Community Mental Health Association of Michigan

Reducing administrative and paperwork burden on Michigan's public mental health system

April 2022 (revised May 2022)

The **"high leverage" recommendations** are boxed, below, and are of two types, both which are recommended to be kicked-off simultaneously, with two different time horizons.

Those items viewed as part of an **overall process change** (longer time horizon) to addressing this issue are boxed and in straight type; those seen as **concrete and discrete steps** (shorter time horizon) that could be taken concurrently to the overall process change, rather than waiting for the completion of this more far-reaching and slower process, are boxed and in italics.

Summary of issue to be addressed

The administrative and paperwork burden borne by Michigan's public mental health system:

- Draws staff time and resources away from providing services to Michiganders
- Hinders staff recruitment and retention efforts
- Inflates the cost of care

Recommendations for reducing administrative burden

A. Increase the use of formalized, regular, and early involvement of the community-based system in the development of paperwork and administrative requirements: With the co-development of and input from, early in the development of statewide policy, requirement, and practices, those with the deep working knowledge of the processes of the state's provider and payer systems and the impact of state policies on these processes - the state's community-based system (CMHSPs, PIHPs, and providers in the CMHSP and PIHP networks) and the state's major advocacy groups – the administrative requirements of the system can be developed to ensure system effectiveness and efficiency. Without such involvement, these statewide policies can lead to unnecessary demands, system ineffectiveness and inefficiency, and work-arounds.

Additionally, lack of clarity around when statewide standards and policies are required and when local discretion is allowed or encouraged, by all involved, causes confusion for persons served, community partners, MDHHS, elected officials, and the community-based system.

Recommendations:

1. MDHHS to call upon the state's community-based system (CMHSPs, PIHPs, and providers in the CMHSP and PIHP system – often through the Community Mental Health Association of Michigan (CMHA), a practice that has been done periodically for years) to appoint staff to join in the co-development of statewide policies. This involvement should reflect a co-development approach, as with any partnership, with the roles of the representatives of the community-based clearly articulated at the start of the design process.

When the process is not one of co-development, but one of MDHHS seeking advice - what should be a rare occurrence - that should be clearly stated early in the process.

2, Clarity provided, in writing, by MDHHS and the community-based system, as when a policy or process is required to be uniform, statewide, and when local, regional, population, or person served-specific differences are allowed or encouraged.

3. Annually, the MDHHS and the community-based system to review the administrative and paperwork demands on the system with the aim of refining or eliminating these demands in light of their relevance and value-added nature.

B. Reduce clinical and contractual paperwork demands: The paperwork demands required of clinicians within Michigan's public mental health system are far greater than mental health practitioners in schools and those in private practices. These paperwork demands reduce the amount of time for skilled practitioners, in the public mental health system, to serve Michiganders while also driving these clinicians out of the public mental health system – thus seriously damaging the recruitment and retention of this behavioral health workforce.

Additionally, because the electronic platforms to which many of the required assessment and waiver enrollment tools are tied lie outside of the electronic health records of the community based system, clinicians and support staff spend an inordinate amount of time in duplicative data entry into systems that do not allow for an integrated clinical monitoring tool.

Recommendations:

1. An in-depth examination of the clinical paperwork required of the practitioners, and persons served, in the public mental health system with the aim of reducing this burden – carried out by a workgroup made up of MDHHS staff and representatives of the state's CMH, PIHP, and Provider system – the latter recruited by the CMH Association of Michigan.

As an example of the work that could be done in this area, Attachment A contains the recommendations of a group of leaders, within the state's public mental health system (the leaders of a number of CCBHCs), around the development of a streamlined clinical record.

However, even this slimmed-down clinical record contains interviewing and recording requirements that harm client engagement and impede prompt access to care.

While a benefit to all served by the community system, a lean clinical recordkeeping system that supports rapid engagement and immediate access to care is especially key for persons with episodic and brief needs for mental health services.

2. Work with the community-based system to develop technical links of the free-standing clinical assessment and waiver enrolment tools into the electronic health records of the community-based system. Examples of these tools that are based on stand-alone platforms include: CAFAS, PECFAS, ASAM Continuum, WSA, and the newly emerging Open Beds/statewide psychiatric bed search process.

3. Allow assessment tool information to satisfy the Personal Care script for T1020 services (AFC home). The SIS, Psychosocial Assessment, and DLA-20 can show the level of care needs such as level of independence/dependence needs with bathing, grooming, toileting, eating/feeding, dressing, etc. without the need to get a script. This will reduce redundant effort for case managers, supports coordinators, and physicians.

4. SHORT TERM CHANGE IN LIGHT OF DEEP AND PROLONGED WORKFORCE SHORTAGE: Pause on SIS assessments for persons with intellectual or developmental disabilities. Staff vacancies mean that cases are being transferred to SIS assessors who do not know the persons served and so cannot be one of the two persons needed to accurately inform the SIS assessments.

5. Develop and foster the use, via liability protections and other means, of a single provider contract for use by the state's CMHs and PIHPs.

C. Overhaul the large number of site visits and reporting requirements on Michigan's public mental health system: Michigan's public mental health system is burdened by a large number of reporting requirements, many with little or no value. MDHHS has the power, internally, or via recommended changes to the budget boilerplate language that requires many of these reports (Section 904 being the most obvious), to dramatically reduce this burden.

A picture of these reporting and site visit demands can be found here:

- Attachment B contains the list of the audits, site visits, and reports required by Michigan's CMHs.
- Attachment C contains the list of reports required by Michigan's PIHPs.
- Attachment D contains the list of areas reviewed by one or more of the some of the most thorough of the site visits experienced by the community-based system.
- Section 904 of the MDHHS budget bill requires extensive reporting to the Michigan Legislature which applies to MDHHS as well as the CMHSPs and PIHPs. Completion of the various required reports necessitate a major time commitment for MDHHS, CMHSPs and PIHPs. The required reports include but are not limited to providing the following data:

  - Demographic description of service recipients
  - Per capita expenditures in total and by population group and cultural and ethnic groups of the services area
  - Detailed financial information
  - Data describing service outcomes
  - Performance indicators

Recommendations:

1. A review, by MDHHS and representatives of the community-based system, of the reporting requirements with which Michigan's community-based system must comply, with the aim of refining some and eliminating others that are not essential. Of those seen as essential, re-examine the frequency of those reports. Examples include:

- *Reduce to one the number of HCBS Heightened Scrutiny documents required of residential providers. The burden of having to respond to three reviews of heightened scrutiny for HCBS – by MSU, MDHHS and PIHPs - is inefficient and burdensome to providers.*

- *Eliminate or replace performance indicators not seen as useful nor indicative of system performance by MDHHS nor the community-based system.*

2. Identify the MDHHS site visits or significant portions of these site visits that can be eliminated when a site is accredited by a nationally recognized accrediting body (often known as deemed status). The deficits identified by an accrediting body would also help to focus on the MDHHS site visits on these areas of deficit.

3. While the views of site visitors can be helpful, it is key that MDHHS ensure, via policy and training of site reviewers, that the findings of a site visit must be limited to compliance, by the site, with the written standards and not the interpretation of the site reviewer.

4. Require that compliance with standards can be demonstrated through observation, dialogue with the staff of the site being reviewed, or oral reporting of practices without requiring that those practices be in writing. Requiring that a practice, which is deeply imbedded in the work of an organization, to be captured in writing (often only via the review of electronic documents) for a site to be in compliance with the standard is a wasteful and artificial approach to ensuring quality.

D. Streamline training and credentialing requirements for clinicians: The training requirements on the system's clinical staff and clinical supervisors draw them away from providing services and supports to Michigander. A number of these requirements can be modified while not reducing the clinical skills of the system's practitioners.

Recommendations:

1. Develop the necessary liability protections and clarity on the use of training reciprocity agreements and single-point of credentialing across the CMH, PIHP, and provider system – using, as one source of guidance, the training reciprocity procedure developed by the state's PIHPs and their partners.

2. Examine the number of hours required of staff – especially clinical and service delivery staff and their supervisors – weighing these requirements with loss of productive time lost by staff attending these trainings. Examples include:

- *Allow substitute trainings for the annual required ACT training. Examples: Motivational Interviewing, Cognitive Behavioral Therapy, Cognitive Enhancement Therapy, Suicide Risk Assessment, and Crisis Management using online platforms such as Relias Learning to allow for greater flexibility in clinical growth and timing for trainings.*
- *Defer the annually required ACT training to every other year.*
- *Reduce, temporarily or permanently, the 24 hours of training required, per year, of clinicians providing children's mental health services.*
- *Reduce CAFAS reliable trainer and reliable rater training frequencies*
- *CAFAS reliable trainer sessions are required every 2 years. For those who have been a trainer for 4 years, please consider deferring the next trainer training for 4 years.*

- *CAFAS reliable rater sessions are also required every 2 years. For those who have been a reliable rater for CAFAS for 6 years (done self-train and booster 1 and 2), please consider retraining every 3 years instead of every 2 years.*
- *Waive the requirement for assessment staff to be at each Trauma informed Cognitive Behavioral Therapy initial cohort training when the organization has already been through intensive Trauma informed Cognitive Behavioral Therapy cohort trainings.*
- *Some EBPs require supervisors to attend trainings with each candidate and then take on a case. Given the number of EBPs being used by clinicians in the public system (a very good thing), reduce the number of EBP trainings in which a clinical supervisor would have to participate.*

3. Retain, post-pandemic, online/virtual training for Recipient Rights and other topics, when appropriate, in place of the in-person training requirements. Virtual training greatly reduces the loss of scarce staff time.

E. Reverse the recent explosion in the number of procedure codes required of the community-based system: Two developments on this front are in immediate attention:

MDHHS and Milliman-led move to 15-minute codes for community living supports (CLS): MDHHS eliminated the per diem H0043 Service Code (used to record community living support encounters, effective October 1, 2020 for supports provided in settings which do not require licensure including self-directed living arrangements. The H0043 per diem code has been replaced with the H2015 code which requires the entry of encounter codes and progress notes in **15-minute increments**.

A high percentage of individuals living in non-licensed settings require an extensive amount of community living supports on a daily basis. For individuals requiring 24-hour supports, the H0043 per diem code provided a straightforward and easy-to-manage system of recording only one (1) encounter code and set of progress notes per day. By contrast, implementation of the H2015 Service Code has resulted in an unmanageable process that **requires the entry of 96 encounter codes and set of progress notes (every 15 minutes) for individuals requiring 24-hour supports – when, prior to this change, only 1 encounter code and set of progress notes were required**. Similar recording challenges exist for supporting other individuals with an intensive level of needs which is less than 24-hour supports. In addition to this change leading to the need to record 96 encounters for each day of care rather than the single encounter under the previous system, the is change exploded the number of codes used to record this work from 5 to 86. Attachment D illustrates this contrast.

Additionally, the administrative challenges from the elimination of the H0043 per diem code are having a discriminatory impact upon persons choosing to live in non-licensed residential settings as lessees or owners of the property. More specifically, the ability of persons living in their own apartments or homes to find providers willing to provide community living supports is harmed by the administrative burdens of the H2015 system in the midst of a severe staffing crisis.

MDHHS and Milliman-led dramatic increase in service code combinations: Over the past year, as part of the overhaul of the financial reporting system, led by MDHHS and Milliman, the complexity and burden on the clinicians and other service delivery staff, finance, and information technology staff of the community-based system have grown exponentially – with little to no value added to the system not the persons it serves. This explosion in the number of codes has led (see Service UNC tab in the attached SFY

2022 P1 BH EQU Template - CMHSP to **7,169 combinations of unit costs that must reported by the community-based system**.

Additionally, the accuracy of cost projections, using these combinations is weak, given that the payer source for persons served by the community-based system is often not know until year's end, when the Medicaid eligibility is finalized. The IT and financial reporting systems of the state's CMHSPs, PIHPs, and providers in their networks have been working to breakdown the costs into these combinations. However, the cost and staff time used in this work is drawn away from the value-added work of these staff.

Recommendations:

1. Rather than the use of the H2015 (15 minute) code reinstate the H0043 (per diem) code for individuals receiving eight (8) or more hours of community living supports (CLS) on a daily basis.

2. Dramatically reduce the number of encounter code combinations (7,169 code combinations) to those that are useful to the provision of care and the accurate reporting of financial and encounter data.

3. Limit changes, co-developed by MDHHS and community-based system representatives, to the encounter codes combinations, to an annual frequency, with a 3 to 6 month notice of the exact changes being made. Such a frequency and notice timeframe allow for the retooling of electronic health records and encounter/claims systems and staff training.

F. Eliminate Event Visit Verification (EVV) requirement for licensed settings and 24/7 non-licensed settings: The Centers for Medicare & Medicaid Services (CMS) is responsible for the enforcement of the electronic visit verification (EVV) requirements that Michigan must implement for Medicaid funded personal care services (PCS). In a June 2019 CMS document, the following guidance is provided regarding personal care services:

"CMS is aware that PCS are provided in a variety of settings, including in congregate residential programs such as group homes, assisted living facilities, etc. Stakeholders have questioned whether the EVV requirements apply to PCS provided in those settings offering 24 hour service availability. CMS interprets the reference in the statute to an "in-home visit" to exclude PCS provided in congregate residential settings where 24 hour service is available. This interpretation recognizes inherent differences in service delivery model where an employee of a congregate setting furnishes services to multiple individuals throughout a shift, and services provided to an individual during an in home "visit" from someone coming to a home to provide PCS as specified in the EVV statute. Consistent with this difference in service delivery model, typical reimbursement for services provided in these congregate settings utilizes a per diem methodology, rather than discrete per "visit" or per service payment structures. Therefore, CMS finds that services provided in a congregate residential setting are distinct from an "in home visit" subject to EVV requirements under the statute."

Recommendations:

1. As allowed by CMS, Michigan should interpret the EVV statute as not applicable to licensed residential settings as well as non-licensed settings where 24 hour service is available.

G. Halt and revisit the aims and methods of MDHHS and Milliman-led overhaul of the system's financial reporting system: The Michigan Department of Health and Human Services (MDHHS) and Milliman (the actuarial firm on contract with MDHHS) have been overhauling the financial reporting system used by the state's community-based system. This overhaul involves the reports cited above and others (Standard Cost Allocation, Encounter Quality Initiative, Independent Rate Determination, Medical Loss Ratio).

The impact of this overhaul includes:

- Tremendous amounts of rework by CMHSP, PIHP, and provider staff without offsetting value added from this effort
- Significant administrative costs with a corresponding reduction in the funds available for services
- Drawing clinicians and direct support staff away from providing services to persons with disabilities by burdening them with unnecessary paperwork
- In conflict with the financial reporting approaches of the emerging Certified Community Behavioral Health Clinic (CCBHC) - a centerpiece in the next generation in the development of Michigan's nationally recognized public mental health system.
- In conflict governmental accounting and standard cost allocation standards
- Based on a lack of understanding of the services provided by and financing of the system

Recommendation:

1. A halt to this process is necessary which should be followed with a series of in-depth discussions and planning sessions around this initiative. The various stakeholders should be involved in this review process including MDHHS, the leadership of the CMH, PIHP, and provider community and the Community Mental Health Association of Michigan. The objective is to develop a sound footing - with clear aims and methods - upon which the CMH/PIHP/Provider/MDHHS financial reporting can be advanced.

Attachment A

CCBHC Demonstration Pilot
Mild to Moderate Recordkeeping Workgroup

Recommendations to MDHHS

It is the recommendation of the workgroup that participating CCBHC Demonstration agencies have the option to use a **modified or "skinny" record** when serving people with Mild to Moderate diagnoses.

A "skinny record" must include:

- Basic demographic information and presenting needs
    - including veteran/military status
    - including questions about trauma
    - including key physical health indicators and vitals
- Guardianship status
- Primary Care Physician status
- Biopsychosocial assessment (abridged from traditional CMH version)
    - Less history, more current info
    - Include current symptoms and meds
    - Include core BH-TEDS components
    - Include trauma assessment
- Mental Status
- Risk Assessment for homicidal and suicidal ideation
- Crisis Plan
- SUD Assessment
- Legal involvement status
- Jail diversion status
- Screening tools:
    - LOCUS for adults
    - ASAM for adult substance use (there is also an adolescent version for ages 12-17)
    - CAFAS for children 7-17
    - PECFAS for children 4-6
    - E-DECA for children 0-3
    - PHQ-9 for adults or PHQ-A for ages 11-17
    - Columbia-Suicide Severity Rating Scale (C-SSRS) for ages 11 and up
    - GAD-7 to assess anxiety level in people 12 and up
    - AUDIT for assessing alcohol use or AUDIT-C for ages 11-19
    - It's recommended that while LOCUS, CAFAS, and PECFAS may be used to help determine level of care, they should not be used on an ongoing basis with people whose diagnoses fall in the mild to moderate range since they were not normed on this population. The PHQ-9/A, C-SSRS, GAD-7, and AUDIT are better to use on a recurring basis.
- Diagnostic formulation, including Co-Occurring quadrant
- Treatment Plan/Recommendations (include any barriers to treatment)

The workgroup recommends that **Training Requirements** remain consistent for staff serving the Mild to Moderate and traditional CMH populations.

The workgroup requests that MDHHS clarify to the PIHPs what **documents** are truly required for the traditional CMH population since many have added additional assessments and/or expanded existing forms multiple times over the years without ever removing anything.

During the two-year pilot, it is recommended that CCBHC leaders collaborate to develop a **master list/spreadsheet of all the federal, state, PIHP, and accrediting agency requirements** that would need to be taken into account and incorporated into foundational EHR modules.

Sample of audits and reports required of Michigan's Community Mental Health Services Programs

2022

Audits

MDDHS Substance Abuse License Renewal
MIFAST Review Trauma Informed
Contract Audits monitoring
MDDHS annual audit - Family Support Subsidy Program
MDDHS CMHSP Recertification
MIFAST Review LOCUS
PIHP Annual UM/QI/Provider Network Review
PIHP Data Audit and POC Progress Update
PIHP QISMC Data Review Project
Compliance Audit
Financial Audit
PIHP Prevention Audit
DDCHMT Fidelity Review
MDDHS ACT Program Approval
MDDHS CDTSP Wraparound Program Approval
MDDHS Home Based Approval
MDDHS Site Review – HSW/CWP
MIFAST Review ACT
PIHP/review of CMH Behavior Treatment Committee
Recipient Rights (MDDHS)
Accreditation (CARF, JCAHO, COA, etc.)
CMH Certification site review (MDHHS)
HSAG - EQR Review

Reports and data submission

BH-TEDS Reporting
Children's Mobile Crisis
Clinical Record Review Data
CMHSP Annual Submission
Community Inpatient and State Facility
Compliance Verification Run
Critical Incident Reporting
Death Report
Encounter 837 Institutional
Encounter 837 Professional
Family Support Subsidy Survey/Report
Intensive Crisis Stabilization Services
Medicaid Claims Data Review

Medicaid Interoperability
MMBPIS (Performance Indicator Report) CMHSP data (all persons served)
MMPBIS (Performance Indicator) PIHP data (Medicaid enrollees only)
PIHP / CMHSP Quality Improvement Plan Revision/Annual Report
PIHP /CMHSP Compliance Plan Review
PIHP Satisfaction Surveys
Administrative Cost Report (within EQI)
BH Fee Screen
Block Grant FSR
Executive Compensation Report
Final - FSR
Final - State Services Reconciliation
Final GF Cash Settlement
EQI (replaced GF cost report, MUNC, sub-element cost report)
Standard Cost Allocation
Executive Administrative Expenditures survey
HMP Cost Report
Interim - GF Cash Settlement
Interim - State Services Reconciliation
Interim FSR
Mid-Year Status Report
PIHP Encounter Reconciliation
PASARR Monthly Billing
Projection - FSR
Projection - State Services Reconciliation
Projection GF Cash Settlement
CAFAS / PECFAS for FY
DHIP CAFAS/PECFAS
Grievance & Appeals
Annual Rights Submission

FY 22 PIHP MDHHS Report Schedule & Tracking		
Department	**Report Name**	**Frequency**
	Follow-up to Hospitalization (FUH) data (admissions/discharges)	Weekly
SUD Treatment	SUD Budget Report	Projection/Initial
	Medicaid YEC Accrual	Final
SUD Treatment	SUD YEC Accrual	Final
SUD Treatment	SUD Budget Report	Projection
	Follow-up to Hospitalization (FUH) data (admissions/discharges)	Weekly
	Follow-up to Hospitalization (FUH) data (admissions/discharges)	Weekly
	Follow-up to Hospitalization (FUH) data (admissions/discharges)	Weekly
	Intensive Crisis Stabilization Service (ICSS) for children Annual Data Report	Annually
SUD Treatment	Children Referral Report	Quarterly
SUD Treatment	SUD - Injecting Drug Users 90% Capacity Treatment Report	Quarterly
SUD Prevention	SUD - Youth Access to Tobacco Activity Annual Report	Annually
Veteran Navigator	Veteran Services Navigator (VSN) Data Collection Form	Quarterly
	Sentinel Events Data Report	Quarterly
	PIHP Medicaid FSR Bundle MA, HMP, Autism, & SUD	Interim (Use Tab in FSR Bundle)
	Complete Subcontracted Entity List	Annually
	Program Integrity Activities	Quarterly
Finance	Performance Bonus Incentive Narrative on "Increased Population in patient-centered medical homes characteristics"	Annually
SUD Treatment	SUD - Communicable Disease (CD) Provider Information Report (Must submit only of PIHP funds CD Services).	Annually

SUD Treatment	Women Specialty Services (WSS) Report	Annually
Quality	Performance Indicators	Quarterly
SUD Treatment	SUD - Priority Populations Waiting List Deficiencies Report	Monthly
IT	SUD - Behavioral Health Treatment Episode Data Set (BH-TEDS)	Monthly
IT	Encounters Submission to MDHHS	Monthly
Quality	Critical Incidents Data Submissions	Monthly
Finance	Risk Management Strategy	Annually
Quality	Medicaid Services Verification Report	Annually
SUD Treatment	SUD - Priority Populations Waiting List Deficiencies Report	Monthly
IT	SUD - Behavioral Health Treatment Episode Data Set (BH-TEDS)	Monthly
	Program Integrity Activities	Quarterly
IT	Service Authorization Denials	Quarterly
IT	Grievances	Quarterly
IT	Member Appeals	Quarterly
Finance	Direct Care Wage Attestation Form	Annually
SUD Prevention	SUD - Primary Prevention Expenditures by Strategy Report	Annually
SUD Treatment	SUD Budget Report	Final
SUD Treatment	SUD - Legislative Report/Section 408	Annually
Finance	PIHP Medicaid FSR Bundle MA, HMP, Autism, & SUD	Final (Use tab in FSR Bundle)
Finance	Encounter Quality Initiative Report (EQI)	Annually
Finance	PIHP TIN Expenditure Summary	With ea EQI report?
Finance	PIHP Executive Administration Expenditures Survey for Sec. 904 (2)(k)	Annually

Finance	Medical Loss Ratio	Annually
IT	Attestation to accuracy, completeness, and truthfulness of claims and payment data	Annually
Finance	DHHS Incentive Payment DHIP Report	Annually
Quality	Performance Indicators	Quarterly
Quality/IT	Narrative Report on findings and any actions taken to improve data quality on BH-TEDS military and veterans fields (PBIP)	Annually
SUD Prevention	Compliance Check Report (CCR)	
SUD Prevention	Michigan Gambling Disorder Prevention Project (MGDPP) 3Q Narrative Report	Quarterly

SITE REVIEW COMPARISON CHART

MI Department of Community Health - Review Dimensions	MDHHS	CARF	PIHP	HSAG (required by Fed HHS)	Comments
A. Consumer Involvement	X	X	X	X	
B.1. Services General	X	X	X	X	CMH recert. - 3yrs
B.2. Peer Delivered & Operated Drop In Centers	X	X	X		Not a Medicaid srvc.
B. 3. Home Based	X	X	X	X	CDTSP cert. - 3yrs
B.4. Assertive Community Treatment	X	X	X		ACT cert. - 3yrs
B.5. Clubhouse Psycho-Social Rehabilitation Program	X	X	X		
B.6. Crisis Residential Services	X	X	X		
B.7. Targeted Case Management	X	X	X	X	
B.8. Personal Care in Licensed Residential Settings	X	X	X	X	
B.9. Inpatient Psychiatric Hospital Admission	X	X	X	X	
B.10. Intensive Crisis Stabilization Services	X	X			
B.12. Habilitation Supports Waiver	X	X	X	X	DCH approves ea. HSW
B.13. Additional Mental Health Services [(b)(3)s]	X	X	X		
B.14. Jail Diversion	X	X	X		
B.15. Co-Occurring Mental Health and Substance Disorders Treatment	X	X	X	X	
B.16. Substance Abuse Access and Treatment	X	X	X	X	DCH license review
C.1. Implementation of Person-Centered Planning	X	X	X	X	
C.2. Plan of Service and Documentation Requirements	X	X	X	X	
C.3. Implementation of Arrangements that Support Self-Determination	X	X	X	X	
D.1. Administrative Functions - Provider Networks	X	X	X	X	
D.2. Administrative Functions - Quality Improvement	X	X	X	X	
D.3. Administrative Functions - Health and Safety	X	X	X		
D.4. Administrative Functions - Access Standards	X	X	X	X	PPG needs assessment
D.5. Administrative Functions - Behavior Treatment Plan Review Committee	X	X	X	X	Rec. Rights cert. - 3 yrs
D.6. Administrative Functions - Coordination	X	X	X	X	
F.1. Staffing and Supervision Requirements	X	X	X	X	
F.1. Staff Training	X	X	X	X	

CARF - The Commission on Accreditation of Rehabilitation Facilities

PIHP - Prepaid Inpatient Health Plan

HSAG - Health Services Advisory Group

CMH - Community Mental Health

CDTSP - Children's Diagnostic Treatment Services Program

ACT - Assertive Community Treatment Team

HSW - Habilitative Services Wavier

PPG - Program Planning and Guidance (Mental Health Code Required)

Rec. Rights Cert. - Recipient Rights Certification

# of Audits/Reviews in 1 CMH – October 2009 thru June of FY 2011	**# of Reviews**
DCH Site Review (included CSDTP certification in FY2009)	3
Substance Abuse Licensing Audit	1
Assertive Community Treatment site review program certification	1
Finance Compliance Audit	2
PIHP UM/QI/Provider Network	2
PIHP Information Systems Audit	2
COD-IDDT Fidelity Review	1
MDCH CMHSP Certification Process	1
PIHP (Substance Abuse) Prevention Audit	3
PIHP Financial Compliance Site Review	1
HSAG/ISCAT - Data Collection and system information review	1
DCH Children's Waiver Program Review	1
CARF National Accreditation	1
Office of Recipient Rights Site Review	1
TOTALS	20

Comparison of the number and complexity of codes that are used to record the provision of Community Living Supports in unlicensed settings: prior structure compared to present structure

A. Prior service recording structure:

5 codes - **1 required to be reported per day** - that correlated to the number of hours of CLS provided per day to each person served

H0043- L1 Comprehensive Community Supports Services per Diem - (Staff intensity: 5 to 7 hours per day.)
H0043- L2 Comprehensive Community Supports Services per Diem - (Staff intensity: 8 to 10 hours per day.)
H0043- L3 Comprehensive Community Supports Services per Diem - (Staff intensity: 11 to 14 hours per day.)
H0043- L4 Comprehensive Community Supports Services per Diem - (Staff intensity: 15 to 20 hours per day.)
H0043- L5 Comprehensive Community Supports Services per Diem – (Staff intensity: 21 to 24 hours per day, or alternative arrangement)

B. Current recording structure:

86 codes – **potentially 96 units required to be reported per day per person** - that correlates to the number of co-workers present, the number of people who live in the setting present, whether provided in the day time or overnight, and whether a wheelchair van was used to provide transportation while these services were provided. The below code list is not inclusive of all modifiers to be applied to these codes (i.e. HK for HAB Waiver services, U7 for self-directed supports)

H2015 / S1 - Comprehensive Community Support Services - One Member/One Staff
H2015 / 21 - Community Living Support Services - Two Staff/One Member
H2015 / UN S1 - Comprehensive Community Support Services - 2 Members; 1 Staff
H2015 / UN S2 - Comprehensive Community Support Services - 2 Members; 2 Staff
H2015 / UN S3 - Comprehensive Community Support Services - 2 Members; 3 Staff
H2015 / UN S4 - Comprehensive Community Support Services - 2 Members; 4 Staff

H2015 / UP S1 - Comprehensive Community Support Services - 3 Members; 1 Staff
H2015 / UP S2 - Comprehensive Community Support Services - 3 Members; 2 Staff
H2015 / UP S3 - Comprehensive Community Support Services - 3 Members; 3 Staff
H2015 / UP S4 - Comprehensive Community Support Services - 3 Members; 4 Staff
H2015 / UQ S1 - Comprehensive Community Support Services - 4 Members; 1 Staff
H2015 / UQ S2 - Comprehensive Community Support Services - 4 Members; 2 Staff
H2015 / UQ S3 - Comprehensive Community Support Services - 4 Members; 3 Staff
H2015 / UQ S4 - Comprehensive Community Support Services - 4 Members; 4 Staff
H2015 / UR S1 - Comprehensive Community Support Services - 5 Members; 1 Staff
H2015 / UR S2 - Comprehensive Community Support Services - 5 Members; 2 Staff
H2015 / UR S3 - Comprehensive Community Support Services - 5 Members; 3 Staff
H2015 / UR S4 - Comprehensive Community Support Services - 5 Members; 4 Staff
H2015 / US S1 - Comprehensive Community Support Services - 6 or More Members; 1 Staff
H2015 / US S2 - Comprehensive Community Support Services - 6 or More Members; 2 Staff
H2015 / US S3 - Comprehensive Community Support Services - 6 or More Members; 3 Staff
H2015 / US S4 - Comprehensive Community Support Services - 6 or More Members; 4 Staff
H2015 / S1 UJ - Comprehensive Community Support Services, Night Time - One Member/One Staff
H2015 / 21 UJ- Community Living Support Services, Night Time - Two Staff/One Member
H2015 / UN S1 UJ - Comprehensive Community Support Services, Night Time - 2 Members; 1 Staff
H2015 / UN S2 UJ - Comprehensive Community Support Services, Night Time - 2 Members; 2 Staff
H2015 / UN S3 UJ - Comprehensive Community Support Services, Night Time - 2 Members; 3 Staff
H2015 / UN S4 UJ - Comprehensive Community Support Services, Night Time - 2 Members; 4 Staff
H2015 / UP S1 UJ - Comprehensive Community Support Services, Night Time - 3 Members; 1 Staff
H2015 / UP S2 UJ - Comprehensive Community Support Services, Night Time - 3 Members; 2 Staff
H2015 / UP S3 UJ - Comprehensive Community Support Services, Night Time - 3 Members; 3 Staff
H2015 / UP S4 UJ - Comprehensive Community Support Services, Night Time - 3 Members; 4 Staff
H2015 / UQ S1 UJ - Comprehensive Community Support Services, Night Time - 4 Members; 1 Staff
H2015 / UQ S2 UJ - Comprehensive Community Support Services, Night Time - 4 Members; 2 Staff

H2015 / UQ S3 UJ - Comprehensive Community Support Services, Night Time - 4 Members; 3 Staff
H2015 / UQ S4 UJ - Comprehensive Community Support Services, Night Time - 4 Members; 4 Staff
H2015 / UR S1 UJ - Comprehensive Community Support Services, Night Time - 5 Members; 1 Staff
H2015 / UR S2 UJ - Comprehensive Community Support Services, Night Time - 5 Members; 2 Staff
H2015 / UR S3 UJ - Comprehensive Community Support Services, Night Time - 5 Members; 3 Staff
H2015 / UR S4 UJ - Comprehensive Community Support Services, Night Time - 5 Members; 4 Staff
H2015 / US S1 UJ - Comprehensive Community Support Services, Night Time - 6 or More Members; 1 Staff
H2015 / US S2 UJ - Comprehensive Community Support Services, Night Time - 6 or More Members; 2 Staff
H2015 / US S3 UJ - Comprehensive Community Support Services, Night Time - 6 or More Members; 3 Staff
H2015 / US S4 UJ - Comprehensive Community Support Services, Night Time - 6 or More Members; 4 Staff
T2027 / S1 - Overnight Health and Safety Supports - One Member/One Staff (HAB Waiver Only)
T2027 / 21 - Overnight Health and Safety Supports - Two Staff/One Member (HAB Waiver Only)
T2027 / UN S1- Overnight Health and Safety Supports - 2 Members; 1 Staff (HAB Waiver Only)
T2027 / UN S2 - Overnight Health and Safety Supports - 2 Members; 2 Staff (HAB Waiver Only)
T2027 / UN S3 - Overnight Health and Safety Supports - 2 Members; 3 Staff (HAB Waiver Only)
T2027 / UN S4 - Overnight Health and Safety Supports - 2 Members; 4 Staff (HAB Waiver Only)
T2027 / UP S1 - Overnight Health and Safety Supports - 3 Members; 1 Staff (HAB Waiver Only)
T2027 / UP S2 - Overnight Health and Safety Supports - 3 Members; 2 Staff (HAB Waiver Only)
T2027 / UP S3 - Overnight Health and Safety Supports - 3 Members; 3 Staff (HAB Waiver Only)
T2027 / UP S4 - Overnight Health and Safety Supports - 3 Members; 4 Staff (HAB Waiver Only)
T2027 / UQ S1 - Overnight Health and Safety Supports - 4 Members; 1 Staff (HAB Waiver Only)
T2027 / UQ S2 - Overnight Health and Safety Supports - 4 Members; 2 Staff (HAB Waiver Only)
T2027 / UQ S3 - Overnight Health and Safety Supports - 4 Members; 3 Staff (HAB Waiver Only)
T2027 / UQ S4 - Overnight Health and Safety Supports - 4 Members; 4 Staff (HAB Waiver Only)
T2027 / UR S1 - Overnight Health and Safety Supports - 5 Members; 1 Staff (HAB Waiver Only)
T2027 / UR S2 - Overnight Health and Safety Supports - 5 Members; 2 Staff (HAB Waiver Only)
T2027 / UR S3 - Overnight Health and Safety Supports - 5 Members; 3 Staff (HAB Waiver Only)
T2027 / UR S4 - Overnight Health and Safety Supports - 5 Members; 4 Staff (HAB Waiver Only)

T2027 / US S1 - Overnight Health and Safety Supports - 6 Members; 1 Staff (HAB Waiver Only)
T2027 / US S2 - Overnight Health and Safety Supports - 6 Members; 2 Staff (HAB Waiver Only)
T2027 / US S3 - Overnight Health and Safety Supports - 6 Members; 3 Staff (HAB Waiver Only)
T2027 / US S4 - Overnight Health and Safety Supports - 6 Members; 4 Staff (HAB Waiver Only)
H2015 / UN S1 WV- Wheelchair Adapted Van, IDD Residential - 2 Members; 1 Staff
H2015 / UN S2WV- Wheelchair Adapted Van, IDD Residential - 2 Members; 2 Staff
H2015 / UN S3 WV- Wheelchair Adapted Van, IDD Residential - 2 Members; 3 Staff
H2015 / UN S4 WV- Wheelchair Adapted Van, IDD Residential - 2 Members; 4 Staff
H2015 / UP S1 WV- Wheelchair Adapted Van, IDD Residential - 3 Members; 1 Staff
H2015 / UP S2 WV- Wheelchair Adapted Van, IDD Residential - 3 Members; 2 Staff
H2015 / UP S3 WV- Wheelchair Adapted Van, IDD Residential - 3 Members; 3 Staff
H2015 / UP S4 WV- Wheelchair Adapted Van, IDD Residential - 3 Members; 4 Staff
H2015 / UQ S1 WV- Wheelchair Adapted Van, IDD Residential - 4 Members; 1 Staff
H2015 / UQ S2 WV- Wheelchair Adapted Van, IDD Residential - 4 Members; 2 Staff
H2015 / UQ S3 WV- Wheelchair Adapted Van, IDD Residential - 4 Members; 3 Staff
H2015 / UQ S4 WV- Wheelchair Adapted Van, IDD Residential - 4 Members; 4 Staff
H2015 / UR S1 WV- Wheelchair Adapted Van, IDD Residential - 5 Members; 1 Staff
H2015 / UR S2 WV- Wheelchair Adapted Van, IDD Residential - 5 Members; 2 Staff
H2015 / UR S3 WV- Wheelchair Adapted Van, IDD Residential - 5 Members; 3 Staff
H2015 / UR S4 WV- Wheelchair Adapted Van, IDD Residential - 5 Members; 4 Staff
H2015 / US S1 WV- Wheelchair Adapted Van, IDD Residential - 6 or More Members; 1 Staff
H2015 / US S2 WV- Wheelchair Adapted Van, IDD Residential - 6 or More Members; 2 Staff
H2015 / US S3 WV- Wheelchair Adapted Van, IDD Residential - 6 or More Members; 3 Staff
H2015 / US S4 WV- Wheelchair Adapted Van, IDD Residential 6 or More Members; 4 Staff