MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM
Section 450 Report
March 31, 2005

Background

The Michigan Department of Community Health (MDCH) began an internal analysis of the reporting requirements of, and MDCH site visits to, the 46 Community Mental Health Services Programs (CMHSPs) following a spring 2003 meeting between MDCH Director Janet Olszewski and the Michigan Association of Community Mental Health Boards (MACMHB). During that meeting, MACMHB members expressed concerns about duplicative and unnecessary administrative requirements. The meeting was followed by receipt of a list of their issues on May 14, 2003 (See Attachment #1). In June 2003, the Legislature passed the MDCH 2004 Appropriations Act (Act 159 of the Public Acts of 2003), with a new Section 450 requiring a report on administrative simplification activities.

The MACMHB list addressed issues in five categories: a) Deemed Status/Accreditation, b) Audits, c) Reporting Requirements, d) Medicaid, and e) Other. The MACHMB subsequently indicated that its priorities were Deemed Status/Accreditation and Audits.

Process for Improvement

In May 2003, MDCH established an internal Administrative Simplification Process Improvement Team (PIT) to analyze the issues addressed in the MACMHB document. MDCH staff on the team represented the Audit Division, Budget and Finance, Office of Recipient Rights, Division of Mental Health Contracts, Office of Mental Health Services to Children and Families, and Division of Quality Management and Planning. The internal group analyzed all of the MACMHB issues to determine what it considered to be negotiable, non-negotiable (because it was a federal or state requirement), worthy of further study, or required clarification to MACMHB. The result of the analysis is in Attachment #2.

The MACMHB named eight representatives to join the PIT in June 2003. This Administrative Simplification PIT met monthly between June and March 2004. In addition, three ad hoc committees were established to address specific issues on the list: Audit (items under B), Documentation (items C 12 and 13), and Quick Fix (all other items under C and D). These committees met multiple times between, and reported at, the Administrative Simplification PIT meetings. Two additional workgroups had already been meeting and were able to incorporate two of MACMHB's issues into their work: 1) identify better measures of person-centered planning implementation (E.6); and 2) identify gaps in the availability of Medicaid-funded transportation service (C. 26).

A report of the progress made in the first year was submitted to the Appropriations Committee on March 31, 2004.

Progress in Year Two

At the September 14, 2004, meeting, the MACMHB provided the Administrative Simplification PIT a list of issues that remain outstanding from the original 2003 list (Attachment #3). All other issues from the 2003 list were either resolved in 2003-04, or were dropped by the MACMHB members. The remaining issues were:

1. Model payments have separate tracking and payment mechanisms than other foster care programs (Item C.7 on 2003 list).
2. Reduce un-funded mandates for payer/provider systems such as standards of care that contribute little value to consumer outcomes (C.11).
3. Evaluate state expectations requiring CMHSPs to complete redundant review. Requiring independent proof that site visits occurred and that staff have been trained adds unnecessary expense (C.15).
4. Find more efficient ways to extract data and eliminate redundant data (C.17).
5. FIA must process Medicaid eligibility determination and re-determination in a timely manner (D.8).
6. Recent documentation requirements for specialized residential homes have resulted in fewer of these programs (E.7).
7. Provide for licensure of community-based locked alternatives to reduce state facility costs (E.9).
8. Allow local units of government to tap into state purchasing to take advantage of economies of scale (E.15)

Issues added by the MACMHB for 2004 were:

9. The fiscal audit sub-group neither finished its tasks nor continued to meet.
10. Establish a clear practice within the department for distribution of documents.
11. Practice guidelines, such as person-centered planning, sometimes have more weight in the site review process than standard contract boilerplate.
12. Provider Alliance reports that there is a high degree of variability in data collection requirements and methods among the CMHSPs. Some do not use HIPAA-compliant methods.
13. Mental Health and Substance Abuse agencies have different reporting requirements and different performance indicators. In addition, delegation of managed care functions to Substance Abuse Coordinating Agencies (CAs) seems to be from MDCH rather than PIHPs.
14. Revisit recommendations for deleting Section 404 data elements in time to be effective in changing the Appropriations Act boilerplate requirements.

The Administrative Simplification PIT discussed the new issue list at its September 14, 2004 meeting, with MDCH reporting on activities already underway that addressed some of the new issues. The Administrative Simplification PIT developed a work plan for addressing the issues (See Attachment #4). Progress on the issues was reported at the subsequent Administrative Simplification PIT meetings: November 16, 2004, January 25, 2005, and March 22, 2005. Minutes are included in Attachment #5. Following is a summary of progress to-date on each of the 14 remaining issues.

1. Model payments have separate tracking and payment mechanisms than other foster care programs

a. **MDCH has implemented an electronic model payments reimbursement system that goes into effect April 1, 2005. CMHSPs and providers were trained during January and February. The electronic system enables CMHSPs to electronically authorize model payments, and the providers to electronically submit to MDCH claims for payment. The system not only eliminates paper authorizations and paper claims, but also decreases the amount of time between claims submission and payment.**

2. Reduce un-funded mandates for payer/provider systems such as standards of care that contribute little value to consumer outcomes.
    a. **The Mental Health Quality Improvement Council, consisting of representatives from MACMHB, Provider Alliance, consumer advocacy organizations, and MDCH, is advising MDCH on the revision of its Quality Strategy for the Mental Health Medicaid waivers. The Quality Strategy describes the quality standards and methods for monitoring compliance with the standards. The Quality Improvement Council has been charged with looking for ways to simplify the strategy and remove redundancies. A report on its efforts and success is due to the Administrative Simplification PIT in May 2005.**

    b. **In the future, MACMHB and MDCH will collaborate on developing standards of care.**

3. Evaluate state expectations requiring CMHSPs to complete redundant review. Requiring independent proof that site visits occurred and that staff have been trained adds unnecessary expense.
    a. **MACMHB surveyed its membership about the preference for a single comprehensive site review each year, or several shorter reviews. The membership responded with a preference for a single comprehensive review. During 2004, MDCH consolidated the site reviews for Mental Health/Developmental Disabilities Medicaid, Substance Abuse Medicaid, and the Children's Waiver into a single site visit at each PIHP. In addition, MDCH eliminated from the Medicaid site reviews all of the Balanced Budget Act standards that are being reviewed on-site as part of the federally-mandated External Quality Review that commenced January 2005. One result of the consolidation was removal of 27 pages from the Medicaid site review protocol.**

    b. **A draft Practice Guideline on Coordination of Rights Protection Services among CMHSPs has been developed by MDCH (Attachment #6). The coordination guideline would allow CMHSPs to recognize each others' training, policy reviews and site assessments of providers they have in common. MDCH intends that the guideline will be discussed as part of the FY'06 MDCH/CMHSP contract negotiations.**

4. Find more efficient ways to extract data and eliminate redundant data.
    a. **The Encounter Data Integrity Team (EDIT), made up of representatives from the MACMHB, Provider Alliance, and MDCH, meets monthly to advise MDCH on data collection through the encounter data system and the cost reports. EDIT produced guidance for the mental health system on how to determine and report costs of Medicaid managed care administrative functions. EDIT also developed and disseminated guidance on how to assign direct and indirect costs to units of services. Currently, EDIT is developing recommendations to MDCH for the most efficient and least-burdensome way of reporting costs for units of service in FY'06.**

    b. **The Quality Improvement Council has completed its evaluation of the current 49 performance indicators the data for which is collected from the CMHSPs quarterly. The evaluation resulted in a recommendation to eliminate 31 indicators. The remaining indicators, and a few proposed new ones, will draw data primarily from the encounter and demographic data already reported to the MDCH data warehouse and the cost data submitted annually by CMHSPs and PIHPs. Some of the indicators that require separate data collection and reporting will be annual indicators rather than quarterly. Such an action will dramatically reduce the need for additional data collection and reporting by the CMHSPs.**

    c. **There is a continued need for information to be disseminated to the CMHSPs via interpretive guidelines, technical assistance, and training.**

5. FIA must process Medicaid eligibility determination and re-determination in a timely manner.
    a. **The Administrative Simplification PIT received a report from the Chief Deputy Director on a new computer system for determining eligibility that will be in place in 24 to 36 months. The PIT will receive reports on the progress of its implementation. The PIT believes that this is an issue for the Cabinet level and beyond the scope of this group to effect change or improvement.**

6. Recent documentation requirements for specialized residential homes have resulted in fewer of these programs.
    a. **In 2004, MDCH required that PIHPs report the services they purchase from specialized residential providers rather than report a day of "specialized residential." PIHPs were asked to unbundle the day of care into covered Medicaid services. In the process of this conversion, PIHPs and CMHSPs conducted time studies (spring and summer of 2004), and re-wrote their provider contracts to require**

that time for services rather than days be reported. Initially, there was considerable confusion about the amount of documentation that would be required of the providers. MDCH and EDIT provided consultation and training to PIHPs and CMHSPs on the documentation expectations.

b. **The Administrative Simplification PIT believes that the Mental Health Code and administrative rules may need to be revisited in light of the current practice of purchasing Medicaid covered services from specialized residential settings, rather than purchasing a day of "specialized residential services."**

c. **During the spring of 2005, the Administrative Simplification PIT workgroup on documentation will complete its work to identify the minimum expectations for documentation of person-centered planning, plan of service, and service delivery. In addition, the PIT would like the workgroup to look at the frequency of documentation and other specialized residential certification documentation requirements.**

d. **An additional workgroup will be formed to investigate the specialized residential certification requirements for training with an eye toward simplification. The workgroup will report its progress to the Administrative Simplification PIT regularly.**

7. Provide for licensure of community-based locked alternatives to reduce state facility costs.
   a. **The Administrative Simplification PIT focused its concerns on children with Serious Emotional Disturbance (SED) who need mental health treatment in community residential settings. Currently in Michigan, licensure for children's residential settings is limited to Child Caring Institutions (CCIs). Federal law prohibits Medicaid funds to be spent in settings where children with SED could be secluded or restrained. Michigan licensure of CCIs permits seclusion and restraint. The PIT has recommended that MDCH partner with the Family Independence Agency, now known as the Department of Human Services (DHS), to pursue a policy or legislation that would allow for licensing of six or less bed treatment facilities, not defined as CCIs, for children with SED. The PIT will receive ongoing reports of progress throughout 2005.**

8. Allow local units of government to tap into state purchasing to take advantage of economies of scale.
   a. **The Administrative Simplification PIT was informed by the Chief Deputy Director of a program that already exists called MITAP.**

9. The fiscal audit sub-group neither finished its tasks nor continued to meet.
    a. **Some limited progress was made in identifying and mapping the current and recommended steps taken between the conduct of an audit and distribution of the final report, and resolution of any dispute between MDCH and a CMHSP. Attachment #7 contains the draft process map.**

    b. **Administrative Simplification PIT requested that MDCH renew its efforts to improve the audit process under the leadership of the new Chief Deputy Director, and to report progress regularly to the PIT.**

10. Establish a clear practice within the department for distribution of documents
    a. **MDCH members of the Administrative Simplification PIT agreed to take the issue of communication with CMHSPs to the Mental Health and Substance Abuse Administration with the goal that a protocol for streamlining out-going communication would be established. MDCH staff will report progress to the PIT in the spring of 2005.**

11. Practice guidelines, such as person-centered planning, sometimes have more weight in the site review process than standard contract boilerplate.
    a. **The Administrative Simplification PIT charged the documentation workgroup with determining minimum standards for policy guidelines to be included in the site review protocols. In addition, the Quality Improvement Council is advising MDCH on its site review process. Improvements will be integrated into the Quality Strategies for 1915(b) and (c) waiver renewals due June 30, 2005. The Administrative Simplification PIT will have the opportunity to provide feedback on the proposed Quality Strategies at its May 2005 meeting.**

12. Provider Alliance reports that there is a high degree of variability in data collection requirements and methods among the CMHSPs. Some do not use HIPAA-compliant methods.
    a. **This issue was referred to EDIT with a request that progress reports be made to the Administrative Simplification PIT. Provider Alliance representatives sit on EDIT. This is also a contract issue since CMHSPs and PIHPs have the capacity to receive claims electronically and be HIPAA-compliant.**

    b. **This issue is also being addressed by the MACMHB Policy Committee with the intent that the requirements for HIPAA compliance for transfer of consumer-level data be broadcast throughout the system.**

    c. **The PIT recommended that the CMHSP contracts clarify this requirement, that there be training on the requirement, and that the**

next year's External Quality Review cover compliance with the requirement.

13. Mental Health and Substance Abuse agencies have different reporting requirements and different performance indicators. In addition, delegation of managed care functions to CAs seems to be from MDCH rather than PIHPs.
    a. **MDCH issued a Technical Advisory on September 30, 2004, to PIHPs on purchasing substance abuse services when the CA encompasses more than one PIHP.**

    b. **MDCH issued a Technical Advisory on November 17, 2004, to PIHPs clarifying the funding and reporting related to people with co-occurring disorders and the provision of substance abuse and mental health services.**

    c. **The federal Centers for Medicare and Medicaid Services (CMS) views Michigan's PIHPs as the managers of all Medicaid specialty services – for Medicaid beneficiaries with mental illness, developmental disabilities, or substance use disorders. Therefore CMS expects MDCH to require the PIHPs to manage their provider networks that include CMHSP affiliates and CAs by purchasing services and, if applicable, delegating managed care functions like customer services, utilization management or information technology. The External Quality Review that commenced in FY'05 is looking at the delegation of managed care functions by the PIHPs to their provider networks, including CAs. Findings from the review will drive changes in the MDCH/PIHP contracts, and the PIHP/CA contracts for FY'06.**

    d. **The MACMHB and the Michigan Association of Substance Abuse Coordinating Agencies have identified this issue as a joint project for 2005.**

    e. **The Quality Improvement Council has recently expanded its scope to include substance abuse. When considering Medicaid performance indicators and site review protocols for the new Quality Strategies, the Council will address all populations served by the 1915 (b) and (c) waivers.**

14. Revisit recommendations for deleting Section 404 data elements in time to be effective in changing the Appropriations Act boilerplate requirements.
    a. At the March 22, 2005 meeting, the Administrative Simplification PIT recommended that the legislative fiscal agencies be asked to assess the elements in Section 404 and propose for deletion the requirements of data elements that the agencies find unusable.

Next Steps

The Administrative Simplification PIT will continue to meet quarterly throughout the next 12 months with the intent of completing the work plan in Attachment #4, thus resolving the 14 issues listed above.

Attachment #1

May 14, 2003

ADMINISTRATIVE SIMPLIFICATION:

In response to requests from the administration and from the Legislature and recognizing the long standing interest of CMHSPs in administrative simplification, I have appointed a workgroup to make recommendations on reducing unnecessary administrative requirements.. Asked to participate were CMH directors serving as MACMHB officers and standing committee co-chairpersons. I intend to serve as a member of the workgroup as well.

CMHSPs were asked to submit their specific ideas on which duplicative and unnecessary administrative requirements should be modified, reviewed or eliminated. Approximately 23 CMHSPs responded. Comments gathered were grouped into 5 categories:

A. Deemed Status/Accreditation Issues
B. Audits
C. Reporting Requirements
D. Medicaid
E. Other Issues

Following are some of the themes which have emerged in each area and a more detailed summary of issues raised in the first four area. Issues falling into the "other" category will be addressed in the future as work on individual suggestions commences. The Association has asked DCH director Janet Olszewski to meet and discuss the themes which have been identified. We have further requested that a DCH/CMH work group be convened to begin to discuss specific suggestions for change. We look forward to moving ahead and addressing these and other issues which may be brought forward.

Thank you!

Mary Balberde
President

A. DEEMED STATUS/ACCREDITATION ISSUES

Overview: ***The current processes of national accreditation and DCH certification reviews overlap one another and are duplicative. For those CMHSPs who have achieved accreditation by one of the national organizations approved by the department, further DCH review is not required. "Deemed status" means elimination of requirements for departmental certification review for those CMHSPs who are nationally accredited.***

1. Eliminate the requirement for an annual DCH review for CMHSPs who have achieved national accreditation.
2. DCH surveying should be limited to areas specific to Michigan and not covered by national accreditation surveys.
3. Reduce frequency and improve coordination of DCH reviews. Multiple DCH reviews should be collapsed into a single review. Some of the current reviews are: DCH site reviews, specialty residential reviews, coordinating agency reviews, recipient rights reviews, AFP reviews, children's model waiver reviews, Medicaid 5% records review.
4. Any DCH certification reviews should be conducted on a 2 year basis, consistent with the waiver period, not annually.

B. AUDITS

Overview: ***Every CMHSP is required to have an annual independent fiscal audit. DCH also conducts fiscal audits which routinely take 3-6 months and are labor intensive and time consuming. DCH, in collaboration with MACMHB, should develop audit specifications for independent auditors which address departmental audit objectives and which may be applied by the independent auditors.***

1. Reduce the scope of DCH financial audits. DCH audits routinely take 3-6 months. DCH, in collaboration with MACMHB, should develop audit specifications for independent auditors which address the audit objectives of the department. Independent audits performed by CPAs are already required of each CMHSP.
2. It is often difficult to obtain clarifications from DCH around issues which may have future audit implications.

C. REPORTING REQUIREMENTS

Overview: ***Complicated and costly reporting requirements do often not add to the quality of care provided by CMHSPs or improved outcomes for consumers. Data definitions are often vague resulting in information which is not reliable, reporting requirements are often too frequent, and realistic time frames for making information system changes at the local level are often not provided. The state has, on occasion, made changes or additions to federal requirements which make compliance more time consuming and costly. When in doubt simplify, simplify, simplify.***

1. State changes to federal 837 transaction requirements have added cost.
2. Eliminate/simplify DCH grant report requirements.
3. Eliminate quarterly reports as there is not an accurate fiscal picture until year end.
4. DCH Microsoft Access report format to submit Hab Waiver data has added costs.
5. Billing model children's waiver on fee for service basis adds cost.
6. Separate OBRA billings add cost.
7. Model payments has separate tracking and payment mechanisms than other foster care programs.
8. Evaluate continued provision of PPG reports.
9. Inconsistency and/or confusion over data definitions are ongoing problem.
10. Sufficient lead time is not always provided to make changes in reporting requirements.
11. Reduce unfunded mandates for payer/provider systems such as standards of care which contribute little value to consumer outcomes.
12. Reduce time direct care staff spend on paperwork including multiple signatures, start and stop times, and others.
13. Develop single form format statewide used for required documentation.
14. Improve timeliness/reliability/accuracy of statewide data.
15. Evaluate state expectations requiring CMHSPs to complete redundant reviews. Requiring independent proof that site visits (CCI/LPU's) have occurred and that staff have been trained adds unnecessary expense.
16. The defined frequency of many reports required by DCH is duplicative.
17. Find more efficient ways to extract data and eliminate redundant data.
18. Consider elimination of outcome measures when statewide performance is consistently good.
19. Other specific recommendations:

    -- Continue with plan to eliminate need for shadow claims reporting and COB model.
    -- QI Data Item #17 - Disability Designation: MDCH can figure this from the diagnoses submitted in the encounter data.
    -- QI Data Item #18 - Service Designation: MDCH can figure this from the diagnosis and service information submitted in the encounter data.
    -- QI Data Item #26.1 - Persons on Hab Supports Waiver is reported monthly to MDCH on the Hab Waiver Report.

-- QI Data Item #'s 26.3, 26.4, 26.8, 26.9, 26.10, and 26.11 - Specific insurance information is reported in the encounter data.
-- QI Data could be sent as a quarterly roll up rather than a monthly roll up.
-- MIMBPIS Table 1 - Unduplicated Counts: MDCH can figure this information from the QI and encounter data submitted.
-- MIMBPIS Table 2 - Penetration rates: MDCH can figure this information from the QI and encounter data submitted.
-- MIMBPIS Table 10 - Quality of Life - Living Situation: MDCH can figure this information from the QI and encounter data submitted.
-- Eliminate the need for trial balance and claims aging reports. The purpose and intended use is unclear.
-- OBRA measure benefits are unclear.
-- Percentage of people in day programs receiving supported employment is both unclear and inconsistent with DCH policy direction.

20. Make reasonable accommodations for CMHSPs in rural areas on performance indicators reporting. Small "Ns" make compliance with performance indicator standards more challenging
21. DCH performance indicator system should be reviewed and reduced. Indicators that remain or are added should have an outcome that is reliable, meaningful and that adds value.
22. Any changes in reporting requirements should meet all compliance criteria, result in improved in improved outcomes for consumers, reduce administrative costs, or improve management efficiency without negatively affecting outcomes for consumers, and be developed with consumer input. Is the new requirement mandatory or optional? If optional, on what basis is it being recommended?
23. Require department to calculate the cost to the system before any new reporting requirements are added.
24. Encounter and demographic data should be reported on a quarterly not monthly basis.
25. Current requirements that copy-righted outcome measures be implemented are costly and often too stringent.
26. Look at better coordination between FIA and CMHSPs on transportation and home health services, especially the portion of these services funded by FIA.
27. When in doubt, simplify, simplify, simplify.

D. MEDICAID

Overview: ***The majority of comments regarding the Medicaid program had to do with the burdensome requirements of the spend down program. The monthly spend down process is onerous for consumers and providers. It results in uncertain coverage for consumers and high administrative costs and fewer dollars for CMHSPs.***

28. Monthly "spend down" process is very burdensome, provides uncertainty about coverage for consumers and results in higher administrative costs and fewer available Medicaid dollars for CMHSPs.
29. Spend down reporting requirements add costs for CMHSPs and FIA.
30. CMHSPs must report information to DCH about some aspects of Medicaid enrollment (such as when redeterminations are effective) that the state already has.
31. Look at longer period of eligibility (than 1 month) for those on spend down.
32. DCH manuals (children's waiver and HAB waiver) should be updated.
33. DCH has added another duplicative layer of reporting by requiring PHPs to monitor and report monthly on utilization of HAB waivers. The department and PHPs should not expensively duplicate their efforts around HAB waiver reporting.
34. Review and streamline various consumer appeal processes.
35. FIA must process Medicaid eligibility determination and redetermination in a timely manner.
36. Specific requirements for nursing services for consumers in crisis residential programs regardless of their medical and/or mental health needs is unrealistic and costly.

E. OTHER ISSUES

1. Video-conferencing and tele-conferencing technology could save travel expenses.
2. FIA home help duplicates community living supports services and should be coordinated.
3. Level of care standards for persons in home care, AFC placement, nursing home would be helpful and efficient.
4. CMH has to bill out Michigan rehab funding on a fee for service basis which is costly.
5. Review ability to pay requirements.
6. Review documentation requirements for PCP.
7. Recent requirements for specialized residential homes have resulted in fewer of these programs.
8. Require integrated services for persons served by multiple systems (FIA, CMH, QHP, SA, MRS, Public Health, Corrections).
9. Provide for licensure of community-based alternatives to reduce state facility costs.
10. Seek additional ways to integrate mental health and substance abuse services including articulation of a specific integration policy by DCH, establishing a single ability to pay schedule for the substance abuse and CMH systems, developing a single set of access standards for substance abuse and CMH systems, fully integrating points of access to the substance abuse and CMH systems, making SA/CA requirements more similar and removing barriers to PHPs serving as CAs where there is local agreements to do so.

11. OBRA/PASSAR screenings. Individuals having state determination of "nursing home/or mental health services" be exempt from annual behavioral review requirements.
12. Annual assessments for those in ACT programs required "as needed."
13. Eliminate OBRA screenings for everyone entering a nursing home regardless of whether a person is in need of a mental health service. As a minimum, OBRA screenings should be able to be performed by a single qualified practitioner. Similar to the evaluation provided to anyone else seeking a CMH service. Current requirements for separate and specific multiple assessments were described by one board to be, in some cases, "so pointless as to be absurd."
14. Seek ways of reducing the scope and impact of federal procurement requirements.
15. Allow local united of government to tap into state purchasing to take advantage of economies of scale.
16. Privacy regulations and requirements of HIPAA and Michigan Mental Health Code should be coordinated.
17. "County of Financial Responsibility" requirements are confusing, time consuming and expensive to implement.
18. Streamline annual assessment process for consumers who are served over the long term.
19. Combine application for service information or provide mechanism for sharing basic demographic information among local service providers.
20. Eliminate any regulation not directly mandated by state or federal law.

This is not an exhaustive list. We expect that as we begin to review these ideas that other areas will be identified as well.

Thank you!

Attachment #2

ADMINISTRATIVE SIMPLIFICATION

PROCESS IMPROVEMENT TEAM

Quality Management Site Reviews & Reporting Requirements Sub-Committee

Revised 2/13/04

egotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further interna investigation
1. Certification ncluding Children's agnostic) Process *CH is working ternally to coordinate e schedule of the cipient rights reviews d certification views so that they incide with the piration of the MHSP's certification. CH anticipates that e coordinated hedule will be mplete by 2006.*	A4. Certification reviews consistent with waiver period. *Certification reviews are conducted every three years per Section 330.123a the MHC.* *Annual Medicaid site reviews have been modified to allow an administrative review of the PIHP once during the 2-year waiver period while maintaining the annual review of a sample of clinical records (10% for HSW), interviews of a sample of consumers, and follow-up on implementation of any previous plans of correction. The admin review, once per waiver period, of CMHSPs will be limited to any functions that the PIHP delegated,*		A.1. Difference between certification review and annual site review *Clarification provided that annual DCH site reviews are conducted at PIHP level per the CMS-approved Quality Strategy (Sect C.1. of the waiver application) and the BBA. National accreditation is a partial substitute for triennial certification of CMHSP per MHC 330.123a*	

egotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further interna investigation
	and to the triennial certification process if the CMHSP is not accredited.			
3. Scope, frequency, nsolidation of site views *uring FY'03 the two-age DCH M'caid views were nsolidated into a ngle annual review at also integrates the , Children's Waiver, SW 10% sample, and e AFP follow-up on ans of correction. The lmin portion of the ngle annual review is nited to those areas at were not covered in e one-time-only AFP e review or were bject to plans of rrection.*	B. 1.Reduce scope of DCH financial audits. *An ad hoc group has been meeting with Dr. Michael Ezzo, Patrick Barrie, and audit staff to resolve this.*	B. 2. Difficult to obtain clarifications from DCH around issues which may have future audit implications. *An ad hoc group has been meeting with Dr. Michael Ezzo, Patrick Barrie, and audit staff to resolve this*	A2. DCH cert surveys. *The site visit associated with the certification process is waived if the CMHSP is accredited*	
ovide incentives for eeting or exceeding andards	Impose sanctions for poor performance			

egotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further interna investigation
12 &13. ocumentation needed verify that direct care as provided; statewide rmat *ad hoc group is viewing all quirements (e.g., hapter III, admin les, MHC) to termine that minimum nount of cumentation that is eded for evidence of mpliance*	C.19.b. Diagnosis code is insufficient for determination of developmental disability, and for eligibility for specialty services and supports. Need to know who is DD and who is MI	C.9. Confusion over data definitions & C.14. Improve timeliness, reliability, and accuracy of statewide data. Would like to discuss strategies for doing this. *EDIT has been an important player in encouraging PIHPs to submit good data. It also conducted a training on 9/11/03, appeared at various conferences, and will put on an additional session 2/26/04. The group will remain a part of the solution to this problem.*	C1. Changes to 837 have added costs. *DCH did not change federal 837 transaction requirements. Because DCH determined that it should collect financial information with the encounter data for use in calculating actuarially sound capitation rates, it required that the PIHP use COB loops to report financial info. DCH compromised with MACMHB to allow PIHPs to report average allowed*	C.8. Evaluate the need for PPGs: Budget offic and CMHSP contracts *This is a MHC requirement that is a valuable source of information.*

egotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further interna investigation
		C.10. Sufficient lead time for implementing changes to reporting requirements. *The contracting process makes changes to reporting requirements difficult.*	*amount to substitute for reporting 4 financial fields.* C.4. & D.6: MACMHB members may need additional training to understand the HSW registration process *Enrollment and re-certification of HSW consumers has been brought back to Central Office. The database will be replaced by the use of the 834 and 837 transaction standards*	
18. What outcome easures should be tained, what measures opped when the stem demonstrates od performance *e use of outcome easures will be nsidered by the newly -established Quality provement Council ong with the rest of e performance dicator system.*	C.19.f. and 24: *QI data needs to be reported monthly so that it can match up with 837.*	C.16. Frequency of reports is duplicative. *ORR data reporting could be consolidated to annual; and categories of reporting consolidated as well.* *This will require a change in the MHC. DCH has analyzed the other reports that are required: frequency, format, etc.*	C.15. *Reviews of CCI/LPUs can be coordinated among CMHSPs thus eliminating duplicative reviews*	C.25. CAFAS requirements: check ou utility with Wotring *CAFAS is used for functional assessment f service need and for outcomes measurement It is likely that we will need to do something similar with all populations.*

egotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further interna investigation
19.a. Need for COB is ing discussed in orkgroup that Fitton d MACMHB are ordinating *greement was reached tween MDCH and ACMHB to report a lculated "allowed nount" for each counter.*	C.19.h. Medicaid penetration rate required by CMS *Once encounter data is submitted in a timely fashion, it will not be necessary to collect this via the performance indicator data.*	C.19.c. Service designation: has proved to be of no use *This QI element will be removed from the contract via amendment #2 of the PIHP contract, and amendment #1 of the CMHSP contract*	C.19.g Unduplicated counts: *cannot get count of people served in the previous qter due to lag time of encounter data reporting to accommodate adjudication of claims*	E. 11. OBRA screening for NH/no MH services exemption: check with Verseput
19.e. Program gibility is not present 837, and collecting it required by Sec. 404. sk Approps to consider 404 quirements? *ogram eligibility is an portant sorting key in ta base management*	E. 3. DCH does not want to impose level of care for home care, AFC, or NH...why would MACMHB want this?	C.19.d. Hab supports waiver designation is redundant now that monthly registry is in place *This QI element will be removed from the contract via amendment #2 of the PIHP contract, and amendment #1 of the CMHSP contract*	C.20. Small "n": *DCH's reporting of Performance indicators accommodates this in the narratives*	
19.h. Information om QI and encounter ll not be available for tly penetration rates. onsider annual netration rates, and/or opping some that are t useful *view of all rformance indicators, cluding penetration tes, has been referred the QI Council for*	E.13. OBRA screening is a federal requirement in exchange for OBRA funds to serve NH residents who need mental health care.	C.21. Performance indicator system requires periodic review. Suggest a QI committee of CMHSPs, advocates, providers and consumers to help *A QI Council was re-established and had its first meeting 1/21/04.*	D.7. There are various interpretations of these requirements. DCH will provide a training on the new tech requirement *The technical requirement is being revised per input from the PIHP hearing officers*	

egotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further interna investigation
ssible refinement.				
19.i. Quality of living uation required by c. 404. Consider nual rather than arterly reporting *rview of all rformance indicators, cluding quality of ing, has been referred the QI Council for ssible refinement*		C.22. & 23. Reporting requirements changes: Suggest the QI committee to help do that *This was referred to the QI Council*	D.9. Individuals in crisis residential require intensive MH care overseen by an RN. If consumers do not need this level of care a regular AFC would suffice.	
19.k. OBRA: mental alth services for rsons in nursing mes needing less than ecialized: consider opping *is indicator will be opped via the nendment #1 of the MHSP contract*		C.27. Simplify, yes: Suggest the QI committee to help do that *This has been referred to the QI Council*	E. 12. ACT consumers need ongoing assessment of their needs for treatment. Annual is minimum for good practice.	
19.l. Percentage of rsons with DD in day ograms receiving SE: nsider dropping or vising *rview of all rformance indicators, cluding employment, s been referred to the Council for possible finement. MARO will invited to participate*		D.5. DCH manuals should be updated *Work on the Children's Waiver manual has begun. DCH agrees that the HSW manual needs to be updated.*	E. 14. Interpretaton by PHPs of the procurement requirements may have created more complexity than is needed. MDCH (P. Barrie) will provide clarification.	
3. Eliminate arterly FSR reports *r the contracts, the st quarter FSR report s been eliminated.*		E. 1. Tele- and video-conferencing	E. 16. HIPAA privacy and MHC coordination: This work has been done by the AG's office	

egotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further interna investigation
CH needs the other ree reports to manage e funds.				
5. Billing model ildren's waiver on fee r service basis. on-negotiable	C. 6. Separate OBRA billings. Federal government regulations require reporting actual costs.	E.5. Ability to pay requirements	E. 18. Annual assessments are not required. Annual review of plan of service is.	
		E.6. Review documentation requirements for PCP: A workgroup to do that was established 2 months ago. Suggest that other CMHSPs attend. *An ad hoc committee on documentation is preparing recommendations for minimum requirements for PCP documentation.*		
		E.8. How would this be done		
		E. 10. Integration of MH and SA		
		E. 20. Agree that we can consider non-mandated (fed, state law) requirements, but some may be needed for contract management		

Items that need further clarification from MACMHB

9. Inconsistency and/or confusion over data definitions. Which ones?
C. 2. Eliminate/simplify DCH grant Report Requirements. We need more clarification from MACMHB. What specific grant reports are they asking us about?
C. 7. The model payments system is currently being reviewed by the Office of Audit. Could MACMHB coordinate obtaining CMHSP input relative to this program, and what changes would they recommend?
11. Un-funded mandates for payer/provider systems such as standards of care. Which standards of care?
17. Efficient ways of extracting data. Please clarify.
E. 2. FIA home help duplicates community living supports. Please clarify.
E. 4. CMH had to bill out Michigan rehab funding on a fee-for-service basis. Please clarify.
E. 7. Recent requirements for specialized residential homes have resulted in fewer programs. Please clarify the problem.
E. 9. Provide licensure of community-based alternatives. Please clarify.
E. 15. Units of government tap into state purchasing. Please clarify.
E. 17. County of financial responsibility requirements are confusing, etc.
It is our understanding that the MACMHB has a workgroup that is studying this. What recommendations does the group have for MDCH?

Attachment #3

(Note: This document was prepared by the MACMHB for the 9/14/04 Administrative Simplification PIT meeting.)

ADMINISTRATIVE SIMPLIFICATION ISSUES – Outstanding for MACMHBA

C.2 Eliminate/simplify DCH grant report requirements.

No additional specific recommendations were made

C.7 Model payments have separate tracking and payment mechanisms than other foster care programs.

The current model payment system is archaic and relies on pieces of paper for processing everything. The system is very labor intensive and there can be substantial time delays in payment being received by providers. (Example: All changes are mailed or faxed to the State. The State mails out a notice to each provider. Each provider needs to sign the form and send back to State.) Also, there could be substantial paybacks when an individual has moved to Specialized Residential and model payments were not discontinued. Improvements to the system would include:

- An electronic data base for tracking the status of individuals
- Making model payment forms available online and being able to process the forms online
- Discontinuation of a nurses' or clinician signature for any minor change or update (individual is absent from program for more than 7 days)
- Less reliance on one individual at the State level to process everything

C.11 Reduce unfunded mandates for payer/provider systems such as standards of care that contribute little value to consumer outcomes.

Unfunded mandates. We understand that most if not all of the recently added administrative requirements occurred as a result of the BBA. All are new standards that add to the administrative responsibilities for review and monitoring and came without any additional funding. We would recommend a cooperative strategy using a workgroup of the QI counsel (similar to EDIT) to assure broad stakeholder input prior to operationalizing. He system should continue to work collaboratively to identify any redundancies with existing State practices when new Federal requirements are added. We should work collaboratively to advocate for reductions in federal guidelines when the added value is unclear or the cost for administering takes away from service dollars.

C.15 Evaluate state expectations requiring CMHSPs to complete redundant reviews. Requiring independent proof that site visits have occurred and that staff have been trained adds unnecessary expense.

> ORR currently requires that every CMHSP/PIHP complete an annual site review for all facilities even those I other counties who may have already been reviewed by a CMHSP/PIHP. The rules also require that we all review policies and procedures for all contracted facilities in the same situation. This is redundant and burdensome not only to the CMHSP/PIHP but also to the provider. We would suggest review by the CMHSP/PIHP in the county of provider location with the referring CMHSP?PIHP retaining a copy on file and assuring attention to any areas of deficit. Most of these facilities are also reviewed as part of the MDCH ORR review anyway.

C.17 Find more efficient ways to extract date and eliminate redundant data.

We agree that continued improvements in this area will evolve over time and needs to be a continued focus of the Statewide QIC.

D.8 FIA must process Medicaid eligibility determination and redetermination in a timely manner. (FIA issues in general)

> Would like to see improvements in cross state Department policy clarifications so that the local system and its consumers are not caught in the middle, examples include:
> - Expectations for timely Medicaid eligibility determination and benefit notice
> - Home Help as a state plan service requiring the same notice rights as other state plan services when denied/discontinued
> - Clear policy guidelines that permit pooled funding around collaborative mandates like Children's Action Network
> - Differing expectations about consumers own home vs. homes requiring a license.

E.4 CMH has to bill out Michigan rehab funding on a fee for service basis, which is costly.

This is not an issue for all Boards some have resolved through cash-match agreements.

E.7 Recent documentation for specialized residential homes has resulted in fewer of these programs.

> These encounter documentation requirements are perceived as particularly more burdensome due to low rates of compensation.

This feedback does not relate to recent documentation changes. However, it is suggested the current training requirements for specialized residential be reviewed as to whether there could be any reduction.

E.9 Provide for licensure of community-based locked alternatives to reduce state facility costs.

Could have value. Likely ties into proposal from Hope Network to create a new level of licensure between inpatient and specialized residential.

This is a real problem with children residential now because of change in rules related to CCIs. We need to work collaboratively on solutions.

There was some pending legislation that would have allowed CMHSP's to have locked units. This would have the potential of reducing costs.

E.15 Allow local units of government to tap into state purchasing to take advantage of economies of scale.

IS there potential to further exploration here?

I would offer the following input regarding administrative simplification issues:

Through this process the following additional issues were raised:

The need to clarify Obtain tax accounting recommendations and decide best an ongoing process for this type of dialogue/action. We would suggest that it be an ongoing function of the statewide QIC.

Concern has been raised that the fiscal audit sub-group neither finished its task(s) nor continued to meet as we agreed. From our perspective this is still a significant unresolved issue.

Further, it has been suggested that we continue to explore the concept of deemed status as it relate to future waiver applications. It is suggested that we work with accrediting organizations to expand the scope of their review and or move the system to a biennial or triennial review process.

The new HSW process is creating some inefficiency and inconsistencies in approval. We have had one case to remove where removal was not approved and we have had a number of cases in which the DCH party is in our impression making a subjective clinical assessment of patient needs with no eyes on assessment. The approval at DCH should really be an administrative review of

whether it has been documented that criteria is clearly met/not met. The referring CMH should receive a clear communication as to what criteria was met/not met.

One final recommendation is to establish a clear practice within the department for distribution of documents. It is not uncommon to have the same e-mail forwarded by three different people from the department and then to also receive a hard copy. Other than contracts it is frequently not clear when a hard copy will also be sent and the practice for sending a hard copy in additional to an e-mail is not consistent so on the service side we are frequently printing in order to retain a record also.

Thanks for your consideration of these additional items

Attachment #4

ADMINISTRATIVE SIMPLIFICATION ISSUES – Outstanding for MACMHBA

Work Plan 2005

1. Model payments have different tracking and payment mechanisms than other foster care programs.
   The state is employing an electronic model payments reimbursement system to be implemented in early 2005
   Action: Report on Progress
   Responsible: Mark Kielhorn

2. Reduce un-funded mandates for payer/provider systems such as standards of care that contribute little value to consumer outcomes.
   Recommendation: The Quality Improvement Council advise the development of the Quality Strategy for the 1915(b) waiver renewal with a "simplification" perspective, and report on efforts to simplify and remove redundancies.
   Date: May 2005
   Responsible: Judy Webb

3. Evaluate state expectations requiring CMHSPs to complete redundant reviews. Requiring independent proof that site visits have occurred and that staff have been trained adds unnecessary expense.
   Recommendation: Administrative Simplification PIT review the draft Practice Guideline on Coordination prior to contract negotiation.
   Date: Spring 2005
   Responsible: Dianne Baker

4. Find more efficient ways to extract date and eliminate redundant data, such as using encounter data to construct performance indicators.
   Recommendation: Administrative Simplification PIT receive and comment on reports from EDIT, II.
   Date: Ongoing
   Responsible: Judy Webb

5. FIA must process Medicaid eligibility determination and re-determination in a timely manner. (FIA issues in general)
   A new computer system for FIA and MDCH that will improve the eligibility determination system will be instituted in 24 to 36 months.
   Recommendation: Administrative Simplification PIT receive reports.
   Date: Ongoing
   Responsible: [To be determined**]**

6. a. Recent documentation for specialized residential homes has resulted in fewer of these programs.

Recommendation: Documentation work group should finish its work and report to Administrative Simplification PIT.
Date: Spring 2005
Responsible: Tom Renwick

b. Current training requirements for specialized residential will be reviewed to determine where there can be any reduction.
Recommendation: Form a workgroup to investigate the specialized residential certification requirements relative to training with the focus on simplification.
Date: Spring 2005
Responsible: Tom Renwick

7. There is a real problem with children residential now because of change in rules related to CCIs. We need to work collaboratively on solutions.
Recommendation: FIA/MDCH pursue a policy that would allow for licensing of six-bed treatment facilities not defined as CCIs for MI and DD children.
Date: Spring 2005
Responsible*:* Mark Kielhorn

8. Allow local units of government to tap into state purchasing to take advantage of economies of scale.
A program called MITAP already exists.
Recommendation: Identify a person to talk to Administrative Simplification PIT regarding MITAP.
Date: Spring 2005
Responsible: [To be determined**]**

9. The fiscal audit sub-group neither finished its task(s) nor continued to meet.
Recommendation: Fiscal audit work group finish its task and report back to Administrative Simplification PIT.
Date: March 2005
Responsible: **Ed Dore**

10. Establish a clear practice within the department for distribution of documents.
Recommendation: MDCH streamline its process for communicating with PIHPs and CMHSPs.
Date: Spring 2005
Responsible*:* MDCH staff

11. Practice guidelines, such as person-centered planning, sometimes have more weight in the site review process than standard contract boilerplate.

Recommendation: Add quality improvement coordinators to the documentation workgroup and determine the minimum standards of what policy guidelines will be included in the site review protocols.
Date: Spring 2005 (in concert with waiver Quality Strategy)
Responsible: Tom Renwick

12. Provider Alliance reports that there is a high degree of variability in data collection requirements and methods among the CMHSPs. Some do not use HIPAA compliant methods.
    Recommendation: Refer to EDIT and receive a report back on progress.
    Date: Spring 2005
    Responsible: Judy Webb

13. Mental Health and Substance Abuse agencies have different reporting requirements and different performance indicators. In addition, delegation of managed care functions to Substance Abuse Coordinating Agencies seems to be from MDCH rather than PIHPs.
    Recommendation: Remove redundancies and inconsistencies.
    Date: 2005
    Responsible: Judy Webb

14. Revisit recommendations for deleting Section 404 data elements in time to be effective in changing the Appropriations Act boilerplate requirements.
    Date: March 31, 2005
    Responsible: Administrative Simplification PIT

Attachment #5

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM

Summaries of Meetings 2004-05

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM
Summary of November 16, 2004 Meeting

I. The meeting was convened by Judy Webb

II. Work Plan: Judy, with the assistance of Dave LaLumia, reported on development of the work plan (see attached) that had been completed just prior to commencement of this meeting. The group began with the outstanding MACMHB issues and developed recommendations. Four additional issues were added during the meeting (Items 11 through 14).

III. Strategies for accomplishing work: see work plan

IV. Updates:

a. Office of Recipient Rights Assessment/Certification consolidation: Dianne Baker reported that draft language has been drafted for a guideline for the contract that includes ORR special investigations, repeat citations, contract sanctions, prior to implementing provisional certification or de-certification. The scoring would be weighted according to whether the issues were technical, substantive, or critical. Floyd Smith asked whether the combined protocol meets the code criteria and administrative rules or whether it exceeds them. He noted that the elements in the current Attachment B and C of the protocols seem to exceed the code and administrative rules requirements.

b. Audit Improvement Update: Mike Ezzo distributed a draft table of steps that would be taken during the audit and post audit process. Nancy Miller asked if there was a written protocol. She added that the fiscal guidelines have not changed to keep pace with fiscal activities, that there are disputes over policies or differences of formal and informal opinions, and that there is no credit for CMHSPs who believe that they are doing the right thing. Jim Hennessy responded that A87 is the guideline. Dave LaLumia asked whether the next step is to re-convene the work group. Pat Barrie responded that we would not re-convene while the department is in circuit court with one of the MACMHB members.

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM
Summary of January 25, 2005 Meeting

I. The meeting was convened by Judy Webb.
II. The agenda was approved with agreement to add Kevin's Law implementation, record retention requirements, and evidence-based practice implications on administrative simplification.
III. The November 16th meeting summary was approved.
IV. Status reports:
    a. Judy reported that EDIT II continues to meet monthly, advising the department as staff receive and analyze encounter and sub-element cost data. EDIT II recently heard from the Provider Alliance about inconsistencies among CMHSPs in their reporting requirements and methodologies that create substantial burden and complexity for the providers.
    b. Judy reported (for Mark Kielhorn) that the new electronic model payments system will go live March 1st. So far, 150 CMHSP staff have been trained, and six sessions were held for home operators in four locations in the state.
    c. Judy reported that the Quality Improvement Council has been focusing on the performance indicator system with a goal of reducing the current 49 indicators to a set of 10 or 12 that measure CMHSP and PIHP performance. Floyd Smith asked whether there would be any employment indicators and she responded that there may be a couple.
    d. Dave LaLumia indicated that he had recently heard Ron Mandershied from the Center for Mental Health Services talk about DS2000+ (Decision Support) and wondered how that might impact data that Michigan would need to collect and report. Judy responded that the department has attempted to track CMHS' development of data element requirements and stay ahead in order to integrate the requirements in the CMHSP/PIHP contracts prior to the time they need to be reported to CMHS. One area that Michigan needs to consider is its definition of serious mental illness as it is currently not consistent with the definition that CMHS uses. Moving to the federal definition would increase the numbers of persons considered to be SMI in Michigan.
    e. The QI Council will also be looking at the impact of the Mental Health Commission recommendations on quality management, how to report quality management to the public, and development of a quality strategy for the upcoming waiver renewals.
    f. Judy passed along a comment from Deb Milhouse Slaine. Deb has received complaints from some CMHSPs about Children's Waiver site visits that coincide with the Medicaid site reviews. Judy reminded the group that the CMHSPs had agreed last year that they wanted site visits consolidated as much as possible. It was suggested that the MACMHB send a note to the membership reminding them that they

asked for the consolidated reviews. MDCH will make sure that CMHSPs receive one communication, and one coordinated agenda when the Children's Waiver staff are visiting along with the Medicaid site reviewers.

g. Dave indicated that the MACMHB recently sent a letter to Janet Olszewski regarding the incompletion of the audit process improvement. She responded that she will assign it to the new Chief Deputy Director.

V. Finalize Work Plan: The group reviewed the draft work plan; changes were made (see attached work plan).

a. Regarding item #6: Floyd asked that his questions regarding Office of Recipient Rights assessment be revisited. It was suggested that there be an opportunity for CMHSPs to have reciprocal agreements with one another that recognizes each other's recipient rights training programs. ORR would accept a statement from a CMHSP that individuals had been trained by another CMHSP.

b. Regarding item #10: It was suggested that when MDCH secretaries send e-mails to CMHSPs that they include the professional staff's names in the subject line. CMHSPs are also confused about when they should expect a hard copy of a document, or when the electronic version will suffice.

c. Regarding item #11: Tom Renwick indicated that 18-20 pages have been deleted from the site review protocols because the external quality review is now covering many managed care elements.

d. Regarding item #14: delete

e. New: Floyd suggested that there be a work plan goal for addressing federal requirements on an ongoing basis.

f. New: It was suggested that the PIT revisit its recommendations for deleting certain Section 404 (of the Appropriations Act) requirements for data, in time for it to be effective.

VI. Kevin's Law: The MACMHB and the Michigan Courts Association are coordinating training on implementation of the law. This group needs to be proactive regarding potential data collection requirements. Dave will check into the language of the law to see if there are any reporting requirements and let us know at our next meeting. The law goes into effect April 1st.

VII. Record Retention: The Thumb Alliance talked with Mark Kielhorn regarding the variability of record retention requirements (specifically, length of time). For example, Department of Management and Budget requires records to be retained locally for 20 years after death or discharge, whichever comes later, and then the records are to be sent to the state archivist. Medicaid requires seven to eight years for record retention. It was suggested that the state archivist might be of some assistance.

VIII. Evidence Based Practice Implementation: Jim Wotring indicated that we should be able to reduce paperwork once the implementation phase is over, however, evaluation of the implementation may create some documentation

burden. It was suggested that we should stop evaluating after we know a practice is working well, then use the performance improvement projects for those practices that are not working well.

IX. Report to Legislature: Appropriations Act boilerplate requires a report to the legislature on the administrative simplification activities March 31, 2005. Judy will develop a draft report and send out to members by February 15th. Members will approve the report at its next meeting, March 22nd.

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM
Summary of March 22, 2005 Meeting

I. Judy Webb welcomed the group.
II. The tentative agenda was adopted as written.
III. No changes were suggested for the January 25, 2005 meeting summary.
IV. Status reports:
    a. EDIT: Judy reported that EDIT has recently been focusing on developing options for reporting costs per procedure code to recommend to the Mental Health and Substance Abuse Administration. EDIT wants the state to require the least burdensome option, which is for the PIHPs to report an allowed amounts table twice a year, as well as a Medicaid sub-element cost report for six months and twelve months. In addition, EDIT would like the due dates for the allowed amounts table, sub-element cost report and financial status report to be moved back 30 days to allow PIHPs additional time for completing the reports. The second EDIT project is to identify additional HCPCS procedure codes or modifiers of existing codes that would distinguish different models of practice – such as one-on-one versus group, different settings – such as day program, group home, own home and supported independent living programs, and different populations – adults with mental illness, children with serious emotional disturbance, and people with developmental disabilities, as these variables are believed to be the primary reasons for the differences in allowed amounts for community living supports and skill building. Dennis Grimski added that EDIT would like these options implemented for FY'05 through a contract amendment, and for the next contract period to commence October 1, 2005.
    b. Quality Improvement Council: Judy reported that the main emphasis of the council work has been on revising the performance indicator system that currently has 49 indicators. A council workgroup has been meeting for six months and, after evaluating the 49 indicators, has reduced the number to 17. The workgroup has also researched national indicators to determine if some should be adopted in Michigan, and has brainstormed about information that the public seems to desire. The result of these efforts has been to propose nearly 20 new indicators. Once the proposed indicators are evaluated against the criteria, it is believed that the revised list will contain approximately 20 indicators. Most of the data for those indicators will come from encounter and demographic data, thus reducing the need for additional reporting from CMHSPs or PIHPs. It was noted that, where feasible, the Medicaid substance abuse indicators will have the same standards as the Medicaid mental health indicators. The largest challenge is to operationally define the data elements since the External Quality

Review has found that we have a problem with data definitions for some of our indicators.

c. Audit: No one was present to give an update on any progress in improving the audit process. Representatives from the MACMHB expressed their concern about the lack of progress in this area since it was the most important issue for the association at the beginning of this project. Judy committed to getting either Pat Barrie or Ed Dore to the next meeting to talk about plans for re-visiting the audit process.

d. Documentation work group: Tom Renwick reported that he has received no feedback from the Association on the draft documentation matrix he sent six months ago. At this point changes need to be made to reflect new requirements for appeals and grievances and the external quality review. Floyd Smith asked for point of clarification about the purpose of the project. Tom responded that the original intent was to identify minimum documentation requirements for person-centered planning and individual plans of service. It was agreed that Tom would make the necessary changes and send to the PIT prior to its meeting in May. After the PIT approves, it will be sent to the Association for input. It was also suggested that there may need to be one provider manual that is a compilation of all the technical memos issued, materials on the MDCH web site, and interpretive guidelines so that all the information is located in one place. It could be posted on the web site, but accessible from the Mental Health and Substance Abuse page. Judy and Dennis reported on a new joint initiative between the Association and MH&SA administration to identify, prioritize and coordinate training topics. Nancy Miller noted that there definitely needs to be a training on reporting requirements.

e. Model Payments: John Jokisch reported that the new automated system goes live on April 1st. He clarified that the CMHSPs will only have to determine eligibility for the personal care, and the group home provider is responsible for submitting the claims to MDCH either electronically or by telephone. Some CMHSPs have not returned their single sign-on form and since there seemed to be lack of understanding about its intent, John will follow up with those CMHSPs.

V. Section 450 Report

a. The draft report was sent to the PIT a week prior to the meeting. During the meeting the group went through each issue and status and made suggested changes or approved it.

b. Nancy Miller will ask Dave LaLumia to send a letter to Janet Olszewski supporting the report by close of business on March 28, 2005. MACMHB representatives noted that the letter will express disappointment in the lack of progress with improving the audit process.

   c. The report will be revised as noted and forwarded to the Legislature by March 31, 2005

VI. Section 404 Report
   a. Previously MACMHB representatives indicated that some of the information required by the Section 404 of the Appropriations Act was burdensome to collect. While the MACMHB could make recommendations on the elements to delete from Section 404, there is not a clear understanding of if or how the information is used by the Legislature or its fiscal agencies.
   b. It was agreed that the MACMHB letter of support would request that the Legislature look at the Section 404, determine what information is used, and delete requirements for any information that is not usable.

VII. Prior to adjournment, the PIT agreed that at its May 17th meeting it would review and approve the Quality Strategy for the managed care waiver renewal (due June 30th), and the documentation grid. Ed Dore, Chief Deputy Director at MDCH, will be invited to the meeting to discuss the audit issue.

Attachment #6

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Mental Health and Substance Abuse Services

COORDINATION OF RIGHTS PROTECTION FOR RECIPIENTS OF CONTRACTED MENTAL HEALTH SERVICES

PRACTICE GUIDELINE

1.0 INTRODUCTION

The Michigan Mental Health Code (MHC), Act 258 of 1974 as amended in 1996, in Section 755 mandates the basic requirements for the establishment of a recipient rights protection system and the responsibilities of each community mental health services program's office of recipient rights. Since the inception of the code required rights protection system, the manner of providing the mental health services has changed while the requirements of the rights office for providing rights protection has remained essentially the same. The result is the necessary adaptation of the rights system to meet the needs of the recipients of the evolving mental health service programs while meeting its legal mandates.

Most significant to the changing needs for the rights system is the ever-increasing use of contracted mental health services in an ever-expanding geographic area. The mandated person-centered planning process and the move towards increasing self-determination has added yet another dimension to the service delivery system and rights protection as mental health services are provided in more non-traditional ways.

2.0 BARRIERS

Experiences of community mental health services program (CMHSP) rights offices in Michigan have identified numerous barriers to the actual implementation of ensuring rights protection for each recipient receiving contracted mental health services. These barriers vary depending, in part, on the size and location of the CMHSP, the resources available to the rights office and the position of the rights office within the CMHSP administrative structure. Identifying and addressing the barriers to accomplishing the mandated elements of a rights protection system resulted in this Practice Guideline.

Barriers identified include the following:

- There are varying definitional interpretations of "mental health" services.
- How does one establish jurisdiction in settings such as adult foster care?
- Distance is a problem when service is provided in another part of the state.
- What rights elements are expected of the small, private practitioner?
- Services are sometimes delivered without a contract.
- Service may include a substance abuse service that falls under a different law.

- A subcontractor of the contracted provider may provide the mental health services.
- The rights office is not notified of new service contracts.
- The rights language in the contract is not consistent with actual practice.
- A recipient may obtain services through a voucher or a self-determination arrangement and not a contract.
- A provider's policies may be reviewed by more than one rights office.
- Licensed private psychiatric hospital/units' (LPH/U) rights policies are requested and reviewed by multiple CMHSP rights offices.
- LPH/U rights policies are also governed by federal standards, e.g. requirements for utilization of restraint and seclusion.
- It is time consuming to review policies of providers who are allowed by Code or contract to develop their own.
- There are no generally accepted standards for a site visit checklist.
- It is time consuming to do site visits outside of the CMHSP service area.
- One provider may have multiple CMHSPs conducting site visits.
- It is difficult to ensure the quality of rights training done by the provider.
- It is impracticable to provide rights training for providers out of the CMHSP service area.
- Providers may have recipients from multiple CMHSPs with varying requirements.
- It is time consuming for LPH/U to track each patient's responsible CMHSP.
- When a provider is allowed to have their own rights office, who monitors them?

3.0 DEFINITIONS

The mandated provision of rights protection services encompasses those recipients who are receiving public mental health services. The Michigan Mental Health Code and Administrative Rules define mental health services thus establishing the minimal standard for the application of rights protection.

1. "Service" is defined as a mental health service. MCL330.1100d (1)

2. The "elements of "service" means one of the mental health services listed in the federal regulations issued under Public Law 88-164, as amended *(the Social Security Act, Title 19 Grants to States for Medical Assistance Programs summarized as follows)*

The five essential elements are: (1) inpatient services; (2) outpatient services; (3) partial hospitalization services, such as day care, night care and weekend care; (4) emergency services, 24 hours per day; and (5) consultation and educational services to community agencies and professional personnel. Five additional elements are: (1) diagnostic services; (2) rehabilitative services, including vocational and educational

programs; (3) pre-care and aftercare services in the community, including foster home placement, home visiting, and halfway houses; (4) training; and (5) research and evaluation. R 330.1021(b)

3. A "service entity" is an organization supplying 1 or more elements of mental health service as a part of a community mental health center. R 330.1021(c)

4. Services of a "specialized program" means a program of services, supports, or treatment that are provided in an adult foster care facility to meet the unique programmatic needs of individuals with serious mental illness or developmental disability as set forth in the resident's individual plan of services and for which the adult foster care facility receives special compensation. MCL 330.1100d(5)

5. "Treatment" means care, diagnostic, and therapeutic services, including the administration of drugs, and any other service for the treatment of an individual's serious mental illness or serious emotional disturbance. MCL330.1100d (12)

6. A "provider" means the department, each community mental health services program, each licensed hospital, each psychiatric unit and each psychiatric partial hospitalization program licensed under section 137 of the act, their employees, volunteers, and contractual agents. R 330.7001 (1)

7. "Rights protection system" encompasses those elements (including but not limited to complaint investigation / resolution, prevention, and monitoring) required by the Michigan Mental Health Code in the establishment of the Office of Recipient Rights by community mental health services programs and hospitals. MCL 330.1755(1)-(6).

4.0 APPLICATION OF RIGHTS PROTECTION

Mental health services are further defined in "Program Elements and Sub-Elements" of the MDCH/CMHSP Managed Specialty Supports and Services FY 03-04 Contract: Attachment C.6.5.1.1, pages 23 – 35 or as hereinafter amended. The lists reflect activity that is authorized, managed and/or provided directly or under contract with a CMHSP whether covered by Medicaid, private insurance or paid for by state or local funds. The descriptions of program elements are consistent with coverage in revised Chapter III of the Medicaid Bulletin.

In addition to the rights protection guaranteed to recipients of mental health services, recipients receiving Medicaid covered services may be afforded additional protections such as the right to request a fair hearing. Those recipients receiving mental health

services while under the jurisdiction of Family Independence Agency (FIA) may have the right to appeal determinations on eligibility for and level of benefits. The Family Independence Agency (FIA) Adult Foster Care Licensing provides rights for residents and law enforcement or state and local corrections systems may have additional complaint grievance mechanisms.

Rights protection may be specifically defined in the contractual agreement with a service provider. The contract may specifically bind the provider to ensuring rights protection for recipients when receiving its service regardless of whether the service meets the definition of mental health service. Examples include a contract for transportation services, an agreement with an adult foster care provider who is not receiving compensation for specialized services, the services of a fiscal intermediary or other services purchased by or on behalf of a recipient pursuant to a choice voucher/ self-determination process.

The CMHSP may establish additional definitions of a mental health service requiring rights protection for recipients of that service. For example, services obtained by the recipient using a voucher system from a provider not otherwise bound to ensure recipient rights.

5.0 CIRCLE OF KEY ELEMENTS

The coordination of rights protection can be viewed as a continuous circle with the recipient at the center. The circle of key elements are, 1) mental health service providers, 2) mental health service contracts, 3) recipient rights protection. In practice, the CMHSP recipient identifies desired goals through a person-centered planning process. Treatment objectives are planned which indicate what mental health services are necessary to carry out the plan. The CMHSP may provide the services either directly or through a contracted service provider. In this case, a contract is put in place for obtaining the desired or required service. Each contract for mental health services should include sufficient language to ensure rights protection for that recipient while receiving the contracted service. The CMHSP rights office either provides or coordinates rights protection to ensure that each of the mandated functions of the rights protection system is in place for that recipient during the course of that contracted mental health service. The circle continues as the recipient's treatment and/or support plan changes and new services are needed.

6.0 PRACTICE GUIDELINES

Every rights office is faced with challenges when trying to meet its responsibility to either provide or coordinate rights protection for recipients receiving the services of a contracted mental health service provider. The Practice Guidelines follow the circle of key elements of rights coordination and state the ideal situations for each element based on mandates of the Mental Health Code and Administrative Rules. The guidelines then offer choices of actions for the rights officer to consider depending on their particular situation.

7.0 ESTABLISHING RIGHTS PROTECTION SYSTEM JURISDICTION

7.1 Ideal

The jurisdiction for ensuring rights protection when a recipient receives mental health services is clearly defined.

7.2 Legal Reference

Each office of recipient rights established under this section shall do all of the following: (a) provide or coordinate the protection of recipient rights for all directly operated or contracted services. MCL 330.1755(5)

7.3 Guidelines

A. Provide rights protections to every recipient, regardless of his/her county of origin, while that individual is receiving services from the directly operated or contracted service provider located within the CMHSP service area.

1. MCL 330.1206(1)(e) establishes that a CMHSP is to provide recipient rights to individuals located within their geographic area regardless of their ability to pay.

2. MCL 330.1306(2) states a CMHSP will not deny or delay requested services on the basis that the individual's county of residence is in the service area of another CMHSP.

B. Establish jurisdiction for rights protection by including specific rights protection language in contracts with mental health service providers. Jurisdiction may be established in written agreements with those service providers with whom the CMHSP wishes (but is not required) to establish such jurisdiction, for example when non-mental health services are provided.

C. Identify those programs within the CMHSP service delivery system that are considered substance abuse treatment programs and therefore are not under the jurisdiction of the mental health rights system.

1. Locate and maintain referral information identifying the individual to contact for substance abuse treatment programs rights services.

2. *Become knowledgeable of the federal laws governing confidentiality in substance abuse treatment programs, found in 42 CFR Part 2 and state rules governing substance abuse rights protection in R 325.14301 – R325.14506.*

8.0 MENTAL HEALTH SERVICE PROVIDERS

8.1 Ideal

Rights protection is established with the contracted service provider prior to the recipient receiving the service.

8.2 Legal Reference

Each office of recipient rights established under this section shall do all of the following: (a) provide or coordinate the protection of recipient rights for all directly operated or contracted services. MCL 330.1755(5)

8.3 Guidelines

A. *Establish a mechanism by which the contracts manager and the rights office are included in the CMHSP process where decisions are made concerning the acquiring of new or retaining of current mental health service providers.*

1. *Ensure timely notification to the contracts manager and rights officer of changes or additions of contracted providers such as, by using electronic mail notification.*

2. *When a contract is considered for renewal, the rights office provides the results of site visit monitoring substantiated rights violations and the timeliness and effectiveness of remedial action concerning the provider under consideration.*

3. *Prior to establishing a contract with a new provider, the rights office obtains from other rights offices information relative to the prospective provider's protection of rights including results of site visit monitoring.*

4. *Establish the role of the rights office in the administrative process in CMHSP policy.*

B. *When interagency agreements, such as for wrap-around services, are developed, include provisions for timely notification of service acquisition to the contracts manager and rights office. Discuss elements of compliance with rights protection agreements at meetings with interagency collaborative groups.*

C. *Establish regularly scheduled meetings with representatives of the provider network as an opportunity to discuss rights protection compliance issues.*

B. *Require the provider, by contract, to submit a monthly list of all new service sites and changes to existing services sites of its sub-contracted service providers.*

8.4 Ideal

Contract manager and rights officer are notified when mental health services requiring a contract are being considered.

8.5 Legal Reference

Each contract between the community mental health services program or licensed hospital and a provider requires both of the following: (i) That the provider and its employees receive recipient rights training, (ii) That recipients will be protected from rights violations while they are receiving services under the contract. MCL 330.1755(2)(f)

8.6 Guidelines

A. *Establish procedures to ensure that those staff responsible for treatment planning notify the contracts manager and rights officer prior to or immediately upon acquisition or implementation of a new contracted mental health service provider or service site.*

B. *Maintain all contracts and agreements for the provision of mental health services in writing. The contracts include appropriate and sufficient provisions specific to rights protection relevant to type, location, and scope of services provided.*

C. Establish in CMHSP policy the role of the contracts manager and rights officer in the administrative process.

D. Include questions related to rights protection in any application process for the procurement of mental health services, such as a Provider Network application. At a minimum, solicit information as to whether the provider has been monitored by a rights office. Contact that rights office for information concerning the provider's rights protection.

8.7 Ideal

ORR has current and complete information regarding providers and individuals over whom it has jurisdiction.

8.8 Legal Reference

Each contract between the community mental health services program or licensed hospital and a provider requires both of the following: (i) That the provider and its employees receive recipient rights training, (ii) That recipients will be protected from rights violations while they are receiving services under the contract. MCL 330.1755(2)(f)

8.9 Guidelines

A. Establish and maintain a database within the CMHSP containing up to date information concerning current mental health service contracts/subcontracts, effective date, type, contractor's address, contact (name, phone number), number of individuals receiving services under contract/subcontract, and service site names and addresses.

B. Require subcontractors of contracted service providers to adhere to the same reporting requirements.

C. The rights office has access to current provider information by accessing the database.

D. Post the database on the CMHSP web site for access by other CMHSPs for purposes of rights coordination.

E. Establish the reporting and data collection process in CMHSP policy and procedure to ensure timely notice to ORR and contract manager of the procurement of new/additional contracted services or sites.

9.0 MENTAL HEALTH SERVICES CONTRACT

9.1 Ideal

Contract language ensures rights protection for recipients while receiving the contracted mental health service.

9.2 Legal Reference

Each contract between the community mental health services program or licensed hospital and a provider requires both of the following: (i) That the provider and its employees receive recipient rights training, (ii) That recipients will be protected from rights violations while they are receiving services under the contract. MCL 330.1755(2)(f)

9.3 Guidelines

A. Establish and maintain boilerplate rights language applicable to the different types of mental health service providers.

1. Language may differ depending on the type of service, such as residential vs. outpatient services.

2. Language may vary depending on the location of service, such as within or outside of the CMHSP service area.

B. Specify contract sanctions for failure to comply with rights protection mechanism.

C. Collaborate with the contracts manager to develop language that is appropriate to the service and setting, and contains the specificity necessary to ensure rights protection. At a minimum, every contract addresses each of the following elements.

9.3.1 Jurisdiction

A. Clearly specify who is responsible for implementing the rights system.

B. If the CMHSP rights office retains jurisdiction, bind the provider

and its employees to compliance with and acceptance of the jurisdiction of the CMHSP rights protection mechanism.

C. If the provider is allowed to establish its own rights system, such as a licensed psychiatric hospital/unit, include language to allow the responsible CMHSP rights office to retain final jurisdiction.

9.3.2 Policy/Procedures

A. Clearly specify whose rights policies, established in accordance with MCL 330.1752, must be followed.

B. If the provider is allowed to develop its own rights policies and procedures, require the provider to submit its rights policies and any revisions to the CMHSP for review as to compliance with MDCH standards as reflected in the most current Attachment B of the MDCH/CMHSP Rights System Assessment Tools.

C. If the provider is expected to follow the CMHSP rights policies and procedures, specify so in the contract. The applicable policies and procedures may vary depending on the type of service such as specialized residential verses outpatient. Identify the applicable policies for each type of service. Incorporate the specific policies by reference and attached to the contract or make part of a provider manual.

9.3.3 Training

A. Clearly specify that the provider's employees must receive rights training within 30 days of hire, at a minimum.

B. Clearly specify who is responsible for provision of this training.

C. If the provider is responsible for providing the rights training, require it to provide the CMHSP rights office with (a) the rights training curriculum for review and approval and (b) the list of trainees with dates of hire and training.

D. Include language requiring rights training periodically thereafter as determined by the CMHSP but minimally upon substantive revisions to applicable federal and state laws, rules, and regulations.

9.3.4 Monitoring/Site Visits

A. Clearly specify who is responsible for site visits/monitoring.

B. If the provider's rights office is responsible, (a) require the use of a checklist form reviewed by the CMHSP rights office to assure it is sufficient to monitor rights protection and (b) CMHSP rights office must be provided copies of all site visit/monitoring reports.

9.3.5 Chapter 7A Complaint Resolution

A. Provider must comply with Chapter 7 of the Mental Health Code and protect the rights of recipients receiving services under the contract.

B. Provider must comply with Chapter 7 and 7A of the Mental Health Code relative to complaint investigations, reports, and remediation.

C. The CMHSP rights office must be guaranteed unimpeded access to provider's premises, staff, records, and the recipients of services under the contract.

D. Staff of the provider are required to cooperate in an investigation by the CMHSP rights office.

E. The CMHSP rights office must be immediately notified of incidents of apparent or suspected abuse, neglect, serious injury or death of a recipient while receiving services from the provider.

9.3.6 Coordination with LPH/U

A. Clearly specify the coordination responsibilities of the CMHSP rights office when the LPH/U rights office implements rights protection services.

B. LPH/U rights office must comply with Chapter 7 and 7A relative to complaint investigations, reports and remediation and MDCH standards as reflected in the most current version of Attachment C of the MDCH/CMHSP Rights System Assessment Tools.

C. The CMHSP rights office must be guaranteed unimpeded access to provider's premises, staff, records and the recipients of services under the contract.

D. The CMHSP rights office must be immediately notified of incidents of apparent or suspected abuse, neglect, serious injury or death of a recipient while receiving services from the provider.

E. Copies of complaints, Acknowledgment Letters, Intervention Responses, Investigative Reports, and Summary Reports relative to a CMHSP recipient are to be provided to the CMHSP rights office for monitoring/coordination purposes.

9.3.7 Coordination with CMHSP

A. In the event of a contract for services provided by another CMHSP and its
contracted service providers, establish which CMHSP rights office has jurisdiction for the provision of rights protection services.

B. The contract may specify that the CMHSP providing the services (i.e., the provider CMHSP rights office) is responsible for the protection and investigation of rights of recipients while receiving services from it or its contracted providers.

C. When requested, the provider CMHSP rights office will submit to the responsible CMHSP rights office appropriate information on investigations related to the recipient in accordance with the confidentiality provisions of MHC Section 748 and 750 and other applicable state and federal laws.

D. Both the provider CMHSP rights office and the responsible CMHSP rights office must be guaranteed unimpeded access to the service provider's premises, staff, records, and recipient/s receiving services under the contract.

E. The responsible CMHSP rights office must be immediately notified of incidents of apparent or suspected abuse, neglect, serious injury or death of a recipient while receiving services from the provider CMHSP system.

9.3.8. Coordination with DCH Facility

A. In the event a CMHSP recipient is on inpatient status at a state hospital or center, the protection and investigation of rights of recipients shall be the responsibility of the MDCH – ORR.

B. When requested, the MDCH-ORR will share appropriate information on investigations related to the CMHSP recipient in

accordance with the confidentiality provisions of MHC Section 748 and 750 and other applicable federal and state laws.

10.0 RECIPIENT RIGHTS PROTECTION - Policies and Procedures

10.1 Ideal

Rights office provides or coordinates rights protection for recipients of contracted mental health services in compliance with the Mental Health Code, Administrative Rules and Master Contract.

10.2 Legal Reference

Each office of recipient rights established under this section shall do all of the following: Review the recipient rights policies and the rights system of each provider of mental health services under contract with the community mental health services program or licensed hospital to ensure that the rights protection system of each provider is in compliance with this act and is of a uniformly high standard. MCL 330.1755 (5)(g)

10.3 Guidelines

A. When the service provider is required to follow the CMHSP rights policies and procedures, the CMHSP Provider Manual is sent with each contract for services, containing all applicable recipient rights policies.

1. Develop a protocol to indicate which rights policies are applicable for each type of service provider. For example, policies concerning rights in specialized residential setting are not applicable to an outpatient provider.

2. Maintain current policies and send policy revisions to providers.

3. Require that all applicable rights policies be maintained at each service site.

4. Check for the accessibility of the rights policies during annual site visits.

B. When the service provider has been allowed, per contract and/or statutory language, to develop it's own rights policies and procedures:

1. The CMHSP rights office must review these policies and procedures and any revisions to assure compliance with the Mental Health Code, Administrative Rules, and standards established by MDCH/ORR in the most current version of Attachment B of the MDCH/CMHSP Rights System Assessment Tools.

2. Identify any policy deficiencies; follow up to assure correction and review/accept the corrected policy. Maintain all documentation/correspondence related to policy compliance review

3. A CMHSP may share its policy review and related documentation upon the request of another CMHSP also holding a contract with the provider. The receiving CMHSP remains responsible for the contents of the policy and the accuracy of the review conducted by the sending CMHSP.

C. If the service provider follows the rights policies and procedures of the CMHSP of the county where the service is located,

1. Confirm with the CMHSP rights office that policies have been given to that provider.

2. Determine the compliance status of the other CMHSP rights office's policies and procedures by accessing the results of the MDCH ORR on-site assessment results for compliance with policy standards.

11.0 RECIPIENT RIGHTS PROTECTION – Site Visits

11.1 Ideal and Legal Reference

Each office established under this section shall do all of the following: Ensure that each service site is visited with the frequency necessary for protection of rights but no less than annually. MCL330.1755 (5)(e)

11.2 Guidelines

A. Develop a tool for documenting the results of annual (minimally) site visits to all mental health service sites. Maintain documentary evidence of site visits.

1. Incorporate all applicable elements from the rights language contained in the contract with the service provider into a checklist to document the findings at the site.

2. Include general rights provision on the checklist based on the basic legal requirements of a rights system. For example, check for postings identifying the rights officer, determine if recipients and staff are familiar with rights officer, are complaint forms and booklets available, are abuse/neglect reporting requirements posted, are rights policies/procedures available, and are staff trained within 30 days of hire.

3. Include clinical record review results on the checklist. For example, record contains evidence of consent, person centered planning, and summary of Sec. 748; behavior treatment plans do not contain provisions that result in rights violations, e.g. restraint, seclusion.

4. Establish a process for documentation of provider's correction of deficiencies.

B. If the service provider or another entity is allowed by contract or statute to establish its own rights office, monitor and maintain documentation of that rights office's compliance with the site visit requirements.

C. When establishing contract sanctions, include sanctions for failure to correct deficiencies identified in site visits.

D. Coordinate site visits with other CMHSP reviews such as Contract Compliance, Quality Improvement, Credentialing, or Safety reviewers.

1. Incorporate rights provisions into the monitoring tool.

2. Provide training on the rights provisions to the other site reviewers to ensure competency of the review.

12.0 RECIPIENT RIGHTS PROTECTION - Postings

12.1 Ideal

Rights office provides or coordinates rights protection for recipients of contracted mental health services in compliance with the Mental Health Code, Administrative Rules and Master Contract.

12.2 Legal Reference

Each office of recipient rights established under this section shall do all of the following: Ensure that the telephone number and address of the office of recipient

rights and the names of rights officers are conspicuously posted in all service sites.
MCL 330.1755 (5)(c)

12.3 Guidelines

A. Include the rights poster identifying the rights officer and contact information with the service provider's contract. Include instructions for posting in a conspicuous place at the service site.

B. Assess the need for postings in alternative language(s) and provide as needed.

C. Include in the site visit checklist, a check for the poster identifying the rights officer and contact information

D. For those sites that also have a rights advisor at the site, provide a space on the poster for that person's name and contact information.

13.0 RECIPIENT RIGHTS PROTECTION – Training

13.1 Ideal

Each rights office assures that all CMHSP employees, contracted employees and employees of contracted service providers receive recipient rights training before or within 30 days of hire.

13.2 Legal Reference

Each office of recipient rights established under this section shall do all of the following: Ensure that all individuals employed by the community mental health services program, contract agency, or licensed hospital receives training related to recipient rights protection before or within 30 days after being employed. MCL 330.1755 (5)(f)

13.3 Guidelines

A. Develop rights training curriculum(s) relevant to target audience(s).

B. Attend DCH/ORR Developing Effective Rights Training (D.E.R.T.) or DCH-ORR equivalent.

C. Establish rights training for residential service provider's staff consistent (at a minimum) with the DCH approved group home training curriculum.

D. Offer "face to face" rights training every 30 days to ensure new employees are informed by the rights officer of performance expectations for rights protection.

E. If the service provider or another entity is allowed by contract to conduct the rights training, require CMHSP-ORR approval based on review of the training curriculum to ensure the adequacy of the content.

F. If the service provider receives rights training from another rights office,

1. Confirm the training provision with the other CMHSP rights office.

2. Determine the adequacy of that CMHSP rights office training by accessing the DCH/ORR on-site assessment results for compliance with training standards.

G. Monitor service provider's compliance with the training requirement.

1. Require service providers to maintain data to demonstrate employees receive rights training within 30 days of hire.

2. Include review of documentation of training compliance during site visits to service providers.

3. Maintain documentation of all service providers' training compliance.

H. Establish the frequency of required rights training in policy and procedures in compliance with the Mental Health Code and at a minimum, when there are substantive changes in Code, Rules or MDCH contract requirements.

I. Establish contract sanctions for failure of a service provider to comply with all applicable policy and procedure standards regarding training.

14.0 RECIPIENT RIGHTS PROTECTION - Jurisdiction for Investigations

14.1 Ideal

Each CMHSP rights office assures that all reports of apparent or suspected rights violations in its service delivery system are investigated and/or resolved in accordance with the requirements of Chapter 7A of the Mental Health Code.

14.2 Legal Reference

Each office of recipient rights established under this section shall do all of the following: Ensure that all reports of apparent or suspected violations of rights within the community mental health services program system or licensed hospital system are investigated in accordance with section 778 and that those reports that do not warrant investigation are recorded in accordance with subdivision (d). MCL 330.1755 (5)(i)

14.2 Guidelines

A. If the service provider is a licensed hospital within the CMHSP service area, include a review of the investigations involving the CMHSP recipients for compliance with Chapter 7A during annual site visit.

B. NOTE: Licensed hospitals are required to comply with Chapter 7 rights protections and 7A complaint resolution process and are monitored by their licensing body in the Department of Community Health.

1. LPH/U rights advisors establish a mechanism to identify those patients who are shared CMHSP recipients.

2. LPH/U rights advisors provide copies of investigation documents to the CMHSP rights office when required by CMHSP contract.

3. LPH/U rights advisors will refer recipients to the appropriate Appeals Committee as determined by identifying those LPH/U recipients who are also CMHSP recipients.

C. If the service provider or another entity is allowed by contract to establish its own rights office, monitor the investigation of the complaint(s) concerning the CMHSP recipients to ensure compliance with the Chapter 7A process.

D. If the service provider is outside the CMHSP service area, establish an agreement with the rights office of the CMHSP for the county where the service is located. The agreement may specify that rights office to do investigations when necessary and provide a report of investigative findings to the responsible CMHSP rights office for completion of Chapter 7A process.

E. Rights office of the responsible CMHSP maintains final jurisdiction to investigate alleged or suspected rights violations for recipients receiving contracted mental health services to ensure Chapter 7A compliant investigation process.

Attachment #7

Audit Reporting Framework

	Role of CMH	**Role of DCH audit**	Role of DCH Admin
	Provide Data as Requested	Develop the findings for preliminary document	
	More data should be provided based on oral presentations.	Oral progress meetings are available upon request during audit process	
	More data should be provided based on oral presentations	**Oral Close-out meeting**	
		Preliminary Report completed.	
	Ask for another meeting if more clarification is needed.		
	Identify where more data can be provide to rectify issues.	**Factual & Interpretive Conference**	Present if requested by CMH
		Alter preliminary report as new data is presented.	
		If there were enough changes a revised preliminary report is issued.	
	A formal response is prepared and submitted.		
		Final report	
	Accept all findings, or		Accept plan of correction as proposed in audit.
	Request hearing with Administrative law judge.		
	Accept findings of judge, or		
	File In Civil Court		

Michigan Association of
COMMUNITY MENTAL HEALTH
Boards

March 28, 2005

Janet Olszewski, M.S.W., Director
Michigan Department of Community Health
Lewis Cass Building
Lansing, MI 48913

Dear Janet:

The Michigan Association of Community Mental Health Boards appreciates the ongoing commitment of the Department of Community Health to examine ways to simplify and streamline administrative and reporting requirements of CMHSPs which add costs to our system but produce little or no value for consumers.

We wish to acknowledge the department's inclusion of CMH representatives to the Administrative Simplification Process Improvement Team and thank you for the opportunity to work with DCH team members on this project once again this year. Representing CMHSPs on the team are: Mary Anderson (Newaygo), Robert Chadwick (Tuscola), Dennis Grimski (St. Clair), David LaLumia (MACMHB), Nancy Miller (LifeWays), Wendy Niven (Macomb), Robert Sheehan (CEI) and Floyd Smith (AuSable Valley). This letter will comment on accomplishments, ongoing efforts and areas in which significant work remains.

We also appreciate the interest and support which the Legislature has expressed in encouraging administrative simplification. The inclusion of Section 450 in the FY2005 DCH appropriation act (Act 349 of the Public Acts of 2004) directs the department to continue the work group on administrative simplification established in FY2004 and to submit a report by March 31, 2005. We respectfully request that this letter be included as part of the Section 450 report on administrative simplification to the Legislature.

This year, the Administrative Simplification Process Improvement Team continued to review service documentation requirements. The Quality Improvement Council continued to provide an ongoing forum for CMH, DCH, consumer, advocate and other stakeholders to review items related to improving quality of care and simplifying administrative and clinical processes. The March 31, 2005 Section 450 report describes, in detail, the progress made on ongoing issues and also describes the new issues added to the agenda by MACMHB for consideration by the group. One new issue is review of the Section 404 CMH reporting requirements contained in the FY2005 DCH appropriation act. We recommend language be added to the FY2006 bill directing that the House and Senate Fiscal Agencies review the Section 404 reporting requirements and recommend elimination of those requirements not used by the Legislature for decision-making. We

ask that the Department of Community Health join us in making this request.

One of the primary concerns of CMHSPs giving rise to the Administrative Simplification Process Improvement Team effort was the DCH fiscal audit process. The most disappointing part of our work with the department for the past two years has been the lack of progress in addressing these concerns. The DCH fiscal audit process remains costly, unreasonably lengthy and time consuming for CMHSPs. This burdensome process continues to result in litigation and legal expenses on issues which ought to be resolved through bi-lateral negotiations. These wasted resources should be available to provide essential services and supports for consumers. As the outcomes we had hoped for have not been achieved, the fiscal audit process will remain a high priority of CMHSPs throughout 2005/2006. We reiterate our interest in working with the department to address the problems which have been identified with the DCH/CMH audit process.

In summary, the administrative simplification process has already produced important results. It is essential that this process continue and that the work of the audit, QI Council and documentation work groups be supported and remain a high priority. We recommend that Section 450 which has kept a legislative focus on this work for the past two years be retained and included in the FY2006 DCH appropriation act which is being drafted by the Legislature. We recommend examination of the Section 404 boilerplate reporting requirements which affect both CMHSPs and the department. Reform of the DCH/CMH fiscal audit process will remain a high priority for Administrative Simplification Process Improvement Team activities in the coming year.

We have learned, and we think the department will agree, that administrative simplification must become more than a time limited task force. It must become a value embraced by both the CMH network and the department and a part of a culture which evaluates all administrative and clinical requirements based on whether or not they improve outcomes for consumers. We look forward to working with the department and the Legislature in 2005/2006 to create this culture and continue this productive process.

Finally, we wish to recognize the leadership provided by Judy Webb throughout this process. Her commitment to a culture change and her willingness to sort through and synthesize requirements which unduly burden the system, especially in areas of quality improvement, are greatly appreciated. Judy, more than any other individual, has made this process work and contributed to its success. We are most appreciative of her efforts and commitment. Thank you.

Sincerely,

Mary Anderson
Immediate Past President

David LaLumia
Executive Director