REGION# 2

2013 Application for Participation

For Specialty Prepaid Inpatient Health Plans

Michigan Department of Community Health Behavioral Health & Developmental Disabilities Administration

2/6/2013

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A. INTRODUCTION

The purpose of the Michigan Department of Community Health (MDCH) 2013 Application for Participation (AFP) for re-procurement of Medicaid Specialty Prepaid Inpatient Health Plans (PIHPs) is to describe the necessary information and documentation that will be required from the applicant to determine whether the Urban Cooperation Act (UCA) formed entity or the Regional Entity applicant, (jointly governed by the sponsoring Community Mental Health Services Programs(CMHSPs)), meets the MDCH requirements for selection to be certified to Center for Medicare and Medicaid Services as a PIHP effective January 1, 2014.

The AFP is the official vehicle which begins solicitation and selection for the PIHPs for the state-defined regions. Specifically, the AFP identifies the plan for meeting the required functions of the PIHP, including identification of functions that are to be direct-operated, delegated and/or contracted within and outside the sponsoring CMHSPs.

The AFP requires response in the following areas: Governance, Administrative Functions including general management and financial, Information Systems Management, Provider Network Management, Utilization Management, Customer Service, Quality Management, Accreditation, External Quality Review, and Public Policy initiatives including crisis response capacity, health and welfare, Olmstead compliance, substance abuse prevention and treatment capacity, and recovery.

In recognition of the short timeframe between issuance of this AFP and the April 1st due date for the response, MDCH will allow an extended response time, up to 5 p.m. on July 1st, for some items so noted in this document. However, an application is not considered complete until all items requested in the AFP are submitted.

Similar to the 2002 Application for Participation, this AFP is targeted first exclusively to entities comprised of Michigan CMHSPs in compliance with Michigan's application for renewal of its 1915(b) Specialty Services and Supports Waiver. In the waiver application, Michigan proposed that a first opportunity should be afforded to CMHSPs since these entities have the necessary expertise with the target populations and strong coordination linkages with other community agencies; control other resource streams (e.g., state funds); sustain local systems of care; have already made durable investments in specialized care management strategies and unique service/support arrangements; and have statutorily prescribed protection, equity and justice functions important to individuals, policymakers and Michigan's citizens.

This AFP is intended to re-procure the PIHPs based on new regional boundaries drawn by the MDCH. There will be one PIHP selected per region, and that PIHP will manage the Medicaid specialty benefit for the entire region defined by the MDCH. The PIHP will contract with CMHSPs and other providers within the region to deliver services. It is relevant to note that beginning October 1, 2013, plans for merging Coordinating Agency functions within the CMHSP system must be developed and initiated, with full compliance (merger of functions) with the law (P.A. 500 and 501) by October 1, 2014. This application response will supply information regarding the activities aimed at reaching these goals, and expected roles and timeframes, as much as they are known to the applicant and member CMHSPs at the time of response.

The only acceptable legal arrangements for affiliation going forward will be either UCA agreements or creation of a regional entity under Section 1204b of the Mental Health Code. In either case, such intergovernmental affiliation formations result in the creation of a new legal entity jointly "owned" and governed by the sponsoring CMHSPs. It is this entity that will be considered, recognized and designated as the PIHP (for a region consisting of more than one CMHSP).

As described in the November 26, 2012, "Discussion Draft", the key objective of this new management entity is to balance and obtain the best two opposites while avoiding the limits of each. The new regional structure must consolidate authority and core functions, while simultaneously promoting local responsiveness. (Please reference the "Discussion Draft-Version 2, November 26, 2012, for further details).

Policies and procedures for "Provider Network Services," "Provider Procurement," "Provider Credentialing" and "Customer Services" must be maintained by the regional entity, with common provider application processes throughout the region. The processes and functions MAY be decentralized among more than one entity or CMHSP, but each decentralized unit will be acting under the common policies and procedures of the UCA/Regional Entity. A provider then, moving from one CMHSP to another to provide service should not experience repeated and different application and procurement processes to become a Medicaid provider in a new CMHSP within the same regional entity.

The regional entity policies and procedures for Provider Services need to include the full breadth of what may be needed by any single CMHSP to respond to local need and to take advantage of increasing opportunity for participating in accountable and integrated systems of care with local partners. An individual CMHSP should not be hindered from participating in opportunities to provide integrated and accountable care to serve the Medicaid population in its catchment area. The objective of this new entity is to balance and obtain the best of both opposites (local control/responsiveness and regional standards/consistency), while avoiding the limits of each.

As with the original AFP, this application process differs from typical request for proposal processes because a) the bid does not include pricing; and b) the process is not competitive at this stage. Applicants are indicating their capacity and commitment to performance in a variety of areas. Pricing is determined by the MDCH in compliance with Medicaid regulations, the 1915(b) waiver, and state appropriations and will be shared with applicants prior to contract negotiations to commence in the Spring of 2013.

Other significant MDCH policy decisions impacting applicants that need to be considered are as follows:

1. Capitation Payments and Data Files

   The base capitation rates and methodology are currently under evaluation by actuaries. The MDCH intends to re-develop rate structures, methodologies and adjusters that increase the percentage of the ratio reflecting morbidity and decrease the percentage that is based on history/geography. In the 2012-2013 year, the ratio is 50/50 morbidity/geography. MDCH will be increasing the percentage of the ratio that reflects morbidity each year. Ultimately, MDCH will be moving to methodologies that are built on a common statewide rate structure where adjusters are entirely based on morbidity differences or cost of living methodologies common to other areas of health care. MDCH will utilize common actuarial methodologies statewide, as approved by CMS. The concurrent 1915(c) Habilitation Supports Waiver allocation of certificates will also be adjusted based on factors such as the number of people with developmental disabilities served within the region, thus moving away from current historical allocation.

   The data files distributed will be a single file for each consolidated service area. This file will be available only to the PIHP. The PIHP must have the capacity to provide information to and collect information from the individual CMHSPs within the region in compliant, efficient and helpful formats for use by the CMHSPs in understanding the broad scope of enrollees, trends and utilization of the individual CMHSP and as it compares to the other members within the region.

   Single CMHSP PIHPs will be required to report both the administrative cost of PIHP functions borne directly by the PIHP and those PIHP functions carried out by the CMHSP, CMHSP core providers, and managed comprehensive provider networks (MCPNs). To promote full transparency of PIHP and administrative costs, MDCH will require reporting of administrative costs of both the PIHP itself, and administrative costs for direct services for the CMHSP. MDCH intends to place a cap on the administrative cost percentage for CMHSP direct services.

2. Sub-capitation

An applicant may sub-capitate for shared risk with its provider network, including CMHSPs, MCPNs, and core providers. The actuarially-sound methodology and rates for sub-capitation, by contractor, must be submitted to MDCH. MDCH retains the right to disapprove any sub-capitation arrangement that is determined not to be actuarially sound or where the arrangement has a high probability to adversely impact the State's risk-sharing. Sub-capitation rates shall be reasonable when compared to other service rates for similar services. Sub-capitation shall not contribute to risk reserve accumulation that exceeds seven and one-half percent (7.5 percent) of annual per eligible/per month, or an amount consistent with Governmental Accounting Standards Board Statement 10, whichever is less, within the applicant's region.

3. Internal Service Fund (ISF)

The ISF risk reserves that exist on December 31, 2013, for PIHPs whose geographically boundaries have not changed may be continued under the new contract, up to the level justifiable by Governmental Accounting Standards Board Statement 10 and the current ISF Technical Requirement (MDCH/PIHP Contract Attachment 7.7.4.1). For PIHP regions where the geography has changed, (such as individual CMHSPs entering and exiting PIHP regions and PIHP regions combining), MDCH will work with actuaries to determine the percentage of the ISF that shall move to the new PIHP for purpose of servicing the enrollees that move to the new PIHP region. It is expected that the actuarially-determined amount of the ISF to be transferred to the new PIHP will be based on prior fiscal years enrollee data, summarized by diagnoses for those belonging to the exiting CMHSP.

4. Integrated Care

All PIHPS will be required to have and provide upon request, signed agreements with all the Medicaid Health Plans (MHPs) in the region. The PIHPs and MHPs shall use the model coordination agreement provided in the contract as a foundational template. The Medicaid Health Plan contracts will contain the same requirement to have signed agreements with the PIHPs. Over the period of the upcoming waiver renewal cycle, new opportunities for integration with physical health care may become available in Michigan. MDCH is exploring options such as Medicaid Health Homes (ACA section 2703) and Integrated Care Dual Eligible Demonstrations (Medicare/Medicaid). Four of the new PIHP regions have been selected as the Dual Eligible Demonstration sites: Regions 1, 4, 7 and 9; others may be selected to participate in the integrated care opportunities. If approved by CMS, both the dual eligible and Medicaid Health Home opportunities will require contract amendments for PIHP regions selected to participate. The PIHPs in the Dual Eligibles regions will also require contracts with the Integrated Care Organizations in order to accomplish the Care Bridge functions and desired outcomes of integrated Medicare and Medicaid-funded behavioral health and physical health care.

5. Performance Monitoring and Incentives

MDCH will be implementing a performance incentive structure for the Medicaid PIHPs. During each contract year, MDCH will withhold a portion of the approved capitation payment from each PIHP (range to be determined, but likely to be between .02 and .015). These funds will be used for the PIHP performance incentive awards. These awards will be made to PIHPs according to criteria pre-established by MDCH. The criteria will include assessment of performance from areas such as: access, health and welfare, and compliance with the Balanced Budget Act (BBA) per External Quality Review, including performance measure data validation. In 2014, the two areas of focus will be PIHP proper and complete reporting of monetary amounts and billing/rendering provider; and completeness of Quality Improvement health conditions and developmental disabilities characteristics data.

6. Program Integrity and Compliance

A strong compliance and program integrity system is critical to all managed care systems. All PIHPs shall comply with 42 CFR 438.608 Program Integrity requirements. This includes key functions to be owned by the PIHP such as: designation of a compliance officer for the PIHP, region wide policies and procedures showing commitment to comply with federal and state laws, training and education for the compliance officer and employees, clear lines of communication with the compliance officer, discipline and enforcement, internal monitoring and auditing and prompt response to detected offenses. The state is seeking more detail on program integrity and compliance programs than has been required in past applications.

7. Sanctions

MDCH will utilize a variety of means to assure compliance with applicable requirements. MDCH will pursue remedial actions and possibly sanctions, including intermediate sanctions as described in 42 CFR 438.700, as needed, to resolve outstanding contract violations and performance concerns. The use of remedies and sanctions will typically follow a progressive approach, but MDCH reserves the right to deviate from the progression, as needed, to seek correction of serious, repeated, or patterns of substantial non-compliance or performance problems. The application of remedies and sanctions shall be a matter of public record.

The range of contract remedies and sanctions MDCH will utilize include:

A. Issuing a notice of the contract violation and conditions to the PIHP with copies to the Board.

B. Requiring a plan of correction and status reports that becomes a contract performance objective.

C. Imposing a direct dollar penalty, making it a non-matchable PIHP administrative expense and reducing earned savings from that fiscal year by the same dollar amount.

D. Imposing intermediate sanctions (as described in 42 CFR 438.700) that may include the following civil monetary penalties:

- A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to beneficiaries or health care providers.
- A maximum of $100,000 for each determination of discrimination or misrepresentation or false statements to CMS or the State.

E. For sanctions related to reporting compliance issues, MDCH may delay up to 25% of scheduled payment amount to the PIHP until after compliance is achieved. MDCH may add time to the delay on subsequent uses of this provision. (Note: MDCH may apply this sanction in a subsequent payment cycle and will give prior written notice to the PIHP.)
F. Initiate contract termination.

The following are examples of compliance or performance problems for which remedial actions, including sanctions, can be applied to address repeated or substantial breaches, or reflect a pattern of non-compliance or substantial poor performance. This listing is not meant to be exhaustive, but only representative.

A. Reporting timeliness, quality and accuracy.
B. Performance Indicator Standards.
C. Repeated Site-Review non-compliance (repeated failure on same item).
D. Failure to complete or achieve contractual performance objectives.
E. Substantial inappropriate denial of services required by this contract or substantial services not corresponding to condition. Substantial can be a pattern, large volume or small volume but severe impact.
F. Repeated failure to honor appeals/grievance assurances.
G. Substantial or repeated health and/or safety negligence.

8. Transition To State Defined Regions:

The applications submitted in response to the AFP must demonstrate that the PIHPs are able to meet, or have viable plans with specified dates for completion of requirements. Because of the complexity and transition time needed to move some functions from single CMHSPs as PIHPs to fewer and regional entities as PIHPs, this AFP allows the applicant to specify target dates beyond April 1, 2013, for some of the functions.

MDCH reserves the right to require the milestone target dates be adjusted in order for a conditional (or provisional) award to be granted. Should the milestone target dates not be met, MDCH reserves the right to notify CMS the PIHP no longer meets requirements for continuing to function as the PIHP. MDCH may then give notice of termination of the contract and proceed to seek another entity to manage the PIHP functions for that region. A new managing entity could be either a neighboring PIHP or a non-CMHSP-governed entity selected to manage the region through a competitive process (with assurances to maintain the statutory purposes the local CMHSP).

B. INSTRUCTIONS

Since 2002, the PIHPs have managed Medicaid specialty services and supports and carried out their responsibilities for ensuring beneficiary freedom, opportunities for achievement, equity, and participation consistent with the history and mission of CMHSPs. MDCH has been responsible for assuring that PIHPs are in compliance with federal laws and regulations, state Medicaid policy, the Michigan Mental Health Code and Administrative Rules, and the contract between MDCH and the PIHPs. To that end, MDCH will use the results of performance and contract monitoring and external quality reviews for existing PIHP (where the new entity adopts the policies of an existing PIHP) and, as applicable, for CMHPs to inform its review of an applicant's suitability to become a new PIHP.

In 2009, MDCH and the PIHPs engaged in a comprehensive quality improvement effort called "Focusing a Partnership for Renewal and Recommitment to Quality and Community in the Michigan Public Mental Health System" referred to as the ARR). The ARR addressed updated (from 2002) public policy considerations. PIHPs with the assistance of community stakeholders, performed environmental scans and developed plans for improvement where they found the need. MDCH and PIHP staff worked together as PIHPs made progress in achieving their own goals.

The 2002 AFP and the 2008 ARR are the foundation of the Medicaid Specialty Supports and Services program and the vision and values, and public policy they addressed – such as person-centered planning and self-determination, and culture of gentleness– are still highly regarded, and while not addressed in this AFP, will continue to be part of the contracts between MDCH and the new PIHPs to fulfill provider network adequacy and capacity requirements for the covered specialty services.

This 2013 AFP is also built upon documents that have been the foundation of the Specialty Services and Supports Program since 2002: the FY'12-13 amended 1915(b) Waiver for Specialty Services and Supports, and the FY'13 MDCH/PIHP contracts and the attachments. Finally, it is expected that the applicants are compliant or are able to become compliant with the 1997 Balanced Budget Act, 42 CFR Part 438, and the External Quality Review Protocols.

This 2013 AFP addresses primarily those public policy areas that are new or evolving; and raises expectations for certain administrative capabilities that a mature specialty managed care system such as Michigan's should be able to demonstrate. This AFP solicits applicant information in the following: Governance; Administrative Functions including General Management, Financial Management, Information Systems Management, Provider Network Management, Utilization Management, Customer Service, Quality Management; Accreditation Status; External Quality Review; and the following Public Policy initiatives: Crisis Response Capacity, Health and Welfare, ADA/Olmstead Compliance, Substance Use Disorder Prevention and Treatment, and Recovery.

We have placed links to documents referred to on this page and other helpful resources identified throughout this AFP on the MDCH web site's Mental Health and Substance Abuse page.

Responses to this AFP shall be entered in the electronic version of this document in the boxes, tables and spaces provided. Supplementary information shall be attached as instructed and labeled with the requested Attachment number.

Certain items in the application may be submitted subsequent to the April 1st due date but **no later than 5 p.m. on July 1, 2013. However, the applicant is cautioned that an application will not be considered complete until all items requested have been submitted.** An incomplete application as of July 2, 2013, will result in loss of first opportunity to CMHSPs in the region (through Urban Cooperation Act or Regional Entities). The state will then proceed to open the region to competitive bid.

Please adhere to the page count limitation specified for text boxes and use no smaller than 12-point font. Some text boxes have limits on the number of characters that can be inserted.

Label each attachment with the Region number and item number, save all attachments in PDF into one document, and submit as instructed below.

Responses must be submitted electronically to Marlene Simon at SimonM4@michigan.gov by 5 p.m. on April 1, 2013. Items submitted electronically between April 1, 2013 and July 1, 2013 are to be labeled with the applicant's region number, the AFP section number and are to adhere to the page count limitation.

C. MDCH DECISIONS

Applications will be reviewed by MDCH staff in the two weeks following submission. MDCH reserves the right to conduct a short site review to interview staff or stakeholders, and/or to follow up on any responses received via this application that are unclear or incomplete.

The review of applications, scoring, and site visits will result in one of three decisions below that will be announced by the Department following the conclusion of these activities:

1. Award without conditions means that MDCH will contract with the applicant without changes required in the application and without any conditions for meeting target dates for milestone activities. This action will be announced in early June 2014. Announcement may be as late as July 2, 2013, where items from the application noted as allowable for two-part submission are delayed. Contracts will be signed in December 2013, effective January 1, 2014.

2. Award with conditions means that MDCH requires that either or both: a) certain improvements must be completed or plans of correction approved before it will contract with the applicant; b) certain milestones must be met by target dates for initiating contract and/or continued contracting as the PIHP for the region. This action will be announced in July 2013, where application is incomplete due to awaiting legal documents or other specifically noted items. Conditions must be met by a date specified in the award announcement. In Wayne County condition may also include transition to authority status by October 1, 2013, as per Public Acts (P.A.) 375 and 376 of 2012. Following the MDCH acceptance of improvements or plans of correction needing resolution prior to January 1, 2014, contracts will be signed in December 2013, effective January 1, 2014.

3. Unsuccessful application means one or more of the following:
   a. The application was received after the deadline and will be returned to the sender immediately.
   b. The application did not pass the Governance Section. The application contained section(s) that failed to meet standards, and for which acceptable target milestones and timeframes were not provided. Notification of such a situation will be made within one week following the review of the application (approximately three weeks after the due date). If the application is incomplete due to items with allowable extended due date of July 1, 2013, notice of unsuccessful application will be made the first week of July 2013.
   c. The application lacked signatures from all CMHSPs in the state-defined region as authorized by appropriate action of all individual boards.
   d. Required legal documents (Urban Cooperation Act, Regional Entity) were not filed with the county clerks before July 1, 2013, for multi CMH regions.

e. Wayne County authority not created by October 1, 2013, as required by PA 375 and 376 of 2012.

4. Open Competitive Process means the following:

a. In the event an unsuccessful application is received from a region, MDCH will proceed with an open competitive bid process specifically for that region.

b. The vendor selected for a particular region via MDCH's open competitive process will be the PIHP for that region, and will be required to report contractually to MDCH.

c. An award of a bid via the open competitive bid process to an entity other than an Urban Cooperative Act or Regional Entity formed by the CMHSPs in that region will not require that PIHP to have CMHSP representation on its board.

Applicants may appeal the decisions in number three above by delivering or faxing a letter requesting reconsideration, within two days of receipt of the notification, to:

Lynda Zeller, Deputy Director
Michigan Department of Community Health
Lewis Cass Building, Fifth Floor
320 S. Walnut Street
Lansing, Michigan 48913
FAX (517) 335-4798

D. THE APPLICATION

1. GOVERNANCE

This section will receive a "pass" or "fail" determination. If any one item receives a fail determination, it will stop the application from further consideration. A fail determination will result from the applicant's answer of either **"no" without sufficient justifiable narrative included** or **an answer of N/A (not applicable) for an application consisting of an affiliation of CMHSPs**. Failed applicants will be notified within one week following review of the application (approximately three weeks after the due date).

The AFP affords initial consideration for specialty prepaid inpatient health plan designation to qualified single county or regional entities (organized under Section 1204b of the Mental Health Code or Urban Cooperation Act). Therefore, the first and most basic requirement is that the organization submitting an application, be comprised of and jointly, representatively governed by all CMHSPs in the region pursuant to Section 204 or 205 of Act 258 of the Public Acts of 1974, as amended in the Mental Health Code.

Check all boxes that are appropriate to the applicant as it will be January 1, 2014

1.1 ☐ Applicant is the sole CMHSP in a state-defined region and is currently one of the following:

- 1.1.2 ☐ County CMH Agency.
- 1.1.3 ☐ Community Mental Health Organization.
- 1.1.4 ☐ Community Mental Health Authority (Required for Wayne County).

OR

1.2 ☒ Applicant is an entity jointly governed by all CMHSPs in a state-defined region and has one of the following legal arrangements:

- 1.2.1 ☒ Section 1204b Regional Entity as defined in Mental Health Code
- 1.2.2 ☐ Urban Cooperation Act (UCA)

1.3 ☒ In Attachment 1.3 is a plan for the legal entity to be finalized with action steps, responsible parties, and timeframes. By no later than 5 p.m. on July 1, 2013, the legal entity shall have by-laws filed with the county clerk, and all member CMHSP board approvals have been completed.

An application for a region comprised of more than one CMHSP shall submit, no later than 5 p.m. on July 1, 2013, one hard copy of the original signed legal documents that establish or validate that the entity making application has status as a Regional Entity under Section 1204b of the Mental Health Code or through Urban Cooperation Act and, where applicable, has the legal basis to enter into a contractual commitment with the Department for a consolidated application for multiple CMHSP service areas. *(These items need not be scanned and submitted electronically. They must, however, be appropriately labeled with the Region number and suitable cover sheets.)* Note: where an application is being made by a single CMHSP, appropriate documentation is currently on file with the MDCH, with the exception of Wayne County which will require proof of Authority Status no later than

October 1, 2013. **Submit the hard copy legal documents to Elizabeth Knisely, Director, Bureau of Community Mental Health Services, 5th Floor Lewis Cass Building, 320 South Walnut Street, Lansing, Michigan 48913.**

1.4 ☐ An original signed paper copy of the legal document(s) including by laws and enabling resolutions that establish or validate that the entity making application has a status as a Regional Entity or entity formed by Urban Cooperation Act has been submitted concurrent with this application.

OR

1.5 ☒ The legal document(s) will be submitted no later than 5 p.m. on July 1, 2013. **The application will not be considered complete until the legal document(s) have been submitted to MDCH, no later than 5 p.m. on July 1, 2013.**

The legal document(s) addresses the following:

1.4.1 ☒ The relationship between the parties.
1.4.2 ☒ The roles of each party to the agreement.
1.4.3 ☒ The rights of each party to the agreement.
1.4.4 ☒ Governance arrangements and conditions.
1.4.5 ☒ Functional consolidation of administrative activities.
1.4.6 ☒ Assurances that all members will comply with federal and state standards and regulation and what processes exist to address non-compliance.
1.4.7 ☒ The financial arrangements and interests of each party to the agreement including, but not limited to: cost-sharing, cost-allocations, local match obligations related to Medicaid funds, fund transfers, re-purchase (contracting back) arrangements, resource/asset claims, liability obligations, risk obligations, risk management, contingencies, areas of limitations, and areas of exclusions.
1.4.8 ☒ Established dispute resolution mechanism(s) between the affiliates.
1.4.9 ☒ Identification of the designated regional entity to act as the prepaid inpatient health plan by all CMHSPs within the region.

1.6 ☒ In the text box below is a list of the PIHP board member categories (e.g., person who receives services, family member of a person who receives services, person with a disability, advocate, provider, county commissioner, CMH representative, community member), the number of people to serve in each category, their affiliation (e.g., county), and if known at the time of application, but no later than July 1, 2013, the name of each PIHP board member.

1.6**The initial membership of the PIHP Board includes the following representations:**
Person who receives services: 2
Family member of person who receives services: 3
Advocate: 1
SUD System: 4

County Commissioner: 2
CMH Representative: 15
Community member: 15
The Board Members include: Gary Nowak, Terry Larson, Roger Frye, Don Tanner, Richard Schmidt,Annie Hooghart, Ed Ginop, Dennis Priess, Karla Sherman, Randy Kamps, Jack Mahank, Armandina Zamora, Patti Casey, Gary Klacking, Joe Stone.

MDCH shall review the applicant's, and CMHSP member status regarding compliance with certification criteria, Section 232 of the Mental Health Code. In order to assure adequate specialty services network and capacity, applications will be reviewed to assure all CMHSPs within the consolidated application meet the criteria. To be referred for scoring of the proposal, applicants must have substantial or provisional certification for each participant CMHSP within the region at the time of application.

MDCH shall review the applicant's status regarding MCLA 330.1232a (6); Recipient Rights System. In order to assure adequate specialty services network and capacity, applications will be reviewed to assure all CMHSPs within the region have overall assessment scores of substantial compliance. To be referred for scoring of the proposal, applicants must be determined to have scores of substantial compliance with Recipient Rights System standards.

1.7 ☒ Assessment scores meet substantial compliance.

Because MDCH continues to value and promote community involvement, there must be documentation that individuals who receive services, family members, and/or advocates representing each service area of the region, if applicable, and all populations served, including, adults with serious mental illness, children with serious emotional disturbance, children and adults with developmental disabilities, and children and adults with substance use disorders were involved in the development of this application.

1.8 ☒ In Attachment 1.8 is a signed statement attesting to consumer/stakeholder involvement.

1.9 ☒ In Attachment 1.9 is a narrative of no more than three pages that defines the vision and values of the stand-alone applicant, or of the UCA/regional entity. Include within the narrative a description of how the affiliation arrangement will actualize this vision and build upon the existing strengths of member CMHSPs. Explain how the PIHP will bring any members with deficits up to standard or acceptable performance.

1.10 ☐ In Attachment 1.10 is a curriculum vitae for the executive director of the applicant organization that verifies that the executive director of the applicant organization meets or exceeds the qualifications of an executive director as specified in Section 226(1) (k) of the Mental Health Code.

OR

1.11 ☒ The executive director of the applicant organization is unknown at the time of the submission of this application. The name and curriculum vitae will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

1.12 ☐ All text boxes are completed and all attachments required to be submitted are included with this Application for Participation response.

OR

1.13 ☒ Not all text boxes are completed and/or not all required attachments are being submitted with this AFP but will be submitted no later than 5 p.m. on July 1, 2013. It is understood that this is considered an *incomplete application.*

1.14 ☒ Name of contact person who can answer questions about this application: Dave Schneider, Karl Kovacs, telephone number: 231-439-1234, E-mail address: Karl's No: 231-935-3645 daveschneider@norcocmh.org, karl.kovacs@nlcmh.org

Additional Governance Responses Required of Wayne County:

MDCH seeks a stable transition and the least disruption possible from County oversight to the newly authorized Authority beginning October 2013. No sooner than six months, but no later than nine months, after the Authority begins oversight and operations of the existing MCPN system, the Authority shall submit a written Plan (the Plan) for approval by MDCH, for the re-procurement and implementation of specialty provider networks that will be administered by two or three Managers of Comprehensive Provider Networks (MCPNs). To achieve better integration and efficiency of administration, the Plan shall include requirements for at least two but no more than three MCPNs to oversee specialty networks that will provide a comprehensive array of services for each of the two primary target populations: (1) people with mental illnesses, substance use disorders, and serious emotional disturbance and 2) people with intellectual/developmental disabilities. Each of the MCPNs shall deliver person-centered, behavioral health or I/DD services, and coordinate those services with the physical health services to be delivered by Integrated Care Organizations in the State's demonstration for people with Medicare and Medicaid eligibility. The Plan shall be reviewed by the MDCH. MDCH shall approve the Plan once the MDCH is confident in the stability of Authority's operations and has ensured that the Plan meets the requirements of this document.

1.14.1 ☐ The Wayne County applicant attests that it will submit, within the time frame noted above, the written Plan for re-procurement of MCPNs that includes all of the following:

a. A description of the process to ensure that there is always a choice of MCPNs (not less than two) for eligible recipients from the two population groups. The Plan shall also include policies and procedures that allow individuals the opportunity to move between MCPNs if they choose.
b. The proposed scope of services for the MCPN contract and procurement. It shall describe the structure and functions of the MCPNs, any legal requirements for corporate status, governance requirements, individual and family representation, financing and reimbursement, and other elements described

below. The Plan shall describe the process for re-procurement of the MCPNs to achieve efficiency and care integration goals. The Plan shall include standards for MCPNs and their specialty provider networks on enrollment, person centered planning, care management, clinical service and utilization review standards, provider standards and physical and behavioral health service coordination and integration. The Plan shall also describe required administrative functions including provider network management, accounting, claims, data systems, reporting, after-hours coverage, quality improvement, member services and any other delegated responsibilities. Evidence (copies of public comment) that The Plan was made available for public review prior to submission to the MDCH shall be provided. This shall include review by consumers, families and other advocacy groups. The Plan shall be approved by the CMHSP Board of Directors and any other applicable Boards and Authorities.

c. Evidence that the MCPNs shall be governed by provider members, members of the community or individuals with specialized experience. The Plan shall also include plans for involving people with lived experience (either as consumers and or family members) in the governance of the PIHP, the MCPNs and perhaps in an advisory role for the specialty provider networks. The Plan shall also outline how the applicant and the MCPNs will employ people who have lived experience in key positions.
d. Identification of the functions that will be provided by the applicant, other public agencies and those delegated to the MCPNs. Specifically this shall include general management/administrative, financial management, information systems management, provider network management, utilization management, customer services, and quality management. The applicant shall demonstrate that it has examined the effects of this decision on care coordination, quality, cost, and availability. Particular attention will be paid to ways to minimize overall administrative costs. The applicant has also examined the implications of these plans for apparent or real conflicts of interest and has adjusted its policies and procedures as needed to minimize conflict.
e. Assurance that each MCPN or its provider network provides coverage to its target population a comprehensive and similar set of services for the entire geographic service area. The Plan may exempt MCPNs from providing certain highly-specialized or culturally-specific services (that may be provided centrally by the applicant or through other contracts) in order to ensure access to unique providers. The Plan shall outline steps to ensure that similar services and management activities are provided across the MCPNs while allowing for innovative approaches by each MCPN. This will include a common set of benefits and consistent policies for credentialing, care coordination, and access to care.
f. A description of the applicant's procedures for reimbursing the MCPNs, including how rates will be established for services for each population group and what incentives will be used to reimburse MCPNs and providers. This will also include a process for assessing the financial soundness of rates that are set on a capitated or case rate basis. MCPNs shall manage a population that is of

sufficient size so that the rates are actuarially sound. The Plan shall also address how financial solvency of the MCPNs will be assessed upon selection and during their contract.

g. The process for MCPN oversight and monitoring. This shall include the implementation of sanctions, including corrective action plans, termination of MCPN enrollment, financial sanctions and contract termination, when the MCPN or its provider network no longer meets the applicant's requirement or standards.
h. Standards for MCPN reporting of data and a uniform set of performance measures and quality improvement protocols. These shall support all of the reporting that are consistent with the requirements for the PIHPs reporting to the MDCH.
i. A description of how substance abuse (SA) services will be delivered to people in the service area. Specifically the Plan shall include language about the SA services that will be delivered by the MCPNs that focus on the behavioral health population, and those that may be delivered by other organizations within the CMHSP and the PIHP.
j. Non-Compete terms that do not restrict the rights of MCPNs to contract with any qualified provider for their specialty networks if they meet the standards and criteria established by the applicant. Similarly, the Plan and MCPN contract terms shall ensure that no provisions of an MCPN's contracts shall restrict otherwise qualified providers from participating in more than one MCPN. However, providers may not have an ownership interest or governance relationship in more than one MCPN in which they also provide services.
k. Assurance that all provisions of the MDCH's Application for Participation for procurement of Medicaid Specialty Prepaid Inpatient Health Plans (PIHP) are either retained as the responsibility of the PIHP or explicitly delegated by contractual terms to the MCPNs. Assurance that each of the re procured MCPNs will be fully operational not later than January 1, 2015.
l. The competitive procurement methodology which assures best value. The Plan shall outline a proposed process for a re-procurement of the existing MCPNs. The actual re-procurement shall be subject to MDCH approval and will be implemented in the first year of this AFP. The re-procurement shall include policies and procurement criteria that ensure an adequate provider network, stakeholder and community input, and adherence to public policies and service standards that are unique to the needs of each target population.

1.14.2 ☐ Until the Plan is implemented, the Wayne County Authority applicant will have executed contracts with the existing MCPNs so that they are fully operational on January 1, 2014.

2. ADMINISTRATIVE FUNCTIONS

Descriptions and activities of the managed care administrative functions may be found in the document "Establishing Administrative Costs within and across the CMHSP System, December 2011" located at this site:
www.michigan.gov/documents/mdch/Establishing_Admin_Costs_12-11_374192_7.pdf

Instructions: check the box provided to attest to the fact. Enter narrative in text boxes where instructed. Attach documents with labels as instructed at the end of the application.

2.1 General Management Functions

The four chief officers below shall be 100% dedicated to the general management functions of the applicant PIHP only. In other words, they may not have a concurrent role at a CMHSP. It is understood that a chief officer might have dual roles within the PIHP, such as managing the finance function AND the information systems function; or may be responsible for the operations function AND provider network management. Likewise the applicant may choose not to have a Chief Operating Officer.

MDCH prefers that the chief officers are direct employees of the applicant PIHP. However, MDCH will not prohibit arrangements that lease the officer from another entity, or that contract with a staffing agency. In such cases, MDCH requires assurances that the officer is accountable solely to the applicant PIHP for purposes of fulfilling PIHP executive functions, and that there are protections against conflict of interest when decisions are made by the officer that impact the entity from which he/she is leased or contracted. The Regional Entity/UCA accepts full responsibility for managing conflicts and compliance with all laws and regulations including but not limited to those of the Internal Revenue Service. The Regional Entity/UCA accepts full responsibility for any and all liabilities resulting from a PIHP executive whose employer of record is a member CMH in the region.

In the boxes below the applicant shall attest that each chief officer is 100% dedicated to the applicant PIHP; that the CEO will be hired, supervised, and terminated, as necessary, by the PIHP governing board; and other chief officers will be hired, supervised, and terminated, as necessary, by the CEO.

2.1.1. **Chief Executive Officer (CEO)**

2.1.1.1 ☒ The chief executive officer is 100% dedicated to the applicant PIHP functions

2.1.1.2 ☐ The chief executive officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.1.2.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP CEO and the entity from

whom he/she is leased or contracted. The PIHP governing board will annually certify to MDCH that it monitors the CEO and assures there are no conflicts of interest in decision-making and that it understands it maintains full responsibility for compliance with all laws and regulations including IRS and any consequences or liabilities resulting from the leased or contracted arrangement.

2.1.1.3 ☒ The chief executive officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and procedures, if applicable, will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.1.2. **Chief Operating Officer (COO)**

2.1.2.1. ☒ There will be no chief operating officer (if box is checked, applicant may skip to #2.1.3).

2.1.2.2 ☐ The chief operating officer is 100% dedicated to the applicant PIHP functions.

2.1.2.3 ☐ The chief operating officer is: % FTE; if less than 100%, identify the other functions that the chief operating officer will perform:

2.1.2.4 ☐ The chief operating officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.2.4.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP COO and the entity from whom he/she is leased or contracted.

2.1.2.5 ☐ The chief operating officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and procedures, if applicable, will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.1.3. **Chief Financial Officer (CFO)**

2.1.3.1 ☒ The chief financial officer is 100% dedicated to the applicant PIHP functions.

2.1.3.2 ☒ The chief financial officer is: **100**% FTE; if less than 100% identify the other functions that the chief financial officer will perform:

2.1.3.3 ☐ The chief financial officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP,

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.3.3.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP CFO and the entity from whom he/she is leased or contracted.

2.1.3.4 ☒ The chief financial officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and

procedures, if applicable, will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.1.4. **Chief Information Officer (CIO)**

2.1.4.1 ☒ The chief information officer is 100% dedicated to the applicant PIHP functions.

2.1.4.2 ☒ The chief information officer is: **100**% FTE; if less than 100% identify the other functions that the chief information officer will perform:

2.1.4.3 ☐ The chief information officer is known and his/her name is: and is:

1. ☐ Employed (or will be employed) by the applicant PIHP

OR

2. ☐ Leased or contracted from: and in Attachment 2.1.4.3.2 are the policies and procedures to be used by the PIHP governing body to assure that there are no conflicts of interest between the PIHP CIO and the entity from whom he/she is leased or contracted

2.1.4.4 ☒ The chief information officer is unknown at the time of this application, but his/her name, employer of record, and conflict of interest policies and procedures, if applicable, will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.1.5. **Other Executive Staff**

General Management of PIHP	% FTE Dedicated to the PIHP Function	Names (if known)* or "Unknown"	Employer of Record (If not PIHP, indicate whether leased or contracted by PIHP)
Medical Director	10	Unknown	
Substance Use Disorder Prevention & Treatment Director	100	Unknown	
Human Resources Director	10	Unknown	
Compliance Officer/Program Integrity	100	Unknown	PIHP

*☒ The name(s) is "unknown," it will be submitted to MDCH along with the Employer of Record no later than 5 p.m. on July 1, 2013.

2.1.5.1 ☒ In Attachment 2.1.5.1 is an organizational chart that depicts the lines of supervision of each position from the PIHP Board and/or CEO.

2.1.5.2 ☒ The applicant attests that it will adopt one set of common General Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.1.5.3 ☒ The applicant attests that the General management policies and procedures used throughout the region will include Program Integrity and Compliance components outlined in 42 CFR 438.602 and 42 CFR 438.608.

2.1.5.4 ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.1.5.4. lists the General Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.1.5.5 ☒ The common policies and procedures are in development at the time of application, and the Attachment 2.1.5.4. will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.2 Financial Management Functions

Financial management functions typically include: 1) budgeting – general accounting and financial reporting, 2) revenue analyses, 3) expense monitoring and management, 4) service unit and recipient-centered, 5) cost analyses and rate-setting, 6) risk analyses, risk modeling and underwriting, 7) insurance, re-insurance and management of risk pools, 8) supervision of audit and financial consulting relationships, 9) claims adjudication and payment, and 10) audits. The responses below should take into account those functions, and any other the applicant has identified.

2.2.1 ☒ In Attachment2.2.1 is an organizational chart that depicts the lines of supervision from executive staff and oversight of each of the ten Financial Management Functions above and any others the PIHP will be adding.

2.2.2 ☒ The applicant attests that it will adopt one set of common Financial Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.2.3 ☐ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.2.3, lists the Financial Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.2.4 ☒ The common policies and procedures are in development at the time of application, and the Attachment 2.2.4 will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.3 Information Systems Management

Overview

The PIHP must have an information management system that supports the core administrative activities of the region including:

a. The ability to accept on behalf of entire region of CMHSPs/CAs, enrollment and revenue files, in HIPAA compliant formats, from the State of Michigan.
b. The ability to accept clinical, financial, utilization, demographic, quality and authorization information from CMHSP/CA sources (including providers) in standard electronic formats (i.e., HIPAA Administrative Simplification X12N). Note if the CMHSP/CA/provider source is capable of sending in standard electronic formats, the PIHP must receive via standard electronic means versus requiring direct entry or non-standard format.
c. The ability to accept clinical, financial, utilization, demographic, quality and authorization information through clearinghouses and other viable, secure and efficient means when requested by CMHSP/CA sources and providers.
d. The ability to analyze, integrate and report clinical, financial, utilization, demographic, quality and authorization information.
e. The ability to submit QI and encounter data in compliant formats as specified by MDCH. Data must pass all required data quality edits prior to being accepted into CHAMPS before it is sent to the warehouse.
f. The ability to identify, analyze and report costs and revenues for service components, including, but not limited to, analysis and reporting by regions and CMHSP/CA sources and providers.
g. The ability to detect and correct errors in data receipt, transmissions and analyses. This includes screening for completeness, logic, and consistency; and identifying and tracking fraud and abuse.
h. The ability (within limits of law) to safely and securely send and receive data to and from other systems. This includes, but is not limited to, the State of Michigan, health plans and providers systems including physical health and non-healthcare support systems of care. (Note: If the PIHP region is selected to participate in Medicaid Health Homes and/or Integrated Care For Dual Eligibles demonstrations, the PIHP must be able to interface with health plans and provider systems).

For new entities representing multiple CMHSPs in a state-defined region:

a. The Information Technology Policies, Procedures and systems from one of the existing hub-PIHP/CMHSPs may be utilized as the foundation of the system for the new entity. (Note: this will allow former hub-PIHP/CMHSP performance as verified by MDCH and external quality review organization to be considered in review of application submission).
b. The PIHP must have the ability to directly transmit and receive data from and to all individual CMHSP/CA sources without the additional step of going through

former hub-PIHP/CMHSP systems for sub-groups of CMHSPs in that same region. If more time is required for smooth transition to a single PIHP IT system supporting all CMHSPs/CAs in the region, then the applicant will list target date for completion. Award and contract with the PIHP entity will include successful transition by target date as a condition of the award and continuing contract past target date.

Response Criteria

Note: For PIHPs representing regions containing more than one CMHSP for each separate response below list the specific name of the former hub PIHP/CMHSP whose policies, procedures, processes and technologies are being adopted as the foundation for the new entity to be deployed region wide. This will allow past performance (as determined by MDCH monitoring and/or third party reviewer) of a hub CMHSP as PIHP to be considered in review of application submission. This is expected to significantly decrease the length of response needed in this application submission and decrease additional information that may be requested by MDCH during review of submission.

2.3.1 ☒ In Attachment 2.3.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each Information Systems function.

2.3.2 ☒ The applicant attests that it will adopt one set of common Information Systems Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.3.3 ☒ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.3.3., lists the Information Systems Management policies and procedures and the PIHP(s) from which they were adopted.

OR

☐ The common policies and procedures are in development at the time of application, and the Attachment 2.3.3. will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.3.4 ☒ In the text box below is a two-page description, of the applicant's process detailing how behavioral health and I/DD data (clinical, encounter, claims, demographics, quality, outcomes) aggregated from all CMHSP/CA sources and providers will be:

a. Tested for accuracy and completeness prior to submission to MDCH. Also, describe the process of that submission.
b. Submitted in a timely fashion to MDCH.
c. A consistent region-wide process by January 1, 2014.

2.3.4**The PIHP will adopt existing procedures from the CMH Affiliation for Mid-Michigan (CMHAMM) relative to data integrity. Under this procedure, each CMHSP within the region will conduct testing of data accuracy and completeness prior to submission to the PIHP. THE CIO for the PIHP will work with the IT staff from each CMHSP to ensure that data integrity testing currently in place for CMHAMM and the Northern Affiliation (NA)**

can be applied to the data files generated by each CMHSP. Through this process, all files will be tested against common criteria by all members. Integrity audits will include, but not be limited to:

- **Appropriate inclusion/exclusion criteria for performance indicators,**
- **Verification of QI data, minimally including: residential living arrangement, race, MI/DD/SA designation, Medicaid eligibility, population, education, employment status, minimum wage, primary language, health proxy measures,**
- **Staff activity samples,**
- **Unclaimed services,**
- **Duplicate services, and**
- **Performance indicator exceptions reports.**

Once received, the PIHP will import the data to its database. Appropriate data testing will also be conducted by the PIHP. This will validate the audits and testing done by the CMHSPs as well as testing the importation of the data. The PIHP will produce standard compliant files for submission to MDCH. The PIHP will adopt internal performance objectives for each PIHP function, including information management, to be used for quality improvement purposes. Among these performance objectives will be standards for timely submission of required data to MDCH, as well as standards for data completeness and accuracy.

The PIHP will utilize the software, servers and personnel currently performing the IT functions for the Northern Affiliation. In order to ensure region-wide data submission processes, IT staff from the NA will work with IT staff from NLCMH and CWN to ensure that appropriate data testing and transmission can be done in a consistent manner prior to January 2014.

2.3.5 ☐ More time is needed for transition, the date by which full transition from former PIHPs to new PIHP will be completed is: . In the one-page text box below are the action steps and milestone dates toward achieving a consistent region-wide process:
2.3.5.

2.3.6 ☒ In the text box below is a one-page description of the protection and security features of the PIHP's information management system to ensure confidentiality, data integrity and protection from intrusion. It includes:

a. The risk mitigation and management procedures for a loss of confidential data or security breach to include notification of affected consumers.

b. Confirmation that this will be a consistent region-wide process by January 1, 2014. If more time is needed for transition, list date by which full transition from former PIHPs to new PIHP will be completed: **(date)**

2.3.6**As noted in Attachment 2.3.3, the PIHP will adopt the current security, breach notification, and back-up policies and procedures used by the Northern Affiliation. While these documents are too lengthy to be included in this one page response, key elements are:**

Breach Notification Policy

Current policy is to carry out a breach notification in compliance with the American Recovery and Reinvestment Act (ARRA)/Health Information Technology for Economic and Clinical Health Act (HITECH), as well as any other federal or state notification laws.

Security Procedures

- **Annually, an Information Systems Risk Analysis will be conducted using the RISKWATCH tool. Findings and recommendations will be reported to the PIHP CEO and the Operations Committee**
- **Staff will be trained on all aspects of the HIPAA security rule as it relates to their functions.**
- **The IS Department will receive notice of new hires to set up a new user network account. This account will be assigned and activated after the orientation session. An IS Policy Acknowledgement form will be included in the orientation package. This form indicates that the employee has been advised of and agrees to abide by all IS policies and procedures. The employee will sign this form at the orientation session to complete the account activation process. This will also apply to all leased employees that are given access to the network.**
- **To ensure the confidentiality of PHI, computers are configured with a standard screensaver that is password protected. Users shall not attempt to bypass, defeat or modify these security settings.**
- **Visitors will not be left unattended in an office with a computer logged into the Information System.**
- **All employee accounts will have email access and the ability to change passwords. All other services, such as access to the client data system require additional authorization which at a minimum includes:**

o **Access to data will be based on the needs of a position.**

o **All staff must comply with policies related to confidentiality and privacy of consumers. This includes the unauthorized use, access, revision, duplication, deletion or dissemination of data containing any manner of PHI.**

o **All Information System servers shall be housed in a secure room.**

o The Information System is backed up each day according to established backup and disaster recovery procedures.

o All agency computers shall be protected by virus protection software. Virus signatures used to provide the protection shall be updated on a regular basis.

o In no cases may users outside the IS Department install packet sniffers, Trojan horses, port scanners, or any other programs that can be used to obstruct or disrupt the use of any computing system or network. IS staff may install such tools from time to time as a means for troubleshooting various network problems. Users shall not, by any means, attempt to infiltrate (that is to gain access without proper authorization) any computing system or network using agency equipment.

o IS Staff shall monitor the information system for unauthorized access or attempts at unauthorized access. Methods shall be implemented as necessary to protect against such access.

2.3.7 ☒ In Attachment 2.3.7. is a process/information flow diagram(s) and in the text box below is a one-page narrative explaining the following:

d. How individual information will be aggregated, stored and compiled by the PIHP from CMHSP/CA and provider network sources.
e. How data completeness, validation, timeliness and accuracy will be confirmed and coordinated with CMHSPs/CAs to ensure accurate and timely submission to MDCH (QI, encounter).
f. How eligibility/enrollment information will be received from the State and then parsed by the PIHP for use by the CMHSP(s)/CAs in the region.
g. How the PIHP information management system supports authorization and utilization management processes both those delegated and not delegated by the PIHP.

2.3.7 **Individual information is aggregated, stored and compiled by the PIHP in accordance with the diagram in Attachment 2.3.7. Essentially, the process includes:**

o Files are submitted to the PIHP in a HIPAA or contractually compliant format. The PIHP uses appropriate software to import the claims data and the QI files.

o Once loaded, it is tested to ensure it loaded correctly. If not, errors are reviewed and corrected and the file is loaded again. If necessary, the provider will make the corrections.

o When claims and QI data are loaded and tested, outbound files are created by the PIHP. These files are again tested for completeness and accuracy.

o Verified files are submitted to MDCH.

o Performance indicator data are submitted to the PIHP and tested against claims and QI data to verify accuracy.

o When PIHP performance indicator reports are completed, they are examined against individual CMHSP data to verify accuracy and completeness.

o Once verified, performance indicator reports are submitted to MDCH and reported back to the CMHSP quality systems.

o Reports from MDCH regarding acceptance of files are reviewed and files are corrected as needed.

o The IT staff report to the PIHP QI system on timely submission of claims and other data consistent with established performance objectives.

Enrollment files are processed by a third party vendor who loads an accessible data base on the PIHP server via secured access. Once loaded, the data base is accessible to all CMHSP members of the region.

Service authorization is a delegated function. Consequently, the role of the PIHP information management system is quite limited. The current software product creates a universal authorization so that claims submitted by the CMHSP can be processed. For any authorizations made by the PIHP, the current software tracks authorized services, quantities and dates. Claims processing is completed against these authorizations. Utilization management functions are supported, both as a delegated function as requested, and as a direct function, with various reports from the claims and demographic information available to the PIHP. As the data analytics capacity is further developed, this will become an integral part of the UM process.

FUNCTIONS SUPPORTING INTEGRATED CARE (Physical, Behavioral/I/DD Supports and Services):

2.3.8 ☒ In the text box below is a one-page description of the steps that will be taken to exchange behavioral healthcare data with local/community partners, Sub-state HIEs (health information exchange), and/or MiHIN/NwHIN (Michigan Health Information Network/Nationwide Health Information Network) that includes:

a. Whether the PIHP will maintain a role in the exchange of HL7 CCD formats on behalf of CMHSPs in the region. If so, there is a description of the process to be used and how consent management will be engaged.
b. How the PIHP will use state and national standards for the transfer and interface of behavioral healthcare data (MI/DD/SUD clinical, encounter, claims, demographics, outcomes) between disparate systems (e.g., Care Bridge, Sub-state HIEs/MiHIN/NwHIN, health plans, providers, etc.).

2.3.8**The regional entity, as the PIHP, will not maintain a primary role in the exchange of HL7 CCD formats on behalf of the CMHSP members. To the extent**

practical, the PIHP will assist in providing information to and between the CMHSP in an effort to support each organization's efforts to implement electronic HIE.

The PIHP will, as has been the practice, utilize appropriate standards, e.g., HIPAA compliant formats, or contractual requirements when transmitting encounter, claims, and demographic data. When clinical information is transmitted electronically, it will be in HL7 compliant format.

2.3.9. ☒ In the text box below is a half-page description of the PIHP's capability and/or plan to conduct population-level data analytics from multiple healthcare sources (both primary and behavioral). This includes dashboard indicators and other data mining capabilities that facilitate population management (historical and predictive capacity for assessing cost/risk), utilization management, and care coordination activities.

2.3.9**The Northern Affiliation is one of five PIHP participating in the current data sharing pilot with MDCH. In order to utilize the physical healthcare, pharmacy and dental claims data to be shared, the NA has contracted with Zenith Technology Solutions, LLC, to provide data analytics software. The software utilizes predictive analytics algorithms developed by Johns Hopkins Hospital. During the pilot period, population analysis reports will be provided on a monthly basis to each CMHSP in the NA. Additionally, during the pilot period, a limited number of staff will have access to the data for purposes of more detailed analytics and care management.**

The dashboard reports have not yet been developed. Staff will utilize the data during the pilot period to determine what reports should be produced on a regular basis. Additionally, the NA is represented on the MDCH Client Level Data Analytics Work Group which is assisting in informing the development of an analytics/care management capacity intended to be made available to all of the PIHPs and MHPs. Current plans anticipate that this software will be available, in at least an initial capacity, later this calendar year, with statewide implementation prior to January 2014. Dependent upon the status of that product, the NMRE will continue to work with Zenith Technology Solutions, LLC, as necessary to supplement the product developed by the MDCH.

2.3.10.☒ In the text box below is a half-page description of the planned actions for engaging standards (statewide/national) that improve care coordination, reduce error, eliminate duplicative data entry efforts, and behavioral healthcare data access to the consumer (promoting meaningful use).

2.3.10**As noted in the text box for Item 2.3.9, above, the Northern Affiliation is currently participating in the data sharing pilot initiated by MDCH to make necessary claims data for care coordination available to the PIHPs and MHPs. In addition to the claims data to be made available, effective care coordination requires timely and secure sharing of clinical information. Each CMHSP within the region will utilize HL7 compliant file formats to electronically share clinical**

data. Currently, each organization is in the beginning stages of making such electronic health information exchange possible.

This capability will eliminate the need for duplicate entry of clinical data as it will be transmitted in a standard format that each CMHSP can receive. Further, CWN is working with a local healthcare partner to co-locate their services and to implement a common EMR.

Each CMHSP is using a software package that is certified as meeting meaningful use criteria. Consequently each CMHSP will, when the EMR is fully implemented, be able to provide access to behavioral healthcare data to those being served. The PIHP will monitor each CMHSPs compliance with these criteria as they become effective.

2.3.11. In the table below, name the CMHSPs and core providers who are utilizing EHRs. The name of the EHR software in use at each and whether purchased or developed in-house, and whether nationally certified should also be entered in the third column.

Note: It is not required to have a certified EHR at the PIHP level, but if one is available to the CMHSPs for use, owned by the PIHP, please make note. It is also understood that EHR certification standards are still evolving for purposes of behavioral health.

Table 2.3.11

CMHSP, MCPN, Core Provider Utilizing EHRs	EHR Software Used	Purchased or Developed In-House, and note if Certified
AuSable Valley CMH	Netsmart Technologies' Avatar Suite of Products	Purchased, Application is certified
Centra-Wellness Network	Streamlines Smart Care	Purchased, Application is certified
North Country CMH	Netsmart Technologies' Avatar Suite of Products	Purchased, Application is certified
Northeast Michigan CMH	Netsmart Technologies' Avatar Suite of Products	Purchased, Application is certified
Northern Lakes CMH	Netsmart Technologies' Avatar Suite of Products	Purchased, Application is certified

2.4 Provider Network Management

Provider Network Management typically includes the functions of 1) network development and procurement (and re-procurement), 2) provider contract management (including oversight), 3) network policy development, 4) credentialing, privileging and primary source verification of professional staff, and 5) background checks and qualifications of non-credentialed staff. The "provider network" of the PIHP includes as applicable, the member CMHSPs, MCPNs, Core Providers, or any other provider with which the PIHP has a direct contract to deliver a covered service. It is the responsibility of the PIHP to perform the functions above, and to assure that its provider network performs these functions in the management of any providers it procures.

In the text boxes below, provide a half-page description of how the PIHP will oversee the five functions listed above:

2.4.1. Network development and procurement.

The PIHP shall establish policies and procedures for procurement of services that meet the requirements of the MDCH contract and any applicable regulations. These procedures will apply when there is a need for the purchase of services of a substantial nature or when the services are not available within the existing network. The CMHSPs will establish policies and procedures that are consistent with those of the PIHP.

The PIHP may, based upon the needs of the consumers and the market for such services, establish, maintain and utilize a competitive bid process. All procurement processes will be conducted in accordance with the policies and procedures of the PIHP, guidelines established in the MDCH Medicaid Managed Specialty Supports and Services Contract, and any addition relevant industry or governmental requirements. The PIHP and the CMHSPs will review provider network policies and procedures; review contract monitoring performance indicators; ensure compliance with State and Federal procurement and provider management requirements; and develop and implement a process for continual evaluation of the adequacy of the network. The PIHP and the CMHSPs will make every effort to involve consumers, as appropriate, in any changes to the provider network policies.

2.4.2. Provider contract management and oversight.

The PIHP is responsible for continuous monitoring of the provider network to ensure access, quality of care, person-centered approach and customer satisfaction. The PIHP will monitor, and the CMHSPs will utilize a variety of methods to assess provider performance, including but not limited to: on-site audits, consumer satisfaction surveys, audits by other licensing and accrediting organizations and utilization and quality improvement data reporting. Plans of Correction will be required by the CMHSPs when providers are found to be out of compliance with contract requirements and/or are not meeting performance indicator requirements.

2.4.3. Network policy development.

The PIHP will develop and maintain provider network policies and procedures to guide and direct the network development, credentialing and re-credentialing, procurement procedures and management and oversight of providers in the CMHSP networks. The expected result is a robust provider network for persons served by the CMHSPs. CMHSP policies will be developed consistent with PIHP policies and procedures, the MDCH Medicaid Managed Specialty Supports and Services Contract, and federal and state statutes. This will promote consistency in network policy development across all counties served in Region 2. The PIHP Operations Committee and the CEO will provide oversight of the network policy development by the CMHSPs.

2.4.4. Credentialing, privileging and primary source verification of professional staff.

The PIHP shall monitor all CMHSP credentialing, privileging and primary source verification of professional staff. The CMHSPs' policies and procedures for these functions shall be consistent with the policies and procedures established by the PIHP. The PIHP will assure that credentialing and re-credentialing processes in place across the affiliation comply with PIHP policies and procedures. Prior to approval of any new contract for the provision of service(s) to any and all consumers in Region 2, CMHSP personnel performing the credentialing, privileging and primary source verification functions will conduct a due diligence process with respect to the prospective contractor or contract organization. Each contract executed shall be accompanied by sufficient documentation to demonstrate that the contracting entity achieves or exceeds Network standards in regard to (1) fiscal stability, (2) ethical practices, (3) adherence to legal requirements, (4) commitment to accessibility, (5) adherence to applicable health and safety requirements, (6) capacity to fulfill the mission of the Network and (7) ability to provide services.

2.4.5. Background checks and qualifications of non-credentialed staff.

The PIHP will monitor that the CMHSPs perform background checks on the qualifications of non-credentialed staff. The PIHP will require that the CMHSP policies and procedures are consistent with the standards of the PIHP. Providers must agree to notify the CMHSP of any substantiated findings of non compliance. The CMHSPs will ensure that direct care staff meet Michigan Mental Health Code requirements and have received all required trainings. The CMHSP will conduct annual site visits, coordinated with the other CMHSPs in the region, to avoid redundancy. The PIHP CEO will monitor compliance.

2.4.6. ☒ In Attachment 2.4.6. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.4.7. ☒ The applicant attests that it will adopt one set of common Provider Network Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.4.8. ☒ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.4.8., lists the Provider Network Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.4.9. ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.4.9. will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.4.10. ☒ In the text box below is a one-page description of how the applicant will assure that the capacity of the provider network is sufficient to make available all the specialty services and supports in the entire region. Include how capacity will be measured. Include how the applicant will assure that existing standards for geographic access and timeliness of access to the services will be met within the region in accordance with 42 CFR 438.206.

2.4.10.**The PIHP will oversee the five CMHSPs that provide a comprehensive array of specialty mental health, developmental disability and substance use disorder services for Medicaid recipients in a twenty-one county area. Services are provided via an assortment of arrangements with comprehensive providers and subcontracted providers, as well as through a contracts with the substance use disorder services provider network. The exact transition of the SUD provider network from the current CA to the PIHP has yet to be determined.**

An emerging trend within the behavioral health industry that significantly impacts the service delivery and provider network is the integration of primary health care and behavioral health care. Each of the five CMHSP have an integrated care work plan that will advance this transition.

Network Adequacy

Adequacy of the provider panel must first consider the service area population and demand. This consists of the current service population and the historical demand for services, both by volume and type.

The PIHP will analyze network adequacy by identifying the square miles of the service area, total population, and population density of the service area. The PIHP will identify various characteristics of the population, such as: Medicaid Health Plan enrollment, by county and by CMHSP, changes over time, and variations in eligbility categories. The information will be evaluated against the available network of providers by location, services, and availability. The

distribution of recipients by eligibility category will be compared against historical eligibility distribution and utilization to determine trends that will impact the adequacy of the provider network and also the impact on funding. Medicaid recipients as a percentage of total people served will be determined for each CMHSP as well as the percentage of services for adult mental health, developmental disabilities, serious emotional disturbance and substance use disorder compared to the total population served.

Service Access and Demand

There are three primary methods of accessing services funded by the PIHP. They are, in order of volume: the Access Center (regional or local), Walk-ins and Emergency and After Hours service requests. Data on the number of individuals screened, assessed and referred to the CMHSPs will be compiled. Adequate availability of services is best indicated by timely access to services. The PIHP will report access timeliness to the Michigan Department of Community Health on a quarterly basis, or as required.

These access timeliness standards provide an indication of adequate access, however, they are limited to initial or emergency services and do not indicate the adequacy of other, non-access services such as Assertive Community Treatment, targeted case management, etc. The PIHP will work with the CMHSPs to ensure that there are no waiting lists for Medicaid services. The PIHP will also evaluate the provider network to determine if services are available within the sixty mile rural service area standard.

2.4.11. ☒ In the text box below is a one-page description of how the applicant will perform oversight of its provider network to assure the health and welfare of the region's service recipients.

2.4.11.**Provider Monitoring**

The PIHP will oversee how the five CMHSPs procure and monitor services in a manner that ensures quality care and promotes health and safety. The PIHP expects that provider monitoring begins with the completion of an application that will be reviewed and assessed, including on-site visits if appropriate. Accepted providers will be credentialed and privileged according to State and PIHP policies and procedures.

The PIHP and the CMHSPs will be responsible for continuous monitoring of the provider network to ensure access, quality of care, a person-centered approach and consumer satisfaction. The CMHSPs will utilize a variety of methods to monitor provider performance:

- **service verification, payment authorization and payment review**

- **re-credentialing, including but not limited to insurance coverage and audits by other licensing and accrediting organizations**
- **review of performance, utilization, financial and quality improvement data**
- **annual on-site reviews of each provider and follow-up reviews as needed**
- **input from individual/family/stakeholder groups involved in the monitoring/oversight process.**
- **review of Recipient Rights Reports and Customer Service data**
- **analysis of risk and sentinel events and incident reports**
- **monitoring of financial management and financial solvency of the Provider**

All provider monitoring activities by the CMHSPs and the PIHP will be coordinated in a manner that avoids duplication and excess burden. Findings from the monitoring process will be shared with all CMHSPs that contract with the provider.

In the event of non-compliance with the contract, network policies and procedures, as well as provider performance problems, the CMHSPs shall require a plan of correction (POC) from the Provider. This Plan of Correction shall be shared with the PIHP and, as appropriate, other CMHSPs. In the event a provider is in continued non-compliance, the CMHSP may impose sanctions up to and including removal from the provider network.

The PIHP, through the CMHSPs, will ensure that all network providers have adequate training in areas that are required in the MDCH Medicaid Managed Specialty Supports and Services Contract.

The PIHP and the CEO will oversee the review of provider network policies and procedures; review contract monitoring of performance indicators; ensure compliance with State and Federal procurement and provider netowrk management requirements; and develop and implement a process for continual evaluation of adequacy of the network. The PIHP shall make every effort to involve consumers in any changes to the provider network policies and this process is predicated on the goal of continuous quality improvement across the service continuum.

2.5 Utilization Management

Utilization management typically includes the following functions: 1) access and eligibility determination, 2) utilization management protocols, 3) service authorization, and 4) utilization review. The functions may be fully or partially-delegated to the PIHP's provider network.

2.5.1. ☒ In Attachment 2.5.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.
2.5.2. ☐ The function will not be delegated.

OR

2.5.3. ☒ The function will be fully or partially delegated. In the text box below is a one-page description of each function that will be delegated and to what entity it will be delegated; and how the governing structure and CEO will provide monitoring and oversight of the delegated functions.

2.5.3**Utilization management functions are partially delegated to all five CMHSPs. A description of this follows:**

Access and Eligibility
The PIHP will initially continue to operate a centralized Access Center for the three Boards currently in the Northern Affiliation (AVCMH, NCCMH and NEMCMH). This Access Center verifies eligibility, conducts an initial screening and either schedules an intake assessment at the local CMHSP office or refers the individual to another resource. All other access functions, as defined in the contractual requirements, are delegated to the CMHSP. For CWN and NLCMH, all access functions are delegated. The performance of these delegated functions will be monitored by the staff of the PIHP, as specified in contract.

Utilization Management Protocols
The establishment of regional standards is not a delegated responsibility. Therefore, the PIHP will set the UM Protocol based on Medicaid and contractual requirements.

Service Authorization
Service authorization is a delegated function to the CMHSP. This will be monitored by the PIHP in several ways. The regular Medicaid claims verification process will verify service authorizations. Additionally, the PIHP's Utilization Management Committee will review a sample of services, verifying authorizations in the process.

Utilization Review
Utilization Review is a delegated function to the CMHSP. Each CMHSP is required to monitor the service utilization to verify the services are provided

in accordance with established protocol. This is monitored via the PIHP's UM Committee review process.

The PIHP will have a Utilization Management Committee that includes representatives from the CMHSPs and SUD providers. Each CMHSP UM Process will provide summary data to the PIHP UM Committee for review. The PIHP UM Committee will report on its activities to the PIHP CEO and Operations Committee. The PIHP CEO will provide regular reports of utilization management activities to the Operations Committee and to the Governing Board. Report formats will vary from time to time to reflect emerging trends and needs.

2.5.4. ☒ The applicant attests that it will adopt one set of common Utilization Management function policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.5.5. ☒ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.5.5., lists the Utilization Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.5.6. ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.5.5. will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.6 Customer Services

Customer services functions are typically: 1) information services that are compliant with 42 CFR 438.10, 2) maintenance and annual provision of the Customer Services Handbook that has been approved by MDCH, 3) facilitation of consumer empowerment and participation in PIHP planning and monitoring, 4) customer complaint, grievances and appeals, and 5) community benefit. While functions number one and two are the responsibility of the PIHP, the other three functions may be delegated in part or in full.

2.6.1. ☒ In Attachment 2.6.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.6.2. ☐ The functions will not be delegated.

OR

2.6.3. ☒ The function will be fully or partially delegated. In the text box below is a one-page description of each function that will be delegated and to what entity it will be delegated; and how the governing structure and CEO will provide monitoring and oversight of the delegated functions.

2.6.3.**Customer services functions are largely delegated to each of the CMHSP members. Functions will be performed in accordance with region-wide policies, but are best accomplished closest to the consumer. Specifically, the core functions will be completed as noted:**

Information Services
Largely, the required information is provided via a regionally produced Member Handbook. This printed document is distributed by each CMHSP. Additional information, as appropriate, is provided by the CMHSP.

Maintenance and Annual Provision of the Handbook
The Member Handbook will be produced by the PIHP. Various pieces, such as the Provider list and those pages with specific staff names, will be maintained electronically by the PIHP and shared with each CMHSP. At the time the handbook is distributed, the provider list and an insert with those specific names, will be printed by the CMHSP and distributed with the book.

Facilitation of Consumer Empowerment and Participation In PIHP Planning
Consumer empowerment is a shared responsibility for all stakeholders in the public behavioral health system. As such, the PIHP will, as appropriate, conduct consumer educational activities such as the Consumer Day of Recovery Education coordinated twice yearly by the Northern Affiliation. Additionally, each CMHSP will be encouraged and supported to promote consumer empowerment within its local communities. Participation in PIHP

planning will be facilitated by the PIHP with assistance from CMHSP to identify individuals to participate. The PIHP will have a regional Consumer Council to provide input to planning and operations.

Customer Complaint, Grievances, and Appeals
Again, customer complaints, grievances and appeals will be a shared function. Dispute resolution, in any form, is best accomplished closest to the point of service. For this reason, the PIHP will formally delegate, to each CMHSP, responsibility for grievance and appeal. These functions are to be accomplished consistent with the PIHP protocol which are based upon the MDCH/PIHP contractual requirements. Additionally, if an individual wishes to file a grievance or appeal with the PIHP rather than the local CMHSP, this is acceptable. In this case, the PIHP will process the appeal according to the established protocol. In the event of a grievance, the PIHP will work with the CMHSP to reach the appropriate resolution.

Community Benefit
Community benefit activities are fully delegated to the CMHSP. This is an essential part of the community presence of the CMHSP.

As with all delegated functions, regular reporting and monitoring will occur. Each CMHSP will provide denial, appeal, and grievance logs to the PIHP on a quarterly basis. The PIHP will collect and trend data relative to this. These data will be reviewed by the PIHP CEO and reviewed with the Operations Committee and the PIHP Governing Board.

2.6.4. ☒ The applicant attests that the Customer Services Handbook that reflects the applicant region will be submitted to MDCH for approval no later than October 1, 2013, and that it will be ready for delivery to the beneficiaries no later than January 1, 2014.

OR

2.6.5. ☐ The applicant attests that the PIHP region is not changing in 2014 and that the current Customer Services Handbook is up-to-date and has been approved by MDCH.

2.6.6. ☒ The applicant attests that it will adopt one set of common Customer Services policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.6.7. ☒ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.6.7., lists the Customer Services policies and procedures and the PIHP(s) from which they were adopted.

OR

2.6.8. ☐ The common policies and procedures are in development at the time of application, and the Attachment XX will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

2.7 Quality Management

Quality Management typically includes the following functions: 1) developing an annual Quality Assessment and Performance Improvement Program (QAPIP) plan and report, 2) standard-setting, 3) conducting performance assessments, 4) conducting on-site monitoring of providers in the provider network, 5) managing regulatory and corporate compliance, 6) managing outside entity review processes (e.g., external quality review, PIHP accreditation), 7) conducting research, 8) facility quality improvement process , 9) facility provider education and oversight, and 10) analyzing critical incidents and sentinel events. MDCH expects that the PIHP will not delegate these functions and understands that some of the functions will be performed in addition by the provider network (member CMHSPs, MCPNs, or core providers).

2.7.1. ☒ In Attachment 2.7.1. is an organizational chart that depicts the lines of supervision from executive staff and oversight for each function.

2.7.2. ☐ The functions will not be delegated.

OR

2.7.3. ☒ The function will be fully or partially delegated. In the text box below is a one-page description of any of the ten functions that will be delegated and to what entity it will be delegated; and how the governing structure and CEO will provide monitoring and oversight of the delegated functions.

2.7.3.**The functions to be delegated include:**

3) **Conducting performance assessments--The PIHP will delegate this function to the CMHSPs with the CMHSPs conducting the performance assessments and submitting the information so that the PIHP can track and trend outcomes across the five CMHSPs.**

4) **Conducting on-site monitoring of providers in the provider network--The PIHP will delegate this function to the CMHSPs and this function is a dual effort of the PIHP with the CMHSPs. The PIHP will be responsible for monitoring its provider network, i.e., the CMHSPs.**

8) **Facilitate quality improvement process—The PIHP will delegate this function and this function is a dual responsibility of the PIHP and the CMHSPs.**

9) **Facilitate provider education and oversight—The PIHP will delegate this function and this function is a dual responsibility of the PIHP and the CMHSPs.**

How the governing structure and CEO will provide monitoring and oversight of the delegated functions.

Providing quality services and ensuring quality improvement is the responsibility of all staff and the Governing Board of the PIHP and the CMHSPs. In addition, formal structures are designed to manage the quality of care, including quality improvement at the CMHSPs and quality oversight at the PIHP level. The Quality Improvement Committee (QIC) reports through the Operations Committee to the Governing Board. The specific charge to the QIC is to engage persons served and staff in an accurate, data-driven, affiliation-wide process, resulting in quality and performance improvement, the achievement of standards, and the establishment of new standards as appropriate.

The ultimate responsibility for quality assessment and performance improvement across the PIHP accrues to the PIHP Governing Board. The PIHP CEO is responsible for a successful quality assessment and performance improvement program implementation. The CEO, working with the PIHP Medical Director and appropriate administrative staff, will ensure implementation of this plan. The PIHP will provide staff support and leadership to the implementation of the plan.

The QIC will be comprised of CMHSP Quality Improvement staff, as appointed by the CMHSP Directors. Additional membership will be specified in the written Quality Assessment and Performance Improvement Plan to be submitted no later than October 1, 2013.

Responsibilities and Accountability

A. The PIHP Governing Board is accountable for quality assessment and performance improvement activities. The Board will annually review the written QAPIP and its evaluation. The Board will regularly receive specific reports of indicators, quality oversight activities, and corrective actions as requested.

B. The PIHP CEO is the staff member who is ultimately responsible for quality assessment and performance improvement activities of network providers.

C. The PIHP Medical Director actively participates as a standing member of the QIC and represents the medical and clinical aspects of operations.

D. CMHSPs will develop, implement and maintain quality improvement programs and will report results of monitoring and improvement activities to the Quality Improvement Committee as requested.

2.7.4. ☒ The applicant attests that the QAPIP plan that reflects the applicant region will be submitted to MDCH no later than October 1, 2013, and that it will be ready for implementation by January 1, 2014.

OR

2.7.5. ☐ The applicant attests that the PIHP region is not changing in 2014 and that the current QAPIP plan is up-to-date and has been submitted to MDCH.

2.7.6. ☒ The applicant attests that it will adopt one set of common Quality Management policies and procedures that will be used throughout the region (among member CMHSPs, MCPNs, or Core Providers).

2.7.7. ☒ If a common policy or procedure is based on one or more from any existing (FY'13) PIHP, the Attachment 2.7.7., lists the Quality Management policies and procedures and the PIHP(s) from which they were adopted.

OR

2.7.8. ☐ The common policies and procedures are in development at the time of application, and the Attachment 2.7.7. will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

ACCREDITATION STATUS

As evidenced by developments in federal and Michigan policy, the ability to perform managed care functions to industry standards while also assuring program integrity with federal and state funds is an expectation for the Regional Entity or Urban Cooperation Act PIHPs. MDCH will determine by October 1, 2013, the specific accreditation requirements including NCQA or URAC category options for PIHPs. It is recognized that accreditation is neither quick nor easy; nor inexpensive. Given these realities MDCH is carefully considering the best course of action and required timeframes for accreditation of PIHPs. It should be noted that the "health plan" categories of accreditation for both NCQA and URAC provide the closest match to federal and state requirements for managed care organizations including PIHPs.

3.1. ☒ In the text box below is a half-page description of the status of any URAC or NCQA accreditation of current (2013) PIHP(s) in the applicant's region.

3.1 **The three PIHPs currently (2013) in the region, CMH Affiliation for Mid Michigan, CMH Affiliation for Northwest Michigan and the Northern Affilation, are not accredited by either NCQA or URAC. No current PIHP represented has begun a formal process for achieving accreditation. The Northern Affiliation, over the past two years. has reviewed the standards for both accrediting groups. While no plans were put in place, NCQA appeared to be the more appropriate choice.**

3.2. ☒ In the text box below is a half-page description of the status of activity, viewpoints, options or plans in this applicant's new region to obtain URAC or NCQA accreditation. Make note of specific categories or programs within NCQA or URAC being considered or evaluated. (examples of categories: URAC-Health Plan, URAC-Health Network, NCQA-MBHO, NCQA-Health Plan). Include target application date if known.

3.2 **The membership of the new region has made no decisions regarding pursuit of accreditation by either NCQA or URAC. Once the entity is in place, and a CEO has been hired, that individual will be charged with researching the two options and making a recommendation to the Operations Committee. Once the CEO and the Operations Committee have reached a consensus, a recommendation, with an initial plan for achieving accreditation, will be presented to the PIHP Governing Board for approval.**

3. **EXTERNAL QUALITY REVIEW**

Beginning January 1, 2015, the external quality review organization (EQRO) will a) review the new PIHPs' compliance with the Balance Budget Act (BBA) standards; b) validate the performance measures; and c) validate the new mandatory performance improvement project that will commence January 1, 2014. Until then, MDCH will rely on the performance, as measured by the EQRO, of existing PIHP(s) in each new region. Where there are weaknesses in an existing PIHP, MDCH expects that applicant to address how performance will be improved. Below is the applicant's assessment of the performance of existing PIHP(s) in the applicant's region.

4.1.1. ☐ All BBA standards in FY'11-12 were determined by Health Services Advisory Group (HSAG) to meet or exceed 95% compliance in any current (FY'13) PIHP in the new region**.**

OR

4.2. ☒ In the text box below is any BBA standard(s) for which, in FY'11-12, there was less than 95% compliance by one or more current PIHPs in the new region; AND a description of the plan with action steps, responsible staff, and timeframes for the applicant achieving a minimum of 95% compliance with every BBA standard by January 1, 2015.

4.2 **The CMH Affiliation for Mid-Michigan received only one score below 95% in the FY11-12 Compliance review. The one standard area found not to be in substantial compliance was XIII. Coordination of Care, with a score of 88%.**

It is intended that the new regional entity will, as the PIHP, hold all coordination agreements with the MHPs serving this region. The PIHP CEO will have all agreements in place by January 1, 2014.

4.3. ☒ All Performance Measures were designated "fully compliant" in FY'11-12 for all current PIHPs in the new region.

OR

4.4. ☐ In the text box below is any Performance Measure that, in FY'11-12, received an EQRO audit designation of less than "fully compliant" by one or more current PIHPs in the new region; AND a description of the plan with action steps, responsible staff, and timeframes for the applicant achieving a minimum of fully compliant on all performance measures by January 1, 2015.

4.4

4.5. ☐ All current PIHPs in the new region scored 100% the Performance Improvement Project Validation for FY'11-12 on *Evaluation Element* Met and *Critical Elements* Met.

OR

4.6 ☒ In the text box below is any EQRO score of less than 100% on the Evaluation Elements *Met,* and any score of less than 100% on Critical Elements *Met* on the Performance Improvement Project validation for FY'11-12 by any current PIHP in the new region; AND a description of the plan with action steps, responsible staff,

and timeframes for the applicant achieving a minimum of 100% *Met* on both Evaluation Elements and Critical elements by January 1, 2015.

4.6 **All three PIHPs; CMHAMM, Northwest CMH Affiliation, and the Northern Affiliation met 100% of Critical Elements. The Northern Affiliation met 100% of all Evaluation Elements.**

CMHAMM met 91% of all Evaluation Elements. In Activity VIII, Analyze Data and Interpret Study Results, two elements were found to be partially compliant. In Activity IX, Assess for Real Improvement, one element was not met.

NWA also met 91% of all Evaluation Elements. In Activity IX, Assess for Real Improvement, three elements were not met.

As of the time of this submission, each PIHP has submitted the current year version of the Performance Improvement Project to HSAG for evaluation. It is anticipated, that both the CMHAMM and NWA have implemented the corrective actions needed based on the previous submission. The findings of the most recent Performance Improvement Projects will be reviewed by the CEO and Operations Committee of the PIHP. Appropriate plans, if necessary, will be developed based on the results of these most recent submissions.

5. PUBLIC POLICY INITIATIVES

The public policy initiatives outlined below reflect MDCH's need to certify to CMS that the PIHP assures the full array of specialty services and supports is available and that it maintains adequate provider network capacity to serve the region's Medicaid beneficiaries (42 CFR 438.207). In addition, these public policies address the need to protect the vulnerable people served and at the same time to offer them opportunities to successfully live in the community, to work, and to develop and maintain meaningful relationships.

5.1 Regional Crisis Response Capacity

Crisis Response Capacity comprises three concepts: 1. Ongoing tracking and trending of critical incidents[1] and sentinel events;[2] 2) employing strategies to prevent critical incidents and sentinel events; and 3) having in place the capacity to regionally respond to behavioral or medical crises. The first concept is not new to Michigan's public mental health system, and it is expected that the applicant is in compliance with the Quality Assessment and Performance Improvement Program (QAPIP) standards where those activities are required and are measured by the External Quality Review and the Medicaid Site Review.

For the past few years MDCH has provided tools to the public mental health system for prevention of, and early intervention in, crises. [See MDCH/PIHP FY'13 Contract Attachment 1.4.1 Technical Requirement for Behavior Treatment Plan Review Committees; Prevention Guide, June 2011 at www.michigan.gov/Mental Health and Substance Abuse (page); Transition Guide for Placement into AFCs; and Center for Positive Living Supports www.positivelivingsupport.org].

Thus the applicant attests that in the region there are common established processes which demonstrate that the provider network effectively:

5.1.1. ☒ Evaluates the systemic factors involved in any occurrence of critical incidents and at-risk health conditions, and behavioral and medical crises.

5.1.2. ☒ Identifies any individual precursors to potential behavioral or medical crises that can serve as a warning to care givers and staff.

5.1.3. ☒ Identifies and implements actions to eliminate or lessen the risk that critical incidents, sentinel events, and behavioral crises will occur.

For this new AFP, it is expected that the applicant describe the crisis response capacity that will be fully available in each PIHP region by January 1, 2015. Crisis response capacity includes clinical expertise that can be immediately accessed for mental health or behavioral crises. That expertise may be a team or teams of clinicians who are available for telephonic consultation and on-site observation and consultation, and have the training and experience to address the needs of children and adults with serious mental illness (SMI/SED) and children and adults with intellectual/developmental disabilities (I/DD), and children and adults with co-occurring SMI/SED and I/DD. This crisis response capacity

[1] Critical incidents as defined by the FY'13 MDCH/PIHP contract Attachments 6.5.1.1 and 6.7.1.1

[2] Sentinel event - an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

must also have a residential or inpatient component to which an individual can be transported, reside for a short period, and receive treatment or intervention until his/her crisis stabilizes. This capacity could be **intensive crisis stabilization or crisis residential services in** a free-standing licensed adult foster care facility and a free-standing licensed children's foster care facility, staffed with clinicians and workers who are specially trained to respond effectively to behavioral crises exhibited by adults or children with SMI/SED or adults with I/DD. This capacity could alternatively be an agreement with a regional inpatient psychiatric unit that is willing and able to receive any individual (SMI, SED or I/DD, adult or child) who is exhibiting a behavioral crisis. This capacity must include emergency admission.

5.1.4. ☒ In table 5.1.4 below is a regional analysis of people who are at risk with answers to the five questions following.

OR

☐ The table below will be completed, with the five questions answered, and submitted to MDCH no later than 5 p.m. on July 1, 2013.

Identify the number of individuals identified as at-risk of crisis placement as determined by experiencing within the last six months: more than one 911 call for police intervention, more than one temporary placement in a crisis home, an on-site visit from the CPLS mobile team, more than one visit to the ER for behavioral episode, an admission to a psych in-patient unit, one or more requests for inpatient admission to a state psychiatric facility. Sort by age (child, adult 18-64, 65+) and disability designation (SED, SMI and I/DD).

Table 5.1.4

	911 calls	Temporary placements in crisis home	On-site visit by CPLS mobile team	ER visit	Admission to psych inpatient unit	Request for inpatient admission to state facility
Child with SED	**2**	**0**	**0**	**7**	**80**	**7**
Adult with SMI 18-64	**4**	**30**	**0**	**114**	**507**	**15**
Adult with SMI 65+	**1**	**1**	**0**	**8**	**27**	**0**
Child with I/DD*	**0**	**0**	**0**	**1**	**4**	**1**

	911 calls	Temporary placements in crisis home	On-site visit by CPLS mobile team	ER visit	Admission to psych inpatient unit	Request for inpatient admission to state facility
Adult with I/DD* 18-64	**2**	**2**	**1**	**3**	**15**	**1**
Adult with I/DD* 65+	**0**	**0**	**0**	**0**	**1**	**0**

***Count people on the Autism Spectrum Disorder or people with co-occurring SMI/SED and I/DD in this category**

5.1.5. ☒ In text box below are the numbers of individuals who have:
- 5.1.5.1. A current (within the last 12 months) behavioral treatment plan with restrictive or intrusive interventions approved by the Behavior Treatment Plan Review Committee: **217**
- 5.1.5.2. Experienced (within the last 12 months) an injury requiring emergency room visit or hospital admission due to an intervention that occurred during a behavioral episode: **0**

5.1.6. ☐ Beds are available in secure settings (e.g., psych unit in a community or private hospital) in the region and organizations "owning" the beds are willing to make them available to people with SMI, SED or I/DD with behaviors.

5.1.7. ☒ In text box below is percent of staff in the region who have participated in the Culture of Gentleness Working with People training:
- 5.1.7.1. Direct care workers: **68%**
- 5.1.7.2. Group home managers: **76%**
- 5.1.7.3. Supports coordinators/case managers: **50%**
- 5.1.7.4. Or other more advanced training such as Culture of Gentleness Practicum or Mentor Training : **7%**

5.1.8. ☒ In the text box below is a two-page description of:
- a. The identification of at least one point person in the region who is available 24/7, 365 days/year to respond to crises that require immediate attention and who has the authority to arrange for temporary placement, regional crisis team or CPLS team consultation or visit.
- b. Agreement(s) between the PIHP and hospitals or licensed AFCs in the region that will be available for short-term crisis placement.
- c. Any plans for developing crisis residential programs.
- d. Target dates for achieving full crisis response capacity by January 1, 2015.

5.1.8. **Each CMHSP in Region 2 has an emergency response system. This 24/7, 365/per year system is consistent with the requirements of the Mental**

Health Code. Each system has the capacity to provide face to face evaluation and crisis resolution, including an established decision tree for obtaining necessary authorizations. This includes the ability to arrange for temporary placement, hospitalization, or accessing the CPLS mobile team. Final accountability, in each CMHSP, is vested with the Executive Director. As the newly formed region develops plans to implement a regional crisis response capacity fully compliant with the requirements of this section, the existing emergency response systems will be a strong base from which to enhance the regional capacity.

In its current structure, the Northern Affiliation holds contracts with community psychiatric hospital units. Within the region, this includes Alpena Regional Medical Center and Munson Hospital. Northern Lakes CMH and Centra Wellness Network hold their own contracts with community hospitals, including Munson Hospital. All five CMHSP manage their own contracts with AFC providers. These include a variety of settings, including short term and long term arrangements. North Country CMH and Northern Lakes CMH both operate crisis residential programs for adults with mental illness, with occasional use by adults with intellectual/developmental disabilities. There is not, currently, the capacity for crisis residential placement for children in the region. This need will be addressed through the planning process noted above. It is anticipated that this capacity will be in place prior to January 1, 2015.

During the next several months, the Directors of the five CMHSP will assign appropriate staff to a regional work group. This group will be charged with developing an appropriate plan for the region to develop the crisis response capacity specified in this section. This will include ensuring that existing capacity is adequate, and where it is not, defining plans for the development of needed capacity, including crisis residential placements for all service populations within the region. Key milestones and target dates include:

- **Plan will be developed for review by the Operations Committee no later than August 31, 2013.**
- **Necessary approval by governing bodies, CMHSP and/or PIHP, will be obtained by December 31, 2013.**
- **Appropriate RFPs developed and published by April 30, 2014.**
- **Full capacity in place by October 1, 2014**

5.2 Health and Welfare

5.2.1. Health

One of MDCH four main strategic priorities for MDCH is to "Improve the Health of the Population". This includes promoting 4x4 wellness activities to reduce obesity and targeting chronic care "hot spots" in population and geography. The public mental health system serves people who are among the most vulnerable of Michigan's citizens, It is well documented that longevity for persons with mental illness is 25 years shorter than persons without mental illness. MDCH is seeking greater integration of systems of care to promote healthy behaviors and management of chronic conditions and all aspects of health: physical health, behavioral health, and habilitation.

Primary behavioral health conditions and disabilities frequently are complicated by co-occurring disabilities (e.g., a developmental disability plus epilepsy, swallowing disorder, respiratory or bowel issues), and by co-occurring chronic diseases (e.g., asthma, hypertension, obesity). These conditions, disabilities and diseases usually require frequent and ongoing intervention, treatment and monitoring by health care professionals.

In the absence of ambulatory and preventive care, treatment and monitoring, people use expensive emergency room services or are hospitalized for acute episodes of their conditions. [Please review the Health Services Advisory Group's "2010-2011 Coordination of Care/Medical Services Utilization Focused Study Report, March 2012" at www.michigan.gov/documents/MDCH/MI2010-11_FocusedStudy_SMI-DD_Report_F1_382152_7.pdf] While PIHPs are not paid to provide primary health care, it is expected that PIHPs assure that individuals being served receive appropriate, culturally-relevant and timely healthcare; that medical care providers are knowledgeable in how to approach and treat individuals with mental illness and/or intellectual/developmental disabilities; and that the PIHPs' provider networks are partners on the health care team for health care planning and monitoring purposes.

The applicant attests to the following:

5.2.1.1 ☒ Reporting on Health Conditions (MDCH/PIHP FY'13 Contracts, Attachment 6.5.1.1, Quality Improvement Reporting, Elements #39 through 41) is currently at 95% or more completeness for all populations served in the region.

OR

5.2.1.2 ☐ A plan that has action steps, responsible staff, and timeframes has been developed for achieving 95% or more completeness by January 1, 2014.

5.2.1.3 ☒ By January 1, 2014, person-centered planning (as documented in the individual plan of service) for each beneficiary will address:

a. Current physical health conditions.
b. Existence of health care practitioners that are treating any physical health conditions.

c. Any assistance (e.g., referral, coordination, transportation) that the beneficiary needs in accessing health care practitioners.

5.2.1.4 ☐ In Attachment 5.2.1A., is a description of no more than 4 pages, of how the applicant plans to assure coordination between the provider network and the beneficiaries' primary care practitioners to assure that appropriate preventative and ambulatory care are provided; existing health care conditions are treated and monitored by the health care team; and incidents of emergency room visits (for physical health or mental health crises) and hospital admissions (for physical health or mental health episodes) are immediately communicated among the health care team members; and that medical care providers are knowledgeable in how to approach and treat individuals with mental illness and/or intellectual/developmental disabilities. The description includes:

a. Any electronic methodology(ies) that will be used to share information among the health care team members.
b. How follow-up care (to emergency room visits and hospitalization) will be coordinated among the health care team members.
c. Steps to be taken to reduce or prevent recurrence of the issue(s) that have required avoidable emergency room visits and hospital admissions, including staff training and professional(s) identified for monitoring and oversight.
d. Plans for assuring adequate capacity to serve individuals with high medical needs, including the ability to assure smooth and timely transitions for individuals being discharged from the hospital.

OR

5.2.1.5 ☒ The plan noted in number 5.2.1.4 above is in development, and will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

5.2.2 Welfare

Many individuals served by the public mental health system are victims of abuse, neglect, and exploitation intermittently or for long periods throughout their lives. These traumatizing events have a profound impact on an individual's ability to recover, to learn new skills to improve functioning, to develop and maintain relationships, and to live and work successfully in the community. For many years, MDCH has provided leadership on evidence-based trauma-informed care.

There are many legal obligations to report abuse, neglect and exploitation to various law enforcement and public entities that will not be repeated here. Assuring welfare goes beyond reporting incident as they occur and includes a robust process for analyzing risk factors and reported incidents by individual beneficiary, population, and provider entity, if applicable. There must be close monitoring and oversight to prevent incidents of abuse, neglect, exploitation and other critical/sentinel events from occurring in the first place whenever possible. Monitoring should include information from other sources, such as licensing reports for group homes where individuals served by the PIHP reside [see Office of Inspector General Report on Home and Community-Based Services in Assisted Living Facilities on the MDCH web site at Mental Health and Substance Abuse page]. Assuring welfare also includes seeing to the immediate safety of the individual and others, as well as

acting promptly and decisively when an incident is substantiated to prevent future occurrences for that individual or others.
The applicant attests to the following:

5.2.2.1 ☒ A signed agreement between each CMHSP in the region and their local Department of Human Services office and the Bureau of Child and Adult Licensing (BCAL) will be in effect on 1/1/14 to coordinate investigations as applicable.

5.2.2.2 ☒ Percent of staff in the region who have participated in the Trauma-Informed Care training:

a. Direct care workers: **19%**
b. Group home managers: **57%**
c. Supports coordinators/case managers:**71%**
d. Other: **49%**

5.2.2.3 ☐ In Attachment 5.2.2.3., is a description of no more than four pages, of how the applicant plans to assure the welfare of beneficiaries. The description includes how the applicant assures that its provider network will:

a. analyze risk factors and reported incidents by individual beneficiary and provider entity if applicable to identify patterns and trends;
b. provide close monitoring and oversight, including the staff responsible and frequency of monitoring and oversight ;
c. assure the immediate safety of the individual and others who may be affected when incidents occur, e.g., provisions for the immediate transfer of recipients to a different provider if their health or safety is in jeopardy.

OR

5.2.2.4 ☒ The plan described above is in development and will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

5.3 Olmstead Compliance

5.3.1 Community Living

Title II's integration mandate of the Americans with Disabilities Act requires that the "services, programs, and activities" of a public entity be provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR 35.130(d). Such a setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 CFR 35, App. B at 673. [Please refer to the recent activities of the Civil Rights Division of the U.S. Department of Justice that has been working with state and local governmental officials to insure ADA and Olmstead compliance: www.ada.gov/olmstead/index.htm]

A state or local government must eliminate any eligibility criteria for participation in programs, activities, and services that screen out or tend to screen out persons with disabilities, unless it can establish that the requirements are necessary for the provision of the service, program, or activity. The state or local government may, however, adopt legitimate safety requirements necessary for safe operation if they are based on real risks, not on stereotypes or generalizations about individuals with disabilities. Finally, a public entity must reasonably modify its policies, practices, or procedures to avoid discrimination. If the public entity can demonstrate that a particular modification would fundamentally alter the nature of its service, program, or activity, it is not required to make that modification.

Michigan has been a long-time leader in developing community-based living supports and services, so the provisions of the Olmstead decision related to community living and working are not new to the public mental health system.

Respond with the applicant's assurances to the attestations below:

5.3.1.1 ☐ The applicant has a written policy defining the standards the region's provider network will follow in releasing people from institutions. The provider network's treatment professionals must determine that the placement is appropriate; the individual must not object to being released from the institution; and the provider is able to provide supports and services that enable them to live successfully in the community.

OR

5.3.1.2 ☒ The written policy is in development and will be completed by this date: July 1, 2013

5.3.1.3 ☐ The applicant has a written regional policy in place that calls for treatment professionals to respect and support the housing preferences and choices of people with disabilities and truly fulfill the mandates of the ADA with respect to community integration.

OR

5.3.1.4 ☒ The written regional policy is in development and will be completed by this date: **July 1, 2013**

5.3.1.5 ☒ There will be a regional plan commencing no later than January 1, 2014 to establish partnerships with local housing agencies and housing providers. The goal of these collaborations should be to develop interagency strategies that increase affordable, community-based, integrated housing options for people with disabilities that meet their preferences and needs.

5.3.1.6 ☒ In the three tables below are regional analyses of the numbers of people served who at the time of application live in the settings noted.

OR

5.3.1.7 ☐ The tables below will be completed and submitted to MDCH no later than 5 p.m. on July 1, 2013.

Table 5.3.1.6 A

Number of all individuals by children (up to age 18), adults (18-64) and seniors (65+) and primary disability – serious mental illness, serious emotional disturbance, and intellectual/developmental disability living in any licensed setting.

	# in licensed setting <6 beds	# in licensed setting – 6 beds	# in licensed setting 7-12 beds	# in licensed setting 13+ beds	# in Skilled Nursing Facilities	Total # per population	Percent of Total Served
Children w/ SED	**9**	**0**	**2**	**7**	**0**	**2031**	**0.9%**
Adults SMI 18-64	**13**	**75**	**65**	**55**	**102**	**6242**	**5.0%**
Adults SMI 65+	**6**	**5**	**20**	**13**	**199**	**642**	**37.9%**
Children w/ I/DD	**3**	**1**	**0**	**2**	**0**	**369**	**1.6%**
Adults I/DD 18-64	**71**	**344**	**84**	**89**	**11**	**1742**	**34.4%**
Adults I/DD 65+	**13**	**81**	**14**	**23**	**12**	**220**	**65.0%**
Total	**115**	**506**	**185**	**189**	**324**	**11,246**	**11.7%**

Note: If a beneficiary lives in a group home licensed for six beds but that home is located on a campus with other group homes, report the total number of licensed beds for that provider at that campus location.

Table 5.3.1.6 B
Number of individuals by children (up to age 18), adults (18-64) and seniors (65+) and primary disability – serious mental illness, serious emotional disturbance, and intellectual/developmental disability living in a licensed setting *outside* the PIHP region.

	# in licensed setting <6 beds	# in licensed setting – 6 beds	# in licensed setting 7-12 beds	# in licensed setting 13+ beds	Total # per population	Percent of Total Served
Children w/ SED	**0**	**0**	**2**	**7**	**2031**	**0.4%**
Adults SMI 18-64	**0**	**19**	**14**	**6**	**6242**	**0.6%**
Adults SMI 65+	**0**	**1**	**4**	**0**	**642**	**0.8%**
Children w/ I/DD	**2**	**1**	**0**	**1**	**369**	**0.8%**
Adults I/DD 18-64	**5**	**27**	**19**	**7**	**1742**	**3.3%**
Adults I/DD 65+	**0**	**0**	**0**	**0**	**220**	**0.0%**
Total	**7**	**46**	**39**	**21**	**11,246**	**1.0%**

Table 5.3.1.6 C
The number of adults who live independently, with or without supports, with or without house/roommates. Home/apartment is not a licensed facility and is owned or leased by the individual.

	Independent without supports	Independent with supports	Independent with house/roommates	Independent without house/roommates
Adults SMI 18-64	4537	730	3306	1961
Adults SMI 65+	256	35	153	138
Adults I/DD 18-64	459	658	929	188
Adults I/DD 65+	22	47	49	20

5.3.1.8. ☐ In the text box below is a narrative of no more than two pages that describes:

a. How informed choice of type of setting, provider, roommates/housemates are guaranteed in the annual person-centered planning process.
b. The transition planning process undertaken to assure that there is the right match between the individual and the licensed setting.

c. How individual opportunities for community integration and inclusion, and productivity are addressed and guaranteed in licensed settings (See Keys Amendment at 1915.1616(e) of the Social Security Act that pertains to social security income recipients living in facilities (e.g., group homes, congregate living arrangements).
d. The determinants of the frequency of PIHP monitoring of individuals living in licensed settings differentiated by Specialized Residential settings, and General AFCs. Include how issues or deficiencies are addressed when noted.
e. Plans with action steps, responsible staff, timeframes and numbers of people for developing increased regional alternative (to licensed AFC) residential capacity. 5.3.1.8

OR

☒ The narrative description above will be submitted no later than July 1, 2013.

5.3.1.9 ☐ In Attachment 5.3.1.10., is a plan with action steps and timeframes for developing capacity for bringing [the number] of people currently living out of the region, or transitioned to another PIHP if chosen by the person, back to live within the region. This may be a phased-in approach, but must commence October 1, 2014.

OR

5.3.1.10 ☒ The plan described above is in development and will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

Olmstead Compliance:

5.3.1 **Employment and Community Activities**

CMS underscores that the competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is the **optimal** outcome of Pre-Vocational/Skill-building services. All pre-vocational and supported employment service options should be reviewed and considered as a component of an individual plan of services (IPOS) developed through a person-centered planning process, no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the choice and preferred outcomes of the individual's goals and reflected in the IPOS. [Center for Medicaid and CHIP Service (CMCS) Informational Bulletin, September 16, 2011. Also see MDCH Employment Works! Policy, revised July 2012.]

Work is a key component to recovery through Evidence-based Practice/Individual Placement Supports. MDCH also strongly recognizes that employing Peer Specialists and Peer Mentors can help organizations improve their service delivery systems.

MDCH is initiating an employment data dashboard to track various employment settings (individual, group, Ability One, Clubhouse, and other employment) by wages per hour, and hours per month as well as expected movement toward competitive, integrated community employment. Accurate, timely, and effective federal and state benefits planning related to working is a key to acquiring and maintaining employment.

MDCH expects that each PIHP will embrace the above tenets and encourage its provider network to provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Respond with the applicant's attestations below:

5.3.2.1 ☒ The applicant will have a regional policy in place no later than January 1, 2014 that assures consistency across the applicant's service area in the provision of competitive, integrated employment services for the individuals served. This policy will be available for review prior to that date.

5.3.2.2 ☒ The applicant will have in place no later than January 1, 2013 a regional policy that assures there are affirmative efforts are in place to increase agency and subcontractor employment of individuals with disabilities including recruitment, placement and development of pay scales including fringe benefits and training. Applicant has individuals who have disclosed they have disabilities on staff: **29.7**#FTEs.

5.3.2.3 ☒The applicant assures that its provider networks will link beneficiaries to accurate and timely information about the continuation of federal and state benefits in preparation for and while they are competitively employed.

5.3.2.4 ☒ In the two tables below are regional analyses of the numbers of people served who at the time of application are engaged in the ways noted.

OR

5.3.2.5 ☐ The tables below will be completed and submitted to MDCH no later than 5 p.m. on July 1, 2013.

Table 5.3.2.4 A

In this table is a regional analysis of the number of adults in age ranges and with disability designation below who are in each activity solely. If in multiple activities, count the activity where the most time per year is spent.

	Sheltered Workshop	**Supported Employment***	**Integrated Employment***	**Volunteer job**	**No volunteer or paid work activity, includes retired**	**Total served**
Adults SMI 18-64	17	98	727	68	4427	6846
Adults SMI 65+	2	3	14	3	508	707
Adults I/DD 18-64	445	157	190	80	1024	1859
Adults I/DD 65+	35	15	16	5	136	231

*Refer to the FY13 MDCH/PIHP Contract for definitions of supported and integrated employment

Table 5.3.2.4. B

In this table is a regional analysis of the number of adults in age ranges and with disability designation below who are involved in the community activities with the general public below *at least once a month*.

	Clubs, Social events, visiting friends/relative	**Continuing Education, Classes**	**Athletic/recreational participant**	**Attendance at sporting, arts, theater, movies**	**No extra-curricular activity**	**Total served**
Adults SMI 18-64	2453	351	407	697	805	6846
Adults SMI 65+	176	14	21	36	43	707

	Clubs, Social events, visiting friends/relative	Continuing Education, Classes	Athletic/recreational participant	Attendance at sporting, arts, theater, movies	No extra-curricular activity	Total served
Adults I/DD 18-64	1561	180	455	783	94	1859
Adults I/DD 65+	293	7	24	72	21	231

5.3.2.6 ☐ In the text box below Attachment is a narrative, of no more than two pages, that describes:

a. How informed choice of a) the type of work and b) community activities are guaranteed in the annual person-centered planning process.
b. How individual opportunities for community integration and inclusion, and productivity are addressed and guaranteed as a result of person-centered planning.
c. The determinants of the frequency of PIHP monitoring of individuals who participate in segregated activities that include day programs, workshops. Include how issues or deficiencies are addressed when noted.

5.3.2.6

OR

☒ The narrative description is being developed and will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

5.3.2. ☐ In Attachment 5.3.2.8. is a regional plan with action steps, responsible staff, timeframes and numbers of people for developing increased regional alternatives to segregated day programs and workshops. This may be a phased-in approach, but must commence October 1, 2014.

OR

5.3.2 ☒ The regional plan is in development and will be submitted to MDCH no later than 5 p.m. on July 1, 2013.

5.4 Substance Use Disorder Prevention and Treatment

Michigan's publicly funded Substance Use Disorder (SUD) Service System is committed to a transformational change that promotes and sustains wellness and recovery for individuals, families, and communities. This change to a recovery-oriented system of care (ROSC) employs strategies to:

- prevent the development of new substance use disorders.
- reduce the harm caused by addiction.
- help individuals make the transition from brief experiments in recovery initiation to sustained recovery maintenance via diverse holistic services.
- promote good quality of life and improve community health and wellness.

Additional information can be found in Michigan's Recovery Oriented System of Care (ROSC) Implementation Plan at http://www.michigan.gov/documents/mdch/ROSC_Implementation_Plan_357360_7.pdf.

To develop a holistic and effective SUD Service System that promotes recovery and resilience, PIHPs shall implement a ROSC. In addition, PIHPs shall implement recent Mental Health Code changes, per Public Acts 500 and 501 of 2012, to incorporate SUD administrative functions. Accordingly, the applicant attests to the following:

5.4.1 ☒ Adoption of ROSC's sixteen guiding principles (pages 14-16 of ROSC Implementation Plan).

5.4.2 ☒ Lead person named for transition of SUD administrative functions into the PIHP by April 1, 2013. The lead person's name is: **Dave Schneider**

5.4.3 ☒ Implementation plan made no later than October 1, 2013, for merger of SUD functions into the PIHP to be completed by October 1, 2014. For reference see the, Coordinating Agency contract (http://egrams-mi.com/dch/user/categoryprograms.aspx?CategoryCode=SA&CatDesc=Substance%20Abuse).

5.4.4 ☒ Adherence of federal Substance Abuse Prevention and Treatment Block Grant (SAPT BG) requirements and maintain staff to support.

5.4.5 ☒ Acceptance of fiduciary and local oversight for federally funded discretionary grants.

5.4.6 ☒ Adherence to PA 258 of 1974, Mental Health Code, section 287 by:

- Establishing an SUD Oversight Policy Board by October 1, 2014.
- Providing a list of members and criteria used to make selection.
- Developing procedures for approving budget and contracts by October 1, 2014.
- Attesting to maintaining provider base (as of December 28, 2012) until December 28, 2014.

5.4.7 ☒ Development of a three-year SUD prevention, treatment and recovery plan to be submitted by August 1, 2014, for fiscal years (FY) 2015 to 2017.

5.4.8 ☒ Implementation of evidence-based prevention, treatment, and recovery services.

5.4.9 ☒ Maintenance of a separate Recipient Rights process for SUD service recipients.

5.4.10 ☒ Submission of timely reports on annual budget boilerplate requirements, including:

a. Legislative Report (Section 408), FY2013 due by January 31, 2014
b. Mental Health and Substance Use Disorder Services Integration Status Report (Sections 407 and 470), FY2013 due by January 31, 2014

Note: boilerplate requirements and due dates are subject to change with appropriations

5.5 **Recovery**

The vision in the *Description of a Good and Modern Addictions and Mental Health Service System* addresses elements necessary for a recovery environment including determinants of health, health promotion, prevention, screening, early intervention, treatment system and service coordination, resilience and recovery support to promote social integration, health and productivity. A good and modern system provides a full range of services to meet the needs of the population with strong integrated efforts between behavioral health and primary care. Integration must be based in a model of community participation, inclusion, and integration with the foundation of trauma informed and recovery oriented supports. The Michigan plan of Bringing Recovery Support to Scale vision for health and wellness includes every person with substance use disorder and/or mental illness will having equal access to and opportunity for person-centered, recovery based services which respect that there are multiple pathways and sources of engagement and support that are dependent on each individual's preference and learning style.

The new working definition published by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) discusses recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA has delineated four major dimensions and ten guiding principles that support a life in recovery:

- ***Health***: overcoming or managing one's disease(s) or symptoms—and making informed, healthy choices that support and promote physical and emotional wellbeing.
- ***Home:*** a stable and safe place to live;
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- ***Community***: relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s).

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.
Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.
Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are keys in determining a person's journey and unique pathway to recovery.
Recovery is supported by addressing trauma: Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.
Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.
Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

5.5.1 ☒ In the text box below is a two-page explanation of how the applicant's mission and vision support the dimensions and principles of recovery according to the SAMHSA working definition. Explain how substance use disorder and mental health recovery are both supported by the mission and vision.

5.5.1 **The PIHP member boards of directors have adopted 11 principles that provide a general vision and strategy for the newly formed entity.**

The first principle states that the PIHP exists to ensure that the best services and supports are available to benefit the persons served. This principle provides a general vision and assumes the foundational principles of person-centered planning, self- determination, culture of gentleness, trauma-informed services and recovery. The additional ten principles provide an understanding of how the regional entity will achieve this vision, including how it will utilize the strengths of the members. The three principles below are particularly relevant to the Description of a Good and Modern Addictions and Mental Health Services System and SAMHSA's four dimensions and the ten guiding principles of Recovery.

- **The PIHP is committed to the development, support and use of evidence based practices and promising practices whenever and wherever practical.**
- **The PIHP is committed to a uniform benefit and the distribution of resources in a manner that supports parity in the availability of services across the region.**
- **The PIHP is committed to the improved wellness of all persons served through the meaningful and beneficial integration of physical health care, behavioral health care, and substance use disorder treatment services.**

The PIHP draws from the successful experience of the five member CMHSPs and the three PIHPs of which they have been and are currently a part. Additionally, there is a commitment to using the expertise of CMHSP staff through active membership on

regional committees and initiatives including those identified in the AFP and particularly Recovery.

The PIHP draws its recovery roots from The President's New Freedom Commission on Mental Health report in 2003, the Michigan Mental Health Commission's report of 2004, the 2006 Morbidity and Mortality Study and the definition of Recovery by the Michigan Recovery Council that was founded in 2005. The PIHP is in the process of developing a Mission Statement. A current draft reads as follows:
Our recovery philosophy: -To promote the behavioral and physical health of the individuals, families and communities that we serve through programs that promote recovery, build resilience, create opportunity and improve quality of life.

A PIHP Recovery policy is being drafted to formally express the concept of "recovery" as the overarching goal of the service system, for persons with severe mental illness and substance use disorder. This policy will focus on the following:

Recovery shall be the guiding principle and operational framework for our system of care provided by the partnership of public and private agencies and consumer-run services. This begins with the belief that recovery is achievable and possible. The PIHP and the CMHSPs will project hope, communicate the expectation of recovery, and empower people to exercise choice and control over their lives, including the purchase of supports and services and the choice of providers. This must begin by establishing a welcoming environment that begins to build hope from the first contact. Instead of focusing primarily on symptom relief, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.

The system is envisioned to be consistent with the four major dimensions and ten guiding principles published by SAMHSA. The foundation of the PIHP and CMHSPs efforts is the incorporation of the recovery principles within the Vision, Mission and Values. This will be further enhanced through the PIHP's strategic planning with the CMHSPs and the creation and implementation of a Recovery Blueprint or work plan.

Maintaining a behavioral health and substance use disorder health system that is based on the principles of recovery requires a concerted effort by all and must include the active participation of consumers, who have "lived experience" and their supporters at every level of the system.

There has been a groundswell of energy to view consumers from a holistic viewpoint and to expect recovery. The three principles above and the draft Mission Statement and a PIHP Recovery policy reflects the combined resolve of the PIHP and the five CMHSPs service providers to provide services that are mindful of the need to address physical health issues as an integral part of the behavioral health services that the CMHSPs provide. The five CMHSPs have fostered integrated health care from bi-directional collocation to full integration. The expertise developed with co-occurring mental health and substance use disorder treatment is a best practice that furthers the ability to care for the whole person. CMHSPs have demonstrated the importance of Health, Home, Purpose and Community in the Person Centered Planning that is a hallmark of CMHSP services. The array of housing services, certified peer training, mutual support, mutual aid groups, club houses, employment support and

volunteerism support promote the sense of purpose and participation in the community. The CMHSPs promote the Hope message "Expect Recovery". Recovery activities start with the focus of "don't plan about me without me". The PCP is ingrained with the overriding principles of multiple pathways to recovery and a holistic focus is clearly stated in the PIHP fourth principle above.

As noted previously, the use of a committee structure populated by the member CMHSP will provide the opportunity to utilize the experience, strengths, and talents of persons served, staff, and the provider network. This is particularly true when one considers the opportunities to learn from each other and develop best practices of Recovery and Integrated Healthcare. The formation of a new region creates an environment in which together we can evaluate what works best throughout the region and then replicate successful programs.

5.5.2 ☒ The applicant will select a region-wide behavioral health recovery survey tool as a Continuous Quality Improvement project in partnership with a group of stakeholders that includes providers and users of services with a majority of members being people with lived experience. By January 2014 the tool will be submitted and approved by MDCH.

5.5.3 ☒ The applicant assures that its provider network employs a sufficient workforce of individuals with lived experiences throughout all levels of the agency who are paid fair and competitive wages, have multiple opportunities for a balance of full and part-time positions and are offered a viable career ladder.

5.5.4 ☒ By January 1, 2014, applicant's provider network's position descriptions for all paid employees and volunteers contain language of recovery. Job responsibilities will outline recovery-based, person-centered and culturally competent practices. Job qualifications will specify that lived experiences with behavioral health issues are desired.

5.5.5 ☒By October 1, 2013, the applicant will present to MDCH a plan for sustaining positions currently supported by federal Mental Health Block Grant funding after the grant has ended. The plan specifically identifies positions that are supporting SUD prevention and Women's Specialty Services for SUD.

5.5.6 ☒By January 1, 2014, the applicant will have region-wide policies, procedures and a process in place that support and encourage the opportunity to for individuals with serious mental illness to participate in a self-determined arrangement.

5.5.7 ☒ By January 1, 2014, the applicant's provider network will have region-wide explicit policies and procedures for admission, discharge, referral, collaborative care that supports individual choice, person centered, culturally competent, trauma informed practice and the attainment of self-directed goals. The policies and procedures will incorporate SUD provider/recovery networks into the service delivery system.

5.5.8 ☒ By January 1, 2014, the applicant will develop and implement region-wide policies and procedures to support the provision of collaborative work between substance use, mental health and primary care providers resulting in an integrated care plan for individuals.