENTS

INTRODUCTION

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

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

These CMH Compliance Examination Guidelines will be effective for contract years ending on or after September 30, 2024, and replace any prior CMH Compliance Examination Guidelines or instructions, oral or written.

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

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

RESPONSIBILITIES

MDHHS Responsibilities

MDHHS must:

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

CMHSP Responsibilities

(As a recipient of Medicaid Contract funds from PIHP and a recipient of GF funds from MDHHS)

CMHSPs must:

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

EXAMINATION REQUIREMENTS

Unless the PIHP managing the Medicaid Contract requires their independent auditor to perform a compliance examination at the CMHSP, the CMHSPs under contract with MDHHS to manage the GF Contract are required to contract annually with a certified public accountant in the practice of public accounting (hereinafter referred to as a practitioner) to examine the CMHSP's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 18 –Attestation Standards – Clarification and Recodification AT-C Section 205. The specified requirements and specified criteria are contained in these CMH Compliance Examination Guidelines under the Section titled "Compliance Requirements."

Practitioner Selection

In procuring examination services, CMHSPs must engage an independent practitioner, and must follow the Procurement Standards contained in 2 CFR 200.317 through 200.327. In requesting proposals for examination services, the objectives and scope of the examination should be made clear. Factors to be considered in evaluating each proposal for examination services include the responsiveness to the request for proposal, relevant experience, availability of staff with professional qualifications and technical abilities, the results of external quality control reviews, the results of MDHHS reviews, and price. When possible, CMHSPs are encouraged to rotate practitioners periodically to ensure independence.

Examination Objective

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

Practitioner Requirements

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

Practitioner's Report

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

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

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

Finding detail must be presented in sufficient detail for the CMHSP to prepare a corrective action plan and for MDHHS to arrive at a management decision. The following specific information must be included, as applicable, in findings:

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

2. A schedule showing final **reported** Financial Status Report (FSR) amounts, examination adjustments [including applicable adjustments from the Schedule of Findings and the Comments and Recommendations Section (addressed below) and examined FSR amounts. **All examination adjustments must be explained.** This schedule is called the "Examined FSR Schedule." All applicable FSRs must be included in the practitioner's report regardless of the lack of any examination adjustments.

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

4. A Comments and Recommendations Section that includes all noncompliance issues discovered that are not individually or cumulatively material weaknesses in internal control over the Medicaid Contract, and/or GF Contract, only in the event the individual comment or recommendation is expected to have an impact greater than or equal to $25,000; and recommendations for strengthening internal controls, improving compliance, and increasing operating efficiency.

Examination Report Submission

The examination must be completed, and the reporting package described below must be submitted to MDHHS within the earlier of 30 days after receipt of the practitioner's report, or June 30th following the contract year end. The CMHSP must submit the reporting package by e-mail to MDHHS at MDHHS-AuditReports@michigan.gov. The required materials must be assembled as one document in PDF file compatible with Adobe Acrobat

(read only). The subject line must state the agency name and fiscal year end. MDHHS reserves the right to request a hard copy of the compliance examination report materials if for any reason the electronic submission process is not successful.

Examination Reporting Package

The reporting package includes the following:

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

Penalty

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

Incomplete or Inadequate Examinations

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

Management Decision

MDHHS will issue a management decision on findings, comments, and examination adjustments contained in the CMHSP examination report within eight months after the receipt of a complete and final reporting package. The management decision will include whether the examination finding and/or comment is sustained; the reasons for the decision and the expected CMHSP action to repay disallowed costs, make financial adjustments, or take other action. Prior to issuing the management decision, MDHHS may request additional information or documentation from the CMHSP, including a request for practitioner verification or documentation, as a way of mitigating disallowed costs. The appeal process available to the CMHSP is included in the applicable contract.

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

COMPLIANCE REQUIREMENTS

The practitioner must examine the CMHSP's compliance with the A-E specified requirements based on the specified criteria stated below related to the Medicaid Contract and GF Contract.

COMPLIANCE REQUIREMENTS A-E
(APPLICABLE TO ALL PIHP AND CMHSP COMPLIANCE EXAMINATIONS)

A. FSR Reporting

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

a. FSRs agree with agency financial records (general ledger) as required by the reporting instructions. (Reporting instructions at http://www.michigan.gov/MDHHS/0,1607,7-132-2941_38765---,00.html).
b. FSRs include only allowed activities as specified in the contracts; allowable costs as specified in the Federal cost principles (located at 2 CFR 200, Subpart E)(GF Contract, Section 6.6.1; and Medicaid Contract, Section1.S.9); and allowed activities and allowable costs as specified in the Mental Health Code, Sections 240, 241, and 242.
c. FSRs include revenues and expenditures in proper categories and according to reporting instructions.

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

The following items should be considered in determining allowable costs:
Federal cost principles (2 CFR 200.403) require that for costs to be allowable they must meet the following general criteria:

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

Reimbursements to **subcontractors** (including PIHP payments to CMHSPs for Medicaid services) must be supported by a valid subcontract and adequate, appropriate supporting documentation on costs and services (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). Contracts should be reviewed to determine if any are to related parties. If related party subcontracts exist, they should receive careful scrutiny to ensure the reasonableness criteria of 2 CFR Part 200, Subpart E – Cost Principles, 200.404 was met. If subcontractors

are paid on a net cost basis, rather than a fee-for-service basis, the subcontractors' costs must be verified for existence and appropriate supporting documentation (2 CFR Part 200, Subpart E – Cost Principles, 200.403 (g)). When the PIHP pays Federally Qualified Heath Centers (FQHC) and Rural Health Centers (RHC) for specialty services included in the specialty services waiver the payments need to be reviewed to ensure that they are no less than amounts paid to non-FQHC and RHCs for similar services. NOTE: Rather than the practitioner performing examination procedures at the subcontractor level, agencies may require that subcontractors receive examinations by their own independent practitioner, and that examination report may be relied upon if deemed acceptable by the practitioner.

Reported rental costs for **less-than-arms-length transactions** must be limited to underlying cost (2 CFR Part 200, Subpart E – Cost Principles, 200.465 (c)). For example, the agency may rent their office building from the agency's board member/members but rent charges cannot exceed the actual cost of ownership if the lease is determined to be a less-than-arms-length transaction. Guidance on determining less-than-arms-length transactions is provided in 2 CFR Part 200.

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

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

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

B. Procurement

The CMHSP followed the Procurement Standards contained in 2 CFR 200.318 through 200.326.

The CMHSP completed the required Federal database checks in accordance with 42 CFR 455.436. The Lists of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) have been completed by the CMHSP no less frequently than monthly.

Subcontracts entered into by the CMHSP have addressed A through M in Part II section 6.4.1 (Provider Contracts) of the GF contract. Furthermore, subcontracts that contain

provisions for a financial incentive, bonus, withhold, or sanctions must have provisions that protect recipients from practices that result in the inappropriate limitation or withholding of required (MCL 330.1206-1) services that would otherwise be provided to eligible individuals (MCL 330.1208).
Note: A *provider* means one who furnishes medical or pharmaceutical services or supplies (42 CFR 50.502). This provider check is not required administrative contracts.

C. Cost of Service and Ability to Pay

Note: This compliance exam section is impacted by the memo issued by Jeff Wieferich on April 18. 2023. CMHSPs should be following their documented methodology until updated administrative guidance is provided and implemented by October 1, 2023. Until this time, MDHHS does not consider this a contract violation or non-compliance with audit and compliance exam criteria.

The CMHSP determined the cost of services for the purposes of compliance with MCL 330.1804. Cost of services means the total operating and capital costs incurred (MCL 330.1800). In the comparison of cost to ability to pay the practitioner may consider a cost-based rate sheet or other documentation that is supported by cost records as evidence of costs of services.

The CMHSP determined responsible parties' insurance coverage and ability to pay before, or as soon as practical after, the start of services as required by MCL 330.1817. Also, the CMHSP annually determined the insurance coverage and ability to pay of individuals who continue to receive services and of any additional responsible party as required by MCL 330.1828.

The CMHSP's charges for services represent the lesser of ability to pay determinations or cost of services according to MCL 330.1804. Until the CMHSP has determined the ability to pay in accordance with the department promulgated rules (MCL 330.1818(2), the responsible party's ability to pay is considered to be $0. If the responsible party willfully refuses to apply for insurance benefits or provide information in accordance with MCL 330.1814, the CMHSP may charge for the full cost of services. Once ability to pay is determined in accordance with MCL 330.1818(2), the CMHSP may, but is not required to, bill for services up to 2 years in the past (MCL 330.1824).

Medicaid eligible consumers are deemed to have zero ability to pay so there is no need to determine their ability to pay. The one exception is during the period when a Medicaid eligible consumer has a deductible. In that case, an ability to pay determination does apply.

D. General Fund Carryforward

The CMHSP's General Fund Carryforward earned in the previous year was used in the current year on allowable General Fund expenditures as required by sections 7.7.1 and 7.7.1.1. of the MDHHS-CMHSP contract.

E. Match Requirement

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

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

RETENTION OF WORKING PAPERS AND RECORDS

Examination working papers and records must be retained for a minimum of three years after the final examination review closure by MDHHS. All examination working papers must be accessible and are subject to review by representatives of the Michigan Department of Health and Human Services, the Federal Government, and their representatives. There should be close coordination of examination work between the PIHP and provider network CMHSP auditors. To the extent possible, they should share examination information and materials to avoid redundancy.

EFFECTIVE DATE AND MDHHS CONTACT

These CMH Compliance Examination Guidelines are effective beginning with the fiscal year 2023/2024 examinations. Any questions relating to these guidelines should be directed to:

Jackie Sproat, Director
Division of Contracts & Quality Management
Bureau of Specialty Behavioral Health Services

Michigan Department of Health and Human Services
Capitol Commons Center 400 South Pine St., Lansing, Michigan 48913
SproatJ@michigan.gov
Phone: (517) 230-8847 Fax: (517) 335-5376

GLOSSARY OF ACRONYMS AND TERMS

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

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

Examination Engagement A CMHSP's engagement with a practitioner to examine the entity's compliance with specified requirements in accordance with the AICPA's Statements on Standards for Attestation Engagements (SSAE) 18 –Attestation Standards – Clarification and Recodification – AT-C 205 (Codified Section of AICPA Professional Standards).

Flint 1115 Waiver .....The demonstration waiver expands coverage to children up to age 21 years and to pregnant women with incomes up to and including 400 percent of the federal poverty level (FPL) who were served by the Flint water system from April 2014 through a state-specified date. This demonstration is approved in accordance with section 1115(a) of the Social Security Act and is effective as of March 3, 2016 the date of the signed approval through September 30, 2026. Medicaid-eligible children and pregnant women who were served by the Flint water system during the specified period will be eligible for all services covered under the state plan. All such persons will have access to Targeted Case Management services under a fee for service contract between MDHHS and Genesee Health Systems (GHS). The fee for service contract shall provide the targeted case management services in accordance with the requirements outlined in the Special Terms and Conditions for the Flint Section 1115 Demonstration, the Michigan Medicaid State Plan and Medicaid Policy.

GF Program.....The program managed by CMHSPs under contract with MDHHS to provide mental health services and supports to

individuals with serious mental illness, serious emotional disturbances or developmental disabilities as described in MCL 330.1208.

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

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

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

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

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