MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Behavioral Health and Developmental Disabilities Administration

PIHP REPORTING REQUIREMENTS
FOR
MEDICAID SPECIALTY SUPPORTS AND SERVICES BENEFICIARIES

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FY 2021 MDHHS/PIHP
MANAGED SPECIALTY SUPPORTS AND SERVICES CONTRACT

REPORTING REQUIREMENTS

Introduction

The Michigan Department of Health and Human Services (MDHHS) reporting requirements for the FY2021 Medicaid Specialty Supports and Services Contract with the Prepaid Inpatient Health Plans (PIHPs) are contained in this document. The requirements include the data definitions and dates for submission of reports on Medicaid beneficiaries for whom the PIHP is responsible: individuals with mental illness and developmental disabilities (DD) served by mental health programs and individuals with substance use disorders (SUD) served by the mental health programs or SUD programs. These requirements do not cover Medicaid beneficiaries who receive their mental health benefit through the Medicaid Health Plans (MHPs), and with whom the Community Mental Health Service Programs (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 document are:

- "Supplemental Instructions for Encounter Data Submissions" which contains clarifications, value ranges, and Encounter Data Integrity Team (EDIT) parameters for the encounter data as well as examples that will assist the PIHP staff in preparing data for submission to the MDHHS.

- The PIHP or the CMHSP Encounter Reporting Healthcare Common Procedure Coding System (HCPCS) and Revenue Codes. This code list contains the Medicaid covered services as well as services that may be paid by general fund and the Common Procedural Technology (CPT) and HCPCS codes that the MDHHS and EDIT have assigned to them. This 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 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 (MMBPIS)" 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 Contract.

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

Collection of each element contained in this document 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 the PIHPs described within these requirements meets several purposes at the 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-level data received at the MDHHS is kept confidential and published reports will display only aggregate data. Only a limited number of the 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 Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules, Health Care Operations.

FINANCIAL PLANNING, REPORTING, AND SETTLEMENT

The PIHP shall provide the financial reports to the MDHHS as listed below. Forms, instructions and other reporting resources are posted to the MDHHS website 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 the table below.

Due Date	Report Title	Report Frequency	Report Period and Submittal Instructions
10/1/2020	SUD Budget Report	Projection/Initial	October 1 to September 30
12/3/2020	Risk Management Strategy	Annually	To cover the current fiscal year

12/31/2020	Medicaid Services Verification Report	Annually	October 1 to September 30
4/16/2021	SUD – Women's Specialty Services (WSS) Mid-Year Expenditure Status Report	Mid-Year	October 1 to March 31
5/15/2021	Program Integrity Activities	Quarterly	January 1 to March 31 using OIG's case tracking system
5/31/2021	Mid-Year Status Report	Mid-Year	October 1 to March 31
5/31/2021	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
6/01/2021	SUD – Notice of Excess or Insufficient Funds	Projection	October 1 to September 30
8/15/2021	Program Integrity Activities	Quarterly	April 1 to June 30 using OIG's case tracking system
8/15/2021	SUD – Charitable Choice Report	Annually	October 1 to September 30
8/15/2021	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
9/30/2021	• 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 the prior fiscal year ending September 30th
2/28/2021	• SUD – Primary Prevention Expenditures by Strategy Report	Annually	October 1 to 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
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 prior fiscal year ending September 30th 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 the 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
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 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 veteran's fields.	October 1 to March 31 Submit through: DCH-File Transfer
06/30/2020	Performance Indicators	January 1 to March 31 Submit to: QMPMeasures@michigan.gov
06/30/2020	SUD – Tobacco/ Formal Synar Inspection period	June 1 to 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
09/30/2020	Performance Indicators	April 1 to June 30 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
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 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. 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 the PIHPs participating in optional programs

*Individual-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 PIHPs 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 the MDHHS MIS via DEG (see above)
2. Send data to the MDHHS, BHDDA, Division of Quality Management and Planning
3. Web-based reporting. See instructions on the MDHHS web site at www.michigan.gov/mdhhs/bhdda and click on 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 the MDHHS website at: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_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 the 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 individuals supported in whole or in part with MDHHS-administered funds.

Policy:
Reporting is required for all individuals 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 the 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 individual begins receiving behavioral health services.

1. Data definitions, coding, and instructions issued by the MDHHS apply as written. Where a conflict or difference exists between the 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 the MDHHS at the program level.

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. The 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 the MDHHS.

6. The PIHP is responsible for generating each month's data upload to the MDHHS consistent with established protocols and procedures. Monthly data uploads must be received by the 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. The 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 the 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 the 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 the MDHHS-administered funding. The PIHPs participating in the Medicare/Medicaid integration project are not to report BH-TEDS records for beneficiaries for whom the PIHPs financial responsibility is to a non-contracted provider during the 180-day continuity of care.

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, BH-TEDS will be replacing them both beginning 10/01/2015. To use BH-TEDS 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, the PIHPs are required to report five fields of data with only three being required. The required fields are the 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 a Medicaid ID and/or a MIChild ID.

The file specifications and error logic for the Registry are available on the MDHHS website 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 10/01/2015.

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	

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 MDHHS 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 the MDHHS benefit plans. The PIHP must report the encounter data for all substance use disorder (SUD) 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. The PIHPs and the 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 the CMHSP that provides the service via a contract should not report the consumer in this data set. Likewise, the PIHPs or the CMHSPs that contract directly with a Medicaid Health Plan (MHP), or sub-contract via another entity that contracts with a MHP 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, 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.

- 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 the MDHHS is requiring for its own monitoring and/or reporting purposes and does not address all aspects of the HIPAA transaction standards with which the 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.

The 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 Association, 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.

The 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 the 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 the 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 the HIPAA 837 transaction implementation guides for exact location of the elements. Please consult the HIPAA implementation guides and clarification documents (on the MDHHS website) 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.

****1a.** ***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.

1b. ***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 the 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 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 the 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 the procedure code from the code list for service/support provided. The code list is located on the MDHHS website. 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 010/1/13):
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 the 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, MHPs populate the DTP field with the date they created the encounter for submission. The MHPs 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, the 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 the 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, the PIHPs will not be discouraged from reporting replacements that require additional time to research or resolve.

The MDHHS 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 the MDHHS management of the 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 (SUD) 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 the 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 website 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 and 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 the MDHHS in the management of the 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 the indicators here are measures of the 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 (MHP), or sub-contracts with entities that contract with MHPs 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 in the "Michigan's Mission-Based Performance Indicator System, Codebook. Electronic templates for reporting will be issued by the 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**

2a. Effective on and after January 1, 2020, the percentage of new individuals during the quarter receiving a completed biopsychosocial assessment within 14 calendar days of a non-emergency request for service (by four sub-populations: MI-adults, MI-children, IDD-adults, IDD-children.

2b. Effective on and after January 1, 2020, the percentage of new individuals 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 (SUD).

3. Effective on and after January 1, 2020, percentage of new individuals during the quarter starting any needed ongoing 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 the PIHPs.

OUTCOMES

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

9. The percent of adult Medicaid beneficiaries with mental illness and the percent of adult Medicaid beneficiaries with DD served by the 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 DD served who live in a private residence alone, with a spouse, or with a non-relative.

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

14. The percent of children with DD (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 SUD 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 the MDHHS collects data from encounters, quality improvement, or cost reports and calculates performance indicators

**Due to FY 20 Performance Indicator Specification changed by the 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

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

EVENT NOTIFICATION

The PIHP shall immediately notify the MDHHS of the following events:

1. Any death that occurs because 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, the PIHPs receipt of notification of the death, or the PIHPs 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 Email 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 the MDHHS 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 the MDHHS within **seven (7) days** of any changes to the composition of the provider network organizations that negatively affect access to care. The PIHPs shall have procedures to address changes in its network that negatively affect access to care. Changes in provider network composition that the MDHHS determines to negatively affect recipient access to covered services may be grounds for sanctions.