Manager and Location Building:
Jeffery L. Wieferich, Lewis Cass Building, 320 S. Walnut
Contract Number#_____

Amendment No. 3 to the Agreement Between
Michigan Department of Health and Human Services
And

PIHP_____
For
The Medicaid Managed Specialty Supports and Services Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs

1. **Period of Agreement:**
   This agreement shall commence on October 1, 2019 and continue through September 30, 2020.

2. **Period of Amendment:**
   October 1, 2019 through September 30, 2020.

3. **Program Budget and Agreement Amount:**
   Payment to the PIHP will be based on the total funding available for specialty supports and services as identified in the annual Legislative Appropriation for community mental health services programs for the period of October 1, 2019 through September 30, 2020. The estimated value is contingent upon and subject to enactment of legislative appropriations and availability of funds.

4. **Amendment Purpose:**
   This amendment incorporates changes to boilerplate contract language and related contract attachments.

5. **The Specific Changes are Identified Below:**
   - SFY 2020 Behavioral Health Capitation Rate Certification Amendment
   - 18. Assurances subsection 18.1.15 Electronic Visit Verification
   - 6.3.1 Recipient Rights and Grievance and Appeals
   - 8.4.2.1 2020 Performance Bonus Integration of Behavioral and Physical Health Services
   - CMS technical corrections for Information Requirements and Standard Consent Form
   - Contract attachment P7.7.1.1 PIHP Reporting Requirements – technical corrections to remove Strategic Enhancement Report and change other reporting due dates

6. **Original Agreement Conditions**
   It is understood and agreed that all other conditions of the original agreement remain the same.

7. **Special Certification:**
   The individuals signing this agreement certify by their signatures that they are authorized to sign this agreement on behalf of the organization specified.

Signature Section:

For the Michigan Department of Health and Human Services

Christine H. Sanches, Director Bureau of Grants & Purchasing	Date

For the CONTRACTOR:

Name (print)	Title (print)
Signature	Date

State of Michigan
Department of Health and Human Services
Amended State Fiscal Year 2020 Behavioral Health Capitation Rate Development
Comparison of Amended Capitation Rates to Original Capitation Rates

	Projected Exposure			SFY 2020 Capitation Rates Excluding IPA/HRA			SFY 2020 Capitation Rates Including IPA/HRA		
	Original	Amended	Percentage Change	Original	Amended	Percentage Change	Original	Amended	Percentage Change
DAB - Enrolled									
DAB - Enrolled - F - 0 - 5	76,606	76,556	(0.1%)	$ 318.98	$ 319.24	0.1%	$ 326.26	$ 326.52	0.1%
DAB - Enrolled - F - 6 - 18	242,443	242,285	(0.1%)	237.69	237.90	0.1%	244.97	245.18	0.1%
DAB - Enrolled - F - 19 - 20	42,071	42,044	(0.1%)	242.44	242.56	0.0%	249.72	249.84	0.0%
DAB - Enrolled - F - 21 - 25	80,147	80,095	(0.1%)	376.79	377.16	0.1%	384.07	384.44	0.1%
DAB - Enrolled - F - 26 - 39	196,721	196,593	(0.1%)	487.70	488.04	0.1%	494.98	495.32	0.1%
DAB - Enrolled - F - 40 - 49	170,361	170,250	(0.1%)	263.81	264.07	0.1%	271.09	271.35	0.1%
DAB - Enrolled - F - 50 - 64	475,363	475,053	(0.1%)	175.36	175.51	0.1%	182.64	182.79	0.1%
DAB - Enrolled - F - 65+	118,925	118,848	(0.1%)	70.62	70.70	0.1%	77.90	77.98	0.1%
DAB - Enrolled - M - 0 - 5	98,725	98,661	(0.1%)	684.72	685.19	0.1%	692.00	692.47	0.1%
DAB - Enrolled - M - 6 - 18	372,610	372,367	(0.1%)	373.14	373.47	0.1%	380.42	380.75	0.1%
DAB - Enrolled - M - 19 - 20	56,332	56,295	(0.1%)	326.16	326.33	0.1%	333.44	333.61	0.1%
DAB - Enrolled - M - 21 - 25	103,894	103,826	(0.1%)	479.14	479.54	0.1%	486.42	486.82	0.1%
DAB - Enrolled - M - 26 - 39	215,943	215,802	(0.1%)	601.59	602.09	0.1%	608.87	609.37	0.1%
DAB - Enrolled - M - 40 - 49	137,651	137,561	(0.1%)	336.98	337.32	0.1%	344.26	344.60	0.1%
DAB - Enrolled - M - 50 - 64	428,066	427,787	(0.1%)	197.83	198.13	0.2%	205.11	205.41	0.1%
DAB - Enrolled - M - 65+	72,708	72,661	(0.1%)	87.23	87.35	0.1%	94.51	94.63	0.1%
Subtotal DAB - Enrolled	**2,888,566**	**2,886,685**	**(0.1%)**	**$ 310.61**	**$ 310.89**	**0.1%**	**$ 317.89**	**$ 318.17**	**0.1%**
DAB - Unenrolled									
DAB - Unenrolled - F - 0 - 5	17,635	17,077	(3.2%)	$ 97.24	$ 100.16	3.0%	$ 104.68	$ 107.77	3.0%
DAB - Unenrolled - F - 6 - 18	80,402	77,858	(3.2%)	155.36	160.16	3.1%	162.80	167.77	3.1%
DAB - Unenrolled - F - 19 - 20	16,991	16,453	(3.2%)	264.54	272.91	3.2%	271.98	280.52	3.1%
DAB - Unenrolled - F - 21 - 25	38,179	36,971	(3.2%)	521.22	537.96	3.2%	528.66	545.57	3.2%
DAB - Unenrolled - F - 26 - 39	133,719	129,488	(3.2%)	600.31	619.87	3.3%	607.75	627.48	3.2%
DAB - Unenrolled - F - 40 - 49	164,823	159,608	(3.2%)	407.10	420.19	3.2%	414.54	427.80	3.2%
DAB - Unenrolled - F - 50 - 64	454,483	440,102	(3.2%)	333.48	344.31	3.2%	340.92	351.92	3.2%
DAB - Unenrolled - F - 65+	887,272	859,196	(3.2%)	106.43	109.77	3.1%	113.87	117.38	3.1%
DAB - Unenrolled - M - 0 - 5	21,257	20,584	(3.2%)	213.91	220.73	3.2%	221.35	228.34	3.2%
DAB - Unenrolled - M - 6 - 18	113,045	109,468	(3.2%)	216.22	223.03	3.1%	223.66	230.64	3.1%
DAB - Unenrolled - M - 19 - 20	25,140	24,345	(3.2%)	321.45	331.75	3.2%	328.89	339.36	3.2%
DAB - Unenrolled - M - 21 - 25	60,918	58,990	(3.2%)	566.41	584.66	3.2%	573.85	592.27	3.2%
DAB - Unenrolled - M - 26 - 39	157,967	152,968	(3.2%)	760.92	785.66	3.3%	768.36	793.27	3.2%
DAB - Unenrolled - M - 40 - 49	147,501	142,834	(3.2%)	602.90	622.67	3.3%	610.34	630.28	3.3%
DAB - Unenrolled - M - 50 - 64	354,737	343,512	(3.2%)	547.73	566.00	3.3%	555.17	573.61	3.3%
DAB - Unenrolled - M - 65+	458,259	443,758	(3.2%)	175.79	181.70	3.4%	183.23	189.31	3.3%
Subtotal DAB - Unenrolled	**3,132,328**	**3,033,213**	**(3.2%)**	**$ 315.27**	**$ 325.54**	**3.3%**	**$ 322.71**	**$ 333.15**	**3.2%**
HMP - Enrolled									
HMP - Enrolled - F - 19 - 20	219,122	218,977	(0.1%)	$ 29.58	$ 29.60	0.1%	$ 34.54	$ 34.56	0.1%
HMP - Enrolled - F - 21 - 25	446,531	446,235	(0.1%)	31.03	31.07	0.1%	35.99	36.03	0.1%
HMP - Enrolled - F - 26 - 39	1,037,427	1,036,740	(0.1%)	45.39	45.39	0.0%	50.35	50.35	0.0%
HMP - Enrolled - F - 40 - 49	583,165	582,779	(0.1%)	45.34	45.36	0.0%	50.30	50.32	0.0%
HMP - Enrolled - F - 50 - 64	929,447	928,832	(0.1%)	30.90	30.96	0.2%	35.86	35.92	0.2%
HMP - Enrolled - M - 19 - 20	203,783	203,648	(0.1%)	31.98	31.97	(0.0%)	36.94	36.93	(0.0%)
HMP - Enrolled - M - 21 - 25	435,276	434,988	(0.1%)	42.50	42.53	0.1%	47.46	47.49	0.1%
HMP - Enrolled - M - 26 - 39	1,156,836	1,156,070	(0.1%)	67.57	67.66	0.1%	72.53	72.62	0.1%
HMP - Enrolled - M - 40 - 49	620,083	619,672	(0.1%)	58.31	58.39	0.1%	63.27	63.35	0.1%
HMP - Enrolled - M - 50 - 64	853,488	852,923	(0.1%)	43.98	44.02	0.1%	48.94	48.98	0.1%
Subtotal HMP - Enrolled	**6,485,158**	**6,480,864**	**(0.1%)**	**$ 46.18**	**$ 46.22**	**0.1%**	**$ 51.14**	**$ 51.18**	**0.1%**
HMP - Unenrolled									
HMP - Unenrolled - F - 19 - 20	72,878	60,232	(17.4%)	$ 30.22	$ 36.52	20.8%	$ 35.90	$ 43.11	20.1%
HMP - Unenrolled - F - 21 - 25	148,269	122,540	(17.4%)	31.11	37.63	21.0%	36.79	44.22	20.2%
HMP - Unenrolled - F - 26 - 39	286,321	236,637	(17.4%)	45.70	55.31	21.0%	51.38	61.90	20.5%
HMP - Unenrolled - F - 40 - 49	119,177	98,497	(17.4%)	48.75	58.99	21.0%	54.43	65.58	20.5%
HMP - Unenrolled - F - 50 - 64	154,307	127,531	(17.4%)	49.56	59.98	21.0%	55.24	66.57	20.5%
HMP - Unenrolled - M - 19 - 20	70,135	57,965	(17.4%)	49.94	60.41	21.0%	55.62	67.00	20.5%
HMP - Unenrolled - M - 21 - 25	158,015	130,595	(17.4%)	56.66	68.56	21.0%	62.34	75.15	20.5%
HMP - Unenrolled - M - 26 - 39	361,579	298,836	(17.4%)	74.63	90.30	21.0%	80.31	96.89	20.6%
HMP - Unenrolled - M - 40 - 49	161,600	133,558	(17.4%)	64.11	77.62	21.1%	69.79	84.21	20.7%
HMP - Unenrolled - M - 50 - 64	189,783	156,851	(17.4%)	65.60	79.41	21.1%	71.28	86.00	20.7%
Subtotal HMP - Unenrolled	**1,722,064**	**1,423,241**	**(17.4%)**	**$ 55.52**	**$ 67.19**	**21.0%**	**$ 61.20**	**$ 73.78**	**20.6%**

State of Michigan
Department of Health and Human Services
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Comparison of Amended Capitation Rates to Original Capitation Rates

	Projected Exposure			SFY 2020 Capitation Rates Excluding IPA/HRA			SFY 2020 Capitation Rates Including IPA/HRA		
	Original	Amended	Percentage Change	Original	Amended	Percentage Change	Original	Amended	Percentage Change
TANF - Enrolled									
TANF - Enrolled - F - 0 - 5	1,591,178	1,590,509	(0.0%)	$ 12.80	$ 12.78	(0.2%)	$ 14.52	$ 14.50	(0.1%)
TANF - Enrolled - F - 6 - 18	2,821,024	2,819,838	(0.0%)	27.59	27.62	0.1%	29.31	29.34	0.1%
TANF - Enrolled - F - 19 - 20	95,459	95,419	(0.0%)	20.32	20.33	0.0%	22.04	22.05	0.0%
TANF - Enrolled - F - 21 - 25	361,549	361,397	(0.0%)	23.24	23.26	0.1%	24.96	24.98	0.1%
TANF - Enrolled - F - 26 - 39	1,337,097	1,336,535	(0.0%)	31.11	31.14	0.1%	32.83	32.86	0.1%
TANF - Enrolled - F - 40 - 49	410,051	409,879	(0.0%)	26.26	26.27	0.0%	27.98	27.99	0.0%
TANF - Enrolled - F - 50 - 64	108,143	108,098	(0.0%)	19.38	19.43	0.3%	21.10	21.15	0.2%
TANF - Enrolled - F - 65+	680	680	(0.0%)	2.02	2.02	0.0%	3.74	3.74	0.0%
TANF - Enrolled - M - 0 - 5	1,638,419	1,637,730	(0.0%)	33.60	33.64	0.1%	35.32	35.36	0.1%
TANF - Enrolled - M - 6 - 18	2,827,442	2,826,253	(0.0%)	38.75	38.77	0.1%	40.47	40.49	0.0%
TANF - Enrolled - M - 19 - 20	31,343	31,330	(0.0%)	20.40	20.42	0.1%	22.12	22.14	0.1%
TANF - Enrolled - M - 21 - 25	34,503	34,488	(0.0%)	20.20	20.21	0.0%	21.92	21.93	0.0%
TANF - Enrolled - M - 26 - 39	314,296	314,164	(0.0%)	25.53	25.52	(0.0%)	27.25	27.24	(0.0%)
TANF - Enrolled - M - 40 - 49	178,061	177,986	(0.0%)	18.94	18.94	0.0%	20.66	20.66	0.0%
TANF - Enrolled - M - 50 - 64	82,272	82,237	(0.0%)	13.36	13.35	(0.1%)	15.08	15.07	(0.1%)
TANF - Enrolled - M - 65+	736	736	(0.0%)	6.49	6.50	0.2%	8.21	8.22	0.1%
Subtotal TANF - Enrolled	**11,832,253**	**11,827,278**	**(0.0%)**	**$ 28.86**	**$ 28.88**	**0.1%**	**$ 30.58**	**$ 30.60**	**0.1%**
TANF - Unenrolled									
TANF - Unenrolled - F - 0 - 5	314,156	309,312	(1.5%)	$ 6.62	$ 6.72	1.5%	$ 8.16	$ 8.26	1.2%
TANF - Unenrolled - F - 6 - 18	633,218	623,454	(1.5%)	19.60	19.94	1.7%	21.14	21.48	1.6%
TANF - Unenrolled - F - 19 - 20	38,068	37,481	(1.5%)	9.58	9.72	1.5%	11.12	11.26	1.3%
TANF - Unenrolled - F - 21 - 25	147,806	145,527	(1.5%)	10.94	11.05	1.0%	12.48	12.59	0.9%
TANF - Unenrolled - F - 26 - 39	285,492	281,090	(1.5%)	19.10	19.45	1.8%	20.64	20.99	1.7%
TANF - Unenrolled - F - 40 - 49	85,086	83,774	(1.5%)	21.03	21.35	1.5%	22.57	22.89	1.4%
TANF - Unenrolled - F - 50 - 64	26,714	26,302	(1.5%)	17.90	18.19	1.6%	19.44	19.73	1.5%
TANF - Unenrolled - F - 65+	2,918	2,873	(1.5%)	5.23	5.35	2.3%	6.77	6.89	1.8%
TANF - Unenrolled - M - 0 - 5	330,576	325,478	(1.5%)	16.41	16.65	1.5%	17.95	18.19	1.3%
TANF - Unenrolled - M - 6 - 18	635,357	625,560	(1.5%)	28.68	29.11	1.5%	30.22	30.65	1.4%
TANF - Unenrolled - M - 19 - 20	7,755	7,635	(1.5%)	16.72	16.97	1.5%	18.26	18.51	1.4%
TANF - Unenrolled - M - 21 - 25	15,565	15,325	(1.5%)	17.03	17.33	1.8%	18.57	18.87	1.6%
TANF - Unenrolled - M - 26 - 39	84,123	82,826	(1.5%)	18.42	18.70	1.5%	19.96	20.24	1.4%
TANF - Unenrolled - M - 40 - 49	44,240	43,558	(1.5%)	16.91	17.18	1.6%	18.45	18.72	1.5%
TANF - Unenrolled - M - 50 - 64	27,026	26,609	(1.5%)	12.45	12.62	1.4%	13.99	14.16	1.2%
TANF - Unenrolled - M - 65+	3,472	3,418	(1.5%)	4.06	4.11	1.2%	5.60	5.65	0.9%
Subtotal TANF - Unenrolled	**2,681,572**	**2,640,221**	**(1.5%)**	**$ 18.98**	**$ 19.28**	**1.6%**	**$ 20.52**	**$ 20.82**	**1.5%**
HSW									
HSW - Other	1,366	1,360	(0.4%)	$ 2,616.78	$ 2,628.63	0.5%	$ 2,616.78	$ 2,628.63	0.5%
HSW - PRFFH	19,922	19,833	(0.4%)	3,430.17	3,445.45	0.4%	3,430.17	3,445.45	0.4%
HSW - PRSNFSIP	24,006	23,899	(0.4%)	6,821.47	6,851.93	0.4%	6,821.47	6,851.93	0.4%
HSW - Specialized Residential	46,348	46,142	(0.4%)	4,808.44	4,829.98	0.4%	4,808.44	4,829.98	0.4%
Subtotal HSW	**91,642**	**91,234**	**(0.4%)**	**$ 5,003.47**	**$ 5,025.84**	**0.4%**	**$ 5,003.47**	**$ 5,025.84**	**0.4%**
CWP	**4,761**	**4,682**	**(1.7%)**	**$ 3,629.94**	**$ 3,691.19**	**1.7%**	**$ 3,629.94**	**$ 3,691.19**	**1.7%**
SED	**5,087**	**5,057**	**(0.6%)**	**$ 2,199.12**	**$ 2,212.16**	**0.6%**	**$ 2,199.12**	**$ 2,212.16**	**0.6%**
Total	**28,741,941**	**28,291,501**	**(1.6%)**	**$ 109.83**	**$ 111.68**	**1.7%**	**$ 113.65**	**$ 115.57**	**1.7%**

Added to Section 18. Assurances:

18.1.15 Electronic Visit Verification (EVV)

The PIHP will ensure that its contracts, or those of their CMHSP participants, for personal care services demonstrate compliance with federal requirements regarding the use of electronic visit verification (EVV) in tandem with the MDHHS implementation timeline. For the terms of this contract, personal care services impacted include community living support and respite services in a person's home, in a non-licensed setting. PIHPs and/or their CMHSP participants must require compliance in the form of either the existence of a EVV system that meets state requirements as confirmed by a PIHP on-site review or participation in the MDHHS-sponsored statewide EVV system. The PIHP will make evidence of compliance available to the State upon request. The PIHP and/or their CMHSP Participant contracts must stipulate that the EVV system support self-directed arrangements and should be minimally burdensome or disruptive to care. See attachment 7.7.1.1 PIHP Reporting Requirements for additional details. Attachment 7.7.1.1 PIHP Reporting Requirements will include additional details when available.

6.3.1 Recipient Rights/Grievance and Appeals

The PIHP shall adhere to the requirements stated in the MDHHS Grievance and Appeal Technical Requirement, which is an attachment to this contract (Attachment P 6.3.1.1) in addition to provisions specified in 42 CFR 438.100.

Individuals enrolled in Medicaid, Healthy Michigan and the Flint 1115 Waiver must be informed of their right to if dissatisfaction is expressed at any point during the rendering of state plan services. PIHPs must offer a local appeal process to resolve the dispute. The local process must be completed or deemed exhausted due to notice or timing requirements not being met before the MDHHS administrative hearing process is requested. The PIHP shall follow fair hearing guidelines and protocols issued by the MDHHS.

The PIHP has no responsibility to conduct oversight activity with regards to the Office of Recipient Rights (ORR) operated by CMHSPs in the PIHP's provider network. Recipient rights requirements for SUD services are specified in 2(d).

The PIHP must assure that all PIHP employees receive annual training in recipient rights protection. The PIHP will forward any recipient rights complaints filed against a PIHP employee to MDHHS-ORR for review and possible investigation.

The PIHP must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider need not be in writing.

The PIHP must maintain records of grievances and appeals.

8.4.2.1 Performance Bonus Incentive Pool

A. Withhold and Metrics

Contract withholds and the Performance Bonus Incentive Program have been established to support program initiatives as specified in the MDHHS Medicaid Quality Strategy. Pursuant to Sec. 105d(18) of PA 107 of 2013, the Department shall withhold 0.75% of payments to specialty prepaid health plans for the purpose of establishing a performance bonus incentive pool (hereafter referred to as "PBIP"). Distribution of funds from the PBIP is contingent on the PIHP's results on the joint metrics detailed in section 8.4.2.1.1, the narrative report detailed in section 8.4.2.1.2, and the PIHP-only metrics detailed in section 8.4.2.1.3.

B. Assessment and Distribution

PBIP funding awarded to the PIHPs shall be treated as restricted local funding. Restricted local funding must be utilized for the benefit of the public behavioral health system.

The 0.75% PBIP withhold shall be distributed as follows:

a. MHP/PIHP Joint Metrics (Section 8.4.2.1.1): 50%
b. PIHP Narrative Reports (Section 8.4.2.1.2): 40%
c. PIHP-only Pay for Performance Measure(s) (Section 8.4.2.1.3): 10%
d. MDHHS will distribute earned funds by April 30, 2020.

8.4.2.1.1 Performance Bonus Joint Metrics for the Integration of Behavioral Health and Physical Health Services (50% of withhold)

To ensure collaboration and integration between Medicaid Health Plans (MHPs) and Pre-paid Inpatient Health Plans (PIHPs), MDHHS has developed the following joint expectations for both entities. There are 100 points possible for this initiative. The reporting process for these metrics is identified in the grid below. Care coordination activities are to be conducted in accordance with applicable state and federal privacy rules.

Category	Description	Criteria/Deliverables
J.1. Implementation of Joint Care Management Processes (35 points)	Collaboration between entities for the ongoing coordination and integration of services	Each MHP and PIHP will continue to document joint care plans in CC360 for members with appropriate severity/risk who have been identified as receiving services from both entities. The risk stratification criteria is determined in writing by the PIHP-MHP Collaboration Workgroup in consultation with MDHHS. MDHHS will quarterly select beneficiaries randomly and review their care plans within CC360. Measurement period October 1, 2019 through September 30, 2020.

		Collaboration Workgroup in consultation with MDHHS. MDHHS will quarterly select beneficiaries randomly and review their care plans within CC360. Measurement period will be October 1, 2019-September 30, 2020.
2. Follow-up After Hospitalization for Mental Illness within 30 Days (FUH) (50 points)	The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with mental health practitioner within 30 Days.	Plans will meet set standards for follow-up within 30 Days for each rate (ages 6-20 and ages 21 and older). Plans will be measured against an adult minimum standard of 58% and a child minimum standard of 70%. See MDHHS BHDDA reporting requirement website for measure specifications, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html Measurement period will be July 1, 2019-June 30, 2020. The points will be awarded based on MHP/PIHP combination performance measure rates. The total potential points will be the same regardless of the number of MHP/PIHP combinations for a given entity.
3. Plan All-cause Readmission (PCR) (10 points)	For members 18 years of age or older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	This measure will be **informational only.** Data validation period will be July 1, 2019—June 30, 2020. Plans will be expected to review and validate data. By June 30, 2020, submit a narrative report (up to four pages) on findings of efforts to review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues (as needed). See MDHHS BHDDA reporting requirement website for measure specifications, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
4. Follow-Up After Emergency Department Visit for Alcohol and Other Drug	Members 13 years and older with an Emergency Department (ED) visit for alcohol and other drug dependence that	This measure will be **informational only.** Data validation period will be July 1, 2019 - June 30, 2020.

Dependence (FUA) (5 points)	had a follow-up visit within 30 days.	Plans will be expected to review and validate data. By June 30, 2020, submit a narrative report (up to four pages) on findings of efforts to review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues (as needed). Analysis should include disparities among racial and ethnic minorities. See MDHHS BHDDA reporting requirement website for measure specifications, at https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

Included in FY 20 Contract Boiler Plate Language:

6.3.2 Information Requirements

A. Informative materials intended to be distributed through written or other media to beneficiaries or the broader community that describe the availability of covered services and supports and how to access those supports and services, including but not limited to provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, shall meet the following standards:

1. All such materials shall be written at the 4th grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 4th grade level criteria).
2. The provider directory must be made available in paper form upon request and in an electronic form that can be electronically retained and printed. It must also be made available in a prominent and readily accessible location on the PIHP's website, in a machine-readable file and format. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PIHP receives updated provider information.
3. All materials shall be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language that is spoken as the primary language by more than 5% of the population in the PIHPs Region. Such materials shall be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2002 Federal Register Vol. 65, August 16, 2002). All such materials shall be available in alternative formats in accordance with the Americans with Disabilities Act (ADA), at no cost to the beneficiary. Beneficiaries shall be informed of how to access the alternative formats.
4. If the PIHP provides information electronically, it must inform the customer that the information is available in paper form without charge and upon request and provides it upon request within 5 business days.
5. Material shall not contain false, confusing, and/or misleading information.
6. For consistency in the information provided to enrollees, the PIHP must use the State developed Definitions for managed care terminology, including appeal, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, physician services, prescription drug coverage, prescription drugs, primary care provider, rehabilitation services and devices, skilled nursing care, specialist, co-payment excluded services, health insurance, medically necessary, network, non-participating, plan preauthorization, participating provider, premium, provider and urgent care, as defined in the PIHP contract and/or Medicaid provider manual.

B. Additional Information Requirements

1. The PIHP shall ensure that beneficiaries are notified that oral interpretation is available for any language, written information is available in prevalent languages, and auxiliary aids and services are available upon request at no cost, and how to access those services.

as referenced in **42 CFR Parts 438.10(d)(3) and 438.10(d)(4).** The PIHP shall also ensure that beneficiaries are notified how to access alternative formats as defined in **42 CFR 438.10(d)(6)(iv).**

2. All written materials for potential enrollees must include taglines in the prevalent non-English languages in the PIHP region, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by § 438.71(a) and as defined in **42 CFR Parts 438.10 (d)(3) and 431.10(d)(4).** In accordance with **42 CFR Parts 438.10(d)(3); 438.10(d)(6) and 438.10(d)(6)(iv**), large print means printed in a font size no smaller than 18 point.

a. The PIHP must provide the following information to all beneficiaries who receive specialty supports and services:

i. A listing of contracted providers that identifies provider name as well as any group affiliation, locations, telephone numbers, web site URL (as appropriate), specialty (as appropriate), the provider's cultural capability, any non-English languages spoken, if the provider's office /facility has accommodations for people with physical disabilities, and whether they are accepting new beneficiaries. This includes any restrictions on the beneficiary's freedom of choice among network providers. The listing would be available in the format that is preferable to the beneficiary: written paper copy or on-line. The listing must be kept current and offered to each beneficiary annually.

ii. Their rights and protections, as specified in "Grievance and Appeal Technical Requirement PIHP Grievance and Appeal System for Medicaid Beneficiaries."

iii. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.

iv. Procedures for obtaining benefits, including authorization requirements.

v. The extent to which, and how, beneficiaries may obtain benefits and the extent to which, and how, after-hours crisis services are provided.

vi. Annually (e.g., at the time of person-centered planning) provide to the beneficiary the estimated annual cost to the PIHP of each covered support and service he/she is receiving. Technical Advisory P 6.3.2.1.B.i provides principles and guidance for transmission of this information.

vii. The Contractor is required to provide Explanation of Benefits (EOBs) to 5% of the consumers receiving services. The EOB distribution must comply with all State and Federal regulations regarding release of information as directed by MDHHS. MDHHS will monitor EOB distribution annually. A

model Explanation of Benefits consistent with Technical Requirement P 6.3.2.1.B.ii is attached to this contract. A PIHP may but is not required to utilize the model template.

b. The PIHP must give each beneficiary written notice of a significant change in its applicable provider network including the addition of new providers and planned termination of existing providers.

c. The PIHP will make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider as defined in **42 CFR 438.10 (f)(1).**

d. The PIHP will provide information to beneficiaries about managed care and care coordination responsibilities of the PIHP, including:

   i. Information on the structure and operation of the MCO or PIHP;
   ii. Upon request physician incentive plans in use by the PIHP or network providers as set forth in 42 CFR 438.6(h).
   iii. The PIHP must provide information on how to contact their designated person or entity for coordination of services as referenced in **42 CFR 438.208(b)(l).**

Included in FY 20 Contract Boiler Plate Language:

7.0 PROVIDER NETWORK SERVICES

The PIHP is responsible for maintaining and continually evaluating an effective provider network adequate to fulfill the obligations of this contract. The PIHP remains the accountable party for the Medicaid beneficiaries in its service area, regardless of the functions it has delegated to its provider networks.

In this regard and **in compliance with 42 CFR Parts 438.414; 438.10(g)(2)(xi)(C)(D)(E) and 457.1260,** the PIHP agrees to:

1. Maintain a regular means of communicating and providing information on changes in policies and procedures to its providers. This may include guidelines for answering written correspondence to providers, offering provider-dedicated phone lines, and a regular provider newsletter.
2. Have clearly written mechanisms to address provider grievances and complaints, and an appeal system to resolve disputes.
3. Provide a copy of the PIHP's prior authorization policies to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to prior authorization policies as changes are made.
4. Provide a copy of the PIHP's grievance, appeal and fair hearing procedures and timeframes to the provider when the provider joins the PIHP's provider network. The PIHP must notify providers of any changes to those procedures or timeframes. Please see attachment P6.3.1.1 GA

Technical Requirement for Grievance & Appeal timeframes and State Fair Hearing process for further detail.
5. Provide to MDHHS in the format specified by MDHHS, provider agency information profiles that contain a complete listing and description of the provider network available to recipients in the service area.
6. Assure that services are accessible, taking into account travel time, availability of public transportation, and other factors that may determine accessibility.
7. Assure that network providers do not segregate PIHP individuals in any way from other people receiving their services.

In addition, the PIHP agrees upon request from MDHHS either through an RFP or other means to:

1. Provide documentation on which the state bases its certification that the MCP complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network as referenced in **42 CFR Parts 438.604(a)(5); 438.606; 438.207(b) and 438.206.**
2. Submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the state or Secretary as referenced in **42 CFR Parts 438.604(b) and 438.606.**

Included in FY 20 Contract Boiler Plate Language:

18.2 Special Waiver Provisions for MSSSP
Effective October 1, 2019 and under approval granted by the Centers for Medicare and Medicaid Services (CMS), MDHHS will be operating an 1115 Demonstration waiver, a 1915 (i) waiver (formerly (b)(3) services), and the 1915 (c) waivers.

Section 1557 of PPACA
Patient Protection and Affordable Care Act. This includes section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of section 1903(r)(1)(F) of the Act and as defined in **42 CFR 438.242(b)(l).**

4.4 Person Centered Planning

The Michigan Mental Health Code establishes the right for all individuals to have an Individual Plan of Service (IPS) developed through a person-centered planning process (Section 712, added 1996). The PIHP shall implement person-centered planning in accordance with the MDHHS Person-Centered Planning Practice Guideline (Attachment P 4.4.1.1). In accordance with **42 CFR 438.208(b)(2)(i)**, the Person-Centered Planning process will include coordination of services between settings of care which includes appropriate discharge planning for short and long-term hospitalizations. This provision is not a requirement of Substance Abuse Services.

Attachment P6.3.1-Customer Services Standards: **Under Template #3-Emergency and After-Hours Access to Services:**

A "behavioral health emergency" is when a person is experiencing symptoms and behaviors that can reasonably be expected in the near future to lead him/her to harm self or another; or because of his/her inability to meet his/her basic needs he/she is at risk of harm; or the person's judgment is so impaired that he or she is unable to understand the need for treatment and that their condition is expected to result in harm to him/herself or another individual in the near future. You have the right to choose any hospital or other setting to receive emergency services at any time, 24-hours a day, seven days a week, without prior authorization for payment of care as referenced in **42 CFR 438.10(g)(2)(v).**

Technical correction to be included with Amendment #3

7.9.3 MDHHS Standard Consent Form

It is the intent of the parties to promote broader sharing of behavioral health records, including mental health records for the purposes of payment, treatment, and coordination of care in accordance with Public Act 559 of 2016, and substance use disorder records via electronic health information exchange environments pursuant to 42 CFR Part 2. To accomplish these ends, the parties shall use and accept the standard release form that was created by MDHHS under Public Act 129 of 2014. Accordingly, the PIHPs have the opportunity to (1) participate in the Department's annual review of the MDHHS-5515 and the related guidance; and (2) submit comments to the Department regarding challenges and successes with using MDHHS-5515.

For all electronic and non-electronic Health Information Exchange environments, the PIHP shall implement a written policy that requires the PIHP and its provider network to use, accept, and honor the standard release form that was created by MDHHS under Public Act 129 of 2014. The PIHP shall ensure its policies, procedures, forms, legal agreements, and applicable training materials are updated in accordance with Public Act 559 of 2016. This policy will recognize that under Public Act 559 of 2016, written consent is not needed in all situations.

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FY 2020 MDHHS/PIHP MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT

REPORTING REQUIREMENTS

Introduction

The Michigan Department of Health and Human Services reporting requirements for the FY2020 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

PIHP REPORTING REQUIREMENTS

MDHHS including:

- 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, instructions and other reporting resources 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 Frequency**	**Report Period and Submittal Instructions**
10/1/2019	SUD Budget Report	Projection/Initial	October 1 to September 30
12/3/2019	Risk Management Strategy	Annually	To cover the current fiscal year
12/31/2019	Medicaid Services Verification Report	Annually	October 1 to September 30
4/16/2020	SUD – Women's Specialty Services (WSS) Mid-Year Expenditure Status Report	Mid-Year	October 1 to March 31
5/15/2020	Program Integrity Activities	Quarterly	January 1 to March 31 using OIG's case tracking system
5/31/2020	Mid-Year Status Report	Mid-Year	October 1 to March 31
5/31/2020	Medicaid Unit Net Cost Report (MUNC)	Four month report Oct to Jan	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
6/01/2020	SUD – Notice of Excess or Insufficient Funds	Projection	October 1 to September 30
8/15/2020	Program Integrity Activities	Quarterly	April 1 to June 30 using OIG's case tracking system
8/15/2020	SUD – Charitable Choice Report	Annually	October 1 to September 30

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8/15/2020	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Projection (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid – Shared Risk Calculation & Risk Financing	Projection (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid – Internal Service Fund	Projection (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid Contract Settlement Worksheet	Projection (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid Contract Reconciliation & Cash Settlement	Projection (Use tab in FSR Bundle)	October 1 to September 30
9/30/2020	• Medicaid Unit Net Cost Report (MUNC)	Eight Month October to May	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
10/1/2020	• Medicaid YEC Accrual	Final	October 1 to September 30
10/1/2020	• SUD YEC Accrual	Final	October 1 to September 30
10/1/2020	• SUD Budget Report	Projection	October 1 to September 30
11/10/2020	PIHP Medicaid FSR Bundle MA, HMP, Autism & SUD	Interim (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid – Shared Risk Calculation & Risk Financing	Interim (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid – Internal Service Fund	Interim (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid Contract Settlement Worksheet	Interim (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid Contract Reconciliation & Cash Settlement	Interim (Use tab in FSR Bundle)	October 1 to September 30
11/15/2020	Program Integrity Activities	Quarterly	July 1 to September 30 using OIG's case tracking system
12/31/2020	Medicaid Services Verification Report	Annually	October 1 to September 30
2/15/2021	• Program Integrity Activities	Quarterly	October 1 to December 31 using OIG's case tracking system
2/21/2021	• Direct Care Wage Attestation Form	Annually	For fiscal year ending 9/30/2020
2/28/2021	• SUD – Primary Prevention Expenditures by Strategy Report	Annually	October 1to September 30
2/28/2021	• SUD Budget Report	Final	October 1 to September 30
2/28/2021	SUD – Legislative Report/Section 408	Annually	October 1 to September 30
2/28/2021	SUD – Special Project Report: (Applies only to PIHP's with earmarked allocations for Flint Odyssey House Sacred Heart Rehab Center Saginaw Odyssey House)	Annually	October 1 to September 30

PIHP REPORTING REQUIREMENTS

2/28/2021	PIHP Medicaid FSR Bundle – MA. HMP, Autism & SUD	Final (Use tab in FSR Bundle)	October 1 to September 30
	Shared Risk Calculation & Risk Financing	Final (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid – Internal Service Fund	Final (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid Contract Settlement Worksheet	Final (Use tab in FSR Bundle)	October 1 to September 30
	Medicaid Contract Reconciliation & Cash Settlement	Final (Use tab in FSR Bundle)	October 1 to September 30
2/28/2021	Medicaid Unit Net Cost Report (MUNC)	October to September	See Attachment P 7.7.1.1. Submit report to: QMPMeasures@michigan.gov
2/28/2021	PIHP Executive Administrative Expenditures Survey for Sec. 904(2)(k)	Annually	October 1 to September 30
2/28/2021	Medical Loss Ratio	Annually	October 1 to September 30
2/28/2021	Attestation to accuracy, completeness, and truthfulness of claims and payment data	Annually	For the fiscal year ending 9/30/2020 Submit report to: QMPMeasures@michigan.gov
3/31/2021	• SUD - Maintenance of Effort (MOE) Report	Annually	October 1 to September 30
6/30/2021	• SUD – Audit Report	Annually	October 1 to September 30 (Due 9 months after close of fiscal year)
30 Days after submission	• Annual Audit Report, Management Letter, and CMHSP Response to the Management Letter.	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov
30 Days after submission	Compliance exam and plan of correction	Annually	October 1 to September 30 Submit reports to: MDHHSAuditReports@michigan.gov

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**
1/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 1Q Narrative Report*	October 1 to December 31. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
1/31/2020	Children Referral Report	October 1 to December 31

PIHP REPORTING REQUIREMENTS

1/31/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 to December 31
1/31/2020	Veteran Services Navigator (VSN) Data Collection form	October 1 to December 31 Submit through: DCH-File Transfer
3/13/2020	SUD Master Retail List	October 1 to September 30
03/31/2020	Performance Indicators	October 1 to December 31, 2019 Submit to: QMPMeasures@michigan.gov
4/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 2Q Narrative Report*	January 1 to March 31 Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
4/30/2020	Children Referral Report	January 1 to March 31
4/30/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	January 1 to March 31
4/30/2020	Veteran Services Navigator (VSN) Data Collection form	January 1 to March 31 Submit through: DCH-File Transfer
4/30/2020	Sentinel Events Data Report	October 1 to March 31
06/1/2020	Narrative report on findings and any actions taken to improve data quality on BHTEDS military and veterans fields.	October 1 to March 31, 2020 Submit through: DCH-File Transfer
06/30/2020	Performance Indicators	January 1 to March 31, 2020 Submit to: QMPMeasures@michigan.gov
06/30/2020	SUD – Tobacco/ Formal Synar Inspection period	June 1-June 30 (To be reported in Youth Access to Tobacco Compliance Check Report)
7/15/2020	Compliance Check Report (CCR)	Submit to: MDHHS-BHDDA-Contracts-MGMT@michigan.gov with cc to: ohs@michigan.gov and ColemanL7@michigan.gov
7/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 3Q Narrative Report*	April 1 to June 30. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
7/31/2020	Children Referral Report	April 1 to June 30
7/31/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	April 1 to June 30
7/31/2020	Veteran Services Navigator (VSN) Data Collection form	April 1 to June 30 Submit through: DCH-File Transfer
7/31/2020	Increased data sharing with other providers/ ADT Narrative	October 1 to June 30 Submit through: DCH-File Transfer

PIHP REPORTING REQUIREMENTS

09/30/2020	Performance Indicators	April 1 to June 30, 2020 Submit to: QMPMeasures@michigan.gov
10/15/2020	Michigan Gambling Disorder Prevention Project (MGDPP) 4Q Narrative Report*	July 1 to September 30. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
10/31/2020	Children Referral Report	July 1 to September 30
10/31/2020	SUD – Injecting Drug Users 90% Capacity Treatment Report	July 1 to September 30
10/31/2020	SUD – Youth Access to Tobacco Activity Annual Report	October 1 to September 30
10/31/2020	Veteran Services Navigator (VSN) Data Collection form	October 1 to September 30 Submit through: DCH-File Transfer
10/31/2020	Sentinel Events Data Report	April 1 to September 30
TBD	SUD – Synar Coverage Study Canvassing Forms	Regions participating and Study Period TBD (August 2020)
11/15/2020	Performance Bonus Incentive Narrative on "Increased participation in patient-centered medical homes characteristics".	October 1 to September 30
11/30/2020	SUD – Communicable Disease (CD) Provider Information Report (Must submit only if PIHP funds CD services)	October 1 to September 30
11/30/2020	Women Specialty Services (WSS) Report	October 1 to September 30
12/31/2020	Performance Indicators	July 1 to September 30, 2020 Submit to: QMPMeasures@michigan.gov
Quarterly	SUD – Injecting Drug Users 90% Capacity Treatment Report	October 1 – September 30 Due last day of month, following the last month of the quarter.
Quarterly	Children Referral Report	October 1 – September 30 Due last day of month, following the last month of the quarter.
Monthly	SUD - Priority Populations Waiting List Deficiencies Report	October 1 – September 30 Due last day of month following month in which exception occurred. Must submit even if no data to report
Monthly	SUD – Behavioral Health Treatment Episode Data Set (BH-TEDS)	October 1 to September 30 Due last day of each month. Submit via DEG at : https://milogintp.michigan.gov.

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		See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	SUD - Michigan Prevention Data System (MPDS)	October 1 to September 30 Due last day of each month, following month in which data was uploaded. Submit to: https://mpds.sudpds.com
Monthly (minimum 12 submissions per year)	SUD - Encounter Reporting via HIPPA 837 Standard Transactions	October 1 to September 30 Submit via DEG at: https://milogintp.michigan.gov. See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly*	Consumer level* Quality Improvement Encounter	October 1 to September 30 See resources at: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html
Monthly	Critical Incidents	Submit to PIHP Incident Warehouse at: https://mipihpwarehouse.org/MVC/Documentation
Monthly*	Michigan Gambling Disorder Prevention Project (MGDPP) Monthly Training Schedule*	Due on the 15th of every month which includes Gambling Disorder (GD) training dates and activities. Send to MDHHS-BHDDA-Contracts-MGMT@michigan.gov and a copy to LucasA3@michigan.gov.
Annually	SUD - Communicable Disease (CD) Provider Information Plan (Must submit only if PIHP funds CD services)	October 1 to September 30 Same due date as Annual Plan.

*Reports required for those PIHPs participating in optional programs

*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: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html

Reporting covered by these specifications includes the following:

PIHP REPORTING REQUIREMENTS

-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.

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.

PIHP REPORTING REQUIREMENTS

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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

PIHP REPORTING REQUIREMENTS

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

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: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

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

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- 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 MDHHS Quality 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 EPSDT; 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). If the Billing Provider is a specialized licensed residential facility also report the LARA license facility number (See Instructions for Reporting Specialized Residential Facility Details 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. **Facility Location of the Specialized Residential Facility**
In instances in which the specialized licensed residential facility is not the Billing

Provider, report the name, address, NPI (if applicable) and LARA license of the facility in the Facility Location (2310C loop). (See Instructions for Reporting Specialized Residential Facility Details at www.michigan.gov/mdhhs/bhdda. Click on Reporting Requirements)

****19. 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 2019. The first production analyses will be run in December 2019.

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,. 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 1115, 1915(i) Waiver 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 http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868---,00.html. Click on Behavioral Health and Substance Abuse, then Reporting Requirements. This report is due twice a year. One for the first six months of the fiscal year which will be due August 31st of the fiscal year a full year report due on February 28th following the end of the fiscal year. Templates for these reports will be made available at least 60 days prior to the due date.

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(i)(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: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html .

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. a. Effective on and after January 1, 2020, the percentage of new persons during the quarter receiving a completed biopsychosocical assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.

2 b. Effective on and after January 1, 2020, the percentage of new persons during the quarter receiving a face-to-face service for treatment or supports within 14 calendar days of a non-emergency request for service for persons with Substance Use Disorders.

3. Effective on and after January 1, 2020, percentage of new persons during the quarter starting any needed on-going service within 14 days of completing a non-emergent biopsychosocial assessment (by four sub-populations**:** MI-adults, MI-children, IDD-adults, and IDD-children).

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 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

**Due to FY 20 Performance Indicator Specification changed by MDHHS on indicators 2, 2b, and 3, data collection for these indicators will not begin on April 16, 2020. Reporting schedules/timelines for all other indicators and quarters will remain the same and reflect the schedule above. Applicable data collection systems/processes should be ready to report the identified indicator specification changes by April 16, 2020.

STATE LEVEL DATA COLLECTION

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.
- **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 https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html.

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 within five (5) business days to contract management staff members in MDHHS's Behavioral Health and Developmental Disabilities Administration (email: MDHHS-BHDDA-Contracts-MGMT@michigan.gov; FAX: (517) 335-5376; or phone: (517) 241-2139)

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.