SECTION 450 REPORT ON ADMINISTRATIVE SIMPLIFICATION
March 31, 2004

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 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 the 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 list addresses issues in five categories: Deemed Status/Accreditation, Audits, Reporting Requirements, Medicaid, and Other. MACHMB subsequently indicated that its priorities were Deemed Status/Accreditation and Audits.

Process for Improvement

MDCH established in May 2003 an internal 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.

MACHMB named eight representatives to join the PIT in June 2003. This Administrative Simplification PIT met monthly between June and March 2004. Summaries of each meeting can be found in Attachment 3. 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).

Findings

Analyses of the reporting and site visit requirements indicated that most resulted from MDCH's need to comply with the following federal and legislative requirements:

- Sections 404 and 426 of the MDCH Appropriations Act, the first of which requires reporting on 12 elements, each containing multiple data elements.

- The Center for Mental Health Services (CMHS) which administers the Mental Health Block Grant ($13.2 million for Michigan) and requires a minimum data set of characteristics of all persons with mental illness served as well as performance indicators that measure the state's progress in meeting its goals and objectives for serving persons with mental illness.
- The Centers for Medicare and Medicaid Services (CMS) which administers the 1915(b) and (c) Medicaid waivers and requires beneficiary encounter data reporting, performance indicator and performance improvement projects reporting, and on-site monitoring
- The Balanced Budget Act of 1997 which requires beneficiary level encounter and demographic data and provider characteristics reporting, annual external quality review (some site visits may be involved) and reporting on grievances and appeals tracking.

Attachment 4 contains a table of all the reporting and their genesis.

MDCH does have the discretion in the following areas:

- The timing and process for its site reviews (Issue A.2 and 3). CMHSPs expressed concerns about having multiple visits from various MDCH units throughout the year. In fact, a CMHSP could be visited as many as seven times in a year for reviews of Children's Waiver, CMHSP certification, Recipient Rights system, Medicaid program Phase I and Phase II, Children's Diagnostic and Treatment certification, and audit. A MACMHB survey of CMHSPs suggested that there is preference for consolidated visits, even if they resulted in larger teams of MDCH staff in attendance, if the frequency could be reduced
- Number and foci of performance indicators (Issue C.17, 18, 19,20, 21, 22, 25, 27). The performance indicator system has grown since 1996 to now include 49 indicators. Although only seven of the indicators have standards that must be met, and a quarter of the indicators can be calculated from other data that are already reported to the state, MDCH can reduce the number of indicators, and can change what they measure. MDCH and MACMHB agreed that there should be more focus on outcomes of service.
- Timing and format of certain reports (Issue C.9, 8,10,16). While some of the reports required by MDCH can be submitted electronically, others are still paper. In addition, due dates differ: some reports are due the last day of the month following a quarter, some the 10th day following the close of the quarter, and others the last day of the third month following the quarter. Cycles of the various report due dates are monthly, quarterly, semi-annually, and annually

Accomplishments

In the ten months since the MACMHB submitted its concerns, the Administrative Simplification Process Improvement Team and MDCH have accomplished a number of improvements that are summarized below.

- MDCH provided clarification to MACMHB about the difference between Medicaid reviews and certification reviews, and what "deemed status" means. Medicaid reviews are conducted annually at the PIHPs for the purpose of reviewing compliance with Medicaid policy and regulation, and the PIHP contract and its attachments (Issues A 1

through 4). Certification reviews occur on a three-year cycle for the purpose of determining a CMHSP's compliance with Section 330.1232a of the Mental Health Code. A certification site visit is waived if the CMHSP and its providers are accredited by a national accrediting body. In this case, a CMHSP is said to have "deemed status."

- MDCH consolidated Medicaid site reviews into one annual visit to the PIHP that includes the Children's Waiver, Habilitation Supports Waiver, and 1915(b) waiver (including Medicaid substance abuse services) (Issue A.3). The foci of the annual visit are clinical record reviews, consumer interviews, meeting with the PIHP consumer advocate advisory committee, and review of any outstanding plans of correction. Review of administrative policies and procedures relative to the 1915(b) waiver will occur during the visit every other year. Any certification reviews that are due to be conducted during the year will occur during this annual visit as well.
- A number of PIHP and CMHSP contract requirement improvements will appear in the next contract amendments:
    - Waived the financial status report (FSR) for 1st quarter (Issue C.3)
    - Eliminated two elements (Habilitation Supports Waiver flag and service designation flag) from demographic data (Issue 19)
    - Eliminated one OBRA performance indicator (Issue 19)
- Eliminated quarterly reporting to the Habilitation Supports Waiver data base (Issue C.4)
- The Administrative Simplification PIT recommended that MDCH re-establish a quality improvement council (QIC) that would advise the department on its quality management activities. Several issues identified on the MACMHB list were referred to the QIC: revamping the performance indicator system (Issue C. 18), reviewing Section 404 for potential recommendations for reductions, and looking at the site review processes for further consolidation. The QIC, made up of five MACHMB representatives, seven advocates, two consumers of mental health services, two providers, and MDCH staff had its first meeting on January 22, 2004. The QIC supported MDCH's proposal to use eight Medicaid performance indicators for the external quality review as the current performance indicators do not focus solely on Medicaid beneficiaries, an requirement of the mandatory external quality review. This will require contract action, and additional reporting for PIHPs. The QIC analyzed the Section 404 requirements and made recommendations for changing and reducing the elements (See Attachment 5). The QIC will also review the performance indicator system, and suggest improvements for the next contract period.
- MDCH Mental Health program and policy staff now include audit staff in discussions about 1915(b) and (c) waiver implementation (Issue B2).
- The Transportation Workgroup, made up of representatives from MDCH, CMHSPs, advocates, FIA central office, and Medicaid Health Plan administration, analyzed the policies that dictate provision of Medicaid-funded transportation services. The group created a matrix that explains what transportation services are covered for what Medicaid beneficiaries (e.g. those enrolled in Medicaid Health Plans and those beneficiaries who are not) and in what circumstances, such as emergencies, to medical appointments, and to community activities (Issue C.26). The matrix will be shared with local CMHSPs, Family Independence Agencies, Medicaid Health Plans, providers, and advocates

Attachment 6 includes a table with the accomplishments and issues for which work continues.

Improvements in Progress

A number of the issues on the MACMHB list are being addressed and are works-in-progress. These include:

- Audit Process Improvement (Issue B 1 and 2). There has been a commitment from MACMHB and MDCH continue discussions, seeking mutual agreement on improvements.
- Minimum expected documentation (Issue C. 12 and 13). The ad hoc group has analyzed all the requirements for documentation, and will make recommendations for disseminating information to CMHSPs, PIHPs and providers about MDCH's minimum expectation for documenting person-centered planning, individual plans of services, and service delivery.
- Performance Indicator System (Issue C.19 - 23). The Quality Improvement Council will appoint an ad hoc group in March to review the indicators, compare them to those collected in other states and to those required at the national level; determine those that best describe the Michigan system and that meet the information needs of various stakeholders; and make recommendations to MDCH for change. The ad hoc group could look for alternative methods for measuring performance, and alternative foci (such as, outcomes or evidence-based practice)
- ORR and cert review coordinated schedule (Issue A.3). MDCH is in the process of coordinating the scheduled Office of Recipient Rights three-year assessments so that the visits will coincide with the expiration of a CMHSP's certification. The feasibility of consolidating the ORR assessment protocol with the remainder of the certification review is being considered.
- Development of incentives. While not an issue addressed in the MACMHB list, the Administrative Simplification PIT asked that MDCH consider incentives for improving CMHSP and PIHP performance. MDCH is in the process of developing such incentives and will work with MACMHB to reach agreement for including incentives in next year's CMHSP and PIHP contracts.

The Administrative Simplification PIT will oversee the implementation of the improvements listed above during the coming year, and will develop an ongoing sustainable process for the MACMHB and MDCH to work together. A letter of support of this report from the MACMHB is included in Attachment 7.

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/no 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 8/01/03

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
A.1. Certification (including Children's Diagnostic) Process	A. 4. Site reviews of 1915(b) and (c) waivers		A.1. Difference between certification review and annual site review	
A. 3. Scope, frequency, consolidation of site reviews	B. 1.Reduce scope of DCH financial audits.	B. 2. Difficult to obtain clarifications from DCH around issues which may have future audit implications.		
Provide incentives for meeting or exceeding standards	Impose sanctions for poor performance			
C.12. Documentation needed to verify that direct care was provided	C.19.b. Diagnosis code is insufficient for determination of developmental disability, and for eligibility for specialty services and	C.14. Improve timeliness, reliability, and accuracy of statewide data. Would like to discuss strategies for doing	C.4. & D.6: MACMHB members may need additional training to understand the HSW registration process	C.8. Evaluate the need for PPGs: Budget office and CMHSP contracts

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
	supports. Need to know who is DD and who is MI	this.		
C.18. What outcome measures should be retained, what measures dropped when the system demonstrates good performance	C.19.f. and 24: QI data needs to be reported monthly so that it can match up with 837.	C.16. ORR data reporting could be consolidated to annual; and categories of reporting consolidated as well.	C.15. Reviews of CCI/LPUs can be coordinated among CMHSPs thus eliminating duplicative reviews	C.25. CAFAS requirements: check out utility with Wotring
C.19.a. Need for COB is being discussed in workgroup that Fitton and MACMHB are coordinating	C.19.h. Medicaid penetration rate required by CMS	C.19.c. Service designation: has proved to be of no use	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
C.19.e. Program eligibility is not present on 837, and collecting it is required by Sec. 404. Ask Approps to reconsider 404	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	C.20. Small "n": DCH's reporting of Performance indicators accommodates this in the narratives	

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
requirements				
C.19.h. Information from QI and encounter will not be available for qrtly penetration rates. Consider annual penetration rates, and/or dropping some that are not useful	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	D.7. There are various interpretations of these requirements. DCH will provide a training on the new tech requirement	
C.19.i. Quality of living situation required by Sec. 404. Consider annual rather than quarterly reporting		C.22. & 23. Reporting requirements changes: Suggest the QI committee to help do that	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.	
C.19.k. OBRA: mental health services for persons in nursing		C.27. Simplify, yes: Suggest the QI committee to help do	E. 12. ACT consumers need ongoing assessment	

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
homes needing less than specialized: consider dropping		that	of their needs for treatment. Annual is minimum for good practice.	
C.19.l. Percentage of persons with DD in day programs receiving SE: consider dropping or revising		D.5. DCH manuals should 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.	
C. 3. Eliminate quarterly FSR reports		E. 1. Tele- and video-conferencing	E. 16. HIPAA privacy and MHC coordination: This work has been done by the AG's office	
C. 5. Billing model children's waiver on fee for service basis.	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		

Negotiable	Essential (non-negotiable)	Agree w/ MACMHB Position	Need to provide clarification to MACMHB	Requires further internal investigation
		requirements for PCP: A workgroup to do that was established 2 months ago. Suggest that other CMHSPs attend		
		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
1. State changes to 837 have added cost
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 the asking us about.
C. 7. The model payments system is currently being reviewed by the Office of Audit. Could MACMHB coordinate obtiaining CMHSP input relative to this program and what changes they would recommend?

C. 8. Evaluation of continued provision of PPG reports. We need more clarification from MACMHB. If they could identify what reports they are referring to it would be helpful.
10. Sufficient lead time is not provided to make changes in reporting requirements: Which ones have been outside the contracting process?
11. Unfunded mandates for payer/provider systems such as standards of care: which standards of care?
12. Direct care staff time spent on documentation: please give examples
16. Frequency of many reports is duplicative: please clarify
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
E. 17. County of financial responsibility requirements are confusing, etc: it is our understanding that the Assoc has a workgroup that is studying this: what recommendations does the group have for MDCH?

Attachment 3

ADMINISTRATIVE SIMPLIFICATION
PROCESS IMPROVEMENT TEAM
Summary of July 29, 2003 Meeting

I. The first meeting of the Administrative Simplification Process Improvement Team held with representatives of the Michigan Association of CMH Boards (MACMHB) was convened by Craig Morris, MDCH's executive-on-loan. Following introductions, Craig explained the purpose of the team: to address issues raised by MACMHB in its May 14, 2003 communication to MDCH about burdensome reporting requirements, site reviews and audits.

II. Judy Webb described the internal process for analyzing the issues: two MDCH workgroups (audit/financial reporting and other reporting requirements/site reviews) placed the issues into one of five categories: negotiable, essential, agree with MACMHB, provide clarification to MACMHB, and needs further investigation or clarification. The items that needed further clarification were sent back to MACMHB. Many of the items fell into the negotiable and agree categories. MDCH staff believes that even the issues that were categorized as "essential" can be explored by this team to make improvements.

III. Craig asked that Dave LaLumia, John Duvendeck, Judy and other members of the team share their thinking about the objectives of this team and what they hope the team accomplishes. The following ideas were shared:

- The team needs to look for ways in which administrative processes can be simplified
- If state boilerplate language, or even federal requirements, get in the way of simplifying the processes, the Association will work to get those changed.
- The team should act quickly to find issues that can be resolved successfully and then convey those successes back to the Association membership.
- We should determine what information is necessary in order to satisfy State requirements and to inform the Department, CMHSPs and other interested parties of the system's performance. Data should not be collected unless it can be used for a necessary purpose.
- The team should examine what requirements are imbedded in rules, and then identify a strategy for changing the rules as necessary.
- The team should start with the issues that were priorities of the MACMHB: listed under "A" and "B" in the correspondence.

IV. The group discussed the relationship of this team and its outcomes, to other groups and activities of the Association, including Contract and Financial Issues Committee (CFI), the Encounter Data Integrity Team (EDIT), and the Association's Best Value proposal. Mary Balberdy, president of the Association, indicated that

recommendations of this team would be taken to the Executive Board of the Association for approval. It was agreed that some encounter and quality improvement data issues will be referred to EDIT without action of this team; and contractual amendment recommendations will be forwarded to CFI.

The group also discussed the role of consumers and advocates, with MDCH staff suggesting that since they have a vested interest in what is decided by this team, consumers and advocates should also be at the table. It was pointed out that under the managed care arrangement the overhead of delivering services is passed on to the CMHSPs where the impact is felt by line staff whose ability to provide service is hampered by documentation activities. Advocates are very interested in the chain of accountability, and MDCH is primarily interested in effectiveness and efficiency. While Association members agreed that consumers should be involved from the very beginning, some expressed the opinion that the team should recruit consumers rather than advocates because advocates do not always truly represent the consumer voice. Team members suggested recruiting consumers from the MDCH site review team, ombudsmen from CMHSPs' customer services departments, and consumer members of the boards (from those not represented on the team).

IV. The group reviewed the matrix developed by the MDCH workgroups. It was noted that the items under "B", audit issues that are a priority for the MACMHB, were omitted from the document. MDCH staff explained it was an oversight. The group decided to focus the remainder of the meeting on the third column – "agree with MACMHB position" – in hopes that the issues listed there might be quick fixes. The following action was recommended by the group:

1. C.14: Refer improvement of statewide encounter and quality improvement data to EDIT as that group has already identified that as an activity
2. C.16: Consolidating the ORR reporting is supported by MDCH but would require an amendment to the Mental Health Code. MACMHB members noted that in addition to consolidation of ORR reports the team would be interested in consolidating the quarterly FSRs. The team also suggested consolidation of grant reporting and the PPGs as these are also on different cycles and reporting formats.
3. C.19.c: The group agreed that the service designation flag would be dropped from the PIHP and CMHSP reporting requirements and the vehicle to do so would be the amendment that incorporates the BBA requirements that will be issued in August.
4. C.19.d: The group discussed the utility of monthly HSW reporting and the tradeoffs of less frequent reporting for the potential monetary consequences of incomplete and inaccurate data. The group concluded that the Hab Supports Waiver flag would be dropped.
5. C21., 22, 23, and 27: The group agreed that there should be a quality improvement committee or council and that multiple stakeholders should be involved. This team needs to identify the scope of the work of such a committee. A discussion about the performance indicators followed that included:

i. The need to identify what is important to us
ii. Ask whether the indicator is appropriate for measuring the process, treatment or outcome we are intending to measure
iii. Identify what indicators the public would use to measure our success
iv. The need to measure appropriateness and adequacy of care and the difficulties in doing that
v. The need to have better operational definitions of the performance indicators.

1. Identify and address the ways in which reporting of data elements varies across CMHSPs.
2. Identify and address ways in which information and results may have different meaning or interpretation across CMHSPs.

6. B. 2: MDCH agrees that the team should look for ways to improve the process of obtaining clarification from MDCH about issues that would have audit implications.
7. C.7.: The Model Payment Systems is currently undergoing an internal audit. There should be recommendations for improvement that result.

The other "B" and "C" issues relative to audit and financial reporting were categorized as:

1. B.1, Audits: DCH audits are essential
2. C.2, Grant (OBRA, HUD, PASSAR, block grant) reporting: negotiable
3. C.3., FSRs: negotiable. Note that the first quarterly report has already been eliminated. The team can look at more efficient ways for CMHSPs to report this.
4. C.5.,Billing Children's Waiver (CW): essential at this time (there was a request that there be dialog about whether the CW could become part of the capitation)
5. C. 6., OBRA billings: essential per federal requirements
6. C.8., PPGs: essential as they are Mental Health Code requirement

V. The group discussed how the team might be divided into workgroups such as quality and audit/financial; or quick fix, deemed status, and audit/financial. It was agreed that issues that can be resolved (e.g., quick fixes) should be forwarded to CFI immediately; and that other items that are being addressed by the EDIT should be referred as quickly as possible. It was also agreed that the entire team would review the priority items (Sections A and B in their document) at the next team meeting, and that a sub-set of the team would handle the quick fixes identified in column 3, and any other quick fixes that could be identified on the chart. The MACMHB will identify several representatives to meet with a small group of MDCH staff to work on the quick fixes.

The next meeting of the Administrative Simplification Process Improvement Team will be Tuesday, August 26th, 1 to 4 p.m. in the Lake Ontario Room of the State Library Building.

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM
Summary of September 30, 2003 Meeting

I. The meeting was convened by Judy Webb

II. The summary of the August 29th meeting was reviewed, no changes were suggested.

III. Dennis Grimski reported on the actions of the Quick Fix Group:

a. Reached agreement on eliminating items 18 (Service Designation) and 26.1 (Habilitation Supports Waiver) from the Quality Improvement data. These deletions will be reflected in Amendment #2 of the MDCH/PIHP contract, and Amendment #1 of the MDCH/CMHSP contract.
b. Reviewed concerns from CMHSPs regarding financial reporting in the encounter data, which will be accommodated in Amendment #2.
c. Agreed that MDCH would produce a matrix that contains all required reports, due dates, formats, and MDCH staff responsible
d. Agreed to set up an ad hoc group to determine the minimum amount of documentation that MDCH needs to see in a record for evidence of person-centered planning, individual plan of service, amount/scope/duration, and delivery of service.
e. Decided to recommend that MDCH re-establish a quality improvement council to act as a sounding board for mental health quality management, the scope of which would include: short and long range quality management plan, performance indicator system, site reviews, best practice and special studies. The council would make recommendations to the Mental Health and Substance Abuse Administration Deputy Director. The council would have a chair and vice-chair, one of whom would be a consumer, and would be made up of four representatives of MDCH, five from the CMHSPs (representing standalone PIHP, affiliate, PIHP hub, CFI, and the Association), two consumers, six advocacy organizations, the Michigan Association of Counties, and the Michigan Psychiatric Society. Bob Chadwick suggested that the council have an equal number of consumers on it.
f. Agreed that the DCH clinical site review process could incorporate the PIHP's monitoring of affiliates and providers and rather than repeating that function would assure that it was done appropriately by the PIHP.

IV. Dave LaLumia reported on the MACMHB's survey of CMHSPs regarding their preference about whether future DCH site visits should be consolidated. Most CMHSPs would like ORR, Children's Diagnostic certification, the clinical review, AFP and Certification reviews rolled into one review. Since many of the policies and procedures reviewed in these visits are redundant, MDCH should coordinate the protocols. Floyd Smith added that there was unanimous support for a single unified review, but that there are still issues with the amount of staff and consumers who might be tied up in such a comprehensive review. It was also suggested that there

should not be a need for follow-up reviews, but rather MDCH staff could check the following year to see that plans of correction were implemented; and that there is no need to do annual reviews of spokes. Other suggestions included:

a. Focus on the six or seven services that require DCH approval
b. Include the rights component in the annual review and do away with the triennial rights review.
c. Distinguish between a compliance review and technical assistance

V. Tom Renwick reported on the current and planned clinical site review process: MDCH has already combined the stage one and two reviews as they were burdensome to PIHPs and MDCH staff. Discussion of the site reviews included:

a. There is interest in a common entrance and common exit for the consolidated reviews
b. Since board members, consumers and staff like to be present, the exits need to be briefer
c. The Certification, Children's Waiver, and ORR exits need to be at the CMHSPs
d. There are concerns about the Substance Abuse Coordinating Agency review. Since some CAs work with counties that are outside the PIHP region, there is redundancy when every PIHP gets a CA review
e. There could be two types of review: full, where clinical, administrative, consumer interviews, and record reviews are done; and focused, where only the plan of correction (where evidence of improvement must be demonstrated), clinical record reviews and interviews are done.

VI. Audits

a. Results of a survey of MACMHB members during the September Directors' Forum were distributed.
b. John Duvendeck made some general comments in response:
    i. MDCH audits to the standards in the contract
    ii. Staff do not use protocols because they do not know what they will be looking at until they get to the site and start looking
    iii. Staff look at information in Lansing such as the contracts and budgets, and on site they look at the ISF, insurance, risk assessments, and independent audits. They see variability across the state in the ways standards are implemented
c. Discussion included:
    i. Mike Ezzo's commitment to meet with an ad hoc group regarding audit issues such as:
        1. The audit report, its content, any appeals, and when the audit report becomes official
    ii. Floyd: It is wrong when the state requires payback of funds that were spent on consumers when the CMHSP was making a best effort to provide services
    iii. Bob Sheehan: Suggest that audit staff meet with policy and programs committees of the Association.

iv. John: The objective of the audit is to see if the financial report is correct, and that the funds have been used correctly.

The audit results in a preliminary working document or analysis that is distributed to the CMH and a small group within MDCH (and is not subject to FOIA); the CMH and audit staff discuss any disputed area; the CMH submits a written response that includes a corrective action plan and/or a statement of disagreement; these are included in the final audit.

v. Nancy Miller: the final audit should reflect the resolved disputes
vi. Pat Barrie: the director of the department negotiates any financial settlement. There is tremendous risk to the state if audit findings that should have resulted in paybacks of Medicaid funds are ignored.
vii. Bob Sheehan: The CMHSPs' reputation is also at stake here; the final audit is a public document and what it says has a tremendous impact.
viii. Floyd: If there has been a signed agreement with the MDCH director or deputy, there should not be pay back when audit staff interpretations are different.

VII. Next meeting: October 28, 2003, 1 to 4 p.m. in the Lewis Cass Building, 3rd floor conference room.

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM

Summary of October 28, 2003 Meeting

I. The meeting was convened by Judy Webb

II. The summary of the September 30th meeting was reviewed, no changes were suggested

III. Status of previous recommendations was reported:

a. Bob Sheehan reported on the agreement reached by the DCH/MACMHB contract teams regarding deleted reporting requirement items from the quality improvement file: Habilitation Supports Waiver flag and Service Designation element
b. Tom Renwick reported that an ad hoc group on documentation has been formed and a first meeting scheduled for November 25th
c. Dave LaLumia reported that Mike Ezzo scheduled an ad hoc group meeting on audits for November 3rd
d. Judy reported that the recommendations for Quality Improvement Council are being considered by MDCH and a response will be reported at the November 25th meeting
e. The draft reporting matrix was distributed. Some changes were suggested. MDCH will finalize the matrix and distribute at the November 25th meeting

IV. Dave LaLumia opened the discussion about reporting requirements found in Section 404 of the Appropriations Act with a question: how much is the Section 404 report used? Points made during the discussion included:

a. Suggest that analysis of what is useful in Section 404 be the purview of the QI Council
b. Timing of suggested changes should occur over the next several months
c. Data that is now being collected should be replaced by something more meaningful
    i. Meaningful to DCH, consumers, advocates, Senate fiscal Agency
    ii. Data that illustrates the stories we have to tell
    iii. Data that counters the negative press with the good work that is being done
    iv. Data that tells who was served, what services they were provide, key cost ratios
    v. Should data be collected ongoing, on an ad hoc basis when a particular area needs to be studied?
    vi. Data collection, reporting, and reward for performance should be based on the Best Value measurements that were identified by the MACMHB, and the Vision statement that was adopted at the Directors' Forum
d. Before we can get to measurement, however, there needs to be an articulated statement of where we are going as a public mental health system. The local

system needs to know what the state expects, for example about integration of mental health and health care such as the Muskegon initiative, integration of corrections and mental health, and integration of mental health with K through 12 public education; and who the public mental health system is to service with the dollars it receives.

V. The next meeting will be held November 25th in the Lake Ontario Room of the State Library Building. The agenda will include reports on ad hoc committee meetings, the formation of a quality improvement council, and tentatively a discussion with a deputy from the Department of Corrections.

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM

Summary of November 25, 2003 Meeting

I. The meeting was convened by Judy Webb

II. The summary of the October 28th meeting was reviewed; no changes were suggested

III. Status of previous recommendations

a. Tom Renwick reported that the Documentation Ad Hoc group met and discussed what it wants to achieve:
   i. The minimum requirements to document a service
   ii. The minimum requirements to document person-centered planning

As source documents the group will be looking at the PCP guideline, the Mental Health Code, administrative rules, the BBA and third party requirements. Several issues that influence documentation and may be out of the purview of this group were identified: accreditation and internal processes.

Floyd Smith noted two issues to keep in mind when looking at source documents: 1) identify the requirements and consider recommending changes to the owner of the source documents; and 2) remember that March 31st is the deadline for reporting on administrative simplification activities as required by Section 450 of the Appropriations Act.

The ad hoc group has three additional meetings scheduled

b. Bob Sheehan reported on the discussions that MACMHB representatives have had with Pat Barrie and Michael Ezzo regarding the Association's issues with audits that include: 1)audit and policy need to be in sync; 2)anything audit staff can do to get out protocols and standards prior to the audit visit would be helpful; 3) consideration that audit findings result in something other than paybacks (CMHSPs should not be held liable for audit findings that arise from recommendations that DCH policy staff have made); 4) expedite the resolution process because of politics and credibility (at the local level); and 5) revise the appeal process so that a CMH would appeal to the DCH deputy, then an ALJ, then circuit court.

DCH agreed to fashion a plan to identify and start with the issues that are fixable. One issue that concerns MACMHB reps is what and who constitutes the authority from DCH to take action when policy questions are asked by a CMHSP of DCH staff. Should all policy questions be made in writing to a specified persons? Should all policy answers be made formally in writing or posted on the web site? How does the MACMHB committee structure and contract amendment fit into this process?

DCH audit staff stated that their focus in on what was spent and did it comply with federal regs, state regs, governmental accounting standards and contractual requirements, in that order of priority.

DCH agreed that it would issue (perhaps on the web site) revised financial guidelines with what current standards apply to what circumstances, e.g., MI Child and Adult Benefits Waiver, identify where there are conflicts, and refer to federal guidelines, like A87.

IV. Pat Barrie led a discussion about Corrections and Mental Health Coordination by observing that the key questions across meetings and initiatives are: What is CMH supposed to be or do in 2005-06? We have moved from what drove us before, de-institutionalization, to what? The paradigm for what the mental health system is supposed to do and how to measure it has changed. Community collaboration seems to be the wave of the future. One example is the corrections system is learning that it cannot be successful in preventing recidivism without working with a community network: housing, jobs, and mental health for example. However, there are no financial incentives to take these activities on. The bulk of the unmatched general fund is in the corrections system. There is a state level advisory group that is looking at the relationship between prisoner re-entry and mental health and substance abuse treatment. Another example is the child welfare and juvenile justice systems. Attention will be paid by the new Mental Health Commission to what the public mental health system should look like. The system will need to look at a new set of performance metrics that are important to external stakeholders, especially those that are not satisfied. The Urban Institute and Bazelon Center are resources for those performance metrics.

V. The next meeting will be held January 13th, 1 to 4 p.m. in the Lake Ontario Room.

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM

Summary of January 13, 2004 Meeting

I. The meeting was convened by Judy Webb

II. The summary of the November 25, 2003 meeting was reviewed; no changes were suggested.

III. Status of actions

a. Tom Renwick reported on the Documentation Ad Hoc meetings of December 12th and January 13th, indicating that the group has reviewed the Person-centered Planning Guideline and Chapter III, and has nearly completed the administrative rules to identify what must be documented. The Mental Health Code has yet to be reviewed. The outcome of the group's work will be a table with the source document requirements, where the documentation should be found, and the minimum expectations for demonstrating compliance. The group's next meetings are January 27th, February 9th and 18th, with an expectation that the work will be completed and ready for the Administrative Simplification PIT by late February. Floyd Smith asked whether the group is also reviewing the Boilerplate Section 404 requirements with an eye to eliminate unreasonable or redundant requirements and Tom answered that where there is relevance to documentation, yes. Bob Sheehan asked is this table will become an addendum to the site review protocol. Tom indicated that it will either be an addendum or an interpretive guidance. He said the group still needs to identify how this information would be disseminated to the system. Dennis Grimsky said there seems to be confusion about how to document the person-centered planning process, and what needs to be in the individual plan of service

b. Bob Sheehan reported that audit ad hoc group planned to meet with Michael Ezzo on January 14th. The agenda for the meeting includes the issues that were identified in the November 25th meeting of the Administrative Simplification PIT.

c. Judy Webb reported on the newly established Quality Improvement Council. Membership includes four CMHSP executive directors, two CMHSP quality improvement coordinators, staff representation from the MACMHB, and advocates. The council's role is to advise the department on its mental health quality management system. The short term tasks are to make recommendations for revising the performance indicator system, reducing the requirements in Section 404 of the Boilerplate, and refining the multiple site review processes. The first meeting is January 21st.

d. Other: Dennis Grimsky pointed out that the PIHP contract does not require a Financial Status Report for January, but the general fund contract does. Teresa Simon responded that a memo is being prepared that indicates the first FSR and state facility report are waived.

IV. Implications of the 1915(b) Waiver renewal on administrative simplification

a. Habilitation Supports Waiver monthly service verification and Central Office enrollment process. Judy explained that HSW beneficiaries must receive a HSW

service monthly to maintain their enrollment in the HSW, so DCH is looking at various alternatives for verifying that. The DCH-preferred way is to use the encounter data, however the lag created by the encounter data being reported post-adjudication of claims would make it difficult to verify monthly. There followed considerable discussion about the ability of PIHPs to know whether a HSW beneficiary received a HSW service in the pre-ceding month, and the administrative costs in trying to track that. There was a suggestion that DCH pay PIHPs for each enrolled HSW beneficiary each month; and at the end of the year, when the encounter data is all in, verify what HSW beneficiaries received HSW services each month, and reconcile the over- or under-payments at that time. Irene Kazieczko indicated that waiting until the end of the fiscal year to reconcile the encounter data will seriously minimize the ability of the PIHPs and MDCH to manage what was spent in each of the three Medicaid "buckets" (state plan, B3s and HSW). There was some agreement that by the end of 30 days after the close of a quarter, a PIHP ought to have the encounter data in for the previous quarter, so that verification would occur at the most 120 days following the provision of the service. DCH could use the encounter data information to reconcile the HSW payments each quarter, and could use the FSR to track the expenditures by bucket. DCH staff also indicated that the 834 would be used to inform PIHPs about who is enrolled in the HSW, and the 820 would be used to make payments and take negative adjustments per individual.

b. Judy Webb handed out the Encounter Data Corrective Action Plan that was submitted with the 1915(b) waiver renewal application. She indicated that seven PIHPs were not yet approved to submit data to the warehouse, and that the encounter data for only about 70,000 people (out of an expected 190,000) were in the warehouse. Her staff are developing formats for issuing profile reports back to PIHPs about the volume and accuracy of the data in the warehouse. Dennis suggested that DCH call together a meeting of PIHP directors, and their IS, QI, and finance staff to inform them of the implications of the encounter data corrective action plan and the external quality review. Bob Chadwick asked that the CMHSP affiliates not be excluded from such a meeting.
c. Best Value (performance indicators developed by a group of MACMHB members) and Standards and Sanctions (PA 597): will be forwarded to the Administrative Simplification PIT.
d. Arnie Greenfield summarized the requirements for the mandated, annual External Quality Review. He indicated that CMS requires that performance indicators focus on the Medicaid population, so eight of the 51 current indicators (on which CMHSPs report) have been selected and will be included in the PIHP contract amendment. Nancy Miller expressed concern about the subjectivity of external quality reviews and the potential for overlapping monitoring visits. Arnie responded that DCH is hopeful that most of the review will occur at DCH Central Office.
e. Looking ahead to the next 1915(b) waiver renewal. There was discussion about the need to have encounter data to calculate actuarially-sound rates; that the PIHP administrative expenditures to be reported on the '04 PIHP sub-element cost

report will be used to develop an administrative rate as part of the cost effectiveness calculation; and that the one method for reducing the incentives to under-treat, and for re-distributing Medicaid funds to PIHPs who serve a more-impaired population is risk adjustment. Arnie Greenfield indicated that some of the best work has been done by Dr. Susan Ettner at UCLA.

f. DCH indicated that the report to CMS on the first quarter of the waiver (Oct-Dec '03) is still up in the air as to whether DCH needs to report on the three funding streams that began January 1, 2004.
g. There was discussion about how expenditures for the Adult Benefits Waiver will be reported. Judy responded that the services and consumers will be tracked via the encounter and quality improvement (demographic) data.
h. Floyd asked that when DCH revises the performance indicators that they be based on a sufficiently large number of consumers for small PIHPs.
i. Irene indicated that there will be two payroll dates for the B and C waiver payments: one on the current payroll date for state plan and B3 payments, and the other a week later for the C waiver payment.

V. Revisiting the original issues list: what still needs to be done, what should be reported for Section 450 of the Boilerplate. Floyd asked that the following be assembled:

i. the revised May 27, 2003 table
ii. reports from the workgroup (especially the fiscal audits)
iii. report on action taken for items C through E in the May 14th MACMHB letter, which were of lesser importance than items A and B

Dennis suggested that new CMS requirements be added to the May 27th document in order to illustrate the burden that is caused locally. Dave LaLumia suggested that the PIT make recommendations for changes in the state-imposed B waiver requirements that can be reflected in the '05 renewal application.

The next meetings of the Administrative Simplification PIT will be February 17 and March 16, 1 to 4 p.m. in the 5th Floor Large Conference Room of the Lewis Cass Building.

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM

Summary of February 17, 2004 Meeting

I. The meeting was convened by Judy Webb

II. The summary of the January 13, 2004 meeting was reviewed; no changes were suggested.

III. Status of actions

a. Tom Renwick reported on the Documentation Ad Hoc February 13th meeting. The group has completed its review of all documents except the Appeal and Grievance Technical Requirement which is currently being revised. The group has developed a matrix that spells out "sufficient" documentation that is expected in records; or in the case of administrative processes, what is expected as evidence of compliance. For example, the requirement for providing the consumer with a copy of his individual plan of service (IPOS) within 15 business days can be confirmed during the consumer interview that the process is working. There was discussion about timeframes between first request for service and completion of an IPOS, and the inconsistencies in the Mental Health Code and administrative rules in using the terms "may" and "shall." Tom indicated that the group will make recommendations about reasonable time frames, as well as what should be in a preliminary plan.

b. Judy reported on the first meeting of the Quality Improvement Council. Its first action was to approve the eight Medicaid performance indicators. CMHSP members of the QIC present indicated that they have concerns about political issues and the tendency to generalize anecdotal stories.

c. Dave LaLumia reported that the audit ad hoc group has reached an agreement in principle on a process that includes early fact-finding with ample time for CMHSP review of the findings. Floyd noted that there is still the issue of CMHSPs having to pay back funds even though they followed the contract.

IV. Review of May 27, 2003 Table: the group discussed the original table of MACMHB issues and MDCH responses as the starting point for developing the Appropriations Section Act 450 report, and to identify what issues have not yet been addressed.

V. Report for Section 450: The group discussed what issues should be highlighted in the report:

a. MACMHB correspondence from May 14, 2003
b. Establishment of Administrative Simplification PIT and the meeting summaries

c. Issues over which MDCH has little control: Section 404 report, spend-down, federal requirements from CMS and CMHS (including the BBA, waiver renewal, HIPAA, and external quality review)
d. Accomplishments: waived 1st quarter FSR, eliminated 2 demographic items and one performance indicator, consolidated some site reviews, established a Quality Improvement Council, and provided clarification about certification and deemed status.
e. Culture change: framework for accountability may be difference as a result of the Mental Health Commission, legislature, and national initiatives
f. External efforts such as EDIT
g. Unfinished business, status: audit, for example.

It was agreed that Judy would get a draft 450 report out to members by March 10th.

Attachment 4

2002-04 MDCH/PIHP AND CMHSP REPORTING REQUIREMENTS

Notes:

- Sec. 404 (sub-element cost report) and 426 (children referred by courts) are from the **MDCH Appropriations Act**
- **Center for Mental Health Services (CMHS)** administers the Mental Health Block Grant ($13.2 m for Michigan) and requires a)uniform data reporting, and b) annual adult and children's goals and objectives that are measured by performance indicators
- **Centers for Medicare and Medicaid Services (CMS)** required certain reporting as part of its February 20, 2001 approval of Michigan's 1915(b) waiver
- **The Balanced Budget Act (BBA)** requires that the state monitor the performance of PIHPs, that each PIHP have a Quality Assessment and Performance Improvement Program (QAPIP), and that it meets standards on performance indicators that the state has established (In Michigan those seven standards were selected by the Quality and Performance Improvement Council, which had representatives of the PIHPs, consumers and advocates)

2002-04 QUALITY IMPROVEMENT (DEMOGRAPHIC) DATA BY CONSUMER

Reporting Element	Required By	Comment
1. Reporting period		Provides a link to 837
2.a. PHP payer ID number		ID's the PHP
2b. CMHSP Payer ID number		ID's CMHSP
3. Consumer Unique ID		Link to 837
4. Social security number		Used to delete dup CONIDs
5. Medicaid ID number		Sort element
6. Race/Ethnic Origin	Secs.404 (2)(a), 426, and CMHS	
7. Corrections Related Status	Secs.426, and CMHS, Children's Goal 6	
8. Residential Living Arrangement	Secs. 404(2)(a), 426, and CMHS	

Reporting Element	Required By	Comment
9. Total Annual Income		Actuarial needs
10. Number of Dependents		Actuarial needs
11. Employment Status	Sec. 404, and CMHS	
12. Education	CMHS: Children's Goal	
13. Wraparound Service	CMHS: Children's Goal	
14. Functional Assessment for C-MI	Sec. 426	
15. Scale Scores	Sec. 426	
16. Interval of Most Recent Functional Assessment	Sec. 426	
17. Disability Designation	Sec. 404 (2)(a)	Sort element (Diagnosis does not alone indicate developmental disability)
37. 18. Service Designation		Sort element
19. Predominant Communication Style/DD		Research: to look at severity of need of person's with DD served
20. Assistance for Independence Needed/DD		same as above
21. Nature of Support System/DD		same as above
22. Status of Existing Support/DD		same as above
23. Health Status/DD		same as above

Reporting Element	Required By	Comment
24. Assistance w/Behaviors/DD		same as above
25. Gender	CMHS	
26. Program Eligibility	Sec. 404 (2)(a), and CMHS	Encounter data does not provide this level of detail Hab Supports and Children's Waiver flags enable the Department of verify Hab Supports data
27. Parental status		Office of Mental Health Services for Children and Families
28. Children served by FIA	CMS 2/20/01	
29. Children enrolled in Early On	CMHS: Children's Goal	
30. Date of birth	Secs. 404 (2)(a), 426, and CMHS	
31. Primary language spoken	BBA 438.10, 438.242	

2002-04 PERFORMANCE INDICATORS

Collected quarterly, except where noted

Performance Indicators	Required by	Comment
1. Pre-admission screening, 3 hours, 95% standard	QAPIP, CMHS: Goal 3	Allows Michigan to compare with other states; published indicator, contract mgt
2. 1st request, 14 days, 95% standard	QAPIP, CMHS: Goal 3, Children's Goal 2	Published indicator; contract mgt
3. Assessment to service, 14 days, 95% standard	QAPIP, CMHS: Children's Goal 2	Published indicator; contract mgt
4. OBRA II assessed, served, 95%	QAPIP, CMHS	Published indicator; contract mgt
5. Readmission rate, 15%	QAPIP	Published indicator; contract mgt
6. Timely reporting, 100%	QAPIP	Contract management
7. Accurate reporting, 95%	QAPIP, Sec. 404(2)(l)(ii)	Contract management
8. Follow-up care in 7 days	CMHS: Goal 3	Allows Michigan to compare with other states
9. Days of inpatient care*	CMHS: Goal 2	Allows Michigan to compare with other states
10. Expenditures for DD in 24-hour care*		Published annually
11. Expenditures for MI in inpatient care*		Published annually

Performance Indicators	Required by	Comment
12. DD in daytime svs, in SE	Sec. 404(2)(e)	Published annually
13. DD earning minimum wage	Sec. 404(2)(e)	Published annually
14. Adults with SMI employed or in SE	Sec. 404(2)(e), CMHS:Goal 4	Published annually
15. Adults with DD employed or in SE	Sec. 404(2)(e)	Published annually
16. Children living with families	Sec. 404(2)(e), CMHS: Goal 5	Published annually
17. Adults with DD living on own	Sec. 404(2)(e)	Published annually
18. Penetration rate, under 18	CMHS: Goal 3	Published annually
19. Penetration rate, over 65	CMHS: Indicator B	Published annually
20. Penetration rate, ethnicity	CMHS: Indicator C	Published annually
21. Penetration rate, SMI 18 and over		Published annually
22. Penetration rate, Medicaid	CMS	Published annually
23. Persons with dementia served*		Internal use
24. # children receiving home-based svs	CMHS: Children's Goal 1	Internal use
25. # children under 18 referred by court*		Internal use
26. OBRA II, less than specialized	CMHS: Indicator G	Published annually

Performance Indicators	Required by	Comment
27. Denials and referrals	Sec. 404/(2)(g)	Published annually
28. Second opinions	Sec. 404/(2)(g)	Published annually
29. Cost per case for MI-A*		Published annually
30. Cost per case for MI-C*		Published annually
31. Cost per case for DD*		Published annually
32. Medicaid beneficiaries receiving care*		Internal use
33. Administrative expenditures*		Published annually
34. Persons in SE working 10+ hours	Sec. 404(2)(e)	Published annually
35. MI-A in SE earning minimum wage	Sec. 404(2)(e)	Published annually
36. MI-A and DD-A in SE for 6 months	Sec. 404(2)(e)	Published annually
37. MI-A living on own	Sec. 404(2)(e), and CMHS Indicator E	Published annually
38. Rights complaints, Abuse and Neglect **	Sec. 404(2)(e)	Published annually
39. Allegations of rights violation**	Sec. 404(2)(e)	Published annually
40. Substantiated allegations**	Sec. 404(2)(e)	Published annually
41. Sentinel events***	CMS: 2/20/01	Internal use

Performance Indicators	Required by	Comment
42. Number of suicides	Sec. 404(2)(e)	Internal use
43. Parents of minor children*		Internal use
44. Children enrolled in Early On*	CMHS: Children's Goal 5	Internal use
45. Children receiving more than respite*		Internal use
46. Adults with schizophrenia receiving Rx*		Internal use
47. Beneficiaries receiving aytpicals*		Internal use
48. Admission CAFAS scores*	CMHS	Internal use
49. Follow-up CAFAS scores*	CMHS	Internal use

*Data obtained via encounter, QI, or sub-element cost report

** Data obtained from MDCH Office of Recipient Rights (they collect semi-annually)

***Sentinel events data is collected semi-annually

Note: encounter and quality improvement data are submitted following adjudication of a claim which can take more than a year. In order to have an accurate count of who was served in a previous quarter, CMHSPs need to submit consumer counts with the performance indicator data.

OTHER DATA COLLECTION

Data element	Required By:	Comments
Annual Quality of Life	Sec. 404(2)(e)	MDCH conducts survey, requests assistance from CMHSP
Annual Consumer Satisfaction	Sec. 404(2)(e), CMS, and CMHS	MDCH conducts survey, requests names and addresses from CMHSP
Grievance and appeals tracking (ongoing)	CMS, BBA	MDCH collects data from Tribunal
Annual Sub-element cost report	Sec. 404(2)(l)(i)	
Sentinel Events (semi-annual)	CMS	

Attachment 5

SECTION 404 REPORTING REQUIREMENTS FOR CMHSPS

Section 404 Elements	Additional Need for Data	Source Document	QIC 2/17/04 Recommendation
(2)(a)Reimbursement eligibility	DCH Tracking, ad hoc reports requested from stakeholders	QI/demographic data #26	Keep, but condense into fewer elements in the legislative report
(2)(a) Client population	CMHS annual BG report: Uniform Reporting System, Table 1 DCH Tracking, ad hoc reports requested from stakeholders	QI/demographic data #17	Keep, but add field for SA in legislative report. Clarify in reporting requirements who goes into MI, DD or SA; Coordinate with Section 408 report
(2)(a) Age	CMHS annual BG report: Uniform Reporting System, Tables 1, 2A, 2B, 3 A, 3B DCH Tracking, ad hoc reports requested from stakeholders	QI/demographic data # 30	Keep
(2)(a) Ethnicity	CMHS annual BG report: Uniform Reporting System, Tables 2A, 2B	QI/demographic data # 6	Keep

Section 404 Elements	Additional Need for Data	Source Document	QIC 2/17/04 Recommendation
	DCH Tracking, ad hoc reports requested from stakeholders		
(2)(a) Housing arrangements	CMHS annual BG report: Uniform Reporting System, Table 15 DCH Tracking, ad hoc reports requested from stakeholders	QI/demographic data # 8	Keep, but condense 11 elements into fewer elements in the legislative report.
(2)(a) Diagnosis	CMHS annual BG report: Uniform Reporting System, Table 1 DCH Tracking, ad hoc reports requested from stakeholders	QI/demographic data #17	Keep, but report in demographic table on #s of MI-A and MI-C in each of 14 DSM categories; [Note from JW: did not discuss DD here, but must include as well]
(2)(b) Breakdown by Diagnosis*	DCH Tracking, ad hoc reports requested from stakeholders	837/Encounter data	Delete, redundant with (2)(a)
(2)(c) Per capita expenditure by population	DCH Tracking, ad hoc reports requested from stakeholders	Sub-element cost report	Keep, add a column for expenditures *per person served.* Consider adding SA?
(2)(d) Expenditure by	DCH Tracking, ad	Sub-element cost	Delete,

Section 404 Elements	Additional Need for Data	Source Document	QIC 2/17/04 Recommendation
client group and fund source	hoc reports requested from stakeholders	report	redundant with (2)(l)(*i*)
(2)(d) Cost information by service category, including administration	Performance indicators:10, 11, 29, 30 & 31 CMS: cost effectiveness calculation DCH Tracking, ad hoc reports requested from stakeholders	Sub-element cost report	Keep
(2)(e) Outcomes: Consumer Satisfaction	CMHS annual BG report: Uniform Reporting System, Table 11; CMS annual consumer satisfaction as part of Quality Strategy	Annual consumer survey using MHSIP instrument	Keep, but reconsider methodology for conducting survey
(2)(e) Outcomes: Consumer Choice	CMHS annual BG report: Uniform Reporting System, Table 11; CMS annual consumer satisfaction as part of Quality Strategy	Annual consumer survey using MHSIP instrument	It is part of consumer satisfaction
(2)(e) Outcomes: Quality of Life		Annual quality of Life Survey (not currently being done due to lack of funds)	Delete from legislative report; but consider how quality of life

Section 404 Elements	Additional Need for Data	Source Document	QIC 2/17/04 Recommendation
			questions can be addressed as part of Consumer Satisfaction feedback process
(2)(e) Outcomes: Housing and Employment	CMHS annual BG report: Uniform Reporting System, Table 15 Performance indicators #16, 17, and 37	QI/demographic data # 8	No recommendation
(2)(f) Access: (*i*) Number of people who requested services	Use for analyzing Community Reinvestment Strategies submitted by PIHPs	Performance indicator #7	Keep, but change to # of people who requested services whose eligibility fell into 4 categories: Medicaid, non-Medicaid but MHC priority pop, non-Medicaid and not MHC priority pop
(2)(f) Access: (*ii*) Number of people who requested services but did not receive them	Use for analyzing Community Reinvestment Strategies submitted by PIHPs	Performance indicator #7	Keep, but change to of those who requested services in the categories above, who were

Section 404 Elements	Additional Need for Data	Source Document	QIC 2/17/04 Recommendation
			referred elsewhere, served, and not served.
(2)(f) Access: (*iii*) Number of people requesting services who are on waiting lists	Use for analyzing Community Reinvestment Strategies submitted by PIHPs	Annual Budget Submissions: CMHSP Waiting List	Keep, but revise the report since Medicaid does not allow waiting lists
(2)(f) Access: (*iv*) Average length of time that people remained on waiting lists for services	Use for analyzing Community Reinvestment Strategies submitted by PIHPs	Annual Budget Submissions: CMHSP Waiting List	Keep, but revise to capture information related to (2)(f)(*iii*)
(2)(g) The number of second opinions	Performance indicator #7	Performance indicator #7	Keep, but revise to capture information about all second opinions.
(2)(h) Analysis re: needs assessment	Use for analyzing Community Reinvestment Strategies submitted by PIHPs	Annual Budget Submissions	Keep, but standardize report from CMHSPs to reflect need for services that they are mandated to cover.
(2)(i) Estimate of number of FTEs in CMHSPs and PIHPs, and as providers		Annual Budget Submissions	Unless there is rationale from fiscal agencies for keeping,

Section 404 Elements	Additional Need for Data	Source Document	QIC 2/17/04 Recommendation
			delete
(2)(j) Lapses and carry forwards	Use for analyzing Community Reinvestment Strategies submitted by PIHPs	Financial status reports	Keep
(2)(k) Contracts for services entered into by CMHSPs or PIHPs with providers, amount, rates, type of service		Annual Budget Submissions	Unless there is rationale from fiscal agencies for keeping, delete
(2)(l)(*i*) Information re: managed care program expenditures by each CMHSP or PIHP by Medicaid eligibility group	CMS: quarterly reports	Capitation and enrollment information	Keep
(2)(l)(*ii*) Performance indicator information	Performance indicators 1-41 part of annual QM report	Performance indicators 1-41	Keep
(3) Include data reporting requirements		Attachment 6.5.1.1 of contract	Keep
(4) DCH take actions to assure that data are complete and consistent among CMHSPs and PIHPs			Keep

Attachment 6

ADMINISTRATIVE SIMPLIFICATION PROCESS IMPROVEMENT TEAM

STATUS

Revised 3/26/04

* Classification of responses: Negotiable, Essential, Agree, Provide Clarification, Requires further investigation

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
A. Deemed Status Issues			
A.1. Eliminate the requirement for an annual DCH review for CMHSPs who have achieved national accreditation.	Negotiable Need to provide clarification to MACMHB	DCH is working internally to coordinate the schedule of the recipient rights reviews and certification reviews so that they coincide with the expiration of the CMHSP's certification 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.	DCH anticipates that the coordinated schedule will be complete by 2006. National accreditation is a partial substitute for triennial certification of CMHSP per MHC 330.1232a.
A.2. DCH surveying should be limited to areas specific to Michigan and not covered by national accreditation surveys.	Need to provide clarification to MACMHB		The site visit associated with the certification process is waived if the CMHSP is accredited.
A.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	Negotiable	During FY 03, the two-stage DCH Medicaid reviews were consolidated into a single annual review that also integrates the SA, Children's Waiver, CDTSP review, HSW 10% sample, and the AFP follow-up on plans of correction. The admin portion of the single annual review is limited	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
reviews, children's model waiver reviews, Medicaid 5% records reviews.		to those areas that were not covered in the one-time-only AFP site review or were subject to plans of correction.	
A.4. Any DCH certification reviews should be conducted on a 2-year basis, consistent with the waiver period, not annually.	Essential: Certification reviews are required to be conducted every three years per MHC Section 330.1232a	Annual Medicaid site reviews have been modified to allow an administrative review of the PIHP once during the two-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, and to the triennial certification process if the CMHSP is not accredited.	
B. Audits			
B.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 that address the audit objectives of the department. Independent audits performed by CPAs are already required of	Essential: It is the responsibility of MDCH to conduct audits of the CMHSPs	An ad hoc group has been meeting with Dr. Michael Ezzo, Patrick Barrie, and audit staff to resolve this.	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
each CMHSP.			
B.2. It is often difficult to obtain clarifications from DCH around issues that may have future audit implications.	Negotiable	An ad hoc group has been meeting with Dr. Michael Ezzo, Patrick Barrie, and audit staff to resolve this.	
C. Reporting Requirements			
C.1. State changes to federal 837 transaction requirements have added cost.	Need to provide clarification to MACMHB	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 information. DCH agreed with the MACMHB to allow PIHPs to report average allowed amount to substitute for reporting four financial fields.	
C.2 Eliminate/simplify DCH grant report requirements.		Analysis of MDCH reporting requirements was completed. Recommendations for improvement have yet to be developed.	
C.3. Eliminate quarterly reports as there is not an accurate fiscal picture until year-end.	Negotiable	Per the contracts, the first quarter FSR report has been eliminated.	
C.4. DCH Microsoft Access report format to submit Hab Waiver data has added costs.	Agree with MACMHB position	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	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
		standards.	
C.5. Billing model children's waiver on fee for service basis adds cost.	Essential: the Children's Waiver program has been approved by CMS as a fee-for-service program		
C.6. Separate OBRA billings add cost.	Essential: MDCH needs to reflect specific OBRA expenditures for federal reporting		
C.7. Model payments has separate tracking and payment mechanisms than other foster care programs			MACMHB and MDCH discussed issue and were unable to determine the problem.
C.8. Evaluate continued provision of PPG reports.	Requires further internal investigation	This is a MHC requirement that is a valuable source of information.	
C.9. Inconsistency and/or confusion over data definitions are ongoing problem.	Agree with MACMHB position		MDCH will continue to work with EDIT, and other MACMHB groups to clarify data definitions.
C.10. Sufficient lead time is not always provided to make changes in reporting requirements.	Agree with MACMHB Position	.	The contracting process makes changes to reporting requirements difficult
C.11. Reduce un-funded mandates for payer/provider systems such as standards of care that contribute little value to consumer outcomes.			MACMHB and MDCH discussed issue and were unable to determine the problem
C.12. Reduce time direct care staff spend on paperwork including multiple signatures, start and stop times, and others.	Negotiable	An ad hoc group is reviewing all requirements (e.g., Chapter III, admin rules, MHC) to determine that minimum amount of documentation that is needed for	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
		evidence of compliance	
C.13. Develop single form format statewide used for required documentation.	Negotiable	An ad hoc group is reviewing all requirements (e.g., Chapter III, admin rules, MHC) to determine that minimum amount of documentation that is needed for evidence of compliance	
C.14. Improve timeliness/reliability/accuracy of statewide data.	Agree with MACMHB Position	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	
C.15. Evaluate state expectations requiring CMHSPs to complete redundant reviews. Requiring independent proof that site visits (CCI/LPUs) have occurred and that staff have been trained adds unnecessary expense.			MACMHB and MDCH discussed issue and were unable to determine the problem
C.16. The defined frequency of many reports required by DCH is duplicative.	Negotiable		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.17. Find more efficient ways to			MACMHB and MDCH

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
extract data and eliminate redundant data.			discussed issue and were unable to determine the problem
C.18. Consider elimination of outcome measures when statewide performance is consistently good.	Negotiable	The use of outcome measures will be considered by the newly re-established Quality Improvement Council, along with the rest of the performance indicator system.	
C.19. Other specific recommendations: (see below)			
C19a. Continue with plan to eliminate need for shadow claims reporting and COB model.	Essential: The COB model for reporting encounters is necessary for collecting financial amounts expended on Medicaid services. This data is needed for cost effectiveness calculations for the 1915(b) waiver	Agreement was reached between DCH and MACMHB to report a calculated "allowed amount" for each encounter.	
C.19.b. QI Data Item #17 – Disability Designation: MDCH can figure this from the diagnoses and service information submitted in the encounter data.	Essential: MDCH cannot determine from diagnoses in 837 files whether the person is MI or DD. This information is needed for Section 404 reporting required by the Appropriations Act		
C.19.c. QI Data Item #18 – Service Designation: DCH can figure this from the diagnoses and service information submitted in the encounter data.	Agree with MACMHB Position	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.d. QI data Item #26.1 – Persons on Hab Supports is reported monthly to MDCH on	Agree with MACMHB Position	The QI element will be removed from the contract via amendment #2 of the PIHP contract, and	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
the Hab Waiver Report.		amendment #1 of the CMHSP contract.	
C.19.e. 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.	Negotiable		Program eligibility is not present on 837, and Sec. 404 requires collecting it. Ask Approps to reconsider 404 requirements?
C.19.f. QI Data could be sent as a quarterly roll up rather than a monthly roll up.	Essential: need information monthly in order to track utilization, expenditures in the 1915 B, B3, and C waiver funding categories, and to verify that C waiver services are provided to each C waiver recipient each month		
C.19.g. MIMBPIS Table 1 – Unduplicated Counts: DCH can figure this information from the QI and encounter data submitted.	Need to provide clarification to MACMHB		Cannot get count of people served in the previous quarter due to lag time of encounter data reporting to accommodate adjudication of claims.
C.19.h. MIMBPIS Table 2 – Penetration rates: DCH can figure this information from the QI and encounter data submitted.	Essential: QI and encounter data that are submitted post-adjudication of claims prohibits MDCH from being able to calculate penetration rates until 4-5 months following a fiscal year. Data is needed quarterly.		Once encounter data is submitted in a timely fashion, it will not be necessary to collect this via the performance indicator data.
C.19.i. MIMBPIS Table 10 – Quality of Life – Living Situation: DCH can figure this information from the QI and encounter data submitted.	Negotiable	Review of all performance indicators, including quality of living, has been referred to the QI Council for possible refinement.	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
C.19.j. Eliminate the need for trial balance and claims aging reports. The purpose and intended use is unclear.	Essential: MDCH needs this information		
C.19.k. OBRA measure benefits are unclear.	Negotiable	This indicator will be dropped via the amendment #1 of the CMHSP contract.	
C.19.l. Percentage of people in day programs receiving supported employment is both unclear and inconsistent with DCH policy direction.	Negotiable	Review of all performance indicators, including employment, has been referred to the QI Council for possible refinement. MARO will be invited to participate.	
C.20. Make reasonable accommodations for CMHSPs in rural areas on performance indicators reporting. Small "Ns" make compliance with performance indicator standards more challenging.	Need to provide clarification to MACMHB		DCH reporting of performance indicators accommodates this in the narratives.
C.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.	Agree with MACMHB position	A QI Council was re-established and had its first meeting on 1/21/04.	
C.22. Any changes in reporting requirements should meet all compliance criteria, result in improved outcomes for consumers, reduce administrative costs, or improve management	Agree with MACMHB position	This was referred to the QI Council.	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
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?			
C.23. Require department to calculate the cost to the system before any new reporting requirements are added.	Agree with MACMHB position.	This was referred to the QI Council.	
C.24. Encounter and demographic data should be reported on a quarterly, not monthly, basis.	Essential: need information monthly in order to track utilization, expenditures in the 1915 B, B3, and C waiver funding categories, and to verify that C waiver services are provided to each C waiver recipient each month		
C.25. Current requirements that copyrighted outcome measures be implemented are costly and often too stringent.	Requires further internal investigation		CAFAS is used for functional assessment for service need and for outcomes measurement. It is likely that we will need to do something similar with all populations.
C.26. Look at better coordination between FIA and CMHSPs on transportation and home health services, especially the portion of these services funded by FIA.	Agree with MACMHB position	Work group developed a matrix explaining the responsibilities for transportation.	
C.27. When in doubt, simplify, simplify, simplify.	Agree with MACMHB position	This has been referred to the QI Council.	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
D. Medicaid			
D.1. 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.	Essential		
D.2. Spend down reporting requirements add costs for CMHSPs and FIA.	Essential		
D.3. CMHSPs must report information to DCH about some aspects of Medicaid enrollment (such as when re-determinations are effective) that the state already has.		Habilitation Supports Waiver re-certifications are now controlled by MDCH.	
D.4. Look at longer period of eligibility (than one month) for those on spend down.	Essential		
D.5. DCH manuals (children's waiver and HAB waiver) should be updated.	Agree with MACMHB position		Work on the Children's Waiver manual has begun. DCH agrees that the HSW manual needs to be completed.
D.6. 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.	Agree with MACMHB position	Enrollment and re-certification of HSW consumers have been brought back to Central Office. The database will be replaced by the use of the 834 and 837 transaction standards.	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
D.7. Review and streamline various consumer appeal processes.	Agree with MACMHB position	The technical requirement is being revised per input from the PIHP hearing officers.	
D.8. FIA must process Medicaid eligibility determination and re-determination in a timely manner.			This is not the purview of MDCH
D.9. Specific requirements for nursing services for consumers in crisis residential programs regardless of their medical and/or mental health needs is unrealistic and costly.	Need to provide clarification to MACMHB		
E. Other Issues			
E.1. Video-conferencing and tele-conferencing technology could save travel expenses.	Agree with MACMHB position		
E.2. FIA home help duplicates community living supports services and should be coordinated			Resolved
E.3. Level of care standards for persons in home care, AFC placement, nursing home would be helpful and efficient.	Need to provide clarification to MACMHB		Resolved
**E.4. CMH has to bill out Michigan rehab funding on a fee for service basis which is costly.			This is not the purview of MDCH
E.5. Review ability to pay requirements.	Agree with MACMHB position		
E.6. Review documentation requirements for PCP.	Agree with MACMHB position	An ad hoc committee on documentation is preparing recommendations for minimum	

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
		requirements for PCP documentation.	
E.7. Recent documentation for specialized residential homes has resulted in fewer of these programs.			This is not the purview of MDCH
E.8. Require integrated services for persons served by multiple systems (FIA, CMH, QHP, SA, MRS, Public Health, Corrections).	Agree with MACMHB position		
E.9. Provide for licensure of community-based alternatives to reduce state facility costs.			MACMHB and MDCH discussed issue and were unable to determine the problem
E.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.	Provide clarification to MACMHB		

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
E.11. OBRA/PASSAR screenings. Individuals having state determination of "nursing home/no mental health services" be exempt from annual behavioral review requirements.	Essential: OBRA requirement		
E.12. Annual assessments for those in ACT programs required "as needed."	Essential: the ACT model requires annual assessments		
E.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."	Essential: OBRA requirement		
E.14. Seek ways of reducing the scope and impact of federal procurement requirements.	Need to provide clarification to MACMHB		

MACHMB ISSUE	DCH RESPONSE: *	ACCOMPLISHMENT/STATUS	COMMENT
E.15. Allow local units of government to tap into state purchasing to take advantage of economies of scale.			MACMHB and MDCH discussed issue and were unable to determine the problem
E.16. Privacy regulations and requirements of HIPAA and Michigan Mental Health Code should be coordinated.	Need to provide clarification to MACMHB		
E.17. "County of Financial Responsibility" requirements are confusing, time consuming and expensive to implement.	Agree with MACMHB position	C.O.F.R. clarification and requirements will be part of the next contract amendment	
E.18. Streamline annual assessment process for consumers who are served over the long term.	Need to provide clarification to MACMHB		
E.19. Combine application for service information or provide mechanism for sharing basic demographic information among local service providers.			This is an issue that should be addressed between CMHSP and provider.
E.20. Eliminate any regulation not directly mandated by state or federal law.	Negotiable.		

Michigan Association of
COMMUNITY MENTAL HEALTH
Boards

March 30, 2004

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 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. Representing CMHSPs on the team are: Mary Balberde (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 FY2004 DCH appropriation act (Act 159 of the Public Acts of 2003) required the department to establish a work group and to report on recommended strategies to streamline audit and reporting requirements for CMHSPs. The report is to be submitted by March 31, 2004. In addition to providing an overview of process improvement team activities from the CMH perspective, we respectfully request that this letter be included as part of the Section 450 report to the Legislature.

In May of 2003, MACMHB submitted to DCH a suggested list of issue areas for joint review. The list includes issues in five areas: deemed status/accreditation, fiscal audit process, reporting requirements, Medicaid related requirements and others. The first task of the Administrative Simplification Process Improvement Team was to identify items from this list which could be modified or eliminated very rapidly. A "quick fix" group was established. CMH group members were Dennis Grimski (St. Clair), David LaLumia (MACMHB), Nancy Miller (LifeWays) and Robert Sheehan (CEI). Several items identified in this initial "quick fix" review have already been eliminated or modified. These include:

- Eliminate the financial status report (FSR) for the first quarter.
- Eliminate two elements (habilitation waiver flag and service designation flag) from demographic data collected.
- Eliminate one OBRA performance indicator.
- Eliminate quarterly reporting to the habilitation waiver data base: eliminate the necessity of monthly eligibility determination by converting the process to the 837 reporting structure.

A work group was established to review service documentation requirements. CMHSP representatives on this group are: Ted Coffeen (Berrien), Stacy Coleman (Genesee), Barry Diaz (Barry), Tracy Gomez (Monroe), Lynn Guernsey (LifeWays), Jim Johnson (St. Clair), Kris Kirsch (St. Joseph), and Lynda Zeller (Hope Network). The initial focus of this work group will be making recommendations on person centered planning and individual plan of service documentation requirements..

A Quality Improvement Council was created to provide an ongoing forum for CMH, DCH, consumer, advocate and other stakeholder review of items related to improving quality of care and simplifying administrative and clinical processes. CMH participants are Karen Henry (Detroit-Wayne), Dennis Grimski (St. Clair), David LaLumia (MACMHB), Nancy Miller (LifeWays), Wendy Niven (Macomb), Greg Paffhouse (Northern Lakes) and Greg Snyder (Newaygo). The QI Council will be examining the current fifty-one element performance indicator system, reviewing reporting requirements mandated by Section 404 of the FY2004 DCH appropriation act (Act 159 of the Public Acts of 2003), and evaluating the cost of any new reporting requirements under consideration. The QI Council will be the venue in which work on simplifying administrative and clinical activities will take place after the Administrative Simplification Process Improvement Team concludes its work.

Another work group was established to review the DCH fiscal audit process. CMHSP participants in the audit process review are: Erv Brinker (Summit Point), Robert Chadwick (Tuscola), David LaLumia (MACMHB), Mac Miller (Livingston), Doug Morton (Pathways), and Robert Sheehan (CEI). While we are encouraged with the initial DCH response to the audit related issues raised by CMHSPs, significant additional work needs to be undertaken. The CMH work group members have recently made a proposal to the department for improving the audit process and we are awaiting a response. We remain concerned that the fiscal audit process is not working for CMHSPs or the department and is wasting resources which should be directed toward 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 2004.

Over the past year, while seeking ways to simplify and streamline, new federal requirements have added significant new CMH reporting and record keeping responsibilities. These new mandates result mostly from the Balanced Budget Act and conditions of renewal of our 1915(b) and (c) waivers. Advocacy around federal funding and regulatory issues is going to be a high priority of MACMHB in 2004. We request that the department join us in seeking to reduce redundant elements of reporting which are not specifically required by federal law/rules and assist with modifying items in our waiver renewal request which require reporting and have been added to

our waiver at state request. We trust that our partnership around these issues will extend to identification and advocacy for changes in federal regulations and practices which add to the administrative burden but which produce little or no value for consumers.

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. Section 450 which kept a legislative focus on this work has been eliminated in the FY2005 DCH appropriation bill. We recommend that new language be drafted and submitted for legislative consideration as the appropriation bill is reviewed by the House this spring.

Significant unfinished business exists in the areas of the department's fiscal audit process and in other areas. A number of items listed included in the original list remain unresolved. The commitment of both the department and CMHSPs to engage in joint planning and decision making prior to issuance of new or revised requirements must become an essential part of the culture we are trying to create.

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 part of a culture which evaluates all administrative and clinical requirements based on whether or not they improve outcomes for consumers. Re-creating this culture would be a return to past practice from which we unfortunately departed several years ago. We look forward to working with the department and the Legislature in 2004 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 K. Balberde

Mary Balberde
President

David LaLumia
Executive Director