MILLIMAN CLIENT REPORT

Behavioral Health Encounter Data Quality Methodology and Instructions – SFY 2020

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I. Background and Executive Summary

Milliman, Inc. (Milliman) has been retained by the State of Michigan, Department of Health and Human Services (MDHHS) to provide actuarial and consulting services related to the Medicaid behavioral health (BH) program. We were requested to assist in the development of encounter and financial monitoring and reconciliation reports. This process will collect financial, eligibility, and encounter information from each of the community mental health service programs (CMHSPs) and prepaid inpatient health plans (PIHPs). The financial information being requested includes revenue (PIHP only), service level utilization and net cost (UNC), non-benefit expenses, and other expenses. The Service UNC tab will reflect internally maintained CMHSP and PIHP data and will facilitate the comparison of data in the encounter data warehouse. The cost information reported in the EQI should reflect total costs attributable to the corresponding programs and populations included within the template. The CMHSP and PIHP reported information should include all Medicaid and non-Medicaid behavioral health services provided by the CMHSPs and other mental health, developmental disabilities, and substance abuse contracted network providers.

The following provide the goals of the behavioral health EQI process.

- to collect high-level information (including but not limited to revenue, membership, and total actual costs) to monitor the managed care program financial status and non-Medicaid expenses
- to provide a comparison of the encounter data to the CMHSP and PIHP reported information so that all stakeholders can identify and address any encounter data quality concerns on an ongoing basis for both the Medicaid managed care and non-managed care populations
- to consolidate and refine several of the historical reporting templates into one comprehensive template
- to streamline processes to enable more frequent and timely reporting

To aid in the validation of encounter data, we will be providing access to reported information via the DRIVE™ Comparison Dashboard for PIHPs who pay a nominal license fee. This Comparison Dashboard is a web-based application that is hosted by Milliman where MDHHS and the PIHPs can access the reports like the excel reports provided for encounter data quality. It provides a dynamic view that allows users to review the PIHP and CMHSP reported information in multiple ways.

Appendix A provides a pre-populated template for each CMHSP and PIHP to summarize and submit their understanding of the Medicaid eligibility and revenue (PIHP only) as well as expenses incurred for providing behavioral health services. The PIHP template is limited to the populations eligible for Michigan's Medicaid behavioral health managed care program and the grant-funded services. The CMHSP template includes the Medicaid behavioral health, non-managed care General Fund, and grant-funded populations and services. The dual CMHSP/PIHP template includes all populations included in either the PIHP or CMHSP templates.

There has been significant discussion about the reporting of SUD Grant and SUD general fund (GF) expenditures in the EQI template. For purposes of SFY 2020, MDHHS is requesting that all entities exclude SUD grant and SUD GF expenditures from the EQI reporting.

Encounters included in the EQI analysis should be limited to those where Medicaid paid all or a portion of the expenditures and should exclude encounters entirely paid by Medicare or other third parties. For individuals enrolled in the MI Health Link program, services entirely paid by Medicare should be submitted to the integrated care organizations (ICOs), who will then report the encounters to MDHHS. Additionally, services provided to individuals with mild-to-moderate behavioral health conditions who are also enrolled in a Medicaid health plan or ICO should not be included on the EQI. These services should be submitted to the Medicaid health plan or ICO, who will then report the encounters to MDHHS.

Appendix A includes the following tabs to collect information for the October 2019 to September 2020 time period using claims paid (adjudicated) as of January 31, 2020 and submitted to MDHHS as of January 31, 2020. Each CMHSP will be responsible for submitting their respective report to MDHHS.

Each regional PIHP will be responsible for providing MDHHS the aggregated report for their PIHP, including the Medicaid expenditures from the CMHSPs in their catchment area. Each CMHSP and PIHP will have their information submitted in a single Excel workbook consistent with the way they received the template.

- Attestation
- Service Code Set
- Eligibility and Revenue (PIHP Only)
- Service UNC
- MHL Medicare Service UNC
- COB Summary
- Non-Benefit Expenses
- Other Expenses
- Spend-Down Summary
- Hazard Pay Summary
- Financial Reconciliation

The Medicaid populations included in the EQI reporting process are consistent with those covered under the Medicaid BH managed care program, including the disabled, aged, and blind (DAB), temporary assistance for needy families (TANF), Healthy Michigan Plan (HMP), 1915(c) habilitation supports waiver (HSW), 1915(c) serious emotional disturbances (SED) waiver, and the 1915(c) children's waiver program (CWP).

Lastly, the CMHSP and dual CMHSP/PIHP templates include a stratification for non-managed care beneficiaries receiving services covered via grants and state general funds

This report contains the instructions to assist the CMHSPs and PIHPs in completing the template with eligibility, revenue, and expense information for the October 1, 2019 to September 30, 2020 (SFY 2020) behavioral health encounter quality initiative (EQI) process. This report also includes the methodology that we will utilize to map eligibility and encounter claims to specific PIHPs, programs, and populations. The encounter data is submitted by each PIHP into MDHHS' data warehouse, which is then provided to Milliman on a monthly basis.

The *Service Code Set* tab in Appendix A provides a listing of each service included in Michigan's mental health code chart, including the description, reporting unit type, category of service, whether it is included in the Medicaid managed care program, and the corresponding Medicaid authority. The *Service Code Set* tab was developed using the PIHP/CMHSP Encounter Reporting Costing per Code and Code Chart on the MDHHS web site[1].

Coordination with the Standard Cost Allocation Workgroup

The EQI template and instructions align with MDHHS long-term goals for CMHSP and PIHP reporting. Concurrently with the SFY 2020 EQI reporting, the Community Mental Health Association of Michigan is sponsoring a Standard Cost Allocation Workgroup, which includes participation from MDHHS and Milliman, to provide further guidance to the field regarding the EQI reporting requirement. It is our understanding that compliance with 42 CFR § 438.8 may be difficult to implement during SFY 2020 until further guidance is provided. One of the goals of this Standard Cost Allocation Workgroup that relates to the SFY 2020 EQI reporting is the following:

Consistently and appropriately allocating administrative costs in compliance with 42 CFR § 438.8 to either CMHSP direct-run service provider administration, contracted network provider administration, or managed care administrative expenses

We anticipate that the CMHSPs and PIHPs will complete the EQI template in SFY 2020 using existing methodologies to allocate administrative costs until further guidance is provided.

[1] https://www.michigan.gov/documents/mdhhs/MHCodeChart_554443_7.pdf

Key template differences across entities

The EQI template generally collects similar information across all entities; however, there are some differences in the reporting template depending on whether the entity is a CMHSP, a regional PIHP, or a dual CMHSP and PIHP. The following provides the key differences in the template across these three entity types:

- Regional PIHP templates are entity-specific, but the only difference is the Service UNC and MHL Medicare Service UNC tabs include a reporting split to capture expenses from all the CMHSPs in their region as well as services contracted through the PIHP and not the CMHSP. The Regional PIHPs should report total costs for the Medicaid behavioral health managed care program.
- CMHSP templates collect expense information for the Medicaid, General Fund, and Grant funded beneficiaries and do not collect revenue or eligibility information.
- The intent is for Medicaid expenditures to be duplicated in the CMHSP and regional PIHP templates as both entities recognize all these costs. General fund and grant expenditures are unique to each entity.
- Dual CMHSP/PIHP templates are consistent with all other CMHSP templates, except that it includes the Eligibility and Revenue tab for the Medicaid managed care program.

II. Master Eligibility File Logic

This section details the methodology for creating a master eligibility file to be used for purposes of data processing, merging with the encounter data, and populating the EQI template. Additionally, guidance is provided for the handling of the merge of eligibility and encounters, particularly, with respect to a member spending down assets and becoming Medicaid eligible.

Program and Population Logic

Most of the tabs included in the template request information to be separated for each program and population. To assign a given individuals eligibility, service utilization, and service cost to a program and population, we would request the CMHSPs and PIHPs use the capitation file (820 data feed) as priority to assign the Medicaid population attributed to your entity. Effective October 1, 2019, MDHHS began making payments for retroactive eligible beneficiaries for up to six months. We anticipate only a small number of individuals to be retroactively Medicaid eligible for a month more than six months following the month of eligibility. We request that the CMHSPs and PIHPs identify these retroactively eligible Medicaid beneficiaries by using the eligibility file (834 data feed). If a beneficiary is not Medicaid eligible using the 820 or 834 files, entities should check the 270/271 to determine if the beneficiary has Medicaid eligibility in another county. Non-managed care general fund and/or grant funded beneficiaries served by the CMHSPs/PIHPs are identified as not having Medicaid eligibility for a given month in the 820, 834, or 270/271 data feeds. If a beneficiary is included in the 820 file, but not the 834 file, we would request that the beneficiary still be included. Figure 1 below provides a list of the behavioral health managed care program codes used to identify the Medicaid program and corresponding populations in the capitation data as well as the qualifying benefit plans used for purposes of the eligibility file.

FIGURE 1: MEDICAID BEHAVIORAL HEALTH MANAGED CARE ENROLLEE IDENTIFICATION

POPULATION / POPULATION GROUP	CAPITATION DATA MANAGED CARE PROGRAM CODE	MEDICAID ELIGIBILITY BENEFIT PLAN
DAB/TANF Enrolled	0006	HAS_BENEFIT_BHMA_MHP
DAB/TANF Unenrolled	0005	HAS_BENEFIT_BHMA
HMP Enrolled	0008	HAS_BENEFIT_BHHMP_MHP
HMP Unenrolled	0007	HAS_BENEFIT_BHHMP
HSW	0045	HAS_BENEFIT_HSW_MC
CWP	0077	HAS_BENEFIT_CWP_MC
SED	0082	HAS_BENEFIT_SED_MC

Figure 2 provides the applicable qualifying eligibility program codes to identify the DAB population separately from the TANF population for purposes of future EQI reporting splits that will be required in SFY 2021.

FIGURE 2: ELIGIBILITY PROGRAM CODE MAPPING

POPULATION	ELIGIBILITY PROGRAM CODES
DAB	A, B, E, M, O, P, Q
TANF	C, F, L, N, T

Although the MI Health Link program enrollees are not separately identified in the EQI for Medicaid only services, this stratification will still be required for purposes of the financial status report (FSR). This identification can be found on the coordination of benefits (COB) loop of the 834 file. Additionally, the spend-down effective date and enrollees in a Medicaid health plan can also be found on the coordination of benefits (COB) loop of the 834 file.

Reference A provides the crosswalk from the county of eligibility to the applicable CMHSP, PIHP, and region. The following provides additional information regarding the identification of individuals.

- Enrollees are attributed to a PIHP based on the health plan id on the capitation data and the behavioral health provider ID from the Medicaid eligibility file. For the HSW population, the PIHP is assigned based on the waiver service authorization (WSA) file, which may reflect a county different from the county of eligibility (i.e. the county of financial responsibility (COFR)). All other populations are attributed based on the county of eligibility. Enrollees are attributed to a CMHSP for purposes of the EQI analysis based on the county of eligibility from the capitation data or Medicaid eligibility file for both waiver and non-waiver individuals.

- The county of financial responsibility (COFR) PIHP is anticipated to continue submitting encounters in SFY 2020 consistent with prior reporting periods. MDHHS is considering changes to this for future time periods to align the PIHP responsibility of submitting encounters and paying claims with the PIHP who is receiving the capitation payment.
- Encounters are assigned to the CMHSP/PIHP that submitted the encounter (identified by the originator plan ID). Encounters submitted by a PIHP for a member with a capitation payment to a different PIHP will be separately identifiable in the EQI reconciliation.

PIHP Identification

In the next section of this report, we have provided instructions for the creation of a master eligibility file to be used in aiding the PIHPs and CMHSPs with populating the EQI Template. Throughout the creation of the master eligibility file, the PIHPs and CMHSPs will be expected to utilize three separate data feeds in order to populate the necessary fields. Figure 3 outlines the data field used by Milliman for identifying PIHP for each of the applicable data feeds.

FIGURE 3: PIHP IDENTIFICATION

DATA FEED	FIELD USED TO IDENTIFY PIHP
820 capitation data feed	CONTRACTOR_ID
834 eligibility data feed	COUNTY (see Reference A for mapping)
270/271 eligibility data feed	N/A

Development of Master Eligibility File

To facilitate the creation of the program and population information on the eligibility and encounter data, we have developed methodology to create a master eligibility file, which is comprised of information from the following three data sources.

1. Capitation file (820 data feed)
2. Eligibility file (834 data feed)
3. Eligibility file (270/271 data feed)

Please note that MDHHS requests that CMHSPs and PIHPs only utilize the 270/271 eligibility file in cases where the CMHSP or PIHP is providing services to individuals that are not Medicaid eligible in a given month (based on the 820 and 834 files) in one of the counties in their geographic catchment area (this would include encounters for COFR individuals as well as other individuals served by CMHSPs outside of the county where the individual lives). Needing to pull the 270/271 eligibility file is only anticipated to be needed for less than 5% of the individuals receiving services. If an individual is not Medicaid eligible in the 820, 834, or the 270/271 files, then they should be covered by the General Fund or Grants.

The following outlines the detailed instructions that should be used to create the master eligibility file for purposes of EQI reporting. The master eligibility file should be created by the PIHP only, and then shared with each CMHSP in their catchment area. CMHSPs should start with step 10, using the master eligibility file created by the PIHP.

1. Within the capitation file, condense a member's payments into a single record per month
    a. Have fields designating non-waiver/waiver payments and revenue separately
    b. Non-waiver payments should include mental health state plan, mental health 1915(i), autism, and substance use disorder state plan payments.
    c. There should not be more than one 1915(c) Waiver payment, so we have only included one revenue column for those payments as well, with flags to indicate which Waiver the revenue is attributable to.
    d. Capitation file should now be unique by MemberID and month
2. Create a unique listing of Member ID and incurred month for those who received a service (based on the from date of the claim). Merge this list of Member ID and incurred month against the 820 and 834 eligibility files to determine which member/month combinations have no corresponding Medicaid eligibility. Pull the 270/271 eligibility file for this list of Member IDs and incurred months where the beneficiary does not have Medicaid eligibility (i.e. is not identified in the PIHPs 820 and 834 files).

3. Assign program and population in capitation and eligibility (834 and 270/271) files based on codes noted in the previous section. Possible population values for the BH Managed Care program include DAB/TANF or HMP. If the eligibility file does not have an applicable BH Managed Care program and population, the program should be assigned to Non-Managed Care and the population should be set to General Fund.
    a. In the eligibility file, one record per member per month will contain the non-waiver population in the population field, with Yes/No columns for each of the three 1915(c) waivers
4. Assign CMHSP and PIHP for non-waiver and waiver payments based on the 820, 834, and 270/271.
5. Assign Spend-down eligibility indicator (Yes/No) using the 834 or 270/271.
    a. Milliman uses the field "HAS_BENEFIT_SPENDDOWN".
    b. This will allow entities to identify GF dollars prior to spend-down for individuals that do not meet spend-down during the month.
6. Add columns for each member month to identify MI Health Link eligibility (enter the health plan or leave blank), Medicaid health plan eligibility (enter the health plan or leave blank), and the effective spend-down date (enter the date, or leave blank) using the COB loop of the 834 file
7. Perform a full merge of the capitation and eligibility file by MemberID and month further grouping each member month into one of the following categories:
    a. Medicaid eligible with capitation payment
        i. Members with a capitation payment that aren't in the underlying eligibility file should be considered eligible
    b. Medicaid eligible without capitation payment
8. The merged file should still retain one record per member per month. The result of step 6 should include a culmination of the following fields:
    - Eligibility fields
        - MemberID
        - Incurred Month
        - Program (eligibility based)
        - Population (eligibility based)
        - CWP 1915(c) eligibility (Yes/No)
        - HSW 1915(c) eligibility (Yes/No)
        - SED 1915(c) eligibility (Yes/No)
        - Eligibility PIHP
        - Eligibility Spend-down (Yes/No)
        - MI Health Link health plan (health plan name or blank) – this field should be included to facilitate FSR expenditure reporting for the MI Health Link program Medicaid expenditures
        - Medicaid health plan (health plan name or blank) – this field is not needed in SFY 2020 but may be used to identify the MHP Enrolled/Unenrolled split in future reporting
        - Spend-down effective date
    - Capitation fields
        - Program (capitation based)
        - Population (capitation based)
        - Non-waiver payment flag (Yes/No)
        - CWP 1915(c) waiver payment flag (Yes/No)
        - HSW 1915(c) waiver payment flag (Yes/No)
        - SED 1915(c) waiver payment flag (Yes/No)
        - Non-waiver capitation revenue
        - 1915(c) Waiver capitation revenue
        - Non-waiver capitation PIHP
        - 1915(c) capitation PIHP
9. The final step of the master eligibility file creation is to create one field for program, population and each 1915(c) eligibility field. Priority should be given to the fields from the capitation file. If the capitation file does not have a valid program or population field (or if it is missing), then the program and population field from the eligibility file should be utilized. The capitation component of the 1915(c) eligibility field is based on whether or not an individual received a capitation payment.
10. The final master eligibility file should include the following fields in addition to the fields initially derived from the capitation and eligibility files:
    a. Eligibility type: Medicaid eligible with capitation payment or Medicaid eligible without capitation payment
    b. Program
    c. Population

d. CWP 1915(c) (Yes/No)
e. HSW 1915(c) (Yes/No)
f. SED 1915(c) (Yes/No)
g. Non-waiver PIHP (use eligibility PIHP if no capitation payment)
h. 1915(c) PIHP (use eligibility PIHP if no capitation payment)

Incorporation of Master Eligibility File into Encounters

11. Merge Medicaid program, population, 1915(c) waiver eligibility flags, MI Health Link health plan, and spend-down effective date (if applicable) onto the encounter data. In general, the program and population used to summarize the encounter data for purposes of the EQI will be correct. However, the following overrides need to be considered:
    a. Fund source overrides to follow Medicaid billing rules and other federal regulations
        i. CMHSPs have stated that several fund source overrides have historically been made to comply with Medicaid billing rules. One reason for overrides is that Medicaid cannot pay for services when the primary payer billing rules are not followed. An example of this is Medicare does not pay for certain services rendered by Licensed Professional Counselors (LPCs). Therefore, Medicaid and Medicare dual eligible beneficiaries receiving certain services from an LPC need an override to transition funding to General Fund.
        ii. For purposes of this override, the applicable program and population may need to be modified (e.g. from BH Managed Care DAB/TANF to Non-Medicaid General Fund).
    b. Services identified as Medicaid 1915(c) Waiver eligible
        i. If a member has 1915(c) waiver eligibility and the encounter is an applicable 1915(c) waiver service (for that same 1915(c) waiver, as identified in the service code sets), then override the population assigned to be the appropriate 1915(c) waiver population (HSW, CWP, or SED)
    c. Services incurred prior to spend-down effective date
        i. Determine within encounter data whether claims occur before the associated spend-down date, or on or after the spend-down date
            1. This date reflects the day they become Medicaid eligible. Using the daily 834 eligibility file (5997), users can identify the effective Medicaid eligibility date for spend-down beneficiaries.
        ii. The program and population assigned to services with an incurred date prior to the spend-down (Medicaid eligibility) effective date should be assigned as program = “Non-Managed Care” and population = “General Fund”.
        iii. If the spend-down date intersects a claim, for example an inpatient stay, break the claim into the spend-down portion and the Medicaid portion.
            1. This can be done by duplicating the claim and splitting the utilization and paid amounts proportionately by day
    d. Grant identification
        i. Services that are paid for by grants should be identified and assigned as program = “Non-Managed Care” and population = “Grants”
        ii. Services that are only partially paid for by grants should retain the program and population assigned from the eligibility file, with grants partially reducing Medicaid costs included in the Service UNC and COB tabs as coordination of benefits

III. Coordination between CMHSP and Regional PIHP

A certain degree of coordination will be required between the Regional PIHP and each of the CMHSPs within that region throughout the process of populating the EQI template. This section of the report details some of the anticipated coordination that will be required, by applicable tab within the template.

Service UNC tabs

PIHPs can paste in each of the CMHSP values from their respective Service UNC tab after validating the Medicaid information. General Fund and Grant expenditures input on this tab for CMHSP rows will be ignored in PIHP totals. Regional PIHP units and expenditures from CMHSPs outside of their catchment area should be reported under the "Services contracted through PIHP" rows of the Service UNC tab.

COB Summary - PIHP

The PIHP should summarize the information reported from each CMHSP and then add in additional COB from services rendered by providers contracted directly with the PIHP.

Non-Benefit Expenses

Non-benefit expenses incurred by PIHP employees and non-CMHSP vendors should be included on the retained column. The PIHP should summarize the delegated administrative costs for Medicaid from each CMHSP. Note, the PIHP *delegated* administrative costs in the CMHSP template will be the sum of the retained (if incurred by the CMHSP) and delegated (if the CMHSP delegated to a subcontractor) columns.

Other Expenses

For the BH Managed Care expense category rows, the PIHP should summarize the information reported from each CMHSP and then add in any additional Other Expenses incurred by the PIHP outside of the CMHSP contracts. MH Code Functions lines are duplicated so they can be reported appropriately to Medicaid or General Fund. Any additional Other Expenses incurred by the PIHP outside of the CMHSP contracts should be included in the Grant rows of the Other Expense tab.

Spend-Down Summary

The PIHP should summarize the information reported from each CMHSP.

Hazard Pay Summary

The PIHP should summarize the information reported from each CMHSP and then add in additional expenditures from services rendered by providers contracted directly with the PIHP.

IV. Methodology and Instructions

For the purposes of this analysis, each CMHSP and PIHP will submit the information as requested above to MDHHS. Figure 4 includes the timing for each of the steps in the SFY 2020 behavioral health EQI process:

FIGURE 4: SFY 2020 BH EQI SCHEDULE

BH EQI PROCESS STEP	DEADLINE
Paid Date of Encounters (Adjudicated)	1/31/2021
Encounter Submission by PIHPs to DHHS	1/31/2021
Optum Data to Milliman	2/3/2021
PIHPs Submits Utilization Only Report to DHHS	2/28/2021
Milliman Delivers Utilization Comparison to PIHPs	3/31/2021
Response to observations due to DHHS, explaining variances/questions/or corrective action plans as appropriate	4/15/2021
PIHPs Submits Full EQI Report to DHHS	3/31/2021
Milliman Delivers 2nd Round of Comparisons/Observations to PIHPs	4/30/2021

Milliman will be utilizing the February 3rd extract instead of the January 3rd extract to ensure that all encounters submitted to MDHHS in advance of the 12/31/2020 deadline are included in the analysis.

The following sections provide the methodology and instructions for completing each of the tabs included in the template.

Attestation

The purpose of this tab is to provide a CMHSP/PIHP representative attestation that the information submitted in the tool is current, complete, accurate, and in compliance with 42 CFR § 438.8 and 2 CFR § 200. It should be signed by a representative of the CMHSP/PIHP that is familiar with the information being reported and has the authority to make the attestation (for example, the Chief Executive Officer or Chief Financial Officer). It should also include the contact information of the individual(s) responsible for preparing the tool as submitted. For purposes of the SFY 2020 EQI report, we have included a user input to document whether the user is providing expenditures in the Service UNC and MHL Medicare Service UNC tabs on a gross or net of COB. Future EQI reporting periods will require reporting gross expenditures and the corresponding COB to determine the net expenditures attributable to the Medicaid program. Historically, the MUNC report was done on a net expenditure basis. We have also included an input on the Regional PIHP template to document which data extract Milliman should use for comparison to reported information.

Eligibility and Revenue (PIHP Only)

The purpose of this tab is to collect the eligibility and revenue data for Michigan's behavioral health managed care program. Eligibility and revenue should be attributed to the Medicaid managed care programs and populations using the logic above. We have included two columns to capture the attributed eligibility, a column for capitation payments and another to capture member months for those who are *Retroactively Eligible* for Medicaid. Please note that the PIHPs do not receive any capitation payments and corresponding revenue directly attributed to these retroactively eligible months. These individuals would be identified in Step 9 of the master eligibility file creation with an Eligibility Type of *Medicaid eligible without capitation payment*. We request that the PIHPs report the following revenue separately for individuals who received a capitation payment:

- Capitation Revenue (excluding insurance provider assessment (IPA) and hospital reimbursement assessment (HRA))
- Withhold Earned/Estimated to Receive
- IPA and HRA Revenue
- Net Payments from Risk Corridor
- Other Revenue

We have also included rows to capture the number of capitation payments and associated revenue attributable to DHIP (identified as MCO_Program_Code = '0030'), Opioid Health Homes (HHO) (identified as MCO_Program_Code = '0027'), and Behavioral Health Homes (HHBH) (identified as MCO_Program_Code = '0076').

Service Code Set

This tab is intended to only be a reference and does not require any user input. It includes a listing of all possible service code combinations for the applicable revenue codes, procedure codes, and modifiers. This tab includes the following information:

- Index and service code index – this tab includes an index, but the primary lookup key that should be used is the service code index, as it will better facilitate comparison across multiple years in the future.
- Service codes – the possible HCPCPS code, modifier, hospital type, and revenue code combinations are provided
- Service category and service category detail – the service categories reflect how the services are grouped for purposes of capitation rate development
- Service descriptions – the service description and reporting code description provide further information about each service
- Reporting units – the reporting units reflect the unit type of each service
- MH or SA – this column represents which benefit the service will be allocated to for purposes of capitation rate development
- Qualifying coverages – these columns represent the Medicaid authority for which MDHHS has received CMS approval. If all coverages are identified as "No", then there is no Medicaid authority and the service is either covered via Grants or state General Fund.

Service UNC

The purpose of this tab is to capture the utilization, gross expenditures, and coordination of benefits (COB) for each service code, program, and population combination. If the user has indicated they will be reporting net expenditures on the Attestation tab, please input net expenditures under the gross expenditure column and do not report any coordination of benefits. The Service Code Set tab includes a listing of all possible services and the qualifying coverages (state plan, 1915(i), HSW, etc.). Based on the qualifying coverages, programs, and populations, we created a full listing of the possible codes for each population. We have also included a fund source based on the qualifying coverages, programs, and populations. We have included rows for the 1915(c) waiver populations for all services that are eligible under one of the 1915(c) waiver authorities, regardless of whether the service is considered a Medicaid service broadly to all beneficiaries. Managed care and non-Managed Care populations may receive Medicaid or non-Medicaid eligible services. If a beneficiary receives a 1915(c) Waiver service and they have 1915(c) Waiver eligibility (regardless of the scope and coverage codes of their Medicaid eligibility) for the respective service, then the units and corresponding expenditures should be reported on the applicable 1915(c) waiver population row on the Service UNC (e.g. HSW services provided to HSW enrollees that are Medicaid eligible as HMP should be reported on the applicable HSW population row).

The CMHSP/PIHP should report both the utilization, gross expenditures, and COB for each service code, program, and population combination included in the template. Section II describes the creation of the master eligibility file logic and merging of the eligibility and encounter data. The following provides the steps needed in addition to those to assign an encounter claim to the applicable row on the Service UNC tab:

1. Create the Service Code Index on the encounter claim file, which includes a combination of hospital type, revenue codes, procedure codes, modifiers (in that order). Reference B includes a crosswalk of the possible modifier combinations to the unique modifier combination used within the EQI template.
2. Identify whether the service is a CMHSP Direct-Run or Contracted through a Network Provider. We will be identifying a CMHSP Direct-Run service if the Billing Provider NPI is the CMHSP.
3. Summarize units, gross expenditures, and COB from the encounter claim file by the Service Code Index, Program, Population, and whether the service is CMHSP Direct-Run or a Contracted through a Network Provider.

Utilization, gross expenditures, and COB should be reported for services provided by a CMHSP separately from other services contracted through a mental health and substance abuse network provider. Please note that all **COB should be input as positive expenditures** as these are subtracted from the gross expenditure columns.

Total expenses attributable to grants should be reflected in one of the following areas for CMHSPs:

- Grant population rows on the Service UNC tab (if covering the full cost of the service)
- Grant payer lines on the COB Summary tab (if only partially reducing the Medicaid or General Fund service cost)
- Grant service administrative expenses on the Non-Benefit Expenses tab
- Grant expense category rows on the Other Expense tab

The CMHSP and dual CMHSP/PIHP template includes all the managed care populations as well as rows for grant-funded and general fund beneficiaries. The regional PIHP template mirrors the CMHSP template for rows attributed to each CMHSP and also includes rows for services contracted through the PIHP (other than the CMHSP) for all Medicaid managed care and grant-funded populations. The regional PIHP templates have been developed such that it is permissible to include CMHSP service utilization and cost for Medicaid, General Fund, and Grants on the Service UNC tab. CMHSP expenses incurred for General Fund and Grants should not be included in the regional PIHP templates Non-Benefit Expense and Other Expense tabs. The applicable unit cost for each combination is calculated.

There are both Medicaid and Medicare covered behavioral health services for MI Health Link program enrollees who are dually eligible under the behavioral health program. Behavioral health services only covered by Medicaid should be reported to MDHHS under the behavioral health program on the *Service UNC* tab, including the full cost of the service on the encounter. Behavioral health services covered by Medicare should be handled using the following approach:

- PIHPs should only report claims reimbursed by the ICO for Medicare service to the ICO and not to MDHHS.
- If the Medicare reimbursement does not sufficiently cover the full cost of the service, the PIHPs should report an encounter (beginning in SFY 2022) under the behavioral health program to MDHHS, including the Medicaid paid amount and the Medicare coordination of benefits amount, consistent with other dual eligible beneficiaries. Given there aren't any encounters in SFY 2020 for these services from some PIHPs, the MHL Medicaid costs for Medicare services should be reported on the *MHL Medicare Service UNC* tab, which is described further in the next section. All other Medicaid utilization and service costs should be reported on the *Service UNC* tab.

TOTAL UNITS AND COSTS FOR ALL SERVICES

A. Enter the number of units per procedure code that were provided during the period of this report for beneficiaries with mental illness, serious emotional disturbance, developmental disabilities and substance use disorders for each program and population. For most of the procedure codes, the total number of units should be consistent with the number of units for that procedure code that were reported to the MDHHS warehouse for all consumers. Follow the same rules for reporting units in this report that are followed for reporting encounters. Refer to the Behavioral Health HCPCS and Revenue Code Chart[2] and the Behavioral Health and Intellectual and Developmental Disability Supports Chapter of the Medicaid Provider Manual[3] for additional reporting rules.

B. We have not separately identified services covered under the state plan, early periodic screening, diagnosis, and treatment (EPSDT), or 1915(i) benefits. All of the units and expenditures, regardless of the coverage, should be reported in the applicable CMHSP Direct-Run or Contracted Network Provider column. Please note that non-Managed Care beneficiaries may receive services defined as Medicaid eligible. These services are captured on the Service UNC tab and identified with a non-Medicaid "Fund Source" but will be excluded from the Medicaid managed care program capitation rate development. All 1915(c) Waiver service units are to be reported on the *Service UNC* tab on the applicable 1915(c) Waiver population rows. Lastly, all non-Managed Care service units are to be reported on the applicable rows of the *Service UNC* tab under the applicable population line. Like above, Medicaid beneficiaries may receive non-Medicaid services that are not covered under the managed care capitation rates but are included for completeness.

[2] https://www.michigan.gov/documents/mdhhs/MHCodeChart_554443_7.pdf

[3] https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87572--,00.html

C. Both inpatient service provider types, IMDs and local psychiatric hospitals, are separated out to distinguish between costs with **bundled per diems and those with the physician costs excluded**. CMHSPs/PIHPs making partial Medicaid payments for an inpatient encounter should report the gross cost in addition to the coordination of benefits in the applicable column so that the unit cost reflects the unit cost net of COB.

D. Community inpatient and IMD services reported should **not** include the estimate of the use (days) for incurred but not reported (IBNR) accruals for the current year. Similarly, all other services should not include estimates of the use for IBNR accruals for the current year.

   CMHSPs and PIHPs should report IBNR costs on the *Other Expenses* tab. There are three rows to report IBNR costs (for PT68, PT73, and all other services) incurred in the reporting year but for which there has not been an adjudicated claim at the time the EQI report is compiled.

E. Inpatient units should include services that were provided during the reporting period but funded by prior year savings or carry-forward or by funds pulled out of the ISFs.

F. Inpatient units should not include accruals or adjustments for services provided in previous years.

G. There are two rows to report Hospital Reimbursement Adjustment (HRA) expenditures on the *Non-Benefit Expenses* tab. The HRA expenditures should **not** be included on the *Service UNC* tab. Report HRA expenditures separately for population and program, including HRA corresponding to both institutions for mental disease (IMDs) (PT68) and for community inpatient (PT73). The sum of these amounts reported on the *Non-Benefit Expenses* tab should reconcile with the applicable FSR row.

H. Peer-support specialist services (H0038), Substance Abuse Peer Services (H0038 with HF), Developmental Disabilities Peer Mentor (H0046), and Drop-in centers (H0023), each have a row to report units and costs for those services reported as encounters. In addition, there is a row on the *Other Expenses* tab for peer-delivered expenditures and drop-in center activities that were **not** captured by encounter data (i.e. the row entitled “Services not reported as encounters/Drop-in centers”). It is important that the appropriate numbers are entered in the correct rows for these procedures for different types of peers. Do not aggregate the units and costs into one row.

I. Several codes have rows without modifiers as well as rows with modifiers: for example, 90849 (HS modifier used to distinguish when a beneficiary is not present), H0031 (HW modifier used to determine whether the assessment is a Supports Intensity Scale (SIS) assessment). It is important that the appropriate number of units and costs are entered in the correct rows for these procedures. Do not aggregate the units and costs for the modified procedures into one row.

J. Enter the total expenditures for each procedure code on the *Service UNC* tab under the applicable row for each population (see exclusions below). We have included all applicable procedure codes for each non-Waiver population. We have also included a row for each 1915(c) Waiver service and population combination. The sum of all expenditures is illustrated on the *Financial Reconciliation* tab.

K. The net cost per unit will be automatically calculated by dividing the net expenditures (gross expenditures less COB) by the total units.

L. Rows for substance abuse procedure codes are included in the CMHSP template. If the CMHSP is providing these services or contracting with a provider for these services, then the number of units and total costs should be included. If a PIHP is sub-capitating with a CMHSP for SUD services and the CMHSP is then contracting with other providers, the CMHSP should be reporting these units and expenditures in the service UNC tab. CMHSPs should not include units and costs for services where the PIHP is contracting with SUD providers.

M. Please review the maximum allowable units included in the mental health code charts on the MDHHS website to ensure that you are not reporting units above the allowable threshold[4].

N. The units tied to the following expenditures **must be excluded** from the Service UNC tab:
   a. Local contribution to Medicaid.
   b. Room and board (except for expenditures reported under S9976)

[4] https://www.michigan.gov/documents/mdhhs/MHCodeChart_554443_7.pdf

c. Payments made into internal service funds (ISFs) or risk pools. These payments must not be incorporated into allowable amounts either. The actuary will use the ISF reports submitted with the final FSR to identify use of fiscal year Medicaid revenues for funding of ISF.
d. Provider of administrative service organization (ASO) services to other entities, including PIHP/hub ASO activities provided to CMHSP affiliates/spokes for non-Medicaid services.
e. Write-offs for prior years.
f. Workshop production costs (these costs should be offset by income for the products).
g. Services provided in the state hospitals and Center for Forensic Psychiatry.
h. Mental health services delivered by CMHSP but paid for by health plan (MHP or ICO) contracts.
i. Medicare payments for inpatient days (where CMHSP has no financial responsibility).

ADDITIONAL NOTES FOR NON-MEDICAID SERVICES

A. The service line for reporting cases, unit and costs for State Psychiatric Hospitals was retired in SFY 2016. Local dollars for state psychiatric inpatient are to be reported on the *Other Expenses* tab.

B. The service line for reporting cases, unit and costs for Intermediate Care Facilities for Intellectual and Development Disability (ICF/MR) was retired for FY16.

C. If room and board is reported as encounters (S9976) to the warehouse, enter the units and costs on the *applicable row of the Service UNC* tab. If room and board was not reported as encounters, report it on the *Other Expenses* tab.

D. A row for All Pharmacy (ServiceCodeIndex = AggJCodes) is included on the *Service UNC* tab to report drugs, including injectables, and other biologicals. Do not report "enhanced pharmacy" units and costs in this row, but rather under T1999.

E. Any procedure codes that are not included in the template should be reported in the reconciling items on the Financial Reconciliation tab under the Benefit Expense section. These are typically additional activities provided to individual consumers for which CMHSPs use general funds.

MHL Medicare Service UNC

This tab is specific for dual eligible members enrolled in the MI Health Link (MHL) program. In SFY 2020, the PIHPs managing the MHL program beneficiaries have not submitted encounters to MDHHS for behavioral health services covered by Medicare, which would document the net Medicaid expenditures for these services. The purpose of this tab is to capture the utilization, gross expenditures, and Medicare coordination of benefits (COB) for behavioral health service codes that are paid partially by Medicare under the MHL program. **This information should not be included in the Service UNC tab so that a comparison of the Service UNC to encounter data in MDHHS' data warehouse can be made.**

In general, utilization, gross (net) expenditures, and COB should be reported for each service code, program, and population combination included in the template consistent with the instructions for the Service UNC tab above. The following provides the steps needed in addition to those to assign an encounter claim to the applicable row on the MHL Medicare Service UNC tab:

1. Create the Service Code Index on the encounter claim file, which include a combination of revenue codes, procedure codes, modifiers (in that order). Reference B includes a crosswalk of the possible modifier combinations to the unique modifier combination used within the EQI template.
2. Limit code list to services that are covered by Medicare under the MI Health Link program, as defined on the *MHL Medicare Service UNC* tab.
3. Limit encounters to individuals who are enrolled in the MI Health Link program.
4. Identify whether the service is a CMHSP Direct-Run or Contracted through a Network Provider.
5. Summarize units, gross expenditures, and COB from the encounter claim file by the Service Code Index, Program, Population, and whether the service is CMHSP Direct-Run or a Contracted through a Network Provider.

COB Summary

The purpose of this tab is for the user to allocate the coordination of benefits input on the Service UNC tab to the various payers by program/population (Medicaid, General Fund, and Grants). We have included common payers and have also allowed for users to attribute COB revenue to additional payers. There is a built-in comparison of the total COB input on the COB Summary tab relative to what was provided on the Service UNC tab to ensure that all COB revenue is being allocated. A row has also been included to capture any incurred but not reported (IBNR) COB revenue that is expected to be collected but has not been reported on the Service UNC tabs.

This tab also provides CMHSPs who have created a Special Fund Account authorized in Section 226a (PA 423) of the Michigan Mental Health Code with the ability to document the transition funds to this account. Based on our understanding of the information shared by several different CMHSP representatives, there appears to be varying approaches on how to report the expenses associated with beneficiary service encounters who have other insurance. We have listed below the two different approaches based on our understanding of the discussions and information that has been shared to date. It is our understanding that either of these approaches can be implemented in the original SFY 2020 EQI template. **MDHHS requests that the SFY 2020 EQI template be completed using the approach that the entity has historically used for purposes of transitioning funds to the Special Fund Account. MDHHS will be reviewing these approaches and will provide further guidance in the future regarding the transition of funds to the Special Fund Account authorized in Section 226a.**

Original EQI Instructions

The primary thought behind this approach is to maintain the effective net cost to the Medicaid program with or without PA 423 being effective. In this example, the net cost to Medicaid for the $100 service is $20 because of the $80 of third-party revenue.
In order to transition the COB revenue to PA 423 local revenue, there also needs to be a transition of expenses from Medicaid to General Fund in order to retain the $20 net expenses attributable to Medicaid.

The following provides the original SFY 2020 EQI instructions for reporting the PA 423 funds:

> *This tab also provides CMHSPs who have created a Special Fund Account authorized in Section 226a (PA 423) of the Michigan Mental Health Code with the ability to transition both expenditures and first- and third-party liabilities (i.e. COB) from Medicaid to the applicable fund source. For example, for a Medicaid/Medicare dual eligible individual with a $100 claim and $80 Medicare COB, the entity could transfer the $100 BH Managed Care gross expenditure to General Fund on row 9 of this tab and transfer the $80 Medicare COB from the BH Managed Care column to the PA 423 column on row 28. Please note that the encounters that will be transitioned to General Fund for purposes of adding to the Special Fund Account should be reflected as BH Managed Care service gross expenditures and COB on the Service UNC tab.*

An example of these instructions applied in the EQI template for the CMHSPs is provided below:

	Program/Population				
	BH Managed Care	General Fund	Grants	PA 423	Total
Gross Expenditures	$ 100	$ 0	$ 0		$ 100
Expenditures transferred because of PA 423	(80)	80			-
Gross Expenditures after PA 423 Transfer	20	80	-		100
Total COB by Payer					
Commercial					-
Medicaid Health Plan					-
Medicare	80				80
Personal Income					-
CMHSP Grants					-
PIHP Grants					-
Other Payers (Please Specify)					
					-
					-
					-
					-
					-
					-
Subtotal COB	80	-	-		80
Total COB from Service UNC tab	80	-	-		80
COB difference between Service UNC tab and COB Summary tab	-	-	-		-
COB IBNR					-
COB expenditures transferred because of PA 423	(80)			80	-
Total COB after IBNR and PA 423 transfer	-	-	-		80
Net Expenditures	$ 20	$ 80	$ 0		$ 100

Alternative Instructions

This approach is consistent with the current EQI instructions, except that the net cost to the Medicaid program with PA 423 is higher than without PA 423 because the $100 of expenses associated with the service are retained under Medicaid. The $80 of third-party revenue is still transitioned as PA 423 local revenue. The arguments we heard for this approach include:

- Transitioning Medicaid expenditures to General Fund expenditures for individuals with third-party insurance is against the Mental Health code
  - The Mental Health code indicates that if a person has third-party insurance, that is considered full ability to pay and should not be charged against the General Fund (Chapter 8 Section 12)
- There are additional flexibilities that permit CMHSPs to charge $100 to Medicaid in this example because they are the services are within a sub-capitated arrangement

An example of the alternative instructions applied in the EQI template for the CMHSPs is provided below:

	Program/Population				
	BH Managed Care	General Fund	Grants	PA 423	Total
Gross Expenditures	$ 100	$ 0	$ 0		$ 100
Expenditures transferred because of PA 423					-
Gross Expenditures after PA 423 Transfer	100	-	-		100
Total COB by Payer					
Commercial					-
Medicaid Health Plan					-
Medicare	80				80
Personal Income					-
CMHSP Grants					-
PIHP Grants					-
Other Payers (Please Specify)					
					-
					-
					-
					-
					-
					-
Subtotal COB	80	-	-		80
Total COB from Service UNC tab	80	-	-		80
COB difference between Service UNC tab and COB Summary tab	-	-	-		-
COB IBNR					-
COB expenditures transferred because of PA 423	(80)			80	-
Total COB after IBNR and PA 423 transfer	-	-	-		80
Net Expenditures	$ 100	$ 0	$ 0		$ 100

Lastly, we have also included a row for users to input General Fund net expenditures attributable to helping beneficiaries meet their spend-down requirements (this is only available to CMHSPs, as these expenditures should only be recorded for the General Fund population.

Non-Benefit Expenses

The purpose of this tab is to capture non-benefit expenses attributable to the behavioral health services. For purposes of this template, non-benefit expenses are being defined consistently with CMS' medical loss ratio (MLR) definitions for administrative costs as defined in 42 CFR § 438.8. The intent is that the information collected in this template is at the same level of detail required for the CMS MLR template required annually. MDHHS will be providing a separate template for completion to meet that federal requirement. Additionally, the CMHSPs may be incurring non-benefit expenses for the non-Managed Care population that has previously been included in the unit cost to deliver services.

Non-benefit expenses encompass the following components:

- **Non-claims costs** – Non-claims costs means those expenses for administrative services that are not: Incurred claims (as defined in paragraph (2) of 42 CFR § 438.8); expenditures on activities that improve health care quality (as defined in paragraph (e)(3) of 42 CFR § 438.8); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of 42 CFR § 438.8). The following must be excluded from incurred claims and are considered non-claims costs under subsection (e)(2)(v)(A) of 42 CFR § 438.8:
  - (1) Amounts paid to third party vendors for secondary network savings.
  - (2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

    - (3) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.
    - (4) Fines and penalties assessed by regulatory authorities.
- **Expenditures on activities that improve health care quality** – Activities that improve health care quality must be in one of the following categories:
    - (i) An MCO, PIHP, or PAHP activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150(c).
    - (ii) An MCO, PIHP, or PAHP activity related to any EQR-related activity as described in § 438.358(b) and (c).
    - (iii) Any MCO, PIHP, or PAHP expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in paragraph (e)(2) of this section.
- **Federal, State, and local taxes and licensing and regulatory fees** – Taxes, licensing and regulatory fees for the MLR reporting year include:
    - (i) Statutory assessments to defray the operating expenses of any State or Federal department.
    - (ii) Examination fees in lieu of premium taxes as specified by State law.
    - (iii) Federal taxes and assessments allocated to MCOs, PIHPs, and PAHPs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.
    - (iv) State and local taxes and assessments including:
        - (A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
        - (B) Guaranty fund assessments.
        - (C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
        - (D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
        - (E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.
    - (v) Payments made by an MCO, PIHP, or PAHP that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:
    - (A) Three percent of earned premium; or
    - (B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the MCO's, PIHP's, or PAHP's earned premium in the State.
- **Fraud prevention activities** – MCO, PIHP, or PAHP expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of 42 CFR § 438.8.

Within the template, non-benefit expenses are broken out into delegated and retained expenses. Both PIHPs and CMHSPs may have retained administrative costs to the extent that they are incurring non-benefit expenses within their organization. Delegated expenses would be any non-benefit expense that is passed directly to CMHSPs by the PIHPs or to providers by the CMHSPs. PIHP delegated expenses should be equal to the sum of both retained and delegated non-benefit expenses reported by the CMHSP within their PIHP catchment area.

Other Expenses

The purpose of this tab is to capture other expenses that cannot be attributable directly to an individual service but are being incurred to fulfill responsibilities the CMHSP or PIHP is required to do in their contract with MDHHS. **These expenses should not be duplicative of any expenses reported on the *Service UNC* or *Non-Benefit Expenses* tabs**. This tab includes a description for each allowable other expense as well as the expense category it is anticipated to be attributed to. To the extent that there are other expenses that are not identified in this list that have been incurred by your organization, please include these under the applicable reconciliation Items section on the *Financial Reconciliation* tab under the Other Expenses section. The following list provides the expenses that may be incurred by a PIHP or CMHSP. Many of these items are only included and applicable for CMHSP entities.

A. Incurred but not reported (IBNR) expenses
B. Services not reported as encounters/Drop-in centers
C. Third Party Liability (Coordination of Benefits) Recoveries not reflected as reduced paid claims
D. Overpayments Recoveries Received from Network Providers
E. Incentives, Bonuses, Withholds, and Other Settlements Paid to Providers
F. Total Fraud Recoveries that Reduced Paid Claims (specify in notes if reductions aren't reflected in Service Cost)
G. Net Payments (or Receipts) Related to State Mandated Solvency Funds
    a. Note, the EQI template references ISF, but this should not be included on this line.
H. Provider stability expenses not associated with service utilization
I. Behavioral health home (BHH) and opioid health home (OHH) service expenditures and administrative expenditures (Note: these health home service expenditures are not included on the Service UNC tab).
J. Michigan Rehabilitation Services (MRS), MRS Cash Match
K. PASARR (not reported as encounter or claim)
L. Other Grant expenses associated with MH grants
M. Room & Board (not reported in S9976) funded by grants or general funds
N. Laboratory Procedures
O. Local Match for Forensic Center Only
P. Local Match for State Psychiatric Inpatient
Q. DHS Worker for eligibility determination
R. Transportation (not reported as encounter or claim)
S. Prior year adjustments
T. Jail Treatment Services - Embedded in General Fund Service Cost
U. Jail Treatment Services - Not Embedded in General Fund Service Cost
V. Mental Health Code Functions, separately for Medicaid and General Fund
    a. Jail Diversion
    b. Pre-admission screening (include only costs that are not reported on the Service UNC tab)
    c. 24-Hour Crisis (include only costs that are not reported on the Service UNC tab)
    d. Recipient Rights Process
    e. Other MH Code Functions (specify in notes)
W. Injectable Medications (not reported as encounter or claim)
X. General Fund expenditures on Supportive Innovation Grant
Y. General Fund expenditures on Health Homes

Spend-Down Summary

The purpose of this tab is to summarize the distribution of expenditures before and after the spend-down effective date. Expenditures for individuals who are spend-down eligible but do not meet their spend-down amount should be included in the 'Prior to Spend-Down Patient Pay/GF' column. The total Spend-Down expenditures reported on this tab should reflect the total expenditures attributable to individuals who are identified as Spend-Down based on the logic provided in *Section II. Master Eligibility File Logic.* These expenses will be duplicative of expenses reported on the Service UNC tabs and are for validation purposes only. Expenditures before the spend-down effective date should be included on the Service UNC tabs on the non-Managed Care Program rows for both beneficiaries that meet spend-down for the month and those that do not. These expenditures will also be reported on the 'Prior to Spend-Down Patient Pay/GF' column in the current tab. Expenditures incurred on or after the spend-down effective date should be included on the Service UNC tabs on a BH Managed Care Program row in addition to being reported on this tab by service category as 'Post Spend-Down Medicaid'. The service category for each service code index can be found in the Service Code Set. For a breakdown of the logic used to identify expenditures prior to and after the spend-down effective date, see *Section II. Master Eligibility File Logic*.

Hazard Pay Summary

The purpose of this tab is to report the expenditures attributable to the direct care worker hazard pay increase for applicable services provided during the COVID-19 pandemic. We have included separate summaries for the April to June 2020 time period and the July to September 2020 time period given the different funding sources for the temporary Hazard Pay increase. Expenses attributable to the direct care worker hazard pay increase should be reflected in the unit cost of services, including both the $2 wage increase and the corresponding increase in employer

related costs (estimated at $0.24 per hour). There is an input at the top of each table to document whether the hazard pay increases were paid for a direct care worker's *Direct Time only* or paid for *both Direct Time and Indirect Time*. If the direct care worker was paid a $2 hourly wage increase for both their direct face-to-face time with the beneficiary and their indirect non-face-to-face time, then the entity should select the *Direct Time and Indirect Time* option. The following provides a brief description of the information being requested.

- **Reported expenditures** (column 2) – reported expenditures by each service code are calculated based on the information submitted on the Service UNC tab.
- **Total Encounter units** (column 3) - the CMHSP/PIHP should report units present in the encounters by service code for the entire reporting period. This information will be used for validation purposes to ensure that the data warehouse reconciles with the CMHSP reported information.
- **Encounter units with Hazard Pay Increase** (column 4) - the CMHSP/PIHP should report units where the Hazard Pay increase applied, regardless of whether the expenditures are actually reflected on the encounters. The following provides examples where encounter units should be excluded from this column:
    - Exclude any units incurred before or after the effective time period of the temporary Hazard Pay increase
    - Exclude any units for non-participating providers
    - Exclude any units for services not provided in the home
    - Exclude any units that were reported after CMHSP pay cycle (if the CMHSP does not plan to go back and pay the hazard pay increase for those units)
- **Encounter expenditures** (column 5) - the CMHSP/PIHP should report the total expenditures present in the encounters by service code. This information will be used for validation purposes and to establish the baseline information for the next two columns of information.
- **Actual expenditures included on Encounters for the $2 Hazard Pay** (column 6) – these expenditures are intended to be a subset of column 5, indicating what portion of the total expenditures included on the encounter data are attributable to the $2 hazard pay increase.
- **Actual expenditures NOT included on Encounters for the $2 Hazard Pay** (column 7) – this column documents the expenditures that should be added to the encounter data to fully reflect the $2 hazard pay increase.

The following provide the key objectives for this tab:

- To establish a baseline number of units and expenditures that the CMHSPs believe are represented in the encounter data in the state's data warehouse for validation purposes
- Understand the subset of expenditures currently included in the encounter data for the hazard pay increase
- Understand what the expenditures need to be added to the encounter data to fully reflect the hazard pay increase

CMHSPs/PIHPs should input all expenses paid to providers under the provider stability expenses row of the Other Expenses tab *if the payment was made outside of your normal contract for services and it is not tied to utilization*. In the case where payments were continued with less or no utilization consistent with the terms of the contract, these expenses should be reported on the Service UNC tab.

Financial Reconciliation

The purpose of this tab is to summarize all revenue and expenses from each of the tabs included in the reporting template for review. Additionally, it provides an area for the CMHSP/PIHP to include any Reconciliation Items that would otherwise prohibit the CMHSP/PIHP from reconciling with other MDHHS reporting requirements (e.g. FSR). Note, the regional PIHP templates separately identify CMHSP grant and general fund expenditures reported on the *Service UNC* tab and exclude these expenditures from the *Grand Total PIHP Expenses*.

Notes

The purpose of this tab is to capture any additional notes that regarding the EQI submission that would be helpful to understand the information reported within the EQI template.

V. Limitations and Qualifications

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved September 13, 2019.

The information contained in this letter, including the appendices, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS by us that would result in the creation of any duty or liability under any theory of law by us or its employees to third parties.

Other parties receiving this letter must rely upon their own experts in drawing conclusions about the MDHHS capitation rates, assumptions, and trends. In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and they meet the qualification standards for performing the analyses in this report.

APPENDIX A - EQI FINANCIAL DATA REQUEST
(Provided Separately in Excel)

REFERENCE A – COUNTY CROSSWALK

State of Michigan, Department of Health and Human Services
Behavioral Health EQI Data Collection Tool
County to Region Crosswalk
Reference A

County Name	County Code	CMH	PIHP Name	Region
Alcona	01	NorthEast CMH	Northern Michigan Regional Entity	2
Alger	02	Pathways CMH	Northcare Network	1
Allegan	03	Allegan CMH	Lakeshore Regional Entity	3
Alpena	04	NorthEast CMH	Northern Michigan Regional Entity	2
Antrim	05	North Country Community CMH	Northern Michigan Regional Entity	2
Arenac	06	Bay-Arenac CMH	Mid-State Health Network	5
Baraga	07	Copper CMH	Northcare Network	1
Barry	08	Barry CMH	Southwest Michigan Behavioral Health	4
Bay	09	Bay-Arenac CMH	Mid-State Health Network	5
Benzie	10	Manistee-Benzie CMH	Northern Michigan Regional Entity	2
Berrien	11	Berrien CMH	Southwest Michigan Behavioral Health	4
Branch	12	Pines CMH	Southwest Michigan Behavioral Health	4
Calhoun	13	Summit Pointe CMH	Southwest Michigan Behavioral Health	4
Cass	14	Woodlands CMH	Southwest Michigan Behavioral Health	4
Charlevoix	15	North Country Community CMH	Northern Michigan Regional Entity	2
Cheboygan	16	North Country Community CMH	Northern Michigan Regional Entity	2
Chippewa	17	Hiawatha Behavioral Health	Northcare Network	1
Clare	18	Central Michigan CMH	Mid-State Health Network	5
Clinton	19	CEI CMH	Mid-State Health Network	5
Crawford	20	Northern Lakes	Northern Michigan Regional Entity	2
Delta	21	Pathways CMH	Northcare Network	1
Dickinson	22	Northpointe CMH	Northcare Network	1
Eaton	23	CEI CMH	Mid-State Health Network	5
Emmet	24	North Country Community CMH	Northern Michigan Regional Entity	2
Genesee	25	Genesee CMH	Region 10 PIHP	10
Gladwin	26	Central Michigan CMH	Mid-State Health Network	5
Gogebic	27	Gogebic CMH	Northcare Network	1
Grand Traverse	28	Northern Lakes	Northern Michigan Regional Entity	2
Gratiot	29	Gratiot CMH	Mid-State Health Network	5
Hillsdale	30	Lifeways	Mid-State Health Network	5
Houghton	31	Copper CMH	Northcare Network	1
Huron	32	Huron CMH	Mid-State Health Network	5
Ingham	33	CEI CMH	Mid-State Health Network	5
Ionia	34	Ionia CMH	Mid-State Health Network	5
Iosco	35	AuSable CMH	Northern Michigan Regional Entity	2
Iron	36	Northpointe CMH	Northcare Network	1
Isabella	37	Central Michigan CMH	Mid-State Health Network	5
Jackson	38	Lifeways	Mid-State Health Network	5
Kalamazoo	39	Kalamazoo County CMH	Southwest Michigan Behavioral Health	4
Kalkaska	40	North Country Community CMH	Northern Michigan Regional Entity	2
Kent	41	network180	Lakeshore Regional Entity	3
Keweenaw	42	Copper CMH	Northcare Network	1
Lake	43	West Michigan CMH	Lakeshore Regional Entity	3
Lapeer	44	Lapeer CMH	Region 10 PIHP	10
Leelanau	45	Northern Lakes	Northern Michigan Regional Entity	2
Lenawee	46	Lenawee CMH	CMH Partnership of Southeast Michigan	6
Livingston	47	Livingston CMH	CMH Partnership of Southeast Michigan	6
Luce	48	Pathways CMH	Northcare Network	1
Mackinac	49	Hiawatha Behavioral Health	Northcare Network	1
Macomb	50	Macomb County CMH	Macomb County CMH Services	9
Manistee	51	Manistee-Benzie CMH	Northern Michigan Regional Entity	2
Marquette	52	Pathways CMH	Northcare Network	1
Mason	53	West Michigan CMH	Lakeshore Regional Entity	3
Mecosta	54	Central Michigan CMH	Mid-State Health Network	5
Menominee	55	Northpointe CMH	Northcare Network	1
Midland	56	Central Michigan CMH	Mid-State Health Network	5
Missaukee	57	Northern Lakes	Northern Michigan Regional Entity	2
Monroe	58	Monroe CMH	CMH Partnership of Southeast Michigan	6
Montcalm	59	Montcalm CMH	Mid-State Health Network	5
Montmorency	60	NorthEast CMH	Northern Michigan Regional Entity	2
Muskegon	61	Muskegon County CMH	Lakeshore Regional Entity	3
Newaygo	62	Newaygo CMH	Mid-State Health Network	5
Oakland	63	Oakland	Oakland County CMH Authority	8
Oceana	64	West Michigan CMH	Lakeshore Regional Entity	3
Ogemaw	65	AuSable CMH	Northern Michigan Regional Entity	2
Ontonagon	66	Copper CMH	Northcare Network	1
Osceola	67	Central Michigan CMH	Mid-State Health Network	5
Oscoda	68	AuSable CMH	Northern Michigan Regional Entity	2
Otsego	69	North Country Community CMH	Northern Michigan Regional Entity	2
Ottawa	70	Ottawa CMH	Lakeshore Regional Entity	3
Presque Isle	71	NorthEast CMH	Northern Michigan Regional Entity	2
Roscommon	72	Northern Lakes	Northern Michigan Regional Entity	2
Saginaw	73	Saginaw CMH	Mid-State Health Network	5
St. Clair	74	St. Clair CMH	Region 10 PIHP	10
St. Joseph	75	St. Joseph CMH	Southwest Michigan Behavioral Health	4
Sanilac	76	Sanilac CMH	Region 10 PIHP	10
Schoolcraft	77	Hiawatha Behavioral Health	Northcare Network	1
Shiawassee	78	Shiawassee CMH	Mid-State Health Network	5
Tuscola	79	Tuscola CMH	Mid-State Health Network	5
Van Buren	80	Van Buren CMH	Southwest Michigan Behavioral Health	4
Washtenaw	81	Washtenaw CMH	CMH Partnership of Southeast Michigan	6
Wayne	82	Detroit-Wayne Multiple CMH	Detroit Wayne Mental Health Authority	7
Wexford	83	Northern Lakes	Northern Michigan Regional Entity	2
Foreign	84	Foreign	Foreign	Unknown

REFERENCE B – MODIFIER CROSSWALK

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2020 Modifier Crosswalk Reference B	
Possible Modifier Combination	**Unique Modifier Combination used within the EQI Template**
AM95	AM95
95AM	AM95
AMGT	AMGT
GTAM	AMGT
HAGT	HAGT
GTHA	HAGT
HBGT	HBGT
GTHB	HBGT
HBHF	HBHF
HFHB	HBHF
HBHFGT	HBHFGT
HBGTHF	HBHFGT
HFHBGT	HBHFGT
HFGTHB	HBHFGT
GTHBHF	HBHFGT
GTHFHB	HBHFGT
HCGT	HCGT
GTHC	HCGT
HCHF	HCHF
HFHC	HCHF
HCHFGT	HCHFGT
HCGTHF	HCHFGT
HFHCGT	HCHFGT
HFGTHC	HCHFGT
GTHCHF	HCHFGT
GTHFHC	HCHFGT
HFGT	HFGT
GTHF	HFGT
HKGT	HKGT
GTHK	HKGT
HMGT	HMGT
GTHM	HMGT
HMHA	HMHA
HAHM	HMHA
HMHAGT	HMHAGT
HMGTHA	HMHAGT
HAHMGT	HMHAGT
HAGTHM	HMHAGT
GTHMHA	HMHAGT
GTHAHM	HMHAGT
HMST	HMST
STHM	HMST

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2020 Modifier Crosswalk Reference B	
Possible Modifier Combination	**Unique Modifier Combination used within the EQI Template**
HMSTGT	HMSTGT
HMGTST	HMSTGT
STHMGT	HMSTGT
STGTHM	HMSTGT
GTHMST	HMSTGT
GTSTHM	HMSTGT
HMTT	HMTT
TTHM	HMTT
HMTTGT	HMTTGT
HMGTTT	HMTTGT
TTHMGT	HMTTGT
TTGTHM	HMTTGT
GTHMTT	HMTTGT
GTTTHM	HMTTGT
HMTTHA	HMTTHA
HMHATT	HMTTHA
TTHMHA	HMTTHA
TTHAHM	HMTTHA
HAHMTT	HMTTHA
HATTHM	HMTTHA
HMTTHAGT	HMTTHAGT
HMTTGTHA	HMTTHAGT
HMHATTGT	HMTTHAGT
HMHAGTTT	HMTTHAGT
HMGTTTHA	HMTTHAGT
HMGTHATT	HMTTHAGT
TTHMHAGT	HMTTHAGT
TTHMGTHA	HMTTHAGT
TTHAHMGT	HMTTHAGT
TTHAGTHM	HMTTHAGT
TTGTHMHA	HMTTHAGT
TTGTHAHM	HMTTHAGT
HAHMTTGT	HMTTHAGT
HAHMGTTT	HMTTHAGT
HATTHMGT	HMTTHAGT
HATTGTHM	HMTTHAGT
HAGTHMTT	HMTTHAGT
HAGTTTHM	HMTTHAGT
GTHMTTHA	HMTTHAGT
GTHMHATT	HMTTHAGT
GTTTHMHA	HMTTHAGT
GTTTHAHM	HMTTHAGT

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2020 Modifier Crosswalk Reference B	
Possible Modifier Combination	**Unique Modifier Combination used within the EQI Template**
GTHAHMTT	HMTTHAGT
GTHATTHM	HMTTHAGT
HMTTST	HMTTST
HMSTTT	HMTTST
TTHMST	HMTTST
TTSTHM	HMTTST
STHMTT	HMTTST
STTTHM	HMTTST
HMTTSTGT	HMTTSTGT
HMTTGTST	HMTTSTGT
HMSTTTGT	HMTTSTGT
HMSTGTTT	HMTTSTGT
HMGTTTST	HMTTSTGT
HMGTSTTT	HMTTSTGT
TTHMSTGT	HMTTSTGT
TTHMGTST	HMTTSTGT
TTSTHMGT	HMTTSTGT
TTSTGTHM	HMTTSTGT
TTGTHMST	HMTTSTGT
TTGTSTHM	HMTTSTGT
STHMTTGT	HMTTSTGT
STHMGTTT	HMTTSTGT
STTTHMGT	HMTTSTGT
STTTGTHM	HMTTSTGT
STGTHMTT	HMTTSTGT
STGTTTHM	HMTTSTGT
GTHMTTST	HMTTSTGT
GTHMSTTT	HMTTSTGT
GTTTHMST	HMTTSTGT
GTTTSTHM	HMTTSTGT
GTSTHMTT	HMTTSTGT
GTSTTTHM	HMTTSTGT
HW95	HW95
95HW	HW95
HWGT	HWGT
GTHW	HWGT
SEGT	SEGT
GTSE	SEGT
ST95	ST95
95ST	ST95
STGT	STGT
GTST	STGT

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2020 Modifier Crosswalk Reference B	
Possible Modifier Combination	**Unique Modifier Combination used within the EQI Template**
TDTT	TDTT
TTTD	TDTT
TETT	TETT
TTTE	TETT
TFGT	TFGT
GTTF	TFGT
TFHF	TFHF
HFTF	TFHF
TFTT	TFTT
TTTF	TFTT
TFTTGT	TFTTGT
TFGTTT	TFTTGT
TTTFGT	TFTTGT
TTGTTF	TFTTGT
GTTFTT	TFTTGT
GTTTTF	TFTTGT
TG95	TG95
95TG	TG95
TGGT	TGGT
GTTG	TGGT
TGHF	TGHF
HFTG	TGHF
TGTT	TGTT
TTTG	TGTT
TGTTGT	TGTTGT
TGGTTT	TGTTGT
TTTGGT	TGTTGT
TTGTTG	TGTTGT
GTTGTT	TGTTGT
GTTTTG	TGTTGT
TJGT	TJGT
GTTJ	TJGT
TSGT	TSGT
GTTS	TSGT
TTGT	TTGT
GTTT	TTGT
TTHA	TTHA
HATT	TTHA
TTHAGT	TTHAGT
TTGTHA	TTHAGT
HATTGT	TTHAGT
HAGTTT	TTHAGT

State of Michigan, Department of Health and Human Services Behavioral Health EQI Data Collection Tool SFY 2020 Modifier Crosswalk Reference B	
Possible Modifier Combination	**Unique Modifier Combination used within the EQI Template**
GTTTHA	TTHAGT
GTHATT	TTHAGT
TTHF	TTHF
HFTT	TTHF
TTHFGT	TTHFGT
TTGTHF	TTHFGT
HFTTGT	TTHFGT
HFGTTT	TTHFGT
GTTTHF	TTHFGT
GTHFTT	TTHFGT
TTST	TTST
STTT	TTST
TTSTGT	TTSTGT
TTGTST	TTSTGT
STTTGT	TTSTGT
STGTTT	TTSTGT
GTTTST	TTSTGT
GTSTTT	TTSTGT
TTTJ	TTTJ
TJTT	TTTJ
TTTJGT	TTTJGT
TTGTTJ	TTTJGT
TJTTGT	TTTJGT
TJGTTT	TTTJGT
GTTTTJ	TTTJGT
GTTJTT	TTTJGT
U595	U595
95U5	U595
U5GT	U5GT
GTU5	U5GT
UBHF	UBHF
HFUB	UBHF