PIHP REPORTING REQUIREMENTS
Effective 10-1-16
Table of Contents

PIHP REPORTING REQUIREMENTS

FY 2016 MDHHS/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT
REPORTING REQUIREMENTS
Introduction

The Michigan Department of Community Health reporting requirements for the FY2017 Master contract with pre-paid inpatient health plans (PIHPs) are contained in this attachment. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: persons with mental illness and persons with developmental disabilities served by mental health programs; and persons with substance use disorders served by the mental health programs or substance use disorder programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans, and with whom the CMHSPs and PIHPs may contract (or subcontract with an entity that contracts with the Medicaid Health Plans) to provide the mental health benefit.

Companions to the requirements in this attachment are
- "Supplemental Instructions for Encounter Data Submissions" which contains clarifications, value ranges, and edit parameters for the encounter data, as well as examples that will assist PIHP staff in preparing data for submission to MDHHS.
- PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes. Code list that contains the Medicaid covered services as well as services that may be paid by general fund and the CPT and HCPCs codes that MDHHS and EDIT have assigned to them The code list also includes instructions on use of modifiers; the acceptable activities that may be reflected in the cost of each procedure; and whether an activity needs to be face-to-face in order to count.
- "Establishing Managed Care Administrative Costs" that provides instructions on what managed care functions should be included in the allocation of expenditures to managed care administration.
- "Michigan's Mission-Based Performance Indicator System, is a codebook with instructions on what data to collect for, and how to calculate and report, performance indicators.
- SUD Guidelines and instructions as found in the Agreement

These documents are posted on the MDHHS web site and are periodically updated when federal or state requirements change, or when in consultation with representatives of the public mental health system it deemed necessary to make corrections or clarifications. Question and answer documents are also produced from time to time and posted on the web site.

Collection of each element contained in the master contract attachment is required. Data reporting must be received by 5 p.m. on the due dates (where applicable) in the acceptable format(s) and by the MDHHS staff identified in the instructions. Failure to meet this standard will result in contract action.

The reporting of the data by PIHPs described within these requirements meets several purposes at MDHHS including:

PIHP REPORTING REQUIREMENTS

- Legislative boilerplate annual reporting and semi-annual updates
- Managed Care Contract Management
- System Performance Improvement
- Statewide Planning
- Centers for Medicare and Medicaid (CMS) reporting
- External Quality Review
- Actuarial activities

Individual consumer level data received at MDHHS is kept confidential and published reports will display only aggregate data. Only a limited number of MDHHS staff have access to the database that contains social security numbers, income level, and diagnosis, for example. Individual level data will be provided back to the agency that submitted the data for encounter data validation and improvement. This sharing of individual level data is permitted under the HIPAA Privacy Rules, Health Care Operations.

FINANCIAL PLANNING, REPORTING AND SETTLEMENT

The PIHP shall provide the financial reports to MDHHS as listed below. Forms and instructions are posted to the MDHHS website address at: http://www.michigan.gov/mdhhs/0,1607,7-132-2941_38765---,00.html

Submit completed reports electronically (Excel or Word) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov except for reports noted in table below.

Due Date	**Report Title**	**Report Period**
10/1/2016	Projection SUD Supplement FSR (formerly RER)	October 1 to September 30
1/31/2017	SUD – Financial Status Report	October 1 to December 31
4/16/2017	SUD – Women Specialty Services (WSS) Mid-Year Expenditure Report	October 1 to March 31
4/30/2017	SUD – Financial Status Report	January 1 to March 31
5/31/2017	Mid-Year Status Report	October 1 to March 31
6/01/2017	SUD – Notice of Excess or Insufficient Funds	October 1 to September 30
7/31/2017	SUD – Financial Status Report	April 1 to June 30
8/15/2017	SUD – Charitable Choice Report	October 1 to September 30
8/15/2017	Projection Financial Status Report – Medicaid	October 1 to September 30
8/15/2017	Projection Medicaid – Shared Risk Calculation & Risk Financing	October 1 to September 30
8/15/2017	Projection Medicaid – Internal Service Fund	October 1 to September 30
8/15/2017	Projection Medicaid Contract Settlement Worksheet	October 1 to September 30
8/15/2017	Projection Medicaid Contract Reconciliation & Cash Settlement	October 1 to September 30

PIHP REPORTING REQUIREMENTS

9/XX/2017	SUD – Preliminary Closeout Report (REREXP-Obligation)	October 1 to September 30 (Due date will be determined by Budget Office in August for year-end closing)
10/1/2017	Medicaid Year End Accrual Schedule	October 1 to September 30
10/1/2017	SUD YEC Accrual Form	October 1 to September 30
10/1/2017	Projection SUD Supplement FSR (formerly RER)	October 1 to September 30
11/10/2017	Interim Financial Status Report – Medicaid	October 1 to September 30
11/10/2017	Interim Medicaid – Shared Risk Calculation & Risk Financing	October 1 to September 30
11/10/2017	Interim Medicaid – Internal Service Fund	October 1 to September 30
11/10/2017	Interim Medicaid Contract Settlement Worksheet	October 1 to September 30
11/10/2017	Interim Medicaid Contract Reconciliation & Cash Settlement v 2009-2	October 1 to September 30
11/30/2017	SUD – Financial Status Report (Final)	July 1 to September 30
1/31/2018	Annual Report on Fraud and Abuse Complaints	October 1 to September 30
2/28/2018	SUD – Primary Prevention Expenditures by Strategy Report	October 1to September 30
2/28/2018	SUD – Revenue & Expenditure Report – (RER) Final	October 1 to September 30
2/28/2018	SUD – Legislative Report/Section 408	October 1 to September 30
2/28/2018	SUD – Special Projects, Earmark funded: Flint Odyssey House Sacred Heart Rehab Center Hispanic Services Saginaw Odyssey House (Applies only to PIHP's who have earmarked allocations for these Programs)	October 1 to September 30
2/28/2018	Final Financial Status Report – Medicaid	October 1 to September 30
2/28/2018	Final Shared Risk Calculation & Risk Financing	October 1 to September 30
2/28/2018	Final Medicaid – Internal Service Fund	October 1 to September 30
2/28/2018	Final Medicaid Contract Settlement Worksheet	October 1 to September 30
2/28/2018	Final Medicaid Contract Reconciliation & Cash Settlement	October 1 to September 30
2/28/2018	Medicaid Utilization and Cost Report (MUNC)	See Attachment P 6.5.1.1 Submit report to: QMPMeasures@michigan.gov
2/28/2018	Medicaid Community Inpatient Psychiatric Services Expenditure Report	FY 14 expenditures
2/28/2018	Administrative Cost Report	For the fiscal year ending October 1 to September 30
2/28/2018	Executive Administrative Expenditures Survey for Sec. 904(2)(k)	October 1 to September 30, 2016
3/31/2018	SUD - Maintenance of Effort (MOE) Report	October 1 to September 30
6/30/2018	SUD – Audit Report	October 1 to September 30 (Due 9 months after close of fiscal year)

PIHP REPORTING REQUIREMENTS

30 Days after submission	Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter. Compliance exam and plan of correction	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov

NOTE: To submit via DEG to MDHHS/MIS Operations

Client Admission and Discharge client records must be sent electronically to:

Michigan Department of Health and Human Services

Michigan Department of Technology, Management & Budget

Data Exchange Gateway (DEG)

For admissions: put c:/4823 4823@dchbull

For discharges: put c:/4824 4824@dchbull

PIHP NON-FINANCIAL REPORTING REQUIREMENTS SCHEDULE INCLUDING SUD REPORTS

The PIHP shall provide the following reports to MDHHS as listed below.

Due Date	**Report Title**	**Report Period**
1/31/2017	Children Referral Report	October 1 to December 31
2/19/2017	SUD Master Retail List	October 1 to September 30
03/31/2017	Performance Indicators (2)	
04/30/2017	SUD – Sentinel Events Data Report (residential treatment only)	October 1 to March 31
4/30/2017	Children Referral Report	January 1 to March 31
06/30/2017	Performance Indicators	
7/11/2017	Compliance Check Report (CCR) to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov	Email OROSC backup to: ohs@michigan.gov and cc foxallc@michigan.gov
07/11/2017	SUD – Tobacco/Formal Synar Inspections – To be reported in Youth Access to Tobacco (YAT) Compliance Checks Report	June 1 to 30 Coverage study activities should be conducted between Aug. 29 to Sept. 17, 2016
7/31/2017	Children Referral Report	April 1 to June 30
08/31/2017	Consumer Satisfaction raw data	
09/30/2017	Performance Indicators	
10/31/2017	Children Referral Report	July 1 to September 30
10/31/2017	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30
10/31/2017	SUD – Sentinel Events Data Report (residential treatment only)	April 1 to September 30
10/31/2017	SUD – Synar Coverage Study Canvassing Forms	October 1 to September 30

PIHP REPORTING REQUIREMENTS

11/30/2017	SUD – Communicable Disease (CD) Provider Information Report (Must be submitted only if PIHP funds CD services)	October 1 to September 30 (e-mail to mdhhs-BDDHA@michigan.gov)
11/30/2017	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2017	Performance Indicators	
Quarterly	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 – September 30 – Due end of month following the last month of the quarter.
Monthly	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30 – Due end of month following the month in which the exception occurred (must submit even if no data to report)
Monthly (Last day each month)	SUD - Treatment Episode Data Set (TEDS)	October 1 to September 30 (Via DEG to MDHHS/MIS Operations – see note below)
Monthly (Last day of month following the month in which the data was uploaded)	SUD - Michigan Prevention Data System (MPDS)	October 1 to September 30 (submit to: mdhhs.sudpds.com)
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 (Via DEG to MDHHS/MIS Operations – see note below)

Monthly	Consumer level**
	   a. Quality Improvement (1)
	   b. Encounter (1)
		October 1 to September 30

Monthly	Critical Incidents (3)	
Annually (Same due date as Annual Plan)	SUD - Communicable Disease (CD) Provider Information Plan (Must be submitted only if PIHP funds CD services)	October 1 to September 30

**Consumer level data must be submitted-within 30 days following adjudication of claims for services provided, or in cases where claims are not part of the PIHP's business practices, within 30 days following the end of the month in which services were delivered.

NOTE: To submit via DEG to MDHHS/MIS Operations
Client Admission and Discharge client records must be sent electronically to:
Michigan Department of Health and Human Services
Michigan Department of Technology, Management & Budget
Data Exchange Gateway (DEG)
For admissions: put c:/4823 4823@dchbull
For discharges: put c:/4824 4824@dchbull

1. Send data to MDHHS MIS via DEG (see above)
2. Send data to MDHHS, BHDDA, Division of Quality Management and Planning
3. Web-based reporting. See instructions on MDHHS web site at www.michigan.gov/mdhhs/bhdda and click on Reporting Requirements

PIHP REPORTING REQUIREMENTS
BEHAVIORAL HEALTH TREATMENT EPISODE DATA SET (BH-TEDS) COLLECTION/RECORDING AND REPORTING REQUIREMENTS

Technical specifications-- including file formats, error descriptions, edit/error criteria, and explanatory materials on record submission are located on MDHHS's website at:
http://www.michigan.gov/mdhhs/0,4612,7-132-2941_38765---,00.html

Reporting covered by these specifications includes the following:

-BH -TEDS Start Records (due monthly)

-BH-TEDS Discharge/Update/End Records (due monthly)

A.   Basis of Data Reporting
      The basis for data reporting policies for Michigan behavioral health includes:

1.   Federal funding awarded to Michigan through the Combined SABG/MHBG Behavioral Health federal block grant.

2.   SAMHSA's Behavioral Health Services Information Systems (BHSIS) award agreement administered through Synectics Management, Inc that awards MDHHS a contracted amount of funding if the data meet minimum timeliness, completeness and accuracy standards
.
3   Legislative boilerplate annual reporting and semi-annual updates

B.   Policies and Requirements Regarding Data
      BH TEDS Data reporting will encompass Behavioral Health services provided to persons supported in whole or in part with MDHHS-administered funds.

Policy:
Reporting is required for all persons whose services are paid in whole or in part with state administered funds regardless of the type of co-pay or shared funding arrangement made for the services.

For purposes of MDHHS reporting, an admission, or start, is defined as the formal acceptance of a client into behavioral health services. An admission or start has occurred if and only if the person begins receiving behavioral health services.

PIHP REPORTING REQUIREMENTS

1. Data definitions, coding and instructions issued by MDHHS apply as written. Where a conflict or difference exists between MDHHS definitions and information developed by the PIHP or locally contracted data system consultants, the MDHHS definitions are to be used.

2. All SUD data collected and recorded on BH-TEDS shall be reported using the proper Michigan Department of Licensing and Regulatory Affairs (LARA) substance abuse services site license number. LARA license numbers are the primary basis for recording and reporting data to MDHHS at the program level.

3. .

4. There must be a unique Person identifier assigned and reported. It must be 11 characters in length, and alphanumeric. This same number is to be used to report data for BH-TEDS and encounters for the individual within the PIHP. It is recommended that a method be established by the PIHP and funded programs to ensure that each individual is assigned the same identification number regardless of how many times he/she enters services in any program in the region, and that the client number be assigned to only one individual.

5. Any changes or corrections made at the PIHP on forms or records submitted by the program must be made on the corresponding forms and appropriate records maintained by the program. Each PIHP and its programs shall establish a process for making necessary edits and corrections to ensure identical records. The PIHP is responsible for making sure records at the state level are also corrected via submission of change records in data uploads.

6. PIHPs must make corrections to all records that are submitted but fail to pass the error checking routine. All records that receive an error code are placed in an error master file and are not included in the analytical database. Unless acted upon, they remain in the error file and are not removed by MDHHS.

7. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

8. The PIHP must communicate data collection, recording and reporting requirements to local providers as part of the contractual documentation. PIHPs may not add to or modify any of the above to conflict with or substantively affect State policy and expectations as contained herein.

PIHP REPORTING REQUIREMENTS

9. Statements of MDHHS policy, clarifications, modifications, or additional requirements may be necessary and warranted. Documentation shall be forwarded accordingly.

Method for submission: BH-TEDS data are to be submitted in a fixed length format, per the file specifications.

Due dates: BH TEDS data are due monthly. The PIHP is responsible for generating each month's data upload to MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by MDHHS via the DEG no later than the last day of the following month.

Who to report: The PIHP must report BH-TEDS data for all individuals with mental health, intellectual/developmental disabilities, and substance use disorders who receive services funded in whole or in part with MDHHS-administered funding. PIHPs participating in the Medicare/Medicaid integration project are not to report BH-TEDS records for beneficiaries for whom the PIHP's financial responsibility is to a non-contracted provider during the 180-day continuity of care.

PIHP REPORTING REQUIREMENTS

PROXY MEASURES FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

For FY16, the PIHPs are required to report a limited set of data items in the Quality Improvement (QI) file for consumers with an intellectual or developmental disability. The required items and instructions are shown below. Detailed file specifications are (will be) available on the MDHHS web site at: xxxxxxx

Instructions: The following elements are proxy measures for people with developmental disabilities. The information is obtained from the individual's record and/or observation. Complete when an individual begins receiving public mental health services for the first time and update at least annually. Information can be gathered as part of the person-centered planning process.

For purposes of these data elements, when the term "support" is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:

- *"Limited" means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.*
- *"Moderate" means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.*
- *"Extensive" means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.*
- *"Total" means the person is unable to complete the activity and the caregiver is providing 100% support.*

Fields marked with an asterisk * cannot be blank or the file will be rejected.

---

*   ***Reporting Period* (REPORTPD)**
        The last day of the month in which the consumer data is being updated*.* Report year, month, day: yyyymmdd.

---

*   ***PIHP Payer Identification Number* (PIHPID)**
        The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transmissions.

---

*   ***CMHSP Payer Identification Number* (CMHID)**
        The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all data transmissions.

---

*   ***Consumer Unique ID* (CONID)**
        A numeric or alphanumeric code, of 11 characters that enables the consumer and related

PIHP REPORTING REQUIREMENTS

services to be identified and data to be reliably associated with the consumer across all of the PIHP's services. The identifier should be established at the PIHP level so agency level or sub-program level services can be aggregated across all program services for the individual. The consumer's unique ID must not be changed once established since it is used to track individuals, and to link to their encounter data over time. **A single shared unique identifier must match the identifier used in 837 encounter for each consumer.**

Social Security Number **(SSNO)**
The nine-digit integer must be recorded, if available.
Blank = Unreported [Leave nine blanks]

Medicaid ID Number **(MCIDNO)**
Enter the ten-digit integer for consumers with a Medicaid number.
Blank = Unreported [Leave ten blanks]

MIChild Number (CIN)
Blank = Unreported [Leave ten blanks]

Gender (GENDER)
Identify consumer as male or female.
>   M = Male
>   F = Female

Date of birth **(DOB)**
<u>Date of Birth</u> - Year, month, and day of birth must be recorded in that order. Report in a string of eight characters, no punctuation: YYYYMMDD using leading zeros for days and months when the number is less than 10. For example, January 1, 1945 would be reported as 19450101.

. Predominant Communication Style (People with developmental disabilities only) **(COMTYPE) 95% completeness and accuracy required**
>   Indicate from the list below how the individual communicates **most of the time**:
>   1= English language spoken by the individual
>   2= Assistive technology used (includes computer, other electronic devices) or symbols such as Bliss board, or other "low tech" communication devices.
>   3= Interpreter used - this includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.
>   4= Alternative language used - this includes a foreign language, or sign language without an interpreter.
>   5= Non-language forms of communication used – gestures, vocalizations or behavior.
>   6= No ability to communicate.

PIHP REPORTING REQUIREMENTS
Blank= Missing

. *Ability to Make Self Understood (People with developmental disabilities only)* (EXPRESS) 95% completeness and accuracy required.

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff

1= Always Understood – Expresses self without difficulty

2= Usually Understood – Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required

3= Often Understood – Difficulty communicating AND prompting usually required

4= Sometimes Understood - Ability is limited to making concrete requests or understood only by a very limited number of people

5= Rarely or Never Understood – Understanding is limited to interpretation of very person-specific sounds or body language

Blank= Missing

. *Support with Mobility (People with developmental disabilities only)* (MOBILITY) 95% completeness and accuracy required

1= Independent - Able to walk (with or without an assistive device) or propel wheelchair and move about

2= Guidance/Limited Support - Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support.

3= Moderate Support - May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed

4= Extensive Support - Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed

5= Total Support - Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day

Blank= Missing

. *Mode of Nutritional Intake (People with developmental disabilities only)* (INTAKE) 95% completeness and accuracy required

1= Normal – Swallows all types of foods

2= Modified independent – e.g., liquid is sipped, takes limited solid food, need for modification may be unknown

3= Requires diet modification to swallow solid food – e.g., mechanical diet (e.g., purée, minced) or only able to ingest specific foods

4= Requires modification to swallow liquids – e.g., thickened liquids

5= Can swallow only puréed solids AND thickened liquids

6= Combined oral and parenteral or tube feeding

7= Enteral feeding into stomach – e.g., G-tube or PEG tube

8= Enteral feeding into jejunem – e.g., J–tube or PEG-J tube

9= Parenteral feeding only—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)

Blank = Missing

PIHP REPORTING REQUIREMENTS

Support with Personal Care (People with developmental disabilities only) **(PERSONAL) 95% completeness and accuracy required.**

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score a "2" to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

> 1= Independent - Able to complete all personal care tasks without physical support
> 2= Guidance/Limited Support - Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity
> 3= Moderate Physical Support - Able to perform personal care tasks with moderate support of another person
> 4= Extensive Support - Able to perform personal care tasks with extensive support of another person
> 5= Total Support – Requires full support of another person to complete personal care tasks (unable to participate in tasks)
> Blank = Missing

. Relationships (People with developmental disabilities only) **(RELATION) 95% completeness and accuracy required**

Indicate whether or not the individual has "natural supports" defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

> 1= Extensive involvement, such as daily emotional support/companionship
> 2= Moderate involvement, such as several times a month up to several times a week
> 3= Limited involvement, such as intermittent or up to once a month
> 4= Involved in planning or decision-making, but does not provide emotional
>   support/companionship
> 5= No involvement
> Blank = Missing

Status of Family/Friend Support System (People with developmental disabilities only) **(SUPPSYS) 95% completeness and accuracy required**

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. "At risk" means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

> 1= Care giver status is not at risk
> 2= Care giver is likely to reduce current level of help provided
> 3= Care giver is likely to cease providing help altogether
> 4= Family/friends do not currently provide care
> 5= Information unavailable
> Blank = Missing

. Support for Accommodating Challenging Behaviors (People with developmental disabilities only) **(BEHAV) 95% completeness and accuracy required**

PIHP REPORTING REQUIREMENTS

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. "Challenging behaviors" include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

> 1= No challenging behaviors, or no support needed
> 2= Limited Support, such as support up to once a month
> 3= Moderate Support, such as support once a week
> 4= Extensive Support, such as support several times a week
> 5= Total Support – Intermittent, such as support once or twice a day
> 6= Total Support – Continuous, such as full-time support
> Blank = Missing

. *Presence of a Behavior Plan (People with developmental disabilities only)* (PLAN) 95% accuracy and completeness required

Indicate the presence of a behavior plan during the past 12 months.

> 1= No Behavior Plan
> 2= Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
> 3= Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
> Blank = Missing

. *Use of Psychotropic Medications (People with developmental disabilities only)* 95% accuracy and completeness required

Fill in the number of anti-psychotic and other psychotrophic medications the individual is prescribed. See the codebook for further definition of "anti-psychotic" and "other psychotropic" and a list of the most common medications.

> 51.1: Number of Anti-Psychotic Medications **(AP)** ___
> Blank = Missing
> 51.2: Number of Other Psychotropic Medications **(OTHPSYCH)** ___
> Blank = Missing

. *Major Mental Illness (MMI) Diagnosis (People with developmental disabilities only)* 95% accuracy and completeness required

This measure identifies major mental illnesses characterized by psychotic symptoms or severe affective symptoms. Indicate whether or not the individual has one or more of the following major mental illness diagnoses: Schizophrenia, Schizophreniform Disorder, or Schizoaffective Disorder (ICD code 295.xx); Delusional Disorder (ICD code 297.1); Psychotic Disorder NOS (ICD code 298.9); Psychotic Disorder due to a general medical condition (ICD codes 293.81 or 293.82); Dementia with delusions (ICD code 294.42); Bipolar I Disorder (ICD codes 296.0x, 296.4x, 296.5x, 296.6x, or 296.7); or Major Depressive Disorder (ICD codes 296.2x and 296.3x). The ICD code must match the codes provided above. Note: Any digit or no digit at all, may be substituted for each "x" in the codes.

> 1= One or more MMI diagnosis present
> 2= No MMI diagnosis present
> Blank = Missing

PIHP REPORTING REQUIREMENTS
CHAMPS BEHAVIORAL HEALTH REGISTRY FILE

Purpose: In the past basic consumer information from the QI (MH) and TEDS (SUD) files were sent to CHAMPS to be used as a validation that the consumer being reported in the Encounters is a valid consumer for the reporting PIHP. With QI eventually being phased out during FY16 and TEDS ending on 9/30/2015, BHTEDS will be replacing them both beginning 10/1/2015. To use BHTEDS to create the CHAMPS validation file would be difficult as there would be three different types of records – mental health substance use disorder and co-occurring.

Requirement: To simplify the process of creating this validation file, BHDDA is introducing a new file called the Behavioral Health Registry file. For this file, PIHPs are required to report five fields of data with only three being required. The required fields are: PIHP Submitter ID, Consumer ID and Begin Date (date less than or equal to first Date of Service reported in Encounters.) The following two fields will only be reported if the consumer has either: Medicaid ID and MIChild ID.

The file specifications and error logic for the Registry are (will be) available on the MDHHS web site at: xxxxxx

Submissions of the BH Registry file by CHAMPS will be ready by 10/1/2015.

Data Record

Record Format: rc1041.06									
Element #	**Data Element Name**	**Picture**	**Usage**	**Format**	**From**	**To**	**Validated**	**Required**	**Definition**
1	Submitter ID	Char(4)	4		1	4	Yes	Yes	Service Bureau ID (DEG Mailbox ID)
2	Consumer ID	Char(11)	11		5	15	No	Yes	Unique Consumer ID
3	Medicaid ID	Char(10)	10		16	25	Yes	Conditional	Must present on file if available.
4	MIChild ID	Char(10)	10		26	35	Yes	Conditional	MICHILD ID [CIN] Must present on file if available.
5	Begin Date	Date	8	YYYYMMDD	36	43	Yes	Yes	

PIHP REPORTING REQUIREMENTS

ENCOUNTERS PER MENTAL HEALTH, DEVELPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER BENEFICIARY
DATA REPORT

Due dates: Encounter data are due within 30 days following adjudication of the claim for the service provided, or in the case of a PIHP whose business practices do not include claims payment, within 30 days following the end of the month in which services were delivered. It is expected that encounter data reported will reflect services for which providers were paid (paid claims), third party reimbursed, and/or any services provided directly by the PIHP. Submit the encounter data for an individual on any claims adjudicated, regardless of whether there are still other claims outstanding for the individual for the month in which service was provided. In order that the department can use the encounter data for its federal and state reporting, it must have the count of units of service provided to each consumer during the fiscal year. Therefore, the encounter data for the fiscal year must be reconciled within 90 days of the end of the fiscal year. Claims for the fiscal year that are not yet adjudicated by the end of that period, should be reported as encounters with a monetary amount of "0." Once claims have been adjudicated, a replacement encounter must be submitted.

Who to Report: The PIHP must report the encounter data for all mental health and developmental disabilities (MH/DD) Medicaid beneficiaries in its entire service area for all services provided under MDHHS benefit plans. The PIHP must report the encounter data for all substance use disorder Medicaid beneficiaries in its service area.Encounter data is collected and reported for every beneficiary for which a claim was adjudicated or service rendered during the month by the PIHP (directly or via contract) regardless of payment source or funding stream. PIHP's and CMHSPs that contract with another PIHP or CMHSP to provide mental health services should include that consumer in the encounter data set. . In those cases the PIHP or CMHSP that provides the service via a contract should not report the consumer in this data set. Likewise, PIHPs or CMHSPs that contract directly with a Medicaid Health Plan, or sub-contract via another entity that contracts with a Medicaid Health Plan to provide the Medicaid mental health outpatient benefit, should not report the consumer in this data set.

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all consumer level data reported after October 16, 2002 must be compliant with the transaction standards.

A summary of the relevant requirements is:
- Encounter data (service use) is to be submitted electronically on a Health Care Claim 5010.
- The encounter requires a small set of specific demographic data: gender, diagnosis, Medicaid number, race, and social security number, and name of the consumer.
- Information about the encounter such as provider name and identification number, place of service, and amount paid for the service is required.
- The 837 includes a "header" and "trailer" that allows it to be uploaded to the CHAMPS system.
-

PIHP REPORTING REQUIREMENTS

- Every behavioral health encounter record must have a corresponding Behavioral Health Registry record reported prior to the submission of the Encounter. Failure to report both an encounter record and a registry record for a consumer receiving services will result in the encounter being rejected by the CHAMPS system.

The information on HIPAA contained in this contract relates only to the data that MDHHS is requiring for its own monitoring and/or reporting purposes, and does not address all aspects of the HIPAA transaction standards with which PIHPs must comply for other business partners (e.g., providers submitting claims, or third party payers). Further information is available at www.michigan.gov/mdhhs.

Data that is uploaded to CHAMPS must follow the HIPAA-prescribed formats for encounter data. The 837/5010 includes header and trailer information that identifies the sender and receiver and the type of information being submitted. If data does not follow the formats, entire files could be rejected by the electronic system.

HIPAA also requires that procedure codes, revenue codes and modifiers approved by the CMS be used for reporting encounters. Those codes are found in the Current Procedural Terminology (CPT) Manual, Fifth Edition, published by the American Medical Associations, the Health Care Financing Administration Common Procedure Coding System (HCPCS), the National Drug Codes (NDC), the Code on Dental Procedures and Nomenclature (CDPN), the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), ICD-10 and the Michigan Uniform Billing Manual. The procedure codes in these coding systems require standard units that must be used in reporting on the 837/5010.

MDHHS has produced a code list of covered Medicaid specialty and Habilitation Supports waiver supports and services names (as found in the Medicaid Provider Manual) and the CPT or HCPCS codes/service definition/units as soon as the majority of mental health services have been assigned CPT or HCPCS codes. This code list is available on the MDHHS web site.

The following elements reported on the 837/5010 encounter format will be used by MDHHSQuality Management and Planning Division for its federal and state reporting, the Contracts Management Section and the state's actuary. The items with an ** are required by HIPAA, and when they are absent will result in rejection of a file. Items with an ** must have 100% of values recorded within the acceptable range of values. Failure to meet accuracy standards on these items will result in contract action.

Refer to HIPAA 837 transaction implementation guides for exact location of the elements. Please consult the HIPAA implementation guides, and clarification documents (on MDHHS's web site) for additional elements required of all 837/5010 encounter formats. The Supplemental Instructions contain field formats and specific instructions on how to submit encounter level data.

1.a. *PIHP Plan Identification Number* (PIHPID) or PIHP CA Function ID
> The MDHHS-assigned 7-digit payer identification number must be used to identify the PIHP with all data transactions.

1.b.   *CMHSP Plan Identification Number* (CMHID)

The MDHHS-assigned 7-digit payer identification number must be used to identify the CMHSP with all mental health and/or developmental disabilities transactions.

**2. *Identification Code/Subscriber Primary Identifier (please see the details in the submitter's manual)*
Ten-digit Medicaid number must be entered for a **Medicaid or MIChild** beneficiary.
If the consumer is not a beneficiary, enter the nine-digit **Social Security** number.
If consumer has neither a Medicaid number nor a Social Security number, enter the unique identification number assigned by the CMHSP or **CONID.**

**3. *Identification Code/Other Subscriber Primary Identifier (please see the details in the submitter's manual)*
Enter the consumer's unique identification number (**CONID**) assigned by the CMHSP **regardless** of whether it has been used above**.**

**4. *Date of birth*
Enter the date of birth of the beneficiary/consumer.

**5. *Diagnosis*
Enter the ICD-9 primary diagnosis of the consumer.

**6. *EPSDT*
Enter the specified code indicating the child was referred for specialty services by the EPSDT screening.

**7. *Encounter Data Identifier*
Enter specified code indicating this file is an encounter file.

**8. *Line Counter Assigned Number*
A number that uniquely identifies each of up to 50 service lines per claim.

**9. *Procedure Code*
Enter procedure code from code list for service/support provided. The code list is located on the MDHHS web site. Do not use procedure codes that are not on the code list.

*10. *Procedure Modifier Code*
Enter modifier as required for Habilitation Supports Waiver services provided to enrollees; for Autism Benefit services under 1915 iSPA; for Community Living Supports and Personal Care levels of need; for Nursing Home Monitoring; and for evidence-based practices. See Costing per Code List.

*11. *Monetary Amount (effective 1/1/13)*:

Enter the charge amount, paid amount, adjustment amount (if applicable), and adjustment code in claim information and service lines. (See Instructions for Reporting Financial Fields in Encounter Data at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements)

**12. *Quantity of Service*
Enter the number of units of service provided according to the unit code type. **Only whole numbers should be reported.**

13. *Place of Service Code*
Enter the specified code for where the service was provided, such as an office, inpatient hospital, etc. (See PIHP/CMHSP Encounter Reporting HCPCS and Revenue Codes Chart at http://www.michigan.gov/mdhhs/0,4612,7-132-2941---,00.html Click on Reporting Requirements, then the codes chart)

14. *Diagnosis Code Pointer*
Points to the diagnosis code at the claim level that is relevant to the service.

**15. *Date Time Period*
Enter date of service provided (how this is reported depends on whether the Professional, or the Institutional format is used).

**16. *Billing Provider Name*
Enter the name of the Billing Provider for all encounters. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

**17. *Rendering Provider Name*
Enter the name of the Rendering Provider when different from the Billing Provider (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

**18. *Provider National Provider Identifier (NPI), Employer Identification Number (EIN) or Social Security Number (SSN)* Enter the appropriate identification number for the Billing Provider, and as applicable, the Rendering Provider. (See Instructions for Reporting Financial Fields in Encounter Data at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

ENCOUNTER TIMELINESS CALCULATION

Requirements

1. The PIHP must have at least one claim accepted by CHAMPS for the report month. This count will be based on the date of service. The adjudication date will not be considered in this calculation. As an example, for the timeliness metrics analyzed in December 2014, the PIHP must have submitted at least one claim with an October 2014 date of service.
2. Based on the logic below, the PIHP must have at least 70% of encounters reported timely. (Percentage based on 75% of the PIHP average for February 2014 using the new methodology. See highlighted section below).

Logic

Encounter timeliness is determined by calculating the percent of encounter lines that are accepted by CHAMPS by the end of the month following the month of adjudication. This calculation is done each month. As an example, on December 15th the query is run to determine what percent of the encounters adjudicated during October were accepted by CHAMPS by November 30th. The analyses are only run once for each adjudication month.

The adjudication date is taken from the DTP segment of the 2430 loop or the DTP segment of the 2330B loop. (The data warehouse uses the date from the line if it is available otherwise it populates with the claim date.) For claims that are not adjudicated, Medicaid Health Plans populate the DTP field with the date they created the encounter for submission. The Medicaid Health Plans are required to report this field and the encounter is rejected if neither DTP field is populated (error 2650). Currently, for mental health encounters this error is informational only. However, PIHPs will also be required to populate this field with either the adjudication date or the date the encounter was created for submission.

These queries only include consumers who are Medicaid eligible at the time of services, with Scope = 1 or 2 and coverage = D, F, K, P, or T. The queries include all PIHP submitted encounters, both mental health and substance abuse.

Concerns have been raised that the timeliness measure will penalize PIHPs for correcting encounter errors. To address this, the query will include all active encounters (original and replacement) except those replacement encounters that are not timely. In this way, PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve.

The Department plans on continuing these test analyses through November 2014. The first production analyses will be run in December 2014.

FY'14 PIHP MEDICAID UTILIZATION AND AGGREGATE NET COST REPORT

This report provides the aggregate Medicaid service data necessary for MDHHS management of PIHP contracts and rate-setting by the actuary. In the case of a regional entity, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its CMHSP partners. This report includes Medicaid Substance Use Disorder services provided in the service area. The data set reflects and describes the support activity provided to or on behalf of Medicaid beneficiaries, **except** Children's Waiver beneficiaries. Refer to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual for the complete and specific requirements for coverage for the State Plan, Additional services provided under the authority of Section 1915(b)(3) of the Social Security Act, and the Habilitation Supports Waiver. All of the aforementioned Medicaid services and supports provided in the PIHP service area must be reported on this utilization and cost report. Instructions and current templates for completing and submitting the MUNC report may be found on the MDHHS web site at www.michigan.gov/mdhhs. Click on Mental Health and Substance Abuse, then Reporting Requirements.

MICHIGAN MISSION-BASED PERFORMANCE INDICATOR SYSTEM
VERSION 6.0
FOR PIHPS

The purposes of the Michigan Mission Based Performance Indicator System (version 1.0) are:
- To clearly delineate the dimensions of quality that must be addressed by the Public Mental Health System as reflected in the Mission statements from Delivering the Promise and the needs and concerns expressed by consumers and the citizens of Michigan. Those domains are: ACCESS, EFFICIENCY, and OUTCOME.
- To develop a state-wide aggregate status report to address issues of public accountability for the public mental health system (including appropriation boilerplate requirements of the legislature, legal commitments under the Michigan Mental Health Code, etc.)
- To provide a data-based mechanism to assist MDHHS in the management of PIHP contracts that would impact the quality of the service delivery system statewide.
- To the extent possible, facilitate the development and implementation of local quality improvement systems; and
- To link with existing health care planning efforts and to establish a foundation for future quality improvement monitoring within a managed health care system for the consumers of public mental health services in the state of Michigan.

All of the indicators here are measures of PIHP performance. Therefore, performance indicators should be reported by the PIHP for all the Medicaid beneficiaries for whom it is responsible. Medicaid beneficiaries who are not receiving specialty services and supports (1915(b)(c) waivers) but are provided outpatient services through contracts with Medicaid Health Plans, or sub-contracts with entities that contract with Medicaid Health Plans are not covered by the performance indicator requirements.

Due dates for indicators vary and can be found on the table following the list of indicators. Instructions and reporting tables are located in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by MDHHS six weeks prior to the due date and also available on the MDHHS website: www.michigan.gov/mdhhs. Click on Mental Health and Substance Abuse, then Reporting Requirements.

ACCESS

1. The percent of all Medicaid adult and children beneficiaries receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours. **Standard = 95% in three hours**

2. The percent of new Medicaid beneficiaries receiving a face-to-face meeting with a professional within 14 calendar days of a non-emergency request for service (MI adults, MI children, DD adults, DD children, and Medicaid SUD). **Standard = 95% in 14 day**s.

3. The percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional. (MI adults, MI children, DD adults, DD children, and Medicaid SUD) **Standard = 95% in 14 days**

4. The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days. (All children and all adults (MI, DD) and all Medicaid SUD (sub-acute de-tox discharges) **Standard = 95% in seven days**

5. The percent of Medicaid recipients having received PIHP managed services. (MI adults, MI children, DD adults, DD children, and SUD)

ADEQUACY/APPROPRIATENESS

6. The percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters in data warehouse who are receiving at least one HSW service per month that is not supports coordination.

EFFICIENCY

7. The percent of total expenditures spent on managed care administrative functions for PIHPs.

OUTCOMES

8. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who are in competitive employment.

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with developmental disabilities served by PIHPs who earn state minimum wage or more from employment activities (competitive, self-employment, or sheltered workshop).

10. The percent of children and adults with MI and DD readmitted to an inpatient psychiatric unit within 30 days of discharge. Standard = 15% or less within 30 days

11. The annual number of substantiated recipient rights complaints per thousand Medicaid beneficiaries with MI and with DD served, in the categories of Abuse I and II, and Neglect I and II.

12. The percent of adults with developmental disabilities served, who live in a private residence alone, or with spouse or non-relative.

13. The percent of adults with serious mental illness served, who live in a private residence alone, or with spouse or non-relative.

14. The percent of children with developmental disabilities (not including children in the Children's Waiver Program) in the quarter who receive at least one service each month other than case management and respite.

Note: Indicators #2, 3, 4, and 5 include Medicaid beneficiaries who receive substance use disorder services managed by the PIHP.

PIHP REPORTING REQUIREMENTS

PIHP PERFORMANCE INDICATOR REPORTING DUE DATES

Indicator Title	Period	Due	Period	Due	Period	Due	Period	Due	From
1. Pre-admission screen	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
2. 1st request	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
3. 1st service	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
4. Follow-up	10/01 to 12/31	3/31	1/01 to 3/31	6/30	4/01 to 6/30	9/30	7/01 to 9/30	12/31	PIHPs
5. Medicaid penetration*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
6. HSW services*	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS
7. Admin. Costs*	10/01 to 9/30	1/31							MDHHS
8. Competitive employment*	10/01 to 9/30								MDHHS
9. Minimum wage*	10/01 to 9/30								MDHHS
10. Readmissions	10/01 to 9/30	3/31	1/01 to 3/31	6/30	4-01 to 6-30	9/30	7/01 to 9/30	12/31	PIHPs
11. RR complaints	10/01 to 9/30	12/31							PIHPs
12. & 13. Living arrangements	10/1 to 9/30	N/A							MDHHS
14. Children with DD	10/01 to 12/31	N/A	1/01 to 3/31	N/A	4/01 to 6/30	N/A	7/01 to 9/30	N/A	MDHHS

*Indicators with * mean MDHHS collects data from encounters, quality improvement or cost reports and calculates performance indicators

STATE LEVEL DATA COLLECTION

CONSUMER SATISFACTION SURVEY

Adults with Serious Mental Illness & Children with Serious Emotional Disturbance
-An annual survey using MHSIP 44 items for adults with MI and SUD, and MHSIP Youth and Family survey for families of children with SED will be conducted. Surveys are available on the MHSIP web site and have been translated into several languages. See
www.mhsip.org/surveylink.htm
-The PIHPs will conduct the survey in the month of May for all people (regardless of medical assistance eligibility) currently receiving services in specific programs.
-Programs to be selected annually by QIC based on volume of units, expenditures, complaints and site review information.
-The raw data is due August 31st to MDHHS each year on an Excel template to be provided by MDHHS.

CRITICAL INCIDENT REPORTING

PIHPs will report the following events, except Suicide, within 60 days after the end of the month in which the event occurred for individuals actively receiving services, with individual level data on consumer ID, event date, and event type:

- **Suicide** for any individual actively receiving services at the time of death, and any who have received emergency services within 30 days prior to death. Once it has been determined whether or not a death was suicide, the suicide must be reported within 30 days after the end of the month in which the death was determined. If 90 calendar days have elapsed without a determination of cause of death, the PIHP must submit a "best judgment" determination of whether the death was a suicide. In this event the time frame described in "a" above shall be followed, with the submission due within 30 days after the end of the month in which this "best judgment" determination occurred.
- **Non-suicide death** for individuals who were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving community living supports, supports coordination, targeted case management, ACT, Home-based, Wraparound, Habilitation Supports Waiver, SED waiver or Children's Waiver services. If reporting is delayed because the PIHP is determining whether the death was due to suicide, the submission is due within 30 days after the end of the month in which the PIHP determined the death was not due to suicide.
- **Emergency Medical treatment due to Injury or Medication Error** for people who at the time of the event were actively receiving services and were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or were receiving either Habilitation Supports Waiver services, SED Waiver services or Children's Waiver services.

26

- **Hospitalization due to Injury or Medication Error** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.
- **Arrest of Consumer** for individuals who were living in a Specialized Residential facility (per Administrative Rule R330.1801-09) or in a Child-Caring institution; or receiving Habilitation Supports Waiver services, SED Waiver services, or Children's Waiver services.

Methodology and instructions for reporting are posted on the MDHHS web site at www.michigan.gov/mdhhs. Click on Mental Health and Substance Abuse, then "Reporting Requirements"

EVENT NOTIFICATION

The PIHP shall immediately notify MDHHS of the following events:
1. Any death that occurs as a result of suspected staff member action or inaction, or any death that is the subject of a recipient rights, licensing, or police investigation. This report shall be submitted electronically within 48 hours of either the death, or the PIHP's receipt of notification of the death, or the PIHP's receipt of notification that a rights, licensing, and/or police investigation has commenced to QMPMeasures@michigan.gov and include the following information:
    a. Name of beneficiary
    b. Beneficiary ID number (Medicaid, MiChild)
    c. Consumer I (CONID) if there is no beneficiary ID number
    d. Date, time and place of death (if a licensed foster care facility, include the license #)
    e. Preliminary cause of death
    f. Contact person's name and E-mail address
2. Relocation of a consumer's placement due to licensing suspension or revocation.
3. An occurrence that requires the relocation of any PIHP or provider panel service site, governance, or administrative operation for more than 24 hours
4. The conviction of a PIHP or provider panel staff members for any offense related to the performance of their job duties or responsibilities which results in exclusion from participation in federal reimbursement.

Except for deaths, notification of the remaining events shall be made telephonically or other forms of communication within five (5) business days to contract management staff members in MDHHS's Behavioral Health and Developmental Disabilities Administration.

ANNUAL FRAUD AND ABUSE COMPLAINT REPORT

The PIHP must report the following to the MDHHS on an annual basis:
1. Number of complaints of fraud and abuse made to the state that warrants preliminary investigation.
2. For each instance that warrants investigation, supply the:
    a. Name
    b. ID number
    c. Source of complaint
    d. Type of provider
    e. Nature of complaint
    f. Approximate dollars involved, and
    g. Legal & administrative disposition of the case
    h. Funding Source(s)

The annual report on fraud and abuse complaints is due to MDHHS on January 31st, and should cover complaints filed with the state during the fiscal year. It should be filed electronically at MDHHS-MHSA-Contracts-MGMT@michigan.gov. Nothing in this Section is intended to preclude the PIHP from fulfilling its obligations under Part III, Section 2.0 of the contract.

NOTIFICATION OF PROVIDER NETWORK CHANGES

The PIHP shall notify MDHHS within seven (7) days of any changes to the composition of the provider network organizations that negatively affect access to care. PIHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that MDHHS determines to negatively affect recipient access to covered services may be grounds for sanctions.