Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy and Procedure* **Organizational Credentialing/Recredentialing and Monitoring**
Department: Network Management	**Local Policy Number (if used)**
Regional Operations Committee Approval Date 2/1/2021	**Implementation Date 2/1/2021**

I. PURPOSE

To establish guidelines that ensure all organizational contractors who provide behavioral health and/or substance use disorder services to consumers of the Community Mental Health Partnership of Southeast Michigan (CMHPSM), meet the minimum standards as described in this policy.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
1/25/11	1	
11/30/11	2	Updated to reflect local practice, changes in delegated functions, and new policy format
8/20/2013	3	Updated to comply with requirements for OIG exclusions VII.C. Procedures removed. Procedures will be available in the Provider Manual.
6/11/2014	4	Revised to reflect the new regional entity.
8/24/2018	5	Rewrite
2/1/2021	6	Policy updates to meet EQR requirements and HSAG EQR review

III. APPLICATION

This policy applies to all organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY

The CMHPSM will ensure that all organizations providing behavioral health and/or substance use disorder services to consumers in the CMHPSM continuously meet the standards set forth in this policy.

V. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM): The Regional Entity that serves as the Pre-Paid Inpatient Health Plan (PIHP) for Region Six (Lenawee, Livingston, Monroe and Washtenaw Counties) for mental health, intellectual/developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Credentialing (or credentials review): The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide mental health or substance use disorder services based on established criteria.

Credentialing Criteria: The minimum qualifications expected for network providers such as: licensure, education, experience, training, current competence, malpractice/liability insurance limitations and claims history, and ability to perform clinical responsibilities.

National Practitioner Data Bank (NPDB): a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers.

Pre-Paid Inpatient Health Plan (PIHP): Organizations in Michigan that manage designated geographic areas for the Medicaid mental health, developmental disabilities, and substance use disorder services outlined in the 1915(b) and 1915(c) waivers that created the CMHSP managed care model in the State.

Regional Operations Committee (ROC): The ROC is comprised of the four CMHSP Executive Directors/CEO's. The Managing Director participates in an ex-officio (non-voting) capacity. The ROC in collaboration with the CMHPSM Board and Managing Director creates the vision, mission and long-term plans for the CMHPSM. The ROC and the Managing Director establishes and coordinates the priorities for CMHPSM Board consideration including matters of policy, personnel and fiscal considerations including the contractual development/agreements related to delegation and/or leasing arrangements between and among the CMHPSM and each CMHSP Partner.

Substance Use Disorder Oversight Policy Board (OPB): Responsibilities for this board include planning for substance use disorder prevention and treatment services, as well as providing advice and consultation to the CMHPSM Board of Directors, the ROC, and the staff of the CMHPSM and the partners.

VI. STANDARDS – The standards within this policy are organized into base categories, and more specific requirements for those categories based upon the payer-provider relationship that exists.

For all payer-provider relationships, the PIHP retains the right to approve, suspend, or terminate providers from participation in Medicaid funded services including when a provider is selected/contracts/subcontracts with a delegated entity.

A. Base Requirements by Category

The following establishes base standards or definitions related to regional organizational credentialing, re-credentialing and monitoring.

1. **CMHPSM Payer/Provider Relationships** – A number of relationships are in place to meet the needs of the CMHPSM region related to behavioral health and/or substance use disorder service provision. The following relationships exist related to this policy:
   a) **PIHP Payer - CMHSP Relationship:** covers the credentialing, recredentialing, monitoring of a CMHSP by the PIHP as payer. The PIHP contracts with CMHSPs to provide mental health services within their respective geographic county.
   b) **CMHSP Payer - CMHPSM Mental Health Organizational Provider Relationship:** covers the credentialing, recredentialing, monitoring relationship of a potential or current behavioral health service provider and a CMHSP as payer. (Note: this policy only applies to organizational providers, Licensed Individual Practitioners (LIPs) should follow the Credentialing and Clinical Responsibilities of LIPs policy.)
   c) **PIHP Payer - SUD Core Provider Relationship:** covers the credentialing, re-credentialing and monitoring relationship of a potential or current SUD Core Provider and the PIHP as payer. The PIHP contracts with SUD Core Providers to provide substance use disorder services, and/or perform one or more functions as delegated by the PIHP.
   d) **SUD Core Provider Payer - SUD Organizational Provider Relationship:** covers the credentialing, recredentialing, monitoring relationship of a potential or current substance use disorder service provider and a SUD Core Provider as payer.
   e) PIHP Payer - SUD Organizational Provider Relationship: covers the credentialing, recredentialing, monitoring relationship of a potential or current substance use disorder service provider and the PIHP as payer.
   f) PIHP Payer - Non-Federally Funded SUD Service Providers: covers the credentialing, recredentialing, monitoring relationship of a potential or current substance use disorder service provider and the PIHP as payer, where only non-Federal funds are utilized.

2. Provider Procurement

   a) Payers this policy applies to (CMHPSM as PIHP Payer, CMHSP Payers or SUD Core Provider) will follow all federal, state and or local rules and regulations when entering into payer/provider relationships for services funded by or through the CMHPSM.
   b) All CMHPSM procurement requirements can be found in the CMHPSM Procurement, RFPs and Bid Review policy.

3. Organizational Credentialing / Re-Credentialing Application

   a) When required by the CMHPSM Payer / Provider Relationship standards within this policy the provider will complete and submit the Organizational Credentialing application. Organizational credentialing applications can be found on the CMHPSM website.

(1) Mental Health Application: http://www.cmhpsm.org/provider-manual
(2) SUD Application: http://www.cmhpsm.org/sudserviceprovidermanual

4. Organizational Credentialing/Re-Credentialing File Management

a. Initial Credentialing Files

The timeframes for completion of the initial credentialing process will be no more than 90 days, for which verification or credentialing requirements is acceptable. If the timeframe is not met, the initial credentialing application will need be declined with clear reasons as to what was not complete in the response to the provider and the steps to take in re-starting the application process.

Initial credentialing applications will be considered complete once the items in the application packet are received.

An on-site review will be completed within this 90-day initial credentialing timeframe.

Verification of provider staff meeting federal and state requirements is a post initial credentialing activity and will be completed within 90 days of a completed contract.

All initial credentialing files will have the following information where applicable:

(1) The start date (receipt of a complete initial application) and the end date (when the credentialing decision is sent to the provider)
(2) The initial credentialing application.
(3) Attestation and disclosure questions.
(4) Review of any Medicare/Medicaid sanctions.
(5) License verification
(6) Screen shots of verification sources in each credentialing file
(7) Once the completed application is received, documentation that an on-site review was completed during the initial pre-contracting process when a provider is not accredited, or acceptance of an on-site review from CMS or licensing in lieu of an on-site review completed by the PIHP should that review align with the credentialing time frame and meet the PIHP's on-site review requirements.
(8) Confirmation that the results on the on-site review were considered when rendered a contracting decision.
(9) Documentation in credentialing files will clarify the scope of service included in the application.
(10) Identification of whether any of the above criteria would be waived based on the payer-provider relationship identified in Standard B of this policy.
(11) If the initial completed application notes the provider will have licensed staff rendering services, the PIHP/CMHSP will ensure, then prior to contracting with the provider that the provider has a credentialing process that meets MDHHS requirements. While the initial credentialing file will have this information, the review of the provider's credentialing process will take place post completed application yet prior to contracting with the provider.

b. Recredentialing Files

The timeframe for completion of the re-credentialing process will be no more than 90 days, for which verification or credentialing requirements is acceptable. If the timeframe is not met, the re-credentialing application will need be declined with clear reasons as to what was not complete in the response to the provider and the steps to take in re-starting the application process.

All re-credentialing files will have the following information where applicable:

(1) The start date (receipt of a complete application) and the end date (when the credentialing decision is sent to the provider)
(2) The initial credentialing and all subsequent recredentialing applications,
(3) A review of member grievances and appeal for that provider during the 2-year recredentialing cycle, including if there was no activity to review.
(4) Attestation and disclosure questions.
(5) Review of any Medicare/Medicaid sanctions.
(6) License verification
(7) Evidence the provider was recredentialed within two years, any approved extensions.
(8) The initial credentialing and all subsequent recredentialing applications,
(9) Screen shots of verification sources in each credentialing file
(10) An on-site review was completed during the recredentialing process when a provider is not accredited, or acceptance of an on-site review from CMS or licensing in lieu of an on-site review completed by the PIHP should that review align with the credentialing time frame and meet the PIHP's on-site review requirements.
(11) Confirmation that the results on the on-site review were considered when rendered a re-credentialing decision.
(12) Documentation in re-credentialing files will clarify the scope of service under each contract and whether licensed staff are providing services under that contract. Should licensed staff render services, the PIHP/CMHSP will ensure the provider has a credentialing process that meets the requirements under its contract with MDHHS.
(13) Identification of `whether any of the above criteria would be waived based on the payer-provider relationship identified in Standard B of this policy.

5. CMHPSM Regional Provider Network Statuses:

a. Credentialed In-Network Status: An organizational provider that has an approved current credentialed status as determined by the PIHP, CMHSP or SUD Core Provider. There is no requirement that a payer identified within this policy be mandated to enter into a contract with an organization that obtains credentialed or In-Network status. Organizations may be credentialed for future capacity or backup capacity. Contract relationships will be determined by the appropriate applicable payer.
b. Contracted In-Network Status: A credentialed organizational provider that is currently contracted with one or more of the following payers: PIHP, CMHSPs or SUD Core Providers.
c. Out of Network Contracted Status: In certain situations, the PIHP, CMHSPs or SUD Core Providers may determine it is necessary to contract with an entity that is unwilling, or unable to join the CMHPSM Provider Network. Examples include but are not limited to:

1. Single Case Agreements;
   (a) Emergency Placements;
   (b) Limited Duration Placements;
   (c) Clinically determined placement for individual consumer with unique clinical need.
2. Out of Region and Network
   (a) Specialty service not delivered within CMHPSM region for a limited number of consumers; (Providers located outside of the CMHPSM region geographically are not required to be In-Network with the CMHPSM, however these providers are encouraged to participate as CMHPSM In-Network or obtain CMHPSM credentialing status through a reciprocity relationship with another PIHP/CMHSP region.

6. Organizational Monitoring

When required by the CMHPSM Payer / Provider Relationship the payer will monitor the provider as required by the standards within this policy. Once a contract is issued to an organization, the payer will monitor to ensure that the organization maintains the contractual agreement in good standing and complies with relevant local, state, and federal requirements.

7. Medicaid Service Verification Policy

All providers delivering Medicaid funded services will follow all requirements outlined within the CMHPSM Medicaid Service Verification policy.

8. Significant Change Notification

All payers and providers must follow the timeliness standards identified within this policy related to notifying the PIHP of any incidents, planned or unplanned changes that would impact the CMHPSM Provider Network capacity, so the PIHP can notify MDHHS (spell out or define) within the seven (7) day standard.

9. Network Adequacy /Sufficiency

The PIHP and CMHSP will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the PIHP.

The Regional Network Management Committee will assess the Regional Provider Network on an ongoing basis.

10. Reciprocity

Payers will comply with all statewide reciprocity efforts as required by the PIHP/MDHHS service contract.

11. Debarment

All payers/providers will follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

B. Variable Standards

1. Payer **/** Provider Relationships Specific Standards
   a. PIHP Payer – CMHSP Relationship

1..	**Payer:**	CMHPSM as PIHP
	Provider:	CMHSP
2. Provider Procurement:		N/A
3. Organizational Credentialing / Re-Credentialing Application Required:		No application required, the CMHSP's MDHHS certification/re-certification status and CMHSP's National Accreditation status allow deemed status for this requirement.
4. Provider Network Status Participation:		CMHSP is required to hold an In-Network CMHPSM Network Status. PIHP may only contract with fully credentialed In-Network CMHSPs.
5. Organizational Monitoring:		CMHPSM/PIHP will monitor CMHSPs on a recurring two-year basis. Every two years the CMHSP will be monitored by the CMHPSM/PIHP through a Full CMHSP Review. A Full CMHSP Review includes a delegated function, clinical chart and CMHSP organizational responsibility review. If the CMHSP achieves a score of 95% or higher on the Full CMHSP Review, the PIHP in the following year will forego the Full CMHSP review and instead will conduct a corrective action verification and delegated function review.
6. Medicaid Service Verification:		CMHSP will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:		CMHSP must immediately notify PIHP of any incidents, planned or unplanned changes that would impact the CMHSP's status within the CMHPSM region. The PIHP will notify MDHHS immediately when becoming aware of a CMHSP which becomes ineligible to participate in federal funding, or if the PIHP/CMHSP relationship is threatened for any reason.
8. Network Sufficiency		The PIHP and CMHSP will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the PIHP.
9. Reciprocity		N/A, the PIHP will not accept reciprocity arrangements for CMHSPs.
10. Debarment		The PIHP and CMHSP must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

b. CMHSP Payer – CMHPSM Mental Health Organizational Provider Relationship:

1.	**Payer:**	Regional CMHSP
	Provider:	Organizational Provider Delivering Behavioral Health Services within CMHPSM region.
2. Provider Procurement:		Each CMHSP will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with Mental Health Service Providers.

3. Organizational Credentialing / Re-Credentialing Application Required:	All organizational providers delivering behavioral health services within the region will complete and submit an organizational credentialing application at minimum once every two years to the CMHSP. New organizational providers may be required by the CMHSP to submit additional credentialing application materials or information. Organizational providers may also be required to submit verification or supplemental documentation to support the credentialing application. Organizational providers are only required to submit credentialing documentation to one CMHSP to obtain regional CMHPSM network status. CMHSPs may require supplemental or additional credentialing information.
4. Provider Network Status Participation:	CMHSPs must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region's preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by CMHSPs to meet service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b. CMHSPs are not required to contract with every organizational provider that is regionally credentialed and considered In-Network within the CMHPSM Provider Network.
5. Organizational Monitoring:	Organizational providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the CMHSP on a biennial basis (once every two years.) Organizational providers that are contracted to one or more CMHSPs typically will receive reciprocal status from one CMHSPs review. CMHSPs may withhold the right to review each contracted organizational provider individually if it the CMHSP determines. Organizational providers that **do not** hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored annually by the CMHSP. In addition to administrative reviews the CMHSP will monitor a sample of service sites of both accredited and non-accredited organizational providers on an ongoing basis. Organizational providers delivering service at more than one location will have at least 25% of active service sites reviewed during a site review.
6. Medicaid Service Verification:	The CMHSP and Organizational Provider will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:	The CMHSP will notify the PIHP within three (3) business days of any incident or situation with a contracted provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a CMHSP, and seven (7) business days of the original incident or situation.
8. Network Adequacy	The CMHSP and Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.

9. Reciprocity	Organizational providers will be credentialed, re-credentialed, and monitored on a reciprocal basis within the CMHPSM region. Providers typically will not be required to submit multiple applications when affiliated with multiple CMHSPs, a single credentialing determination can be made by one CMHSP and provide in-network status for the entire region. CMHSPs reserve the right to conduct additional monitoring or require additional information from providers when the CMHSP determines it necessary. CMHSPs will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. CMHSPs reserve the right to conduct additional monitoring or require additional information from providers when the CMHSP determines it necessary.
10. Debarment	All In-Network and Out-of-Network Organizational Providers delivering mental health services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

c. PIHP – SUD Core Provider Relationship

1.	**Payer:**	PIHP
	Provider:	SUD Core Providers
2. Provider Procurement:		The PIHP will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Core Providers.
3. Organizational Credentialing / Re-Credentialing Application Required:		SUD Core Providers within the region will complete and submit an organizational credentialing application at minimum once every two years to the PIHP.
4. Provider Network Status Participation:		SUD Core Providers are required to hold an In-Network CMHPSM Network Status.
5. Organizational Monitoring:		SUD Core Providers will be monitored on an annual basis by the PIHP.
6. Medicaid Service Verification:		The PIHP and SUD Core Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:		The SUD Core Providers will notify the PIHP within three (3) business days of any incident or situation with a contracted provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a SUD Core Provider, and seven (7) business days of the original incident or situation.
8. Network Adequacy		The PIHP and SUD Core Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.
9. Reciprocity		N/A, the PIHP will not accept reciprocity arrangements for SUD Core Providers.
10. Debarment		The PIHP and SUD Core Providers must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

d. SUD Core Provider- SUD Organizational Provider Relationship

1.	**Payer:**	SUD Core Provider
	Provider:	SUD Organizational Provider
2. Provider Procurement:		Each SUD Core Provider will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Organizational Service Providers.
3. Organizational Credentialing / Re-Credentialing Application Required:		All organizational providers delivering SUD services within the region will complete and submit an organizational credentialing application at minimum once every two years to the SUD Core Provider. New providers may be required by the SUD Core Provider to submit additional credentialing application materials or information. Providers may also be required to submit verification or supplemental documentation to support the credentialing application.
4. Provider Network Status Participation:		SUD Core Providers must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region's preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by SUD Core Providers to meet service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b. SUD Core Providers are not required to contract with every organizational provider that is regionally credentialed and considered In-Network within the CMHPSM SUD Provider Network.
5. Organizational Monitoring:		SUD Organizational Service Providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the SUD Core Provider on a biennial basis (once every two years.) Organizations that are contracted to one or more SUD Core Providers typically will receive reciprocal status from one SUD Core Provider's review. SUD Core Providers withhold the right to review each contracted provider organization individually if the SUD Core Provider determines.
6. Medicaid Service Verification:		The SUD Core Provider and SUD Organizational Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:		The SUD Core Provider will notify the PIHP within three (3) business days of any incident or situation with a contracted SUD provider which would induce a significant change on the regional provider network. The PIHP will notify MDHHS within four (4) business days of being notified by a SUD Core Provider, and within seven (7) business days of the original incident or situation.
8. Network Adequacy		The SUD Core Provider and SUD Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.

9. Reciprocity	Organizational providers will be credentialed, re-credentialed, and monitored on a reciprocal basis within the CMHPSM region. Providers typically will not be required to submit multiple applications when affiliated with multiple SUD Core Providers, a single credentialing determination can be made by one SUD Core Provider and provide in-network status for the entire region. SUD Core Providers reserve the right to conduct additional monitoring or require additional information from providers when the SUD Core Provider determines it necessary. SUD Core Providers will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. SUD Core Providers reserve the right to conduct additional monitoring or require additional information from providers when the SUD Core Provider determines it necessary.
10. Debarment	The SUD Core Provider and all SUD Organizational Providers delivering SUD services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

e. PIHP - SUD Organizational Provider Relationship:

1.	**Payer:**	PIHP
	Provider:	SUD Organizational Provider
2. Provider Procurement:		The PIHP will follow all federal, state rules and regulations, as well as all CMHPSM policy related to the procurement and contract processes with SUD Organizational Providers.
3. Organizational Credentialing / Re-Credentialing Application Required:		SUD Organizational Providers within the region will complete and submit an organizational credentialing application at minimum once every two years to the PIHP.
4. Provider Network Status Participation:		The PIHP must contract with a sufficient number of service providers to meet the demand and provide consumer choice for service provision in their local milieu. While the region's preference is to utilize fully credentialed In-Network providers, Out-of-Network providers may be utilized by the PIHP to meet SUD service demand when certain standards are met: CMHPSM Regional Provider Network Statuses 4a. & 4b.
5. Organizational Monitoring:		SUD Organizational Service Providers that hold a current accreditation status from a nationally qualified accrediting body will be administratively monitored by the PIHP on a biennial basis (once every two years.)
6. Medicaid Service Verification:		The PIHP and SUD Organizational Providers will follow all requirements within the CMHPSM Medicaid Service Verification Policy.
7. Provider Network Significant Change Notification:		The PIHP will notify MDHHS within seven (7) business days of any incident or situation involving a SUD Organizational Provider which would induce a significant change on the regional provider network.
8. Network Sufficiency		The SUD Organizational Providers will participate in all regional network adequacy, provider network sufficiency and provider network status activities as requested by the CMHPSM.

9. Reciprocity	The PIHP will accept qualified statewide reciprocity arrangements related to monitoring, credentialing / re-credentialing of providers. The PIHP reserves the right to conduct additional monitoring or require additional information from providers when determined to be necessary.
10. Debarment	All In-Network and Out-of-Network Organizational Providers delivering SUD services must follow all applicable CMHPSM Debarment and Exclusion Policy requirements.

f. PIHP – Non-Federally Funded SUD Service Provider.

1.	**Payer:**	PIHP
	Provider:	Non-Federally Funded SUD Service Provider
2. Provider Procurement:		The PIHP will follow the CMHPSM PA2 Procurement for non-federally funded SUD service provider procurement to ensure the fair and efficient utilization of local and state tax dollars.
3. Organizational Credentialing / Re-Credentialing Application Required:		N/A
4. Provider Network Status Participation:		N/A
5. Organizational Monitoring:		The PIHP will determine all necessary organizational monitoring requirements for non-federally funded SUD service providers.
6. Medicaid Service Verification:		N/A
7. Provider Network Significant Change Notification:		N/A
8. Network Sufficiency		N/A
9. Reciprocity		N/A
10. Debarment		N/A

I. EXHIBITS

None

II. REFERENCES

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 and 438 et al. (Medicaid Managed Care Rules)		438.230(b)

Public Law 109-171, Deficit Reduction Act of 2005,		Title VI
Public Law 111 – 148:Patient Protection & Affordable Care Act of 2010 Public Law 111 – 152: Health Care & Education Reconciliation Act of 2010		Title I, Subtitles C and D
45 CFR Parts 160 & 164 (Health Information Portability and Accountability Act (HIPAA) and HITECH Act of 2010		
42 CFR Part 2 (Substance Abuse)		
Michigan Mental Health Code Act 258 of 1974		
The Joint Commission - Behavioral Health Standards		
Michigan Department of Health and Human Services (MDHHS) Medicaid Contract		
Michigan Department of Health and Human Services (MDHHS) General Funds Contract		
MDHHS Substance Abuse Contract		
Michigan Medicaid Provider Manual		